PLANNING FOR HEALTHY AND EQUITABLE COMMUNITIES IN BRITISH COLUMBIA:
A CRITICAL ANALYSIS OF THE IMPLEMENTATION OF AN EQUITY LENS IN HEALTHY BUILT ENVIRONMENTS INITIATIVES

by

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Abstract

British Columbia’s communities, as settings in which we work, learn, and play, have a significant role in shaping our health and well-being. Recently, the provincial government has encouraged health authorities to join with local government planners to create local Healthy Built Environment (HBE) teams, so that they can work together for healthier communities.

Within our communities, there are significant differences in health status that are unjust or unfair, and are rooted in underlying socio-political processes. International research suggests that we must reduce those inequities if we are to improve health for all. To help address health inequities, researchers have suggested that public health practitioners use an ‘equity lens’ in their day-to-day work. Yet implementing such a lens is challenging.

This case study explored the implementation of an equity lens in HBE work in BC. The project examined the work of intersectoral HBE teams at the provincial and local levels, through an in-depth examination of HBE projects within three different BC communities. Data was collected through interviews, participant observation, and the collection of key documents, maps, and photographs. The main research question was: How is an ‘equity lens’ being implemented in association with Healthy Built Environments work in British Columbia?

Influenced by the shifting strategic direction of the provincial government, HBE teams reported only limited progress in actively considering equity as integral to their work. The key elements of the implementation of an equity lens included targeting specific, ‘vulnerable’ populations and using community health data to monitor key outcomes. In general, however, the political will to more fully consider equity as integral to HBE work was just not present at either local or provincial levels. There was hope, however, in the form of champions, who worked to re-frame equity issues in more palatable ways, and the desire to explore new tools to better understand equity issues at the local level. There is also evidence of a growing desire within HBE teams to build meaningful, authentic, partnerships, consistent with a broad Healthy Communities approach. The development of those partnerships will be key to collectively building more just, inclusive, and healthier communities.
Preface

This dissertation is original, unpublished, independent work by the author, Victoria J. Barr. The study was approved by the University of British Columbia Behavioural Research Ethics Board, Certificate number H11-02897.
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Chapter 1: Introduction

“the built environment is the embodiment of what we love, our imagination, and our will. It is what we value and reflects what and whom we care about ... I think that when we design and construct environments that give joy and comfort, safety and beauty, we get places that reflect the best of ourselves in which to live our lives.” (Jackson & Sinclair, 2012, p. 3)

We are fortunate to live in British Columbia - a place of incredible natural beauty, in a country with excellent public services to help support our health and wellbeing. It is no surprise, then, that on the whole, British Columbians are among the healthiest people in the world. Yet not all British Columbians are able to experience excellent health. A relatively large proportion of the population who are disadvantaged in some way – the unemployed and working poor, children and families living in poverty, Indigenous peoples, new immigrants, and others – experience significantly worse health than the average British Columbian (The Health Officers Council of British Columbia, 2008, 2013).

Health inequities are reflected by consistent differences in measures of health status, including the prevalence of some chronic diseases, life expectancy, and self-rated health, among people from the highest to the lowest income and education groups across the province. Those inequities appear to be increasing over time (Canadian Institute for Health Information, 2015a; The Health Officers Council of British Columbia, 2013). In general, the lower a person is on the socioeconomic hierarchy, the greater their risk for ill health (Canadian Institute for Health Information, 2015b; Raphael, 2012a; The Health Officers Council of British Columbia, 2008). The reasons for these inequities are complex and caused by the unequal distribution of power, income, services and living conditions. This unequal distribution is, in turn, based on political, social and cultural structures, including education,
taxation and health care systems, labour and housing markets and government regulation (Raphael, 2012b; World Health Organization & Committee on the Social Determinants of Health, 2008).

Local and regional governments across Canada are increasingly forced to deal with complex health and social issues, including poverty, homelessness, and food insecurity. Inequities in health status are now considered to be at the root of many of the social issues that cities and other communities face (Wilkinson & Pickett, 2009). In what Sarah Curtis (Curtis, 2004) calls landscapes of power, urban geographers try to explain the importance of spatial contexts in the development and maintenance of power structures within a city. Socially constructed spaces and the actions of dominant groups interact to reinforce power relations in society. Spatial contexts are important in the development and maintenance of power structures associated with social inequities, which, in turn, influence health equity.

The consideration of these relationships is important for urban and community planning, since the practices of planners and local government officials have the potential to affect those spatial contexts, through the design and use of socially constructed spaces, housing developments and transportation systems. These connections among community planning, the spatial contexts associated with health, and health equity, has led the World Health Organization (WHO) to recommend that planners “place health and health equity at the heart of urban governance and planning” and that both the processes and outcomes of urban planning promote healthy and safe environments equitably (World Health Organization & Committee on the Social Determinants of Health, 2008). As American public health researcher
and advocate Howard Frumkin eloquently sums up, “ultimately, healthy places ... need to be well designed, well built, attractive, and functional for all people who live, work, learn, and play in them” (Frumkin, 2005, p. A290).

Public health and urban planning have enjoyed a long history of partnership going back more than 150 years. Public health and city planning evolved together as a consequence of late-19th century efforts to deal with the harmful health effects of rapid industrialization and urbanization (Corburn, 2004; Frank et al., 2003; Hancock, 1993; Sarkar et al., 2014). While public health worked to establish sewage systems, control rodents and collect garbage, planners used the power of the state to separate populations suspected of causing disease. However, by the latter half of the 20th century, the biomedical model of health, which focuses on the influence of individual lifestyles and genetics, became the dominant paradigm in the health field. The fields of planning and public health drifted apart. Despite the common historical origins and interests of planning and public health, until recently only minor overlaps existed between the two fields (Corburn, 2004).

Fortunately, over the last five to ten years there have been an increasing number of calls for public health practitioners and planners to work collectively at designing healthier and more equitable spaces in our cities and regions. In British Columbia, Health Authorities have been mandated by the BC Ministry of Health to engage with planners, collective work that has given rise to Healthy Built Environments (HBE) projects across the province. Yet to adequately address community health status, the work associated with these emerging HBE projects will need to address the social and economic aspects that are so inherent in health status and
form the root cause of health inequities (Graham, 2007; World Health Organization & Committee on the Social Determinants of Health, 2008). Some researchers and policy makers have suggested that developing and using an ‘equity lens’ during policy development and implementation is one way for diverse fields and sectors to begin to work together to address the complex problems that lie at the root of health inequities (Graham, 2007; Marmot, 2007; Pauly, 2009; Population Health and Wellness - BC Ministry of Health Services, 2005). Such a lens has been considered as part of HBE work in BC, but it has been unclear how this lens has been defined and how it has been used. The use of an equity lens has been suggested from the conceptualization of HBE projects, as early as 2005 (Population Health and Wellness - BC Ministry of Health Services, 2005). Yet we know little about the implementation of the equity lens – that phase of project management in which the project team directs project resources to meet the objectives of the project plan (Watt, 2014) – with regard to HBE work in BC. The research I detail here used a case study approach to critically analyze the implementation of the equity lens in HBE work in BC.

New research associated with the built environments and neighbourhoods of cities and communities is beginning to shed light on the complex ways in which the social, physical and political environments act to influence health status and health inequities, leading many experts in the field to suggest that the way forward to reduce inequities must involve a wide range of sectors working together, with a set of common goals (Sarkar et al., 2014). So the implementation of an equity lens must involve a consideration not just about what to do, but also how to do it.
Using our knowledge of the importance of intersectoral processes in tackling health inequities, and the calls for planners and public health staff to join with other members of the community to tackle health and social issues, it is important to learn more about how that process happens. This line of research considers: who was involved? What challenges were faced? What strategies were utilized? What was achieved in terms of the evolution of public policy? This is important information, especially in the first few years of the initiation of new projects, before any substantive outcomes can be expected. Such an analysis may provide key strategic assistance for those wanting to launch new projects, and it might lend new perspectives to our understanding of the development of key strategic partnerships needed for public policy change. Unfortunately, this kind of a process analysis of the development of intersectoral partnerships for health has rarely been done (O’Neill & Simard, 2006), especially in the last ten years. The latest Canadian study of this kind (found in the peer-reviewed literature) was published in the mid-1990s (Ouellet et al., 1994).

This study is an example of implementation research: a systematic examination of the processes used in the implementation of initiatives, as well as the contextual factors that affect those processes (Peters et al., 2013b). The purpose of implementation research is to understand how and why interventions work in the ‘real world’, in part so that we can find ways to improve them (Peters et al., 2013a). Implementation research helps to fill the gap between what theory and science tells us about effective programs or policies, and what is actually done in practice (Fixsen et al., 2005).
1.1 Purpose and Research Questions

The purpose of this research was to explore the ways in which planners and public health staff are working together to build healthier and more equitable communities, through a critical analysis of the implementation of an ‘equity lens’ as part of the newly developed HBE projects that are led by health authorities in BC. The project was conducted as a case study of HBE work at two levels: the provincial level, in which some key HBE-related policies have been developed, and at the local level - a study of three HBE projects within three different health authority areas in BC.

The overall research question for this study was:

How is an ‘equity lens’ being implemented in association with Healthy Built Environments work in British Columbia?

Sub-questions address more specific aspects of the research, and include:

- How has the ‘equity lens’ been defined, and how did those definitions differ among local planners, public health staff, and provincial-level policy makers?

- What aspects of context (e.g. municipal governance models, role of health authority staff, health authority organizational structures, types of community health issues) affected how the equity lens has been implemented?

- What factors have supported or challenged the implementation of an equity lens in Healthy Built Environments work in BC, and what is needed to overcome those challenges?
Both the provincial level work and the local level initiatives were examined with an emphasis on the degree to which they approached equity and social justice – issues that are vital to improving health, quality of life and human development. The research explores how the equity lens was defined in each setting, with special consideration to the ways in which the lens was defined differently at the provincial and local levels. If an equity lens was used in the development and/or implementation of the HBE work, the research describes how that lens has been conceptualized and its use has been evaluated. Finally, the factors that support and challenge the implementation of an equity lens are described.

1.2 Structure of this Dissertation

The structure of this dissertation is based on the key research question and its three sub-questions. This study is quite interdisciplinary in nature, so I began with a broad review of the existing trends in the literature in three fields, or disciplines: urban / community planning, public health, and sociology/ethics (equity and social justice). In Chapter 2, I present a review of the existing literature related to interactions among each of those three disciplines.

In Chapter 3, I introduce the three HBE projects (in three different cities) that, together, act as the local-level case study for this research. In that chapter I also offer a brief description of the important policy context that has helped to shape the study. Chapter 4 outlines the methodology used, including the design and case selection, as well as details about data collection and data analysis procedures.

In Chapters 5, 6, and 7, I present the results, based on the local level data (for each of the three case study communities), combined with provincial level data. Those three chapters are
organized according to the three research sub-questions: Chapter 5 describes how the equity lens has been defined and used in the three HBE projects, Chapter 6 offers insights about how elements of the local and provincial-level contexts have influenced the ways in which the equity lens has been implemented in those projects, and Chapter 7 describes those factors that have both supported and challenged the implementation of the equity lens. In Chapter 8 I bring the results together, offer a set of conclusions, and provide some ideas for next steps with regard to both research and practice.
This study is based on the interaction of three separate research and practice areas: urban/community planning, public health, and sociology/ethics (equity and social justice). After offering some basic definitions of key concepts discussed in the literature, in this chapter I set the stage for this study by presenting a review of the existing literature related to interactions among each of those three disciplines. The chapter is organized around a Venn diagram (Figure 2, below), which illustrates the ways in which these three key research areas intersect.

I therefore describe four key areas of the literature: links between community planning and public health (healthy built environments), connections between planning and equity/social justice (The Just City and equity planning), links between equity/social justice and public health (health inequities), and how all three key fields or subject areas intersect (healthy cities/communities). I end Chapter 2 with a description of two theoretical frameworks that I used to view both the design of the study and its results.

2.1 Understanding the Complex Influences on Health

The strongest determinants of health are social, economic and environmental – lifestyle and personal decisions or choices shape health, but these choices are constrained by the economic and social opportunities, income, education and quality of the environment experienced by each person or family. City planning and local/regional governments shape the nature of those environments, yet most planning systems do not openly encompass health issues.
Figure 1, below, describes the factors influencing human health as layers of influence. Individuals are at the centre of the figure with a fixed set of genes. Surrounding those individuals are the determinants of health that can be modified. The first layer is personal behaviour and other ‘lifestyle factors’ that can promote or damage health. The next layer, social and community networks, can provide important supports for individuals and families. The third layer includes structural factors like housing, working conditions and access to services. Finally, general socio-economic, cultural and environmental conditions are factors that can affect whole societies (Dahlgren & Whitehead, 1991). Any systematic attempt to improve health must support action at all of these levels.

**Figure 1: Determinants of Health** (adapted from Dahlgren & Whitehead, 1991)

The Ottawa Charter for Health Promotion (World Health Organization et al., 1986) represents a key framework for health promotion worldwide. This important document acknowledges that “the fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity”
Local governments play a significant role in developing and sustaining many of these conditions through their impact on protecting public safety through waste disposal and water systems, food handling and other health-oriented regulations, recreational programs and facilities, education, transportation, economic development and land-use planning. Given the important role of local government in community health, many researchers have identified urban planning as a key sector to become involved in building healthier and more equitable communities.

2.2 Key Definitions and Concepts

Before delving into the literature, it is important to briefly define some key terms. In this discussion, I take the view that health is much more than a lack of illness or disability. Health also encompasses mental and social well-being, quality of life, life satisfaction and happiness. In this study, I therefore define health quite broadly, consistent with the definition that has been provided by the National Collaborating Centre for Determinants of Health: “Health is the physical, spiritual, mental, emotional, environmental, social, cultural and economic wellness of the individual, family, and community” (National Collaborating Centre for Determinants of Health, 2014, p. 2).

Variations in our individual and societal/collective experiences with the determinants of health translate into variations in health status. This type of observable variation between population groups is frequently referred to as an inequality or disparity. When inequalities are considered unfair and avoidable, even unjust, then they are referred to as inequities (Kawachi et al., 2002). Because the term ‘inequities’ offers the opportunity to question those
differences and acknowledge the struggles they create, it is the term I prefer. The World Health Organization (WHO) defines health equity as “the absence of unfair and avoidable or remediable differences in health among populations or groups defined socially, economically, demographically or geographically” (World Health Organization & Committee on the Social Determinants of Health, 2008). **Social justice** can be defined as “a particular application of just principles to conflicts which arise out of necessity for social cooperation in seeking individual advancement” (Harvey, 1973, p. 97), or, more simply, a “just distribution justly arrived at” (Harvey, 1973, p. 98). In a contemporary context, social justice is typically taken to mean distributive justice.

A **community** can be both spatial and non-spatial. However, for the purposes of this review I am concerned mostly with spatial communities, particularly those communities designated as municipalities. In addition, the focus here is on community health, rather than the health of individuals or families. Health at the community level is far more than an aggregate of the health of its individual residents. Community health is also about how well the community functions, whether the community as a whole is ‘healthy’ (Hancock et al., 1999). There are a variety of ways to conceptualize and measure community health, which vary between countries and among various cultures. In Canada, the most commonly measured elements of community health are air/water quality, safety/security, housing affordability and quality, commitment to public services, economic disparity, unemployment, educational attainment, and illness among residents (Frankish et al., 2002). Decades of epidemiological evidence suggests that the factors that determine the health of a community relate to meeting the
basic needs of all residents, achieving adequate levels of social and economic development, nurturing mutually supportive social relationships, and ensuring the quality and sustainability of the natural environment (Hancock et al., 1999).

An equity lens is an example of a health equity tool – a resource that helps promote the inclusion of health equity in policies or programs. These tools often include a set of questions, or a framework, that allows practitioners to assess a program, project, or policy for the ways in which that project has the potential to affect health equity (Pauly et al., 2013). As discussed in Section 3.2, the equity lens has not been well described or defined in the original documents that were meant to help guide HBE work in BC. However, some local governments in other provinces and US states have developed initial guidelines for using an equity lens, although in most cases, that lens is not associated with health outcomes. The City of Toronto, for instance, has described their Equity Lens in this way:

“*The Equity Lens is a practical tool that helps to ensure City policies and programs result in equitable outcomes for all residents. It is a tool that helps the Toronto Public Service to consider equitable treatment of Toronto’s diverse communities and workforce when planning, developing and evaluating City policies, programs and services … The Equity Lens is a set of questions that you can ask yourself when you are planning, developing and evaluating a policy, program or service. These questions will help all of us diagnose barriers and identify, measure, and evaluate best practices within access, equity and diversity. “* (City of Toronto, 2009)

Because social equity and health equity are so interconnected (see Section 2.3.4), I use the terms ‘health equity lens’ and ‘equity lens’ interchangeably.

**Planning** is a field of study and practice that includes:

“*designating land use, designing social and community services, managing cultural and heritage resources, creating economic capacity in local communities and addressing transportation and infrastructure.*” (Canadian Institute of Planners, 2016)
Planning is a very broad field, yet most HBE work in BC focuses on land use planning as the key function or role that is linking with public health professionals. In most cases, therefore, when I refer to planning, I am emphasizing the land use aspects of the field. It is important to note that social planning, which includes those efforts to deal with social issues, including homelessness, poverty, and access to transportation at the community level (Clague, 1993), is vital to building healthier communities. However, social planning cannot necessarily be equated with planning while using an equity lens, because the effects of inequities on the wellbeing of the entire community is not necessarily considered as a framework for practice. More specifics about the implementation of an equity lens, including an exploration of the health gradient, is provided in Chapter 2, Section 2.3.

Finally, public health is defined as a professional field that uses a combination of programs, services and policies designed to keep people healthy and prevent injury, illness and premature death (Butler-Jones, 2008; Last & International Epidemiological Association, 2001). Within BC, many public health professionals work in public health departments within regional health authorities.

### 2.3 The State of the Literature: Three Sets Overlapping

The following section reviews the research in this area, and places this study in the context of that literature. The intent of this section is not to present a comprehensive review of the literature, but to highlight relevant trends in the literature and the research gaps that remain.

As illustrated in Figure 2, below, the literature that I present in this dissertation derives from three separate sets of research areas: equity and social justice, planning, and public
health. Where planning and public health intersect, without consideration of equity and social justice, the focus is on developing Healthy Built Environments. Where equity and social justice intersects with public health, the result is the rapidly growing area of health inequalities, health inequities, and health disparities\(^1\). Where equity and social justice connects with planning, practitioners and researchers talk about equity planning, advocacy planning, and some planning theories that consider utopian ideals of the city, including the ‘just city’. Finally, when all three areas converge, researchers and practitioners practise in the realm of Healthy Cities/ Healthy Communities, Healthy Urban Planning, and Healthy City Planning.

The literature in which each of these three fields converge will be briefly explained in turn: first the connections between planning and public health, then the connections between equity and social justice and planning, and the ways in which the literature draws connections between equity and social justice and planning. Finally, I will explore the ways in which the literature and key international policy and programs highlight the convergence of all three fields, through a description of the essential elements of Healthy Cities/Communities, Healthy Urban Planning, and Healthy City Planning.

\(^1\) In Europe, Australia and New Zealand, the term ‘health inequalities’ is used. In the United States, the preferred term is ‘health disparities’. Canadian researchers and policy makers often refer to ‘health inequities’.
2.3.1 Connections between Planning and Public Health: The Birth and Rebirth of a Partnership

Public health and planning have enjoyed a long history of partnership going back more than 150 years. In fact, a concern for public health presented a key impetus for the birth of Canadian planning:

“the issues of public health, fire safety, and adequate housing became the first social goals of community planning. These issues would be found, time and again, enshrined in the preambles of planning legislation proclaiming that the bylaw or plan was aimed at ‘improving the health, safety, and public welfare’ of the community” (Hodge & Gordon, 2008, p. 72).

Public health and city planning in North America evolved together as a consequence of late-nineteenth century efforts to deal with the harmful health effects of rapid industrialization.
and urbanization. From about 1820 through to the end of the 19th century, industrialization, trade and migration led to massive changes in the size, form, and demographic makeup of cities all over the world. In North America², nineteenth century industrial cities were densely settled, with most residents living in a relatively small geographic area. There was also a mixture of functions, with homes, businesses, manufacturing, recreation and schools built next to one another. Cities of the time, then, were highly walkable; people lived close to where they worked, and so were able to commute on foot. However, the very conditions that made the industrial city highly walkable were also blamed for making these environments crowded, dirty, noisy and unsafe places (Frank et al., 2003). Of course, the poor were the worst off, many of whom were living in crowded, poor quality housing.

Beyond the housing issues, early North American cities also lacked clean water, sewage treatment, and garbage collection systems. The City of Toronto had a public water system in place as early as 1872, but many homes in the city were not connected to it. Some residents still used well water or shared an outdoor city water faucet with neighbours. Backyard privies were common, and when they leaked or overflowed, they contaminated water in nearby wells. Some houses had no toilet facilities at all and residents simply threw the contents of their chamber pots into street gutters or their yard. Until 1912, sewer waste was dumped directly into Lake Ontario, which also acted as the source of drinking water (City of Toronto Archives, 2010).

² Most of the available literature on the historical connections between planning and public health is American. To add to the Canadian content in this section, I have included examples from the City of Toronto.
A result of these unhealthy living conditions in early North American cities was the rapid spread of communicable disease, including yellow fever, cholera, and tuberculosis (Frumkin et al., 2004). In Toronto, typhoid and smallpox were common (City of Toronto Archives, 2010). Physicians and early health researchers hypothesized that miasma – dirty and foul-smelling air – was the cause of these rapidly spreading diseases. Although the miasma theory of disease has, of course, been replaced by germ theory, it did help to make the connection between poor sanitation and disease.

Public water and sewage systems established in the early 1900s (1912 in Toronto) helped reduce the spread of disease in urban centres, but these improvements were accompanied by industrial growth that resulted in air and water pollution.

That industry attracted people from rural areas and immigrants from other countries, and from the nineteenth century through the twentieth century, North American cities grew quickly. Coupled with some challenging physical conditions, cities became places of crowding and social dislocation. Immigrants and members of ethnic minorities crowded into poor urban neighbourhoods, and the central cities became pockets of concentrated poverty (Frumkin et al., 2004). Public health staff responded to the continued incidence of disease in these areas by removing the sick in large quarantines, a strategy that some felt were used to justify policies of social exclusion (Corburn, 2009).

Reformers associated with the planning field argued that parks and open outdoor recreation areas were needed to alleviate crowded and unhealthy urban living conditions, including prominent landscape architect Frederick Law Olmsted, who suggested that compact
urban design led to living conditions in which ‘sickening’ and ‘deadly’ gases could not be eliminated (Frank et al., 2003). By the early 20th century,

“modern American urban environmental health planning emerged as a field that used physical interventions to respond to urban public health crises ... the driving ideology was physical removal, of both ‘environmental miasmas’ – garbage, waste water, slum housing, ‘swamp’ land, and so forth – and ‘undesirable and sick’ people” (Corburn, 2009, p. 37).

At about this time, zoning regulations first appeared in Germany and the United States. Early proponents argued that zoning would create a more orderly city, and separating residential districts from noxious industrial uses was seen as a key public health strategy (Frumkin et al., 2004). The first Canadian zoning by law was enacted in London, Ontario in 1903. There were (and, arguably, still are) serious concerns that zoning bylaws worked to segregate racial, ethnic, or income groups. The key goal of the early North American zoning advocates was the protection of the physical health and financial well-being of the upper classes, not immigrants and the poor (Frank et al., 2003). They wanted to protect property values in the low-density, leafy suburban environments in which more and more wealthy, mostly white, families were living. Zoning “effectively ‘immunized’ wealthy and white populations from having the poor and African-Americans live in their neighbourhoods” (Corburn, 2009, p. 45).

While the fields of public health and planning shared this common birth and early development, by the middle of the 20th century, the focus of each discipline had begun to change. The biomedical model of health, which focuses on the influence of individual lifestyles and genetics, became the dominant paradigm in the health field, and the focus of public health (especially the health promotion sub-specialty) shifted to personal ‘risk factors’ of
smoking, diet, and physical activity. At the same time, planners across North America focused their efforts on ‘urban renewal’ (in the form of improving housing conditions and slum clearance) and highway construction. The fields of planning and public health drifted apart.

Fortunately, over the last ten years, members of both fields have begun to take steps to re-establish this important relationship. From the research side, there are now hundreds of new studies that explore the relationships between land use, transportation systems, urban design characteristics, recreation, housing, and food systems with health. Many of those studies have been published since 2003, when both the American Journal of Public Health and the American Journal of Health Promotion published special issues dedicated to this topic, kick starting a wave of new research that shows no sign of slowing down.

While the research that directly links community planning and public health as fields is relatively new, that literature draws on decades of work that examines the effects of social policy on well-being and quality of life, both important components of health. In the interests of brevity, I have presented here only that research that is most pertinent to the Healthy Built Environments work now being developed in BC and elsewhere in Canada.

Much of this research is a reaction against urban sprawl and the tendency (since the 1950s and 1960s) for North American cities to separate residential from other land uses, build relatively large homes on large lots, and plan transportation environments that favour the car, not pedestrians or cyclists. A number of excellent reviews (e.g. (Barton et al., 2015; Bauman & Bull, 2007; Dannenberg et al., 2011; Frank et al., 2003; Frank & Kavage, 2008; Frumkin et al., 2004; Heath et al., 2006; Jackson & Sinclair, 2012; O. Ferdinand et al., 2012; Sallis & Glanz,
2009; Transportation Research Board & Institute of Medicine, 2005) agree about the following associations between aspects of the built environment and health:

- **Physical Activity** - People who live in homes within ‘walkable’ communities walk more and drive less than people who live in sprawling, automobile-dependent communities.

Walkable communities have the following characteristics:

- They are centrally located, so that public transit is easier to access and commute distances are shorter;
- They are compact, with higher residential densities, so that residents can more easily walk to visit friends or shop;
- They consist of mixed uses within the same small geographical area, combining homes, shops, and services;
- They have interconnected street networks (often a ‘gridiron’ street layout), rather than cul-de-sacs or large, busy highways, that can discourage walking and cycling; and,
- The landscape in the community is designed for pedestrians, with narrow streets, wide sidewalks, safe street crossings, and architecture that is easily accessible and visually appealing (Frank & Kavage, 2008).

The research has consistently found that residents of walkable communities have higher physical fitness levels and lower obesity rates than do residents of more automobile-oriented communities. Conceptual models guiding this stream of research have suggested that different types of physical activity (e.g. activity for leisure purposes, active transportation) are
influenced by different characteristics of the built environment (Giles-Corti et al., 2005; King et al., 2006; Owen et al., 2004; Sarkar et al., 2014). Leisure-time physical activity may be most affected by access to, and characteristics of, recreation facilities, whereas active transportation may be most related to walkability of the neighbourhood (Brownson et al., 2009).

- **Food Environments and Healthy Eating** – People who live in neighbourhoods in which there are accessible and affordable stores that carry healthy foods (e.g. lean meats, fresh fruits and vegetables, whole grains) appear to have healthier eating patterns than those who live in communities in which healthy food is more difficult to access. Many studies have highlighted income, urban/rural, and ethnic/racial inequities with regard to food access. Lower income, minority urban neighbourhoods and rural areas lacking supermarkets are sometimes referred to as “food deserts” (Morton & Blanchard, 2007). The high concentration of fast-food restaurants in some lower-income neighbourhoods has also been identified as a potential contributor to a higher prevalence of obesity (Brownell, 2004).

- **Exposure to Air Pollution** – Research that has combined issues of land use, transportation planning, and environmental health has consistently demonstrated that walkable communities are associated with less driving per capita. The study of air quality is complex, especially when one considers the variety of potential pollutants in the air, and their range of sources. However, cars and trucks are considered among the most important sources of many harmful air pollutants. The result is that people living in more
walkable neighbourhoods breathe air with fewer pollutants, and therefore experience a reduced risk of some respiratory and cardiovascular diseases (Frumkin et al., 2004).

- **Pedestrian and Traffic Safety** – Lower density, disconnected neighbourhoods in which people are forced to drive to work, shops, or services are associated with a higher risk of car crashes, just through greater exposure. In addition, pedestrians and cyclists report feeling less safe in environments in which traffic speed is high, street crossings are challenging, and sidewalks are poorly lit or non-existent.

- **Mental and Social Health** – The research in the exploration of the relationships between built environment and mental and social health is much less well developed than that of other sub-areas (especially physical activity). However, there is at least speculation at this point that urban sprawl works to separate people and degrade social relationships, in part because many suburban dwellers spend so much time commuting that they have less time for their families, social activities with friends, or volunteering for church or other community-based organizations (Frumkin et al., 2004). Robert Putnam, in his 2001 book *Bowling Alone*, brought to public attention the decline of social capital in the United States since the 1950s. Putnam defined social capital as “connections between people – social networks and the norms of reciprocity and trustworthiness that arise from them” (Putnam, 2001). Social capital is important for health because it is linked with social relationships, which can be powerful forces for both maintaining good health and for fostering healing when one’s health is compromised. Some researchers have speculated that part of the decline in social capital is related to an increase in sprawl. For instance,
leading researchers Howard Frumkin, Larry Frank, and Richard Jackson (2004) note that sprawl could undermine social capital by restricting the time and energy people have for civic involvement, reducing opportunities for spontaneous social interaction with neighbours, and segregates people into relatively homogenous suburban neighbourhoods.

Beyond the research literature, it is also important to consider the policy context related to the emergence of the collective work of planning and public health. This policy and practice area is rapidly developing, especially as some governments have begun to see merit in using the results of the recent research described above.

Most of the emerging work in the United States and Canada is focused on bringing municipal planners and public health staff together to examine the potential health impacts of key directions in Official Community Plans, regional growth strategies and major development proposals. This type of work is often referred to as Healthy Built Environments (HBE).

Most of the HBE work in the planning or implementation phases focuses on active transportation and urban design that promotes physical activity. For instance, Miro and Siu (2009), of Smart Growth BC, suggest four goals of HBE work:

- Improving air and water quality;
- Getting people outdoors and active – e.g. enabling active transportation, and providing green space;
- Building community and connecting neighbours to each other – e.g. designing crime-free, well-serviced neighbourhoods, providing affordable housing choices; and,
• Increasing access to healthy eating choices – e.g. zoning for mixed uses, enhancing farmland and promoting local agriculture (Miro & Siu, 2009).

This relatively narrow approach builds on widespread dissatisfaction with the anonymity and lifestyle that urban sprawl encourages. The adverse health effects of sprawl are emphasized, including the negative health effects of long commutes, limited physical activity opportunities in suburban neighbourhoods, and the relative social isolation of life in lower density environments. While there is some discussion about building social networks and exploring potential ways to plan for more inclusive communities, especially with regard to seniors and children, the emphasis continues to rest on changing aspects of the ‘built environment’ through urban design.

In another example, the document Healthy Communities, Sustainable Communities from the Ontario Professional Planners Institute (2007) does mention poverty, unemployment and social cohesion, but focuses many of its policy recommendations on urban design and transportation planning. Toolkits and other recent documents designed to bring the two fields together (e.g. (Ontario Professional Planners Institute, 2007; Provincial Health Services Authority, 2009)), also encourage a vision of a ‘healthier community’ that influences personal health behaviours (or lifestyle) such as becoming more physically active and eating healthier foods. There is some focus on improving air quality, reducing neighbourhood-level crime and even food security and affordable housing, but these more social factors are far overshadowed by the emphasis in this work on individual behaviour change.
The following conclusion of an extensive review of HBE research (Sallis & Glanz, 2009) illustrates the focus on policy change in land use, transportation, recreation and building codes:

“zoning ordinances continue to favor low-walkable developments; transportation investments for pedestrian and cycling facilities are trivial; parks are low priorities in many communities; school-siting decisions are not coordinated with community planning; and building codes do not consider physical activity inside and around buildings. Thus every day, buildings, communities and roads are constructed that discourage or prevent physical activity, and these built environments will last a long time” (Sallis & Glanz, 2009, p. 143).

2.3.2 Connections between Equity, Social Justice and Planning

“It would be wonderful if the shapes of our cities maximized utility for everyone. It would be wonderful if city builders were guided purely by an enlightened calculus of utility. But this is not how the world works. Urban spaces and systems do not merely reflect altruistic attempts to solve the complex problem of people living close together, and they are more than an embodiment of the creative tension between competing ideas. They are shaped by struggles between competing groups of people. They apportion the benefits of urban life. They express who has power and who does not. In so doing, they shape the mind and the soul of the city.” (Montgomery, 2014, p. 227)

The field of planning has a rich history in issues of equity and social justice. In this section I will briefly review some debates within planning theory that relate to social justice, and then describe how some planners in the 1960s and 1970s worked to incorporate social justice into their practice.

The built environment is a critical setting for considerations of equity because it influences the complex and interrelated social, political, and economic factors that help form the conditions in which people live, learn, work, and play (Ng, 2016; Zupancic et al., 2016). Those conditions form spatial contexts in the development and maintenance of power structures within a city. Socially constructed spaces and the actions of dominant groups interact to reinforce power relations in society. The consideration of these relationships is important for
urban and community planning; decisions made by planners everyday affect those spatial contexts. Planners and local government officials routinely make decisions that affect who can live where and by what means individuals and families can travel to access basic resources and services.

Marxist geographer David Harvey explored the possibility of applying the distributive principles of justice suggested by Rawls (Rawls, 1971) to the planning and management of spatial systems such as cities and regions. In this way Harvey attempts to explain the basis of inequities that exist in the way urban space is occupied and utilized. In his key 1973 book, *Social Justice and the City*, Harvey points out that the way space is organized can have a profound effect on social processes, and that problems are best approached by a new way of thinking of the city that encompasses both the sociological and geographical “imaginations” (Harvey, 1973). The challenge is that the relationship between social processes and urban form is complex and continuously changing.

Reducing inequities (and working toward social justice) will require the redistribution of resources within the urban system, Harvey claims. Since the 1950s, the growth of a capitalist economic system in the United States has resulted in a change in the spatial form of cities. These changes in spatial form have altered the location of job opportunities and affordable and accessible housing – the rich and relatively resourceful within a city can reap great benefits from this spatial form, while the poor have increasingly limited opportunities. Harvey argues that in a capitalist system, inequality is inescapable, change through a naturally arising
political process is unlikely, and that, by collaborating with property developers, planners have contributed to creating a spatial form that exacerbates inequities (Harvey, 1973).

According to Harvey, the redistribution of income within a city can be brought about by changes in the location of jobs and housing, the value of property rights, and the price of resources to the consumer. The introduction of policies to achieve these goals will depend, he says, on a broad, interdisciplinary assault on the social process and spatial form aspects of the city system (Harvey, 1973).

The philosopher John Rawls, in his book *A Theory of Justice* (1971), proposed principles to guide the assignment of rights and duties in society, and to define the ‘just’ distribution of the benefits and burdens of social co-operation. Rawls suggested two principles:

- "Each person is to have an equal right to the most extensive scheme of equal basic liberties compatible with a similar scheme of liberties for others" (p. 60); and,
- "Social and economic inequalities are to be arranged so that they are to be of the greatest benefit to the least-advantaged members of society (the difference principle) and offices must be open to everyone under conditions of fair equality of opportunity" (Rawls, 1971, p. 303).

So, according to Rawls, fairness and justice require that resources and opportunities are distributed equally (‘primary social goods’). In contrast, Amartya Sen argues that justice requires that resources and opportunities are distributed in ways which enable people to live lives which have equal value to them (‘capabilities’) (Sen, 1995). Taken together, these two perspectives propose that just and fair societies are those whose structures and institutions promote equality in basic freedoms, with Sen looking beyond equality in what people have, to equality in what they can do and achieve. The concepts of primary goods and capabilities can
be extended to include access to resources and opportunities needed for good health (Graham, 2007).

But equity is more than just about distribution of resources and opportunities. According to Iris Marion Young, reducing a discussion of social justice to distribution tends to focus thinking on the allocation of material goods, income or wealth, possibly obscuring broader social structural issues of power, the division of labour and culture (Young, 1990). So equity and social justice also include a consideration of power, decision-making and respect. The thought, choice and action or agency of individual actors interacts with the power structure of the society in which they live, producing mental and physical health differences between more and less powerful social groups. Discussions of health equity and the development of an equity lens need to take these deeper values into account.

The United Nations has identified three critical domains of equality and equity as central to fair distribution: equality of rights, equality of opportunities, and equity in living conditions (The International Forum for Social Development, 2006). Specific to efforts at the local level, four different types of equity are most relevant:

- Procedural equity – inclusive and meaningful engagement in planning processes and decision making;
- Distributional equity – the fair distribution of benefits and burdens across all groups within the community, with priority for those in most need;
• Structural equity – a recognition of historical, cultural, and institutional structures and traditions that have routinely disadvantaged some groups in the community, while providing advantage for already privileged groups; and,

• Transgenerational equity – decisions are made with consideration of the potential impacts of those decisions on future generations (Park, 2014).

Peter Marcuse and Ronald van Kempen (2002) explore the relative roles of the state and globalization in creating a spatial form in which the rich and the poor are separated from one another - to create what they call the ‘partitioned city’. Marcuse and van Kempen confront their fear that state and local governments are helpless to do anything but tinker with this design – that “under the relentless pressure to compete, urban leaders have no choice but to move even faster in the direction all the others are going, each seeking their own bit of competitive advantage over each of the others.” (Marcuse & van Kempen, 2002, p. 3). Their analysis concludes that powerful forces of economic systems, including the distribution of wealth and power in the market, combined with a complex array of other factors, including ideologies and cultural beliefs, have had a key role in establishing partitioning. But the state is not powerless; it has had a central role in the implementation of partitioning, and therefore can be effective in influencing to what extent and in what form partitioning takes place in the future.

More recently, Edward Soja has argued that justice has a geography, and that the equitable distribution of resources, services, and access is a basic human right. It is crucial therefore, in both theory and practice, to emphasize the spatiality of justice and injustice at all
geographical scales, from the local to the global (Soja, 2010). To support planning systems and practices that help to reduce injustice, we must be aware of the spatial component of underlying power structures continually operating within the day to day workings of cities and communities:

“The normal workings of an urban system, the everyday activities of urban functioning, is a primary source of inequality and injustice in that the accumulation of locational decisions in a capitalist economy tends to lead to the redistribution of real income in favor of the rich over the poor. This redistributive injustice is aggravated further by racism, patriarchy, heterosexual bias, and many other forms of spatial and locational discrimination ... these processes can operate without rigid forms of spatial segregation.” (Soja, 2009, p. 3)

Adding an emphasis on the spatial aspects of justice opens up new ideas for social and political action (Soja, 2010), and planners can play an important role in supporting that action.

The Just City

Susan Fainstein (2005) states unequivocally that “the purpose of planning is to create the just city” (Fainstein, 2005, p. 121). A theory of the just city values participation in decision making by relatively powerless groups in society, and aims to achieve equity in outcomes. Those outcomes include relative material equality as both a pre-condition and outcome of urban development, coupled with a culture of tolerance and a commitment to equity (Fainstein, 2000).

One of the ways in which a ‘just city’ has been conceptualized is by introducing the concept of diversity. Social diversity can be linked to equity in two important ways. First, social diversity is equitable because it ensures better access to resources for all social groups – it builds the ‘geography of opportunity’. Second, diversity can be seen as a utopian ideal; mixing
population groups together in one space is the ultimate basis of a better, more creative, more tolerant and peaceful world (Talen, 2008). In a more ‘just’ or equitable city, groups of people interact with one another without exclusion, in what Iris Marion Young (1990) calls “openness to unassimilated others”. In such a city, Young argues:

“different groups dwell in the city alongside one another, of necessity interacting in city spaces. If city politics is to be democratic and not dominated by the point of view of one group, it must be a politics that takes account of and provides voice for the different groups that dwell together in the city without forming a community.” (Young, 1990, p. 227)

So the outcomes of efforts to embrace equity and social justice include the development of institutions that promote respect for differences between groups without oppression – a key component of a more diverse city.

In Towards Cosmopolis (1998), Leonie Sandercock’s conceptualization of the just city is one that is socially inclusive, where difference is not merely tolerated but treated with recognition and respect. Sandercock describes her utopia in this way:

“I dream of a city in which action is synonymous with change, where social justice is more prized than law and order, where I have a right to my surroundings and so do all my fellow-citizens ... I want a city where the community values and rewards those who are different ... I want a city where my profession contributes to all of the above, where city planning is a war of liberation fought against dumb, featureless public space as well as against the multiple sources of oppression and domination and exploitation and violence; where citizens wrest from space new possibilities, and immerse themselves in their cultures while respecting those of their neighbours, and collectively forging new hybrid cultures and spaces.” (Sandercock, 1998, p. 219)

Finally, Susan Fainstein’s new book, The Just City, (Fainstein, 2010), urges planners to embrace a different approach to urban development that builds on the equity concerns of material well-being with considerations of diversity and participation. She then presents a series of principles to guide planning and policy, principles that support the development of
affordable housing, accessible public transit, economic development schemes that give priority to the interests of employees, and enhancing the role of diverse populations in planning processes.

**Advocacy and Equity Planning: Putting Efforts towards the Just City into Practice**

In the 1960s and 70s, small groups of planners began to discuss and practice an alternative form of planning called ‘advocacy planning’. Advocacy planning began in response to political practices that excluded the poor and to the rigid devotion of the planning profession to physical planning with little community involvement (Clavel, 1994). In 1965, Paul Davidoff proposed that planners reach out to the poor and minority groups in their cities, acting as advocates and enticing debate on fundamental issues. These planners experienced some success in broadening the focus of the profession, at least at that time and within some regions (Clavel, 1994).

Equity planning is a framework that has much in common with advocacy planning. In equity planning, planners work within government to use their research, analytical, and organizing skills to influence opinion, mobilize underrepresented populations, and advance policies and programs that redistribute public and private resources to poor or marginalized groups in the community (Metzger, 1996). The story of a group of Cleveland planners, led by Norman Krumholz in the 1970s, tells of the challenges and rewards of this type of work.

Krumholz was director of the Cleveland City Planning Commission in Ohio from 1969 to 1979. In his book (with analysis by John Forester) *Making Equity Planning Work: Leadership in the Public Sector*, (Krumholz & Forester, 1990), Krumholz offers a reflective, first-person
account of how his team ignored the downtown physical needs of the city, and instead diagnosed Cleveland’s problems as stemming from poverty, unemployment, neighbourhood abandonment, and inequitable service delivery. In their vision document, the *Cleveland Policy Planning Report*, the team vows to insert the concept of equity in their daily work. Their essential goal was to use methods of planning (broadly defined) to expand the realm of choices available for those in their city with limited housing, employment, and transportation options. Through several case studies, Krumholz tells the story of how his planning team worked to scrutinize the costs and benefits of development and policy proposals according to social equity principles. These Cleveland planners won and lost battles in policy areas that included transportation systems, housing and neighbourhood policies, and parks development.

The ways in which Krumholz and his colleagues in Cleveland diverged from the more narrowly defined role of land-use and physical planning designed to encourage real estate development that was common in most U.S. cities at the time is striking (Metzger, 1996). Krumholz describes the planning profession at the time as “suffering from bad advice and recently borrowed, hopelessly technocratic illusions” (p. xxii) and repeatedly shows the limits of the strictly rational approach to planning that relies on data and analysis to influence urban development. Instead, Krumholz advocates for planners to take an active role in public policy development, which necessarily involves politics, saying that politics and planning have always been intertwined.
Scott Campbell (1996) offers a more current model with which to actively integrate considerations of equity into planning practice. Using sustainable development as an ultimate goal or vision, Campbell describes three key planning conflicts (the planner’s triangle): to ‘grow’ the economy, to distribute this growth fairly, and in the process not degrade the ecosystem. In an ideal world, he states, planners would strive for a balance of all three interests (Campbell, 1996); unfortunately, in practice this equal balance is limited by professional or fiscal constraints.

2.3.3 Equity, Social Justice, and Public Health

In the field of public health, the issues associated with health inequities are considered some of our most significant challenges. Health inequities are reflected by consistent differences in the prevalence of chronic diseases (including diabetes, heart disease, and some cancers) among people from the highest to the lowest income and education groups across the province; the lower a person is on the socioeconomic hierarchy, the greater their risk for developing these diseases. Of particular concern is the poverty rate in this province: BC has the highest rates of poverty (especially child poverty) in Canada. People in the downtown eastside of Vancouver live approximately ten fewer years than do people in Richmond (The Health Officers Council of British Columbia, 2008).

The reasons for these inequities are complex and caused by the unequal distribution of power, income, goods and services (World Health Organization & Committee on the Social Determinants of Health, 2008). This unequal distribution is, in turn, based on political, social and cultural structures, including education, taxation and health care systems, labour and housing markets, and government regulation. Between and within cities and communities,
too, there are social and health inequities, that are (or can be) affected by municipal and regional governance systems, including those associated with urban and community planning.

In the last ten years there has been a rapid increase in research and, to some extent, policy responses to the issue of health inequalities and inequities, especially in the United Kingdom, Australia, New Zealand, and, to some extent, Canada. The reasons why some population groups become ill, while other groups do not, have now been extensively studied at local, national, and global levels. The patterns in the data are clear: across more wealthy, ‘developed’ nations like Australia, the United States, and Canada, those people who live on lower incomes consistently experience poorer health (Graham, 2007; World Health Organization & Committee on the Social Determinants of Health, 2008). Health inequities originate in our social structures and work via the position (or status) people hold in society, shaping their access to the resources that support good health (Graham, 2007).

Public health researchers, policy makers and advocates from around the world are now highlighting the importance of efforts to reduce health inequities, in part because of recent research that illustrates that all social and economic groups benefit from greater equity (Wilkinson & Pickett, 2009). As summarized by the Public Health Agency of Canada (Public Health Agency of Canada, 2011):

“Greater health equality has the potential to contribute to healthier children, a more productive workforce and a more sustainable healthcare system. Most importantly, it means a more equitable and just society, where all Canadians have the opportunity to live longer and healthier lives” (p. 5).
The Health Gradient

Health inequities don’t exist in our cities as a dichotomy, with the poorest populations in communities struggling and all other population groups doing well. For many indicators of health status, health inequities (which are based on social inequities; (Graham, 2007)) are seen in a stepwise, gradient pattern; populations on each step struggle a little less than the one below.

The prevalence of heart disease among population income groups in BC offers an excellent example of this gradient pattern. BC men from low income households are more than two times more likely to report heart disease than are men from the highest income group. For women, the gradient is steeper: women from the lowest income group are more than three times more likely to experience heart disease than women from the highest income group (The Health Officers Council of British Columbia, 2008).

The identification of the ‘health gradient’ began in the mid-1980s, when Michael Marmot and colleagues (1984) in the UK found a step-wise relationship between death rates among 17,530 male civil servants and the job positions those men held. That group of men who held administrative or professional positions died at a much slower rate than did groups of men who held clerical or other positions that required fewer special skills and education (Marmot et al., 1984).

For the public health field, which, during the 1970s and 1980s was dominated by a medical model that emphasized individual responsibility and played down social and political aspects to health, the introduction of the health gradient represented a significant turn for both
research and practice. Not only could the health and quality of life of the most disadvantaged
groups in communities no longer be ignored, it was now vital to look at the whole gradient as
one important indicator of overall community health.

There are a growing number of hypotheses as to how health inequities act to affect the
overall population health of a city, province or nation. For instance, in their fascinating book,
The Spirit Level: Why More Equal Societies Almost Always Do Better, Richard Wilkinson and
Kate Pickett (2009) review some of the international literature on health inequities in
developed nations, focusing on nine health and social problems, including obesity, life
expectancy, mental illness, and infant mortality. They conclude that health and social
problems are more common in countries with more significant levels of income inequality. In
wealthy nations, say Wilkinson and Pickett (2009), many health problems are not caused by
the society’s overall lack of funds, but by the material differences between people in each
society being too great. What matters most is where we stand in relation to others in our own
society. That inequality is a powerful social divider, leading to high levels of anxiety, stress,
and lack of trust. At its core, the result of inequities is a loss of a sense of identity:

“People’s sense of identity used to be embedded in the community to which they
belonged, in people’s real knowledge of each other, but now it is cast adrift in the
anonymity of mass society. Familiar faces have been replaced by a constant flux of
strangers. As a result, who we are, identity itself, is endlessly open to question.”
(Wilkinson & Pickett, 2009, p. 42)

According to Wilkinson and Pickett (2009), those societies with the greatest income inequities
are characterized by a lack of trust and less community spirit, dimensions which in turn lead to
physical and mental manifestations of stress and poorer health.
Moving Toward Solutions to Health Inequities

The literature on health inequities, particularly in Canada, is gradually moving from a focus on describing the problem to considering concrete solutions. One thing is clear, however – spending more on health care will not result in further improvements in population health (Public Health Agency of Canada, 2008). Health and social policies need to operate work together if they are to make an impact on health inequities. Intersectoral solutions to health inequities will be difficult to deliver without interdisciplinary understandings of their causes (Graham, 2007).

Some analyses of effective practice to reduce health inequities (e.g. (Graham & Kelly, 2007; Pedersen et al., 2007)) suggest that, because of the gradient nature of inequities, policies and programs that focus solely on those most in need will not be sufficient. In most Western countries, the gradient is becoming steeper over time; relative inequities are increasing. Policy changes that focus, then, on only those most economically or otherwise disadvantaged run the risk of obscuring what is happening to groups whose population is still poor, but not the absolute worst in that region. The approach can also be challenged on ethical grounds: is it acceptable “to give absolute priority to improving the [living conditions] of the worst-off class if those who are next to the worst-off are also doing very badly?” (Marchand et al., 1998, p. 461).

Because the health of advantaged populations is improving over time, narrowing the gap will require a rate of health improvement among low-income and other high-risk groups that outstrips that in higher income groups – “in order to close the gap, we must ensure that the
most marginalized and excluded groups and areas in society see faster improvements in health” (UK Department of Health, 2004, p. 11).

Therefore, policies and programs will have the greatest impact on reducing health inequities if they work on the entire health gradient, rather than focus only on members of the community who are poor or otherwise disadvantaged. The answer lies in developing policy that sees the greatest improvement for the most disadvantaged populations, with the rate of gain progressively decreasing for higher socio-economic groups. Policies in this subgroup not only target the disadvantaged minority, but also extend to the larger majority of people who are not socially excluded, but are relatively disadvantaged in health terms. This approach provides a more comprehensive policy goal – one that includes improving the health of disadvantaged populations and narrowing health gaps within the broader objective of equalizing health chances across socio-economic groups (Graham, 2006). We therefore need a combination of both targeted and universal policies and programs to be most effective in reducing health inequities and improving health for all. This approach, known as proportionate universalism, suggests intersectoral action across many areas of society (Marmot et al., 2012; Marmot & Bell, 2012; National Collaborating Centre for Determinants of Health, 2013b; Ontario Agency for Health Protection and Promotion (Public Health Ontario) et al., 2015).

The key is to apply an ‘equity lens’ to all policy development (in this case, in community or city planning), so that potential implications of any proposed policy on the whole gradient (and not just on those groups struggling the most) can be identified (Association of Local
Public Health Agencies-Ontario Public Health Association (alPHa-OPHA) Health Equity Working Group, 2014; Graham & Kelly, 2007; O'Neill et al., 2014).

2.3.4 The Convergence of Equity and Social Justice, Public Health, and Planning – Connections Among all Three

It is clear that many aspects of the built environment, including the way communities are planned and how the resources available within them are organized, have a direct influence over people’s physical, mental, and social health. We are also gaining an understanding about how those aspects of communities affect equity and social justice. Now, researchers are beginning to examine the interplay of all three fields together when they ask ‘how can the way communities are planned shape patterns of health equity?’

Recent reviews of the research that examines the links between built environments and health inequities highlight the evidence that neighbourhood deprivation is a significant predictor of poor health, associated with both physical and mental chronic health conditions (Zupancic et al., 2016). Specifically, recent research has revealed a social gradient of health related to air pollution exposure, heat-related illness, and access to green space (Bélanger et al., 2014; Gelormino et al., 2015; James et al., 2015). Within homes, low income is associated with household crowding, increased exposure to environmental risks at home, and poor quality housing (Gibson et al., 2011)

Despite this strong evidence that there are significant links between neighbourhood characteristics and social and health inequities, there is also some emerging research that suggests that the built environment can positively contribute to health, independent of a person’s income level or social status. For instance, neighbourhoods with greater resources
and a strong sense of community cohesion are significantly associated with some indicators of better mental and physical health, including lower rates of depression and anxiety, and lower body mass index (Zupancic et al., 2016).

This recent research about the spatial relationships associated with health inequities highlight the complexities that are operating to shape health and wellbeing in our communities. Rather than just describing the relationship between one determinant of health with aspects of the built environment, researchers are now working to explain how many determinants are acting together to influence people’s lives. For instance, intersectionality, a theoretical framework for understanding how multiple social identities, like socio-economic status, gender, or sexual orientation, might interact to reflect unique experiences of privilege or discrimination for individuals or groups (Bowleg, 2012), is now being used to help explore and explain health inequities (Morrison, 2015). The contextual effects on health status and health inequities are complicated, and therefore require an intersectoral systems approach to better understand how underlying social and environmental processes shape human health and wellbeing (Sarkar et al., 2014). As we gain a better understanding of these complex factors operating within our communities, it is important that the strategies we develop to foster good health among all residents of those communities, are also multi-faceted. In the next section I describe three frameworks that offer a multi-faceted and intersectoral set of solutions to improve health and reduce health inequities in cities and communities: Healthy Cities / Communities, Healthy Urban Planning, and Healthy City Planning.
The Healthy Cities / Communities Approach to Planning

The Healthy Cities framework to planning offers a unique model for tackling the complex problems that shape health in cities across the world. The approach suggests that all sectors must work together in order to collectively build a healthy community. The process involves community members coming together to develop a shared vision of their healthy community, assessing the capacity of their community to realize that vision, and then developing strategies to collectively move toward that goal.

Worldwide, the Healthy Cities approach addresses multiple determinants of health, including the social, economic, environmental, physical, psychological, spiritual and cultural. At its core, the Healthy Cities movement is about the connection between urban living conditions and human health. The concept includes an explicit recognition of the scale and complex nature of health and social issues in urban areas. Conventional health-sector focused approaches which focus on the prevention or treatment of diseases are not adequate to address complex health issues (including violence and many chronic diseases) and key underlying causes of those health issues (including poverty). The central ideas behind the Healthy Cities movement are:

- Because cities are centres for human action, they provide a unique setting in which to develop action strategies to promote health; and,

- When attention is paid to the values of those living within the city, cities have significant potential for supporting the development of healthy individuals and families (Kenzer, 1999).
There is an emphasis on equity in the Healthy Cities literature; a connection is drawn between a clear commitment to local government policies that reduce the exclusion of low income and other marginalized groups and the success of local efforts. The European Healthy Cities network suggests four elements for action:

- Explicit political commitment at the highest level to the principles and strategies of the Healthy Cities project;
- Establishment of new organizational structures to manage change;
- Commitment to developing a shared vision for the city, with a health development plan and work on specific themes; and,
- Investment in formal and informal networking and co-operation (Regional Office for Europe, 2016).

The World Health Organization recommends two aspects of governance at the local level: technical aspects which involve mobilizing local level resources and formulating Healthy City plans; and representational aspects, which include greater participation by groups outside government, and increased transparency and accountability in the workings of local authorities (World Health Organization, 1996). The approach looks different in each region or municipality, reflecting diversity in local priorities. The Healthy Cities movement now includes more than 7500 cities and towns worldwide, in at least 20 regional and national networks.

The Healthy Cities approach is important for urban planning because it stimulates sound planning policies and practice in the areas of equity, sustainability and community participation. The approach also facilitates intersectoral cooperation, which can minimize
duplication and avoids discrepancy between the policies of different sectors. Finally, the approach provides an opportunity for planners to connect with those in other cities, and to share experiences (Barton & Tsourou, 2000).

In Canada, the Healthy Cities approach is being implemented under the title ‘Healthy Communities’, to reflect the more rural nature of many Canadian areas. Originally begun as the Canadian Healthy Community Project (CHCP) in 1988, by the Canadian Institute of Planners (CIP), the Federation of Canadian Municipalities and the Canadian Public Health Association (Witty, 2002), the Healthy Communities activity in Canada today consists of relatively strong networks in Ontario, Quebec, and British Columbia, with some smaller centres of activity in other provinces. There is no formal national network. Launched in 2005 with provincial government funding, BC Healthy Communities works with local governments and community groups across the province to help them develop health and sustainability plans, and follow through with those plans as opportunities arise.

Evaluation of Healthy Cities / Healthy Communities

The majority of the literature looking at the implementation and evaluation of initiatives designed to integrate city planning and public health is limited to those projects that have taken a Healthy Cities approach, mostly in Europe and Australia. Understandably, such studies have proved challenging, mainly because the assignment of causality to a Healthy Cities project is very difficult. Within such complex settings as cities, there are a number of factors that directly or indirectly influence city health; isolating one particular intervention as the ‘cause’ of change is problematic (Baum et al., 2006; Costongs & Springett, 1997). Instead,
researchers assess whether there is evidence that a Healthy Cities project has fostered activities that can be reasonably linked to expected health outcomes (Baum et al., 2006), like improvements to air/water quality, safety/security, housing affordability and quality, commitment to public services, economic disparity, unemployment, educational attainment, and illness among residents (Frankish et al., 2002).

It seems that, for many Healthy Cities projects and networks, especially those outside Europe, projects are not likely to be rigorously evaluated. For example, a survey of Healthy Cities initiatives in 57 municipalities across the Americas demonstrated that only 58% had a follow-up and evaluation plan (Arteaga et al., 2007). One of the few Canadian studies of Healthy Cities projects (Smith et al., 2008) described a process in which health authority and local government staff worked with local community members to identify a set of indicators that would drive the project’s evaluation. In interviews, community members admitted that the formal set of indicators agreed on by the group lacked relevance to them, and they felt little ownership of the indicators. Instead, community members drew upon measures of success that were informal or experiential in nature.

From an evaluation perspective, a review of the available evidence on the effectiveness of Healthy Cities initiatives (especially the European Healthy Cities Project) concluded that “there is fair evidence that Healthy Cities works” (de Leeuw & Skovgaard, 2005, p. 1338). These authors found that, in many cases, the breadth and depth of activities outlined by the original intent of Healthy Cities projects has not been realized – there is tension between the original purpose of the Healthy Cities model and the operations of ongoing projects. As Awofeso
described: “... the Healthy Cities ethos has been characterized more by action than by reflection” (Awofeso, 2003, p. 223). This finding is consistent with an approach informed by complexity theory. If, as Callaghan suggests, “transferable knowledge to be gained is not direct and cannot be based on extracting factors from context” (Callaghan, 2008, p. 404), practice becomes not the use of a potential ‘model’ that all communities can follow, but a process individual to that particular local context.

One of the ‘fathers’ of the Healthy Cities approach, University of California at Berkeley professor Leonard Duhl has said that part of the reason that city governments have been unable to effectively address urban health and social problems is due to the lack of systems of governance in cities which are able to respond to the multiplicity and complexity of the contemporary urban environment. To remedy this, Duhl argues, we must collect skills that bring diverse, heterogeneous people and populations together. The healthy city is one that is “multi-dimensional, multi-age, multi-cultural, multi-directed, and coherent” (Duhl, 1993, p. 119).

**Healthy Urban Planning**

In Europe, the World Health Organization (WHO) has actively encouraged some cities to take a broader approach to city planning, an approach that WHO calls Healthy Urban Planning. The Healthy Urban Planning approach works to integrate health considerations into city planning processes, programs and projects. The approach highlights the importance of recognizing the health implications of policy and practice in planning, and then suggests that pursuing health objectives should be a central part of urban planning work (Barton & Tsourou,
Healthy urban planning encourages planners to consider the key influence of the social, economic and environmental determinants of health in their practice:

“The condition of the urban environment and how it is managed and used by its inhabitants are fundamental to human health and well-being. Many of the problems in cities today relate to poor residential and other environments, poverty, inequity, pollution, unemployment, lack of access to jobs, goods and services, and lack of community cohesion. Urban planners influence the social, physical and economic environments and how cities function. They therefore have a key role to play in addressing these problems and securing conditions in cities conducive to health and well-being and a high quality of life.” (Barton & Tsourou, 2000, p. 1)

Healthy urban planning focuses on humans and how they use their environments, rather than simply concentrating on buildings and economics. The approach implies a need to place values such as equity and collaboration at the heart of the decision-making process. The WHO suggests that planners consider using twelve key health objectives when assessing city planning-related policies and proposals (Barton & Tsourou, 2000); see Table 1, below).
<table>
<thead>
<tr>
<th>Objective</th>
<th>Potential Effects of Planning Decisions</th>
</tr>
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<tbody>
<tr>
<td>Healthy lifestyles</td>
<td>Planning can create attractive, safe and convenient environments that encourage people to walk or cycle to work, shop, school and other local facilities.</td>
</tr>
<tr>
<td>Social cohesion</td>
<td>Social cohesion can be undermined by dispersal of residential communities and by constructing barriers to pedestrian connectivity. Social cohesion can be facilitated by creating safe and permeable environments where people are encouraged to meet informally.</td>
</tr>
<tr>
<td>Housing quality</td>
<td>Overcrowding and housing that is conducive to social isolation can affect mental health. Providing a broad range of housing types with easy access to health, education and leisure services is essential.</td>
</tr>
<tr>
<td>Access to work</td>
<td>Planning, linked to economic development, can assist in increasing access to employment opportunities by facilitating attractive opportunities for business, especially those that encourage diversity in employment. Equitable transport strategies can also play an important part in providing access to job opportunities.</td>
</tr>
<tr>
<td>Access to key community services</td>
<td>Access to shopping, health care, recreation and education services can be improved through urban design and transportation planning that centralizes these services and provides easy access through public transport or by walking.</td>
</tr>
<tr>
<td>Local, low-input food production</td>
<td>People on low incomes, including young families, elderly people and the unemployed, are least able to eat a healthy diet, in part because the centralization of shopping facilities and growth of large supermarkets reduces the variety of food available locally and disadvantages those without access to a car. Planning can assist by preserving and protecting areas for small-scale community projects and opportunities for local food production.</td>
</tr>
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### Objective | Potential Effects of Planning Decisions
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**Safety** | Where the local pedestrian environment is intimidating and inconvenient, people use cars, and social interaction is reduced. Planning can emphasize urban design that ensures a natural process of surveillance over public space that reduces fear and the actual incidence of crime.

**Equity** | Planning can help in the process of providing lower-cost housing, facilitate the provision of job opportunities, and help enhance accessibility to services and facilities. Local networks of mutual support are enhanced by these factors, which can help foster a sense of local community.

**Air quality and aesthetics** | Planning can segregate polluting and noisy industrial uses of land, promote less polluting forms of public transport, deter car use and restrict trucks to specific routes, and support the development of energy-efficient buildings.

**Water and sanitation quality** | When assessing potential new developments, planning can impose standards and criteria that protect water quality and ensure adequate sanitation systems.

**Quality of land and mineral resources** | Planning can ensure that recycled and renewable materials are used whenever possible in building construction processes, that urban open spaces, local allotment gardens, market gardens and food-growing activities on the urban fringe are safeguarded.

**Climate stability** | Planning can affect the rate of human emissions of greenhouse gases by influencing energy use in buildings and transport and by developing renewable energy sources.

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**Healthy City Planning**

In perhaps the most comprehensive look at the relationships between planning and public health available, Jason Corburn of the University of California at Berkeley offers a detailed account of how city planning and public health practices can reconnect to address health inequities in his 2009 book *Toward the Healthy City*. Corburn argues that urban planning must return to its roots in public health and social justice, and asks three main questions:

*How can modern city planning, a profession that emerged in the late nineteenth century with a goal of improving the health of the least well-off urban residents but lost this focus throughout the twentieth century, return to its health and social justice roots? What are the connections among contemporary city planning processes, not just...*
physical outcomes, and health equity? What new political processes can help reconnect planning and public health with a focus on addressing the social determinants of health inequities in cities?” (Corburn, 2009, p. 1).

Corburn is critical of recent efforts in North America to reunite planning and public health, saying that, by focusing on how physical design changes in cities might increase physical activity and thereby improve health, researchers and practitioners have used a very limited idea of healthy planning. If physical, design-oriented changes are made to cities, without accompanying political and institutional change, Corburn argues, they will ultimately fail to improve the health of disadvantaged and marginalized people within urban settings. Perhaps worse, these limited changes to urban form will fail to move city political systems toward planning healthier and more equitable spaces. By presenting an in-depth case study of a long-term planning process within one neighbourhood of San Francisco, Corburn introduces the term ‘healthy city planning’, which he defines as

“healthy urban governance, where both the substantive content of what contributes to human well-being – the physical and social qualities that promote urban health – and the decision-making processes and institutions that shape the distributions of these qualities across places and populations are improved” (Corburn, 2009, p. 2)

The political frames he considers in moving toward healthy city planning include:

- considerations of population health, which seeks to identify the combination of political, social, economic, and biologic, forces that drive distributions of health, and the policy changes that might influence these forces;
- a relational view of place – healthy places should be understood as being built both physically (the ‘built environment’: buildings, streets, parks, etc.), and socially (through the assigning of meanings, interpretations, and narratives about the physical
and social characteristics of particular spaces, as well as the construction of networks, institutions and process to shape these meanings and outcomes);

- processes of governance that shape both place-based characteristics of a city, and the health-promoting opportunities for people. Healthy city planning suggests that not only are policies focused on people and place important for healthy cities, but that more consideration needs to be paid to the institutional processes that influence these policies, and

- relations of power – revealing the underlying influence of power relationships in planning processes and in urban governance more generally, including addressing the role of ‘experts’ in shaping science-based policy decisions, and structural racism, particularly as they relate to urban renewal.

Corburn demonstrates a unique understanding and appreciation for the complex political, economic and social processes that lie at the root of health and health inequities. His broader emphasis not only on health, but also on the unequal distribution of good health within and between urban neighbourhoods, is evident in the way in which Corburn describes the potential impacts of city planning processes on human health and health equity. His recommended practice and policy changes go beyond a consideration of land use, transportation planning, and urban design, to include more meaningful participation in urban governance and planning processes, working to provide more opportunities for child care and neighbourhood health centres, and actively supporting urban agriculture (Corburn, 2009).
These three approaches: Healthy Cities / Healthy Communities, Healthy Urban Planning, and Healthy City Planning, offer us comprehensive frameworks with which to plan and implement strategies that could begin to address health inequities within local communities. However, to ensure that those strategies will be as successful as possible, we need more research, to shed light on what kinds of actions to take, and how that might best happen, within our complex socio-political environments.

2.3.5 Review of Key Gaps in the Literature

This brief review of the relevant literature suggests that working to build communities that are socially just and maintain a sense of diversity and equity is not just a moral imperative, it is also a significant public health issue. Epidemiological evidence supports the notion that a just community is also a healthy community. Both the planning and public health fields have a literature that describes practice strategies to reduce inequities – equity planning and health promotion have much in common. And there is both theoretical and policy-based research on the need for cross-sectoral action to tackle the complex nature of inequities.

Health equity is a complex concept that has roots in some of society’s core values and philosophies. Given broad forces of globalization, urbanization and a continued emphasis on market forces to set government policy, change is not likely to be easy. The use of an equity lens appears helpful, especially to engage diverse sectors to see their role in improving equity and health. Health promotion programs and policies, whether they are developed by one sector or many, run the risk of increasing inequities, because such programs and even policies are often taken up more easily by middle and upper income individuals. As Fran Baum (2007) notes:
“unless designed with a very strong equity lens, health promotion can act to increase the difference between groups rather than reduce them, even if they improve population health as a whole” (Baum, 2007, p. 91).

The examination of equity in community planning shows some of the challenges with implementing an equity lens in such complex contexts. There is a clear need for research that considers how the use of an equity lens is being used during the planning process in one particular community, by whom, and the how the relationships between local context and the individual actors in that community shape how such a lens is used. What is most important, however, is that the lens is used in conjunction with a questioning of the structures and conditions that shape policy and practice, rather than restricting this analysis to the level of the individual. Political and other ideologies have a powerful (and sometimes covert) effect in shaping those structures. Research on the implementation of an equity lens, then, need to also explore the role of higher-level political contexts.

Yet at this point there is a lack of research (especially Canadian research) on how an equity lens is defined and being used, especially with regard to the joint work of planning and public health. How do higher-level policy makers conceptualize the equity lens, and in what ways do they support or challenge its implementation? How do local governments and community participants understand issues of health inequity in their communities, and then work to deal with them? How do underlying social processes, including power differentials, affect how cross-sectoral partnerships develop and work toward common goals? These questions represent key gaps in the current literature which are explored in this case study. Other pertinent research gaps include:
Use of a Wider Variety of Methodologies, to Answer Questions of Process

The research on the potential connections between planning and public health is still in an infancy stage, having been only re-introduced less than fifteen years ago. However, it is fascinating that most of the research done in this area so far has focused almost entirely on quantitative methods to measure the health impacts of planning-oriented decisions (e.g. urban sprawl, urban design elements). With only quantitative measures of the built environment and health used, much is missing from the discussion.

The research in this area needs to expand beyond quantitative studies that measure the correlation between some aspect of the built environment and health status, to research that describes how relationships are developed between planners and public health at the local level, and why their collective work does or does not achieve its goals. Asking these ‘how’ and ‘why’ questions will involve a greater breadth of approaches to research. Case studies appear to be particularly helpful, due to their ability to ‘tell a story’, using a variety of different data sources.

Urban vs. Rural Environments

Much of the literature about the connections between planning and health, and the role of each in addressing issues of equity, reflects theoretical reflections or empirical research about life in urban centres. That research might not be relevant in the context of smaller communities and rural areas, which experience somewhat different struggles. In terms of those factors which influence health status, Canadians in rural communities are, in general, more likely to be in lower socio-economic groups, have less education, and die at an earlier
age than Canadians living in urban areas (Canadian Population Health Initiative, 2006). Some of the small towns in rural British Columbia have witnessed dramatic declines in its traditionally dominant economic sectors of forestry, mining and fisheries, and growth in new service sector industries, especially tourism. Rural communities like many of those in BC are now less likely to have a diverse economic base, and regional economic development programs have yielded mixed results. Intersectoral approaches have been identified as playing a potentially important role in assisting small and/or rural communities to adjust to changes in economic cycles, and to reduce a community’s dependence on one industry for economic sustainability. We cannot assume that the research presented here is applicable outside of urban centres. It is possible that entire new frameworks are needed for rural communities. Building and testing those frameworks will be important next steps for research in this area.

Lack of Conceptual Frameworks or Models

The focus of much of this research has been on the use of tools (e.g. Geographic Information Systems, environment audits) to draw correlates between aspects of the built environment and health or health behaviours. Few authors have taken a step back to try to explain the inter-relationships among the many social, physical, economic, and political factors influencing the ways in which place, the built environment, and community shape human health. The exceptions are Jason Corburn of University of California at Berkeley, and Mary Northridge, from Columbia University, who each offer thoughtful theoretical frameworks with which to ask pertinent research questions, interpret findings, and connect the research with relevant policy. But more examples of conceptual models are needed,
especially those which are informed by theories of public policy change (Breton & De Leeuw, 2010), a crucial aspect of community health work.

Lack of Canadian Data

Most of the literature that describes the research in the Healthy Built Environments arena describes the work of American or European researchers. When dealing with issues of social or health inequities, the authors of these reports frequently refer to ‘racial disparities’ to describe a spatial pattern of minority, low income residents who reside in the inner city almost exclusively, leaving the suburbs to ‘white’, higher income populations. Some research suggests, however, that such a segregation of ethnic/racial and income groups is not nearly as clear cut in Canada. For instance, University of Toronto geographers Walks and Bourne used census data to examine spatial patterns of low income populations in Canadian cities (Walks & Bourne, 2006). Their findings suggested that the ‘ghettoization’ described in U.S. studies is not a factor in Canadian cities and that a high degree of racial concentration is not necessarily associated with greater neighbourhood poverty. So patterns of social inequities in Canadian cities are, indeed, different than in American cities. Acknowledging these differences will be important when trying to advocate for urban policies that might have an impact on health inequities. More research is needed to better understand how characteristics of the built environments of Canadian cities are related to social and health inequities, and how intersectoral relationships might play out differently here.
2.4 Theoretical Frame

Recent reviews of the use of theory in health promotion research, and especially research related to local action for healthy public policy change (Breton & De Leeuw, 2010; Martineau et al., 2010) have found that very few studies have been grounded in a particular theoretical approach. This is unfortunate, because without a strong theoretical framework to guide the research questions and chosen methodology, the research may have left many vital questions unanswered. In addition, any successes or failures cannot be fully explained and therefore run the risk of becoming strictly anecdotal accounts. Finally, health promotion research that takes an atheoretical approach provides less support for policy advocacy practice (an important part of healthy communities work), because it results in a less comprehensive understanding of the barriers to change (Breton & De Leeuw, 2010).

This research is based on two theoretical approaches: the conceptualization of the ‘nutcracker effect’ put forward by Australian Healthy Cities researcher Fran Baum to explain a two-pronged approach to ensure that a consideration of equity makes it to the policy agenda (Baum, 2007); and political scientist John Kingdon’s Multiple Streams Model, a theory that attempts to explain why some public policies end up on the agendas of decision makers, while others do not (Kingdon, 2003).

Policy, as defined by de Leeuw is “the expressed intent of an institution (government, corporation, volunteer group, etc.) to act strategically towards the attainment of specified goals” (de Leeuw, 1999, p. 264). This case study deals with a definite public policy issue; HBE work deals mostly with altering the content of Official Community Plans and other key local
policy documents. In addition, the decision to frame HBE initiatives as relating to social justice and equity is a key strategic (i.e. policy) direction. So the choice of Kingdon’s model, drawn from the field of political science, makes sense. While it is a real challenge to try to explain the public policy process through one theory or model, Kingdon’s Multiple Streams Model (Kingdon, 2003) is particularly suitable when designing research about the study of policy within a Healthy Communities context (E. De Leeuw, personal communication, May 23, 2011).

The Kingdon model is one of the most often used theoretical approaches in healthy public policy research (Breton & De Leeuw, 2010).

In this study, I used the ‘nutcracker effect’ concept and approach to guide how the research asks the ‘what’ questions: what needs to be done (and by whom?) to effectively address health equity? And at what levels should we examine the work of actors as they work to address equity-focused policy issues? The Multiple Streams Model has guided the ways in which the research looks at the ‘how’ questions: how do provincial and local actors work to get social justice and equity on the agenda so that they become part of Healthy Built Environments work?
2.4.1 The Nutcracker Effect: Top Down and Bottom Up Action for Health Equity

Fran Baum (2007) has coined the term ‘nutcracker effect’ (see graphic in Figure 3 below), to describe the power of the combination of top down and bottom up action on health equity. Baum de-emphasizes the need to present more evidence on health inequities, saying that policy makers also need to know what can be done to reduce inequities. At the top of the nutcracker, government action on the social determinants of health exerts pressure when policy makers work from a values base that emphasizes the pursuit of social justice as fundamental to society, and when they have an understanding of the complexities of health promotion. But bottom up pressure, exerted by civil society, can also persuade governments to change those public policies that have an impact on health equity (Baum, 2007). Civil society can apply this pressure through advocacy and incremental change, or, in some circumstances, by being oppositional to government. Baum summarizes her approach in this way:

“bringing about action on health equity will reflect a complex mix of sufficient evidence, good understanding of what changes population health, a political elite committed to changes and active civil society pressure for that change.” (Baum, 2007, p. 93).
In this study, I examined the applicability of this approach, by exploring the degree to which pressure is exerted on both levers of the nutcracker: at the provincial government level and at the local level through community action.

2.4.2 Kingdon’s Multiple Streams Model of Public Policy

John Kingdon’s book *Agendas, Alternatives and Public Policies* (2003) outlined the Multiple Streams Model of public policy, which aims to explain why some issues and problems become prominent in the policy agenda and are eventually translated into concrete policies, while others never do. Kingdon’s model (see Figure 4, below), focuses more on the flow and timing of policy action than on its component steps, and can be extremely useful in understanding the complexities and realities of policy-making. In this model, attention is focused on three streams which move independently through the policy system. Kingdon argues that issues gain agenda status, and alternative solutions are chosen, when elements of the three streams come together. Each of the three streams contains individuals, groups, agencies, and institutions that are involved in the policy making process. The three streams are:

- **The politics stream**, which encompasses the state of politics and public opinion. This stream acknowledges that political events, such as an impending election or a change in government, can lead to a given topic and policy to be included or excluded from the agenda. Other factors, such as interest group pressures, can affect public reaction to an issue, and are therefore included in this stream;

- **The policy stream** is concerned with the formulation of policy alternatives and proposals. In this stream, the various possibilities are explored and narrowed down. The components of this stream are influenced by Kingdon’s belief that proposals and solutions are not
initially built to resolve given problems, but rather they float in search of problems to which they can be tied; and,

- The *problem stream*, which refers to the perceptions of problems as public issues requiring government attention. A given situation has to be identified and explicitly formulated as a problem for it to have a chance of being transformed into a policy. Indeed, a situation that is not defined as a problem, and for which alternatives are never imagined or proposed, will never be converted into a policy issue. This stream encompasses the attributes of a problem, including the degree to which it is getting better or worse, whether the problem has suddenly come to the attention of policy makers because of sudden events or crises, and whether it is solvable with the alternatives available in the policy stream (Kingdon, 2003).

Figure 4: A Visual Representation of Kingdon's Stream Model (2003) (de Leeuw, 1999, p. 262)
Within any particular problem area, Kingdon asserts that the streams run parallel and somewhat independently of each other until something happens to cause two or more of the streams to meet in a ‘window of opportunity’ (represented in Figure 4 by the oval shape at right). This window presents the possibility of policy change, but it does not guarantee that change will take place. The trigger can be a change in our understanding of the problem, a change in the political stream that is favourable to policy change, a change in our understanding of the degree to which the problem can be solved with available solutions, or a focusing event that draws attention to the problem (Kingdon, 2003).

The Multiple Streams Model also emphasizes the actors involved in helping to open windows of opportunity. Kingdon (2003) distinguishes between visible and invisible participants. The visible actors include elected officials and the media, while the invisible actors are academic researchers, consultants, and government staff. The visible participants affect what topics are presented for the agenda, while the more hidden participants influence the identification of alternatives to address those issues.

Kingdon’s thesis is that a window of opportunity can be opened only if a policy entrepreneur – active, well-connected individuals or organizations that use persistence to promote the development of the public policy – is aware of the dynamics of each stream, and of the stakes both visible and invisible participants in each stream have. Policy entrepreneurs, or what de Leeuw calls social entrepreneurs (de Leeuw, 1999), act as catalysts for change. To be successful, social entrepreneurs have certain capacities and skills, including the ability to appreciate different perceptions of the social issue, agility to capitalize on opportunities as
they arise, and the ability to reflect on their continuously changing positions to adapt to shifting contexts (de Leeuw, 1999; Selsky & Smith, 1994).

2.5 Summary

Thus far in most of the available North American literature that relates to Healthy Built Environments, researchers have designed studies and presented their data in ways that fail to take into account those social, political, economic and historic processes that are so much a part of how, why, and for whom poor health develops. In some of this research, a narrow definition of ‘health’ is being used that relies strictly on biomedical explanations for disease and illness. Limited, if any, attention has been given to broad political or social policy change associated with a social justice orientation to planning and to the promotion of health. Healthy Built Environments research will gain strength when, instead of resulting in policy recommendations on its own, it is combined with the work of international researchers and practitioners in the Healthy Cities / Healthy Communities area, and those, like Jason Corburn from the University of California at Berkeley, whose work has developed from a concern for environmental justice.
Chapter 3: Context

The HBE projects that have been examined in this study have been planned and implemented in two contexts: a geographical/spatial context (within a particular city), and a policy context. In this chapter I will describe both types of context, in turn. These contexts have had a significant influence on how (or if) HBE work has been done with the use of an equity lens in each community. For instance, the size and location of each case study community has affected the types of social and community health issues with which each local government and HBE team has had to grapple, while the policy context at the provincial level has shaped the ways in which HBE teams have been formed, and the activities they have undertaken.

3.1 The Three Case Study Communities

The three communities that will be examined as part of the local level component of this project are: Surrey, Kelowna, and Terrace. Please see Map 1, below.
3.1.1 Surrey, BC

Surrey is the second largest city in British Columbia, with a population of over 400,000\(^3\). The city is one of the most rapidly growing cities in Canada; Surrey’s population is projected to increase by 300,000 over the next 30 years (City of Surrey, 2014b). Surrey is expected to absorb much of the Lower Mainland’s population growth over the next two to three decades, in part because of the city’s relatively low housing costs and its abundant land base to accommodate urban development (City of Surrey, 2013b).

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\(^3\) Population according to the 2011 census was 468,251 (Statistics Canada, 2012e).
As Surrey’s population grows, so does its diversity, in terms of ethnicity, age, income levels, and physical abilities. Rates of immigration continue to grow in Surrey. Immigrants made up 33.2% of the population of the city in 2001, and grew to 38.3% of the population in 2006. The most common countries of birth of those new immigrants were India, the Philippines, South Korea, and China (City of Surrey, 2009). Almost half (43%) of Surrey residents speak a language other than English at home (Statistics Canada, 2012e).
A growing population of seniors within the city will require new forms of housing or adaptations to their existing housing. Yet Surrey has a relatively young population; over 27% of the city’s population is under 19 years old (Statistics Canada, 2012e). That population of children and youth is expected to increase over the next two decades, which will put pressure on schools and other community-based services (City of Surrey, 2013b). The city currently has 99 elementary schools, including 21 new schools built over the last 14 years (City of Surrey, 2014d).

About one in five Surrey residents (71,000 people) live in poverty. Poverty rates are highest among recent immigrants and refugees, single parent families, Aboriginal people, and persons with disabilities (City of Surrey, 2012b). Poverty rates vary considerably among Surrey’s six communities.

At the time of writing, the City of Surrey was currently finalizing an update of its Official Community Plan (OCP), called PlanSurrey 2013 (City of Surrey, 2013b). The revised OCP is connected to other municipal strategic plans, including the Sustainability Charter (City of Surrey, 2008a) and the Plan for the Social Well-Being of Surrey Residents (City of Surrey, 2006b). The City also has a Poverty Reduction Plan (City of Surrey, 2012b) and a Child and Youth Friendly City Strategy (City of Surrey, 2010a).

Fraser Health is the health authority that operates in Surrey, and many other parts of the Fraser Valley. The health authority employs approximately 25,000 people to provide health care and public health services in a geographic region that stretches from Burnaby to Hope, an area with a population of more than 1.6 million (Fraser Health, 2016).
3.1.2 Kelowna, BC

Kelowna is a small city of approximately 115,000 in British Columbia’s Okanagan Valley\(^4\). It is also a rapidly growing area. Providing affordable housing options for newcomers to the region, while protecting the valuable agricultural land immediately adjacent to the city, are important considerations for the future.

**Image 2: City of Kelowna**

Photo source: City of Kelowna (http://www.kelowna.ca/CM/Page67.aspx)

Kelowna is expected to grow to a population of 161,701 by 2030, at an annual growth rate of 1.51\% (City of Kelowna, 2011). The proportion of residents in older age groups is expected

\(^4\) Population as of the 2011 census was 117,312 (Statistics Canada, 2012d)
to grow at a much faster rate than that of younger age groups. That growth will require approximately 20,100 new housing units by the year 2030 (City of Kelowna, 2011).

Kelowna is an expensive place to live, and it appears that living there is becoming more expensive over time; the 2013 Living Wage\(^5\) for Kelowna and surrounding areas was $18.01 per hour, up 4.9% over the previous year (Regional District of Central Okanagan, 2013). From 2012 to 2013, there significant increases in terms of costs of child care (up 8.5%, an increase of $89 per month) and transportation (up 4.5%, to $492 per month; (Regional District of Central Okanagan, 2013).

The City of Kelowna is part of the Regional District of Central Okanagan, which is made up of Peachland, Lake Country, the District of West Kelowna, and several unincorporated communities. Kelowna is the largest community in the Regional District. A new Official Community Plan, called Kelowna 2030: Greening our Future, was adopted by City Council in 2011. The top three goals of the new OCP are to contain urban growth, address the housing needs of all residents, and develop a transportation network that emphasises walking, cycling, and public transit (City of Kelowna, 2011).

\(^5\) The Living Wage reflects the actual costs of living in a community. The calculation is based on an established format from the Canadian Centre for Policy Alternatives, and is endorsed provincially by First Call: BC Child and Youth Advocacy Coalition. The Living Wage calculation includes expenses such as food, rent, transportation, child care and education expenses. A Living Wage of $18.01 per hour means that, to keep a two parent, two child household out of extreme poverty, each adult must be working full-time, earning at least $18.01 per hour in order to meet their family’s basic needs (Canadian Centre for Policy Alternatives, 2013).
Interior Health is the health authority that offers health care and public health services in the Southern Interior of BC, including the Kelowna region. The health authority provides services to a population of 750,000, with a staff of over 19,000 (Interior Health, 2016).

3.1.3 Terrace, BC

Terrace is a town in Northwestern BC with a population of about 11,0006. Terrace is located about 550 air miles northwest of Vancouver, and is the regional business centre for the communities in the Skeena River Valley. The city’s proximity to the ocean, its low altitude, and its location within the shelter of the Coast Mountains has created a natural ‘greenhouse’ effect. Temperatures in Terrace are warm enough to permit the growing of fruit orchards and other specialty crops, including peaches.

6 According to the 2011 Census, the population of Terrace is 11,486 (Statistics Canada, 2012g).
Because Terrace is located at the geographic centre of Northwest BC, it serves as a hub for highway, rail and air transportation routes. As a result, the City hosts many of the region’s business, retail, health care, and government services. Those services are used by the surrounding communities of Kitimat, Prince Rupert, and Stewart, as well as the nearby First Nations communities (City of Terrace, 2013). The City has a relatively compact built form; when I visited there in February 2012, I found that I could access all parts of the city on foot within a short period of time.

Terrace experienced population decline in every census year from 1996 to 2006. There was a slight increase in population in 2011 (Statistics Canada, 2012g). Its economy has struggled over the past 10-20 years, and that has affected the town’s population distribution. Between 1996 and 2006, there was an out-migration of young adults ages 20-24 and 25-29 (City of Terrace, 2013).
Terrace, 2011). A significant proportion (over 10%) of the town’s population identifies as Indigenous. The Kitselas people, a tribe of the Tsimshian Nation, have lived in the Terrace area for thousands of years.

The people of Terrace receive health care services from Northern Health. The health authority is responsible for health care and public health services for more than half of the geographic area of BC, covering over 600,000 square kilometres, from Quesnel north to the borders with the Yukon territory and Alaska. Given its size, Northern Health is divided up into three Health Service Delivery Areas: Northwest, Northern Interior, and Northeast. Each Health Service Delivery Area has its own Chief Operating Officer and Executive team (Northern Health, 2016). Terrace is located in the Northwest region of Northern Health’s territory.

3.2 Policy Context

Given the emphasis of this research on policy development and implementation, it is important to consider the policy context related to the collective work of planning and public health, and the emerging work on the use of an equity lens in public policy and program development and evaluation. This policy and practice area is rapidly developing across North America. As mentioned in Section 2.3.1, much of this collective work of planning and public health in BC is focused on developing healthier built environments, a process that is overseen by HBE teams in many communities.

Each of the six health authorities in BC is now required to build community-based partnerships and new programs and/or policy changes that demonstrate a formal working relationship with local government (especially, but not limited to, municipal planning
departments). This requirement is part of the multi-year Core Functions in Public Health process (Population Health and Wellness - BC Ministry of Health Services, 2005), which aims to enhance capacity in public health and disease/illness prevention across the province. Health authorities are required to assess their activities in building Healthy Community Environments (BC Ministry of Healthy Living and Sport, 2009) and develop plans to work with local government to ensure healthier environments.

The Core Functions in Public Health framework (Population Health and Wellness - BC Ministry of Health Services, 2005), encourages health authorities to use an ‘equity lens’ in their review of current public health programs and in the establishment of new programs and policies. The equity lens is poorly defined, but incorporates an assessment of health inequalities in all communities and the orientation of new programs so that they provide greater assistance to disadvantaged or vulnerable populations. The Framework document states:

“public health has a duty, as one of its fundamental tasks, to work to reduce inequalities in health. This can be accomplished in several ways:

- By documenting inequalities, reporting on them so as to draw public attention to them, and analyzing the factors that contribute to those inequalities;
- By working with communities to change the conditions that contribute to inequalities in health in their community; and
- By advocating for healthier public policies and changes in social, economic, cultural, and environmental conditions that will reduce inequalities in health” (p. 48).

The Framework document concludes its brief description of the ‘equity lens’ by suggesting that health authorities “ensure that the core programs provided by the health authorities reflect the priorities of the people with greatest need” (p. 49).
Among the province’s five regional health authorities, there are some ideas as to what using such a ‘lens’ entails (e.g. Interior Health’s Health Equity Assessment), but much of that work still focuses on the use of population health data to describe inequalities and justify the use of a lens. Despite a great deal of exploration and debate, there is still little consensus among public health leaders in BC as to what an equity lens should contain and how it should be used as part of the Core Functions process.

Most of the health authorities have embraced the development of new HBE initiatives and have begun implementing HBE programs, especially over the last two or three years. In some cases, health authorities have re-organized their public health departments to ensure stronger connections to local governments. Each health authority in the province has organized their HBE program quite differently, depending on the needs of their particular area and on the organizational culture and priorities that drive decisions. The health authorities therefore act as important contexts for this HBE work.

At the provincial level, the BC Ministry of Health’s Chronic Disease/Injury Prevention and Built Environment Branch is involved in a number of HBE-related initiatives, including Age-Friendly Communities, a program that supports local-level policy changes, upgrades to public facilities, and urban design changes to better accommodate seniors and people with disabilities. The Ministry has also supported the Built Environment and Active Transportation (BEAT) program, an initiative of the BC Healthy Living Alliance’s physical activity strategy, which was led by the BC Recreation and Parks Association and the Union of BC Municipalities. The focus of BEAT was to create more supportive environments for physical activity by
addressing community design, policy and transportation planning through the delivery of regional built environment workshops and by distributing planning grants. Finally, the Ministry of Health wrote and introduced the new Public Health Act (passed in 2008), which stipulates that local governments must designate one of its staff to act as a liaison to the public health department, and then report to a health official any conditions of the environment that might adversely affect community health.

The Provincial Health Services Authority (PHSA), BC’s provincial health authority, has recently released a *Health 201 for Planners* resource, designed to introduce municipal planners and local government decision makers to key health terms and concepts, so that they can take action in their respective sectors to reduce preventable illness and injury through design, by creating healthier built environments. The PHSA has also commissioned a number of other resources that each offers a series of policy recommendations in the HBE area.

In 2008, the BC Healthy Built Environment Alliance was formed to bring together planning, architecture and engineering with public health professionals, to better understand the health impacts of the built environment, and to support the creation of healthier built environments in BC communities. The Alliance meets at least three times a year. Its membership includes representatives from the Planning Institute of BC, Smart Growth BC, BC Transit, BC Recreation and Parks Association, all six health authorities, and three provincial ministries: Community Services, Transportation, and Health. The Alliance has been active in producing a number of policy documents and educational materials / workshops designed to help bridge the work of
local government and public health. These documents include *Foundations for a Healthier Built Environment*, *Indicators for a Healthy Built Environment in BC*, and *Introduction to Land Use Planning for Health Professionals* (written resource and workshop). The Alliance is currently chaired by a Director from the BC Ministry of Health. Day-to-day coordination of the Alliance is done by staff at PHSA.

### 3.3 Summary

Overall, the policy context suggests that this is a dynamic policy and practice area that is a priority of the provincial government and regional health authorities. The time is right to more systematically explore the implementation of HBE initiatives in BC, to better understand the potential of these projects to bring planning and public health together in a way that is consistent with an emphasis on equity. While it is part of the mandate for health authorities to develop HBE programs with an ‘equity lens’, that lens has thus far been poorly defined, and there is reason to believe that each health authority has interpreted the lens a little differently. As well, given the diverse set of planning priorities, health and social needs, and municipal resources of local governments across the province, it is reasonable to assume that the use of an equity lens will be implemented differently in different cities and towns. Little contemporary research is available on the processes and outcomes of the implementation of HBE initiatives in Canada, and even less has been written on HBE work from a health equity or social justice frame. The study I describe here helps to explore those processes, to better define an equity lens and help to understand more about how it is being implemented with regard to HBE work.
In this chapter I provide a description of the research strategy I selected, and my rationale for choosing that approach. I begin with some general reflections on the overall goals for this project, including how my experience in public health helped to shape my decisions about the methods described here. I then outline the general research design used in the project, and explain why a case study approach was an appropriate strategy with which to address the research questions. This leads to a detailed description of the data collection procedures used at both the provincial and local levels, including interviews, participant observation in meetings, and the collection of key documents, maps, and photographs. Finally, I summarize the data analysis procedures I used, and explain both the validation and the limitations of the findings.

4.1 Research Design and Case Selection

This dissertation is not a narrative account of a phenomenon; I do not use narrative analysis as an analytic technique. Yet I see this process as one in which I am telling a story – a story about how individuals and groups within BC are working with other sectors and groups to integrate a consideration of equity and social justice into their efforts as they relate to HBE. The research on the potential connections between planning and public health is still in an infancy stage, having been only re-introduced less than fifteen years ago. However, it is fascinating that most of the research done in this area so far has focused almost entirely on quantitative methods to measure the health impacts of planning-oriented decisions (e.g.
urban sprawl, urban design elements). With only quantitative measures of the built environment and health used, much has been missing from the discussion.

Part of my aim for this research was to expand beyond those quantitative studies that measure the correlation between some aspect of the built environment and health status, to research that describes how relationships are developed between planners and public health at the local level, and why their collective work does or does not achieve its goals. As noted in the Literature Review (Chapter 2), there is a lack of research (especially Canadian research) on how an equity lens has been defined and how it is being used, especially with regard to the joint work of planning and public health. In the design phase of this research, I was interested in asking challenging, process-oriented questions, such as: how do higher-level policy makers conceptualize the equity lens, and in what ways do they support or challenge its implementation? How do local governments and community participants understand issues of health inequity in their communities, and then work to deal with them? How do underlying social processes, including power differentials, affect how cross-sectoral partnerships develop and work toward common goals? Asking these ‘how’ and ‘why’ questions was essential to more fully explore the political, economic, social, and cultural aspects of context that have such an influence on the day-to-day decisions of planners, public health officials, and others working with local government within the province.

I began this research with several years’ experience in the public health field within British Columbia. For almost 20 years, I have been working in the public health policy area in the province, alongside policy makers from the Ministry of Health, the Provincial Health Services
Authority, academic groups from the University of British Columbia and the University of Victoria, practitioners working in health authorities, and groups from a number of non-profit or non-governmental organizations, including the BC Healthy Living Alliance and BC Healthy Communities. I have worked as a Health Promotion manager and Population Health Planner for Island Health, and currently work as a private consultant, a role I have held for 17 years. In addition, from 2000 – 2003, I was President of the Public Health Association of BC and I sat on the Board of Directors of the Canadian Public Health Association. Given all of this experience, I am familiar with how decisions are made at the provincial level, and the context of policy development and implementation within health authorities. My previous work experience shaped my decisions during the design of this research and during data collection and analysis.

During the early planning of this research (2008-2010), I spent considerable energy building on my previous networks so that they included many of the key players in HBE work in BC. I attended conferences and committee meetings where possible, invited some people for informal meetings over coffee, and made a point of searching out consulting contracts that were associated with the newly emerging HBE work in the province. As a result of these networking efforts, by the time I began the research design process for this research in earnest, I was very aware of the ways in which HBE work was developing in BC, where that work was developing most rapidly, and the general approach that was being taken in different areas of the province. The design of the research for the project, including the choice of case
study communities, was heavily influenced by this informal knowledge that had been gathered over three years.

For this research I chose to use a case study design, involving the critical analysis/evaluation of the implementation of the equity lens in new HBE initiatives within the province of British Columbia. Case studies have a unique ability to ‘tell a story’, in part because case studies allow the researcher to deal with a wide variety of evidence sources - documents, interviews, observations – all at the same time (Yin, 2009). The simultaneous use of evidence from a variety of diverse sources offers the case study a key advantage as a research method. Each of these sources has its strengths and limitations; using multiple sources in this case study allowed for the triangulation of data, which provided a more comprehensive picture of the implementation of an equity lens in HBE work within BC. Triangulation also helped to compensate for the limitations of each individual source.

The choice of a case study design for this research has allowed data from each of those sources to answer a slightly different type of question. For instance, I have used documents found online (and websites themselves) to answer the ‘what’ questions: What were health authorities and local governments doing together? What were their collective goals? How were those strategies geared to the unique characteristics of each community? In contrast, the interviews and one focus group allowed a much deeper look into what was happening in communities, together with a look at how particular strategies were being implemented, and why those strategies were chosen. Together, the data sources complement one another, and have allowed me to get a relatively comprehensive view of some very complex aspects of
community planning. The case study method was therefore an excellent choice. As Yin (2009) asserts, “the case study method allows investigators to retain the holistic and meaningful characteristics of real-life events” (p. 4).

4.1.1 Provincial and Local Levels

I designed this research so that I could most comprehensively explore how the use of an equity lens was being used during the planning process in particular communities, by whom, and the how the relationships between local context and the individual actors in those communities shaped how such a lens was used. The research design also had to capture the ways in which that lens was used in conjunction with a questioning of the structures and conditions that shape policy and practice, rather than restricting the analysis to the level of the individual. Political and other ideologies have a powerful (and sometimes covert) effect in shaping those structures. This research on the implementation of an equity lens, then, needed to also explore the role of higher-level political contexts.

This case study was therefore designed to examine HBE work from two main perspectives: at the provincial level, which focused mainly on education / training and policy, and at the local municipal level, through an in-depth exploration of projects in three geographic areas of the province. Both the provincial level work and the local level initiatives were examined with an emphasis on the degree to which they approached equity and social justice – issues that are vital to improving health, quality of life and human development. The research explored how the equity lens was defined in each setting, with special consideration to the ways in which the lens was defined differently at the provincial and local levels. When an equity lens had been used in the development and/or implementation of the HBE work, the research
design allowed for a description of how that lens was conceptualized and how its use was evaluated. Finally, the factors that supported and challenged the implementation of an equity lens were described.

**Units of Analysis at the Local Level: Surrey, Kelowna, and Terrace**

Because the study’s research questions aimed to describe how the implementation of an equity lens was associated with HBE work in BC, I decided to use three units of analysis in this case study, rather than just one or two. Given my previous experience working within and alongside the BC Ministry of Health and the province’s six health authorities, I knew that the ways in which projects take shape among health authority regions can vary significantly, in part because of the different organizational cultures of the health authorities. In order to shed some light on any different approaches in rural and urban areas, it was also important to examine HBE projects in communities of different size.

Therefore, HBE projects were chosen as units of analysis as they were taking place within three communities: Surrey, Kelowna, and Terrace. These three local communities chosen were all actively involved in HBE initiatives for at least the year prior to the start of data collection. They were selected in part because each of the cities is in a different health authority region, which allowed the examination of how the different contexts provided by the health authorities affected how the equity lens was defined and used.

The selection of the main components of this case study, including the three local projects, is an example of theoretical sampling: they were chosen because they helped to test
preliminary theories that have been developed based on the literature and through early discussions with HBE coordinators across the province.

When designing this research, I expected that the implementation of aspects of equity and social justice associated with this complex, intersectoral work would vary widely across the province, and that that variation would be connected with aspects of both the community/local government in question, as well as the strategic direction of each individual health authority. The three health authorities (Fraser, Interior, and Northern) provided a fascinating context for analysis of the HBE work in these three communities, because each health authority has chosen different approaches to how they have organized their HBE projects. As well, the three cities vary in size and type, which affected the types of community health issues each city/town has dealt with; issues of health equity therefore looked considerably different among the three communities. The choice of the HBE projects within these three communities, then, provided enough variation to learn about the breadth of the ways in which the equity lens was being implemented across the province. The choice of these three separate units of analysis in this case study offered a substantial breadth to explore and appropriately analyze the use of an equity lens within HBE work.

The methodology for this research involved an embedded case study design (see Figure 5, below), in which HBE initiatives in BC made up the main case being studied. The provincial policy direction and the three local projects were designated as units of analysis.
Figure 5: Model of Research Design

Design Overview

Case Study: Implementation of the ‘Equity Lens’ within HBE Work in BC

Provincial, Public Policy Level
- Document analysis
- Key Informant Interviews

Local Level
- Interior Health: City of Kelowna
- Fraser Health: City of Surrey
- Northern Health: City of Terrace
- Key Informant Interviews
- Participant observation
- Document & Archival Records analysis

Key Questions:
How has the equity lens been defined? How is it being implemented at the policy level? At the community level?
4.2 Data Collection Procedures

I collected data for this research over a period of two years. Following ethics approval from UBC, I began data collection in January 2012. I visited Surrey three times: in January, May, and June 2012. I visited Kelowna twice, in April and June 2012, and Terrace only once, in February 2012. In the summer of 2013, I went back to collect more data, mostly in the form of strategic documents from the local governments of Surrey, Kelowna, and Terrace, as well as from the health authorities and the provincial Ministry of Health. Finally, I did a series of follow-up interviews in December 2013 and January 2014.

As mentioned in Chapter 3, the HBE policy area, and the emerging practice surrounding it, is rapidly developing. The following briefly describes the methods I used to collect the data.

4.2.1 Provincial Level

At the provincial level, my aim was to learn about how the upper level policy contexts affected how an equity lens was conceptualized and used at the local level. That policy context was complex and rapidly developing, so it was important that I collect data from a number of different types of sources, so that I could get a comprehensive picture of how provincial level perspectives and priorities might have affected the work of HBE teams at the local level.

Key Informant Interviews

In late 2011, before I began formal data collection, I developed a list of potential key informants at the provincial level. At that time, HBE work in BC was still relatively new, and so the number of people actively involved in that work from the provincial level was small. Given my previous knowledge and experience in public health in the province, I was able to identify
and make contact with a total of seven people in Victoria and Vancouver. All agreed to an interview, to explore issues from the level of the province. In choosing people with whom I might request an interview, I made sure that I included leaders within the provincial government. In addition, I offered invitations to interview leaders within the provincial-level health authority, the academic community, and provincial level non-profit groups. All of these groups have supported HBE projects in some way.

After an appropriate date and time had been set for the interview, all interviewees were sent a copy of the consent form (see Appendix A) and a two-page summary of the project (see Appendix B) by email. I sent these documents ahead of time (sometimes a month before the meeting was to be held) for two reasons: to allow the interviewee to adequately prepare for the interview, and to save time during the interview itself. In my experience as a consultant, I have learned that pre-reading documents are common for professional meetings, and sending them before a meeting is considered respectful practice. A few days before each interview, I also confirmed the date, time, and place by email.

The key categories of provincial level key informants interviewed are presented in Table 2, below.
Interviewees at the provincial level included BC Ministry of Health public health staff focused on Core Functions and Built Environment work, members of the Healthy Built Environment (HBE) Alliance, Provincial Health Services Authority (PHSA) staff helping to coordinate HBE work, and staff from a relevant non-governmental organization. All of these interviewees were actively working on HBE-related issues and/or the implementation of an equity lens from policy and/or research levels. Four of the interviewees were women, and three were men. All were professional practitioners with advanced degrees. Five of the interviewees were white, two were people of colour. Prior to data collection, I had known all but one of these interviewees. In a couple of cases, I had worked with the interviewees quite closely on a number of projects over the past 10 years.

All of the interviews were done in a face-to-face format at a place determined by the interviewee. In all but one case, the interviews took place at the interviewee’s office. One interview took place in a coffee shop. All interviews lasted from 50 – 60 minutes, and were

### Table 2: Provincial-Level Interview Participants

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of Key Informants Interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provincial Government (BC Ministry of Health)</td>
<td>2</td>
</tr>
<tr>
<td>Academics Involved in research of HBE and/or the equity lens</td>
<td>2</td>
</tr>
<tr>
<td>Provincial-level Health Authority (PHSA)</td>
<td>2</td>
</tr>
<tr>
<td>Non-Profit Organizations</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7</strong></td>
</tr>
</tbody>
</table>
audio-recorded, with the permission of the interviewee. Later, each of these audio recordings was transcribed. I hired two graduate students to help with transcription.

I used a semi-structured approach for all of the interviews. I used a set of pre-determined questions that addressed the key research questions (see Appendix C for the provincial-level interview questions), while still allowing some flexibility to explore new questions or themes as they came up during interviews. During interviews, key informants were asked about their impressions of what an ‘equity lens’ means with respect to HBE work, how it has been or might be implemented in the future, and the challenges and barriers to implementing the lens at the provincial, health authority, and local levels.

I began each interview with small talk to help to put the interviewee at ease and to become re-acquainted. I then explained the project briefly, and referred to the two-page summary of the project. Before I began asking questions, I checked with each interviewee, to make sure they adequately understood the project, my role as a student researcher, and their rights to refuse to answer any question and/or to request that the interview stop at any point.

For the first two or three interviews, I began each interview by asking each question on the script. However, I soon realized that the questions as they were written in the fall of 2011 were out of date, even though some of the interviews were held as early as January 2012. The questions assume the prominence of the Core Functions in Public Health work at the provincial level, but, by early 2012, that Core Functions work was no longer a high priority. Instead, the provincial government was then emphasizing the Healthy Families BC initiative, and HBE efforts were structured around that new initiative. Given this significant change in the context
surrounding HBE work, I altered the interview questions, and framed them as relating to Healthy Families BC, rather than the Core Programs in Public Health initiative.

**Documentation**

The collection and analysis of documents is useful in most case studies because that analysis allows the researcher to support or verify findings that have come from other sources (Yin, 2009). To this end, I gathered and analyzed provincial-level policy reports, training/education materials, and conference/workshop proceedings that pertained to Healthy Built Environments work in BC. This information took the form of formal reports, presentations, websites, YouTube videos, and social media (Facebook and Twitter) interactions/postings. All of these sources were available online, and were collected (in some cases, downloaded) between January 2012 and December 2013. I analyzed the reports and online material to help shed light on how issues of equity were defined and used at the provincial policy level, and how policy makers suggested equity be considered as part of local-level HBE work. The collection and analysis of these documents, particularly those that described the Healthy Families BC initiative, was vital for shedding light on the context in which HBE work was taking place.

At the provincial level, I collected data from a total of 7 strategic reports, 6 webpages, 4 YouTube videos, one presentation, and one Facebook page (see Table 6 in Section 4.2.3). To locate these documents, I relied on simple web searches, as well as recommendations from key informants. Some examples of the types of provincial-level documents I analyzed are available in Table 3, below.
### Table 3: Examples of Provincial-Level Document Sources

<table>
<thead>
<tr>
<th>Title</th>
<th>Author / Publisher</th>
<th>Type of Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010-11 Gap Analysis &amp; Improvement Plan: Healthy Community Environments Core Public Health Program</td>
<td>Provincial Health Services Authority</td>
<td>report</td>
</tr>
<tr>
<td>Building a Healthy Community – Healthy Families BC</td>
<td>Province of BC</td>
<td>webpage</td>
</tr>
<tr>
<td>Rural Land Use Planning for Health Practitioners</td>
<td>Provincial Health Services Authority</td>
<td>presentation</td>
</tr>
<tr>
<td>Healthy Families BC</td>
<td>Province of BC</td>
<td>Facebook page</td>
</tr>
<tr>
<td>Building Collaborations for Healthier BC Communities (2009)</td>
<td>BC Healthy Built Environment Alliance</td>
<td>report</td>
</tr>
<tr>
<td>Local Governments &amp; Healthy Communities (PlanH)</td>
<td>BC Healthy Communities &amp; Healthy Families BC</td>
<td>video</td>
</tr>
<tr>
<td>Picture of Health (Plan H)</td>
<td>BC Healthy Communities &amp; Healthy Families BC</td>
<td>video</td>
</tr>
</tbody>
</table>

**Participant Observation**

When the original prospectus for this research project was developed, my intent for data collection at the provincial level was to undertake only interviews and the analysis of key websites and other policy-related documents. However, when I began interviews with people working at the provincial level on HBE initiatives, I realized that it would be beneficial for me to attend some key meetings taking place within the time frame of my fieldwork.
I therefore attended two meetings as a participant-observer. Both meetings were closed; they were not open to the general public. I attended the following meetings:

- Healthy Families BC Communities Initiative Consultation, Vancouver Island Local Government Area Association, February 2012
- BC Healthy Built Environment Alliance strategic planning session, April 2012

In both cases, I received invitations to attend the meeting from the event’s organizing committee or key sponsor.

Attending these meetings and participating in them as a student researcher allowed me to gain access to provincial-level groups working in HBE. Participant observation is often considered a key tool in studies that use ethnographic techniques, but the method can be an essential component of case study research too, in part because it can allow access to events or groups that might otherwise be inaccessible to the researcher (Di Domenico & Phillips, 2009; Yin, 2009). As it relates to ethnographic study, the literature identifies four positions of the researcher in participant observation:

- The ‘insider’ role, in which the researcher is a member of or has strong links with the community being studied, vs. the ‘outsider’ role, in which the researcher is new to that community.
- The ‘covert’ role, in which the research participants or members of that group or community are not aware that the researcher is observing or participating for the purposes of studying the group. In contrast, when in an ‘overt’ role, the researcher has
been open and honest with the group that he or she is conducting research while interacting with the group or community (Uldam & McCurdy, 2013).

While there are debates in the literature about the pros and cons of each position or role of the researcher, many authors have pointed out that, in reality, these positions are best seen as ends of two continuums (Jorgensen, 1989; Mercer, 2007) that are interrelated and may change over time as fieldwork progresses (Uldam & McCurdy, 2013).

In any of these positions, it is important that researchers be very aware of the ethical implications of the practice of participant observation. For instance, the participants within a meeting might be informed at the beginning of that meeting that the researcher is there to formally study the meeting’s proceedings, but might ‘forget’ or lose touch with that information as the event progresses. The potential for this result can increase with those researchers who were familiar with the group prior to the start of the study (Uldam & McCurdy, 2013).

A separate, but related, challenge can occur when the researcher brings with him or her preconceptions or ‘baggage’ into the event or situation that is being observed. These preconceptions can influence the researcher’s observations and interpretations of the event. Finally, because the researcher is participating in the event, and not just passively observing, he or she may change the course of the event and the behaviour of the participants, by, for instance, introducing values, language, or norms that can disrupt those that existed before he or she joined the group (Di Domenico & Phillips, 2009).

Participant observation within case studies can be a useful tool to better understand the viewpoints of people ‘inside’ the study, rather than external to it (Yin, 2009), but it is important
for the researcher to be open and honest about the lens with which he or she was both participating and observing. In addition, results from participatory observation should be compared and corroborated with other sources of evidence, to verify the results.

At both of the provincial-level meetings I attended, at the beginning of the meeting I introduced myself to the whole group, briefly described the nature of my research, and indicated that I was participating in the meeting as an observer. Specifically, I mentioned that I would be taking hand-written notes throughout the meeting about the main discussion topics. I stated that I would not record names nor would I identify people by name or position in my research. Finally, I asked for (and received) verbal permission from the facilitator and from the rest of group for me to attend the meeting as a participant-observer.

Of the 15 people at the BC HBE Alliance Strategic Planning session, I had worked with about 10 in the past. At that meeting, I initially observed only, and did not get involved in the discussion. Towards the end of the meeting, however, the facilitator (a person I have known for 15 years) encouraged me to become more actively involved. I therefore took part in the small group discussions, and helped the facilitator by recording the group’s ideas on flipchart paper.

At the Healthy Families BC Communities Initiative Consultation, I was less active in discussion. I had gained entry to that meeting by offering to take notes during one of the small group discussions. About 20 people attended the meeting. Most were staff or elected officials from municipalities within the Capital Regional District (Victoria, B.C.).

4.2.2. Local Level

Data collection at the local level was somewhat more complicated than at the provincial level because I had the added task of understanding aspects of the community’s health and
well-being, as well as the ways in which HBE work was moving forward in that area. Learning about the population health and planning-oriented issues within each community was important, because those issues provided important considerations for how HBE work was being planned and implemented, including how equity was considered.

As I mentioned early in this chapter, I did not take an ethnographic approach to this study. I therefore did not spend an extended period of time in each community. From January to June 2012, I visited Surrey three times, Kelowna twice, and Terrace only once. Each visit lasted from three to four days. I had intended to return for a second visit to Terrace, but found that the plane fare was, unfortunately, outside my budget.

During those visits, I used a variety of methods to collect data. Those methods are described in the sections below.

**Key Informant Interviews**

I interviewed eight people in each community (Surrey, Kelowna, and Terrace) as part of this study. To decide on the group of people within each community to invite for an interview, I used a type of purposive sampling, a strategy that involves considering the person or place or situation that has the largest potential for advancing our understanding of the research question, and starting there (SAGE Publications Inc., 2008). Specifically, I used both theory-guided sampling and criterion sampling techniques.

In each of the three communities, my sampling strategy was based on my desire to learn everything I could about how HBE work was happening in that community, and how issues of social justice or equity were being approached. That meant talking with key members of the
emerging HBE committees in each community, as well as potential members of those committees. I therefore started my search for potential key informants at the health authority level, because I knew from my review of provincial-level documents and through my interviews with policy makers at that level, that health authority staff were actively building HBE committees as part of the Healthy Families BC mandate.

In each of the three communities, I made initial contact with the health authority-based Healthy Communities or HBE coordinator in that area. Given my experience in public health in BC, these are three people I had known prior to beginning my fieldwork. During email discussions and through questioning at the interview with this key contact, I was able to build a list of potential key informants from each community. In Kelowna and Terrace, where a formal HBE committee was still being formed, my list was quite short. In both of those cases, the list of potential key informants included the few people actively involved in the initial HBE work in that area, plus two or three other individuals who had not yet been involved with the HBE committee, but who were aware of the community planning and/or health issues that were unique to that area. In Surrey, where the Healthier Communities Partnership committee had been formed and was up and running, my list of potential key informants included some of the key organizers of the committee, as well as those people focused on general community health and social planning issues in the city.

The emerging research literature into the integration of a consideration of equity and the social determinants of health in health promotion work at the city or community level suggested that intersectoral collaboration was important (Chomik, 2007; Public Health Agency
Therefore, one of my goals in each community was to have a cross-section of interviewees from each sector (local government and public health). In addition, because this research was informed by the ‘nutcracker approach’ theory suggested by Fran Baum (2007), an approach that suggests that social inequities are best tackled by the simultaneous action at both the policy and grassroots levels, I knew it was important to invite potential key informants at both of those levels. I therefore sought out potential interviewees in each community who were elected officials (city councillors) and others who were associated with community-based organizations. Throughout my fieldwork, I continued to add to my list of potential key informants until all of the key players directly involved in HBE work in that community had been interviewed. This was possible because HBE work in BC was still at a relatively new stage in 2012-2013, and HBE teams were just being formed.

As mentioned regarding the provincial-level interviews (Section 4.2.1), I made initial contact with each local-level key informant by email, at which time I sent each prospective interviewee a two-page summary of the research design and objectives (see Appendix B). Over the course of fieldwork, that summary document was altered twice, when I found that the language was too technical for some key informants to relate to. After each interviewee with whom I made initial contact agreed to an interview, I then sent them the consent form and again, the two-page summary. As with the provincial-level interviews, I confirmed the date, time, and place of each interview about a week prior.
Each interview lasted approximately 45-60 minutes. I conducted all interviews in person (at a location chosen by the interviewee – often their office, or a coffee shop near their office), with the exception of two interviews with key informants from Terrace, which were conducted by phone. In addition, the three follow-up interviews in December 2013 and January 2014 were done over the phone. All interviews were audiotaped with the permission of the interviewee. At the end of each interview, I asked the interviewee for names of other people I should invite to participate in the research, a process known as snowball sampling (Silverman & Marvasti, 2008). In one case, I met with three interviewees at once, in a group interview. The interview was held in this way at the request of the three interviewees.

During each interview, I asked key informants to describe or identify the following:

- some aspects of the unique ‘character’ of that community and key local events that may be influencing the implementation of an equity lens in the HBE project;

- local issues of inequity or poor health;

- how health equity issues are being incorporated into HBE work; and,

- his or her reflections on the potential strengths and challenges of integrating a consideration of equity/social justice and/or the social determinants of health as part of the HBE project (see Appendix D for the interview questions).

Time was also allotted during each interview to insert other, unanticipated questions that arose during the course of the research. For instance, in some cases I asked interviewees to help clarify or corroborate a piece of vital information that had come from the review of key documents.
As with the provincial-level key informant interviews (Section 4.2.1), the local-level interviews were semi-structured, in that I asked interviewees each of the questions from the standard list I had developed (see Appendix D), but I allowed each interview the freedom to digress. This use of a semi-structured format for interviews allowed the interviews to reflect an awareness that individuals understand the world in different ways (Berg, 1998). Throughout the local-level key informant interviews, I was aware that, due to their background or role within the community, my key informants might vary in the ways in which they reacted to my questions. Therefore, I remained flexible during the interviews, and at times I changed the order of the questions, depending on the responses of the interviewee. When an interviewee brought up a topic that was particularly interesting or unexpected, I probed to find out more. Finally, I changed the wording of the standardized questions, at times, to reflect the realities of that particular community or the role of a certain key informant. For instance, when interviewing key informants in Surrey, I asked about the role of their social planning team. However, I did not mention social planning in the same way in Terrace or Kelowna, given that neither city had a staff team dedicated to social planning at the municipal level.

The people from each community who took part in interviews included city council members, health authority staff, local government staff (chiefly land use and social planners), and local community leaders, including representatives from non-profit organizations, local activists, and community members who have been active in local planning issues. These roles are summarized below in Table 4.
Table 4: Summary of Interviews at the Local Level

<table>
<thead>
<tr>
<th>Sector / Category</th>
<th>Surrey</th>
<th>Kelowna</th>
<th>Terrace</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health authority (public health)</td>
<td>5</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Local government (comprehensive or land use planners, social planners, or recreation administrators)</td>
<td>1</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Local elected officials (councilors)</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Community groups or non-profit organizations</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>8</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

The interview questions did not ask about demographic information. However, all of the interviewees were professional practitioners or elected officials, presumably with at least an undergraduate degree and a good salary. Of the 24 people interviewed at the local level, 16 were women and 8 were men, and most were between the ages of 35 and 55. All of the people I interviewed in person were white. As with the provincial-level interviews, the audio-recordings of all local-level interviews were transcribed to assist with analysis.

Documentation

As mentioned in Section 4.2.1, above, documentation offers an important set of insights for case studies (Yin, 2009). For the local level data collection process, I retrieved and reviewed a variety of documents from each community, including:

- agendas and minutes of meetings of HBE project teams (Surrey only), municipal council meetings, and results of community planning public hearings or meetings;
• administrative documents – proposals, progress reports, and other policy documents relating to the HBE project or other, more general areas of community and health planning (e.g. Official Community Plans, Local Neighbourhood Plans); and,

• news clippings and other articles in local newspapers or Internet sites.

Like the documents relating to the provincial level, the documents pertaining to the local level also took the form of formal reports, presentations, websites, YouTube videos, and social media (Facebook and Twitter) interactions/postings. All of the above documents were found online, with the exception of the agendas and meeting minutes of Surrey Healthier Community Partnerships Committee (HBE project team), which were given to me in paper format by the co-chair of the committee.

Despite the importance of using documentation in case studies to corroborate and augment other sources of evidence, I kept in mind during the collection and analysis of the documents that they were prepared for another purpose outside of my research, and therefore should not treated as literal accounts of how a particular community or organization functions or the prevailing perspective of community members. All documents, of course, reflect the bias of the author and/or the publisher, and therefore should be treated with caution in case study research (Silverman & Marvasti, 2008; Yin, 2009).

To help shed light on the strengths and challenges of each community, as well as how HBE work in that area was being conceptualized and implemented, I examined all local level documents based on how concepts of equity were defined and used. Again, document analysis was used to support the triangulation of other data sources.
The following table (Table 5, below) offers examples of the key types of documents gathered in each community.
### Table 5: Examples of Local Level Documents Retrieved

<table>
<thead>
<tr>
<th>Type of Document</th>
<th>Community</th>
<th>Report / Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy / Strategic Report</td>
<td>Terrace</td>
<td>City of Terrace (2011). <em>Terrace 2050: City of Terrace Official Community Plan</em></td>
</tr>
<tr>
<td></td>
<td>Surrey</td>
<td>Health &amp; Community Design Collaborative (2011). <em>Housing + Transportation + Health: Connecting Ideas and Practice for Healthier Communities (Workshop Report)</em></td>
</tr>
<tr>
<td></td>
<td>Kelowna</td>
<td>Fresh Outlook Foundation (2011). <em>Collaborative Planning &amp; Action for Community Wellness: Local Governments and Health Authorities Working Together (Workshop Report)</em></td>
</tr>
<tr>
<td></td>
<td>Surrey</td>
<td>Vibrant Surrey (2012). <em>The Facts on Poverty in Surrey</em></td>
</tr>
<tr>
<td>Website</td>
<td>Terrace</td>
<td>Northern Health. <em>Putting the Population Health Approach into Action</em>.</td>
</tr>
<tr>
<td></td>
<td>Kelowna</td>
<td>Interior Health. <em>Healthy Built Environment</em>.</td>
</tr>
<tr>
<td>YouTube Video</td>
<td>Surrey</td>
<td>Fraser Health: <em>Committed to Healthier Community Partnerships</em></td>
</tr>
<tr>
<td></td>
<td>Terrace</td>
<td>Northern Health: <em>Healthy Communities</em></td>
</tr>
<tr>
<td>Social Media</td>
<td>Surrey</td>
<td>Fraser Health: Healthier Community Partnerships (Facebook)</td>
</tr>
</tbody>
</table>

**Direct Observation**

In this case study, it was important to help to set a context for HBE work at the local level.

Given that the key aspect of my research examined how issues of equity and social justice were being integrated into HBE at both the provincial and local levels in BC, I needed to make sure...
that I gathered a clear picture of the contexts in which that work was developing. I needed to understand the social and community health issues each city was facing, and the ways in which social inequities were manifesting, so that I could put my questions into context, and get a better idea of how to ask them. For instance, my travels in Kelowna helped me to understand how income levels in different neighbourhoods of the city varied, which helped me to ask about inequities; during interviews with Kelowna city councillors, I was able to ask directly about issues with affordable housing in that city, as well as resource distribution for some low income neighbourhoods versus more affluent ones. In another example, my observations in Surrey helped me to understand just how rapidly that city is growing, and how that rapid growth had affected planning strategies, including HBE planning. My observations in each of the three case study communities therefore helped to ‘set the stage’ for the other elements of the research.

During my fieldwork visits to each community, I spent several hours each day touring the area, making sure to visit all neighbourhoods. In Terrace, I did this touring on foot. In Surrey and Kelowna, a car was necessary. I made a point to spend more time in those neighbourhoods in which a considerable amount of residential development was taking place (Surrey and Kelowna). I also spent considerable time in the lower income neighbourhoods of each city. While visiting all of these areas, I recorded what I saw, heard, felt, and experienced in the form of written field notes. While driving or walking through the community, I often stopped by the side of the road to jot down notes. At the end of each day, I pulled those jottings together in the form of more comprehensive field notes. Because my field notes were taken and summarized/elaborated immediately after visiting a particular neighbourhood, it was easier to
remember what I saw and how I experienced that neighbourhood. This practice is consistent with general guidelines on developing field notes (Berg, 1998; Emerson et al., 1995).

During my touring by car or on foot, I took over 100 photographs of key neighbourhoods in each city, especially those areas that were considered important (e.g. requiring re-zoning, areas for new proposed development) to community planning in the area, or areas that reflected issues of income inequity. I photographed parts of each city that reflected the general economic situation of each community, because that economic situation affected how social inequities might have been shaped and established. Specifically, I made a point of photographing the condition of housing and public spaces (e.g. parks) within each neighbourhood, as well as aspects of the built environment that might affect active transportation, such as walking paths or sidewalks, bike paths, and access to public transit.

Most of the time during my observations within the three communities, I maintained a sense of ‘invisibility’ (Berg, 1998) – I tried to blend in with my surroundings and did not announce my intentions as a student researcher. This role was appropriate, given that my observations were more about the state of the built environment of that neighbourhood, rather than the social interactions of people. However, in Kelowna and in Terrace, I did get involved with some local residents in informal conversations, typically in coffee shops. I engaged with these people mostly to be polite at first. But I later realized that these casual conversations might be more important than I first thought, because they helped me to better understand the concerns of some community members and the general ‘culture’ of each community. For instance, during my time in Terrace, I spent several hours (in between meetings) in a coffee shop in the city’s
downtown district. Two or three people approached me in a friendly way, to ask about what I was doing. When I offered a very brief explanation of my research questions, one person provided me with her ideas of how those questions relate to Terrace. In another instance, an older man gave me some of the highlights of the history of Terrace over the last 50 years or so. I enjoyed these conversations and included them in my field notes of that day.

**Observing Meetings**

In each of the chosen communities, I observed at least one public and one private meeting. The public events included city council meetings in each community. As well, I observed a meeting of a HBE project team or a social planning committee in each community. During observations, I was attentive to issues of language with regard to issues of equity, social justice, inclusion, and diversity and the involvement and role of local community members, especially as these issues related to land use or other areas of community planning.

Before each meeting, I introduced myself and reminded the group of my role as an observer/researcher. I recorded brief field notes during each meeting. None of the meetings were audio- or video-taped, and no photographs were taken during the meetings.

**Archival Records**

Finally, archival records were gathered that helped to bring forward a more comprehensive idea of the strengths and struggles of each of these local communities - issues that influence the form that any consideration of health and social justice issues might take during the planning and implementation of the HBE project. These records were found on the websites of the associated health authorities and/or the local governments. They included statistical
information about each community’s health status and economic situation, and maps and charts of the geographical characteristics of each community, including land use characteristics and the location and characteristics of new developments that have been planned.

4.2.3. Summary of Data Collection Methods

Over the course of approximately 18 months, I collected a total of 243 data sources (please see Table 6 on the next page).
Table 6: Data Sources by Location/Community

<table>
<thead>
<tr>
<th>Location / Community</th>
<th>Interviews</th>
<th>Group Interviews (# of people)</th>
<th>Documents</th>
<th>Photos</th>
<th>Meeting Notes (sets)</th>
<th>Field Notes (sets)</th>
<th>Websites</th>
<th>Videos (YouTube)</th>
<th>Social Media (Facebook / Twitter)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kelowna</td>
<td>8</td>
<td>---</td>
<td>13</td>
<td>2</td>
<td>23 + 31 = 54</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>--</td>
</tr>
<tr>
<td>Terrace</td>
<td>8</td>
<td>1 (2)</td>
<td>21</td>
<td>4</td>
<td>26</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Surrey</td>
<td>8</td>
<td>1 (3)</td>
<td>11</td>
<td>3</td>
<td>18 + 5 = 23</td>
<td>2</td>
<td>3</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Provincial</td>
<td>8</td>
<td>---</td>
<td>7</td>
<td>--</td>
<td>---</td>
<td>2</td>
<td>---</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>2</td>
<td>52</td>
<td>9</td>
<td>103</td>
<td>8</td>
<td>6</td>
<td>19</td>
<td>9</td>
</tr>
</tbody>
</table>
4.3  Data Analysis Procedures

There is no standard ‘recipe’ or ‘formula’ for the analysis of data collected in a case study (Yin, 2009). Instead, the process is custom-built, revised, and ‘choreographed’ (Creswell, 1998; Huberman & Miles, 1994). However, because this case study involved gathering a large quantity of different types of data (i.e. from interviews, participant observation, and review of various kinds of documents), it was important to have a general analytic strategy to allow the development of a rich and full description of the case. As Yin (2009, p. 130) says, “all empirical research studies, including case studies, have a ‘story’ to tell”. The analytic strategy presents a guide to telling this story.

The general strategy that I used for data analysis was informed by the theoretical framework I used, which guided the ‘how’ and ‘why’ questions about the ways that the equity lens was defined, described, and used during implementation of HBE initiatives. The analysis was also informed by previous research, including the San Francisco case studies as presented by Corburn (2009) and the Healthy Communities case study research provided by Stern and Green (2005, 2008). Finally, the data collected in this study of the use of an ‘equity lens’ was compared to the use of similar lenses used in other jurisdictions, including the United Kingdom, Seattle, WA, and Ontario.

Because the data collection and data analysis procedures used was informed by a defined theoretical framework and previous relevant research, I used an approach to content analysis that has been referred to as ‘directed content analysis’ (Hsieh & Shannon, 2005). Through this type of content analysis, the project helped to validate or extend conceptually the framework
provided by a combination of the ‘nutcracker effect’ suggested by Baum (2007) and the Multiple Streams Model of public policy change (Kingdon, 2003). This framework has helped me to focus attention on certain data (i.e. that most relevant to one or more of the research questions) and put aside other data that were less relevant.

I used this strategy to identify the initial coding schemes that I used to organize text into themes. I used a number of coding methods, including attribute coding, sub coding, simultaneous coding, and structural coding, as described by Saldaña (2013), for interviews and documents. Descriptive coding was used for content analysis with field notes, websites, videos, and social media data. Analytic memos were continuously prepared for all types of data. The codes used in this first stage of coding included intersectoral work, diversity/inclusion, social planning, role of Medical Health Officer (MHO), and equity language.

For much of the key codes (and their accompanying data) coming from the first stage of coding, I reorganized and reconfigured the data and codes, so that I had a better organized and streamlined collection of categories, themes, and concepts on which to reflect. This process can be referred to as second cycle coding (Saldaña, 2013). As patterns and themes began to emerge across data sources, and relationships between categories became apparent, I revisited each data source and sets of codes using pattern coding and other coding strategies, together with additional memo writing. I based some of the organization of second cycle codes and data on my three key research questions.

For all of the content analysis, I used NVivo 10 software as a data management and organizational tool. NVivo seemed ideal for this case study, since it allows the simultaneous
analysis of many different types of data, including interviews, websites, written documents, video and social media.

For the final stage of analysis, I did a cross-case analysis that compared the patterns and themes in the data of the provincial level data with the local level data, to explore differential ways in which policy makers and local community members conceptualized the equity lens, and the struggles and successes staff from each level have experienced. Data from each of the local level projects were also compared to one another, to identify any significant aspects of context (in this case rural vs. urban settings, and health authority region) that may have influenced the way that the use of the equity lens has played out in those communities. These patterns and themes were then compared to the key concepts and approaches that emerged from other case studies found in the literature, as well as the two key theoretical approaches that have helped shape this research.

4.4 Ethical Considerations

The complex nature of a case study of this type brings up some important ethical issues that are important to address. Throughout this chapter, I have mentioned some of the ethical considerations I kept in mind during the data collection process. The following is a brief summary of the steps I took during the research process to maintain ethical practice.

Free and informed consent was obtained from all participants of this research, including those taking part in small group discussions as part of public meetings. When written consent was not feasible (e.g. when interaction with a participant is brief), verbal consent was sought. Please see Appendix A for a copy of the consent form. All interview participants were advised
that they could withdraw from the research at any time, and were given the opportunity to review a transcript of their interview if they wished.

Throughout data collection, analysis, and reporting, I ensured confidentiality of the research participants by deleting names and other references that could identify individuals. Each interviewee was assigned a code number to which all of their comments were matched. Only I had access to the consent forms, the full list of participants, and their assigned codes. Of course, anonymity was not possible during public or committee meetings.

I carried out this research according to the University of British Columbia Behavioural Research Ethics Board protocol under a certificate of approval for minimal risk.

4.5 Validation of Findings

In qualitative research, the researcher must be able to demonstrate that the findings of the study represent an accurate picture of the phenomenon he or she was attempting to describe or explore (Creswell, 1998). One of the key advantages of using a case study design is the ability to gather evidence from a variety of diverse sources. Each of these sources has its strengths and limitations; using multiple sources in this case study allowed for the triangulation of data, which provided a more comprehensive picture of the implementation of an equity lens in HBE work within BC. Triangulation also helped to compensate for the limitations of each individual source. Most importantly, however, my use of triangulation in this study provided corroborating evidence from different sources to shed light on particular themes or perspectives.
Miles, Huberman, and Saldaña (2014) refer to triangulation as “not so much a tactic as a way of life” (p. 300), and remind us that there are different ways to incorporate triangulation into qualitative research studies. In this study, by collecting a variety of types of data (websites, interviews, photographs, etc.) in three different communities, by various methods (observation, interviews, document review), I was able to triangulate by data source, method, and data type (as described by Denzin, 2001).

One of the key criticisms of case studies is that the method presents too much opportunity for bias – that ‘subjective’ judgements are made during data collection and analysis (Yin, 2009). This bias might threaten the validity of the study, that aspect of the research that confirms the ‘truth value’ of the work. Several authors, including Creswell (1998) and Miles, Huberman, and Saldana (2014) suggest that qualitative research can help to ensure a higher level of validity if a variety of specific steps are taken during research design, data collection, and analysis. Triangulation is one of those key steps. Others include connecting the data to categories of prior or emerging theories, and providing rich, thick description of the setting and phenomenon under study. Finally, it is important that the researcher is open from the outset of the study about his or her position with regard to the research issue, and how that affects his or her interpretation of the data (Creswell, 1998; Miles et al., 2014). I have used all of these techniques in this research.

4.6 Limitations

There are four main limitations to my research design and methodology. Those limitations are:
• The use of a case study research design does not allow me to generalize beyond this particular case. The challenge of generalizing case study research beyond that particular case is one of the key “misunderstandings” of this approach to qualitative research (Flyvbjerg, 2006). Yet generalizing is not always necessary, nor is it always useful. I selected a case study because of the nature of the research problem and the questions being asked. This method was the best way to answer those questions. Using this approach, I was able to investigate a complex set of interactions among people in real-life situations. In this way, I could gather a rich and holistic account of this particular phenomenon, with the idea that describing the connected work of planners and public health staff might help others outside of those three HBE teams in Surrey, Kelowna and Terrace to learn from those experiences. I was not attempting to generalize beyond this case. Case studies do not attempt to simplify inherently complex phenomena; instead, they help us to acknowledge that there are no simple or straight forward answers, which I see as a strength of the approach, not a limitation.

• The research method I used does not offer the depth to really delve into some of the political and interpersonal processes happening within the three communities. Due to time and financial constraints, I was not able to spend a substantial amount of time in each community, as might be the case with a design that focused more on ethnographic methods, for instance. However, I was able to raise a number of interesting and useful questions that could be follow-up in further studies, as this research area develops.
• *My prior experience as a consultant and practitioner might have biased how I gathered and interpreted the data.* The nature of my prior experience did help to shape the research design and how I reacted to the data. I chose to study something that was familiar to me, in part because my prior knowledge of this area and the people involved allowed me an ‘in’ that other researchers might not share. Throughout the research process, I was completely open and honest about my past experience with the topic area and the people involved. The process of triangulation (described above in Section 4.5) also helped to ensure the validity of the approach.

• *The demographics and characteristics of the interviewees are not representative of the general population, so they offer a limited perspective.* The people who served as interviewees in this study were carefully chosen in terms of their ability to provide crucial insight into a process which is hidden from the general public. They could therefore be considered ‘experts’ because they provided important insider knowledge and perspectives for this qualitative research (Bogner et al., 2009). I needed to gather these expert opinions, experiences and ideas in order to answer the research questions; sampling from a broader set of interviewees, which might have been more representative of residents within each of the three communities, did not make sense, because I wanted to know about the policy making process from within. During the time period of my fieldwork, HBE initiatives across the province were at an early stage of development, and there were only a few individuals in each community who were involved in this emerging work. With the exception of one or two people in Surrey, the eight people interviewed in each community made up a relatively
comprehensive list of the individuals who were actively involved in HBE work at the time. They did, indeed, offer a limited perspective that has been shaped by their demographics and their position in society, but that is the perspective I needed to answer the research questions. It is important, however, to be cognizant of underlying power dynamics (especially with regard to gender) that can underlie interviews with experts (Abels & Behrens, 2009).

4.7 Summary

In this chapter, I outlined the overall design of this research and the ways in which data was collected and analyzed. I have organized this study to provide both breadth and depth in an understanding of the complex set of factors that have affected how an equity lens has been defined and implemented within HBE work in BC. The research design and the case study approach I have used allowed me to collect information about both the provincial and local levels. This design has offered a good case with which to study the ways in which equity and social justice have been integrated into HBE work in BC.

Completing the fieldwork and data analysis for this project was an eye-opening experience for me. Despite my years of experience as a public health practitioner and consultant, this qualitative inquiry helped me to better understand how policy decisions are made, and how ‘messy’ this process can be, especially when organizations from different sectors are working together.
Chapter 5: How the Lens has been Defined and Used

In this chapter, I explore the foundations of the implementation of the equity lens as it has been associated with HBE work in BC. Specifically, in this chapter, I aim to address the first research sub-question: How has the ‘equity lens’ been defined, and how did those definitions differ among local planners, public health staff, and provincial-level policy makers?

First, I will demonstrate how the terms associated with social and health equity have been understood and used, because the use of language about these complex concepts illustrates the ways in which planners, health authority staff, and community members have defined and have found meaning in the notion of a lens. The discussion then delves into the different ways an equity lens has been used or implemented at the provincial level, and within each of the three case study communities. Throughout the discussion, I reflect on the discrepancies between what new research is suggesting an equity lens (as it’s associated with planning) might look like, and what has actually occurred in these three BC communities. More detail about the day-to-day work of HBE committees or teams in Surrey, Kelowna, and Terrace is provided in Chapter 6. In Chapter 7, I offer an exploration of the supports and challenges in terms of the ways in which that work is associated with equity and social justice.

5.1 Language and Framing: How the Equity Lens has been Defined

In this study, issues of equity were framed and understood in different ways, depending on the group or sector. I learned quite early when collecting data in these communities that I should not use the word ‘equity’ when talking with my interviewees. In some cases (particularly
with elected officials), I received subtle feedback that the word ‘equity’ was too nebulous for them, and so I began to use the terms ‘diversity’ or ‘inclusiveness’ or I referred to ‘healthy communities for all’ instead. In other cases, I provided only concrete examples of what greater equity might look like at the local level. For instance, we talked about affordable housing, or access for low income neighbourhoods to recreation services, green space, or public transit.

This type of reframing of equity issues in order to emphasize the concrete, policy-oriented issues that local government could relate to was consistent with what some health authority HBE or healthy communities staff were doing to better connect with local partners, especially elected officials. One health authority staff member summed up their strategy for re-framing in the following way:

“we’re addressing health inequities, but we’re doing it in a covert way. Like, not in the “okay, now we’re here, Mayor ______, and we need to talk about poverty”. We’re going, ‘okay, Mayor, we need to look at things like institutional food policy”. And when we’re looking at that we’re looking at things like affordability, accessibility … so we have some particular actions associated with that. Things like … everything from setting up community gardens, community kitchens … it’s all embedded in our strategies”.

A couple of health authority representatives told me quite clearly that they purposely avoid the terms ‘equity’ and ‘poverty’, because they suspected that the Ministry of Health would be displeased. As one health authority representative told me,

“back when we designed HCP what was very, very clear to us- and at that time there was lots of conversations happening provincially about this too … nobody was getting anywhere with the equity discussion. Politicians are tuning out, citizens are tuned out”. Another interviewee was skeptical that equity will ever be discussed while the current provincial government is still in power, saying:
“They’re not talking about inequities ... they’re not talking about it because it doesn’t play to their base. Like their base, they’re fiscal conservatives - it doesn’t play to the people that elected them”.

For instance, one health authority representative, who has done quite a lot of work with local governments, suggested that the way(s) that the health authorities understand and frame health equity issues do not necessarily coincide with the understanding of local governments:

“when we’re talking about inequities, if the city’s talking about it and we’re talking about it, are we really talking about the same thing? Like I’m not sure. 

VB: Is the city talking about it? 

They talk about social determinants, right? Like they talk about, I mean, it’s embedded in some of the documents that they’ve created. I don’t know...how much they really understand it, or if they really understand how they can influence. The roadmap of the actions that they can take to actually influence ... I’m not sure that they’re completely clear on that.”

Discussions about issues of equity and social justice are, of course, intimately connected to individual and societal values. Recent research about how people react to information about the social determinants of health and health equity suggests that people are more likely to resist or ignore health and equity-related messages that do not align with their values (Andress, 2006; Robert Wood Johnson Foundation & Commission to Build a Healthier America, 2009). My impetus to change the wording of questions based on the role of each interviewee therefore made sense, and is consistent with the recommendations given to Canadian public health professionals when they are addressing questions of equity with members of the community (Canadian Council on Social Determinants of Health, 2013). As one interviewee put it:

“If what you’ve got to sell- know your audience ... ‘cus we’re all really in the business of selling ... at the end of the day, that’s what advocacy is. I mean you’re selling someone on an idea or, whatever. So, it’s the same principles as commercial marketing, really. It’s
about how you meet your customer where they’re at, how you’re able to morph and change your pitch or your proposal or whatever, into the language that they can understand. They have to be able to visualize and see themselves in it, and you have to be able to adapt and change on the fly.”

Another interviewee agreed:

“It’s how do you speak to the different groups, the different people, the different organizations at the different levels ... to know that we’re getting the job done. That’s our job - connecting the dots.”

Yet another interviewee admitted that she changes the frame of the ‘message’ of equity and health equity in order to build better connections with local partners, with the end point of policy change in mind:

“what it comes down to is ... it’s not about how we get there. It’s the fact that we get there. So do I care if they call it health inequities, or whatever they want to call it? The fact is they’re giving a hand up to the folks that they need to give the hand up to in order to make that level field in their communities, so that everybody is afforded good health. Do I care what they call it? No I don’t care what they call it, as long as they’re doing it! And does it have to be a quote end-quote “poverty reduction strategy”, or can it be whatever they want it? I don’t give a shit what they want to call it! It could be ‘food for all’ or whatever the hell they want to call it. I don’t care ... it doesn’t matter to me. It’s not about how we get there. And I’m willing to change it, morph it, move it, shake it, do whatever it takes for them to do that.”

Understanding the world view and set of values of the ‘audience’ is key to presenting messages in ways that community members from all sectors and backgrounds can understand and relate to. Language is important. The ways in which the interviewees in this study framed these complex issues associated with equity and social justice can help to shed light on the ways in which the equity lens has been implemented in BC.
5.2 Strategies Used to Implement an Equity Lens into Healthy Built Environments Work

The Core Functions in Public Health process in BC over the last 10 years has helped to bring forward the need to use an equity lens. As described in Chapter 3, Section 3.2, the Core Functions framework included reference to an ‘inequalities lens’ (Population Health and Wellness - BC Ministry of Health Services, 2005). Yet, as one provincial level expert told me in an interview, Ministry staff were themselves unsure about how that lens ought to be implemented:

“And as we got into implementation in that first year or so, what we began to get back from the folks of the health authorities who are implementing core programs was ‘well what exactly is, there’s no instructions that come with the notion of the equity lens. What are we supposed to do, how are we supposed to do it?’ And it ended up with them asking us to do an equity in public health evidence review. So, we hadn’t ever intended to do evidence reviews of that, never had crossed our minds, but it made sense. So we were doing evidence reviews for all the programs but we hadn’t anticipated doing an evidence review for that. But, it made sense and so we commissioned an evidence review ...

Since that review was published in 2007, a more recent review of the ways in which community planning has addressed equity (Haber, 2011) has suggested six key strategies to implement an equity lens at the local level:

1. community participation in planning processes;
2. targeting specific populations in planning;
3. monitoring and evaluating outcomes;
4. use of equity-focused tools;
5. incentives or policy levers; and,
6. consideration of social determinants of health and how they intersect. In the following sections of this chapter, I will explore each of these six strategies in turn, and consider how those strategies have been implemented with regard to HBE work in British Columbia.

5.2.1 Community Participation in Planning Processes

Involving community members, especially those from disadvantaged groups, in decision-making regarding local policies or programs, can help to mitigate the negative health impacts of existing governance structures, which can reinforce the unequal distribution of power and resources (Burris et al., 2007). While it has been difficult for researchers to definitively demonstrate that community engagement and empowerment initiatives help to improve community health and well-being (Woodall et al., 2010), some recent research suggests that these initiatives can foster increased contact between neighbours and improved knowledge of the local democratic process; both of these outcomes have been linked to improved well-being at the individual level (Hothi, 2008).

Unfortunately, many initiatives have experienced difficulties in including affected community members in planning processes (Blackman, 2006; Pittman, 2010). Even Healthy Cities initiatives, which are centred around active community involvement, have used the rhetoric of broad public participation, but have fallen short of that goal in practice (Barten et al., 2007). Some initiatives have attempted to reduce barriers to participation, by setting meetings at alternate

7 These methods to implement an equity lens at the local level are consistent with more recent reports or toolkits for both public health staff working in communities (e.g. (Centers for Disease Control and Prevention - Division of Community Health, 2013)) and municipalities (e.g. (City for All Women Initiative, 2015)).
times, providing childcare, or holding meetings in more convenient locations (Haber, 2011). Of course, supporting greater community involvement in local decision making can extend beyond simply arranging public meetings at more convenient times and locations; a wide variety of approaches have been used to support greater community ownership of processes and community empowerment. Those strategies include citizen governance, electronic participation, and participatory budgeting (Pratchett et al., 2009). Regardless of the technique used, the research literature suggests that it is vital to understand local history, culture, values and politics, which might present more of a barrier to participation than would more concrete issues like scheduling or location (Pittman, 2010).

It seems that, at least in Surrey and Kelowna, at the time of data collection, HBE work had yet to emphasize the importance of broad community involvement in planning processes. However, in Terrace, Northern Health had given some importance to community capacity building within the development process of the Healthy Communities teams. One Northern Health staff member described the overall strategy of the organization’s HBE work in this way:

“So that’s the basis of everything we do in Northern Health ... Public health now is you don’t put up a sign, you don’t stand up and even educate quite so much anymore. You ask the most vulnerable um- you show the most vulnerable what their issues are if you can, but you ask them what they need and what they’d like to see, and you ask them if they’d like help or if they’d like to be a part of it. And so that’s kind of the new direction.”

At least from this person’s perspective, members of the community were, indeed, involved in helping to set priorities for HBE work. There was an acknowledgement, however, that those priorities, set by local Healthy Communities teams and committees, might conflict with what current data or research might suggest:
“It will be whatever those committees want, and there will be time where they choose things that we don’t agree with, but that’s alright. We’re okay with that. We’ve already made the decision that they’re going to make some decisions that we’re not going to love, but we’re going to support them. So they’re going to decide what it is that they want to focus on and we’re going to show them the social determinants, underlying factors, that have resulted in this economic disparities, education disparities, things like that and um we’re going to make some suggestions to them but the committee’s got to have the power.”

So, in Northern Health, the decision had been made to take a community development approach, in which the needs and desires of the community are actively sought out and then used to make key decisions in HBE work.

In Surrey, planners expressed the need to have broader community involvement in planning processes. However, it appears that that the impetus for more extensive community engagement was not necessarily for the purposes of improving community health or reducing inequities, but to help to push through particular policies or projects that have traditionally had resistance. The City of Surrey has asked for Fraser Health’s help in incorporating more extensive community involvement, as one Fraser Health staff member told me:

“… they’ve also said that community engagement is a big thing. So as I said about the resistance to densification, that was an example of some of the issues that they face on regular basis, so they’d like to see Fraser Health more involved in some of those public consultations, so you know actually being present at a public meeting where their experience is backlash from the community as to “Why are you doing this? Why are you putting these trees here and taking these trees out there? Why are you redesigning this street?” That type of thing.”

In this quote, bringing in the voice of Fraser Health to help support particular policy directions is portrayed as part of the concept of ‘community engagement’, as if the Health Authority could help to diminish community-based resistance. The emphasis was not on the health and/or wellbeing benefits of that engagement.
Fraser Health staff advised the City of Surrey and other community partners that community members, and particularly members of vulnerable or disadvantaged groups, needed to be part of the planning process. Yet, as two Fraser Health staff members told me in a focus group, that had yet to happen as part of the HBE (or Healthier Communities Partnerships) work in Surrey. Instead, representatives of community-based organizations were invited to meetings and community forums:

P2: “We actually did say that ... the planning process needs to be very inclusionary, and intentionally inclusionary of including marginalized populations ... whether that happens or not is another- you know, they do have community forums, but do they specifically go out and ask populations that have been- no, not as of yet.

P1: Are they ... represented by any particular, you know, perhaps community groups or NGO’s where you could get, you know...or do they run into the same problem, probably?

P2: And well ... that’s frequently what happens with vulnerable populations is that we end up inviting the heads of the community organizations rather than the members themselves, and is that the same?”

Intersectoral Action

Despite the fact that, outside of Terrace, in the three case study communities examined here there appeared to be little importance put on direct community involvement as a way to promote community health and health equity, there was a strong emphasis in HBE work on intersectoral action at both the provincial and local levels. Because health authorities have now been mandated to work more closely with local governments, there is an emphasis on breaking down the ‘silos’ that have often made it difficult for different sectors, including public health and planning, to connect and work collaboratively on joint projects. Some have speculated that the new emphasis on intersectoral work has occurred due to a lack of funding and increased responsibilities put on local government. As one provincial level interviewee reflected:
“... people are seeing that, wow, the way we’ve been doing our work in silos doesn’t work. They’re starting to get that it doesn’t work and there needs to be another way. Is it because there’s been so many cutbacks and the lack of capacity they’re forced to work together in a different way, and one great result of that is more of an integrated approach ...?”

The assumption here is almost that, if we break down the silos and work together more often or in more explicit ways, we can reduce health inequities and improve health for all. This emphasis on intersectoral action as one way to apply an equity lens was evident when referring to both the local level and the provincial level. One provincial-level interviewee stated:

“we recently did a scan of all the provincial ministries, and we looked at their strategic documents from a healthy communities lens, and we pulled out...we pulled out the pieces from every strategic document from each of those ministries that links to healthy communities, and every one of them has something that links to it. So what we see is there’s an opportunity for us to bring these ministries together, together so they’re connecting around healthy communities, but also working with them individually to say here’s how we can support you in this. So, I think there’s more movement in that direction, that integrated approach.”

The theme of intersectoral action is further explored in Chapter 7, Section 7.1.

5.2.2 Targeting Specific Populations in Planning Work

In a very common strategy to implement a health equity lens, planners and public health staff in many parts of the world have explicitly focused their efforts on certain subpopulations that are considered highest priority (Haber, 2011). For instance, the National Strategy for Neighbourhood Renewal program in England aimed to reduce inequities across the country by focusing on disadvantaged neighbourhoods and communities (Blackman, 2006). Begun in 2001, the program was designed to reduce the gap between residents in the poorest neighbourhoods and the rest of the country in terms of unemployment and crime rates, work skills, housing, elements of the physical environment, and general health status. Funds were distributed to 88 local governments in those neighbourhoods considered most in need of support. An evaluation
of the Neighbourhood Renewal program concluded that it was at least partially responsible for a narrowing of the gap between deprived and less deprived areas of the country, but there is considerable variation in terms of success among communities (AMION Consulting, 2010). The most significant lesson to be learned from the Neighbourhood Renewal program in the UK is the way in which the program fostered a new emphasis on the development of multi-sectoral partnerships at the local level, with local governments playing a strong role in that cross-sectoral work (AMION Consulting, 2010).

In another example, the Municipal Responses to Childhood Obesity Collaborative in New York City and London recommended that public health and local government staff channel obesity programming and resources to communities which were identified as high risk (Freudenberg et al., 2010). New York City’s Take Care New York 2012 initiative has resulted in targeted action in the city’s lower-income neighbourhoods. That action has included improving aspects of the built environment by developing roads, homes, and parks (New York City Dept. of Health & Mental Hygiene, 2009b).

In this study of HBE and Healthy Communities initiatives in BC, targeting interventions or policy work with a focus on assisting ‘vulnerable populations’ was a common method with which equity was addressed as part of their work. In all three case study communities, focusing HBE efforts on particular populations was expressed as a key method to address health equity issues. Seniors, children, people with disabilities, and low income families were most often mentioned as the main groups of focus. Assisting vulnerable populations as part of HBE work often took the form of working to improve access to services and resources for those groups.
within the community. As one Healthier Communities Partnership team member from Surrey stated:

“the way that I see it, equity is just access for everybody in all places within a community.

VB: Access to what?

Access to everything; access to housing, access to park and recreation facilities, access to healthy food, access to green space, access to transit, because certain areas will be better served than others for all of those different things. And then ensuring that the community is designed in a way that everybody can get around at least to the best of their ability. Now I know that that may not be the official definition of equity in terms of the healthy built environment, but that’s what I- that’s how I frame it in my mind.”

In some cases, the justification for focusing on these populations revolved around the population health data that indicated that health status was worse among these population groups:

“... in some of our planning, equity involves is ... making sure that people who live on low incomes have access to affordable housing and opportunities to be physically active, because we know that chronic disease tends to be more prevalent in those- in that population. It’s ensuring that seniors have access to the amenities that they need in their communities, and housing that would be appropriate for them. Now whether that be assisted living, residential care, adaptable and accessible housing what have you or at least accessible that streets and sidewalks are designed in a way that they can get around and same with those who have disabilities. And then it’s- we focus on three populations pretty much, and then children and youth. So ensuring that children and youth have access to recreation facilities and parks and green space so that they can be physically active...and um...and um get to school, that type of thing.”

However, there was some indication that some groups might have been designated as priority, based on available funding opportunities, rather than identified need. For instance, seniors were mentioned fairly frequently, given the emphasis on our aging population within the province:

“we’ve seen opportunities and we’ve done work around seniors and immigrants and new comers, largely due to funding opportunities and we’ve seen that that’s an opportunity
to contribute to and maybe impact a certain kind of conversation with those two groups, and there’s been supports for that.”

In some cases, participants likened the emphasis on vulnerable populations to a ‘target group’, as if this was a marketing exercise. For instance,

“So number one is inclusion, so you find your target and you include them ... So we spent two days and then we had facilitators and breakout groups where we talked about so how do we better target, and we were looking for target groups, so how do we better target low-income? .... “

Given the poor state of health among many Indigenous peoples in BC, it would make sense that Indigenous population groups might be seen as a special population of interest for HBE or Healthy Communities work. But the interviews I did with some key informants uncovered political or ‘turf’ issues associated with focusing on the unique needs or perspectives of Indigenous peoples:

“I would say First Nations because First Nations is on every list, but at the same time, we haven’t really worked with First Nations as, oh, this is our special population group... we’ve had a lot of conversations about that, and...very challenging ... there [are] a lot of politics involved. When you’re trying to navigate through that to see how, how First Nations and their governance structure would fit in, and how it works in relation to local governments, and how we might be able to support. And it was really challenging.”

Much of the frame for focusing on ‘vulnerable’ or special populations came from the Ministry of Health’s emphasis in the Healthy Families BC initiative on what they called “priority populations”. Those populations are: children and youth, seniors, and people with disabilities. A Ministry of Health staff member working on the Healthy Families BC initiative described to me how the focus on these priority populations is a way in which an equity lens is implemented at the provincial level:

“So we always go and put in the equity lens in everything we do.
VB: Okay, and how do you do that?
Whatever project that we have that we would be going to look at the general groups of people who would have access for example, and then we would take a look at groups that might not or might have identified barriers to having access to those types of services. In terms of population groups, we in our ministry… we also have specialized branches that deal with either vulnerable groups or special populations. So we would have the Seniors Secretariat kind of looking at everything from what their needs are, we would have a branch for mental health, we have an Aboriginal branch, we also have the Child and Youth branch, and they would be the experts that we would then tap into to find out where there may be gaps and what we should be looking into. So we’re always kind of tapping into all of those resources as we’re building our programs to ensure that they’re also engaged so that they can bring those forward.”

Interestingly, these priority populations could not necessarily be called ‘vulnerable’ or ‘marginalized’, in part because there appeared to have been little consideration of income or societal level in their choosing. As one Ministry of Health representative explained,

“when I say priority populations, I say the populations that are … [stuttering], we don’t say ‘in most need’, but through a community review, a community sort of assessment … profiling where you, where there may be some inequities in terms of health and in terms of where you could get better health gains, in terms of focusing your efforts … So that’s how we position.”

It is no wonder that much HBE work has reflected an emphasis on helping ‘vulnerable populations’ at both the provincial and local levels. Several key policy documents and toolkits provided for both planners and public health staff have framed health equity issues in this way. For instance, a factsheet published by the Canadian Institute of Planners in 2013 about Health Equity and Community Design offered this suggestion to planners who are interested in considering health equity in their HBE-oriented work:

“There are many opportunities for planners to get involved in raising the profile of health equity at the planning table … Look for opportunities to include health equity and accessibility concerns of vulnerable groups (children and youth, seniors, lower income populations, people with disabilities, etc.) in your community’s transportation and land use plans”. (Canadian Institute of Planners, 2013, p. 8)
Concerns about Targeting Population Groups

Because it was a key strategy used within HBE and Healthy Communities contexts to address health equity, it’s important to acknowledge that focusing on particular population groups has ethical implications. Health inequities are formed by social norms, and those norms influence how we make sense of complex relationships and how we use language to describe those relationships. By identifying and focusing our attention on particular population groups, we run the risk of oversimplifying complex relationships and reinforcing bias and social exclusion. In a recent report entitled *Populations and the Power of Language* (National Collaborating Centre for Determinants of Health, 2013a), staff at the National Collaborating Centre for the Determinants of Health encourage Canadian public health professionals to keep the following principles in mind when considering an approach that focuses on particular population groups:

- Remember that diversity exists within population groups – groups within one community or geographic area are often identified based on a sole characteristic (e.g. income level, cultural group, or gender), but individuals within each of these groups can experience multiple and overlapping disadvantages (Hankivsky O et al., 2012). In the end, it is vital to consider the diversity within each population group, and the ways in which that diversity creates complexities that our simple sets of language cannot accurately portray.

- Advantage and disadvantage coexist – as planning or public health professionals, we need to examine our own social position, and how that position influences how we see and describe other groups’ circumstances. A focus on disadvantage requires also shining the light on advantage, including the ways in which that advantage is formed and reinforced in
our society.

• Language has power and can influence relationships between individuals and groups – when we label populations of people, we run the risk of fostering an ‘us vs. them’ mentality that can lead to victim blaming, stigmatization, and the reinforcement of power imbalances. When we choose to use words to describe a group of people that that group or community has not chosen to describe themselves, we can help to build stress and anxiety for that group, even if our intention was to be helpful (Alex & Whitty-Rogers, 2012).

The term ‘priority populations’ – a term that has been used by the Ministry of Health in their strategic documents for Healthy Families BC, can be problematic. The term implies that particular populations have been identified through a process that involves epidemiology to gather data about those groups of people who are most in need. However, as I experienced in interviews with Ministry of Health staff, populations are not necessarily indicated as priority in a way that has considered elements of social justice or equity. The term, therefore, has the potential to be interpreted too broadly, so that priority is not given to groups of people who are experiencing disadvantage (National Collaborating Centre for Determinants of Health, 2013a).

The term ‘vulnerable populations’ has also been criticized because, by highlighting susceptibility or vulnerability, we run the risk of further disempowering individuals and groups (National Collaborating Centre for Determinants of Health, 2013a). The term also underplays and oversimplifies the complex set of processes that lead to the unequal distribution of power and resources (Frohlich & Potvin, 2008).
Equity Work as Supporting Greater Inclusion and Diversity

Related to the strategy of focusing on particular population groups, there was some emphasis in this research on addressing equity by fostering a greater sense of inclusion and improved support for diversity within the community. The use of a lens that encourages local government staff to consider diversity (usually cultural diversity) in their daily work is fairly common in large urban centres. The cities of Ottawa and Toronto, for instance, both have such lenses (City of Ottawa, 2010; City of Toronto, 2009). Other resources are available to encourage planners to consider inclusion and diversity in recreation planning (Social Planning and Research Council of BC & BC Recreation and Parks Association, 2006) and to be aware of potential racism and discrimination in their work (Ontario Human Rights Commission, 2010).

Multnomah County, of Portland, Oregon, has recently introduced an Equity and Empowerment Lens. The Lens consists of a series of questions that all teams involved in the development of new policies or programs should consider (Balajee, 2012). The County’s website describes the lens in this way:

“The Equity and Empowerment Lens (with a racial justice focus) is a transformative quality improvement tool used to improve planning, decision-making, and resource allocation leading to more racially equitable policies and programs. At its core, it is a set of principles, reflective questions, and processes that focuses at the individual, institutional, and systemic levels by:

- deconstructing what is not working around racial equity;
- reconstructing and supporting what is working;
- shifting the way we make decisions and think about this work; and
- healing and transforming our structures, our environments, and ourselves.” (Multnomah County).

At the municipal or regional level, these equity or inclusion lenses are designed to create policies and programs that address systemic barriers and foster the active participation of all in

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community activities, including employment and education. Beyond a moral or ethical
obligation, the rationale for the development and consistent use of these lenses is often to help encourage greater diversity from an economic development perspective; if all people within a city or community who are able to work are supported to secure meaningful employment, the city’s economy will flourish.

Interestingly, few local governments have connected fostering inclusion and diversity with community health, and the three case study communities examined in this study were no exception. The HBE work in neither Terrace nor Kelowna referred explicitly to fostering greater social inclusion or celebrating diversity as a key strategy for building healthier communities. The City of Surrey, however, did emphasize diversity and inclusion as part of strategic planning and there is an active Diversity and Inclusion committee, chaired by a city councillor (City of Surrey, 2013a). However, at the time of data collection, this inclusion work was not well connected to the HBE work being done as part of the City’s Healthier Community Partnerships committee.

Related to this effort to support inclusive and diverse communities, the City of Vancouver has developed a Healthy City Strategy, which is guided by a vision of “A Healthy City for All”, defined as “a city where together we are creating and continually improving the conditions that enable all of us to enjoy the highest level of health and well-being possible” (City of Vancouver, 2014). The concept of Health for All originated with the Declaration of Alma-Ata, which re-

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8 Please see Chapter 6, Section 6.2, for a more detailed exploration of the work of the Healthier Community Partnerships committee in Surrey, and its relationships with other services and programs offered in connection with the local government.
affirmed the importance of the social determinants of health in public health and health promotion, and urged all governments and the world community to protect and promote the health of all people, in part through fostering stronger primary health care systems (World Health Organization, 1978).

5.2.3 Monitoring and Evaluating Outcomes

A third way in which an equity lens can be implemented in community planning is through the assessment and monitoring of a community’s health (Haber, 2011). Equity can be considered during that community assessment process by presenting data that is differentiated by geographic area or population group (Gardner, 2011). Focusing on particular population groups or neighbourhoods can help planners to target programs or develop policies where and how they are most needed (Haber, 2011). Specific data can also help to monitor or evaluate new or existing policies or programs, to get a sense of those initiatives’ impact on social and health equity.

The routine assessment of community health, and the surveillance of key health indicators, including disease rates, is done by all public health departments within BC, and it has been slowly connecting with HBE work. The strongest example of connecting community-based data with HBE or Healthy Communities work came from Terrace. Over the past few years, Northern Health has adapted its health status reports to provide more emphasis on the determinants of health and identify the most vulnerable or disadvantaged people in the community. Through presentations and meetings with the mayor and city council, Northern Health staff have used that data to help to both build stronger relationships with the municipality and to set in motion a community health assessment process. As a senior Northern Health staff member explains
below, the emphasis for that community planning process was to support the municipality to work with the health authority and other community partners to come up with a vision for a healthier Terrace:

“we now call them Report Cards, and so they show the good and the bad but it starts with mortality, morbidity, upstream risk factors, contributing factors, even cultural factors - community specific ... and then we’ll show a few things that are working- some of the people, community groups that are doing good work in those specific areas. So our original proposal was that we would do a presentation to mayor and council and planners and eventually it would be develop a formal relationship. And then we would have a visioning session where we would ask all of these people “what is your vision of a really healthy Terrace?”

Northern Health worked hard to make this community health assessment and planning process engaging, and there is an explicit equity component in their approach:

“we have some professional facilitators on our staff. So we’d kind of facilitate that, and they’d come up with lots of really fun, exciting ideas and what they’d like to see, and then we’d show them their Health Status Report. So this is actually where you are right now, so in order to get from here to here, what we would like to form an affiliation with you and the municipality to move upstream together to target those things that have resulted in this discrepancy, this disparity. And so that’s the whole vision.”

In the cities and towns in Northern Health’s jurisdiction, this planning process was meant to kick start local Healthy Communities committees, which had broad involvement from a wide variety of organizations, including the health authority, the local government(s), community-based organizations, and community members themselves.

In Surrey, a similar process has begun. Data was seen as a way to open up a conversation about healthy communities work, particularly with the mayor and council. The difference was that the community health assessment process appeared less community-driven, and the data was presented alongside a set of recommended strategies for the new Healthy Community
Partnerships committee to consider. One Fraser Health staff member explained the process in this way:

“it’s a data snapshot ... we had our decision support staff just break down some chronic disease information for each of our communities and then we have the strategies attached to them and the whole purpose of the strategies is to use them as sort of like a conversation starter with communities - ‘Here’s what you could do to improve the health of your population’”.

This type of process, in which the health authority provides community health data to local governments, was supported at the provincial level. As a senior Ministry of Health staff member explained to me, a consideration of inequities within the community was meant to be a part of the way the data was reported:

“what we’re keen on is the way the Fraser Health Authority is gone about it. It’s really to do, to generate the community health profile, to understand where the health issues are, where the inequities are in terms of that community. So use that as a basis, then look at the evidence base and generate pretty much a review checklist ... they call it a scorecard ... To look at then what are the policies and services available and programs available from that local government that are related to those key areas around ... physical activity, healthy eating, tobacco reduction, built environment ... then jointly between the Health Authority and the local government, they’re coming up with key actions in terms of where to focus to go next to improve that community, in terms of what to do.”

Through a series of consultations with local government representatives across the province, Ministry of Health staff heard that many local government staff and elected officials needed more accurate, timely, and easy to understand data on the health and well-being of their communities. The Ministry of Health therefore supported the development of a standardized set of community health data called the Community Health Profiles. The profiles for 131 BC communities, produced by the Provincial Health Services Authority (PHSA), were released in September 2014 (Provincial Health Services Authority, 2014b). Each Community Health Profile consists of demographic and health status statistics, a description of the factors that influence
community health and well-being (including income, education, and built environment factors like transportation systems and housing), and comparisons between that community or region and provincial averages. There is some emphasis on inequities in some of the profiles, specifically in terms of differences in health status for those with lower incomes or lower levels of education, but no neighbourhood-level inequities are described. According to Ministry staff, the vision is that the new Community Health Profiles will be used to identify key strategies for HBE or Healthy Communities teams within each city or community, but it is too early to tell whether that is how the Profiles are being used.

5.2.4 Use of Equity-Focused Tools

A number of tools have been used to alert planners to potential health equity concerns in their communities, and to encourage the consideration of equity within the development of new policies or initiatives. These tools include health equity impact assessments (HEIA) and health equity audits. The intent of the tools is to identify social and health inequities, highlight how proposed programs or policies might have an effect on health or health equity, and identify how inequities might be reduced (Haber, 2011; Pauly et al., 2013). There has been a rapid increase in the use of these tools over the past five to ten years, particularly in some countries, including England and Australia. With this rapid development of many new tools, the Equity Lens in Public Health (ELPH) project at the University of Victoria has put together an inventory of equity-based tools that includes information about how each tool is meant to be used (Pauly et al., 2013). Little research is available which describes the impact of the use of these tools, but some practitioners and researchers have found that these tools can help to
identify issues not previously considered in planning, and can help to change the way that programs are implemented (Haber, 2010; Livingstone, 2010).

Health (Equity) Impact Assessments

A Health Impact Assessment (HIA) is a set of procedures, methods and tools designed to analyze a non-health specific policy, program or project in order to determine its potential effects on the health of population groups. Health Impact Assessments work to evaluate how changes in the natural and built environments, social and cultural relations, and socio-economic conditions may improve or harm the health of populations. Health Equity Impact Assessments (HEIA) follow the same processes as HIAs, but focus more intently on issues of equity and social justice.

Essentially, the HIA process presents a series of questions for discussion. Those questions are designed so that policy makers, decision makers, and (sometimes) the general public, can look at policies in new ways – to see how they might have an impact on health, and how those health effects could affect some population groups in different ways.

Different countries are using HIA processes in different ways (Williams, 2013). In general, Canada has been slow to explore HIA. Ontario and Quebec seem to be the first provinces that are examining HIA and its potential implementation, although HIA was used in BC in the early 1990s, and then subsequently abandoned.

The HIA process can have a significant role in building relationships and communication channels among local planners, public health staff, community members, and local government (Bourcier et al., 2015; Dannenberg et al., 2008; Williams, 2013). In fact, incorporating active
community involvement into an HIA process can promote social equity and environmental justice (Bhatia & Corburn, 2011; Corburn, 2009), help identify locally relevant issues, improve transparency of decision-making, and facilitate community empowerment (Bourcier et al., 2015; Haigh et al., 2013).

There is some emphasis in the HIA literature on community participation in the HIA process, but much of the focus remains on the use of health surveillance data and census data with which to assess potential health impacts. For instance, in a 2006 review of HIA research and practice, Dannenberg and colleagues stress the need for HIA practitioners to have better health information systems, and that planners ought to be better trained to deal with health-related data. The role of community involvement and environmental justice in the HIA process is mentioned, but practitioners are encouraged to “ensure that community participants understand the objectives of the process and their roles” (p. 266). Thus far in the HIA-related literature, there has been a failure to embrace the action-oriented potential of HIA as a research method and as a health promotion process, especially for disadvantaged communities.

**Health Equity Audit**

The Health Equity Audit (HEA) was developed in 2002 by the UK Department of Health. From 2003 – 2008, Primary Care Trusts, the community-based portion of the health care system that includes public health, were required to use the HEA to inform local service planning and delivery. Primary Care Trusts were expected to work with local governments and community service providers through the development of local strategic partnerships (UK Department of Health, 2003).
The HEA is a process through which local partners systematically review inequities in the causes of ill health, and in access to effective services and their outcomes, for a defined population. Actions required to make services more equitable (and thereby reduce health inequities) are agreed and incorporated into local plans, services and practice, including that collective work between public health staff and local governments.

Unfortunately, at the time of data collection, there was little indication that these types of tools have been used in connection with HBE work in BC. The Kelowna group did do some development work on a health impact assessment tool with which to evaluate proposed development in that rapidly growing city, and it is possible that issues of equity could be integrated into that assessment tool as it develops further, but at the time of data collection, that initiative was in its early stages. There was some indication, however, that staff at the Ministry of Health have considered how using tools, like an HIA process, could be integrated into the emerging HBE work that is being done across the province.

5.2.5 Incentives and Policy Levers

A less well used strategy for implementing an equity lens in planning initiatives involves using policy to motivate action at the local level. This is particularly common in Healthy Cities projects; as a requirement of involvement as part of the Healthy Cities Network in Europe, for instance, member cities must create health development plans that identify and work to address health equity concerns (Green et al., 2009).

Outside of North America, national equity-oriented initiatives, with corresponding local or regional targets, can help drive local planning (Haber, 2011; Ritsatakis, 2009). Recent reviews of
health equity strategies in these countries suggest that an explicit national initiative helped support equity-oriented planning at a local level (Wong & Gardner, 2013).

As part of these policy levers, the setting of targets has been suggested as an appropriate strategy. This has usually been in the context of more comprehensive national-level strategies; the local level targets help to identify the baseline and progress of each local area or region, so that geographic comparisons can be made. Target setting has not been well supported in the research literature, although some suggest that the strategy does hold promise (Sudbury and District Health Unit, 2011). Experts caution that the key is to set targets that are realistic and attainable, and to connect target setting with community engagement processes, if possible (Sudbury and District Health Unit, 2011). Targets must be chosen carefully because they have the potential to highlight some aspects of inequity (e.g. geographic inequities), while masking others (e.g. inequities based on income or education levels) (Porter et al., 2007).

In the three case study communities examined in this study, the setting of equity-oriented targets did not seem to be a key strategy used by HBE teams. None of the interviewees mentioned target setting or other policy levers as part of their overall approach. Some did, however, express an appreciation for target setting as an action-oriented approach that would help to build relationships with local government partners. For instance, one health authority staff member in Surrey mentioned that a stronger HBE strategic plan with clear outcome targets would merge with the current mayor and council’s emphasis on concrete plans with careful monitoring and evaluation strategies build in:

“I mean the fact is it is a political-internal political thing just as much as it is external, which is the reason why I can’t have the Surrey stuff...sit and spin, sit and spin, sit and
spin— it needs to be action focused. We need to be working towards this outcome, here’s the progress markers— y’know … That’s what we have to be in Surrey, because two years from now … I’m going to have our CEO and the mayor who has agreed to partner going ‘well what has this done anyway?’ If we don’t have A and B … we’re screwed.”

At the provincial level, the setting of targets was also seen as an important as a way to both evaluation HBE efforts and to prove the worth of those efforts at higher political levels. As one Ministry of Health staff member explained:

“So we’ve got accountability frameworks that have been developed for the Health Authorities, their evaluation plan being developed … there’s a measure, and it’s important as you know. Measures are important.

So we are being monitored by the Premier’s office on the result of the, and what they’re, the articulation of those Healthy Living strategic plans is that process I talked about is doing that sort of baseline review or scorecard … and then identifying joint actions to move forward.

So the healthy living strategic plan measure … sort of really ramps it up as not just a sort of “flash in the pan” sort of initiative. This is something that we’re looking at quite closely and we need to make good on the end points. We need to get the process right.

What we know is ‘what gets measured gets done’.”

However, there was no indication at either the provincial or local levels that these targets would incorporate issues of equity or a consideration of social justice.

5.2.6 Consideration of the Social Determinants of Health and How They Interact

Health inequities arise from power imbalances as they relate to social and economic conditions in our environments. Planning processes that consider these social determinants of health therefore have the greatest potential to have an effect on social and health inequities (Haber, 2011; Sadana et al., 2011; World Health Organization & Committee on the Social Determinants of Health, 2008). Linking planning with policies and other interventions in these broader domains is an important way to implement an equity lens within HBE work. However, focusing on improving particular social determinants of health does not necessarily improve
health equity; in fact, it just might further entrench health inequities. Work on the social
determinants of health needs to have an explicit equity orientation so that it improves universal
access to healthy social and physical environments while taking into account the special needs
of particular populations groups. In addition, social determinants of health-oriented initiatives
need to consider the complex inter-relationships of the determinants, while keeping in mind
broader forces like globalization and climate change (Global Research Network on Urban Health
Equity (GRNUHE), 2010).

In all of the three case study communities examined in this study, action was taken to
improve the social determinants of health. For example, local government leaders in both
Kelowna and Terrace worked to improve access to affordable housing in their communities, and
City of Surrey staff grappled with high rates of poverty, especially among families with young
children and new immigrants⁹. However, many of these initiatives were not formally connected
to HBE work.

In strategic documents at both the local and provincial levels from health authorities and the
Ministry of Health, the emphasis was less on action with regard to the social determinants of
health, and more about developing relationships between public health staff, local
governments and other community partners (see (Interior Health, 2012) and (Healthy Families
BC, 2012b). Even the key components of Fraser Health’s Healthier Communities Partnership

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⁹ See Chapter 6 for a more comprehensive description of the local activities in each case study community.
initiative have been described as focusing on the built environment (e.g. healthy neighbourhood design (Fraser Health, 2012)) rather than the social determinants of health.

5.3 Social Planning: An Application of the Equity Lens?

Within the field of planning, much of the work that relates directly to the social determinants of health is done as part of social planning initiatives. Social planning is a process for setting priorities and acting to support community needs and interests in social, economic, cultural and environmental spheres (Clague, 1993). Social planning processes share much in common with community development, in which community groups, individuals, and organizations work together in collaboration to address critical social issues facing a community. In local governments, social planning departments usually exist only in large urban centres. Their work is very much related to social and health equity (Canadian Institute of Planners, 2013).

In Kelowna and Surrey, social equity, diversity, inclusion, poverty, and other concerns associated with equity were actively dealt with through those municipalities’ social planning departments. Terrace does not have a social planner, but, at the time of data collection, the city did have a group of committed community volunteers, active non-profit organizations, and a couple of supportive city councillors who worked on issues of food security, access to affordable quality housing, and sustainability as those issues related to economic development. Unfortunately, in all three cities, I found that the work of social planning was mostly separate from the efforts that took place around Healthy Built Environments. One public health practitioner, who had had a lot of experience working with local governments, perceived this separation between social planning and other types of planning this way:
“Social planning seems to be kind of its separate entity from the rest of the planning, and the city in general- how the city does its business, which is kind of fascinating to me because I’m not really understanding how the social fabric of your community is not completely connected to all the different parts of how you operate. But it does seem like... ’Oh, oh it’s about that, well that’s a social planning thing’.”

Interestingly, it seems that part of that separation was strictly because HBE was associated with land use planning and urban design, not with other areas of planning. Land use planners were therefore the first to be invited into the process. That tendency to invite strictly land use planners to the table may be due to a lack of knowledge about the breadth of planning among health authority staff, who have driven HBE processes.

5.4 Building Healthy Built Environments vs. Building Healthy Communities

Over the 4-5 years of this study, from the time of first developing the idea for this case study, through data collection and finally analysis, there has been a significant shift in the policy context in which the collaborative work of planners and public health staff has occurred. Early in the process, in 2009 / 2010, ActNowBC was still a dominant force. Informed by initiatives like the national ParticipACTION program that was developed in the 1970s and then resurrected in the 1990s, the focus of ActNowBC was on ‘lifestyle’: encouraging British Columbians to increase their physical activity, reduce or eliminate smoking, and eat a variety of healthy foods. Chronic disease prevention was often the chief goal of that work, and there was little emphasis on equity or social justice at that early stage.

In 2010/2011, the provincial HBE work began to take off. Several health authorities, including Fraser Health and Interior Health, began to set up formal HBE working groups, often emphasizing the connections between the planning and public health fields. While equity and
social justice were not yet explicitly addressed in this early HBE work in BC, that work did emphasize intersectoral collaboration, in part due to the prominence of Healthy Families BC. In the follow-up interviews that I did in early 2013, I noticed a gradual shift from an emphasis on HBE to a broader Healthy Cities / Healthy Communities approach. As one provincial level interviewee stated,

“So, I mean, the pillars of the Healthy Communities approach, local government commitment, political commitment, healthy public policy, community engagement, asset based community development, and multisectoral collaboration; and we’re pretty much incorporating all of that into this process.

And then I don’t know if you heard … but, I mean…a lot of…Healthy Communities is getting a lot more attention, and it’s being spoken about in a lot more conversations. Not BC Healthy Communities, but Healthy Communities, and people have different definitions of it. But I think that the context has shifted and that they’re talking about it more so now as that integrated approach. They’re starting to recognize that.”

Some health authorities have embraced this broader approach more than others. For instance, Northern Health staff in several communities are working with local mayors and councillors, together with other community members, to bring forward a community health assessment process and work with the community in a ‘visioning’ exercise to set common health goals and strategies.

In this Healthy Communities work, Northern Health takes a more community development approach, in that they support the community’s desire to identify their own community health goals, even if those goals and the strategies they decide on don’t always coincide with ‘best practice’ in health promotion.

Some interviewees were more aware than others of the differences between HBE work and Healthy Communities work. That was the case most explicitly with Northern Health staff. As
one Northern Health manager stated, the Core Public Health Functions requirements to do a gap analysis on what was then called ‘Healthy Community Environments’ really only emphasized indicators and strategies as they applied to HBE. The broader approach of Healthy Communities was not included in that early work, in part because “they [Ministry staff] didn’t really understand the next level up”.

That same Northern Health manager quite clearly labelled the distinction between HBE and true Healthy Communities work: “there’s a difference between Healthy Built and Healthy Community provincially.” His assessment was that, to some extent, Northern Health stood alone in terms of its broadly-based Healthy Communities approach:

“There’s a difference between Healthy Built and Healthy Community provincially.”

When asked about the reluctance to extend beyond an HBE approach, this Northern Health manager suggested that:

“So they don’t understand this stuff and they- and it sounds a bit risky to them so they were only allowing their staff to discuss things that went as far as Healthy Built ... here we’re Healthy Community.”

Despite the cautious approach of some of the health authorities, my research suggests that the orientation of Healthy Families BC has shifted (or at least has been challenged to shift) toward a broader Healthy Communities-like orientation. This is in part because of the involvement over the last two years of BC Healthy Communities Society (BCHC), which has been contracted by the BC Ministry of Health to develop PlanH, an online resource dedicated to helping build relationships between municipal and regional governments, health authorities,
and community-based organizations around local health issues. As Jodi Mucha, BCHC Executive Director stated, “it’s really the Healthy Communities approach as we know it that is informing Healthy Families BC”.

5.5 Summary

The data presented in this first of three analysis chapters has explored the ways in which an equity lens has been defined and used in association with HBE work in BC. It is important to examine efforts at both provincial and local levels with an emphasis on the degree to which those efforts consider equity and social justice, because those issues are vital to fostering human development and improving health for all.

Contrary to the research literature in public health, which has embraced the term ‘equity’, in this study I found that the term, and therefore the concept of an equity lens, was significantly re-framed to reflect the political and social contexts within each sector. In local governments, equity was re-framed to reflect more concrete or do-able endeavors, like food security or housing issues. Health authority staff followed the lead of the Ministry, which has avoided the both the term ‘equity’ and discussions of how issues of poverty, inclusiveness and even affordable housing are related to healthy communities or healthy built environments.

Recent reviews of the literature have suggested that an equity lens in community planning can take the form of six key strategies: 1) involving community members in planning processes; 2) targeting specific population groups; 3) monitoring and evaluating outcomes from an equity perspective; 4) using tools designed to bring out equity-oriented issues and questions; 5) using incentives or policy to actively support equity efforts; and 6) incorporating the consideration of
the social determinants of health in planning work (Haber, 2011). Of these six strategies, only the two: targeting marginalized or ‘vulnerable’ groups and monitoring and evaluating outcomes, were widely used during the early development of HBE and Healthy Communities work in BC. A final strategy, involving community members in planning processes, was done in the Northern Health (Terrace) region only.

Following the direction set by the Healthy Families BC initiative of the Ministry of Health, some population groups, including seniors, children and youth, and people with disabilities were designated as high priority for some HBE initiatives in Surrey, Kelowna, and Terrace. At the time of data collection, other local government work that aims to foster greater inclusiveness and diversity had not been connected with HBE work. The same is true of those efforts to address the social determinants of health. Important work was done in all three communities to address complex issues like poverty, the quality and affordability of housing, and food security, but this work was not often connected with HBE efforts. The exception to that might be Terrace, where the health authority staff planned a process in which the community was supported to assess the health of their community, and to identify the particular issues they would like to address.

To be most successful in reducing social and health inequities, these strategies should incorporate a consideration of population groups in the planning processes and outcomes, while not losing sight of equity and social justice as key principles that flavour all aspects of planning work (Gardner, 2011; Wong & Gardner, 2013). It’s important to have both these aspects acting simultaneously, to avoid the possibility (indeed, probability) that community
planning initiatives could inadvertently increase inequities. For example, a planning process might be developed that actively encourages community members to participate, but if that process is not explicitly focused on equity, it might not reach specific groups in the community that might be otherwise disengaged or silent (Haber, 2011).

Healthy Built Environments initiatives in BC are still in their early stages of development, yet it is clear, even at these early stages, that equity was not explicitly considered during planning and early implementation. However, the gradual shift to a broader Healthy Communities approach offers an important opportunity to broaden the dialogue of these emerging HBE teams to include a consideration of equity. To offer even more potential for HBE work in BC to more effectively address health inequities, the implementation of an equity lens will require a wider variety of strategies to be used, together with a more explicit consideration of equity and social justice in all components of the process.
Chapter 6: Elements of Context

In this investigation of the ways in which an equity lens is defined and implemented as associated with HBE work in BC, it is vital to consider the context of that work. In order for inequities to be successfully addressed in communities, we must make significant changes to the complex nature of the social and environmental determinants of health. A number of excellent reviews of successful strategies to address inequities have concluded that the ‘web’ of determinants (and their social and political roots), can only be tackled in a policy context that involves leadership at the provincial and/or national levels, combined with local level intersectoral work (Danaher, 2011; Earwicker, 2010; Wong & Gardner, 2013).

In this chapter, I explore how that policy context has influenced how an equity lens has been defined and used in connection with HBE work in BC. This analysis may provide new viewpoints to help us to better understand how key strategic partnerships have developed that are most needed for effective public policy change to tackle social and health inequities. Specifically, this chapter addresses the second sub-question that has framed this research: What aspects of context have affected how the equity lens has been implemented?

I begin the chapter with an overview of recent changes to the policy context in BC, changes which have influenced how both the health authorities and local governments have organized and moved forward with their HBE work. I then present how the key community health issues each of the three case study communities has dealt with have framed how issues of equity are
being addressed in connection with HBE work. I conclude the chapter with a summary of how context at both the provincial and the local levels affected the application of an equity lens.

### 6.1 Changes to the Provincial Policy Context

When I first wrote the bulk of my prospectus, back in the spring and summer of 2011, the BC Ministry of Health was actively encouraging health authorities to connect with planning staff in their regions, and to collectively come up with Healthy Built Environment strategies. At that time, the Ministry had integrated HBE work into the multi-year Core Functions in Public Health program, which aimed to enhance capacity in public health and disease/illness prevention across the province (Population Health and Wellness - BC Ministry of Health Services, 2005). Health authorities were required to assess their activities in building Healthy Community Environments (BC Ministry of Healthy Living and Sport, 2009) and develop plans to work with local government to ensure healthier environments.

An ‘Inequalities Lens’ (later referred to as an ‘equity lens’) was a component of that Core Functions work. Each of the health authorities were expected to somehow implement the ‘Inequalities Lens’ as part of the development of each Core Program. The lens was poorly defined, but incorporated an assessment of health inequalities in all communities and the orientation of new programs so that they provide greater assistance to disadvantaged or vulnerable populations. The Framework for Core Functions document (Population Health and Wellness - BC Ministry of Health Services, 2005) states:

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10 A discussion about how community health has been conceptualized and measured is available in Appendix E.
“public health has a duty, as one of its fundamental tasks, to work to reduce inequalities in health. This can be accomplished in several ways:

- By documenting inequalities, reporting on them so as to draw public attention to them, and analyzing the factors that contribute to those inequalities;
- By working with communities to change the conditions that contribute to inequalities in health in their community; and
- By advocating for healthier public policies and changes in social, economic, cultural, and environmental conditions that will reduce inequalities in health” (p. 48).

The Framework document concludes its brief description of the ‘equity lens’ by suggesting that health authorities “ensure that the core programs provided by the health authorities reflect the priorities of the people with greatest need” (p. 49). In 2012 and 2013, when I completed my data collection, there were some ideas as to what using such a ‘lens’ entailed, but much of that work still focused on the use of population health data to describe inequalities and justify the use of a lens. Despite a great deal of exploration and debate, there was little consensus among public health leaders in BC as to what an equity lens should contain and how it should be used as part of the Core Functions process.

Over the past three or four years, work to continue the Core Functions review process has been de-emphasized, as the focus on a new program, Healthy Families BC, has grown. A senior BC government official explained that a major programmatic review at the BC Ministry of Health in 2011-12 resulted in the identification of Key Result Areas (KRAs) that now serve as high priority areas for implementation. At that time, there were 15 KRAs. As a senior government official explained, the Core Functions work entered its next stage, which involves its integration into Healthy Families BC:
“when that innovation and change agenda was set up, there was a number of key result areas that were established. And at the time, there were about 32 different key result areas. And in the last fiscal – so 2011-12, that was pared down to 15 key result areas. Key result area #1 was prevention and health improvement strategy – AKA Healthy Families BC. KRA #2 was public health renewal, AKA Core Functions for Public Health.

So, as we move forward into the next fiscal, there is going to be a combination ... an integration of KRA 1 and 2, as we go forward. So, whatever that will be called – maybe it’s a renewed KRA 1, will be very clear in terms of how it is supporting the prevention and health improvement strategy, with the underpinning of the public health Core Functions piece. Because from a health authority perspective, we had moved Core Functions into an operational stage, rather than a, sort of, new change and innovation ... and expecting that to be ongoing practice.

And because KRA 1 came along with specific initiatives ... so there is a combination of 10 specific initiatives within KRA 1, that prevention and health improvement strategy when we started it ... so that is where the emphasis went. And actually, there is direction given to the health authorities to focus in on the Core Programs that are aligned to those initiatives within KRA 1.”

6.1.1 Healthy Families BC

Since 2011, there have been significant changes in the ways in which HBE work is conceptualized and is organized in BC, including the way in which the Equity Lens is being considered. From the health authorities’ perspective, HBE work is now integrated into the Communities section of Healthy Families BC. This new provincial initiative aims to “help British Columbians to better manage their own health and reduce chronic disease by focusing on four key areas: proper nutrition, healthy lifestyles, resources for parents, and fostering healthy communities” (Healthy Families BC, 2012a).

When Healthy Families BC was first launched in early 2012, there was a limited emphasis on issues related to social or health equity. Instead, the emphasis was on chronic disease and lifestyle-oriented issues linked to chronic disease, including physical activity, healthy eating, and tobacco reduction. Healthy built environments and what were referred to as ‘priority populations’ were presented as the final two areas of focus (BC Ministry of Health, 2011;
Healthy Families BC, 2012a). There was little mention in most of the Healthy Families BC documents of the social determinants of health, social or health equity, or even a ‘health for all’ approach. There was some emphasis on diversity and inclusion, but that discussion seemed to have been limited to encouraging seniors and those with physical disabilities to also engage in healthy lifestyles. However, the Healthy Families BC Policy Framework, released two years later in 2014, does refer to health inequities, but reducing health inequities is seen as one particular approach to use to reduce chronic disease (BC Ministry of Health, 2014), rather than a ‘lens’ with which to view both the problems and the solutions.

The Communities section of Healthy Families BC focused on building local and regional partnerships that can be used to create more supportive environments for people to live active lifestyles and make healthier choices. Here is a summary of the Communities portion of the program, from the Healthy Families BC website:

- Healthy communities make it easier for residents to make healthier choices every day. Choices that over the long term will help them achieve and maintain their best possible health and well-being. People who are active and healthy will thrive in their communities and their communities, in turn, will also prosper …
- Healthy living habits help reduce two of the leading causes of preventable death and disability among British Columbians: chronic disease and obesity. Fortunately, many local B.C. governments are already leaders and promoters of healthy living in their communities. To build on that momentum, the Province is partnering with local governments and health authorities in a grass roots effort to help families live healthier lifestyles, reduce chronic disease and to promote healthy weights. (Healthy Families BC, 2012a).

From February to May 2012, staff from the Ministry of Health, together with facilitators from Context Research and BC Healthy Communities Society, held seven consultations with local governments across the province, to explore further opportunities for ways to work
together to make regional districts, cities and towns healthier (Healthy Families BC, 2012c). As a senior government administrator told me in an interview, some of the impetus to undertake a consultation process with local governments came from the Union of BC Municipalities (UBCM). Staff from UBCM mentioned to the BC Ministry of Health that, under the Community Charter, the Ministry was obligated to do a consultation with local governments, given that the new Healthy Families BC-Communities initiative had the potential to have a significant impact on local governments themselves. These consultations kick-started the province-wide efforts to build stronger relationships among the Ministry of Health, health authorities, and local governments. The Healthy Families BC-Communities initiative maintains a strong focus on the important role of local governments, as this excerpt from their website demonstrates:

“Local governments are already leaders and promoters of healthy living in their communities. The Healthy Communities Initiative builds on those efforts by supporting collaborative action between local governments, health authorities, and community leaders. This is to ensure the health needs of communities are supported in the best possible way. We believe that local governments, as leaders within the community, play a pivotal role in creating environments which promote healthy lifestyles.” (Healthy Families BC, 2012b).

Part of the effort to facilitate stronger relationships between health authorities and local governments in the province included acknowledging the important work that local governments were already doing in terms of HBE work. For instance, a provincial-level administrator suggested that part of the reason for highlighting how the current work of local governments has a positive impact on health stems from reflecting back to them what various departments are doing:

“So from what a local government could potentially do in terms of their health promoting activities, this is where you’re at today and you should celebrate that, because how often does that sort of packaging get presented to council? Of what a local
government is doing around health improvement, and really combating chronic diseases, and promotion of healthy weights, that sort of thing. So, really package up and see you’re doing a lot of stuff. You may not know your recreation staff is doing this, transportation is doing this, planning is doing this, so it’s all packaged up together.”

6.1.2 Change in Relationships between Health Authorities and Ministry of Health

Alongside this shift in 2011/2012 to the Healthy Families BC initiative, the relationship between the Ministry of Health and the health authorities also changed. As mentioned earlier in this chapter, the relationship between the Ministry and health authorities is important because it helps to shape how HBE initiatives are envisioned and implemented in BC communities.

According to the Health Authority representatives with whom I spoke, the Ministry of Health became more directive with the health authorities. With the Core Functions work, there was an implicit understanding that health authorities could implement the various Core Programs in a variety of ways, depending on what was needed in their particular region. The Core Functions processes and outcomes, therefore, varied significantly among the Health Authorities. The kind of flexibility that Health Authorities had within the Core Functions process has been portrayed as less of an option with the new Healthy Families BC initiative.

6.1.3 Spread of the Fraser Health Model

Health Authorities have been encouraged to implement the Communities portion of Healthy Families BC based on the model that Fraser Health used. In 2009, Fraser Health reorganized its public health department, so that several regional representatives were hired. Each of those representatives acted as a liaison to one or several municipalities, and put together Healthier Communities Partnership committees (one per municipality) that include public health staff, planners, elected officials, and other community leaders, including representatives from school
districts, parks and recreation, and police/fire departments. Each of these committees was co-chaired by a municipal elected official and a senior administrator from Fraser Health. Each Healthier Communities Partnership committee was supported by Community Health Specialists within Fraser Health. As one Fraser Health staff member explained,

“the whole purpose of Healthier Community Partnerships is to really link with our municipal government to sort of have those broader conversations of what the health issues are at the community level to engage the stakeholders, such as municipal government and other community agencies to talk about those issues, whether they be health inequities issues, social determinants of health issues, healthy living, risk factors for chronic disease … and to start building those relationships, come up with some common strategies that we can all work towards to improve the health of the population.”

The BC Ministry of Health chose to encourage Health Authorities to follow the Fraser Health model in part because Fraser’s strategic use of community health data helped to build partnerships with local governments. Within each municipality, Fraser Health staff, together with the Healthier Community Partnerships committee from that area, put together community health profiles that use data to provide a brief, yet clear, picture of the strengths and challenges that community is dealing with as they relate to health and wellbeing. A provincial government staff person explained it this way:

“But what we’re keen on is the way the Fraser Health Authority is gone about it, is really to do, to generate the community health profile, to understand where the health issues are, where the inequities are in terms of that community. So use that as a basis, then look at um the evidence base and generate pretty much a, um, like a review checklist. They call it a scorecard.

To look at then what are the policies and services available and programs available from that local government that are related to those key areas around physical activity, healthy eating, tobacco reduction, built environment. Do they have health promoting policy statements within the OCPs, for example?”
6.1.4 Re-connecting with Local Governments

A key component of Healthy Families BC-Communities is about re-connecting local governments with health authorities, particularly public health departments within each health authority. As a senior government staff person indicated,

“So part of what Healthy Families BC is ... is around rekindling those relationships and understanding what the roles of health authority and local government and how health authority can better support local government around a health improvement role.”

As outlined in the Literature Review (Chapter 2), the fields of planning and public health originated together in the 19th century as a result of a concern for urban living conditions. In B.C., the first local government legislation, the Municipality Act of 1872 (Province of BC, 1877) listed “the preservation of public health” as one of 31 key areas of local government responsibility. This act also named municipal councils as local boards of health. In the first half of the 20th century, local governments in BC had direct responsibilities for public health services and programs. But by the middle of that century, the formal legislated role of local governments diminished, as provincial ministries of health took on more responsibility for health care services and national-level programs for health promotion and health protection grew in importance. Despite the increase in other levels of government in health-related policies and programs, in the 1990s regional health boards and community health councils in the province facilitated the continued local involvement in the planning of both public health and health care services. However, in 2001 regional health authorities were established, and the role of local governments and locally based organizations to provide input about community health was drastically reduced.

In many ways, this history of the relatively recent separation of public health from local
government mirrors that in many other provinces in Canada, and in other countries, including the United Kingdom and the United States. Dr. Jesse Parfitt, a retired medical health officer, was one of the first to raise alarm bells about this trend with her book, *The Health of a City: Oxford 1770-1974* (Parfitt, 1987). In that book, Dr. Parfitt relays a narrative history of the development and ultimate disintegration of public health services in Oxford, concluding that the connection between local government and public health (which has now been largely lost) has been valuable for population health:

“Many would be surprised to learn that the greatest contribution to the health of the nation over the past 150 years was made, not by doctors or hospitals, but by local governments. Our lack of appreciation of the role of our cities in establishing the health of the nation is largely due to the fact that so little has been written about it.” (Parfitt, 1987, as cited by Hancock, 1997, p. 11))

Over the last ten years, there has been a growth of interest and, increasingly, active support for acknowledging the important role that local government in Canada has played in community health, and for facilitating the development of more explicit partnerships between local governments and health authorities. Within the recent literature, three main rationales have been presented for this move to involve local governments in health promotion and planning as it relates to community health: through policy development and the provision of services at the local level, through governance systems that emphasize health and well-being, and through strategies that specifically emphasize equity and social justice. Each of these rationales is described below.

1. **Promoting Health through Policy and Service Provision.** The most common argument, especially within North America, is that local governments provide services that, through action on the social and environmental determinants of health, have a direct impact on
population health within that community or region. For instance, the recent report, *How Do Local Governments Improve Health and Community Well-Being?*, published by BC Healthy Communities Society and Healthy Families BC (Habkirk, 2013), summarizes the role of local governments in helping to maintain community health in this way:

>“local governments have the ability to promote health in their communities through healthy community design, parks and recreation facilities and healthy living programs, health-related policies, and building partnerships with non-profit and community organizations ... local governments have no formal role in health care delivery in B.C., however, they have an important role to play in building healthy communities, creating the conditions for citizens to make healthy choices and working with partners to promote health and well-being.” (p. 5)

Local governments can therefore promote the health and wellbeing of residents in their area in several spheres, including the economy, transport, recreation and parks, housing, and the environment. They can do this through various policies and programs or other types of intervention, such as those that support social inclusion and diversity, healthy and active living, efforts to mitigate the effects of climate change, healthy urban planning, and participatory processes for citizens. Finally, intersectoral partnerships and initiatives designed to empower community members have the potential to be more effective and more easily implemented with the active support of local government.

2. **Local Governance for Health and Wellbeing.** Some researchers and policy advocates, particularly in the United Kingdom, are highlighting the leadership role of local governments to help shape the social and cultural environments in which people live and work. In part, this leadership is borne out through local governance systems, which in themselves have the potential to influence individual and community health. For instance, South, Hunter, and Gamsu (2014) suggest that:
“Local government is the leading local democratic institution and as such is responsible for shaping the way that citizens are involved in their own wellbeing, can improve wellbeing in their communities, and hold local health and wellbeing services to account.” (South et al., 2014, p. 4).

Local governments can exert this leadership by developing systems of governance which emphasize health and wellbeing. For instance, local governments can use a Health in All Policies approach, and integrate a consideration of health when developing and implementing new programs or policies (Kickbusch, 2013). They can also work to identify the needs and assets of the community, and then help to mobilize community members to address issues that are relevant to health and wellbeing. Much of this leadership effort involves encouraging others that health and wellbeing are relevant concerns in all sectors. As Agis Tsouros, of the WHO Regional Office for Europe (2013), suggested, “local leadership for health means ... ultimately acting as a guardian, facilitator, catalyst, advocate, and defender of the right to the highest level of health for all residents” (p. S6).

Citizen engagement in planning processes, as part of a governance style that emphasizes inclusion and diversity, offers another way to link local governance and equity. Recent research from the United Kingdom suggests that inclusive engagement strategies have been shown to produce better policy outcomes (Pratchett et al., 2009) that are associated with better health and well-being (Hothi, 2008). There is evidence to suggest that empowerment and engagement of individuals is, in and of itself, health promoting (Woodall et al., 2010). Many studies show that health improves with the ability to control our circumstances and environment. Many of the traditional consultation practices used by local governments, like holding community meetings or distributing online surveys, reach only a portion of the residents within a
community. Some groups, like busy parents, renters, or people with low education levels, might be excluded from these consultations, in part because of the ways in which those consultations were designed. Part of building healthy communities is finding a way for all members of that community to become engaged in local decision-making.

Reviews of intersectoral approaches to promote equity and health have stressed the importance of the active involvement of local government. In these reviews, local government has often provided the initial invitation to begin an intersectoral approach. They took the first steps in bringing people to the table, and they provided a framework and other supports for intersectoral action to happen at the local level (Public Health Agency of Canada & World Health Organization, 2008). This local level work often facilitated the active participation of civil society in community planning, and allowed program development to ebb and flow as necessary, based on the changing needs of the community.

Despite the acknowledged importance of local government in maintaining the public’s health, it is disappointing that few researchers studying the connections between planning and health have mentioned the role of governance systems, either as a means to implement changes to the built environment or as a process that might improve community health in its own right. There is a small, but growing, literature on governance and its impact on health. At the local level, governance reflects broad social structures, and as such, it can act as one of the

11 Governance is not just the work of governments. Local (or urban) governance is made up of the many ways in which individuals and institutions (public and private) plan and manage the common affairs of the city (Burris et al., 2007).
ways in which power, resources, and knowledge are distributed among population groups within one urban centre or community (Burris et al., 2007). The Healthy Cities approach, described in Chapter 2, incorporates the active participation of local government representatives in working toward healthier communities, and so offers a venue with which to explore issues of healthy local governance.

3. Local Equity Strategies. A final way in which local governments have the potential to influence health and wellbeing is through the implementation of strategies that are designed to directly influence social and/or health equity.

For instance, Take Care New York 2012 was a broad strategy with ten key intervention areas, each of which considered health equity. The strategy worked to improve access to quality housing and nutritious and affordable food, and included targeted programs in some of the city’s lowest income neighbourhoods (New York City Dept. of Health & Mental Hygiene, 2009a). The London Health Inequalities Strategy aimed to reduce health inequities through improving equitable access to high quality health and social care services, improving employment prospects and resources for individuals living near or in poverty, and supporting the development of healthier places, by investing in housing and public spaces within lower income neighbourhoods (Greater London Authority, 2010).

In another example, The City of Portland, Oregon’s official community plan, The Portland Plan, presents a framework and clear strategies for advancing social, economic, and health equity. The Plan is the result of two years of research that involved extensive community input, including dozens of workshops, hundreds of meetings with community groups, and 20,000
comments from residents, businesses and non-profit groups. The overall vision for The Portland Plan is “a prosperous, educated, healthy and equitable Portland” (City of Portland, 2012).

In 2007, King County, Washington, which includes the City of Seattle, launched an Initiative on Equity and Social Justice (King County, 2008), which aimed to invest as far ‘upstream’ as possible to avoid more costly ‘downstream’ impacts. Another goal of the Initiative was to use an equity lens in making decisions about policies, budgets and program development. Planners developed an Equity Impact Review Tool to help to facilitate the use of that lens, and County officials used Geographic Information System-based data sets to inform their policy discussions, especially with regard to neighbourhoods in which poverty is concentrated (King County, 2016). The Initiative has resulted in the rewriting of the zoning code to allow greater flexibility for developers and to encourage more mixed-use neighbourhoods in return for providing public benefit, such as mixed-income housing. It has also helped to encourage underrepresented groups to participate in neighbourhood revitalization and transportation planning projects, in part through enhanced translation policies (Whitney, 2010).

In a final example, in 2007 the Scottish government published a policy statement on health inequalities called Equally Well (Scottish Government, 2008), and invited pilot projects to help tackle issues of health inequity as they relate to planning. One of those pilot projects involved the use of the Healthy Sustainable Neighbourhoods Model in Glasgow (Higgins, 2010). The Model was developed by the city’s planning department as part of an HIA process for the city’s East End area. The Model is based around nine components: employment and training, health and well-being, climate, lifelong learning, people, transport, green engineering, leisure and
recreation, and housing diversity. One of the project’s elements is to gather qualitative experiences around ‘healthy place-making’, with a goal to produce place-making design guidelines and Quality of Place Indicators.

A recent review of equity strategies at both the national and local levels (South et al., 2014) found that the most effective approaches have involved a balance between a strong national vision and set of policies and a flexible, yet strong, set of local and regional level strategies. Another current review (Park, 2014) suggests that equity is emerging as a key goal in local level sustainability strategies, mostly in the USA, but also in some Canadian cities. In part, that encouraging trend is the result of a stronger economic and political case being made that emphasizes how investing in disadvantaged groups and neighbourhoods is good for the long-term health and vitality of the entire community (Park, 2014).

Because of the complexity of health inequities and their underlying determinants, Wong and Gardner (2013) found that action across multiple sectors and all levels of government is necessary. Action at the national level is insufficient by itself to effectively address health inequities. Even the strongest, most comprehensive national strategies need to be adapted and then implemented at the local level.

6.2 Community Health Status of Three Case Study Communities

The following section describes the key issues each of the three case study communities was dealing with at time of data collection, as described by key informants within each community, coupled with statistical data and observations from fieldwork. While I have labelled these issues as community health concerns, it is important to note that in many cases, the community
members I talked with did not use those terms, but instead referred to broader social terms (e.g. poverty, housing, transportation issues). In describing the key issues that are of significant concern to each community, I aim to outline the local context in which an equity lens is (or could be) implemented at the local level. Further information about how community health status is measured can be found in Appendix E.

6.2.1 Surrey

As mentioned in Chapter 3 (Section 3.1), Surrey is a rapidly growing suburb of Vancouver. Managing for this growth in population is a priority for planning within the City of Surrey (City of Surrey, 2013b). Surrey has seen a great deal of growth over the last 10-15 years, both in terms of population as well as economic power. Yet the city continues to struggle with a number of social issues that have a significant impact on community health and wellbeing. One interviewee from Surrey explained the recent history of the city in this way:

“The city of Surrey used to be one of those bedroom suburb communities from what I understand, and it was a fairly...interesting place to live. I heard a lot of stories that people always joked “Oh you’re from Surrey? Oh that’s too bad, really”. Um... this area that we’re in now, North Surrey or Whalley as it’s called- our Central City, it’s still low income but it used to be very low income. So more- it was for a lot of the people who lived in Vancouver who couldn’t afford to live in Vancouver moved out here, so for the longest time there was a lot of crime, lots of drugs, lots of issues- lots of social issues. And then over the years it started to shift and change. But when mayor Dianne Watts was elected ... she came in with the idea that Surrey was going to be the next Vancouver in BC, and it was going to have- or this area, Central City, was going to be a hub where people could go, and she really wanted to make it a destination so she focused a lot on developing the economic side of the city of Surrey, because it was such a bedroom sort of suburb where people just came to live and they commuted into the city- into Vancouver to work. So she created this vision where Surrey would be an economic contributor to the province, and over the last ... five years, she’s worked to make sure that that happens, and the growth in Surrey has been, you know, exceptional.”
As described in Chapter 3, Surrey is made up of six communities, or “town centres” (City of Surrey, 2014d): Whalley/City Centre, Guildford, Fleetwood, Newton, Cloverdale, and South Surrey (see Map 2, below). Income levels and poverty rates vary considerably among Surrey’s six communities.

Map 2: Six Communities within Surrey

Source: City of Surrey (2009)

The area of Whalley, in North Surrey, has a reputation for lower income neighbourhoods and has been associated with high crime rates, but is in the midst of change as part of it has been developed into a walkable, transit-oriented downtown, renamed City Centre. When I visited
North Surrey in April 2012, I saw many small older homes that needed significant repair sitting on relatively large lots (see photos, below). In the residential areas of Newton and Whalley, there were few sidewalks, and I rarely saw people walking or cycling in those areas of the city.

Images 4 and 5: Homes in North Surrey neighbourhood. Photos: author.

In contrast, many of the neighbourhoods of South Surrey were made up of newer, more costly homes with manicured lots, bike paths and sidewalks.


New developments have been built over the last 5-10 years in all areas of Surrey, much of it housing. In North Surrey, development tends to be more focused on multi-family condominium
units in both high-rise and mid-rise buildings, mixed with some single family housing. When I toured the neighbourhoods of North Surrey, especially in Whalley and Newton, I saw street after street in which older homes had been torn down and replaced with larger, new homes (see photos, below). Theoretically, this type of new development will allow a greater mix of income levels within those neighbourhoods.

Images 7 and 8: Examples of new development in North Surrey. Photos: author.

In South Surrey, however, entire new neighbourhoods have been built (see photos, below), some of them on greenfield sites.

Community Health Status

Overall, Surrey residents enjoy relatively good health. When compared to other areas of BC, Surrey ranks about average on many indicators of physical health, including life expectancy and prevalence of chronic disease. Yet some data suggest that, in some of the key social determinants of health, including education, low income/poverty and early childhood development, Surrey has significant challenges. In particular, crime and human economic hardship present cause for concern.

In terms of health status, the life expectancy of Surrey residents (83.2 years for women and 79.3 years for men) is similar to the BC average (83.6 years for women and 79.2 years for men) (Fraser Health, 2010).

After an analysis of both the available local-level data and the responses of the eight interviewees, the following six issues emerged as the key health and social issues currently facing the city of Surrey. These six issues are not presented in any particular order. Of course, while I have presented the six issues separately here, it is important to remember that they do interact with each other and with other, related factors that originate from within and outside the city.

Housing and Homelessness

Despite the efforts of many groups in Surrey, including the City of Surrey, housing affordability and homelessness continue to be issues in the city. The 2014 Metro Vancouver Homeless Count found 403 homeless people in Surrey, representing approximately 15% of the region’s 2650 homeless (Greater Vancouver Regional Steering Committee on Homelessness,
The number of homeless people in Surrey has remained fairly constant since 2008, which is positive, considering the large increase in Surrey’s overall population during that time period.

Housing in Surrey is more affordable than it is in other areas of Metro Vancouver. In 2011, the Canadian Mortgage and Housing Corporation (CMHC) reported that the average monthly rent for a 2-bedroom unit in Metro Vancouver was $1,237, and the average monthly rent for a 3-bedroom unit was $1,463. In Surrey, average monthly rents were $897 and $982, respectively. In 2011, these rents were not affordable for households living at or below the poverty line. Even with the higher levels of affordability when compared to rents across the region, the average rent in Surrey is between $100 and $200 per month above the level that is affordable to a household living at the poverty line (City of Surrey, 2012b).

In interviews for this research, homelessness and housing issues (including affordability and quality) were consistently mentioned as key issues affecting the health of Surrey residents. Some interviewees attributed the challenges with housing affordability to the rapid rate of development within the city. Some families, especially those living in North Surrey, have been forced to look elsewhere for housing they can afford:

“in this area here of Central City/Whalley, because this is where I think a- quite a number of the low income population lives in this area, and it happens in lots of different places as soon as you start to redevelop and more people move in and the housing prices go up and it pushes those people out.”

One interviewee referred to this redevelopment in North Surrey, particularly Whalley, as a “sprucing up” process, done in part to combat the poor reputation that neighbourhood has had for decades.
Another interviewee suggested that the problem with housing affordability is more complex, and is related to the lack of incentives for developers to build rental housing units:

“what’s happening is that particularly in the Newton area and Gilford and North Surrey, that’s where a lot of the federal housing was built that was more affordable ... all these homes were built in the seventies and eighties, and that was in the North Surrey area ... they took away the tax credits for the developers to build a rental housing, so there’s been hardly any rental housing built in the city since the early 1990’s. Then there, y’know the federal government pulled out of building- giving any more capital money for building social housing, that’s subsidized housing. So the province through the early 1990’s tried to build about six-thousand units. They tried to fill that gap somewhat, but then in 1996 that was finished, that program.

So there’s just been hardly any rental housing built, and what’s happening which is what I feared was going to happen is that there is hardly any infrastructure left to build that housing ... the real fear is that the rental stock that is there is in areas like around sky trains and different things where re-development is all taking place. They want to create higher density and the numbers don’t work to keep the rental housing in there, so people are going to be displaced. So the lack of rental housing over the next ten years is going to become really a major issue.”

Led by the Social Planning department, City of Surrey staff are actively working with a number of community partners to address housing and homelessness issues in the city. The City has a Housing Action Plan (City of Surrey, 2010b), a Master Plan to House the Homeless (CitySpaces Consulting Ltd., 2013), and a Memorandum of Understanding with BC Housing (BC Housing Management Commission and the City of Surrey, 2008) to provide supportive housing.

Crime

The crime rate in Surrey has been a significant concern for many years. In 2011, the crime rate¹² in Surrey was 91, much higher than the overall Metro Vancouver rate of 72 (Police

¹² Crime rate defined as the number of Criminal Code offences or crimes (excluding drugs and traffic) reported for every 1,000 permanent residents.
Services Division & BC Ministry of Justice, 2012). This issue has been tackled head on by Surrey’s Mayor Dianne Watts and her council. In 2006, the City put forward a Crime Reduction Strategy (City of Surrey, 2006a). Annual progress reports are integrated into the Strategy.

The 106 recommendations within the Crime Reduction Strategy follow four key themes:

- Prevent and deter crime;
- Apprehend and prosecute offenders;
- Rehabilitate and reintegrate; and,
- Reality and perceptions of crime (City of Surrey, 2006a).

The Strategy is linked with many of the City’s other strategic plans, including the Plan for the Social Well-Being of Surrey Residents (the Social Plan), and plans for Recreation and Culture, Transportation, Parks, and Energy and Sustainability (City of Surrey, 2014a).

Substance Use / Abuse

It is difficult to present statistics on substance use or abuse within a particular geographic area, like the city of Surrey. Despite this lack of definitive data on the scope and breadth of the substance use/abuse issue in Surrey, social planners and city councillors acknowledge that the issue is a significant one for the city.

Planning and action to address issues of substance use and abuse in Surrey are integrated with other aspects of the Social Plan, especially those components that deal with housing and crime reduction. One city councillor with whom I spoke acknowledged that the issue of homelessness in Surrey is connected to mental health and addictions issues:

“I see Fraser Health being able to take on a strong partnership role, because one of the issues to is ... [at the] housing count we still had about four-hundred people that were
homeless in Surrey even though the community grew by a thousand people a month. We’ve kept in under control, but the people that are homeless now are people that are chronically homeless that have major problems. So putting them in housing is very difficult. We’ve had outreach workers that have been able to place almost four-hundred people in housing with some supports, but the ones that now need housing are people who need quite a lot of supports and that has to come through the Health Ministry ‘cause the city doesn’t have that. It has to come through the Health Ministry ...”

As this city councillor notes, Fraser Health staff from the Mental Health area of the health authority have been working with City of Surrey staff to help establish housing within the community for people with long-standing mental health concerns.

Diversity and Inclusion

Surrey is a rapidly growing city with a large proportion of children and youth. It is also one of the most ethnically diverse cities in BC, with 33% of residents speaking a language other than English at home (Fraser Health, 2010). In 2011, the percentage of the population aged 65 and over in Surrey was 12.1%, lower than the national average of 14.8%. The percentage of children aged 0 to 14 years is above the national average: 19.0% in Surrey, compared to 16.7% Canada-wide (Statistics Canada, 2012a). The large number of children in Surrey has important implications for education and community health. For instance, in the 2007/8 school year, the percentage of grade 4 and 7 students below their reading level was significantly higher in Surrey (27.9%) than in the province in general (21.2%; (Fraser Health, 2010).

Research has long demonstrated that early childhood development is an important predictor of school readiness, health, and coping skills across the entire life course. A tool used to assess children’s development at kindergarten age is the Early Development Institute (EDI). The EDI consists of five scales: physical wellbeing, social competence, emotional maturity, language and
cognitive development, and communication and general knowledge. These five dimensions are considered important markers of children’s health and wellbeing (Human Early Learning Partnership, 2014). In 2007-2008, about 30% of Surrey children under the age of five were vulnerable on at least one of the five EDI scales. This proportion was similar to the provincial average (Fraser Health, 2010).

Education is a key determinant of social and economic status, as well as health status. Adults with minimal schooling are less likely to get high paying jobs, and tend to have less control over their work environments, both of which can have direct and indirect impacts on health and wellbeing (Mikkonen & Raphael, 2010). In the 2006 census, 20.7% of Surrey adults aged 25 years or older reported that they had completed less than a grade 12 education, with no other trades or college certificate or diploma. In BC overall, the proportion with a similar level of education is 16.6% (Fraser Health, 2010).

Despite issues with housing affordability and homelessness in Surrey, homes are, in general, more affordable there than in many other parts of Metro Vancouver. The wide variety of types of homes being built in Surrey was also seen by some of my interviewees as crucial to facilitating greater diversity in the community, as more newcomers to Canada and young families are able to find homes in Surrey. One interviewee from Surrey explained it this way:

“So they’re really trying to, to move in that direction and I think they’re having some progress and more and more young families move out this way, and as more and more young single people move out this way, and as more and more of the population gets older they’re finding that these, that these new communities are quite attractive because people can downsize into smaller homes, townhouses or young families can move you know, can get a home - their first home - for an affordable price and still be able to do what they want to do in their community. And as more and more businesses come out this way then people can live and work in the same area ...”
As described in Chapter 3, Surrey is home to many immigrants and refugees who have recently come to Canada. Surrey is a primary destination for immigrants in Metro Vancouver. The 2011 National Household Survey revealed that 40.5% of Surrey’s population were immigrants. Surrey’s immigrant population has grown by 25% since 2006 (Statistics Canada, 2012e). Surrey is also a primary destination for Government-Assisted Refugees (GARs) in Metro Vancouver (City of Surrey, 2014c). Government-Assisted Refugees are identified by the United Nations as being among the world’s most desperate people in need of protection and support for resettlement (Government of Canada, 2011). A study of refugees in Surrey found that the majority of GARs in the city live in housing that is both unaffordable and overcrowded. Many of the refugee families who participated in the study were struggling with unemployment and poverty (Sherrell & Immigrant Services Society of BC, 2009).

In interviews, city councillors and staff at the City of Surrey expressed deep concern for these refugee families. One city councillor explained the issue in this way:

“I’m going to start with the refugees. We have the largest number of refugees that come in and live in our city. We have been fighting with the provincial government- not the provincial, the federal government because these refugee families, some of them come with eight, ten kids, and they have no money, most of them don’t speak English, most of them don’t have a work plan, they live in a one bedroom house, and they have to pay back the federal government thousands of dollars. So, the federal government gives them the money to get here, and then within one year they have to pay that back. Well, if they can’t work and they don’t speak English ... what do they do?”

Until March 2014, the Surrey Welcoming Communities Project brought together 25 agencies and organizations to help to build capacity within Surrey as “place for all” (Welcoming Communities Project, 2014). The project was co-chaired by the senior social planner at the City of Surrey.
Poverty and Income Inequality

In 2006, 13.6% of the Surrey population lived in poverty\(^\text{13}\), similar to the BC average of 13.1% (Fang & Quantz, 2008). However, the child poverty rate in Surrey is more of a concern: 17.6% of Surrey’s children lived in poverty in 2006, higher than the BC average of 14.9%, and much higher than the overall Canadian rate of 13.1% (Fang & Quantz, 2008). In March of 2012, Vibrant Surrey, together with a variety of local and regional partners, including the City of Surrey, Fraser Health, and the Social Planning and Research Council of BC, held a Poverty Dialogue to bring forth ideas for a strategic plan to reduce poverty in Surrey. That plan, called the Surrey Poverty Reduction Plan, was released in July 2012. The plan focuses on four main action areas: transportation, housing, income, and support (City of Surrey, 2012b).

It is, of course, difficult to measure inequities within any one particular society or geographic area. Yet differences in income levels, or income inequality, can be measured. In a 2008 report from the Provincial Health Services Authority (Fang & Quantz, 2008), income inequality is defined as “the difference between average family income and median family income with a zero value indicating income is homogeneously distributed, a positive value indicating prosperity concentrates in the high income groups and a negative value indicating opposite a direction” (p. 3). Measured in this way, Surrey’s level of income inequality of $13,135 is similar to the province’s average of $14,724 and the overall Canadian average of $15,980 (Fang & Quantz, 2008).

\(^{13}\%\) of population with an after-tax family or household income below the Low Income Cut-off (LICO) as defined by Statistics Canada.
All of the people I interviewed in Surrey mentioned the challenges with poverty in the community. Some expressed frustration at having to deal with this issue at the city level, when in many ways the policies that support poverty have come from the provincial and/or federal levels. One interviewee described the challenges of many families in this way:

“people that are living here on a day-to-day basis it’s just impossible, so they can’t look for work ‘cause they can’t get around to look for work, the requirements are there that they do that but they don’t have the funding to do that, and y’know, things like the minimum wage- there’s people working two or three jobs just to support their families. Single parents or even two people working in a family because they are being paid minimum wage or below for these jobs, and so it’s- there’s things that could be quite simply changed that can make huge differences in people’s lives.”

Another interviewee expressed frustration about the lack of action to combat poverty within the city:

“I mean I think that there has to be a concentrated effort. People have to take the issue seriously, and there’s been an incredible study at the federal level too, on the fact that the Canadian economy is really dependant on raising the poverty levels or getting people out of poverty in Canada. So, anymore studies ... like there needs to be no more studies, there needs to be a commitment to take recommendations and act upon to prioritize and just take some action, set some benchmarks and some goals, and see what a difference it makes, because then government feels like it’s putting the dollars in the right places.

Right now there’s just so much wasted dollars on more and more studies, and we all just shake our heads.”

Related to issues of poverty across Surrey is the concern about the continued inequalities in income levels between neighbourhoods. Rates of low income vary considerably between North and South Surrey, for instance, but despite those obvious inequalities in income, there are also pockets of low income and poverty in all areas of the city, including South Surrey, as one interviewee pointed out:

“most people don’t realize that there can be as many problems in Cloverdale, and South Surrey, and Gilford as there is in Whalley or Newton. They just have that much bigger
focus so they’ve settled in people’s minds. South Surrey has some major issues with drugs, alcohol, and poverty …”

Transportation

According to several of the people I interviewed, transportation can present significant challenges for many people in Surrey, particularly those who don’t have access to a car. As one city councillor mentioned, many essential services, including health care and food banks, are not easily accessible via public transit:

“I will also say a major obstacle, for not only our refugees, but seniors and families that are new immigrants, is transportation. Transportation is a huge issue for us. We do not have enough transportation to get from point A to point B anywhere in the city. We have social services that are placed within the Newton Corridor, and most of these people they live in North Surrey, they live in Fraser Heights, or they live … so far away and they don’t have cars because they can’t afford them, and they can’t get to the services they need in order for them to get some help and get some support.”

This need to use a car to access work, school, and important services, is acknowledged in the City of Surrey’s Transportation Plan:

“there is an over-reliance on the car that is having serious implications for congestion and the environment, particularly climate change, safety and health. Peak oil forecasts and escalating fuel costs will impact all aspects of transportation and affect people’s transportation decisions and travel patterns. For those who do not have access to a car, or who want to use their car less, getting around can be difficult.” (City of Surrey, 2008b), p. 6).

One of the key objectives in Surrey’s Transportation Plan is to improve accessibility to jobs, education, health and recreation for all. Part of the challenge of making this objective a reality is the way the current public transit system is designed. According to some of my interviewees, the current public transit system, which is operated by Translink for the entire Metro Vancouver area, is oriented to allow easy access for Surrey residents to and from downtown Vancouver, but not to other areas within Surrey itself. It is particularly challenging to travel to
and from South Surrey to North Surrey. Some of the city councillors have been quite vocal with Translink about these concerns. For instance, one city councillor commented:

“I mean we have screamed and advocated for transportation … it’s just criminal that there’s nothing for the amount of money that we collect from our tax payers and give to transit, we get hardly anything in return, so that needs to be changed, that’s all I can say. People of youth, and seniors, and low income people, they all- they don’t have cars, they can’t get around right? And so it’s really, it’s making it very difficult for people especially as a community grows, and … that transportation issue is a big, big factor.”

Of course, a lack of access to transportation choices is related to other community health issues in Surrey, particularly poverty. As a Surrey city councillor explained, the way Surrey’s public transit system is organized has been especially difficult on low income families:

“… the city is also a bit more affordable from a housing perspective than Metro-Vancouver or Burnaby, people that are struggling with high housing costs are moving here, but then they’re having to pay such high costs for transportation because we none [laughs]. Or, if we do have it it’s just so expensive like, people have to pay five or six dollars to get to the food bank, to get food right? And they’re going to the food bank because they don’t have the money, and the way the transit works is they have to buy two passes for the one zones because it only works on an hourly basis. So, if you have to stand in a line longer you have to pay the second pass.”

6.2.2 Kelowna

The city of Kelowna lies within the Regional District of the Central Okanagan (see Map 3, below), on the shores of Okanagan Lake in the southern interior region of the province. In 2011 the Kelowna census metropolitan area (CMA) had a population of 179,839, an increase of 10.8% from 2006 (Statistics Canada, 2012e). The region’s economy is rapidly developing. Jobs in manufacturing, high technology, health care, tourism and the post-secondary education sectors, combined with an excellent perceived quality of life in the region, are attracting new business and residents to the area (Central Okanagan Economic Development Commission, 2012). The area surrounding the city is abundant with rich agricultural land, and its warm
climate makes the region one of the most important agricultural centres for the province. The climate and beautiful landscapes of the Okanagan region also contribute to a thriving tourism industry.

Map 3: Regional District of Central Okanagan (Central Okanagan Economic Development Commission, 2012, p. 4)

The population of the Kelowna CMA is significantly older than the BC average. In 2012, 13.8% of the population of the city were under the age of 15 years, compared with 14.8% in BC and 16.2% in Canada as a whole (Central Okanagan Foundation, 2013). In contrast, 19.3% of the population were 65 years or older, compared to 15.9% in BC and 14.9% in Canada (Central Okanagan Foundation, 2013).
Over the next several years, population growth for Kelowna is projected to be higher than the provincial average of 1.19 percent (City of Kelowna, 2014a). The population of the Kelowna CMA is expected to continue to age, as the proportion of working-age adults decreases and the proportion of seniors aged 65 and over increases (City of Kelowna, 2014a). Kelowna’s aging population is emphasized in community planning processes and in the city’s new Official Community Plan (City of Kelowna, 2011), and some of the people I interviewed for this study acknowledged that increasing number of seniors in Kelowna will require more local services as they age, including health care resources.

However, interviewees in this study also pointed out that the significant proportion of seniors in the community can sometimes overshadow other population groups in planning and policy development, as well as mask the interaction of other determinants of health, including income and employment. For instance, one interviewee suggested that planning and community-based program development should keep all groups in the population in mind:

“\textit{I think there’s a huge emphasis on seniors. It’s great, but I think we need to realize in order to sustain our seniors we need other populations to be recognized and heard. It’s, you know- you’re either a family with young children, or you’re a senior, and there’s that big bunch in between- there’s the singles ... there’s many sectors here that comprise a community ... if I’d wave a magic wand, it would be to have awareness and include, you know, sectors or representatives who work with vulnerable people. Because they need a voice beyond seniors. There’s vulnerable people beyond seniors.}”

Many interviewees also mentioned that the seniors moving to Kelowna have higher than average incomes, which has an influence on the entire housing market. The caution is that these wealthy seniors demand expensive homes, which drives up the price on all housing in the community. One local government staff person noted the following:
“Lots of seniors ... our growth is dependent on in-migration alone, there isn’t enough people having children here to sustain our growth; we would be in a negative situation. So, we’re reliant on that growth and it happens to be an attractive area for seniors. Many of them have money so they’ve been fueling the housing market.”

In addition, many of the interviewees suggested that the population of Kelowna is becoming increasingly unbalanced; as more seniors move to Kelowna, it is difficult to attract and keep young adults in the community, in part because of the limited job market.

“we are a very seniors oriented community. The one area that we struggle with is how do we attract and keep younger people here? Because as those people age and retire, somebody has to fill those jobs. And to a certain extent, will there even be the same kind of jobs anymore that people will be needing? So then, we’ve got young people in our schools who are being trained for jobs that don’t exist here yet. We’ve haven’t attracted those industries ... so we have a hard time keeping younger people here.”

Another interviewee, a city councillor, agreed:

“And one of the challenges we ... we find also a lot of twenty-something year-old people-like once they graduate from high school, they can’t find enough opportunities in Kelowna to want to stay put. So there’s a real drain of our twenty to thirty year old young people to Vancouver, Calgary, Victoria, the cities where they perceive that there’s more opportunity. They don’t perceive that we have enough good paying jobs and career opportunities to keep them local. So, that’s a problem. Also, people graduating out of UBCO, Okanagan College, they just don’t see the opportunities here once they get their degrees ... they’re not staying in our community. They relocate.”

The City of Kelowna stretches out along the shores of Okanagan Lake. The older, more established neighbourhoods (e.g. Rutland) are closer to the city core, while the new, rapidly growing areas are to the north (e.g. North Kelowna) and south of downtown (e.g. Okanagan Mission) follow the lakeshore (see Map 4, below).
Despite its relatively small population, the city stretches over a significant area. The land area of the city is 211.82 square kilometres; in 2011 the population density of Kelowna was 553.8 persons per square kilometre (Statistics Canada, 2012c). In comparison, Surrey’s population density was more than double at 1,479.9 persons per square kilometre (Statistics Canada, 2012b). As one interviewee recounted, the low population density of the city is related to its history and growth pattern over the past 50 years:

“Kelowna is a community which was a small agricultural community up until the 1960’s when we got the bridge built in 1958, the Rogers Pass opened in 1968 and people started to pour in, largely from the prairies but some from the coast, and we had a significant amount of residential sprawl in the areas around the city that took place in the 1960’s and 70’s. Then the Agricultural Land Commission came to be, and about forty-seven percent of the city was placed in the Agricultural Land Reserve, which was a good thing to reserve agricultural land, but we already had development out on the edges. So, we have always had a problem of having development beyond the ALR, which means it’s difficult to provide services to people who are physically a long distance away.
from the city core. So, we have sub-divisions which are hard to get transit to, that kind of thing, hard to get emergency services to, and- which are such a low density that it’s very difficult to put in place community services - social services, parks and that kind of thing ... But the geography, the fact that we’re partly on the hills, partly on the flat, the location of the Land Reserve around the main part of town with more sprawl out beyond it creates physical challenges for us in terms of services."

The continued spread of the city was evident when I visited Kelowna in the spring of 2012.

The photographs below demonstrate that new suburban developments (many of them made up of large, expensive homes) were being built in the hills that surround the city’s core.

Images 11 and 12: New development in north (left) and south (right) Kelowna (photos: author)

In interviews, key informants confirmed that many of the new subdivisions in the outlying areas of Mission, Dilworth, and the Glenmore highlands are largely high-income areas. The neighbourhood of Rutland, near the city’s downtown core, was described by one Kelowna interviewee as “generally lower income, but it’s more family oriented. It seems to reach the affordability needs and service needs of families better than some other parts of the city.”
Community Health Status

Like in Surrey, residents of Kelowna generally experience good overall health and well-being. The life expectancy at birth of Kelowna residents (2007-2011 average) is 82 years, similar to the average life expectancy of BC residents, and rates of chronic disease (including prevalence of anxiety/depression) for Kelowna are on par with BC average rates (Provincial Health Services Authority, 2014a).

During interviews and meetings, three issues were consistently raised as elements that have a significant impact on the health and well-being of Kelowna’s residents, and on the community as a whole. Again, I present these three issues in no particular order. Each one is explored in turn below.

Poverty and Income Inequalities

The issue of income inequalities, and the associated issue of poverty, was identified as a key concern that is affecting the health and well-being of Kelowna. For instance, one person I
interviewed identified that poverty is not always easily seen in Kelowna, and that the gap between the rich and the poor is increasing in the city:

“poverty is probably a real barrier. Kelowna tends to be- has a lower income than many other- median income if you go to the look at the income figures. It’s- income is lower than Prince George and other comparable size cities across BC. Um, and yet we’ve got this top of the bubble, you know, very, very high incomes.

Some moderate income households, and then we’ve got a lot of people making like less than 40 thousand and trying to live here and, you know, take care of their families and so on, and there’s no housing stocked, and you know, in the market anyway that would meet their needs. And there’s not enough subsidized housing, and then they can’t afford food and all the other essentials.

VB: Okay, so what you’re saying too is that there’s quite a gap in terms of-
There’s a huge gap, yes.”

As the Central Okanagan Foundation, in their Vital Signs 2013 report pointed out,

“the ability of everyone to engage in all aspects of community life is central to our quality of life and well-being. Differences in power created by unequal access to social and economic resources can impact residents’ health, housing, education, and life opportunities. These differences can be mitigated by reducing economic inequality by ensuring meaningful employment, and the availability of secure work at a living wage. How we move forward on the issue of Inequality as a community is essential to our overall wellness.” (Central Okanagan Foundation, 2013, p. 14)

At $77, 452, the average family income in Kelowna is roughly on par with that of BC (average family income = $78, 580 (Provincial Health Services Authority, 2014a)), but that statistic can easily mask income inequalities. For instance, in 2010 the poverty rate of single parent families in Kelowna was 34.2%, 7.9% higher than the national average (Central Okanagan Foundation, 2013), and the 2013 Living Wage14 for Kelowna was $18.01 per hour, up 4.9% over the previous year’s figure ($17.17)(Regional District of Central Okanagan, 2013).

14 The Living Wage is calculated as the hourly rate at which a two-parent, two-child household is able to meet its basic needs, once expenses such as food, rent, transportation, child care and education expenses are considered.
The ‘face’ of poverty has also changed in Kelowna. According to one social planner I interviewed, the economic downturn that began in Canada in 2008 has affected Kelowna by driving some individuals and families into poverty:

“And I’m meeting women who are becoming homeless for the first time in their sixties ... we have a stereotype about homelessness that you’re addicted, that you’re criminal justice, that you’re, you know, from chaos.

But we’re meeting a different demographic of homelessness, and we’re also seeing people, as some of our resources would say, the people who used to donate to us are now our recipients. So, we’re seeing with the economic downturn, we’re seeing a lot of people who could get by before who are not getting by now. So, that’s a big issue for us in the region.”

In a survey of Kelowna residents, done in 2012 as part of the development of the Central Okanagan Vital Signs report (Central Okanagan Foundation, 2013), survey participants graded Inequality in the Central Okanagan region as a D, the lowest grade given on a number of aspects of community. Survey participants identified the following three sub-issues as top priorities:

- Increasing affordable and appropriate housing options;
- Promoting local adoption of the living wage;
- Reducing income disparity between highest income and lowest income brackets

(Central Okanagan Foundation, 2013).

The Living Wage allows families to get out of severe financial stress by lifting them out of poverty and providing a basic level of economic security (Living Wage Canada, 2013).
Interviewees also consistently identified housing affordability as one of the key issues that affects Kelowna’s community health and quality of life. Compared to the BC average, Kelowna residents spend more on housing as a proportion of their income. For those Kelowna families (or households) who own their homes, 24.7% spent more than 30% of their income on shelter in 2011. The BC average was 23.8%. More of concern is those Kelowna families or households who rent their homes; in 2011, 51.1% of renter households spent more than 30% of their income on shelter. In comparison, on average only 45.3% of BC renter households spent that same proportion on shelter costs (Provincial Health Services Authority, 2014a).

Every one of the eight people I interviewed for this study identified ‘housing affordability’ as a key issue that is negatively affecting Kelowna’s community health. As one community planner told me,

VB: “... you said homelessness has gotten worse, but is housing becoming less affordable in Kelowna in general?

Oh most definitely, most definitely. The housing costs in Kelowna are, you know, the fourth highest in the country. It’s really quite staggering ... a lot of that has to do with the fact that historically our housing stock has been largely single family, or single detached housing, which is the most affordable and inefficient form of housing. So, we’ve certainly been making a lot of strides toward switching that balance and creating more affordable forms of housing, but a lot of the market that’s here is geared toward the resort market; it’s people who can afford a second home, or it’s people who are looking for a high end product because they want to come and retire here.”

One of the people I interviewed, a social planner, challenged the notion of ‘affordable housing’ in Kelowna by saying that the income levels of some Kelowna singles and families is still not sufficient to have access to much of what might be labelled as ‘affordable’. Here is a segment of her comments:
“And again, even going to accessibility, talking about, you know, access- ‘cus what is affordable housing? Now we’re talking about attainable housing, accessible housing. Well in the end, what you still read about for attainable housing is still beyond what most people can access.”

Another planner in the community questioned just how much of a problem the lack of affordable housing is in Kelowna, suggesting that the problem has been exaggerated by community groups competing for resources:

“Affordable housing is perceived as a really big issue, and I’m not saying that it’s not, but...like in most communities, the squeaky wheel gets the grease, and they tend to be a very vocal, a vocal group.

VB: Who’s they?

When I mean “they”, I mean there are agencies out there that are all competing for grant money ... and many of them are competing for the same grant money, and they’re running the same programs, and so they’re trying to magnify the size of the problem because it impacts how much money’s available, or who gets money.”

In 2011, the Social Planning and Research Council of BC completed an in-depth study of homelessness in five BC communities, including Kelowna. During a formal count of homeless individuals in Kelowna, 279 were identified (Social Planning and Research Council of BC, 2011). However, the study emphasized that each of these communities includes a much greater number of ‘hidden homeless’: persons staying on a temporary basis with family or friends, and who do not have a regular, stable address of their own (Eberle et al., 2009). Over the course of 2011, it was estimated that there were 1,489 individuals who could be considered ‘hidden homeless’ in Kelowna (Social Planning and Research Council of BC, 2011).

**Transportation**

In 2011, only 3.4% of Kelowna residents regularly used public transportation to get to work, while 94.8% drove their cars to work (Statistics Canada, 2013a). Kelowna’s new Official
Community Plan emphasizes the need for better urban design and infrastructure development that supports active transportation. For instance, the Plan states:

“City of Kelowna transportation objectives are focused on generating greater use of sustainable modes - active transportation (cycling / walking) and transit - as well as TDM programs that promote reduced car ownership, reduced vehicle trips, reduced peak hour trips and managing parking supply toward reduction of the need to expand the road network or capacity ... Policy direction focuses on maximizing connectivity for pedestrians and cyclists and prioritizing funding on active transportation. Policy does not provide for roadway modifications that increase capacity until failure is imminent, unless there are safety issues” (City of Kelowna, 2011).

The emphasis on sustainability and active transportation in the City’s overall strategic direction is showing benefits: in 2013, the City of Kelowna added 2,880m of sidewalk and 2,100m of bike lanes, and continued with construction of a new Rails to Trails corridor (City of Kelowna, 2014b). The percentage of bike paths available to cyclists in Kelowna increased 71% between 2009 and 2012 (Central Okanagan Foundation, 2013).

In addition, the City of Kelowna has worked with the Regional District of Central Okanagan and BC Transit to expand service for the Kelowna Regional Transit system. As a planner at the City of Kelowna told me:

“It’s [the public transit system] certainly been getting better over the years and we’re putting a great deal of our time and energy into making it better. There’s now a bus rapid transit system that links the development in West Kelowna right through to UBC Okanagan. It goes along the highway and it comes into the bus loop, which is right here, and there are major, major stops along the way, but it’s a high-speed network that connects all or most of our urban centers. So, our goal is to get more and more people living within four hundred meters of that transit line.”

Despite the improvements that have been made to the transit system, it has still been a challenge to encourage Kelowna residents (i.e. those who have the choice) to take the bus. One person I interviewed explained it in this way:
“It’s very difficult to get people out of their cars. Many people have come here from somewhere else where it’s an hour to an hour and a half commute one way, and they get here and it takes twenty minutes to get anywhere, and they say “Why would I give up my car?” You know, they just, they’re just not motivated to do it. And, you know, when it only takes that amount of time to get around and there’s ample parking that’s free, you know, there’s no penalty for driving their vehicle.

The bus system is fairly concentrated in the core areas and it doesn’t go out into those neighbourhoods as frequently as it probably will in the future ...there’s no time competitiveness for transit. It takes them too long to get where they think they need to go, and ... they’ve got to make stops along the way, you know. After work they want to go shopping or they’ve got to go pick up the kids, and it’s difficult to do that on transit.”

The design of the city, with its new housing developments beyond the ALR, adds to the transportation challenge, as one city councillor described:

“our plan over the last years I’ve been on council ... has been to try to discourage sprawl, protect the agricultural land, and create a significant area of natural park land around the city, and to densify four town-centers, mixed use town-centers, which will be connected by a variety of transportation options, but focusing on alternative transportation- mainly transit, cycling and walking, and putting less emphasis on the automobile. So, in doing this we’ve been trying to reverse a huge trend that has gone in the opposite direction, and it’s been a challenge.”

Beyond the measures taken to improve transportation infrastructure and services, the City of Kelowna has also emphasized the continued development of several town centres, in an effort to create more livable, ‘complete’ communities.
6.2.3 Terrace

Terrace, British Columbia is a small city centrally located in the Northwest area of the province, approximately 550 air miles northwest of Vancouver. The city is home to many of the region’s businesses, government offices and community services. Terrace lies within the Regional District of Kitimat-Stikine (RDKS). Other communities within the RDKS include Kitimat, Hazelton, and Dease Lake (see Map 5, below). Neighbouring First Nations include the Tsimshian communities of Kitsumkalum and Kitselas/Gitselasu. To the northeast of the city are the Gitxsan communities of Gitwangak/Kitwanga and Gitanyow/Kitwancool.

In 2011, the population of the city of Terrace was 11,486, an increase of 1.5% since the 2006 census (Statistics Canada, 2012f). From 1996 to 2006, Terrace experienced a slight population decline in every census year, losing an average of 2% of its population per year (City of Terrace, 2011).

The population of the city is relatively young, compared with many other cities in the province: approximately 20% of Terrace residents are under age 15 (Statistics Canada, 2012f). Over the past five to 10 years, the city experienced a
decrease in the numbers of residents aged 20-24 and 25-29 (City of Terrace, 2011), as young adults left the city to find work elsewhere.

The city of Terrace is surprisingly ethnically diverse: in 2006, approximately 13% of the population were recent immigrants (City of Terrace, 2011). Almost 20% of residents of Terrace and one-third of residents of the RDKS self-identify as indigenous (or Aboriginal), a proportion that is significantly higher than the provincial average of approximately 5% (City of Terrace, 2011).

The location of Terrace on the Skeena River and at a key junction point of major highways and the Canadian National Railway, has encouraged economic development experts to view the city as well positioned for economic growth, particularly with regard to mining and other energy-related projects (Northern Development Initiative Trust, 2015).

Images 15 and 16: Downtown Terrace (photos: author)

Community Health Status

On the basis of some indicators, the population of Terrace appears somewhat less healthy than residents of both Surrey and Kelowna. In 2011, the average life expectancy of Terrace
residents was 77.1 years, less than the BC average of 82 years (Provincial Health Services Authority, 2014c). The number of early deaths due to alcohol use and smoking in Terrace were also significantly higher in 2007 – 2011 than the BC average (Provincial Health Services Authority, 2014c). Finally, rates of chronic disease, including diabetes and heart disease, were higher in Terrace than for the province as a whole (Provincial Health Services Authority, 2013).

The following section describes the key community health issues that were discussed in interviews I held with Terrace key informants in 2012.

**Food Production & Food Security**

The city of Terrace is located on a series of natural flat benches, or terraces, within the valley of the Skeena River. The city’s proximity to the ocean (approximately 60 kilometres), its low altitude (60 metres – 196 feet above sea level), and its location within the shelter of the Coast Mountains has created a natural ‘greenhouse’ effect. Rainfall is less than half of that found on the coast of BC and temperatures are surprisingly moderate. Despite the northern location of the region, the unique climate and excellent soil quality of the area surrounding Terrace allows farmers to grow many types of fruit and speciality crops, including peaches. Agriculture was once prolific in Terrace, but unfortunately local food production has decreased sharply over the years, and only a handful of farmers are left in the region.

One local planner in Terrace described the region’s food production history to me in this way:

“we used to grow a lot more of our local food and produce. At one point Terrace was called the ‘Okanagan of the North’... if you were to look at those kind of historical aerial maps you see that most of Terrace was covered in orchards. But we don’t have as much agricultural production anymore. We are food secure just in the sense that we’re fifteen
hundred kilometers by road from our major suppliers - the Lower Mainland. You know, local people still rely heavily on salmon and hunting, but even that is becoming increasingly compromised as people move away from kind of more traditional lifestyles.

So, I guess food security is kind of looking at where we used to be, how much food we used to produce and where we are now.”

The history of Terrace as a significant agricultural area has been confirmed by local elders, in a series of stories recently published by the Skeena Diversity Society. In that book, called Skeena Stories: Strangers No More (Skeena Diversity Society, 2008), Rita M. Jouy recounts the arrival of her family to the area in 1944:

“After somehow surviving the 1930s Great Depression on their almost-barren farm in Saskatchewan, my parents, Joseph and Lidwina Rolfsen, decided to look for ‘greener pastures’ and soon found them here, in Terrace. On an earlier trip by train, Dad consulted Will Robinson, who was Terrace’s realtor then, and who showed Dad around until they arrived at the former Corlett farm. Dad must have thought he was in heaven when he saw the large orchard – full of apple, cherry, crab apple, and even pear trees; not to mention the berry bushes: raspberries, strawberries, gooseberries, boysenberries, currants, etc. Nothing like this was seen in the part of Saskatchewan we lived in.

There was lots of pasture and gardening land there as well. In order to get there, they had to go along Queensway Drive and then left onto a narrow, steep, winding road. Today, you drive Highway 37 south and turn right onto Churchill Drive. The first house on the right was to become our home for the next four years. The house, which had been vacated earlier by Bob Corlett, wasn’t in the ‘greatest condition’, Dad told Mom when he got back to our home in Saskatchewan, but he happily bought it anyway. Couldn’t get those fruit trees out of his mind.” (Skeena Diversity Society, 2008, p. 107)

Despite the capacity of the area for food production, the requirement to ship food from the Lower Mainland and beyond has helped ensure that food costs in Terrace are more expensive than in many of the southern parts of the province. High food costs are common in Northern BC, due to these issues of transportation and storage (Dietitians of Canada, 2012). Of course, lower income families in Terrace are affected more significantly by these high costs than are higher income residents, as one person I interviewed reminded me: “… it’s very expensive … if
you’re on reserve or if you’re lower income then you’re not eating fruits and vegetables up here.

It’s quite expensive.”

When I spoke with one of the few local farmers in the area, she described the challenges with farming in Terrace as two-fold: she perceives that there is a lack of demand for local meat and produce, and stricter regulations from the BC Ministry of Agriculture and Northern Health have made farming costly and unsustainable. Here are some of her comments:

“At one time there were a lot of people farming in the Terrace region. So, farming with my parents and then my husband and I took over their farm about fifteen or so years ago, and we were farming after the fact, again market gardening. And then the last five years we’ve stopped doing that because the appetite for local product was disappearing, so we went into hay sales, which is really different than market gardening.

... it’s interesting because now the trend over the last probably two years is eat local, and you know, it’s really a trend more than anything else. I don’t know how real it is because we’ve experienced some reactions that made me think people are just saying this because it feels good, but they’re not really living it. It’s coming, but it’s not there yet.

... we were really selling our product into the stores and the stores were willing to take our product, and then we came up against a certification policy that came through the BC Ministry of Agriculture and required that we couldn’t- that we could no longer sell certified sweet potatoes, for example. So, we have thirty acres of potatoes, and we were selling sweet potatoes every spring to people in the community ... we didn’t have problems with diseases, but they required that we go through a certification process, and this certification process was really, was really bureaucratic and it was cumbersome and it wasn’t user friendly, and the same time we were losing our agricultural representatives here as well. So we didn’t have the backup of that, so my dad and my mom decided it just wasn’t worth all the effort and the cost and all this stuff, so they didn’t certify it. So, we started- so technically they were willing to still come to us and say, ‘Well you can’t sell, you can sell certified.’ Well we thought, ‘Okay that’s fine we’ll just sell uncertified’. ‘No you can’t sell at all. If you don’t have certified seed you can’t sell to anybody. We wanted to make sure that the product that’s going out is of a certain standard’. Interesting enough that the policies didn’t actually ensure a certain standard, it just created bureaucratic paperwork.”

Other regulations, designed to ensure the safety of the food produced by local farmers, and enforced by the health protection area of Northern Health, have also hindered the ability of
Terrace farmers to produce local food in a way that also ensures they can make a living.

**Housing Quality and Affordability**

In terms of housing, many of the people I interviewed in Terrace commented that there are significant issues with both the quality and the affordability of housing in the community. For instance, a local planner mentioned that there is a lack of rental housing being constructed in the city, and some units have been lost to fire, then not re-built. As that planner mentioned to me, “probably the last apartment was constructed in about the early nineties”, reflecting that the aging of the current housing stock is also a concern in Terrace. The recently updated Official Community Plan for Terrace identifies, as key objectives, improvements to the quality of existing housing in the city, and the provision of housing to meet the needs of all residents, including persons with disabilities and low income families (City of Terrace, 2011).

Image 17: A Relatively New Housing Development in Terrace (photo: author)

As the demand for short-term housing continues to build in Terrace as a result of the impending major industrial and resource projects planned for the region over the next few
years, pressure will continue to mount on the existing housing stock if no new rental housing can be built. In 2011, 43.9% of renting households in Terrace spent more than 30% of their income on shelter (Statistics Canada, 2013b)\textsuperscript{15}. As one city councillor stated, the need for housing that has come from these large resource projects (largely mining) has had an impact on both the demand for and the cost of housing in Terrace:

“now Alcan is building a camp for their modernization project so they were looking at hiring three-hundred people this month or next month alone ... and for small communities that’s a huge increase in the housing demands. We’re seeing the rents climbing again and the vacancy dropping ... so we’re definitely seeing a crunch again, and so whenever there’s a crunch the rents go up ‘cus people realize the demand is high.”

Even higher income families looking for a home in Terrace is likely to struggle, as one Terrace city planner suggested:

“... how they [the new mining projects] are going to impact Terrace from a housing perspective is not really clear. Most of them tend to have big camps on site for the construction, but what it seems to be doing is getting a lot of supply and service out of Terrace from Terrace companies. And so those companies are potentially growing slowly, but bringing people on staff who need housing, and we have real limited amount of new housing being built, very little spec housing being built ... So, if anyone new comes into town there are limited options on buying homes, especially when they’re coming in from somewhere with lots of dollar value, from a recent sale in the lower mainland or Calgary or something, and they’ve got money to buy a nice new home, but there’s very few on the market, and there’s nothing being built that they can buy in to.”

But, as this planner mentioned to me, low income individuals and families are expected to be most affected by the housing shortage in Terrace. Resource development companies have struggled to find housing for their new employees, many of whom have come from elsewhere to work on these new mining projects:

\textsuperscript{15} Spending 30% or more of your household income on housing is considered “unaffordable”. Households spending 30% of their income on housing are less able to afford healthy food and other basic living costs (Provincial Health Services Authority, 2014c).
“a local construction development property management company is looking at buying an old motel—older motel in town that’s been for sale for years, simply to house their employees related to some of these bigger projects in the region ... So, we might lose sort of the older, cheaper apartments, which isn’t really any kind of long term housing for anyone at this stage, but it’s the same building that’s been eyed up as potential supportive housing project for the hard to house or place.”

As a result of this new economic activity in the region, several of the interviewees with whom I spoke expressed a concern that the stock of affordable, good quality housing in the city will be further depleted, leaving long-term, low-income residents with few options.

Economic Development and Poverty

Of course, that new resource-based economic activity in the region has affected other aspects of the community beyond housing. The economy of Terrace was on a downturn for several years, as the lumber industry struggled. With the close of the Skeena Cellulose sawmill in 2007, economic development efforts in Terrace began to focus on diversifying the economy to capitalize on the public and private sector services the city provides, a growing tourism sector, and, now, mineral-based developments to the north and northwest of the city, including the area near the town of Kitimat. The City Council meeting I attended in Terrace on February 27, 2012 focused almost entirely on preparing for new natural resource development projects in the region. For instance, during the meeting a representative from Seabridge Gold provided a project update on a proposed gold/copper mine in the region, and a representative from the Terrace-Kitimat Northwest Regional Airport requested support from Council to prepare a funding proposal to expand part of the airport and repair runways, in order to better prepare for the increased in airport traffic expected over the next five years.
Despite the emerging opportunities for Terrace that new mining and other natural resource development projects might bring, during the interviews I held with local leaders in Terrace, I identified some fear that the economic benefits for Terrace might be fleeting, as one interviewee articulated:

“Northern Canada’s faced with that whole resource boom and bust, and we seem to be on another one of those verges of the boom. And the building component of it is going to have huge impact, but ya; it’s going to be short-term.”

In 2012, when I completed my data collection for this study, Terrace was still experiencing the community health and social consequences of its economic challenges, as one city councillor explained to me:

“I mean we’re a city that’s been in a recession for ten years, right? So we’ve been facing what the rest of the country is facing, but for a lot longer. So, we have high addictions, we have some crime issues, and we have high poverty rates. You know … that’s just a reality and you can drive around town and see that, like it’s actually visible, right?”

The after-tax low-income rate\footnote{Data from the 2011 National Household Survey. According to the way in which Statistics Canada analyzed this data, a household of four with after-tax income below $38,920 would be considered low income. For a person living alone, the threshold was $19,460. For the purposes of these low-income statistics, households in First Nations communities were excluded.} in Terrace in 2011 was 19.3%, above the rate of 16.4% for British Columbia as a whole. Families with children appear to have been struggling more than other age groups: for persons under 18, the low-income rate in 2011 in Terrace was 26.6%, while for the population aged 65 years and over, it was 11.3% (Statistics Canada, 2014).

Of course, the determinants of that poverty are complex and intertwined with other community health issues, including food production and food security, as one interviewee reminded me:
“Terrace has a problem with poverty, but it also has a problem with poverty because of work. So we kind of go in the up down cycle of, you know, with the resource industry more than anything else. So when people run off and they do work for resourcing and they may be supporting a family here or not, but for a while it was forestry, and forestry was right here, so people were living here and they were making good money, and that’s one of the reasons agriculture started dying, because people could go and work in forestry and make way better money.”

In addition, the cold Northern climate of the region adds to the challenges to survive on a low income in Terrace:

“when we look at affordability here, we have to address the fact that- I mean we have much longer winters, we are dark a lot longer so you’re using higher utilities in the winter ... we don’t have a really long summer of hot, you know, glorious weather that we can we turn everything off or anything like that ... my niece had to get hers [heat] hooked up because her pipes were freezing otherwise ... So even with, you know, space heaters in the house- in the trailer, the pipes were freezing so she had to hook it up. So you sometimes just don’t have that choice.”

Income inequities are highly visible in Terrace, which, again, is related to the economic conditions and the key industries in the city. Service-oriented jobs in Terrace, including those in retail, are often not high-paying jobs, as one interviewee explained:

“we have some big gaps in income between the have and the have-nots ... So just making sure that those things are addressed ... we’re really a service centre which is a lot of retail jobs, but retail jobs are not high paying by any stretch, and Wal-Mart being one of our largest employers shows that”

The lower income neighbourhoods of Terrace are near the downtown core, on either side of the train tracks. Higher income housing is mostly concentrated in the suburbs on a hill north of the city centre.
As mentioned earlier in this chapter, with regard to ethnicity, Terrace is surprisingly diverse.

As one city councillor mentioned to me, that diversity includes many recent immigrants:

“We have an incredibly diverse community for being so isolated. We were working on some projects over the summer, Cultural Night Markets ... and we planned four events based around one particular culture each time. And it was so interesting to me, I had no idea we had such a large Spanish speaking population here. Like, it was shocking to me. I was like ‘really? We have that many Latin Americans here?’, and we really do.
It’s interesting because normally as such a remote and smaller community you don’t really reach out much to immigrant population, right? You kind of expect it just to be from people moving for jobs. But really we can draw that in and figure out a way that it grows our community … and really enhances our diversity.

The Skeena Diversity Society is an active community organization in Terrace dedicated to assisting immigrants to the city with connecting with needed services and other aspects of the community (Skeena Diversity Society, 2015).

Despite the positive aspects such diversity brings to Terrace, one person I interviewed for this study blatantly identified an underlying racism and intolerance that exists in Terrace. That interviewee outlined her concerns in this way:

“obviously we have some racial tension that nobody ever wants to talk about. You have very political cultures here, and that creates underlying tensions that nobody wants to talk about.”

In particular, that interviewee identified racism towards First Nations and other indigenous populations in Terrace as being particularly salient:

“it’s not everybody but it is just really interesting to me because people will say ‘no there isn’t racism’, but you know, I help the young First Nations try and find housing, and [they are] clearly discriminated against. So I deal with that aspect of it and I see it first hand, the way that they’re treated in stores or restaurants … so anybody who says it’s not there is just simply, you know, shoving it under the rug. But there’s ways to build those bridges … figuring out a way as a whole that we can work together … [to] find the common ground and build from there instead of focusing on the differences and trying to solve them.”

Transportation

Building an integrated network to support active transportation is one of the key goals of Terrace’s new Official Community Plan (City of Terrace, 2011), and in 2009 the City developed an Active Transportation Plan (Lees & Associates & dpl Consulting, 2009). The city is fairly compact, which makes it ideal for active transportation, but, as both of the local planners I interviewed mentioned to me, there exists a strong culture in the city of reliance on vehicles for transportation.
day-to-day travel. In 2011, 81.6% of Terrace residents drove to work, compared to 11.7% who walked, and 3.9% who biked to work (Statistics Canada, 2013b). At the time of data collection, there was a perceived lack of infrastructure that might support walking and biking among Terrace residents and visitors. When I visited Terrace in 2012, I noticed few trails, sidewalks, and bike paths. A further challenge is presented by the train tracks which effectively divide the city in half (see photos in 2.5, below). There is one main bridge that allows drivers, cyclists and pedestrians to cross over the train tracks, but I found the bridge awkward to access and an unpleasant walk.

Images 22 and 23: Train tracks divide Terrace in two (photos: author)

6.2.4 Summary

Despite their differing size and location, local governments and public health staff working in the three case study communities examined in this research described many of the same community health issues that helped to shape their work. The following table (Table 7, below), summarizes those key community health issues.
Table 7: Key Community Health Issues in the Three Case Study Communities

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<th>Issue</th>
<th>Case Study Community</th>
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<td>Kelowna</td>
<td>Terrace</td>
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<td>Poverty &amp; Income</td>
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<td>Food Security</td>
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6.3 Local Responses to HBE and Health Equity Issues

The community health issues described in the previous section helped to shape how HBE teams in each city have defined and implemented an equity lens. The issues provided a context for that equity-focused (or equity-informed) work. But there was considerable variation among the three cities in terms of the ways in which a consideration of these challenging community-based issues were integrated with HBE efforts. The next three sections describe the core elements of those HBE efforts in each city, and reflects on the ways in which the community health issues each city is faced with have shaped that HBE work. The chapter concludes with some overall conclusions about the ways in which context helped to shape the conceptualization and the implementation of the equity lens, as it is connected with the work of HBE teams in Surrey, Kelowna, and Terrace.
6.3.1 Surrey

At the time of data collection, the Surrey Healthier Communities Partnership (HCP) committee had been operating for over a year. The Committee’s draft Terms of Reference states that the committee:

“provides leadership within the community to identify the health needs of Surrey residents, to address social determinants of health through measurable actions, and to support and encourage collaboration amongst community stakeholders, with the goals of achieving an improved state of health for all communities in the City of Surrey.” (City of Surrey, 2012a, p. 1)

The HCP committee was co-chaired by an executive from Fraser Health and one of the city councillors. The committee had five key focus areas: healthy eating, physical activity, tobacco reduction, vulnerable populations, and healthy built environments. When I attended a meeting of the committee on May 4, 2012, the focus of the agenda was on ‘healthy living’ initiatives, including active living / active transportation, tobacco reduction, and healthy schools initiatives.

This limited scope of the HCP committee is consistent with the conservative ideology put forward by the dynamic mayor of Surrey at the time, Dianne Watts. An extremely popular municipal politician, Ms. Watts served three terms as the first female Mayor of Surrey, after serving a previous three terms as a Surrey City Councillor from 1996 – 2005. In 2015, Ms. Watts was elected to become the federal Minister of Parliament for South Surrey-White Rock, with the Conservative Party of Canada.

The HCP committee operated separately from the social planning area of the City of Surrey. A separate committee, the Social Planning Advisory Committee, was chaired by a different city councillor. When I attended the Social Planning Advisory Committee meeting on March 29, 2012, the emphasis of the discussion was on reducing poverty, improving access to public
transit, and finding ways for Surrey residents to feel more connected to one another – all issues consistent with a focus on health equity. It seemed that there was little coordination or consultation between the two committees. Public health staff did attend the HCP committee meetings, but did not attend the Social Planning Advisory Committee meetings. In turn, the City’s social planning staff did not attend the HCP meetings. In an interview, the lead social planner for the City of Surrey confirmed that her connection with the HCP was limited.

The way in which health is defined narrowly in the context of the HCP committee reflects how Fraser Health staff were trying to find their ‘fit’ with what the City of Surrey was doing. As one Fraser Health employee mentioned,

“they have a whole social planning committee that deals with um…with homelessness and housing and poverty … I don’t think health was ever really a…focus or an element of that, but now actually in the last Healthier Community Partnership meeting that we had we actually went over a structure with the built environment encompasses all the different elements and we were talking about the different things that the city was involved in, Fraser Health was involved in, school districts etcetera, and now we’re starting to see and the city- staff from the city are starting to see that is an element of health in every single thing that goes on in the community, and that any inequities that exist will be those gaps that we will have to address as we move forward.”

Due to the emphasis of Surrey’s social planning team on working towards inclusion and diversity, especially with regard to ‘vulnerable populations’, including new immigrants and refugees, one Fraser Health public health practitioner mentioned that that emphasis made it easier to begin to start conversations with City of Surrey planners about equity issues:

VB: “And how when you talk about that sort of stuff with folks at the city, how- what’s the reaction?”

“With the City of Surrey? They’re fairly open to it because they already have a real focus as a community on vulnerable populations. They may not necessarily understand what equity means in terms of built environment planning unless we actually go into the details and say “Well this is what it means with a planning perspective”, because health
inequities outside of the health field is one of those terms that not everybody understands.

So over the course of the last few years as we have more and more conversations with them they understand what we’re trying to say from the health perspective, and once we’re able to link it more with the planning principles then it becomes clearer for everybody. But the City of Surrey has always been aware of inequities, maybe not health inequities but inequities in the population.“

However, as mentioned above, the work of the HBE team in Surrey (the HCP) was disconnected from the work of those involved in social planning in the City.

6.3.2 Kelowna

For the past several years, there has been a full-time position in Interior Health dedicated to highlighting and influencing the health impacts of land use planning decisions. The nature and duration of that position is unique in BC. The position, centred in the Kelowna area, has allowed Interior Health to become a real leader in HBE work. As part of that leadership work, public health staff in the region were actively involved in the review and development of the new Official Community Plan for the City of Kelowna. Interior Health staff have also developed a draft Land Development Health Review Tool, a type of Health Impact Assessment, to assess the potential health impacts of particular land use decisions.

However, in 2012, when the data for this study was collected, the focus of the HBE work in Kelowna was very much centred on land use decisions as they related to active transportation and the creation of ‘complete communities’, and there was little integration of equity within that work. For instance, when I asked a local planner whether the needs and characteristics of low income neighbourhoods (and the people who live there) were considered during the development of the newest version of the OCP, or within general planning in the city, his
response focused on the general population, rather than on the specific needs of particular groups:

“staff are trying to bring all those disparate pieces of it together. I call them disparate, but they’re not really, they’re part of the package that makes a neighborhood or a community livable. And so they’re starting to see that as being the challenge. How do we make our neighbourhoods desirable places to live?

VB: For whom?

For- primarily for the people that are there today.”

When I asked that same planner about the ways in which decisions were made in the City’s planning department with regard to issues related to public transit, he responded that specific population groups and/or neighbourhoods are not offered special consideration:

“VB: And I was just thinking about the rapid transit and public transit in general. Has the city focused on particular neighbourhoods that need better access, and if so, which neighbourhoods are those?

I think…we haven’t focused on neighbourhoods that need better access. We’ve focused on the core areas that we need to link.

So that people can get back and forth to work, back and forth to school, along those major cores. That’s where the high density is, and then there are- then there will be what’s considered neighbourhood loops that will depart from one of those stations. Go out into a neighbourhood and then come back to one of those major transit exchanges, so that people can then get on the express bus.

VB: Okay. Because I’m thinking about that, you know, the distinction between people who need to ride transit because they have no access to a vehicle if they can’t afford one usually, or they, they have disability or something, and people who choose to ride … There’s a captive market, ya. And Kelowna does have a captive market of students, seniors and handicap people.”

Finally, I asked about whether concerns about equity (or particular population groups) were part of the planning in relation to active transportation in Kelowna:

VB: Here in Kelowna…so, is your… who are you hoping will become more active? Is there a discussion about particular populations you’re interested in, or just in general?

No, I think, I think it’s just about making - creating a system out there so that anybody who cares to can use it. I don’t think that we’re targeting any particular segments simply
because we all need to be healthier. You know, if you have access to cycling trails, or a bike network, or linear path network that it encourages you to get out and walk and run and, you know, or use it on your way to - use it as a way to commute. Whatever it may be, that’s a good thing regardless of whether it’s anybody in particular.”

This finding that planning decisions in the City were made with little regard to the needs of specific populations was confirmed by a local social planner, who expressed concern that transportation planning decisions were made in the City without a consideration of the special needs of low income populations, seniors, and people with disabilities – those groups who might be most likely to use public transit:

“We also have problems with transportation. There’s a bus route in the City of Kelowna that’s been completely underfunded. Transportation’s a huge issue for our struggling citizens, and ... there isn’t awareness of that. So, again that’s my job and other people’s job to bring that forward, saying, ‘You know, this program’s not adequate’ …”

Staff within Interior Health presented concerns about this approach to the City’s planning staff.

For instance, one public health professional I interviewed described the health authority’s strategy to highlight the needs of some populations when the City was working on a plan for the downtown core:

“we did a joint response back on this downtown plan, ‘cus there was lots of stuff that was in there, you know, it was all compact design, mixed use, walkability, connectivity, all those words, but you haven’t looked at your marginalized populations; where will they go?”

During the year in which I was collecting data for this study, the staff of Interior Health worked hard to develop relationships with local government planning staff, and there were efforts to establish a formal committee or working group focused on HBE issues within Kelowna. In September 2012, four Community Health Facilitators were hired by Interior Health to begin to develop formal and informal relationships with local governments. The mandate from the Ministry of Health to complete this work was centred on an HBE framework that
referred to ‘priority populations’ (see Chapter 5, Section 5.2.2), but did not expressly require health authorities to address equity or the social determinants of health as part of that HBE work. In early 2013, Interior Health staff faced a challenge when they began trying to set up a formal Healthy Communities committee in Kelowna. That challenge was due, in part, to some initial reluctance from the City of Kelowna to engage in a more formal way.\footnote{In October 2014, a formal Healthy City Partnership Statement of Cooperation was signed by the City of Kelowna, UBC-Okanagan, and Interior Health. The agreement is designed to lead to the development of a formal Healthy City Strategy for Kelowna. For more information, see: \url{https://news.ok.ubc.ca/2014/10/28/ubc-kelowna-and-interior-health-sign-healthy-city-partnership/}}

Part of the difficulty with integrating a consideration of equity and social justice into HBE work in Kelowna has been the question of jurisdiction; it was unclear whose job it was to consider equity-oriented issues in the City, and those local government staff who were focused on land use and urban development strategies within Kelowna did not think of equity concerns as central to their job. When trying to explain to me the nature of the HBE ‘culture’ in Kelowna, one Interior Health staff person used affordable housing as an example:

“I still come up against this stumbling block in planning in relation to affordability, and in relation to some social issues because they say “It’s not our job to provide a continuum of housing” … I’m not recognizing it as a culture in the planning department. And I don’t know if that’s a lack of education, or it’s a lack of looking at it … [local Kelowna planners] refer to that sort of stuff as ‘soft health’; mental health and substance use is soft health, right? Whose responsibility is it?”

Instead, many of the planners with whom I talked in Kelowna took a more conventional view of HBE work, and emphasized elements of zoning and other land use tools to facilitate active transportation, access to parks and recreation. Affordable and quality housing has been a priority of the City, but there were not strong links made between affordable housing strategies
and community health. Again, a key Interior Health staff person explained the tendency to see HBE issues in more narrow terms in this way:

“affordability ... they have put in lots of these DCC [development cost charges] charges, reduction DCC’s, they’ve put in secondary suites, city council has just passed secondary suites, or they’ve asked- they’ve asked their staff to go back and do a business case for secondary suites across the whole city. So, they’re looking at affordability from those very bricks and mortar things, but it doesn’t seem to be a decision...it doesn’t seem to be a cultural- just as we want planning to include health as part of the decision, the subculture of health is inequity, right? ... it's not a factor in the decision making process.”

The City’s Social Framework, released in December 2012, does have a section on Equity and Inclusion, but that section is devoted to City of Kelowna internal hiring policies, grants for arts and culture projects, and a playground that is barrier-free for persons with disabilities (City of Kelowna, 2012). Little mention is made of broader issues of equity, including poverty and building relationships with local First Nations or other Indigenous communities, and few explicit links are drawn between community health and social sustainability.

Part of the issue, according to one Kelowna planner, was that the HBE direction that Interior Health proposed lacked clarity and concreteness, and was not presented in terms that related to the way in which local government planning happens:

“it was our perception that it wasn’t related to land use. The difficulty is that ... there’s a real dichotomy in the language. What the Ministry of Health wanted, and what Interior Health wanted in our OCP was very high level language that said something about, you know, ‘thou shalt ... provide affordable housing’. Not so much that kind of a wording, but the kind of wording that says, you know, very motherhood and apple pie kind of stuff, very high level, that didn’t really say how we’re going to address those things on the ground when you actually come down to built form.

It doesn’t require us to do anything; it’s just nice words. We took that and turned it around and said, ‘Okay, we’re going to do something a lot more specific. If we’re going to affect the built form, then it has to be specific enough that there are requirements on the city or on the development industry to provide certain things to affect that
Linked to the efforts of Interior Health staff to connect planning to health (in terms of HBE work), and then connect HBE issues to health equity, were the ways in which the health authority, as an organization, was perceived from the perspective of local and regional governments. One local social planner suggested to me that it was difficult to work with Interior Health staff as much as she would have liked, in part because she doesn’t see the health authority as a true community partner:

“You know, the services should be reflected based on the community … I do link with public health a bit with community care, and I don’t think there’s necessarily the recognition or the awareness of the value of working as a community. It’s very much an ‘us’ and ‘them’; it’s the Health Authority and the community.

...in a healthy, safe community we’d be an ‘us’, not an- we wouldn’t be our silos, and it’s very much that way here, that everyone’s operating in different silos. And I attended this presentation from Interior Health and ... they had to include community in part of the consultation. And it was very clear with the university and Interior Health that they had, with a capital “‘H”, to include community. That it was basically perceived as a nuisance ... that they had to dialogue with community. And as I listened to them talk and give a presentation ... I thought, ‘There’s so much knowledge in the community. There is so much information that could probably save so much time and energy if you hear the community’. It was too bad that it was seen- at least I interpreted it as it was seen as a nuisance.

And I think that kind of sums things up, is that you know, the Health Authority has many of them, not everybody, but there’s an assumption that they have all the knowledge, they have all the wisdom to share with everyone, where it goes both ways, it goes both ways, and I don’t think we have that recognition that we need to. I don’t think they’re as community minded as they need to be, and our community definitely doesn’t feel linked to our Health Authority, but hopefully that will continue to change over time.”

According to that same planner, those ‘silos’, in which groups working on community issues (including issues related to health and equity) operate separately, existed within local government, as well. From her perspective, discussing social and health issues, including issues
of equity, was important, so that municipalities and regional governments could begin to see their role in addressing those issues:

“My motivation is dialogue. I want people to be aware, and I want people to talk about the challenges, because it’s not all about the wage; it’s about what else can municipalities do?”

6.3.3 Terrace

As of 2012, when data collection was done for this study, the focus of much of the HBE work in Terrace was on building capacity within Northern Health to work with local governments and other partners to integrate planning and health considerations. In particular, the emphasis was on educating public health protection staff (Environmental Health Officers, or EHOs) about general planning issues and practice, community development and sustainability concepts/practice, and how they might build relationships with local government partners. In 2011/2012, Northern Health hired three Healthy Community Environments Lead staff for Northern BC; one of these positions was located in Terrace.

As part of that effort to build internal capacity and re-orient the EHO role away from strictly enforcing health and safety regulations to a role that integrates a broader set of considerations around HBE and the social determinants of health, the new HBE team at Northern Health (led by staff in Terrace) developed a number of key resources, including Health Considerations for Environmental Assessments (Northern Health, 2011b) and the EHO Guide to Reviewing Official Community Plans (Northern Health, 2011a). A series of position papers was also developed to help set the stage for more collaborative work between Northern Health staff, local governments, and other community partners. For instance, in the report Position on the Environment as a Context for Health (Northern Health, 2012), the health authority sets the
stage for conversations between their newly trained public health staff and local partners by outlining their approach to connect our physical environments with health and quality of life, as it is supported by research. The report begins in this way:

“This paper outlines the position of Northern Health regarding the environment as a context for health. Health is tied to social, economic and personal development and these can be determined by the settings where we live, work, learn and play. This paper highlights that these settings are embedded in the physical environment. Using a population-health approach, we will engage with communities and individuals to move toward increased health and wellness for people and their environments. This will be accomplished by supporting and promoting that the health and well-being of (current and future) populations depends on healthy environments. We will work with community partners to improve the health, well-being and quality of life of those living, working, learning and playing in Northern BC.” (p. 1).

Throughout the region, these newly trained staff within Northern Health have been forging new relationships with municipal planners, and offering local governments more specific data on the health of their communities. Unfortunately, as of data collection in 2012, the process of developing meaningful relationships in Terrace between Northern Health staff and the local and regional governments in the area was slower than had been hoped. When I asked some of the interviewees in Terrace why this way the case, several replied that the mayor and council of that time were not fully on board with the approach, and that the vision for any new partnership was not clearly articulated. The Northern Health staff I asked responded that it was difficult to convince the health authority’s executive to embrace a population health / prevention approach, so it was a challenge to obtain the resources needed across the region to put the necessary time and energy into building partnerships and addressing HBE issues more fully.
The implementation of HBE work in the North focused on particular health issues in specific communities, based on the needs of that area. In Terrace, those efforts incorporated a consideration of equity through their focus on food security. In an interview, a local planner acknowledged the connections between food security, equity, and social sustainability as related to her work in Terrace:

“Well, I think whether we’re talking about food, or transportation, or energy, it’s always the vulnerable populations that are most impacted when there are fluctuations, so as food prices increase there’s going to be people with lower incomes that aren’t able to buy as many fruits and vegetables. The same with when gas prices increase, or when energy costs increase, so you know I would say that everything we do is done to some degree for social sustainability lens, because to the degree that we can provide or help support the community in providing more options [like] the option to grow food in a community garden. Then we are to some degree helping those people that have lower incomes.”

Northern Health HBE-oriented staff worked with local organizations, including the Greater Terrace Food Association, to break down some of the regulatory and other barriers that prevented local restaurants and businesses (including the health authority itself) from buying and re-selling locally produced meat, fruits and vegetables. Other food security efforts included supporting a community-led initiative that diverted extra food from local grocery stores and restaurants to school and community food programs.

Beyond the focus on food security, during interviews with community leaders in Terrace, I found little evidence of an explicit emphasis on equity and social justice as it related to the HBE work in the community. In interviews, one local planner did state that equity is a consideration of the overall approach:

“It’s certainly a consideration … we realize that … for the most part, when we’re improving the roads to people that cycle it is people that are lower income that are cycling, and it is kids. Is it the only factor? No, but ... it is a consideration.”
Yet other interviewees admitted that an equity lens is not being used routinely or explicitly in planning or implementing HBE work in Terrace. For instance, when I asked directly whether an equity lens was being used, one Northern Health staff person replied that his job was to develop concrete tools for day-to-day use in the community, not to guide the more ‘theoretical’ side of planning. That more theoretical function, he surmised, was the role of the Population Health department of Northern Health, rather than the HBE teams themselves:

“No, no. And see that’s why ... in preparing for this today, just using the language “the equity lens”, I kind of feel like that would be more [responsibility of the Population Health department of Northern Health] ... like how do we deal with this and how we are looking the more kind of theoretical side of things, right?

I’m developing ... kind of ground level tools on ... our health comments be more representative of a healthier built environment, but the people don’t really do that so just kind of getting the tools to do it, right? And so I’m kind of developing tools rather than ... ya- it hasn’t really been sort of uh articulated or anything like that.”

6.4 Summary

In this research, the ways in which an equity lens was implemented at the local level was influenced by three different aspects of context:

- Shifts in the policy context at the provincial level;
- Orientation of the local policy or political context, including facets of local governance systems; and,
- Other local-level characteristics, including geographical considerations, local economic issues, and particular community health issues.

First, the shift in the provincial policy context from an emphasis on Core Programs to a clear mandate for health authorities to participate in the Healthy Families BC – Communities
initiative encouraged health authorities to actively engage local governments in HBE work. Inspired by a model developed by Fraser Health, the Healthy Families BC approach encouraged health authorities to set up formal committees with local governments and other community organizations to collectively work on HBE issues. Following the framework of Healthy Families BC, those committees tended to focus on issues connected to chronic disease, rather than the more complex community health issues associated with the social determinants of health and health equity. For instance, Surrey’s Healthier Communities Partnership committee focused its work on healthy eating, physical activity, tobacco reduction, vulnerable populations, and HBE. Work in Kelowna focused on active transportation and the design of ‘complete communities’, in an emphasis on land use and built form. Staff in Terrace perhaps came the closest to directly dealing with equity-oriented issues, notably in the area of food security. However, at the time of data collection, much of the energy of the HBE efforts in Terrace focused on building capacity within the health authority itself.

In many ways, this limited scope of HBE work at both the provincial and local levels is not surprising, given the conservative orientation of the political party in power at the time: the BC Liberals. Despite their name, the BC Liberals have consistently emphasized individual responsibility for health and wellbeing, in part as an overall strategy to reduce reliance on government services and keep public spending as low as possible. The party’s website emphasizes a strong economy as the number one driver, and in fact, credits economic success with enhancing wellbeing:
“Make no mistake, British Columbia’s economy is growing. And it’s the fact that it’s growing that allows us to create the compassionate society we all care about.” (BC Liberal Party, 2016)

The website goes on to identify the party in this way:

“As BC Liberals, we’re proud of our diversity – and united by the free enterprise values shared by the majority of British Columbians. We’re focused on making BC even stronger, more prosperous, and more sustainable.” (BC Liberal Party, 2016)

In addition to working in a provincial level political environment that holds a conservative ideology, HBE efforts in both Surrey and Kelowna have been challenged by ‘silos’ within those municipalities. In those cities, HBE work was taken on by city planners responsible for land use and/or long range planning. Other municipal staff, including social planners, were responsible for dealing with issues that might have a more direct connection with equity considerations, including food security, poverty, and affordable housing. There was therefore a disconnect between HBE work and equity-focused work in those cities, and I did not get the impression that significant efforts had been made to connect the two teams. In Kelowna and Terrace, HBE efforts were further challenged by a perceived reluctance on the part of mayor and council to fully embrace a new relationship with their respective health authorities in order to collectively work on healthy communities issues.

Finally, the unique characteristics of each local context had a significant impact on the ways in which an equity lens was used in relation to HBE work. One of the key elements of that context was provided by the community health issues with which each community has been struggling. Healthy Built Environment teams in each city geared their collective work to identify and address these unique issues, some of which are related to equity and social justice. Of course, the way in which those issues have played out in the three different cities did vary
significantly. For instance, given its size and history, it is no surprise that Surrey has dealt with a number of significant community health issues in the recent past. However, as was mentioned above, I found few formal connections between the significant efforts to manage these considerable health issues in Surrey with HBE work.

Rural communities in more remote areas of the country, like Terrace, do have unique needs, in part because the built environment in rural communities is very different from that of urban areas. In terms of HBE considerations, some of the differences between rural and urban centres include the distances residents must travel to get to services and other destinations, a smaller tax base that results in reduced financial resources for municipalities, and declining overall health of residents in rural areas (Caldwell et al., 2015; Canadian Population Health Initiative, 2006). It is unclear just how much the rural quality of Terrace affected how the staff team there framed their HBE work, although the fact that the City of Terrace does not have a social planner could have encouraged the two other planners at the municipality to take on a broader range of community health and social issues than their counterparts in more urban areas.
Chapter 7: Supports and Challenges

The use of equity tools, including equity lenses, in the context of local government, is still relatively new, and few studies exist that share knowledge about how those tools are being implemented in real communities. Health inequities highlight extremely complex underlying social problems that stem from dynamic and inter-dependent factors associated with a broad range of determinants of health (World Health Organization & Committee on the Social Determinants of Health, 2008). Solving these complex problems cannot be done by one sector or level of government alone. We need multifaceted solutions with action from a number of sectors at multiple levels (Danaher, 2011). Understanding the ways in which the use of an equity lens is being facilitated and challenged is important, therefore, because it could help us to navigate those relatively unchartered waters. This chapter explores the final research sub-question:

What factors have supported or challenged the implementation of an equity lens in Healthy Built Environments work in BC, and what is needed to overcome those challenges?

There is not yet a substantive literature about the ways in which an equity lens has been implemented (especially as it that implementation relates to HBE work), yet two recent reviews are available (Tyler et al., 2014; Wong & Gardner, 2013) that summarize key learnings from the development and implementation of city and regional-level health equity strategies. Ingrid Tyler and her colleagues from Public Health Ontario suggested that the use of health equity tools (similar to equity lenses) was supported by a common vision, a clear mandate and buy-in from high-level leaders, and attention to the composition and dynamics of the planning team or
committee. That review emphasized a lack of organizational commitment and specifically allocated resources as some of the key challenges (Tyler et al., 2014). Emily Wong and Bob Gardner from the Wellesley Institute in Toronto, Ontario agreed that local coordination, clear priority setting, and targeted actions were important as supporting factors, but also emphasized that collaboration between sectors and levels of government is a vital factor in the successful implementation of equity-based strategies. These researchers highlighted the key barriers of the local government’s limited scope of powers to influence the social determinants of health, and the lack of long-term political commitment and funding to put strategies into place (Wong & Gardner, 2013).

This background knowledge about the use of equity-focused strategies and tools (like equity lenses) is helpful because it sets a framework that can be used to examine my own research. In my study, the following elements emerged as key themes that reflect the factors that either supported or challenged the use of an equity lens in HBE work in BC:

- intersectoral collaboration and partnership development;
- political will; and,
- the use of concrete tools.

In the rest of this chapter, I will discuss each of those themes in turn.

7.1 Intersectoral Collaboration and Partnership Development

Given a population health approach, in which the social, political, and economic complexities of the determinants of health are highlighted, some recent analyses of the available literature on efforts to improve population health and reduce health inequities have identified the
importance of various sectors working together. This ‘intersectoral action,’ or ‘intersectoral collaboration’ in which representatives from local government, health, education, business, and community organizations build partnerships to work on health and social issues together, is key to improving community health (Public Health Agency of Canada, 2007). Policy change at national, provincial, regional, and local levels is necessary, and multiple sectors need to be involved to help to address the multifaceted issues that are beyond the scope of any one sector (Danaher, 2011; World Health Organization & Committee on the Social Determinants of Health, 2008). Seen as both a tool for action and a process, intersectoral collaboration has been defined as:

“a recognized relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes … in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone”. (World Health Organization, 1997, p. 3)

A recent review of literature on intersectoral action to address issues associated with the social determinants of health and health inequities (Danaher, 2011), found that collaboration across sectors is a dynamic, complex process that is highly influenced by the context in which it happens, as well as by the special social or community issues being addressed. Due to this complexity and the specific nature of intersectoral work, there is no ‘right way’ to go about it.

Two key types of intersectoral collaboration have been identified: horizontal and vertical collaboration (Public Health Agency of Canada, 2007). Horizontal collaboration occurs between sectors at the same level. For instance, a local committee or working group made up of representatives from municipal or community-based housing, environmental, transportation, health, and education groups or governments is using a horizontal collaboration approach. It is
an effective way to bring together a diverse set of expertise and resources to work on complex issues for which solutions lie outside the capacities of one sector (Chomik, 2007; Public Health Agency of Canada, 2007). The most important benefit of horizontal collaboration is its potential to pool resources to address problems in which many sectors have a stake. In contrast, vertical collaboration occurs at different levels (local, regional, provincial or national). Vertical collaboration is important when there is a need for a broad policy approach that both government and non-government partners can influence (Frankish, 2007). While both horizontal and vertical collaboration are considered important to successfully address health inequities at various levels, intersectoral work of both types can occur at the same time (Danaher, 2011).

A review of case studies of intersectoral action to reduce inequities in 18 countries (Public Health Agency of Canada & World Health Organization, 2008) concluded the following about how intersectoral action is carried out:

- Successful intersectoral action requires the sharing of power. The creation of new entities, committees, or other bodies to formalize and institutionalize power sharing is helpful. Building trust is key to developing and maintaining intersectoral action. Building and nurturing trust ensured a strong foundation for effective working relationships.

- Intersectoral approaches can be initiated from the top-down (as seen with ‘whole of government’ approaches) or from the bottom-up. Small scale, local initiatives in which community members share control over the process, or are otherwise able to meaningfully participate in that process, show significant potential for success.
Rural or remote populations lend themselves to intersectoral action because economies of scale do not support effective action by individual sectors. In more rural locations, the building of key interpersonal relationships necessary for two sectors to work together was somewhat easier, given the smaller number of people involved in the process.

Public participation, empowerment of marginalized groups at the local level, and a significant partnership role for non-government organizations are strong drivers of intersectoral work.

In circumstances where health issues were defined or framed more narrowly (e.g. in terms of access to health care), the partners invited to the intersectoral table were more limited in their scope.

The use of a common model that views health and social issues from the ‘lens’ of the social, economic and political influences on health is useful in order to frame the issue and establish the impetus for intersectoral work. Such a framework can simplify complex issues in ways that people from all sectors can better understand and allow people from a variety of sectors to find their place in working toward solutions to complex problems.

A more recent study (Danaher, 2011) emphasized the importance of building a sense of trust among partners:

“successful intersectoral collaboration relies on individual partners knowing and trusting each other. Trust at a personal level was seen as the most important component of successful collaboration. It relies on the capacity to listen to what the other is saying.” (p. 10)
Trust in intersectoral partnerships can be facilitated through a common and accessible language among the partners, as well as a sense that the various partners have an equal say in decision-making.

7.1.1 Connections with Sustainability Planning

Over the past several years, local governments across BC have been focused on planning within the context of sustainability, in part because the provincial government has offered incentives to local governments to present and implement sustainability plans. If sustainability is defined in terms of the triple bottom line of “measures taken to protect and enhance the environment, the economy, and equity for current residents and future generations” (Svara et al., 2014, p. 1), then those sustainability planning efforts that include aspects of equity and social justice work could be very consistent with the goal of healthier communities. Sustainability could offer a common focus for intersectoral work, as it relates to healthy built environments.

In 2014, two American groups conducted separate analyses of the ways in which local governments across the USA are integrating social equity into their sustainability planning work (Park, 2014; Svara et al., 2014). Interestingly, neither group drew strong links between that social equity work and healthy communities. Instead, the focus was on the need for local governments to incorporate social equity considerations into their work, in order to work towards all of the three main components of sustainability. Svara, Watt and Takai (2014) put it beautifully when they suggested that:

“Without a strong commitment to social equity, local governments have moved only part of the way toward achieving true sustainability. The experience of American urban areas shows that inequality and social exclusion are not sustainable practices because
they undermine the viability of communities. Thus communities might have programs that protect the natural environment, reduce energy use, and address other aspects of sustainability, but without programs to promote social equity, they are not strengthening their social foundation for long-term viability.” (p. 1)

Both of these research groups found that only a minority of local governments across the USA are incorporating social equity considerations into their sustainability planning efforts. However, that proportion appears to be increasing over time, and we can learn a great deal from those local governments that are exploring social equity as it links to sustainability. Both of these excellent reports include ‘lessons’ or ‘good practices’ from which other local governments can learn (Park, 2014; Svara et al., 2014).

In my research, some interviewees mentioned the potential of sustainability work to bring in elements of community health, and therefore bring people from different sectors together to work towards a common goal. This was particularly the case in Kelowna, where a city councillor noted:

“It’s interesting to start to see the connections, so you can take people who say, ‘I’m only interested in economic development’, you can say, ‘Okay, well these things will reduce your taxes, these things will increase the economic growth, these things will lead to other benefits,’ right? Or you can take people who have an interest in the environment and spin that story, or people interested in society and spin that story. So, they’re all connected, and it’s all about getting people to understand the connections ... you can see a general trajectory of much greater understanding of what it takes to make community, I think, from elected officials, and a greater sophistication, and understanding that all these things are important and you’ve got to nurture different components of community, not just one thing.”

At the provincial level, too, there was some recognition that it will be important to somehow connect HBE efforts with sustainability work, especially that ‘third pillar’ of sustainability that refers to social sustainability. However, despite the fact that connecting community health, social equity, and sustainability was referred to in theory in my interviews with community
leaders, when I examined the key sustainability planning documents from the cities of Surrey, Kelowna, and Terrace, there were few direct links made between sustainability and social equity. There were no references to how both concepts might be linked to health and well-being. As mentioned in Chapter 6, Surrey’s planning strategies did include a focus on diversity and inclusion, but that emphasis was separate from the City’s initiatives regarding both sustainability and community health.

7.1.2 Challenges for Intersectoral Action

Due to the intersectoral nature of Healthy Built Environments work, and its potential to reduce social and health inequities, its success rests with the capacity of the people involved in each community to develop lasting, meaningful relationships with one another. As I described in Chapter 6, in this study the provincial-level policy context was one that valued the development of intersectoral partnerships, particularly partnerships between local governments and health authorities, as key to HBE work. Yet beyond that context that is essentially forcing people to work together, there was general widespread support for developing a greater sense of partnerships between sectors, especially at the local level. As one provincial-level interviewee stated,

“people are seeing that, wow, the way we’ve been doing our work in silos doesn’t work. They’re starting to get that it doesn’t work and there needs to be another way ... because there’s been so many cutbacks and lack of capacity. They’re forced to work together in a different way.”

Role of Health Authorities

Although prior studies have highlighted the importance of developing trust among intersectoral groups working on community-based issues associated with health inequities
(Danaher, 2011), unfortunately I found few examples of a sense of reciprocal trust when exploring the ways in which HBE or Healthy Communities groups were working within BC. In part the lack of trust was connected to the behaviour of health authority staff, who were told by the Ministry of Health that they must initiate and maintain strong relationships with local government and other community stakeholders. It was not surprising, therefore, when in my research I found that support for building stronger intersectoral partnerships was more strongly expressed among public health staff than among those within local government or from community-based agencies.

Some city councillors, for instance, seemed skeptical that intersectoral collaboration was the right approach, in part because they feared that the health authority’s reaching out was a veiled attempt to ‘download’ some of health’s responsibilities onto local government and add to their burden. As one city councillor mentioned to me in an interview:

“And so when you hear … health saying ‘we’re going to work more with the city’, there’s a bit of a skeptical side that comes [with] our saying ‘Okay, so what’s the next thing they’re going to try and get us to do that they don’t want to pay for anymore?’ And that’s the big risk I see.”

Some health authority staff, who were then tasked with building substantive relationships with local government and other community stakeholders, have struggled to deal with that skepticism. As one health authority representative mentioned, “the Health Authority has to have a carrot; I have to offer them something that they see as valuable for me to be included in the conversation”.

Other local government representatives with whom I spoke seemed cautious of building partnerships with health authorities because they perceived the health authorities as part of a
system that eats up such a giant portion of the provincial budget, yet still comes across as needing help from local governments. This cautious approach is made worse by misunderstandings caused by a lack of awareness on the part of both public health and local government groups about what each other does and what each group values professionally. Planners claimed to want clear, concrete recommendations from public health, but they stated that they didn’t want health authorities to use their considerable power to tell local governments what they should be doing, or try to take over the process. They wanted a truly collaborative process. Some public health practitioners understood the importance of developing those collaborative relationships. For example, this public health practitioner described the ideal type of partnership between health authorities and local governments like this:

“You’re in a relationship, you’re working together, you’re realizing that people bring different strengths and weaknesses to the table and you’re able to collectively work together towards a common goal. So if we do this right then we’re one of the partners at the table. We’re not the partner, [or even] the big partner, we are part of the entire group. And if we get it right with the cities, the cities will play a strong leadership role to influence other stakeholders like the chamber, like the non-profits, like the community groups to get alongside what they’re trying to achieve. Then in the end it will be that whole of community approach ...”.

Not all the public health staff with whom I spoke had such clarity around what the goal of a collaborative relationship with local governments would look like, and some of the planners I interviewed admitted that health authorities have an uphill battle to build trust and mutual respect in the community. In addition, some health authority staff admitted that building relationships with other sectors in the community (especially with regard to the complex issues of community health and equity) was made even more difficult due to the silos that existed
within the health authority itself. Even within the public health area of each health authority, there are multiple professional groups with different sets of training and responsibilities. As one public health staff person explained to me in an interview, the way that health authorities are structured, and the ways in which that structure has continually changed, has made it difficult for him to understand how best to move forward on building intersectoral collaboration and together tackling health equity issues in the community:

“Right now [health authority name] is in real structural change ... we’re heavily siloed, in a way. Population Health, Public Health Protection, and... the Environmental Health Officer side of things ... they’ve had their blinders on with regard to health in a sense that they’ve been doing the traditional things forever ... there just isn’t that kind of theoretical aspect of things. Like how are we going to deal with this in our community, how do we deal with ... there was a really good National Collaborating Center paper on equity that I just think ‘wow, that’s something we should all’ ... it’s such a huge part of our program and I just thought for me being part of the Healthy Built Environment, that’s kind of something that it should be important to me, right? But it hasn’t really filtered down ...”

While some local government staff and elected officials clearly welcomed a better relationship with the health authorities, others told me that health authority staff members appeared to want to control these new relationships, rather than contribute as equal partners. Some local government staff members have been left with the impression that the health authorities want them to change planning policy and/or practice, yet are not supporting them as a true partner to achieve those goals. For example, some of the social planners with whom I spoke expressed concern that health authority staff were not genuinely concerned with bringing members of the community into projects as true partners:

“in a healthy safe community we’d be an ‘us’ ... we wouldn’t be in our silos, and it’s very much that way here, that everyone’s operating in different silos. I attended this presentation from [health authority] and ... they had to include community in part of the consultation. And it was very clear ... that they had, with a capital ‘H’, to include
community. That it was basically perceived as a nuisance ... as I listened to them talk and
give a presentation, then we had to talk to community, I thought, ‘There’s so much
knowledge in the community. There is so much information that could probably save so
much time and energy if you hear the community’. It was too bad that it was seen ... as a
nuisance.”

Related to those concerns, some local government and community organization
representatives expressed frustration with what they perceived as health authority staff
consistently taking on an ‘expert’ role that could undermine the development of community-
based partnerships on an equal footing. As one community representative mentioned to me in
an interview:

“the Health Authority has- many of them, not everybody - but there’s an assumption
that they have all the knowledge, they have all the wisdom to share with everyone. [But]
it goes both ways ... and I don’t think we have that recognition that we need to. I don’t
think they’re as community minded as they need to be, and our community definitely
doesn’t feel linked to our Health Authority. Hopefully that will continue to change over
time.”

Even some health authority staff members, mostly those ‘veterans’ who have been working in
HBE for a few years, expressed that the ‘expert’ role is not an appropriate one for the health
authority to take on, especially in the early stages of trying to build these intersectoral
partnerships. One such health authority representative identified the typical health authority
role in collaborative HBE work as arrogant. As she put it, “I think sometimes there is an ego ... a
large ego with the Ministry and Health Authority that assumes that they will find the answer.”

Other health authority staff with whom I spoke, especially those with community
development experience, were aware of the dangers of taking on such an ‘expert’ role. As one
public health staff person mentioned to me, health system representatives need to come at
collaboration with a sense of the need to learn, as well as contribute:
“I’m not interested in telling planners how to do their job. I know very clearly that they understand the built environment principles. Actually, to be frank, I’m almost offended when I see some of the work that comes out of health and it almost sounds like we’re ‘Oh well they don’t get it. We need to tell them’.”

The flip side to the concerns about health authority staff taking on an ‘expert’ role was that some planners with whom I spoke stated that they wanted health representatives to provide clear research evidence that planning staff could then use to advocate for some approaches, like increased densification or mixed land use. This reaction was particularly manifest in Surrey, which, more than Terrace or Kelowna, had a clear and established mandate for HBE work. One public health professional from Surrey mentioned that local planners told her, in a frank conversation, that they would appreciate support from Fraser Health staff to help them to push for development changes that could support healthier built environments:

“[they] basically told me kind of road map of the type of stuff they’d like to see from us: ‘When we go and take in a crap kicking from the public about a particular, whatever it is, we would like our health partners to be able to stand up - densification being the perfect example ... people like their cul-de-sacs and their community, their urban sprawl ... I would like to go into a meeting and have someone from health standing right next to me and talking about ‘Here are the health benefits to creating walkable dense neighbourhoods’.”

Of the three health authorities with whom I connected for my research, Northern Health’s approach to overcome these challenges with the complex structures and functions of health authorities, was unique. In keeping with NH’s reputation for a stronger community development orientation to their health promotion work, the NH staff working in Terrace were clear that the development of a true partnership with the community, including local government, was foremost. They acknowledged that the Healthy Communities committees in the North might choose a different path than might have been suggested by the Ministry of
Health. There was a sense that the NH staff consciously decided to share power and control, so that the health and social issues that were most important to their communities were addressed through this initiative. That might mean, however, that issues of social and health equity might not be tackled, as was the concern among some Northern Health staff in Terrace (see Section 5.2.1).

**Role of Local Governments**

Through the development and implementation of plans and policies, local governments play an important role in maintaining (and therefore helping to reduce) health and social inequities. That capacity exists regardless of whether those plans and policies have explicit health-related mandates (Collins & Hayes, 2010).

Municipal governance systems are changing from a model that emphasizes managerialism (i.e. delivering on slated responsibilities) to one with a greater sense of entrepreneurialism (i.e. protection and promotion of local economies) (Harvey, 2001). That shift in municipal governance style has included the increasing involvement of a wider variety of stakeholders, such as private businesses, non-profit organizations, and residents themselves. Local governments offer significant potential as sites to address health inequities because of the opportunities they present for top-down policy interventions, together with bottom-up participation from community stakeholders (Collins & Hayes, 2010). Their potential, therefore, rests in the implementation of the nutcracker approach (Baum, 2007) to address the social and environmental determinants of health and reduce health and social inequities.

Local governments are therefore in a position to identify and address many of the social
problems linked to health inequities, but they exist within a wider political context that is shaped by the provincial and federal governments. Even if they have adequate resources, local governments are not likely to have the power or responsibility to fully address issues related to health equity (Wong & Gardner, 2013).

In my research, most planners with whom I spoke seemed to clearly see the ways in which policies, programs, and infrastructure, like those that affect housing quality and affordability, access to services, and food security, have an influence on health. My impression was that some of these local government staff would like to put forward policies that strengthen the social determinants of health in their communities. Yet many expressed that their hands are often tied. Planners can make recommendations to their local mayor and council, but those recommendations might not be followed, especially if they run contrary to the strategic direction of the current council. As one provincial-level representative stated, “the local government staff ... if you are talking about those in recreation or those in planning ... they get it ... But they are not the decision makers.”

As an experienced health authority representative noted:

“I’ve watched the evolution of what’s gone on, so you know, my kind of perch- I see how when we first started in ’06 you saw a bunch of the staff coming out, right- this Healthy Built Environment, ‘Healthy Built Environment, ya, ya, ya!’ And then we all spent our time ... I don’t know how many workshops ... and we talked to planners and you’re like ‘Oh we’re all on the same page! It’s good, good, good!’ No action items, but we’re ‘all on the same page’ ... and then you run into the elected officials.”

When asked to think about how the dynamics of local government decision-making affects what kinds of issues are put forward, that same interviewee reflected on her observations of planners’ reactions to HBE workshops that had been held:
“a lot of the participants in the course were fearful of making some decisions ... either because they knew their council wouldn’t support it ... so they’d fall and default and approve a development proposal even though they knew it was the worst thing possible because of almost a fear factor there. And you saw that in a lot of the smaller communities …”

One health authority representative suggested that there is a shift in strategy happening.

Despite the apparent hesitancies on the part of some local government elected officials, there has been a change in direction of HBE work over the last three to five years. Where once the emphasis was on planners and public health staff building partnerships and learning about each others’ roles at the local and regional levels, there has been a gradual shift toward public health staff working to connect more closely with elected officials:

“She planners are doing that staff level trying to ... push the boulder up the hill in their department, trying to get the attention of mayor and council to do this. We are in a very unique role to be able to help them push that boulder a lot faster by connecting that health piece that makes it easier for the decision that politicians ... [to agree to] some of the work that the planners want to do.”

Some planners have asked their local public health staff for help in getting elected officials on board with healthy communities and/or HBE actions, given that local mayors and city councillors are bound to have other priorities that might clash with health or equity goals. This was particularly the case in Surrey, as one health authority representative there mentioned to me in an interview:

“And that’s what [local planners] from the city have said to us is that [they] need help with convincing the politicians and the government - and our council - that this is a good idea. Because Surrey is such an economically driven community now, and that’s a big focus is economic development, that sometimes when some of these principles and you know sort of like the health - the basic issues of health and equity and all that - come up ... it may be important, but not as important as what the economic side of it is.”

Part of the challenge with encouraging local government staff to engage with health authority and other representatives in working collaboratively towards health and equity goals
centres around the legal frameworks in which local governments work. The Local Government Act defines the responsibilities of local governments in BC. The Act rarely mentions community health, and then only in a vague way. Section 523 of the Act states:

“Subject to the Public Health Act, a board may, by bylaw,

a) regulate and prohibit for the purposes of maintaining, promoting or preserving public health or maintaining sanitary conditions, and

b) undertake any other measures it considers necessary for those purposes.”

The Local Government Act Section 875 outlines the required elements of Official Community Plans (OCPs). That section of the Act focuses on land use, and does not explicitly require regional districts or municipalities to integrate aspects of the social determinants of health, indicators of community health, or a consideration of social and/or health inequities. Housing policies, including affordable housing, rental housing and special needs housing, are included in the requirements for OCPs, however, as are elements of sustainability planning, including targets for the reduction of greenhouse gas emissions (Government of British Columbia, 1996).

When I asked a municipal planner during an interview why his planning department had not included explicit mention of community health or inequities in their recently renewed OCP, he replied that the Local Government Act did not require it:

“The OCP itself is a major undertaking particularly when you read the legislation in terms of the Local Government Act about what an OCP is supposed to contain, or may contain, or must contain, all that kind of stuff. It’s a very, very complex document and we took the step this time to weed out a bunch of stuff from our old OCP that didn’t really need to be there because it wasn’t land use- and land use and development are growth management related. But, it tended to be soft stuff- housing policy, social development stuff, those kinds of things, because we couldn’t see how it fit into land use.”
It is clear that the process of developing a system of true collaboration and mutual support is necessary to begin to work together toward healthier, equitable communities. However, my research highlights that building that intersectoral collaboration has presented a significant challenge for groups working on HBE issues in BC. That I encountered this challenge in my study was not surprising, given the previous research in this area, which highlights the struggles to develop and maintain mutual, trusting relationships among sectors in the community.

For instance, a review of those studies that deal with the implementation processes of intersectoral community-based health promotion initiatives found that, in many cases, the breadth and depth of activities outlined by the original intent of the projects has not been realized – there is tension between the original purpose of the project’s guiding model or framework and its operations (de Leeuw & Skovgaard, 2005). In two case studies of Healthy Cities initiatives in the UK and South Africa, Stern and Green (2005) explored the development of partnerships between local governments and community members. These researchers described two inherent tensions in those partnerships: first, the partnerships were generally set up as ‘top down’ initiatives, yet advocate a ‘bottom up’ approach. Second, the gains made by partnerships tended to be limited compared with the claims made for them. Both government representatives and community members were aware of the tensions, yet still engaged in a variety of compromises, restricting their activities to specific ‘boundary’ issues that would not threaten the main agenda of the authorities.

In another, similar study, Stern and Green (2008) explore the role of meetings in shaping the contribution of communities in those same two initiatives. In these projects, Stern and Green
suggest that the power differences between the government and non-formal sectors are played out intersectoral initiatives through cultural styles of engagement in meetings; government representatives offered ‘a seat at the table’ to community partners, but then controlled the form and content of meetings, limiting the possibilities of policy change to the margins only.

7.2 Political Will

In order to tackle inequities and improve community health, what will these new intersectoral groups work toward? There is now ample evidence that health inequities will only be reduced by substantive policy change across a number of sectors (Scott S et al., 2013; World Health Organization & Committee on the Social Determinants of Health, 2008). The policy changes that are needed go beyond exhorting downstream ‘lifestyle changes’, such as encouraging people to eat a healthier diet and exercise more, to include ‘midstream’ policies, like those that limit the availability of tobacco and junk food, or those that ensure bike lanes and trails will be built. Finally, more fully ‘upstream’ policies are needed that target deeper structural issues, like income, power, and social status (Rice, 2011; Scott-Samuel & Smith, 2015). Those policy changes will not happen without strong, sustained political will among all levels of government.

In my research, the importance of political will to identify and address equity issues as part of HBE work was a key theme at both the local and provincial levels. During key informant interviews and meetings in the three case study communities, some interviewees were quite clear that the political will of local government elected officials was just not evident. There was a tendency on the part of mayors and city/town councillors to shy away from issues of equity.
There was some speculation on the part of interviewees as to why this hesitancy exists. One health authority representative suggested that issues of equity and health equity just don’t resonate with the general public, especially those who are likely to vote:

“but it’s not us standing up going ‘Well, y’know, you have to do it this way, and you have to deal with homelessness, and you have to deal with ...’, because you know what I’m finding? I feel like that hammer is missing the political will. It’s missing the citizen average Joe guy who makes up essentially the electorate that elects either local government or provincial government. It doesn’t mean anything to them.”

A provincial representative agreed, saying that local government elected officials made it clear in consultations with the Ministry of Health and other provincial-level stakeholders that they were comfortable staying at a level of discussion that emphasized issues of lifestyle, rather than delving into deeper economic, social, and cultural issues like poverty, homelessness and education, as they relate to health:

“what we’re hearing from the local governments ... is keep it simple. They don’t want to be hearing, in overall of course there are differences but from elective member perspective, they don’t want to be hearing about the whole raft of public health issues, and poverty, and homelessness. They want it pretty clear and where they’re at, at the moment, they’re on board now with the lifestyle pieces. So it’s about that thin edge of the wedge, capitalizing on where the interest is and the momentum; use that to develop the relationships and then expand beyond there.”

The power of individual local governments is constrained by the political will of provincial and national governments, and so part of the effort of improving health through local governance is bolstering local governors’ ability to influence those public policies that are affecting residents’ health and health equity (Burris et al., 2007). The authority and potential power of municipalities in Canada is limited by the Constitution Act of 1867, which states that there are only two legitimate orders of government: federal and provincial (Sancton, 2005). Since Canadian municipalities are not formal orders of government, their responsibilities are
outlined by their corresponding provincial government, and they rely heavily on revenue from property taxes. Municipalities therefore have pressure to keep property taxes low to appease wealthy residents, yet they also need to provide more and more service to lower income and/or higher need residents, who normally concentrate in urban areas (Collins & Hayes, 2013; Freudenberg, 2000). From a political standpoint, then, local governments in Canada face an uphill battle in building the capacity to offer leadership in tackling social and health inequities within their communities (Barten et al., 2007; Collins & Hayes, 2013).

That battle was certainly made worse by the predominant ideology that was put forward by the provincial (BC Liberal) government that was in power when I collected my data. As I explained in Chapter 6, the political context in the BC Ministry of Health at the time was shifting from an emphasis on Core Programs in Public Health (with its emphasis on the use of an inequalities lens) to the Healthy Families BC initiative and the development of relationships between health authorities and local governments. At the same time, the Ministry of Health was exerting greater control over how public health programming was designed by health authorities and implemented in communities across BC. The lack of political will inside the Ministry of Health to address health and social inequities therefore transferred directly to the health authorities, as was described to me by a provincial level key informant:

"the government of the day, which is still the government – the Liberal government- had little or no interest in inequalities, certainly didn’t want to do anything about them, didn’t really want to acknowledge them ... so there was little or no appetite within the government and within the higher levels of the Ministry to actually address inequalities in health and so no pressure on the Health Authorities to do so. In fact, because the Health Authority boards are appointed by the government, ... [and there was] no interest in pushing them to do it or wanting them to do it ... so what you had was a few of us in
Despite the reluctance at the Ministry level to acknowledge or tackle health equity issues, there was some variation in the way in which the health authorities approached equity issues. When I asked the same provincial level interviewee what strategic approach the health authorities had used in relation to health inequities, he replied in this way:

“it sort of varied. Some of the health authorities, just about nothing. Northern, who basically opted out of the whole process of Core Programs and decided they knew better and would do it their own way, would argue that they were very equity oriented, and to some extent they were, but they were doing it their way and it was showing up in different ways. The most committed was Interior, and also Vancouver Coastal …

... it would have helped enormously if there had been provincial direction, but there wasn’t, and there was no way to get provincial direction because it wasn’t … the ideology of the government …

... all of this actually, is the sort of stuff that a left-wing government might allow you to do unless it got too tricky, but certainly a right-wing government is not going to allow you to do, so it’s tricky work … [it’s] not easy.”

That same uphill battle was evident during my discussions with key informants at the local level. For instance, one city councillor with whom I spoke expressed frustration about the lack of action by the health authority in her area, saying that the health authority was constrained by the cautious attitude of the provincial government, which funds health authorities:

“I don’t think Fraser Health has much courage … because I think that they’re so dependent on government funding that they can’t play a more aggressive advocacy role, and that’s really disappointing. They should be. I totally believe they should be playing a really strong public advocacy role, and they’re not doing that.

They’re not doing that … like the non-profit organizations, they have to be so careful and not speak out about the problems because their funding gets cut, or they get targeted as a radical non-profit, then they can lose their funding. And so, it’s hard enough to keep all the groups together so that they’re not all fighting for the same piece of pie … but will they speak out?”

Interestingly, when I interviewed health authority public health staff, some wished for more
support for addressing community-level equity issues, not from their provincial-level colleagues, but from community members themselves. One health authority representative put it this way:

“And so - something simple like in the community is going to put in a new ... where to put in a new soccer stadium, or a new soccer field, very often what happens is [that] the soccer moms [are] talking the loudest. But the soccer moms who are talking loud are the ones who have a voice, and so plain and simply ... where are their low-income populations? They don’t need to know everything about that low-income populations. They can quite simply go, ‘I know that those kids are probably going to have less’ ... prioritizing placement of service, things like the soccer fields, in those locations that are more likely to - to have benefit over all.”

This emphasis on needing concerted effort from both the policy levels and through grassroots community action is consistent with one of the two theoretical frameworks used to guide the development of this study. Specifically, these findings affirm the ‘nutcracker approach’ described by Fran Baum in 2007 (see Chapter 2, Section 2.4.1 for a full explanation of this theoretical framework). The nutcracker approach describes the need for both government action and advocacy on the part of community-based individuals and organizations – progress on reducing health inequities will happen only when both of these forces (i.e. both the top and the bottom of the nutcracker) act at the same time. The findings of my study support the nutcracker approach, but also highlight that the policy level of the nutcracker includes a number of actors at both the local and provincial levels, whose work intersects. In my research, the perceived viewpoints and priorities of local elected officials influenced the actions of the provincial-level decision makers, which, in turn, influenced the work of community-level public health staff within health authorities. Advocacy on the part of bureaucrats at all levels influenced, and was influenced by, the political trends at both the local and provincial levels.
7.3 Windows of Opportunity

Another theory that has informed this study is Kingdon’s Multiple Streams Model (Kingdon, 2003), a model that suggests that policy change occurs when policy windows open. That policy change is most likely when at least two of the three ‘policy streams’ have been addressed by advocates: how a problem is defined (the problem stream), what kinds of solutions are available (the policy stream), and the political and/or grassroots support available (the political stream). This converging of the three streams is represented in Figure 6, below. See Chapter 2, Section 2.4.2, for a more complete explanation of Kingdon’s theory.

Figure 6: Key Components of Kingdon’s Multiple Streams Theory (adapted from (Kingdon, 2003))

In my study, there were few obvious windows of opportunity that advocates (or what Kingdon calls ‘policy entrepreneurs’) identified and took advantage of. Perhaps the political environment at both the provincial and the local levels was too strongly unfavourable to open discussions about social and health equity. Some of the key informants I interviewed did tell me
that there were ‘closed door’ meetings about the possibility of connecting issues of equity and social justice (chiefly about housing affordability, food security, and poverty – see Chapter 6 for a more complete description) with HBE work, but in the end, strategies associated with building a strong economy often took precedence.

There were two exceptions to the scarcity of reference to windows of opportunity, however: describing the problem as it related to ‘vulnerable populations’ and the work of champions at the local level (see Section 7.4, below). As I described in Chapter 5, the political climate in the province at the time, as it related to issues of health equity, included a focus on ‘vulnerable’ or ‘priority’ populations. While there are ethical and strategic issues with framing equity concerns in this way (see Section 5.2.2), according to one provincial key informant I interviewed, this strategy was consistent with the window of opportunity that was available to advocates, particularly to those working inside the government:

VB: “So tell me more about why PHSA [Provincial Health Services Authority] is focusing on the vulnerable populations as opposed to the broader-“

“Oh I think that’s true of all the health authorities, I mean that’s true of BC in general; you can’t talk about poverty really.”

VB: “Why not?”

“It’s just politically not acceptable.”

VB: “Is there pressure from the ministry to go into that vulnerable populations way, like the route there.”

“I would ... I don’t know if I’d call it direct pressure. It’s just people who have been working on the health inequities issue. It’s the window that’s open.”

This framing the issue as specific to particular population groups is an example of advocates addressing the problem stream: how the issue is defined, together with the potential solutions that arose within the policy stream. At the time of data collection, however, the actors involved
in identifying this minor window of opportunity were mostly ‘invisible’ ones – often health authority and government staff, working with academics and consultants.

7.4 Role of Champions

A final theme that emerged in interviews, meetings and key documents was the important role that champions played in introducing and/or pushing ideas of equity and social justice as they related to HBE work in the province. Specifically, the following individual roles and groups of people were mentioned during data collection:

- Internal provincial-level and regional staff, including those at the Ministry of Health and higher-level management staff within health authorities;
- Public health professional groups operating outside of health authority structures. Examples include Health Officers’ Council, the Population Health Network, and the Healthy Built Environment Alliance;
- Local organizations dedicated to promoting economic vitality within cities;
- Individual city councillors;
- Consultants working for provincial level organizations and governments.

Interestingly, no planners within local governments were identified as champions, but that is likely due to the fact that, at the time of data collection, the mandate of HBE work resided with the health authorities, not with local government. The omission of planners as champions could also reflect their role within local government, which tends to focus on a behind-the-scenes approach.
When referring to how champions helped to bring forward ideas and influence political will to take a broader, more upstream approach to HBE efforts, the key informants with whom I spoke noted the way in which champions used their networks, their professional relationships, and their position in the organization to use their specialized knowledge to advocate. For instance, one planner described the influential role of an influential health authority manager in this way:

“He’s really good. I don’t know [name of champion] very well yet, but the few times I’ve talked to him ... he’s a champion, and he can sell his ideas, and he can convince people in doing that, which is good because I think they need to change their approach. I think they - I think at the core, I think most people involved in public health and the health care system know they need to change that. They’re talking about, you know, the need to shift to more preventative health care and get people healthier before they show up in a hospital where it costs us millions of dollars, or thousands of dollars a day to take care of someone. But, I think they’re finally seeing some real action on - and I think he’s managed to convince the executive at the top, the board for [health authority name] that this is the way to go, and they bought it and they’re endorsing it.”

Another interviewee described the pivotal role of a Ministry of Health staff person in this way:

“[name of champion] is that broader, visionary, and he does get it. And he’s kind of bound by the system in which he works. That said, he’s good at navigating that. Like, thank goodness he’s in his new role, and, you know it’s like wow, we’ve got, you know someone inside who actually has some ability to make some decisions and hopefully implements change at that level. And he sees the value of the work that we do, and it’s gonna help him win. [Laughing] You know what he’s got on his agenda for what he’d like to do, to seek change there, so ... Hopefully that can continue.”

Kingdon’s Multiple Streams Theory suggests that, to effectively recognize and take advantage of open policy windows, advocates must possess knowledge, time, relationships, and good reputations (Kingdon, 2003; Stachowiak, 2013). In this study, key informants mentioned each of those attributes when referring to the role and importance of champions in the efforts to include a more equity-focused approach to HBE work. In particular, relationships played a
central role, especially with regard to influencing the political climate and push the boundaries of HBE work to include a broader, healthy communities approach that emphasized the social determinants of health. As one experienced provincial-level key informant mentioned to me in an interview:

“it depends on the people. It depends on the people, who, if they’re systems thinkers, and they get it, and they get the connections and they can make the connections.”

Champions were perceived as being particularly effective if they found a way to capitalize on the prevailing priorities of the organization they were trying to influence, and then ‘pitch’ the idea of upstream strategies (consistent with an equity approach) in a way that fit with those priorities. For instance, in Surrey, one local champion successfully advocated for a greater emphasis on poverty reduction planning, in part by pointing out the connection between lower poverty levels and the overall economic success of the city. In another example, described to me in an interview (see below), a series of champions from within the public health field appealed to the fiscally conservative senior leadership team within a health authority that upstream approaches will help save the health system money:

“there is an understanding that we’re going to do something about the health status of the population and to ease the pressures on the health care system we need to deal with equity issues ... So that really has become part of the thinking, whether in [health authority] and the other health authorities, whereas five years ago it wasn’t just there. I think the pressure that’s been mounted by the population health people is starting to have an impact. The message really is starting to get through”

7.5 The Use of Tools

The final factor that supported the use of an equity lens as part of HBE work in BC was the use of tools, including gathering, reporting, and planning for policy change by using data to
describe the community’s health and wellbeing. The tools that have been used as part of
integrating equity and social justice into HBE work in BC included:

- Community health assessments and profiles;
- Measuring and monitoring issues of equity, including setting targets; and,
- Concrete policy tools designed to integrate a consideration of health into local
government policies and programs, including the HBE Linkages Toolkit, health impact
assessment, and Health in All Policies.

In this section, I will describe and discuss each of the above sets of tools in turn.

7.5.1 Community Health Assessments and Profiles

As Healthy Communities committees have been set up across the province, some have
started with an informal community health assessment process, to begin to get a sense of what
the priorities might be in terms of population needs, particularly for those groups in the
community that might be struggling. Data from each community health assessment would then
be used to design policy strategies for HBE and healthy communities work. Health authority
staff have been tasked with gathering this data and/or contributing the community health data
they already have, as one of their contributions to intersectoral work with local governments
and other community partners. Ministry of Health staff told me in interviews that they expect
health authorities to include data about health inequities in the community health profiles they
are providing for their region. Healthy Communities / HBE teams have embraced this function
with varying levels of formality. See Section 6.2 for some of the community health data as it
related to equity issues in Surrey, Kelowna and Terrace.
In Terrace, this process of gathering data as an initial step in planning was described by a Northern Health staff person in this way:

“if you look at each HSDA [Health Service Delivery Area], it’ll differ. And then if you look at men and women in each HSDA they differ, so even to say like in this town we have a really high [rate of] teenage pregnancies in this certain area, or respiratory diseases in this area, well…when we’re kind of all at the table we’re looking at kind of health inequities, but what can work with us with data to be able to kind of design our programs or what not. So that’s kind of the theory behind that … it’s basically kind of a health report card for communities … to bring that disparity out and see the degree of disparity - things really jump out. So you, so bringing that to the table and also supporting the committee with sort of some facilitation so having some facilitating come up to really get all the stakeholders at the table and kind of look at those regional disparities or those major risk factors and how we’re going to deal them.”

In my interviews and in the meetings I attended, it was clear that the gathering and reporting of community health data was an important role for public health staff, in part because planners and other local government staff hoped to use that data to advocate to city council. Health authority staff recognized the value of their role, and saw it as crucial to help them build relationships with local government staff and elected officials, and together formulate a healthy communities planning process. As another Northern Health staff person mentioned to me:

“our original proposal was that we would do a presentation to mayor and council and planners and eventually it would develop a formal relationship. And then we would have a visioning session where we would ask all of these people ‘what is your vision of a really healthy Terrace?’ … we’d show them their Health Status Report.”

One provincial-level key informant suggested that community health assessments help to present meaningful stories, which can be an important way to implement an equity lens at the local level.

7.5.2 Measuring and Monitoring Issues of Equity

Part of the impetus for the collection and use of data at the local level originated with the Ministry of Health, which has encouraged health authorities to ensure that the activities they
implement as part of Healthy Families BC are evidence-based. As one provincial-level key informant described to me:

“there’s a big push, and it’s coming from the top - it all has to be evidence based. So I think when you’re saying that it’s ... it’s mandated and controlled by the provincial government ... they have some very specifics that they’re wanting to evaluate, and it’s based on evidence; does this work?”

Equity lens advocates from within health authorities have used this evidence-based mandate to their advantage, by presenting Ministry staff and their own executive leadership with research and data that demonstrates that upstream strategies are important. In addition, some health authority staff have set targets to reduce inequities within their region. The process of setting targets was portrayed as an important advocacy strategy on its own; equity-based targets were expected to drive attention and resources to upstream interventions. As one veteran public health advocate noted, “if you don’t count it, it doesn’t count”.

Some US cities involved in equity work as part of their sustainability initiatives have used data as an advocacy tool, as well as a way to inform and engage community members in the discussion (Park, 2014). Presenting the demographics of neighbourhoods and cities in visual, easy to understand ways has helped some cities, like Raleigh, North Carolina and Portland, Oregon to shine the light on existing inequities and help bring a wide variety of community groups to the table (Park, 2014). Equity Atlases, like the National Equity Atlas, provide a resource for policy makers and community leaders across the United States to track, measure, and make the case for social equity. The Atlas, produced by PolicyLink and the USC Program for Environmental and Regional Equity, presents region-specific and national data on demographics
and other population-based indicators, to highlight the increasing diversity of the country and link that diversity with economic growth and wellbeing (Atlas, 2014).

Of course, from a research perspective, it can be difficult to agree on what data should be gathered, how that might happen, and what targets should be set. Indeed, indicators of performance in efforts to reduce social inequities at the local level are not well developed (Svara et al., 2014). A research-based key informant highlighted these concerns with me in an interview when she said:

“what evidence do we look at around inequities? ... Health Officers Council did that report in 2008 about health inequities in BC, and I think what they probably had to grapple with, and we all have to grapple with, is what do we even mean by health inequities? How do we know what data to look at and what data to collect?”

7.5.3 Concrete Policy Tools

The use of more concrete, systematic tools emerged as a final set of ways in which to develop and implement an equity lens as part of HBE work. All of these tools are designed to link policy options with community health outcomes, including health inequities. The most relevant tools included:

- **Healthy Built Environment Linkages Toolkit** – designed by the BC Healthy Built Environment Alliance and the Provincial Health Services Authority (PHSA), the Linkages Toolkit is a resource for public health staff, planners, community organizations and intersectoral Healthy Communities committees to connect to the evidence about how community design and health outcomes are linked. The Toolkit content is organized into five key features of the built environment: neighbourhood design, transportation networks, natural environments, housing, and food systems. For each of these
categories, the Toolkit presents the types of planning policies or strategies that, according to the available research, are most likely to associate with good health outcomes in the community (BC Healthy Built Environment Alliance & Provincial Health Services Authority, 2014).

- **Health Impact Assessments** – a process that makes it possible to shed light on decision-making related to proposed or established policies, programs, or projects, and their potential effects on the health of a population. Most if not all public policies have potential or actual health impacts. The concept of healthy public policy (Hancock, 1985) requires that those impacts be understood and assessed, both proactively in the development of public policy and retroactively in the evaluation of public policy. Health impact assessment (HIA) is the process by which these assessments are made (Forsyth et al., 2010; Harris et al., 2007). Essentially, the HIA process presents a series of questions for discussion. Those questions are designed so that policy makers, decision makers, and (sometimes) the general public, can look at policies in new ways – to see how they might have an impact on health, and how those health effects could affect some population groups in different ways. Equity-focused HIA, or health equity impact assessment (HEIA) assesses the impact of public policies on health equity (Haber, 2010; Povall et al., 2013).

- **Health in All Policies (HiAP)** - a relatively new approach to policy making that involves embedding health promotion, health equity, and sustainability in policies throughout a particular government (e.g. in all provincial ministries, or throughout the work of the
federal government). Ultimately, HiAP strives to make all government departments considerate of, and accountable for, their potential impact on health and its underlying social determinants (Freiler et al., 2013; Kickbusch, 2013; Leppo et al., 2013; Rudolph et al., 2013).

During the period of time when I collected data for this research, there was only vague mention of the importance of the use of tools to support the implementation of an equity lens in association with HBE work. In particular, the use of health impact assessments (especially equity-focused health impact assessments) was mentioned as an important new tool to explore. At that point in time, the HBE Linkages Toolkit was under development, and some of the key informants I interviewed were part of that development process. Those interviewees noted that the Linkages Toolkit does not explicitly address equity, but that further iterations of the tool might need to include a more overt emphasis on equity.
7.6 Summary

Please see Table 8, below, for a summary of the factors that have both supported and challenged the implementation of an equity lens in HBE efforts.

Table 8: Factors that have Supported and Challenged the Implementation of the Equity Lens, as it Relates to Healthy Built Environments Work

<table>
<thead>
<tr>
<th>Factors that have Supported Equity Efforts</th>
<th>Factors that have Challenged Equity Efforts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Champions at all levels</td>
<td>Lack of clarity about respective roles</td>
</tr>
<tr>
<td>Policy context that is encouraging health authorities and local governments to work together</td>
<td>Previous history leading to lack of trust of health authority staff</td>
</tr>
<tr>
<td>Ability of health authority staff to gather and provide community health data</td>
<td>Silos operating in health and local government sectors</td>
</tr>
<tr>
<td>Genuine interest in working together</td>
<td>Limitations of Local Government Act and other legislation</td>
</tr>
<tr>
<td>Availability and use of concrete tools, like health impact assessments</td>
<td>Role of planners vs. role of elected officials</td>
</tr>
<tr>
<td>Highlighting the convergence of equity work within (or connected to) sustainability planning</td>
<td></td>
</tr>
</tbody>
</table>

Poor health at both the individual and community levels is the result of the inter-relationships of a complex web of factors. Addressing community health concerns, and the inequities that are associated with those concerns, requires direct action on the social and environmental determinants of health, with an explicit emphasis on how those determinants are distributed in society. It is an understatement to say that this is a challenging mission, so it is vital that we learn as much as we can about the experiences of HBE teams across the province, so that we can better understand how to bolster those factors that support health equity work, and how to mitigate those factors that can challenge our efforts. Incorporating an equity lens into HBE work requires strong, sustained cross-sectoral relationships, but clearly
developing that level of collaboration and trust has been difficult for healthy communities and HBE teams across the province.
Chapter 8: Conclusions

When asked about the success of health promotion efforts in Canada, Trevor Hancock, one of the founders of the international Healthy Cities movement, wrote, in an article entitled ‘Health Promotion in Canada: 25 Years of Unfulfilled Promise’:

“In my view, this failure can be laid squarely at the feet of the political and the healthcare system leadership at the federal, provincial and regional (health authority) levels in Canada, who have failed to recognize the potential of health promotion to improve the health of the population. They have remained fixated on the healthcare system, misunderstood health promotion as (still) being mainly a matter of exhorting people to behave properly, failed to invest adequately in prevention and health promotion, failed to adopt a ‘whole of government’ approach and thus failed in their duty to the public to improve health and reduce inequalities in health.

In fact, the very concept of inequalities in health and health inequity has been largely ignored, it is the topic that dare not even speak its name; the preferred term in leadership circles is disparity, which is seen as being more neutral, less controversial, less politically troublesome. If we cannot even speak clearly about this fundamental issue, how can we ever begin to address it?” (Hancock, 2011, p. ii264).

Unfortunately, this ‘unfulfilled promise’ appears alive and well in Healthy Built Environments work in BC.

It is clear that there are synergies between planning and public health, and that the two fields share a common concern for equity and social justice. However, most recent development in the efforts to link public health and planning in North America have been relatively narrowly focused, as scholars and policy makers alike try to put into practice new research that has demonstrated the links between the effects of our automobile-centred society and suburban environments on air quality and obesity. Many policy documents in this category have centered on physical activity patterns and healthy eating, rather than on the broad social, economic and environmental factors that form the foundation for good health.
The conventional approach has been to build on widespread dissatisfaction with the anonymity and lifestyle that urban sprawl can facilitate. The adverse health effects of sprawl are emphasized, including the negative health effects of long commutes, limited physical activity opportunities in suburban neighbourhoods, and the relative social isolation of life in lower density environments. While there is some discussion about building social networks and reducing health inequalities through collective work between planners and public health officials, the emphasis is on changing aspects of the ‘built environment’ through urban design and the use of health impact assessments to consider the health consequences of new development. Limited attention has thus far been given to broad political or social policy change associated with a social justice orientation to planning and to the promotion of health.

Instead, planners and public health practitioners have been invited to come together to build “Community Health as a Goal of Good Design” (Public Health Law & Policy, Public Health Institute, n.d.). Toolkits and other documents designed to bring the two fields together (e.g. Smart Growth BC, 2009; Provincial Health Services Authority, 2009; Ontario Professional Planners Institute, 2007) encourage a vision of a ‘healthier community’ that influences personal health behaviours (or lifestyle) such as becoming more physically active, and eating healthier foods. There is some focus on improving air quality, reducing neighbourhood-level crime and even food security and affordable housing, but these more social factors are far overshadowed by the emphasis in this work on individual behaviour change.

Planning theorists such as Susan Fainstein and Leonie Sandercock have explored ideas of social justice and equity in planning, with the understanding that social justice should be an
integral part of planning practice. In fact, Susan Fainstein (2005) has stated unequivocally that “the purpose of planning is to create the just city” (p. 121). A theory of the ‘just city’ values participation in decision making by relatively powerless groups in society, and aims to achieve equity in outcomes. Those outcomes include relative material equality as both a pre-condition and outcome of urban development, coupled with a culture of tolerance and a commitment to equity (Fainstein, 2000). Leonie Sandercock’s (1998) conceptualization of the just city is one that is socially inclusive, where difference is not merely tolerated but treated with recognition and respect.

The vision of a more just or equitable city is consistent with a healthier city, in which systems that foster social interactions among population groups are strengthened, part of building inclusiveness and producing a less divided society, one with reduced social inequities and more equitable access to the resources needed for good health (Dahlgren & Whitehead, 2006). To realise this vision, much of the public health literature recommends that representatives from various sectors (e.g. health, local government, education, social services) begin to work more closely together, at municipal, regional, provincial and federal levels. This ‘intersectoral action’ is key to enhancing equity and improving community health (Public Health Agency of Canada, 2007). Local government, in its responsibility to set policies related to land use, transportation, housing, community and social services, parks and recreation, education, policing, and public works, plays a powerful role in shaping the health and well-being of the residents of a community.
So the application of an equity lens in planning involves, at least in part, explicitly working towards a vision of a more just and diverse city. And, as a field, public health has acknowledged the importance of addressing the social determinants of health and health equity in all of its strategies (World Health Organization & Committee on the Social Determinants of Health, 2008). But how does this play out in practice when these two fields join forces? What should planners and public health practitioners do differently, together?

In this dissertation I aimed to help answer those questions, through a critical examination of the degree to which these broader social and political issues were integrated into HBE work across the province. Specifically, my study explored how an ‘equity lens’ was defined and used at both the local and provincial levels, including the factors that supported and challenged the use of that lens. To answer the key research question: *How is an ‘equity lens’ being implemented in association with Healthy Built Environments work in British Columbia?*, I have used a case study approach that integrated data from a number of sources, including semi-structured interviews and one focus group, participant observation in meetings, and the analysis of documents, including reports, maps, websites, and videos. I spent a year collecting data at the provincial level in Victoria and Vancouver, and at the local level in three cities: Surrey, Kelowna, and Terrace. That data was also used to address the three research sub-questions:

- How has the ‘equity lens’ been defined, and how did those definitions differ among local planners, public health staff, and provincial-level policy makers?
• What aspects of context (e.g. municipal governance models, role of health authority staff, health authority organizational structures, types of community health issues) affected how the equity lens has been implemented?

• What factors have supported or challenged the implementation of an equity lens in Healthy Built Environments work in BC, and what is needed to overcome those challenges?

8.1 Answering the Research Questions: Key Findings

At the time of data collection, the prevailing approach of the Ministry of Health was reluctance to address social and health equity issues as part of the Healthy Families BC initiative. Given the Ministry’s relationship with the health authorities, a relationship which had become more explicitly directive, it is not surprising that the Healthy Communities committees in Surrey, Kelowna, and Terrace had not yet directly linked equity with their emerging work. There were some efforts on the part of individual committee members to bring forward ideas for action as they relate to building more diverse and inclusive communities, but these initial ideas fell short from the original plan for an Equity Lens. That plan (though loosely defined) called for all actions associated with the core public health functions to be continually assessed based on the potential of those actions to exacerbate social and health inequities.

Staff at the Ministry noted that they didn’t associate their Healthy Families BC work with equity or social justice issues because they feared they might be offending elected representatives and staff of other Ministries, like Social Development & Social Innovation or Children & Family Development, whose work (it was perceived) is more directly related to the
social and economic determinants of health. If the Ministry of Health were to take on issues of poverty, education, affordable housing, or other aspects of those determinants, they could be seen as trying to interfere in another Ministry’s territory, and that interference could have drastic political consequences. This finding is consistent with the experience of Norman Krumholz and his colleagues in Cleveland in the 1970s, who found that planning with equity in mind (what they called ‘equity planning’) involves a significant political component (Krumholz & Forester, 1990).

Given these contextual issues, members of the Healthy Communities partnership groups in Surrey, Kelowna, and Terrace shared with me that they felt that their hands were tied in terms of directly addressing equity issues as part of their HBE work. Despite those limitations to the scope of their work, some HBE team members have slipped these challenging issues into that work, and re-labelled it or re-framed it so they do not attract the attention of the Ministry. Yet the key strategies used to integrate equity or social justice considerations into HBE work focused on providing specialized resources for ‘vulnerable’ or ‘priority’ populations (a strategy that brings with it ethical concerns – see Section 5.2.2) and using community health data to help facilitate intersectoral relationships and drive HBE-related planning. Those and other strategies are summarized below in Table 9:
Table 9: Methods Used to Implement the Equity Lens in HBE Work in BC

<table>
<thead>
<tr>
<th>Strategies to Implement a Health Equity Lens in Planning (as suggested by Haber, 2011)</th>
<th>Local / Provincial Level Implementation (Chapters 4 &amp; 5)</th>
<th>Elements of Context that Affect Implementation (Chapter 6)</th>
<th>Relevant Supports / Challenges (Chapter 7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>community participation in planning processes</td>
<td>Community members involved in creating Healthy Communities plans, based on community health data (Terrace only)</td>
<td>Northern Health strategic direction / philosophy Rural nature of community</td>
<td>Lack of political will among local elected officials</td>
</tr>
<tr>
<td>targeting specific populations in planning*</td>
<td>Focus on ‘vulnerable’ or ‘priority’ populations: seniors, people with disabilities, children, low income families</td>
<td>Provincial level mandate</td>
<td>Data from community health assessments</td>
</tr>
<tr>
<td>monitoring and evaluating outcomes*</td>
<td>Development &amp; use of Community Health Profiles and other data to help direct HBE strategic direction</td>
<td>Provincial level mandate Economy &amp; work force (Kelowna &amp; Terrace)</td>
<td>History of preparing community health data (Northern Health)</td>
</tr>
<tr>
<td>use of equity-focused tools</td>
<td>Development of preliminary HIA tools to support HBE work (Kelowna &amp; Terrace)</td>
<td>Innovation &amp; experience of health authority staff, who act as champions</td>
<td>HBE implemented by Environmental Health Officers (Terrace)</td>
</tr>
<tr>
<td>incentives or policy levers</td>
<td>Not used</td>
<td>Cautious approach of Ministry of Health</td>
<td>Not used</td>
</tr>
<tr>
<td>consideration of social determinants of health</td>
<td>Not widely used – considered the realm of social planning, which was poorly connected with HBE work</td>
<td>Population demographics &amp; community health issues (Surrey)</td>
<td>Silos at all levels Local level champions (Surrey &amp; Kelowna)</td>
</tr>
</tbody>
</table>

*Key strategies associated with HBE work in BC
At the time of data collection in 2012/2013, Healthy Built Environments initiatives in BC were in an early stage of development, and the degree to which an equity lens was implemented at the local level was influenced by shifts in the provincial policy context from an emphasis on Core Programs to a clear mandate for health authorities to connect with local governments, as part of the Healthy Families BC – Communities initiative. Health authority staff in all three cities approached local governments within their regions to together build intersectoral committees that focus on HBE issues, but the work of these committees was challenged by the endurance of silos that limit the consideration of social justice-oriented efforts to the purview of social planners, who were not necessarily connected to the new HBE committees. The unique social, economic, and community health issues each city is dealing with, from the needs of new immigrants and refugees in Surrey, to the lack of affordable housing in Kelowna, to the need for better access to good food in Terrace – all of these considerations have affected how HBE work has been shaped.

The development of intersectoral partnerships and the ability of intersectoral groups to work together emerged as a key factor that both supported and challenged the use of an equity lens in HBE work in BC. These relationships were, in theory, valued by many stakeholders involved in HBE efforts, yet establishing those relationships proved to be a significant challenge, in part because of a sense of mistrust of the intentions of the health authorities. A lack of political will at both the provincial and local levels also offered a significant hindrance to the application of an equity lens, in part attributed to a lack of interest in social justice or equity issues among the general public. Some local government elected officials were
more comfortable with an HBE approach that was limited to lifestyle issues, like physical activity or healthy eating, rather than openly identifying and tackling deeper social concerns like poverty or homelessness, as they relate to health. Yet ground-up, community level action was also highlighted as a vital strategy to tackle health equity issues, a finding which confirms the ‘nutcracker approach’ theory put forward by Baum (2007). That approach identifies the need for simultaneous action from the ‘top down’ policy level and from the ‘ground up’ community level, in order to successfully reduce health inequities. Consistent with some elements of Kingdon’s Multiple Streams Theory (Kingdon, 2003) champions played an important role in influencing political will through their use of their networks and professional relationships, their position within the organization, and their specialized knowledge.

This research confirmed the perspectives of David Harvey, who emphasized the notion that changes in the spatial form of cities (in particular, elements of urban sprawl) have changed the access in which some population groups have to jobs, good housing, and other opportunities needed for a healthy and prosperous life (Harvey, 1973). In all three communities I visited as part of this study, there were distinct neighbourhoods in which residents’ options were limited. There was little indication that local planners affiliated with HBE projects in each community considered the unique needs of these neighbourhoods. As Edward Soja has suggested, justice has a geography, and we must emphasize the spatiality of justice in our efforts (Soja, 2010).

Finally, the use of tools that presented data to describe the community’s health and wellbeing, and then used that data to identify and advocate for strategies to tackle health inequities, was another factor that supported the use of an equity lens as associated with HBE
work. Those tools, including the use of community health profiles, were meant to help bring different sectors together within each community.

### 8.2 Building Healthy Cities & Communities: An Application of an Equity Lens?

There is now quite a bit of research on describing the need to better link planning and public health (particularly with regard to urban design and physical activity patterns), but there is a lack of research on interventions – putting that descriptive research into action at the local level. As Forsyth, Schively Slotterback, and Krizek (2010) highlight, so far research and practice efforts have been “long on rhetoric ... [but] unfortunately short on execution” (p. 231), and very few studies have addressed health equity issues.

Much of what is available on interventions is associated with the Healthy Cities/Healthy Communities\(^\text{18}\) approach to planning, which offers a method to draw connections between city planning and public health in a broader way that acknowledges the social and political influences on health. Healthy Communities advocates a social democratic, collectivist approach to ultimately affect the social determinants of health within a particular city, neighbourhood or town. It suggests that all sectors of a community must work together in order to collectively build a healthy community. The process involves community members coming together to develop a shared vision of their healthy community, assessing the capacity of their community to realize that vision, and then developing strategies to move toward that goal (Larsh, Shamley

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\(^{18}\)The original term for this approach, introduced by the World Health Organization, was ‘Healthy Cities’, a term that is still used in Europe, Australia, and other regions. The equivalent Canadian term is ‘Healthy Communities’, a broader term that recognizes small towns and rural areas, as well as cities.
& Heidenheim, 2002). The healthy communities approach provides a clear framework for establishing strategic community plans, organizational development and collaborative community action.

As mentioned in Chapter 2, there is an emphasis on equity in the Healthy Communities literature; a connection is drawn between a clear commitment to local government policies that reduce the exclusion of low income and other marginalized groups and the success of local efforts. In fact, equity is at the heart of the Healthy Communities model: “above all else, Healthy Cities is about directing social change to achieve more health and a more equitable distribution of the resources that create health” (Baum, 1993, p. 31).

However, the Healthy Cities / Healthy Communities approach has been questioned about its ability to address equity and health equity, both from a theoretical perspective and in practice. In a paper entitled *The Healthy City: Expertise and the Regulation of Space*, Petersen (1996) asserts that the language used in Healthy Cities projects suggest the international community’s acceptance of the modernist belief in the power of science and in strictly rational solutions to complex socio-political problems. Petersen argues that the concept of Healthy Cities reinforces professional dominance of those in the public health field, and runs the risk of using only token forms of community participation, in part because of a lack of common understanding of what ‘community participation’ means. Finally, Petersen questions the assumption in Healthy Cities projects that ‘community’ is equated with place, usually a neighbourhood or village. This narrow definition of what is meant by ‘community’ can underplay the political nature of the struggle over ownership or rights to a particular place, in that:
“the importance of place-based affiliations for identity and action is taken as a given and prioritized over other bases for identity that overlap with and may cut across place-based identities such as those based on socio-economic circumstance, gender, sexuality, ‘race’, ethnicity, age, and so on. This amounts to a denial of the fact that the local community can be a site for exclusion and the suppression of internal differences.” (Petersen, 1996, p. 162)

The challenges of ‘community’ inherent in the Healthy Cities / Healthy Communities model reflects concerns in the urban studies and planning literature with ‘communitarianism’ – a term used to describe those interested in exploring the value of community and civic efforts at the community level. Contemporary proponents of communitarianism include John Kretzmann and John McKnight, who, in their 1993 book, *Building Communities from the Inside Out*, suggest identifying and mobilizing assets to build community, involving as many people as possible in the process. Robert Putnam (2001) added the concept of social capital to this discourse, emphasizing the importance of working to build trust and cooperation among citizens. The danger in this approach, say Defilippis, Fisher and Shragge (1996), is that there is so much attention on the day-to-day work of community members, that broader political and structural issues are masked. Communitarians, say Defilippis, Fisher and Shragge:

“focus on ‘social capital’, ‘community capacity’, ‘community assets’, ‘building communities from the inside out’ and so forth, as if all or most of the resources to address community concerns already rest in communities, as if most community problems are not caused by structures and decisions made outside the community. This turning away from the private and public sectors as cause and as targets minimizes outcomes within any community and ignores long-term social change.” (p. 678).

According to this view, social justice work to enhance equity (and, presumably, health equity) through an overemphasis on community-level work (such as that suggested by the Healthy Communities model) is unlikely to have much success if not accompanied by broader political
work at provincial, national and international levels. This analysis supports the themes of the ‘nutcracker effect’ put forward by Baum (2007).

Despite those cautions about emphasizing too heavily on community-level interventions, my research did reveal an emerging trend to more fully embrace a Healthy Communities approach to HBE efforts. As illustrated in Figure 7, below, with that broader Healthy Communities approach, there is the potential to better incorporate an equity lens into this collective work of planners / local government and public health. As the provincial political context has shifted away from a lifestyle-based focus (the general approach of ActNowBC) towards a stronger Healthy Communities / Healthy Cities model, there is an opportunity to focus more readily on policies and other actions consistent with an equity lens (the WHAT) in an increasingly collaborative way, emphasizing the development of stronger intersectoral partnerships (including those with community-based organizations and informal community groups) in which a more ground-up, participatory model of leadership and governance is used.

In Table 10, below, I summarize some of the differences between the three key components of this model: HBE, Healthy Families BC, and the Healthy Communities approach.
Figure 7: Continuum of Approaches to Planning-Health Connections Work in BC

- ActNowBC
- Healthy Built Environment (HBE)
- Healthy Families BC
- Healthy Communities (Canada)
- Healthy Cities (Europe, Australia, etc.)

Emphasis on equity & the social determinants of health (WHAT)

Emphasis on intersectoral work & participatory governance (HOW)
Table 10: Key Differences between Three Approaches: Healthy Built Environments, Healthy Families BC, and Healthy Communities

<table>
<thead>
<tr>
<th></th>
<th>Healthy Built Environment (HBE)</th>
<th>Healthy Families BC</th>
<th>Healthy Communities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Content focus</strong></td>
<td>Urban design &amp; walkability</td>
<td>Building relationships between health authorities and local governments</td>
<td>Content depends on the nature of the community Tends to focus on social &amp; environmental determinants of health</td>
</tr>
<tr>
<td><strong>Focus on equity / social justice</strong></td>
<td>Little to none</td>
<td>Some, depending on the community Tends to focus on special populations</td>
<td>Integrated into all planning &amp; implementation</td>
</tr>
<tr>
<td><strong>Concerned with Relationships Among</strong></td>
<td>Planners and public health staff</td>
<td>Local governments and health authorities</td>
<td>Local governments together with a broad cross-section of organizations and community members</td>
</tr>
<tr>
<td><strong>Emphasis on evidence / research to drive activities</strong></td>
<td>Strong influence – in part because of role of Medical Health Officers</td>
<td>Involves developing and sharing Community Health Profiles with local governments</td>
<td>Less important – often a community development approach is used to identify important topic areas</td>
</tr>
<tr>
<td><strong>Role of Provincial Government (Ministry of Health)</strong></td>
<td>Supportive role only – driven by individual health authorities</td>
<td>Mandated – health authorities directed to apply Fraser Health model</td>
<td>Little involvement or support</td>
</tr>
</tbody>
</table>

8.3 Significance of this Research

By providing an in-depth look at both the strategies associated with the use of an equity lens in HBE work and an analysis of how that work happens, this study presents a valuable contribution to both research and practice in this area. In terms of research, this study offers a
unique example of how the research community can move beyond simply describing and explaining the connections between the design of the built environment and health. It does that by filling many of the existing gaps in the research. This study helps to fill those gaps by:

- adding an essential equity / social justice component to HBE research;
- emphasizing the importance of building intersectoral relationships as key to this work;
- hinting at some of the unique strengths and challenges of working in small cities and rural areas;
- shining a light on interventions that are happening in communities (rather than staying at a more theoretical level in the discussion);
- highlighting the political aspects of this work; and,
- drawing some initial links between health promotion and political theory, which can help to explain both what we need to do, and how to go about that work.

The case study method of qualitative research has been criticized for providing knowledge that is so specific to a particular context, it has limited use beyond that context (Flyvbjerg, 2006; Yin, 2009). This argument is akin to asking the question, “how can you generalize about a single case?” According to Yin (2009), one of the ways to answer this question is to propose that case studies are not attempting to generalize to populations, but to theoretical propositions and ideas.

With that goal in mind, I have connected the key aspects of this case study, from the research questions to the data collection strategy and the framework for analysis, to two particular theoretical frames: the ‘nutcracker approach’ of reducing health inequities (Baum,
2007), and Kingdon’s Multiple Streams Model of policy change (Kingdon, 2003). My research does not attempt to generalize about what is happening in HBE work in BC, especially as that work relates to the implementation of the equity lens. As I have mentioned earlier in this report, HBE work across Canada is developing at such a rapid pace, that even if I had meant to generalize about HBE work in BC, that generalization would have been out of date long ago.

Instead of working to generalize about the implementation of the equity lens within HBE work in BC, my intent was to explore and describe how that work was happening within three communities. I was interested in getting a thorough look at how local work was connecting with provincial-level directives and guidance, and how this element of policy (i.e. the equity lens) was put on the table (or not). Having a look at what is happening at both the local and provincial level in the province has value for growth and development in public health and planning practice, including translating and spreading knowledge about role and nature of intersectoral work, and the ways in which policy is developed and implemented at both the provincial and local levels. It also provides a unique contribution to the research literature in this area.

Bent Flyvbjerg, one of the key proponents of case study research in the planning field, outlined what he called the key “misunderstandings” about case studies. One of those misunderstandings involves the idea that general, theoretical (context-independent) knowledge is more valuable than concrete, practical (context-dependent) knowledge, and therefore, case studies, which provide knowledge about one particular context, are less valuable than other types of research methodologies (Flyvbjerg, 2006). Flyvbjerg argues that cases are vital for
human learning, because they provide examples for people to go beyond the ‘rules’ of action, to actually understand how those rules work within a particular context. This contextual-based learning helps individuals move from a beginner to an expert within one area or field:

“Common to all experts, however, is that they operate on the basis of intimate knowledge of several thousand concrete cases in their areas of expertise. Context-dependent knowledge and experience are at the very heart of expert activity. Such knowledge and expertise also lie at the center of the case study as a research and teaching method; or to put it more generally, still: as a method of learning. Phenomenological studies of the learning process therefore emphasize the importance of this and similar methods: it is only because of experience with cases that one can at all move from being a beginner to being an expert.” (Flyvbjerg, 2006, p. 223)

The interest in defining and implementing an equity lens has recently grown, in part due to some new research studies (e.g. Equity Lens in Public Health at the University of Victoria) and the testing of some new tools in some jurisdictions (e.g. Ontario). In the United States, that equity lens work is beginning to become connected with HBE work. It is just a matter of time before we see an equity lens tool developed specifically for HBE projects and policies in Canada. Yet, using Flyvbjerg’s terms, the use of such a tool will require ‘experts’, not just beginners, if they are going to get the most out of these new tools. Practitioners, planners, public health staff, and those outside of both of those fields, will need to understand and navigate the complexities that individual community contexts provide. One tool will not work for all communities, and we need to build our learning of how to shape tools for use within each community. This case study helps us to understand how to move forward in that shaping process.
8.4 Next Steps: Implications for Future Research and Practice

This research has offered a unique look ‘behind the scenes’ in HBE work. Not surprisingly, it is work that is highly political, and affected by both provincial and local level contexts. I am sure that my conclusions will come as no surprise to those people, both paid and volunteer, who have been working in communities over the long term. This is indeed ‘messy’ work.

To be more effective in using an equity lens in HBE strategies, and therefore better fulfilling our goals to improve community and population health, we will need to delve more deeply into that ‘mess’, and work to more fully understand it, rather than resorting to quick fixes and ‘low hanging fruit’. My project offers three main directions for further research:

• Explore (and embrace!) the political – While many planners are quick to understand and explain the political nature of their work, this tendency to embrace the political is still quite new to public health professionals, especially for those working at the community level. Many authors have commented that public health professionals are not always politically savvy. For instance, Lawrence Brown, from Columbia University, suggests that:

  “because health policies (‘public’ health or other) do not arise spontaneously from scientific evidence and arguments, public health professionals should be familiar with the policymaking process and the cast of institutional characters that shape its outcomes for better and for worse. Such familiarity is now acquired largely on the job.” (Brown, 2010, p. 171)

Using an equity lens in HBE work will involve asking fundamental questions about what kinds of communities we want to collectively build. That will include an examination of issues of power, diversity, inclusion, and distribution of services – a political exercise, for sure.
We need to better understand how public health staff can identify and use the political nuances around them to tackle those tough problems, like poverty, inclusion, and food insecurity. Research is particularly needed in the area of governance systems, so we can begin to better understand what ‘healthy local governance’ might look like, and how we can achieve it. Case studies, like this one, can help practitioners, both planners and public health professionals, to learn more about the political messiness that is integral to work in the community.

- **Learn more about how to build effective partnerships** – My project has emphasized that much of this work rests on building and maintaining respectful partnerships among those in the health and planning sectors, along with other community leaders. My data suggests that there is general widespread support for developing a greater sense of partnerships between sectors, especially at the local level. Many would agree that we cannot hope to make change in the determinants of health if we don’t work together, yet relationships have emerged in this study as one of the key barriers to meaningful collective action. It would be helpful to develop more practice-based research to more effectively guide community leaders, especially health authority staff, to better shape their role in these vital relationships.

As part of that partnership development, we must spend more energy fostering and supporting community-based, ground up, approaches (e.g. poverty activists, environmental advocates). That support might include opening up healthy communities committees to community members from all walks of life, and connect with organizations and networks.
working on poverty reduction, housing or homelessness, supports for children and families, inclusion and diversity, for instance. Consistent with the Nutcracker Effect suggested by Baum (2007), we must dedicate ourselves to ensuring that both sides of the nutcracker have power. Unfortunately, most of the efforts so far have been devoted to the upper part (policy) of the nutcracker.

- **Better connect Healthy Built Environments to Healthy Cities / Communities** – As I mentioned earlier in this chapter, there appears to be a movement in BC from a narrowly-defined HBE model to one closer to a Healthy Cities or Healthy Communities approach. This is an exciting development, but at this point we still are faced with two different sets of people engaged in HBE and Healthy Communities work, guided by two different sets of literature. Rather than develop a third set of practice guidelines, it would be most useful, at this stage of the development of HBE work in Canada, to intentionally and explicitly merge HBE practice into Healthy Communities work. There is much to learn from the 30 years of the international Healthy Cities movement. To best learn from that wisdom, the integration of practice in the HBE and Healthy Communities arenas needs to be accompanied by the assimilation of practice-informed research in both of these areas.

- **Explore the use of equity-focused tools** – Throughout my project, the need for tools to support both research and practice emerged as a key theme again and again. Some exciting new equity-focused tools are now available that have been tested in some cities in the US and Europe. Not all of these tools have been associated with HBE work, but many of them
(including those linked to sustainability planning in the US), could easily be adapted to support the work of HBE and Healthy Communities teams across the province.

- **Integrate issues of equity into relevant legislation** – The efforts of local champions to advocate for a broader approach to HBE work that focuses on the social determinants of health and equity issues has been hampered by a lack of strong policy that could force local governments to consider equity as part of their planning processes. From a practice perspective, it is important to explore opportunities for the development of such a policy, whether that policy be directed to health authorities, local government, or both. From a research perspective, we need to know more about how legislation associated with European Healthy Cities initiatives has helped (or hindered?) the use of an equity lens in those jurisdictions.

8.5 **Summary**

This is such an exciting time for both the planning and public health fields in Canada. The rapidly developing area of Healthy Built Environments has offered a wonderful opportunity for the two fields to learn from each other and to revisit a partnership that had once had such a positive impact on people’s health and well-being. Yet, as seen from this research, the development of those partnerships, and the joint creation of policy that is designed to help to build more just, inclusive, and healthier communities, is fraught with challenges. In many ways, those challenges should not be surprising, given the complexity of the social, economic, and political forces that are all operating simultaneously in our communities to help shape our collective health and well-being. Rather than avoid these complexities, and focus on the less
controversial HBE-related topics of ‘lifestyle issues’ as they relate to urban design, we need to ‘dive-in’ to the messiness of this work, and embrace it together, with a clear vision in mind. Only then will we be successful in helping to truly achieve greater health for all.
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Appendix A: Consent Form

Consent Form: “Planning for Healthy and Equitable Communities in British Columbia: A Critical Analysis of the Implementation of an Equity Lens in Healthy Built Environments Initiatives”

Principal Investigators:            Co-Investigator:
Penny Gurstein, Professor          Victoria Barr, PhD Candidate
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University of British Columbia
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University of British Columbia
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This research is part of the Co-Investigator’s PhD thesis. The thesis is a public document. Upon its completion, it will be available on-line through the UBC library.

Purpose:

This research explores the implementation of an ‘equity lens’ as part of Healthy Built Environments (HBE) projects in British Columbia. The project will be conducted as a case study of HBE work at two levels: the provincial level, in which some key HBE-related policies have been developed, and at the local level - a study of three HBE projects within three different health authority areas in BC. The research asks how the ‘equity lens’ is being defined and used, including identifying the factors that support or challenge its implementation. The hope is that this research will help those working in HBE projects across the province to integrate a social justice and equity component into their work, so that they might have the best chance at improving community health.

You are being invited to take part in this study because of your involvement in HBE work, either at the provincial level or the local/regional level.

Study Procedures:

If you choose to participate, the Co-Investigator will interview you about your connections with HBE projects and your consideration of equity issues within those projects. She will meet you at a time and place that is convenient for you. The interview will last approximately 45 - 60 minutes. With your permission, the interview will be tape-recorded and later transcribed, coded and analyzed using computer software. Please contact the Co-Investigator if you wish to review your entire interview transcript before the dissertation is completed. You will be sent a summary of the final research report.
Potential Risks:

No harm is expected to come to you as a result of your participation in this study. If you do not wish to answer a particular question, please let the Co-Investigator know, and she will skip that question. Every effort will be made to protect the identity of interview participants who do not wish to be identified by name. In those instances, when quotes are used in the dissertation they will ascribed to “a municipal planner”, “an academic researcher in the public health field”, etc. However, it may not be possible to completely protect your identity, if, for example, a quote is ascribed to “a public health professional from Kelowna” and there are only a few people holding such a position.

Potential Inconvenience:

Participation in this study may cause some inconvenience to you in taking the time to speak with the Co-Investigator.

Potential Benefits:

There are only indirect benefits to you for participating in this study. Talking with the Co-Investigator may provide you with new knowledge about issues of community health, health equity, or the connections between urban/rural planning and public health. There is also a small likelihood that you will experience a long term benefit of increased awareness about issues and factors that affect health in your community, and therefore also increase your capacity to be able to deal with those issues in the future. Your participation may also help inform BC Ministry of Health, the Provincial Health Services Authority, the Union of BC Municipalities, BC’s Health Authorities, and local municipalities about how they might best contribute to improving population health.

Confidentiality:

The data collected for this research will be published as a doctoral dissertation and may be used in future publications related to the research as well as presentations at national or international conferences. As a study participant you may choose not to be identified by name in any publication. The recording and transcript of your interview will be coded with an identification number such that only the researcher can identify the responses belonging to you. If you chose to allow your name to be used in the dissertation, and any future publications derived from this data, you will have an opportunity to review any quote or paraphrase attributed to you before publication. Study documents will be kept in a locked cabinet in the Co-Investigator’s office. All computer files will be password protected.
Contact for information about the study:
If you have any questions or would like further information about this study, please contact Victoria Barr at [phone], or by email at [email].

Contact for information about the rights of research subjects:
If you have any concerns or questions about your treatment or rights as a research participant, you may contact the Research Subject Information Line at the UBC Office of Research Services at [phone] or [email].

Consent:
Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time.

Your signature below indicates that you have received a copy of this consent form for your own records and indicates your consent to participate in this study.

___________________________________   _______________________________
Participant’s Signature    Date

___________________________________
Please print your name
Planning for Healthy and Equitable Communities in British Columbia:
A Critical Analysis of the Implementation of an Equity Lens in Healthy Built Environments Initiatives

Victoria Barr, MHSc
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In general, British Columbians are among the healthiest people in the world. However, a relatively large proportion of the population who are disadvantaged in some way, including the unemployed and working poor, children and families living in poverty, and Aboriginal people, experience significantly worse health than the average British Columbian. The reasons for these inequities are complex and caused by the unequal distribution of power, income, goods, and services.

Local and regional governments across Canada are increasingly forced to deal with complex health and social issues, including poverty, homelessness, and food insecurity, that are related to these health inequities. Over the last five to ten years, planners, public health staff, and representatives from community-based organizations have begun to collaborate on projects that aim to help ensure that cities grow and develop with a consideration of residents’ health and quality of life. These initiatives, which I call Healthy Built Environments (HBE), are now up and running in many parts of BC.

Some researchers and policy makers have suggested that using an ‘equity lens’ when developing new programs or policies is one way for diverse sectors to work together to address the complex issues associated with health inequities and therefore better address community health. Such a lens has been considered as part of HBE work in BC, but it is unclear how this lens has been defined and how it is being used. My research uses a case study approach to critically analyze the implementation of the equity lens in HBE initiatives in BC.

Research Questions:

1. How has the ‘equity lens’ been defined, and how do those definitions differ among local planners, public health staff, and provincial-level policy makers?

2. What aspects of context (e.g. municipal governance models, role of health authority staff, health authority organizational structures, types of community health issues) affect how the equity lens has been implemented?

3. What factors support or challenge the implementation of an equity lens in Healthy Built Environments work in BC, and what is needed to overcome those challenges?
Methodology

This case study examines HBE work from two main perspectives: at the provincial level, which focuses mainly on education/training and policy, and at the local municipal level, through an in-depth exploration of projects in three geographic areas of the province. Data collection will take place from February – June of 2012.

The following is a more detailed plan:

Provincial level:

- **Key Informant Interviews** with 5 – 10 people who are knowledgeable about HBE initiatives and/or the use of an equity lens in planning or public health work;
- **Document analysis** of provincial-level policy reports, training/education materials, and conference/workshop proceedings that relate to HBE work in BC.

Local Level:

I will examine the HBE initiatives in three BC communities (Surrey, Kelowna, and Terrace) and collect data in the following ways:

- **Key Informant Interviews** with 5 to 10 people in each community;
- **Document analysis** of local policy documents relating to the HBE project or to other, more general areas of community and health planning (e.g. official community plans, local neighbourhood plans), articles in local newspapers or internet sites, meeting minutes, etc.;
- **Participant Observation** of meetings or community events; and,
- **Archival Records Analysis**, which involves gathering and analyzing statistical information about each community’s health status, maps and charts, land use characteristics, and photographs.

Design Overview

Case Study: Implementation of the ‘Equity Lens’ within HBE Work in BC

Provincial, Public Policy Level

- Document analysis
- Key Informant Interviews

Local Level

- Interior Health: City of Kelowna
- Fraser Health: City of Surrey
- Northern Health: City of Terrace

- Key Informant Interviews
- Participant observation
- Document analysis

Key Questions:
- How has the equity lens been defined?
- How is it being implemented at the policy level? At the community level?
Appendix C: Provincial Level Interview Questions

1. What is your job title and role with regard to the Healthy Families BC / Core Functions in Public Health process / Healthy Community Environments?

2. I know that the Ministry’s Core Functions for Public Health process includes the use of an ‘equity’ or ‘inequalities’ lens within each of the core programs. What are the key components and processes of an ‘equity lens’ in the context of public health core programs work?
   a. What was the process by which the ‘inequalities lens’ was introduced as part of the Core Functions process? Who were the key advocates/champions? What struggles did they meet along the way?
   b. What is your vision about how an equity lens could be developed and used at the regional and/or local levels?

2. With regard to the Healthy Community Environments / healthy built environments work, how is the equity lens being implemented in BC?
   a. How have the health authorities used an equity lens differently? (please provide examples)
   b. What factors have influenced how the health authorities have implemented the lens differently?

3. What factors support the further development of the equity lens concept (i.e. development of health impact assessment tools, evaluation of its use at the local level) at the provincial level?
   a. What challenges does this kind of work face?
   b. What will be needed to overcome those challenges?

4. Can you recommend key documents I should access to help me better understand what is happening in this area in BC?

5. Who else should I talk to?

6. Do you have any other comments you would like to add?

7. If I have follow up questions, would it be OK if I contacted you again?

Thank you so much for your time!
Appendix D: Local Level Interview Questions

1. What is your position and role within the Healthy Built Environments (HBE) project?
2. For how long have you worked with the HBE project?
3. Please tell me about the HBE project in your community:
   a. What are the project’s goals and objectives?
   b. What activities has the project team been involved with so far?
   c. How successful has the project been in achieving its objectives so far?
4. What is a healthy community?
   a. What key issues need to be addressed to help [city/town] become healthier?
   b. How could you tell if [city/town] became healthier?
5. Who is involved in the planning and implementation of the HBE project?
   (partner/community organizations, roles on the project team)
6. What process was used to help the HBE project team identify key issues in the community?
7. What issues were identified? What priorities have been set?
8. What action has the HBE project team taken (or plans to take) to address those priority issues?
9. Are some members of your community less healthy than others? Who? And why do you think these inequalities have occurred?
10. To what degree is reducing health inequities a priority for your HBE project?
11. What is the HBE project doing (if anything) to address health issues among marginalized or disadvantaged groups?
   a. To what degree do you think these efforts will be successful?
   b. What factors support these efforts?
   c. What are the challenges to a focus on marginalized or disadvantaged groups?
12. What groups or organizations in the community are involved in social justice / equity work?
   a. To what degree are they involved in the HBE project?
13. Do you have any other comments you would like to add?
14. Who else should I talk to?
15. If I have follow up questions, would it be OK if I contacted you again?

Thank you so much for your time!
Appendix E: Measuring Community Health Status

A key ingredient of both HBE and equity-focused work is the successful collaboration of local groups from various sectors in the community. That collaboration depends on those groups working together to come up with a common understanding of a particular problem. In effective efforts to address inequities, what brings people together is a shared concern or issue. It helps when everyone at the table shares the belief that change is possible, and that change can be articulated in a language that all understand (Danaher, 2011). Community-level concerns that are linked with social and health equity are rarely articulated in those terms; instead, they might be labelled as issues of poverty, or affordable housing, or access to services, for instance. And how those issues are framed and then collaboratively addressed in the community depend on the local context. For example, how an issue is framed and addressed can vary depending on the geography of that community (Northern BC versus the Lower Mainland, for instance, or rural versus urban settings), the cultural background of the population (First Nations communities, for instance), or the urgency of the problem (if, for example, there have been recent deaths in the community).

Measuring Health and Wellbeing at the Community Level

Given that the local context is important for framing how equity and social justice might be integrated into HBE work, it is important to describe each of the three case study communities (Surrey, Kelowna, and Terrace) in terms of community health and well-being. Yet the research literature is not clear about just how to do that, in part because the ways in which ‘community health’ is defined (and therefore measured) varies considerably. For instance, some indicator
frameworks, like that developed by Hillemeier and colleagues in 2003, focuses on those aspects of the economic, social, and physical environments of a community that have been shown through epidemiological study to be related to health status (Hillemeier et al., 2003).

Other sets of indicators focus on wellbeing, and are reactions to an over-emphasis on economic indicators, like the Gross Domestic Product (GDP). For instance, Ron Colman, former Executive Director of Genuine Progress Index (GPI) Atlantic, recommends that community-based indicators focus on wellbeing-focused indicators such as social supports and work-life balance (Colman, 2005). The Canadian Index of Wellbeing, an initiative housed at the University of Waterloo, is a tool for measuring quality of life in a community. The Index is based on a framework that suggests that we shift our focus solely from the economy to include other critical domains of people’s lives that have been shown to lead to enhanced wellbeing. Those domains include community vitality, democratic participation, education, living standards, and time use (University of Waterloo & Faculty of Applied Health Sciences, 2014).

The Canadian Index of Wellbeing has been used at the national and provincial levels, but is increasingly used at a local level, in partnership with municipalities and community-based leadership teams. For instance, in Guelph, Ontario, the Guelph Wellbeing project team is using the Index to help them to better understand the community’s needs and to assist with strategic planning, so that the city can achieve a higher level of wellbeing for all its citizens. The Guelph Wellbeing group has chosen to focus on community connectivity, housing, and food, as key issues (City of Guelph, 2014). In other Canadian cities, including the BC cities of Victoria, Abbotsford, and the Central Okanagan (an area that includes Kelowna), local level foundations
have partnered with community agencies to produce regular reports called Vital Signs. These reports present the results of measurement of the community’s “vitality” in key areas, which help to provide the community with important information to assist in priority setting and strategic planning (Community Foundations of Canada, 2014). The Central Okanagan 2013 Vital Signs report presents locally-relevant data in 12 key domains: arts and culture, belonging and engagement, economy, environment, food security, getting around (transportation), getting started (supports for early childhood, newcomers to the area, and youth), health and wellness, housing, inequality, learning (education), safety and work. The data comes from Statistics Canada, local and regional reports, and from an online survey of community members (Central Okanagan Foundation, 2013).

The city of Glasgow, Scotland, has been doing some very innovative work in measuring and reporting on its city’s health and well-being. A number of research and policy groups have been putting significant effort into understanding community health in Glasgow, in part because Glasgow has higher levels of mortality and poor health than other areas of the United Kingdom. This inequity, known worldwide as the ‘Glasgow Effect’ cannot be fully explained by considering differential patterns of the strongest determinants of health, including differences in socio-economic circumstances (Landy et al., 2010). The Glasgow Centre for Population Health has developed a model to describe health and well-being in the city. The model (shown below) shows the dynamic interconnections among 12 key domains (Glasgow Centre for Population Health, 2014). Indicators are drawn from each domain.
While all of these diverse perspectives are important to keep in mind when attempting to describe the health of a particular community, the framework that is perhaps most applicable to this study is the one put forward by Trevor Hancock, Ron Labonté, and Rick Edwards, in the article “Indicators that Count!” (Hancock et al., 1999). Hancock and his colleagues assert that the health of a population of people, including those residing in one particular geographic community, is more than simply taking an aggregate measure of the health of all the individuals within that area. Measuring and reporting on community health must also include:

“the distribution of health across a community (and thus, inevitably, must address issues of inequalities in health and inequitable access to the determinants of health). A further aspect of ‘population health’ at the community level has to do with how well the community functions, whether the community as a whole is ‘healthy’”. (Hancock et al., 1999, p. S23)
That sense of how well the community functions includes a look at processes of governance in the community, with indicators such as voter turnout and rates of voluntarism. The set of indicator categories Hancock and his colleagues suggest is based on a framework that links the elements of community sustainability and community well-being. Based on this framework, 10 categories of indicators are arranged in 3 sets that measured:

- The six key determinants of health: environmental quality / ecosystem health, economic activity, social cohesion/civicness, equity (including power), sustainability, and livability;
- The process by which all of the above is achieved: education, participation, empowerment and civil rights, and government performance; and,
- The outcome: health status (Hancock et al., 1999).

Reviewing this set of literature and the ongoing practice in the measurement and reporting of community-based health and wellbeing, it is clear that the area is complex and rapidly developing. A detailed exploration of the pros and cons of each set of indicators is beyond the scope of this particular case study. However, based on this prior work and the availability of data at the local level in BC, the indicators I decided to focus on when reporting on the health and wellbeing of each of my three case study communities are listed in Table 11, below. Key sources of much of this data came from the Health Authorities’ community health profiles, each municipality’s official community plans, and reports from local non-profit organizations, including Vital Signs.
Table 11: Indicators used to Report on Community Health and Wellbeing of the Three Case Study Communities

<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicator Category</th>
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<tbody>
<tr>
<td>Community</td>
<td>Belonging &amp; engagement</td>
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<td></td>
<td>Food security</td>
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<tr>
<td></td>
<td>Economic inequality</td>
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<tr>
<td></td>
<td>Early childhood development</td>
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<tr>
<td></td>
<td>Family safety &amp; security</td>
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<tr>
<td>Environment</td>
<td>Housing quality &amp; affordability</td>
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<td></td>
<td>Transportation</td>
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<td></td>
<td>Air / Water quality</td>
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<td></td>
<td>Green &amp; open space</td>
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<tr>
<td>Economy</td>
<td>Employment / Unemployment</td>
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<td></td>
<td>Education levels</td>
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<tr>
<td></td>
<td>Economic resilience / diversity</td>
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<tr>
<td>Health Status</td>
<td>Physical activity rates</td>
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<td></td>
<td>Smoking rates</td>
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<td></td>
<td>Mental health</td>
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<td></td>
<td>Life expectancy</td>
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