Examining Municipal Government Uptake of Health Inequities Discourse: An Analysis of Official Community Plans of Five Metro Vancouver Municipalities

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Résumé
La recherche sur les déterminants sociaux sur la santé et les inégalités en matière de santé implique les villes comme sites clés pour intervenir mais encore peu est connu sur comment les municipalités incorporent ces idées dans leurs politiques. Cette étude analyse les plans communautaires officiels de cinq municipalités de Vancouver métropolitain sur quatre aspects: la présence de concepts sur la santé; comment la santé est encadrée; la discussion des déterminants de la santé; et les stratégies d'intervention sur les déterminants sociaux sur la santé. Les concepts sur la santé sont peu mentionnés et très peu de passages expliquent spécifiquement les inégalités en matière de santé. Pour les déterminants de la santé, 35% et 29% des passages sont reliés aux environnements physiques et sociaux, respectivement. La stratégie mentionnée le plus souvent était "l'amélioration de l'environnement social et physique," tandis que les interventions avec un focus exclusivement sur la santé étaient les stratégies les moins mentionnées. Les résultats suggèrent que les municipalités de Vancouver métropolitain sont minimalement engagées avec les discours sur les inégalités en matière de santé.

Mots clés: inégalités en matière de santé, determinants sociaux sur la santé, politiques municipales, urbanisme, Canada

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Abstract
Research on the social determinants of health (SDOH) and health inequities (HI) has implicated cities as key sites for intervention, yet little is known about how municipalities incorporate these ideas into policy. This study analyzed Official Community Plans of five Metro Vancouver municipalities on four domains: presence of health concepts; framing of health differences; discussion of health determinants; and strategies for intervention on the SDOH. Health concepts were minimally mentioned, and very few passages explicitly discussed HI. For health determinants, 35% and 29% of passages related to physical and social environments, respectively. The most commonly mentioned strategy was "improving the social and physical environment", while interventions with an explicit health focus were the least mentioned strategy. The findings suggest Metro Vancouver municipalities are minimally engaged with HI discourse.

Keywords: health inequities, determinants of health, municipal policy, urban planning, Canada

Introduction

Early Connections and Divergences between Public Health and Urban Planning

The connections between public health and urban planning in North America date back to the Sanitation Era of the mid-19th century (Corburn 2004), and were particularly strong in Canada between 1914 and 1917 through Thomas Adams' work for the Public Health Committee of the Commission on Conservation (Armstrong 1959). The coordination of these two professions led to the establishment of basic municipal infrastructure (e.g., sewerage systems, potable drinking water, waste management) that has become the foundation for healthy and safe conditions for daily life. Yet, despite vast improvements in living conditions realized by the synergies between these fields, planning and public health diverged considerably over the course of the early to mid-20th century: urban planning became fixated with land-use planning, urban renewal, and postwar subdivision development (Davidoff 1965, Hayden 2006), while public health, inspired by the acceptance of germ theory (Tomes 1998), shifted its practices more towards laboratory-based medicine and widespread administration of vaccines (Jones and Moon 1987, Ostry 1994). The net result of this divergence was the establishment of specialized and technocratic professions at the expense of considerations of equity and social justice, and the development of highly segregated cities, particularly in the United States, characterized by class and racial divides (Goldsmith and Blakely 1992).

Discursive Shifts in Planning and Public Health: Equity Planning and the Social Determinants of Health

Fuelled by the civil unrest at the time, it became clear in the 1960s that the traditional approach to land-use planning in North American cities was generating and

perpetuating severe socioeconomic inequities (Metzger 1996). At this time, there was growing recognition within the American planning profession that urban planners ought to become advocates for disadvantaged groups within cities (Davidoff 1965). In turn, equity planning emerged in the 1970s as a novel approach to planning that considers the redistributive potential of municipal government policies and programs (Clavel 1994). The pursuit of equity planning and social justice, especially in the United States, has persisted over the ensuing decades (Forester 1994, Talen 1998, Brenman and Sanchez 2012, Talen 2008), while related considerations, such as diversity and multiculturalism (Fainstein 2005, Talen 2006, Qadeer 1997), gender (Blumenberg 1998), and environmental sustainability (Touché 2004), have also emerged.

During this same timeframe, a comparable discursive shift was also taking place in public health. By the 1970s and 1980s, the limitations of modern medicine in improving longevity and reducing health disparities in developed countries became apparent (McKeown 1979, Black et al. 1980). This realization led health researchers, especially in Canada, to argue for greater attention to be paid to the influence of non-medical factors on the health of populations (Lalonde 1974, WHO 1986). The shift away from a focus on medicine within public health was buttressed by emerging evidence from social epidemiologists that empirically demonstrated strong links between non-medical factors (such as education, income, occupation, gender, race, social support networks, etc.) and population health outcomes (Lynch et al. 1998, Marmot 2004, Marmot et al. 1991, Marmot et al. 1978, Wilkinson 1996, Wilkinson 1992). Thus, to better understand the multitude of non-medical factors that create health inequities[1] within populations, and to develop strategies for action, the *social determinants of health* framework emerged and became institutionalized in the 1990s as the prevailing discourse within the public health profession in Canada (Butler-Jones 1999, Coburn and Poland 1996, Whitehead 1990, Frank 1995, FPT-ACPH 1996, WHO 1986, Edwards 1999, Evans and Stoddart 1990, Bhatti 1999, Robertson 1998, FPT-ACPH 1999, Evans, Barer, and Marmor 1994, Health Canada 2001).

Local-level Health Inequities and the Importance of Municipalities in Reducing Them

As the world's population continues to urbanize, municipal governments are playing increasingly important roles in intervention strategies to address the social determinants of health (SDOH) and health inequities (HIs) (Friel et al. 2011)B; strategies that scholars have argued may require new approaches to urban governance and planning (Smit et al. 2011). Population growth in developing countries is occurring most rapidly in large urban centres (van der Ploeg and Poelhekke 2008, McMichael 2000), while in developed countries like Canada, nearly half (46%) the population is living in one of six metropolitan regions (Statistics Canada 2011). Through exclusionary zoning practices (e.g., limiting the areas where multi-unit dwellings can be built that primarily house low-income households), urban systems act as socio-spatial sorting mechanisms, generating tremendous differences in the socioeconomic profiles of neighbourhood units. The resulting socioeconomic inequalities between neighbourhoods translates into neighbourhood-level inequities on various health outcomes, including obesity, mental illness, depression, respiratory illness, heart disease, and death (Lopez and

Hynes 2006, Diez-Roux et al. 1997, CPHI 2006, Dunn 2000, Chen, Myles, and Picot 2012, Collins, Hayes, and Oliver 2009, Ellaway, Macintyre, and Kearns 2001, Galea et al. 2005, Kershaw et al. 2006, Ming Wen, Browning, and Cagney 2007, Ross, Tremblay, and Graham 2004, Santana, Santos, and Nogueira 2009, Frumkin 2002, Frank, Andresen, and Schmid 2004, Yang et al. 2004, Saelens et al. 2003, Chaikiat et al. 2012, Pickett and Pearl 2001). Thus, HIs can be created and exacerbated when municipal governments are unable to plan, deliver, and manage equitable and viable spaces to live amidst rapid population growth.

Since HIs are manifested at the local level, it is reasonable to investigate the potential roles municipal governments can play in reducing such inequities. Municipalities are well positioned to mitigate socioeconomic inequities in health through land-use decisions, zoning by-laws, economic development incentive programs, urban design standards and processes, affordable housing programs, poverty reduction strategies, public transit, and other policies and programs that redistribute public goods in a socio-spatially equitable manner (Barton 2005, Weinstein and Sciara 2006, McCarthy 2002). Thus, while municipalities in Canada have little jurisdiction over health care services and make minimal direct expenditures on health, whether they realize it or not, they *do* have jurisdiction over population health vis-à-vis their considerable influence on the conditions of daily living for local residents (i.e., the SDOH). Indeed, Northridge, Sclar, and Biswas (2003) contend that urban structures offer the best domains through which to tackle HIs:

> [T]he impact of the built environment is especially subject to policy manipulation…these types of interventions may have the greatest potential benefit for improved population health and well-being. (560)

Described by Glouberman et al. (2006) as complex adaptive systems, cities also offer promising sites for interventions on HIs because of the combined opportunities for top-down policy interventions delivered by municipal governments, and bottom-up participation from mobilized citizens and community groups. Indeed, there is a growing body of literature that is calling for reconnecting public health and urban planning to create healthier and more equitable spaces to live (Malizia 2006, McCarthy 2002, Northridge, Sclar, and Biswas 2003, Corburn 2004, Boarnet and Takahashi 2005).

Study Objectives

Despite calls for reconnecting planning and public health, there is limited research on the extent to which the SDOH and HI considerations have permeated the long-term planning visions of municipal governments, and whether these high-level municipal government plans reflect the multifaceted nature of population health equity. Drawing from Health Canada's framework for the social determinants of health (Health Canada 2001), the objective of this study was to assess the prevalence and context of HI-related discourse within official policy statements of five municipal governments in the Metro Vancouver region of British Columbia, Canada.

Methods

Methodology

This paper reports on the findings from one phase of a multi-phased research study (Collins 2009) that employed a mixed methods research design (Tashakkori and Teddlie 1998). A mixed-methods approach was employed for the purposes of developing subsequent phases, expanding the scope of inquiry, and triangulating the research findings. The research phase reported here involved qualitative content analysis of policy documents from selected Metro Vancouver municipalities. Similar analyses of policy documents for equity-related discourse have been conducted at the local level in the US, Europe, and New Zealand (Fulop and Elston 2000, Andersson et al. 2003, Bullen and Lyne 2006, Talen 2008), and at the provincial level in Canada (Iannantuono and Eyles 1999, Davidson 1999). Yet, the policy activities of Canadian municipalities have evaded scrutiny.

Selection of Municipalities and Documents

Municipalities sampled for this study were selected from within the Metro Vancouver region. Metro Vancouver consists of 22 member municipalities, and had a 2011 population of 2.3 million (Statistics Canada 2011). In an earlier phase of this study, a survey was administered to senior staff in 17 of these 22 municipalities, which asked questions about the health-related activities and priorities of their municipality of employment (Collins 2009). From these data, five member municipalities (namely the Cities of Burnaby, New Westminster, Richmond, Surrey, and Vancouver) were selected based on being identified by their staff as assigning high priority to addressing the SDOH and HIs in their jurisdiction (Table 1). The 2011 populations of these cities total more than 1.5 million combined (Statistics Canada 2011), and represent more than two-thirds of the total population for the region.

Table 1: Characteristics of Municipalities and their OCPs Selected for the Study

Municipality	2011 Population[2]	Year of Adoption	Year of Most Recent Review	Citation
Burnaby	223,000	1998	2003	Burnaby, 1998
New Westminster	66,000	1998	2003	New Westminster, 1998
Richmond	190,000	1999	2004	Richmond, 1999
Surrey	468,000	1996	2006	Surrey, 1996
Vancouver	603,000	1995	N/A[3]	Vancouver, 1995

Official Community Plans (OCPs) were selected[4] for in-depth analysis because they articulate broad, long-term visions for the municipality, while delineating departmental roles and responsibilities for achieving these visions. In addition to the typical requirements for policies on land-use planning and development restrictions,

OCPs in the province of British Columbia *must* also include policies for "affordable housing, rental housing and special needs housing", and *may* include policies "relating to social needs, social well-being and social development" (BC 1996). As such, OCPs were viewed as appropriate documents for examining if, and how, HI-related discourses have permeated the planning visions of municipal governments in Metro Vancouver.

The OCPs that were analysed for this study were adopted between the 1995 and 1999, and analysed in 2008 (see Table 1). While these original plans predate some of the literature on HIs and the SDOH, they were developed after several seminal publications that could have influenced their contents (HWC 1986, WHO 1986, Evans, Barer, and Marmor 1994, Marmot et al. 1991, Frank 1995, FPT-ACPH 1996), including emerging literature from the Healthy Cities/Healthy Communities movement (Hancock 1987, Hancock and Duhl 1988, Sabouraud 1992, Davies and Kelly 1993, Hancock 1993, Flynn, Ray, and Rider 1994). Additionally, according to Section 866 4(c) of the Local Government Act of British Columbia, municipalities must undergo a major review of their OCPs at least every five years (BC 1996), offering additional opportunities for new ideas to have been taken up into these high-level plans. Thus, all but Vancouver's CityPlan had been analysed following at least one major review. Documents were retrieved from municipal government websites, converted to rich text format files, imported into the qualitative data analysis program QSR NVivo® (version 2.0), and reviewed for relevant material. The analysis focused on the sections of the OCPs that offered broad vision statements for the future, while more technical sections referring to specific development permits, plans and guidelines, as well as all tables, figures and maps, were omitted.

Coding and Analysis

A codebook was developed to facilitate a deductive approach to coding and analysis (Table 2). The components of this codebook focused on five questions:

1. Was health (or a related concept) discussed?
2. How were differences in health and disease outcomes framed?
3. Which of the social determinants of health were mentioned?
4. Which strategies for municipal intervention on health determinants were mentioned?[5]
5. Were any challenges to municipal intervention identified?

These questions were then redefined as nodes, and codes were developed within each node. Once the initial codebook was complete, coding commenced with the City of Burnaby OCP. This involved reading the entire document, and coding any applicable passage that was encountered. Entire sentences were coded at a minimum to maintain passage context. Upon completion of coding for the first OCP, the City of New Westminster OCP was read and coded using this initial codebook. After coding these two OCPs, reports were generated for each code to assess the effectiveness of the codebook in accurately capturing the themes of interest, and to establish searchable keywords for each code. Each coding report was reviewed, and keywords were developed and added to the codebook as they arose. This comprehensive code-specific

keyword list was then used to validate, correct, and revise the coded passages on the first two OCPs. The keywords then facilitated more efficient and reliable coding for the remaining three OCPs.

Table 2: Codebook for Analysis of Health Inequities Discourse within Official Community Plans of Metro Vancouver Municipalities

Question	Node	Codes
Was health (or a related concept) discussed in the OCPs?	Discussion of health	• Health • Well-being • Disease, illness, disability, injury
How were differences in outcomes (health, disease, other) framed in the OCPs?	Framing of differences	• Equality/inequality • Equity/inequity • Social determinants of health
Which of the SDOH are mentioned in the OCPs?	SDOH [Health Canada 2001]	• Income & Social Status • Social Support Networks • Education & Literacy • Employment & Working Conditions • Social Environment I – Social Services • Social Environment II – CommunityCharacteristics • Physical Environment I – BuiltEnvironment • Physical Environment II – Natural Environment • Personal Health Practices & Coping Skills • Early Childhood Development • Biology & Genetic Endowment • Health Services • Gender • Culture & Tradition
Which strategies for municipal intervention on the health determinants were mentioned in the OCPs?	Municipal intervention strategies (Collins and Hayes 2010)	• Conduct assessments, gather data • Health strategies, programs, education • Inter-governmental initiatives, relations, roles • Intra-governmental capacity, leader, facilitator • Develop community partnerships, networks • Improve infrastructure, built environment
Were any challenges to municipal intervention identified in the OCPs?	Challenges	• Challenge

Once the coding was complete, coding reports were thoroughly reviewed and scrutinized, and recurrent themes were documented for each code within each OCP. Then, the results of these thematic analyses were further analyzed to capture themes that were common across OCPs, as well as themes that were unique to particular OCPs. Themes were considered common if they were mentioned in three or more OCPs, and

unique themes were those that were mentioned in only one OCP. Common themes were identified and documented by code, while unique themes were identified and documented by OCP.

Results

Passages about Health and Health Outcome Differences

Discussions of health- and health-equity related concepts totalled 100 passages across the five OCPs (Table 3). 'Health' and 'well-being' themes were mentioned roughly the same number of times (N=38 and N=37, respectively), while themes related to 'disease and illness' received the least attention (N=25). The Richmond OCP mentioned 'health' most frequently, Surrey mentioned 'well-being' most frequently while the Vancouver OCP had the fewest references to health or health-related concepts. Though not systematically captured in this study, the OCPs were far more attentive to issues of sustainability and livability than health, likely owing to the provincial government's mandate that municipal governments articulate a regional growth strategy that encompasses the principles of the Livable Region Strategy Plan (LRSP) (BC 2008, GVRD 1996).

Table 3: Frequency of Health Concept and Health Outcome Difference Passages within Selected Metro Vancouver Municipalities' Official Community Plans

Node	Code	Municipality					Total
		Burnaby	New Westminster	Richmond	Surrey	Vancouver	
Health-Related Concept	Health	10	9	14	5	0	38
	Well-being	11	7	5	14	0	37
	Disease or Illness	8	11	2	3	1	25
	Total	**29**	**27**	**21**	**22**	**1**	**100**
Framing of Health Outcome Differences	Equality	1	0	1	1	0	3
	Equity	4	0	4	3	2	13
	SDOH	1	1	1	0	0	3
	Total	**6**	**1**	**6**	**4**	**2**	**19**

Thematic analyses revealed that 'health' passages focussed on creating healthy communities (either through addressing the SDOH or forming partnerships with the regional health board), and reducing hazardous exposures. 'Well-being' passages were

broader in scope, ranging from enhancing availability of services, reducing pollution, conserving energy, and increasing community pride, while passages on 'disease and illness' focused on providing accessible services and infrastructure, and special needs housing. No distinct differences across OCPs were observed for themes relating to health and health-related concepts.

Discussions of differences in health outcomes were assigned one of three codes: 'equality or inequality', 'equity or inequity', and 'social determinants of health'. A total of 19 passages across the five OCPs framed outcome differences along these dimensions. 'Equity or inequity' was the most commonly employed frame for discussing outcome differences (N=13), and Burnaby and Richmond were the most likely to employ one of the three frames (both at N=6).

Thematic analyses demonstrated a tendency among both 'equality'—and 'equity—framed passages to focus on the distribution of, and access to, services and facilities across the city. The 'SDOH'-framed passages described healthy communities as products of the interplay between social, environmental, and economic factors. The Burnaby OCP discussed the 'SDOH' as follows:

> The determinants of health go beyond the availability of medical care services; they include such diverse elements as housing adequacy and quality, income levels, job opportunities, and people's sense of control over their lives. (Burnaby 1998, 937)

Meanwhile, Richmond's was the only OCP to employ the 'equality' frame in a context that went beyond basic access to services and facilities:

> The benefits of investment in high quality child care/early childhood education include supporting healthy child development and success in school; facilitating the economic self-reliance of families by allowing parents to enter the workforce and/or to participate in training and education; helping to reduce poverty; and providing a key to women's economic equality. (Richmond 1999, 1451)

Passages about the SDOH

Quantity of Passages

Over 2000 passages were coded based on discussing one or more of Health Canada's SDOH (Health Canada 2001), but the number of passages per SDOH varied considerably, from N=0 for 'biology & genetic endowment' to N=577 (24.1%) for 'built environment' (Table 4). The two social environment determinants—'social services' and 'community characteristics'— also generated considerable attention, while 'gender', 'social support networks', and 'early childhood development' were less prominent.

Table 4: Frequency of Social Determinants of Health Passages within Selected Metro Vancouver Municipalities' Official Community Plans, and Intersections of SDOH Passages with Health Passages

SDOH	Municipality					Total by Code	Intersections of SDOH and Health Passages	
	Burnaby	New Westminster	Richmond	Surrey	Vancouver		Number	Percent by SDOH
Physical Environment I – Built Environment	107	196	99	124	51	577	5	0.9
Social Environment II – Community Characteristics	81	112	65	61	40	359	9	2.5
Social Environment I – Social Services	77	111	53	38	52	331	8	2.4
Personal Health Practices & Coping Skills	57	78	51	78	23	287	10	3.5
Physical Environment II – Natural Environment	51	69	60	39	34	253	16	6.3
Employment & Working Conditions	40	57	24	32	44	197	3	1.5
Education & Literacy	15	28	34	18	10	105	4	3.8
Culture & Tradition	16	31	21	17	11	96	0	0.0
Income & Social Status	11	28	12	18	16	85	3	3.5
Health Services	13	14	5	6	8	46	3	6.5
Early Childhood Development	7	10	8	4	3	32	3	9.4
Social Support Networks	10	3	7	1	3	24	1	4.2
Gender	4	0	2	1	0	7	0	0.0
Biology & Genetic Endowment	0	0	0	0	0	0	N/A	N/A
Total	**489**	**737**	**441**	**437**	**295**	**2399**	**66**	**2.8**

Common Themes Across Municipalities

Increasing, and improving upon existing city-based services, programs, and facilities was a common context within which the SDOH were discussed among all OCPs; from increasing affordable housing, providing childcare facilities, increasing arts & cultural programs, providing support-based and community-based services, to advocating for improvements in healthcare services. Another commonality was the focus on issues of environmental sustainability, likely reflecting the requirement to incorporate LRSP principles in their OCPs. Common themes included intensification of land use to create complete communities, reducing impacts on the natural environment, increasing opportunities for alternative travel modes, offering opportunities for residents to work closer to home, and creating more cohesive neighbourhood centers.

Unique Themes by Municipality

Several municipality-specific trends in SDOH themes were observed, and reflected the issues of unique concern or interest in each municipality. There was a focus in the Burnaby OCP on building community-based social capital, and fostering inclusivity and equity for marginalized populations. New Westminster stressed the need for advocating on behalf of disadvantaged groups for increased social assistance and public programs, providing supports for youth, and promoting the local tourism sector. Richmond mentioned promoting and protecting agricultural land, and fostering women's equality through support services and advocacy for national day care. Implementing Crime Prevention through Environmental Design (CPTED) to improve building design and reduce nuisance behaviour was stressed in Surrey, and improving environmental quality through various city programs was a focus of the Vancouver OCP.

Intersections between SDOH and Health Passages

The SDOH passages were also examined for instances of intersection with health passages. The greatest number of intersections with health was found in passages that profiled 'natural environments' (N=16) and 'personal health practices and coping skills' (N=10), while 'early childhood development' passages had the highest proportion of health-related intersections, with just under 10% of these passages discussing health.

Passages about Interventions and Challenges

Quantity of Passages

Like the SDOH-coded passages, the quantity of intervention-coded passages varied considerably across the six interventions, from N=40 (2.5%) for 'health promotion, education, strategies', to N=547 (34.5%) for 'improve social, physical environment' (Table 5). 'Inter-governmental initiatives, relations, roles' featured often, while 'develop community partnerships, networks' was the second least discussed intervention. A rather low quantity of passages discussed 'challenges' (Burnaby N=56; New Westminster N=41; Richmond N=51; Surrey N=32; and Vancouver N=26), suggesting that OCPs might not represent the appropriate venue for such statements.

Table 5: Frequency of Passages Describing Strategies for Action on Health Determinants

Code	Municipality					Total by Code
	Burnaby	New Westminster	Richmond	Surrey	Vancouver	
Improve social, physical environments	106	174	114	120	33	547
Inter-governmental initiatives, relations, roles	87	64	65	68	21	305
Conduct assessments, gather local data	65	84	58	45	35	287
Intra-governmental capacity, leader, facilitator	45	39	58	54	29	225
Develop community partnerships, networks	43	43	46	28	23	183
Health promotion, education, strategies	4	18	8	3	7	40
Total by Municipality	**350**	**422**	**349**	**318**	**148**	**1587**

Common Themes in Intervention and Challenge Passages Across Municipalities

Recurring 'intervention' themes were environmental stewardship, creating complete communities, coordinated and comprehensive planning and service delivery, and partnerships with key stakeholders (e.g., Provincial ministries, neighbouring municipalities, school boards, local non-profits, etc.) to implement such interventions. The complexities of environmental stewardship, and the challenges associated with it, are captured in the following passage:

> Environmental stewardship should be viewed as a shared responsibility of senior and local governments, non-government organizations, the private sector and the general public. For its part, the City is committed to continue to show leadership in this area. It acknowledges the fact that environmental stewardship runs deeper than regulatory bylaws or individual initiatives. Such stewardship must reflect an attitude that extends both broadly and deeply within the City's organization, the community at large, the development industry and other levels of government. (Burnaby 1998, 76)

A number of common challenges were also articulated in the OCPs, including increased downloading of responsibilities from senior governments (e.g., social planning

responsibilities); reductions in funding transfers from senior governments; constraints imposed by Provincial legislation (e.g., Growth Strategies Act); lack of jurisdictional responsibility; and population growth amidst shortages in affordable housing options. The multitude of challenges these municipalities face in implementing their OCPs are captured in the following passage:

> However, with increasing population, changing demographics, down-loading of services from senior levels of government, and increasing demands and expectations of the public, civic governments must look for a variety of ways to ensure services are available, and to fund facilities and operations. (Richmond 1999, 1432)

Unique Themes in Intervention and Challenge Passages by Municipality

'Intervention' and 'challenge' themes that were unique to particular OCPs were observed. Burnaby's OCP stressed the need for consultation (e.g., local communities, neighbouring municipalities) in planning initiatives. New Westminster demanded greater accountability from senior governments, stressing the importance of monitoring, and advocating on behalf of, social needs of local residents, and monitoring and evaluating the effectiveness of Provincial programs in meeting these needs. Richmond focused on ensuring social and emergency services are available, accessible, responsive to local needs, and conform to the priorities and budgetary constraints of the OCP. And, Surrey emphasized the need to promote development that enhances image and social fabric, reducing the social impacts of growth, and supporting innovative developers and businesses (e.g., promote work/live concept, agricultural-related, provide recreation facilities).

Discussion

OCP Framing of Health, Health Differences, and the SDOH

Health and health-related concepts were minimally discussed in the OCPs. Passages that discussed 'health' or 'well-being' tended to be broader in scope (e.g., describing the connections between human well-being and environmental health), while 'disease' and 'illness' passages were more specific (e.g., accessible infrastructure, special needs housing). While OCPs are primarily intended to serve as "a statement of objectives and policies to guide decisions on planning and land use management", the British Columbia Ministry of Community Development also makes provisions for policy statements regarding "social needs, social well-being and social development" (BC 2008). Thus, the findings here suggest that these municipalities could be doing more to profile health and health-related concepts in their OCPs.

As with health concepts, discussions of health outcome differences were minimal. When 'equity' or 'equality' was mentioned, it was primarily in the context of accessibility to services and facilities across the city. With the exception of a few references to gender equity/equality, the OCPs made little to no mention of the connections between socioeconomic inequalities and health inequities. The lack of attention paid

to health differences was surprising, especially in the City of Vancouver with its gross disparities between rich and poor (Rockel 2006), and the visibility of abject poverty in its Downtown Eastside neighbourhood (Christoff and Kalache 2007).

Compared to health-related passages, there were over 2000 SDOH-related passages across the OCPs. This large volume of discussion on factors that influence health outcomes demonstrates the tremendous amount of work that these municipalities are doing to improve conditions of daily living, even if municipal planners do not recognize this work as health-related. The determinants that featured most prominently in the OCPs were those pertaining to the 'physical environment' (i.e., built and natural), 'social environment' (i.e., social services and community characteristics), and 'healthy lifestyles', reflecting the domains over which municipal governments have greatest control. Meanwhile, 'early childhood development' was one of the least featured determinants, which was surprising given the considerable attention paid to this issue in the province of British Columbia (Hertzman 2009, Kershaw et al. 2006).

There were two general themes within which the OCPs commonly contextualized the SDOH discussions. The first theme focused on increasing, or improving upon, existing City-based services, programs, and facilities (i.e., protecting and maintaining status quo policies and programs). The second theme was to develop and implement new policies and programs that reflect the priorities[6] of the Livable Region Strategic Plan (LRSP) (GVRD 1996). Thus, development of new policies and programs appeared to be motivated more by concerns for managing the impacts of population growth and related expenditures, than concerns of the health and well-being of local residents.

Each OCP also provided their own context-specific discussions of the SDOH, reflecting concerns and issues of local relevance. Themes emphasized in the City of New Westminster OCP were likely motivated by its low median household income levels compared to other Metro Vancouver municipalities (GVRD 2001), as well as the detrimental impacts (environmentally and socially) of its geographical position as a major transportation corridor for the region. Richmond uniquely emphasized agricultural themes, which may reflect municipal priorities to increase its total land area for farming (Metro Vancouver 2006), while Surrey's unique focus on CPTED is likely driven by local concerns about high crime rates in that jurisdiction (CBC 2007). Thus, while Health Canada's SDOH is a universal framework that can be used to understand the factors that influence the health of populations, the individual determinants within the framework are broad enough to be adaptable to unique geographical and political contexts.

Interesting findings emerged from the analysis of the intersections between SDOH and health-related themes. First, there was no single health determinant in which a clustering of health-related messages emerged. While health-related passages were minimally featured, the distribution of health-passages across most of the health determinants is a promising finding, as it suggests that health is not being conceptualized in overly narrow ways. Second, less than 1% of all built environment passages also discussed a health-related theme. This is especially noteworthy given the present emphasis placed on health and the built environment (Frank, Engelke, and Schmid 2003, NCCHPP 2011), particularly in British Columbia (Lees, Redman, and Holy 2014).

Municipal Policies to Address Health Inequities and Challenges Therein

Whilst the OCPs did not make direct statements about reducing HIs at the local level, discussions of municipal interventions that have been prescribed by HI researchers (Collins and Hayes 2010) were taken as implicit strategies to address HIs. As such, the most commonly articulated intervention was to improve the social and physical environment through existing municipal services, programs and facilities. The emphasis on this strategy was not surprising given that it most closely resembles the kind of activities (e.g., infrastructure improvements, public utilities, redevelopment) in which municipalities are typically engaged (Sancton 2000). Similarly, inter-governmental collaboration featured highly, as a strategy for tackling issues that fall outside the municipalities' jurisdictions.

The OCPs also reflected considerable interest and willingness to engage with residents to identify and address local problems, signalling a desire among the municipalities to gather local data and ensure that the services they are providing are responsive to local needs. This approach also mirrors recent shifts towards more collaborative approaches to planning (Forester 1994, Healey 1998, Innes and Booher 1999). While citizen engagement is a key component of more equitable approaches to planning, deference to local citizens without political leadership is unlikely to move the issue of HIs onto the municipal policy table given empirical research that has found low levels of public awareness of the SDOH (Reutter, Neufeld, and Harrison 1999, CIHI 2005, Collins, Abelson, and Eyles 2007). In addition to a supportive citizenry, leadership, both political and among staff, is essential to truly advance a health equity agenda at the municipal level (Metzger 1996).

Relative to their interests in engaging with other governments and local residents, the municipalities did not demonstrate strong interests in working with local health and social service providers to address HIs, and thus to employ more bottom-up approaches to governance that have been suggested for creating more livable communities (Laverack and Labonte 2000). These findings were surprising and troubling given the role of the non-profit sector in the delivery of social services in Canada, and in tackling HIs (Clark 2000, Clavel, Pitt, and Yin 1997, Hancock 2001, Wallerstein 2002). Meanwhile, the municipalities appeared to be least interested in leading, or become involved in, health-based interventions, such as health promotion or education strategies. This finding may reflect the fact that explicit health-oriented interventions are the most divergent from traditional municipal activities, since the decision-making, financing, and delivery of healthcare and public health services in British Columbia is primarily the responsibility of provincial governments and regional bodies.

The challenges articulated in the OCPs were not novel or unique, but rather represent long-standing issues in Canadian municipal governance. The OCPs' concerns about municipal fiscal imbalance (either from downloading of responsibilities or reductions in transfers from senior governments) reflect contemporary challenges in municipal governance in Canada (FCM 2008a){FCM, 2008 #723;FCM, 2008 #1018}, while lack of municipal autonomy is rooted in the Canadian constitution dating back to 1867 (Sancton 2000). Similarly, concerns expressed in the OCPs about how best to accommodate population growth is a nation-wide challenge (FCM 2005), and

of growing importance amidst contemporary priorities for creating environmentally sustainable cities (FCM 2008b).

Study Limitations and Directions for Future Research

A few limitations are worth noting from this study. The different strategies that were employed for coding the OCPs may have introduced some bias in the study. The first two OCPs were coded using a more inductive approach (immersion and crystallization), while the remaining three OCPs were coded deductively after employing keyword searches. The weakness with this approach was the reliance on the first two OCPs for generating a comprehensive keyword list that could extract relevant passages in the remaining three OCPs. The strengths of this approach were that the keyword list was grounded in the data, and facilitated a standardized coding process. Thus, while standardization may have been less comprehensive, it ensured that all five documents were treated in an analytically comparable manner.

It is also worth acknowledging that discussion of HIs in the OCPs did not necessarily come from direct exposure to research on HIs. There are a multitude of influences that shape whether an issue or idea gains salience among policy makers and sets the policy agenda (Soroka 2002), but, more often than not, the existence of research evidence tends to be a weak overall influence (Lavis 2002, Lavis et al. 2004). The rather limited discussion of health-related issues in the OCPs analysed for this study suggests that not enough time had passed since the establishment of the HI and SDOH discourses within public health in the early to mid-1990s to have influenced the initial development of the OCPs. While health concepts could have been taken up in the major OCP reviews, the study findings suggest that the city's planners did not capitalize on those opportunities.

Given the strong connections between public health and urban planning in British Columbia today (Miro and Siu 2009, PHSA 2014, Klein and Barter 2011, Lees, Redman, and Holy 2014), OCPs developed now might look substantially different from a health perspective. As the Cities of Richmond and New Westminster having recently adopted new OCPs, and the City of Surrey's new OCP under development, the findings from this study offer a useful baseline for future research to examine how health-related discourse within these OCPs has changed over time. Additionally, since roughly 20% of the province's Aboriginal peoples reside in the Metro Vancouver region (Statistics Canada 2007), future research ought to examine whether and how the social determinants of Aboriginal peoples' health are taken up in these important municipal plans (Reading and Wien 2009).

Conclusions

Socio-spatial health inequities in cities can be partially reduced through the redistributive functions of municipal governments (e.g., property taxes, affordable housing, public transit) (Clavel 1994). Yet, there is little understanding of how the health inequities discourse is brought to bear on the long-term planning visions of Canadian municipalities. This study observed that relatively little attention was paid to HIs, and to the more innovative strategies required to address these inequities, in high-level municipal government policy in a major urban region of Canada. Yet, the

OCPs dealt quite extensively with the majority of the social determinants of health, even though they rarely discussed health themes. Taken together, these finding suggest that municipal planners need to be made more aware of the important health-related nature, and the health implications of, the work that they do.

Given the OCPs' minimal engagement with an inequities discourse, it is unlikely that the planning objectives outlined in the OCPs were driven by a goal of reducing inequities. While the OCPs commonly discussed the need for municipal government investments with redistributive potential (e.g., increasing public transit, provision of social services, affordable housing), the principles of the LRSP appeared to be the primary motivators of these discussions—principles that do not explicitly prioritize reducing socio-spatial inequities, and thus may have no impact on HIs, or worse, exacerbate inequities if they disproportionately benefit already well-served neighbourhoods. The findings also highlighted the unique challenges faced at the municipal level of policy-making, which are primarily related to lack of constitutional authority of municipal governments in Canada and the ensuing culture of resistance to engaging in activities that fall outside their purview. Thus, to truly reinvigorate the link between public health and urban planning in Canada and elsewhere, health inequities researchers and the public health profession needs to think more creatively about how to constructively engage municipal planners in a way that moves health equity onto the municipal government agenda. While efforts are underway in the Province of British Columbia to connect public health and planning (Lees, Redman, and Holy 2014), most of this work is heavily focused on built environments; since population health is determined by much more than simply the built environment, municipal-level dialogue on health needs to reflect the true complexity of population health. This, along with political leadership (Metzger 1996), is what's really needed to ensure that our cities are viable spaces to live for everyone.

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Notes

[1] Health inequities are often conflated with health inequalities and health disparities. Health inequalities and disparities refer to measurable differences in health outcomes between groups; health inequities imply that these health outcome differences are unjust.

[2] Statistics Canada. (2011). Population and dwelling counts, for *census metropolitan areas and census agglomerations, 2011 and 2006 censuses. Ottawa, ON: Statistics Canada.*

[3] Since it is not an OCP, the City of Vancouver's CityPlan is exempt from reviews.

[4] As the City of Vancouver has been exempted from requiring an Official Community Plan, the CityPlan was analyzed as the document most comparable to the other municipalities OCPs.

[5] The codes that were used for this question were developed based on findings from an earlier phase of the study that involved a synthesis of health researchers' prescriptions for municipal government action on the SDOH and HIs (Collins and Hayes 2010).

[6] These priorities are: Protect the Green Zone; Build Complete Communities; Achieve a Compact Metropolitan Region; and Increase Transportation Choice (GVRD 1996).

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