UK HEALTH
PREVENTION FIRST
FORUM

Case study:

Healthy Canada by Design

Case study: Healthy Canada by Design

Produced by the UK Health Forum and commissioned by the Health Foundation.

Authors: Alison Giles, Danielle Costigan, Hannah Graff, Rebecca Stacey and Modi Mwatsama

About the UK Health Forum

The UK Health Forum is a health charity generating evidence to support better policymaking through policy research and modelling.

www.ukhealthforum.org.uk

About the Health Foundation

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

www.health.org.uk

Contents

Case study: Healthy Canada by Design

Summary

This case study was picked to exemplify how an effective cross-sectoral coalition that spans national and regional organisations can be built around a shared concern, in this case urban planning.

The Urban Public Health Network (UPHN) is a national body representing the Medical Officers of Health in Canada's largest urban centres. In 2008, in response to rising obesity levels, the UPHN drew together a coalition of organisations interested in nurturing health-promoting built environments. The coalition included four national partners – the Heart and Stroke Foundation, the Canadian Institute of Planners, the National Collaborating Centre for Healthy Public Policy, and the Canadian Institute of Transportation Engineers – and six provincial health authority members – Peel Region, Toronto, Montreal and three health regions of southern British Columbia.

The coalition, called Healthy Canada by Design (HCBD), was formalised in 2009 with funding from the Canadian Partnership against Cancer's 'Coalition Linking Action and Science for Prevention' (CLASP) grant programme.

The CLASP grant was used to fund a number of different initiatives at national, regional and local levels, to upskill and support the health sector to help influence transport and planning decisions. This was in recognition that health professionals and planning and transport professionals shared common goals but had limited skills or opportunity to coordinate their advocacy efforts.

The coalition delivered projects in six provinces. An evaluation of activity in British Columbia demonstrated that HCBD catalysed the creation of new relationships across sectors and between different health authorities and improved the knowledge and skills of public health professionals in influencing land use planning processes. As a result, HCBD directly facilitated the inclusion of health considerations in some local plans, policies and decisions during the evaluation period.

The CLASP grant was a significant catalyst for action, serving to make urban planning a more strategic priority for coalition members and stimulating them to invest resources in the initiative (financial and in-kind). It also marshalled a diversity of interests and specialisms into a more coherent movement for change. The coalition has remained active since the grant funding ceased owing to the commitment of the organisations to keep working together.

Lessons for UK public health include:

1. Frame the problem as one of urban planning rather than public health.
2. Recognise that the public health and planning professions share the same goals but lack an understanding of each other's language and ways of working.
3. Bring planning expertise into public health departments to upskill public health professionals to advocate for better planning and transport decisions.
4. Marshall the expertise of the medical profession because they may hold greater influence over politicians and officials than planners and transport professionals.

Introduction

This case study describes a coalition that was established in Canada to support health professionals and planning and transport professionals to better coordinate their efforts to nurture health-promoting environments (see timeline below). The case study outlines activities undertaken by the coalition at the national level and those implemented regionally in British Columbia. It is informed by a former Medical Health Officer who was instrumental in establishing the coalition.

Timeline

Year	Event
2008	The Urban Public Health Network (UPHN) established a Healthy Built Environment working group for its members (Medical Officers of Health in Canada's largest urban centres)
2008	UPHN established a loose cross-disciplinary coalition of organisations interested in healthy built environments
2009	The UPHN coalition members put in a bid for Coalition Linking Action and Science for Prevention (CLASP) funding to formalise the coalition, led by the Heart and Stroke Foundation
2009	The Healthy Canada by Design (HCBD) coalition was formalised
2009–2012	HCBD phase 1 projects delivered
2010–2012	Evaluation of HCBD phase 1 process and outcomes [1, 2, 3, 4]
2012–2014	A second phase of HCBD projects was funded
2014	Publication of the Healthy Built Environment Linkages Toolkit in British Columbia [5]

Description of the policy

Recognition of a shared interest in urban planning

UPHN is a national body representing the Medical Officers of Health in Canada's largest urban centres.[6] In 2008, in response to the rising rates of obesity in Canada, UPHN established a working group on the Healthy Built Environment to look at how they could influence planning and transport policies, plans and practices to promote walking and cycling.

UPHN's starting premise was that they needed to convince the planning and engineering community about the benefits of a healthier built environment. Public health professionals lacked knowledge about how to accomplish this so that health would become a consideration in the development of policies, plans and practices that shape the built environment.

Meanwhile, the planning and engineering community in Canada was already concerned to address urban sprawl, reduce congestion and promote cleaner air.[7]

> *'It was interesting for planning, because when we first started, we'd say, "Now, listen you planners, you've got to do this this way to build healthier communities," and they'd look at you and shake their heads and go, "What do you think we've been trying to do for the last 50 years?" We had to accept these guys really knew their planning and they already knew how to build healthy cities. They did. What they wanted was the support.'*
>
> Source: Commentator from the health sector

> *'[We need] professional development opportunities for planners to upgrade their ability to effectively work with others. This includes learning opportunities that are for planners AND OTHERS at the same time. We need to integrate with others rather than keep ourselves separate. We think we do this; but we don't. It will take courage to do this—it's like asking the other kids if we can join in on the playground.'*
>
> Source: Canadian Institute of Planners survey respondent[8]

At this time, politicians and voters started adding their voices to those of the professionals. Boards of trade recognised that congestion was damaging economic growth in cities, and the built environment became a central theme of local and provincial elections in Canada.

> *'For example, one of the biggest advocates for a better built environment in Toronto was the Board of Trade. They realised the city was becoming so congested that it had enormous impact on the economy.'*
>
> Source: Commentator from the health sector

> *'Then, the other one that's really important, because I worked at the municipal level at one time, is that councillors were finding that sprawl is incredibly expensive. So they built these sprawling suburbs and now they were having to pay to maintain it and it was forcing tax rates up and they didn't like that.'*
>
> Source: Commentator from the health sector

In addition, there had been a growing movement in support of active travel in high-density urban places, in particular among younger Canadian voters who were shunning the car and demanding safer roads and trails for walking and cycling.

The emergence of an informal coalition

This groundswell of diverse interests looking to achieve the same outcomes created a positive environment in which to act. In 2008, the UPHN brought together a loose cross-discipline coalition of interested parties to look at how their efforts could be better supported and coordinated.

The coalition comprised:

- six provincial health authorities who were members of the UPHN – Peel Region, Toronto, Montreal and three health regions of southern British Columbia
- four national partners – the Heart and Stroke Foundation, the Canadian Institute of Planners, the National Collaborating Centre for Healthy Public Policy, and the Canadian Institute of Transportation Engineers.

For the Canadian Institute of Planners and the Canadian Institute of Transportation Engineers, the value of joining the UPHN coalition was to be able to deploy health arguments and the influence of public health professionals to help remove blockages and drive forward changes. A key purpose of the coalition therefore became to upskill public health professionals so that they could bring their influence to bear on planning decisions.

> *'Although not an effect of our actions, we were surprised by the very clear message that came from the planners that day: They all understood the benefits of Healthy Built Environment [HBE] and incorporating HBE principles into municipal policy, and didn't need more education on it. What they needed was support from health authorities in developing and implementing policy.'*
>
> Source: Policy impacts respondent[4]

In summer 2009, an opportunity arose for the UPHN coalition partners to bid for a CLASP grant* to provide funding for the delivery of specific projects. For practical reasons, the CLASP bid was fronted by the Heart and Stroke Foundation.

> *'Heart and Stroke was chosen as the lead, only because they could receive the money without a lot of hassle. I didn't want to take the money because I would have to go to council and get it voted on and all the rest of this nonsense. So we said Heart and Stroke will take the money and then disperse it to the rest of us. So that's why they were involved.'*
>
> Source: Commentator from the health sector

The funding bid was successful and HCBD formally came into being.[9]

* The Canadian Partnership against Cancer, funded by Health Canada, was established in 2006 and administers the Coalition Linking Action and Science for Prevention (CLASP) grant programme.

Healthy Canada by Design

The HCBD coalition aimed to 'demonstrate the means of moving knowledge about the effects of the built environment on health into policy and practice, and to disseminate the results, thereby bolstering Canada's capacity to prevent chronic diseases.'

It would do this by:

1. Improving understanding across sectors in Canada of the relationship between the built environment and health, including how policy, programmes and public engagement can be used to develop healthier environments that will, ultimately, contribute to the prevention of cancers and other chronic diseases.
2. Making new, state-of-the-art decision-making tools available to policy makers and practitioners across sectors.
3. Developing a new community of practice uniting non-governmental organisations (NGOs), the public health community and planning professionals in order to translate the literature linking the built environment and health into useable, practical tools.

The HCBD coalition was awarded around $2m in funding[(4)] between autumn 2009 and March 2012. It focused on creating communities that promote physical activity, and in particular active travel (walking and cycling) with the long-term goal of reducing obesity and associated chronic diseases such as heart disease, cancer and diabetes.

The HCBD partners with national reach took on an overarching knowledge transfer and exchange role. Their activities involved dissemination of published outputs and lessons learned, for example through webinars, reports, conference presentations and workshops, and meetings with key strategic stakeholders. In parallel, the coalition funded delivery of a number of projects in six provincial health authority areas (termed 'nodes'). The experience of British Columbia is described below.

HCBD: British Columbia

The British Columbian UPHN health authorities involved in HCBD were Vancouver Coastal Health (VCH) Authority, Vancouver Island Health Authority and Fraser Health Authority. These areas span urban, suburban and rural settings across relatively large and diverse geographies. The populations covered by the health authorities are diverse in terms of socio-economic status, demographic profile and cultural and political background.

Local leadership and responsibility for the project differed within each of the three health authorities and came from the Population Health department, the Office of the Medical Health Officer and Healthier Community Partnerships.[(6)] Medical health officers, environmental health officers and other health authority staff provided leadership and participated in or contributed to the project on either an ongoing or an ad hoc basis.

The three British Columbian health authorities jointly contracted an experienced Planning Consultant to help them to engage in land use planning processes and translate health knowledge into policy recommendations and actions that promote healthy built environments.[(2)] The consultant conducted situational assessments to understand each authority's baseline knowledge and skill

gaps, assets and objectives for built environment work. From this, the consultant developed a customised year-long training and technical assistance work plan for each of the health authorities to fit within the budget and timeframe of the CLASP funding. The capacity-building activities included:

- researching health and built environment strategies, policies and evidence
- transferring health evidence and promising policies and practices from other jurisdictions to local planning contexts
- providing training and support to health authority staff with regard to health and the built environment
- bringing public health staff and local planners together for networking
- participating in land use planning processes.

Evaluation

A process and outcome evaluation was conducted by a specialist in qualitative, quantitative and social research. It was guided by an Evaluation Working Group made up of representatives of the CLASP initiative, the CLASP Knowledge Translation and Exchange Working Group, and the project manager. The evaluation was based on frameworks for the overall HCBD project and each of the nodes, developed in 2010 and updated in 2011. Each of these frameworks contained a logic model, specifying the expected outputs and immediate, medium and long-term outcomes for each. The evaluation drew on several information sources as outlined below.[(1)]

These sources were from respondents within public health:

- two annual self-assessment surveys, conducted in December 2010 and November 2011
- end-of-project interviews in early 2012 with leads from five of the six nodes
- email exploration of policy impacts.

These sources were from respondents outside of public health:

- post-event questionnaires for the participants of 16 HCBD meetings, workshops and activities that took place during 2009–2011 as part of the project delivery or to support knowledge translation
- two surveys of non-health project partners, in May 2011 and January 2012
- focus groups and observations in two of the nodes.

Outcomes

Outcomes achieved across the HCBD coalition as a whole (the six nodes):

- New relationships were created across sectors and between health authorities.[1]
- Public health staff increased their skills for working with partners outside of public health to improve the built environment. In 2010, 62% of public health survey respondents felt they had increased their skills, and this rose to 80% in 2011. [1]
- Built environment decision-makers intending to change practice – such as the inclusion of health considerations in some local plans, policies and decisions – because of increased awareness of health evidence. [1]
- The CLASP grant was a significant catalyst for action and served to make urban planning a more strategic priority for coalition members. The funding led to in-kind resources allocated by each of the national partners and each of the node sites amounting to $1.4m additional investment. [1]

'The pioneers of built environment in Canada are the people in Montreal and they'd been flogging away for probably 12 years or so by the time we started and just didn't have the resources behind them to make a huge difference. They weren't speaking to the rest of the country. So having the funding was… You'll appreciate this and may have found it elsewhere. The funding was 1.5 million, 2 million for a few years. And that's spread out to a lot of players, so it wasn't masses, but it was not bad. The actual money spent over that time was two to three times that amount.'

Source: Commentator from the health sector

'Because all of the in kind and extra money that certainly increases appeal… We used this as an excuse to make it a strategic priority and really get going and we could go to council and say, "Here's the plan," and they were actually very enthusiastic, so we just built on it. So having outside money is very often a catalyst and politicians can't say no. These nice people are going to give us money to do this work and that immediately pushes it right up to the top of the agenda. And then you start spending your own money on it.'

Source: Commentator from the health sector

Outcomes achieved in British Columbia specifically:

- Public health staff increased their planning and transport knowledge and process expertise.

'CLASP has helped [health authority] to develop and hone the tools and approaches that are most effective in our work. For example, we have developed and adapted a Memorandum of Understanding agreement for defining and solidifying partnerships. We have also developed tools and resources that help us to proactively connect and work with the various audiences that are involved in land use planning processes: elected officials, community and stakeholders, and community/residents.'

Source: Policy impacts respondent[3]

- The health authorities made structural changes to support ongoing built environment work. For example, built environment responsibilities were added to the job descriptions of community health staff and environmental health officers; and new teams of environmental health officers were created to work with local government and other stakeholders on the built environment and related policies.[6]
- Health authorities forged new relationships within and across sectors, in particular with local government planning departments. This facilitated knowledge exchange and access to opportunities to influence built environment decisions. [2]
- There was emerging evidence of a health presence in land use policy documents. For example, health authority staff provided comments on the City of Surrey Official Community Plan.

  'Fraser Health provided feedback on our regional plan. They provided a "health lens", and provided policy advice on how to strengthen the plan from a health perspective.'

  Source: Survey respondent from a non-health background [4]

- Both Fraser Health Authority and VCH were invited by Metro Vancouver to provide input into the development of the Metro Vancouver Regional Growth Strategy. [4] The two health authorities coordinated their input. The Regional Growth Strategy was adopted by regional council in summer 2011. Health-related policies include a commitment from Metro Vancouver regional government to collaborate with health authorities to advance measures to promote healthy living through land use policies. The Strategy outlines specific performance measures to assess progress regionally towards the 'Development of healthy and complete communities with access to a range of services and amenities.'
- In working with the District of North Vancouver on its Official Community Plan (OCP), VCH adopted a formal Memorandum of Understanding (MOU) [10] in 2013 to lay out expectations for the partnership, including consideration of the social determinants of health and raising awareness with council, staff and community of the important role OCP plays in community health and wellness. The MOU process allowed VCH to work with planners as a proactive member of the planning team, rather than reacting to drafts.

  'We can trace some policy changes to our input, e.g. inclusion of policies related to food availability and access. We have been told by municipal staff that there are many "built environment" policies that VCH was instrumental in supporting; if VCH had not been a strong policy supporter of progressive policies for connected neighbourhood centres and active transportation, it is quite possible that these policies would have been diluted in the plan. Also, the ongoing involvement and support from VCH in social and community services with the District (in the OCP process, and at many other planning tables in the community) was recognized as a contributor to the OCP social development policies.'

  Source: Policy impacts respondent[1]

- A Healthy Built Environment Linkages Toolkit was developed, which outlined common healthy built environment principles for all British Columbia health authorities.[5]

Recent developments

The HCBD project entered a second phase in 2012–2014. In recognition of the success of the model adopted in British Columbia, a further four health authorities in Canada received funding to recruit a planner to work with them for an extended period (from 12 to 18 months) to help build relationships with planners and transportation professionals in their local communities; build capacity for healthy built environments within the health authorities; and bring health considerations into land use and transportation planning processes.[11]

Lessons learned

What worked

1. Professionals working across public health, planning and transport share similar goals and need opportunities to learn and work together.
2. External funding can help to catalyse partnerships, lead to ongoing partnership working, and stimulate internal prioritisation and investment.
3. Bringing experienced planning professionals into public health departments is an effective way to upskill public health professionals to work with planning colleagues and influence the planning process.
4. Framing obesity as a planning issue, rather than a health issue, and upskilling medical officers to advocate in planning terms, impacts positively on planning decisions – leading to healthier built environments.

   'When building up to launch the OCP [Official Community Plan] process, our city's planning group was mindful that… when the health authority weighs in as an objective/neutral outsider – and speaking on behalf of the public's health – it really helps to support the municipal initiatives and OCP process.'

   Source: Member of planning staff in one of the nodes[1]

What didn't work

1. The evaluation of HCBD suggested that stronger integration of the built environment into public health departments' work programmes would require a longer timeframe than the three-year period of the project.[4] Greater continuity planning to prepare partners for when the funding ended may have helped in this regard.
2. Similarly, given that the community planning process can take 5–10 years, allowing a longer timeframe for the project delivery and evaluation would have enabled more policy outcomes to be demonstrated. [4] The HCBD programme was delivered and evaluated over three years.

   'Appreciable community-level change can only happen over a 10-year planning spectrum.'

   Source: End of project interview with a node lead[4]

3. At the national level, developers were broadly accepting of the HCBD approach.

   'The one thing we found, there was not a lot of pushback here from interests that were against us. I actually spoke to groups of developers. And you would think, "Oh, they wouldn't like us." And they said, "We don't care, just as long as it's a level playing field. You tell us the rules and we'll build to the rules, as long as you give everybody the same rules." '

   Source: Commentator from the health sector

   However, at the level of specific proposals the potential for conflict between profit and public health objectives remained. For example, some developers failed to engage in the

HCBD programme out of concerns that healthy design would increase costs and reduce profit margins, as illustrated by the quote below.

'These meetings could be more targeted to developers and development consultants, who often resist the implications of a healthier community and neighbourhood design, since it is perceived to limit their development options or add costs onto projects.'

Source: Public health survey respondent[6]

The power of developers to block plans was recognised in another study that found that weak political commitment and market pressures frustrate planners' desires to create accessible and open communities.[12]

4. The need to engage health professionals. One of the coalition founders observed that they had failed to engage the wider health profession about the importance of prevention, and within the built environment.

'I think we did a good job talking to politicians. I think we did a good job talking to bureaucrats at senior levels in the government. I think the people who were never really effectively reached and really have no clue about this are senior health care executives… If it's not a programme of care "What the hell are we doing that for?"... "What are you spending money on that for? How many patients does that reach?" You know, this kind of nonsense. So we should have hammered away at them a bit more.'

Source: Commentator from the health sector

One health authority in British Columbia identified this as an issue during the HCBD project, commenting on a lack of support for population health projects by the executive directors who at that time were prioritising acute care initiatives.[2]

'Need to work more with communities, general public and politicians. Planners and public health professionals are already very closely aligned and "singing off the same song sheet". Where we run into challenges is with the public and decision-makers. Hospital boards should also be the target for further education.'

Source: Public health survey respondent[2]

Implications for the UK context

1. The creation of Metro mayors in some of the UK's largest cities presents an opportunity to establish cross-disciplinary teams to focus on the urban realm and the development of health-promoting environments.
2. Air quality is an emerging priority across the UK and represents a policy area under which actions to create health-promoting environments could be championed and taken forward.
3. The clear links between air quality and chronic disease prevention and management present an opportunity to engage the health care profession in promoting action on planning and transport.

References

1. Natalie Kishchuk Research and Evaluation Inc. *Healthy Canada by Design CLASP: final evaluation report.* Heart and Stroke Foundation of Canada; 2012.
2. Miro A, Perrotta K, Evans H, Kishchuk NA, Gram C, Tanwick RS, et al. Building the capacity of health authorities to influence land use and transportation planning: Lessons learned from the Healthy Canada by Design CLASP Project in British Columbia. *Canadian Journal of Public Health.* 2015; 106: eS40-eS49.
3. National Collaborating Centre for Healthy Public Policy. *Health authorities and the built environment: actions to influence public policies.* Interview report. Gouvernement du Québec; 2012.
4. Miro A, Kishchuk NA, Perrotta K, Swinkels HM. Healthy Canada by Design CLASP: Lessons learned from the first phase of an intersectoral, cross-provincial, built environment initiative. *Canadian Journal of Public Health.* 2015; 106: eS50-eS58.
5. Healthy Built Environment Alliance. *Healthy Built Environment Linkages. A toolkit for design, planning, health.* Population & Public Health; 2014.
6. Urban Public Health Network. The voice of the medical officers of health of Canada's large cities 2013 [cited 2018 08 June]. Available from: http://uphn.ca/
7. IBI Group. *Toronto-related region future study. Interim report: implications of business-as usual development.* Neptis Foundation; 2002.
8. Barr V. *"Taking the pulse": benchmarking planning for healthier communities - questionnaire results.* Canadian Institute of Planners; 2011.
9. Office of the Chief Medical Officer of Health (OCMOH), New Brunswick Department of Health. *Chief Medical Officer of Health's recommendations concerning shale gas development in New Brunswick.* OCMOH, New Brunswick Department of Health; 2012.
10. Vancouver Coastal Health. *A healthy Vancouver for all: a healthy city partnership MOU between the City of Vancouver and Vancouver Coastal Health.* Vancouver Coastal Health; 2013.
11. Perrotta K. Building a community of practice: Healthy Canada by Design CLASP renewal - Postscript. *Canadian Journal of Public Health.* 2015; 106(1): 59-61.
12. Grant JL. Theory and practice in planning the suburbs: challenges to implementing new urbanism, smart growth, and sustainability principles. *Planning Theory & Practice.* 2009; 10(1): 11-33.