Examining the Capacities of Municipal Governments to Reduce Health Inequities: A Survey of Municipal Actors' Perceptions in Metro Vancouver

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ABSTRACT

OBJECTIVES: Canada is an increasingly urban nation, with considerable health inequities (HI) within its urban centres. While Canadian municipalities have a range of policy and planning levers that could reduce the burden of HI, little is known about how municipal employees perceive the capacities of municipal governments to address HI within their jurisdictions. This study sought to capture these perceptions through a survey of politicians and senior-level staff working in Metro Vancouver municipalities.

METHODS: The survey was administered by mail to 637 politicians and senior-level staff from 17 municipal governments in Metro Vancouver. The survey captured respondents' perceptions on the responsibilities of, opportunities for, and constraints on, municipal-level action to address HI, as well as respondents' input on existing municipal policies and programs that could reduce HI in their jurisdictions.

RESULTS: Respondents perceived senior governments to bear greater responsibility for reducing HI than municipalities. Investing in "parks & recreation facilities" was considered the most promising policy lever for addressing HI, while "insufficient federal and provincial funding" was perceived to be the greatest constraint on municipal action. "Affordable housing" and "recreational programs" were the most commonly identified existing strategies to address HI in the municipalities sampled.

CONCLUSIONS: Our findings revealed concerns about inter-governmental downloading of responsibilities, and behaviour-based assumptions of disease etiology. To advance an urban health equity agenda, more work is needed to engage and educate municipal actors from a range of departments on the social determinants of health inequities.

KEY WORDS: Inequalities; municipal government; survey; British Columbia; Canada

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The fields of public health and urban planning share common origins dating to the mid-19th century.¹ The sanitation era that emerged at that time launched an array of public health engineering interventions (e.g., sewerage systems, potable drinking water, waste management systems, public health inspection, etc.) that have become mainstays of healthy urban living in much of the developed world.¹ 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 20th century.

In the past century, population growth has occurred most rapidly in large urban centres.² Canada is no exception to this trend, with nearly half (45%) of Canadians now living in one of six metropolitan regions.³ Acting as socio-spatial sorting mechanisms, these large urban systems are characterized by immense socio-economic heterogeneity across the urban landscape, with correspondent inequities in population health and well-being.⁴⁻⁶ Health and social problems in urban centres, such as unemployment, poverty, food insecurity, pollution, climate change, obesity, and sedentarism, coupled with prior synergies between urban planning and public health, have spurred calls to rekindle the connection between these fields to improve the structural conditions of daily living and reduce health inequities (HI) in urban systems.^{1,7}

Opportunities and challenges for municipalities to address HI in Canada

Municipalities are well positioned to mitigate HI through a range of policy and planning levers, including land-use decisions, zoning by-laws, economic development, poverty strategies, public transit, and other policies and programs that socio-spatially redistribute public goods.⁸ Indeed, Northridge et al. contend that interventions targeting built environments in particular "may have the greatest potential benefit for improved population health and well-being" (p. 560).⁷

Despite their potential to impact health, the legitimacy and authority of municipalities in Canada has been limited since the *Constitution Act, 1867*, when it was declared that only two orders of government (federal and provincial) existed.⁹ Since municipalities are not formal orders of government, their responsibilities are conferred by their corresponding provincial government. Canadian

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Table 1. Response Rates by Municipality, Elected Versus Non-elected, and Department

	N (%) of Respondents	N (%) Total Sample	Response Rate
Position			
Elected	64 (18.6)	133 (20.9)	48.1
Non-elected	281 (81.4)	504 (79.1)	55.8
Department			
City Council	64 (18.7)	133 (20.9)	48.1
City Manager	21 (6.1)	36 (5.7)	58.3
Corporate Services	87 (25.4)	167 (26.2)	52.1
Engineering & Operations	33 (9.6)	66 (10.4)	50.0
Parks, Recreation & Community Services	47 (13.7)	100 (15.7)	47.0
Planning & Development	38 (11.1)	59 (9.3)	64.4
Fire & Rescue	24 (7.0)	34 (5.3)	70.6
Police	20 (5.8)	26 (4.1)	76.9
Libraries	9 (2.6)	16 (2.5)	56.3
Total	345 (100.0)	637 (100.0)	54.2
Position*			
Councillor/Mayor	64 (18.7)		
City Manager	7 (2.0)		
Department Director or GM	65 (19.0)		
Deputy Directors	36 (10.5)		
Unit Manager	105 (30.6)		
Program Manager	16 (4.7)		
City Clerk	10 (2.9)		
Fire Chief	12 (3.5)		
Police Chief	12 (3.5)		
Library Director	6 (1.7)		
Other (e.g., solicitors, officers, planners)	10 (2.9)		
Total	343 (100.0)		

* In constructing the contact list, position information was inconclusive due to incomplete information on municipality websites. Thus, response rates by non-elected position type could not be calculated.

municipalities have limited revenue-generating capacity, relying heavily on property taxes. They are thus torn between their need to keep property taxes sufficiently low to retain wealthy residents, yet high enough to provide services to high-need residents, who normally concentrate in cities where services are delivered.¹⁰

Discursive shifts also underpin the constraints municipalities endure in engaging in healthy urban planning; taxpayers increasingly see themselves as victims, reducing their compassion for the welfare of distant strangers.¹¹ Meanwhile, public and non-profit services designed to assist vulnerable populations are increasingly privatized or undervalued.¹² The resulting socio-political climate leaves Canadian municipalities with limited options for tackling HI, and yet, they are increasingly being looked to for leadership and expertise in developing multisectoral approaches to reconnect urban planning and public health, and to make cities more viable and equitable places to live.¹³

Study purpose and objectives

Research on action to address HI in Canada has focused on the capacities and challenges faced by higher orders of government.^{14,15} While they are often implicated in the rhetoric, the capacities of municipal governments to reduce HI in their jurisdictions have been overlooked. Little is known about how individuals working within municipal governments perceive solutions to HI, or how pronouncements being made by the research community for municipal government intervention resonate with the visions, priorities, and challenges faced by these governments. Drawing from literature on urban health equity,^{10,13} governance,^{9,11,12} and planning,^{1,4,7} the objective of this study was to capture the perceptions of influential municipal government actors working across Metro Vancouver concerning the roles and responsibilities of municipal

Table 2. Policies, Plans or Programs That May Address Health Inequities

Policy, Plan or Program	All Policies, Plans or Programs Mentioned N (%)
Affordable housing/homelessness programs	71 (14.8)
Fitness programs, parks & recreation programs	58 (12.1)
Low income subsidies for fitness access	38 (7.9)
Community development, revitalization, zoning	36 (7.5)
Infrastructure for parks, recreation, bikeways, paths	30 (6.3)
Drug policy, harm reduction programs	20 (4.2)
Community Services or Social Well Being Plan	18 (3.8)
Youth programs	18 (3.8)
Official Community, Corporate or Municipal Plan	18 (3.8)
Early child development, child care strategies	17 (3.5)
Sustainability, ecodensity, mixed land use	16 (3.3)
Parks, Recreation, Culture & Leisure Plan	14 (2.9)
Relations with NGOs, private sector, committees	14 (2.9)
Seniors programs	13 (2.7)
Community services & outreach, w/ health focus	13 (2.7)
Intergovernmental collaborations, relations	13 (2.7)
Grants for NGOs, non-profits	12 (2.5)
Basic services (sewerage, water, libraries)	10 (2.1)
Arts & cultural programs	9 (1.9)
Local health care, rehabilitation, health promotion facilities	9 (1.9)
Support for disabilities, injury prevention	7 (1.5)
Food security programs	6 (1.3)
Crime & fire prevention, protection programs	6 (1.3)
Citizen engagement	5 (1.0)
Public transit, transportation programs	5 (1.0)
Employee wellness program	4 (0.8)
Total	480 (100)

governments in reducing HI in their jurisdictions. By illuminating these perceptions, researchers and practitioners will have an increased awareness of the challenges and opportunities for constructive collaborations between the public health and planning sectors to effectively address local-level health inequities.

METHODS

Methodology and ethics approval

This study was part of a three-phased mixed-methods research program that investigated the *prescriptions*, *capacities*, and *intentions* of municipal governments to address HI at the local level.¹⁶ Ethics approval was granted by the Simon Fraser University Ethics Review Board in October 2007, and primary data were collected in 2008.

Study setting

Metro Vancouver consists of 22 independently governed municipalities and one electoral district.¹⁷ It is a unique metropolitan region in Canada that has not undergone amalgamation processes that have taken place elsewhere in the country.⁹ The Metro Vancouver Region bears responsibility for providing potable drinking water and garbage disposal sites, recycling, sewage treatment, and regional urban growth management,¹⁷ while member municipalities are responsible for governing activities that fall directly within their jurisdiction. Metro Vancouver offered a unique opportunity to compare municipal policy and planning activities across numerous jurisdictions that are exposed to similar social, political, economic, and geographical contexts.

Sampling and recruitment

Sampling and recruitment was conducted at two levels: first at the level of municipal governments, followed by individuals working within eligible municipalities. Drawn from the Metro Vancouver region, eligible municipalities had to be at least a census agglomeration (population of 10,000 or greater) and have their own gov-

Figure 1. Mean level of responsibility of major sectors of society for addressing health inequities

erning system; the resulting sample consisted of 17 municipalities. All politicians and senior-level staff from the selected Metro Vancouver municipalities were deemed eligible, *a priori*. To facilitate recruitment, the organizational charts and websites of each included municipality were perused to gather department names and position types. Non-senior/managerial staff members, such as program coordinators, planners, engineers, and supervisors, were excluded, except when they were the only representative for a given department. Detailed contact information for every eligible participant was inputted into a Microsoft Access® database. The final contact list contained 637 eligible respondents.

Survey design

The survey was organized into four sections: 1) respondents' understanding of and attitudes towards the determinants of health;¹⁸ 2) respondents' views concerning the roles, policy levers, and barriers faced by municipal governments in addressing HI; 3) identification of existing municipal policies and plans that could reduce HI; and 4) respondents' occupational and demographic characteristics. Several questions were adapted from existing instruments,^{15,19} while the remaining were developed using Dillman's (2000) methodological guide.

Survey rigour

Sampling and coverage error were minimized by soliciting all eligible respondents, while non-response error was minimized using a five-contact approach to survey administration.²⁰ The survey instrument was piloted with a sample of politicians and senior-level staff working at the City of Victoria, British Columbia. Twenty-four individuals representing a range of positions and departments were

recruited for the pilot study; ten individuals completed and offered critical feedback on the survey instrument.

Survey instrument reliability was assessed using *internal consistency* and *test-retest reliability*. Internal consistency, using Cronbach's alpha, was assessed for six multi-item questions, and ranged from 0.622 to 0.885. Using proportionate sampling, one quarter of the respondents from each municipality and department were contacted for the test-retest reliability analysis; 83 surveys were reissued, and 26 were completed and returned. Test-retest reliability ranged from 0.704 to 0.934, and was 0.840 for the entire instrument.

Survey administration, management and analysis

Implementation of the survey involved a five-contact mail administration that spanned a 5-week window (between January 22nd and February 27th, 2008).²⁰ Survey data were inputted and managed in SPSS® (version 15.0), and analyzed non-parametrically. Differences in respondents' perceptions about sectoral responsibility, as well as municipal-level levers and constraints were tested for significance by municipality, department, and position within municipality using Mann-Whitney and the Kruskal-Wallis tests. However, as no consistent differences were observed in these tests, this paper reports on descriptive findings for the survey sample as a whole.

RESULTS

General characteristics of respondents

The response rate for the survey was 345/637 (54.2%) (Table 1). While it was expected that the response rate would be higher among non-elected officials (56%), the response rate for elected officials (48%) was surprisingly high given their role in the munic-

Figure 2a. Mean level of priority for various policy levers for addressing health inequities

ipality and the likelihood that most had other sources of employment. Police departments had the highest response rate (77%), while the lowest participation rate came from parks, recreation & community services departments (47%).

A range of positions were represented in the sample; 19% were elected officials (i.e., city councillors or mayors), 19% were directors or general managers of departments, and 31% were managers of units within major municipal departments. The majority of respondents were male (64%), had an undergraduate degree or higher (70%), had an annual household income of over \$100,000 (81%), and rated their health as excellent or very good (79%). Respondents' ages ranged from 26 to 80 years, and the average age was 51.1 years (± 7.7 years).

Roles, opportunities and challenges for municipal government intervention on health inequities

Respondents were asked to rate the level of responsibility that each major sector of society holds for addressing HI (Figure 1). The *provincial government*, *federal government*, and *regional health authorities* were assigned the highest mean levels of responsibility, while only two sectors – *market* and *non-profit* – were assigned less responsibility for HI than municipal governments. Respondents were also asked to rate the level of priority for various municipal policy levers, and level of constraint posed by various barriers on addressing local HI (Figures 2a and 2b). *Parks & recreation facilities*, *community centres*, and *citizen engagement* were considered the highest priorities for

intervention to reduce HI, while *property taxes*, *bylaw enforcement*, and *relations with businesses* were considered the lowest priorities. Respondents perceived *insufficient government funding* as the biggest constraints on action on HI, and population *migration* as the least constraining factors.

Existing municipal policies and plans

Less than half of the survey respondents ($n=145$, 44%) reported that their municipality assigned high overall priority to addressing local HI. When asked which departments bear the greatest responsibility for addressing HI, respondents most frequently identified *parks & recreation* ($n=180$, 43%), followed by *planning & development* ($n=159$, 38%), reflecting the departments commonly associated with local-level health and well-being. Respondents identified a broad range of existing policies, plans and programs that address HI in their jurisdictions (Table 2). Policies or programs that deal with *affordable housing* and *homelessness* were most commonly identified (15%), followed by *fitness, parks, and recreation programs* (12%). *Subsidies for low-income families* to access fitness programs (8%) and *community development, revitalization & zoning bylaw changes* (8%) were also popular suggestions. These findings highlight a disconnect in respondents' perceptions on these issues: respondents perceived municipal governments to bear little responsibility for addressing HI, yet the broad scope of policies and programs identified by respondents suggests that municipal governments are poised to address and are actively addressing HI in their jurisdictions.

Figure 2b. Mean level of constraints posed by various policy barriers to addressing health inequities

DISCUSSION

Profile of survey respondents

Response rates for elected officials were higher than expected, while response rates for non-elected officials were lower than those obtained in similar studies.¹⁴ It is noteworthy that individuals from police departments were most willing to participate, while those from parks & recreation departments were the least willing. We suspect that police departments were enthusiastic about having an opportunity to offer their views on a topic for which they are not often consulted but in which they are often implicated (homelessness, harm reduction, violence, mental health, etc.). That most respondents were highly educated, high-income-earning males likely reflects the educational requirements and compensation levels of the positions occupied, as well as lagging gender equity that pervades much of Canada's skilled labour force.²¹

Respondents' views on roles of municipalities in addressing health inequities

Respondents felt that higher orders of government in Canada bear the greatest responsibility for addressing HI. These findings reflect concerns within municipalities across Canada about fiscal imbalance and downloading of responsibilities from senior governments to the municipal level. It is intriguing that the *market* was assigned lower responsibility than municipal governments, given its role in creating and reinforcing conditions that breed HI in cities.²² That

individuals were assigned relatively high levels of responsibility for HI highlights the preponderance of individualistic attitudes towards health that have been observed elsewhere.^{15,23,24}

The barriers that respondents perceived to be most constraining on municipalities' abilities to address HI all relate to the marginalized constitutional status of Canadian municipalities. *Insufficient funding* from higher levels of government, *insufficient tax bases*, and *too few options for taxation*, all signal the challenges municipal governments face in generating revenue to support the infrastructure improvements, services, and programs that municipalities need to enhance the health and well-being of its residents. Meanwhile, *insufficient autonomy* and *insufficient inter-governmental collaboration* highlight the marginalized voice and limited powers of Canadian municipalities to operate freely within their jurisdictions.

In terms of municipal policy levers to reduce HI, respondents assigned high priority to levers that: 1) represent politically palatable and feasible domains of intervention for health and well-being at the local level (i.e., *parks & recreation*, *community centres*), and 2) reflect the emerging shift towards collaborative approaches to planning that aim to be responsive to community needs (i.e., *community engagement*).²⁵ The low priority assigned to *property taxes* was not surprising given the resistance municipal officials face from local residents in this domain; however, it does beg the question of how municipalities would pay for increased investments in infrastructure and/or programming to improve health outcomes.

In terms of existing action at the municipal level, respondents perceived the burden of responsibility to fall almost squarely on two department types: parks & recreation; and planning & development. The high levels of responsibility assigned to these two departments mirror much of the public health literature that focuses on increasing physical activity through modifications to the built environment,^{26,27} as opposed to more integrated approaches to intervention that would centralize health goals, engage all municipal departments, and target more upstream determinants of HI.^{5,13,28}

Capacities of municipal governments to reduce health inequities

The study findings offer conflicting assessments of the capacities of Metro Vancouver municipalities to reduce HI. Policy levers aimed at increasing physical activity were perceived to bear the greatest positive influence on health at the local level. Yet, research suggests that built environment interventions focused on behavioural change may have little impact on activity levels among inactive groups,²⁶ especially for those facing deeper burdens on their health and well-being (e.g., poverty, unemployment, racism, disability). The limitations of the behavioural model have triggered calls for increased investments in the social safety net,²⁹ but these points are largely unheard by the general public²³ and mass media³⁰ in Canada.

One resounding message from the survey was that respondents do not feel their municipalities are empowered to reduce HI. Respondents felt strongly that municipalities bear little responsibility for reducing HI, and that they are highly constrained by insufficient funding from senior governments. These perceptions of low autonomy, coupled with strong aversions to increasing revenue (i.e., property taxes), demonstrate a low capacity for municipal intervention. Health inequities researchers have been attentive to the issue of community empowerment,³¹ but challenges of disempowerment among municipal governments have been overlooked.

Despite behavioural-based assumptions about, and lack of empowerment to act on, HI, this study observed *some* municipal-level capacity to intervene. The response rates demonstrate willingness among influential municipal actors to engage in dialogue on HI, even if they feel limited in their ability to reduce them. Bringing these key actors to the table is critical in generating the leadership necessary to facilitate broader support from within municipalities.³² Additionally, respondents offered an extensive list of municipal policies and programs that could contribute to reducing HI, ranging from affordable housing, to drug policy, to fitness subsidies. Implementing a range of programs that simultaneously target multiple health determinants mirrors calls for comprehensive, coordinated and intersectoral action to effectively reduce HI.²⁸ The *Health in All Policies* approach, which has been implemented by the Province of British Columbia,³³ has promise for both engaging and educating diverse sectors about the health impacts of their work, and may be adaptable to the municipal level.

Study limitations

This study possesses a few limitations. In terms of sampling, there was a lack of consistency across municipalities in the availability of names and contact information for non-elected officials, as well as the names and functions of municipal departments and positions

within them. Overcoming these limitations involved contacting information departments within each municipal government to ensure that the data retrieved was accurate, as well as developing a generic sampling scheme to ensure each department and relevant position was sampled.

It is possible that participants interpreted the survey questions in different ways. The pilot study minimized this potential response error by highlighting ambiguities in the survey questions before it was administered in the field. The open-ended question that requested information on existing policies, plans, and/or programs that could address HI likely underestimates the scope of existing interventions in the municipalities surveyed. This presumed underestimation is because 1) busy respondents may have been less inclined to complete this section of the survey, and 2) inclined respondents may not have been able to recall these interventions, or may have been unaware of them at the time.

CONCLUSIONS

This study highlights the challenges to translating knowledge of the social determinants of health into healthy public policy to reduce HI at the local level. In contrast to challenges among senior governments, municipal-level challenges relate more to lack of constitutional authority of municipal governments in Canada, as well as resistance to engaging in activities that fall outside their purview (both inter- and intra-governmental). To truly reinvigorate the link between health and planning and facilitate greater health equity in cities, public health practitioners need to be mindful of constitutional and resource-related limitations at the municipal level, while at the same time move the conversation beyond simply modifying built environments to increase physical activity. This requires public health practitioners to engage with municipal government actors from a range of departments (and not simply parks and planning); such engagement would challenge prevailing behaviour-based assumptions of disease etiology, as well as facilitate the development of intersectoral solutions to multifaceted health problems. Additionally, future research should focus on establishing best practices for intersectoral approaches to tackling HIs.

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RÉSUMÉ

OBJECTIFS : Le Canada s'urbanise de plus en plus, ce qui crée d'importantes iniquités face à la santé (IFS) dans les centres urbains. Les municipalités canadiennes disposent de divers leviers stratégiques et de planification qui pourraient réduire le fardeau des IFS, mais on en sait peu sur la façon dont les employés municipaux perçoivent la capacité des administrations municipales de redresser les IFS sur leur territoire. Nous avons cherché à recueillir ces perceptions au moyen d'une enquête auprès des élus et des hauts fonctionnaires des municipalités du Grand Vancouver.

MÉTHODE : L'enquête a été administrée par la poste à 637 élus et hauts fonctionnaires de 17 administrations municipales du district régional du Grand Vancouver. Les répondants ont été interrogés sur leurs perceptions des responsabilités, des possibilités et des contraintes de l'action municipale pour redresser les IFS, et nous leur avons demandé leur avis sur les politiques et les programmes existants susceptibles de réduire les IFS sur leur territoire.

RÉSULTATS : Les répondants percevaient les paliers de gouvernement supérieurs comme ayant une responsabilité plus grande que celle des municipalités à l'égard de la réduction des IFS. L'investissement dans « les parcs et installations de loisir » était considéré comme le levier stratégique le plus prometteur pour redresser les IFS, tandis que « le financement fédéral et provincial insuffisant » était perçu comme le plus grand obstacle à l'action municipale. « Les logements à prix abordable » et « les programmes de loisirs » étaient les stratégies existantes les plus communément citées pour redresser les IFS dans les municipalités échantillonnées.

CONCLUSIONS : Nos constatations font état de préoccupations sur le transfert des responsabilités entre les ordres de gouvernement et d'hypothèses comportementales sur l'étiologie des maladies. Pour promulguer un programme d'équité en santé en milieu urbain, il faut faire davantage d'efforts pour mobiliser et sensibiliser les acteurs municipaux, travaillant dans un éventail de services, à la question des déterminants sociaux des iniquités en santé.

MOTS CLÉS : inégalités; administration municipale; enquêtes de santé; Colombie-Britannique; Canada