Good Governance for Local Environment and Health Decision-Making: Insights from the Saskatoon pilot study

David Noble and Cory Neudorf

Presentation notes

Note:
The following document contains speaking notes for a presentation on the project Good Governance for Local Environment and Health Decision-Making, made March 2, 2009, as part of the Centre for Urban Health Initiatives' (CUHI) Spotlight on Urban Health Seminar Series.

Outline

- Backgrounder and rationale for the project
- Insights from work on the Saskatoon pilot study

Backgrounder and rationale

The idea for the Good Governance project emerged out some work I was doing around public health capacity to manage health risks from climate change. In a series of interviews with MOHs across the country, I asked the question about whether they though they could manage health risks from climate change. And I heard a very common response, something to the effect of:

The role of Public Health is NOT to manage these health risks, it is to inform, and advise, and influence. Decision authority for most of the interventions or risk management activities that we were talking about lay outside of public health, in many cases with local governments.

And so I asked: are you able to adequately able to inform, influence and advise. Invariably, the answer was NO. There was this pervasive sense that public health wasn't always "at the right tables", or "at the right tables at the right time". And though we were initially thinking about health risks from climate change, we quickly realized the fundamental issue here was more widely relevant.

Local governments have decision authorities in respect to various issues like urban planning, transportation, housing, community and social services,

parks and recreation, education, policing, public works, and other areas that play a significant role in shaping the health and well-being of people. Public Health has an important role to play in ensuring that local officials account for public health in their decision-making, but for various reasons, can't fulfill that role to the extent it would like.

This has always been a challenge to some extent, but it has become more of a challenge over the last couple of decades due to some institutional changes that have effectively severed some of the linkages between public health and local government departments have been severed.

Here in Ontario, downloading is an issue. The Ontario Medical Association (OMA, 2005) points out that Bill 152, which was passed in 1997 and allowed for downloading of public health to municipalities, "has had the devastating impact of transferring responsibility for public health to some governing bodies whose employees lack the qualifications, insights, and commitment to public health to make the best strategic choices".

Outside of Ontario, it was regionalization. Health reforms have resulted in the establishment of some form of regional health authority across much of the country... Where there was a municipal public health service,

> *this reassignment removed public health from its important links to local government and, in particular, to local government departments that have an important role to play in improving the living conditions and thus the health of the public.*

There is a problem here. There is a disconnect between local governments, which make all sorts of decisions that can have major implications on health outcomes, and public health, which has the knowledge, expertise and commitment.

That is the problem we sought to better understand and hopefully identify how to redress in some way through the Good Governance project.

One of the first things we learned, even before we had really gotten started in the project, was that this notion of governance was mostly unfamiliar, or at least people had very different interpretations of what it meant or how it was relevant to local public health practice.

What do we mean by governance?

Governance, in an urban context, refers to **the sum of the many ways that individuals and institutions plan and manage** the affairs of the city.

A system of governance has three fundamental components:
- **Institutions**: organizational sites where governance happens, that is, where governing resources are gathered and mobilized
- **Tools of influence**: methods or tools that governors use to control or influence
- **Constraints**: limitations on the actions that governors can take, derived from law, competition (ie. as in a market) or culture (eg. social norms)

"Good governance" reflects a situation that is:
- **good at delivering results** (ie. is efficient and effective), and that
- **delivers results that are deemed good** (ie. are fair, health-promoting).

So we were looking to better understand the system of governance in the context of local environment and health decision-making. How good is it, and how can it be strengthened?

So, notionally, governance is new to local public health practice, but the substance of it is more familiar to practitioners in healthy public policy. Healthy public policy as both an APPROACH to population health that considers the implications of the wider policy and institutional environment on health, or as an ACTION – for example, working on a particular policy. In some ways, our exploration of governance was about the context for action within this approach. What are the sites where we can influence? What are the tools that we can employ? Is our operating environment ENABLING so that we can be successful in this APPROACH and actually create healthy public policies?

There is also much relevance here to the modern healthy cities movement. In a sense, the Healthy Cities initiative offered a framework for implementing healthy public policy at the local level. It was an APPROACH to healthy public policy – a PROCESS that "engages local governments in health development through a process of political commitment, institutional change, capacity building, partnership-based planning and innovative projects".

So, again, this idea of governance seems new and unfamiliar, but we have some experience in thinking and practice focused on the wider context within with more specific public health activities are practiced.

With those ideas in mind, we started to explore the governance context in Saskatoon. Due to a lack of funding, we were unable to undertake the research as we originally envisioned, but we did gain some interesting insights from the work we were able to do.

Insights from the Saskatoon pilot case study

First, when we bore down to the community level, what does the problem look like?

In Saskatoon, there is no systematic way set into to policy to ensure PH is consulted on various issues. We sometimes get invited to things, but often not until the proverbial 11th hour, after much of the substantive decision-making is made. Too much is left to chance.

We completed a couple of workshops with various personnel from Saskatoon Public Health (a department of Saskatoon Health Region (SHR)), Saskatoon Health Region and City of Saskatoon, and completed a series of interviews as well, to gather perspectives on the existing governance context and on how it might be strengthened.

Additional background for readers:

Saskatoon Public Health is a department of Saskatoon Health Region since 1992. Prior to that, it was a department of the City of Saskatoon. This instance of reorganization of Public Health as part of the regional health authority was typical of the wider trend toward regionalization of Public Health across much of the country, and is an important feature of the local governance context.

Since regionalization, some of the linkages between public health and local government departments have been severed. Public Health is not necessarily as integral to municipal government as when it was a municipal department. In many cases, this has detracted from its ability to contribute to healthy public policy.

The Ontario Medical Association (OMA, 2005) points out that Bill 152[1], which was passed in 1997 and allowed for downloading of public health to municipalities, "has had the devastating impact of transferring responsibility

[1] Bill 152, Schedule D, the Services Improvement Act amended the Health Protection and Promotion Act, and allowed for the downloading of public health to the municipalities (OMA, 2005).

for public health to some governing bodies whose employees lack the qualifications, insights, and commitment to public health to make the best strategic choices".

Outside of Ontario,

> *health reforms have resulted in the establishment of some form of regional health authority... Where there was a municipal public health service, this reassignment removed public health from its important links to local government and, in particular, to local government departments that have an important role to play in improving the living conditions and thus the health of the public.*[2]

According to one Dr. Cory Neudorf, MOH with Saskatoon Health Region:

> *We may or may not be consulted on projects and programs that may affect health. When it comes time for public debate, we no longer sit as a member of the staff responding to council's questions; instead, we need to apply to speak from the gallery, and are given our "five minutes just like anyone else". This is bad enough when it comes to issues such as tobacco bylaws, water treatment, and housing inspection issues, but is even more hit and miss when it comes to policy decisions that have environmental impacts.*

We looked at organizational sites where the City and SHR work together. Suffice it to say: there are lots of them. For example: various city advisory committees; the Regional Intersectoral Committee; community-based initiative called Roadmap 2020

We also identified some sites where they didn't really work together in the same way, but which are mutually of interest, and so might be candidates for shared action.

The really interesting example of this relates to SHR being the largest employer in Saskatoon – with around 12,000 employees. These make up a significant population in the community. And so, SHR was thinking in terms of how it could engage its workforce as a very large workplace community. But they went beyond that, and were thinking in terms of how

---

[2] Hancock, T, From public health to the healthy city. In Fowler, P and Siegel D, *eds* (2002). Urban policy issues: Canadian perspectives, 2nd edition. Oxford University Press Canada.

to encourage its staff to play their part at home, in their neighbourhoods, and in the community more generally

And we looked at tools of influence that are being used by City and SHR. Again, suffice it to say: there are lots. For example: policy advocacy, relationships, education, engagement, leading by example

One of the interesting tools that we talked about is the idea of reframing the relationship between SHR and City. You can look at it through different lens, and get different perspectives.

- Public admin – effective and efficient delivery of public goods and services
- Planning – negotiated allocations of public resources
- Exchange relationship – give and take

In Saskatoon, there was an exploration of the idea of SHR as the City's largest industrial partner – how does that change the relationship between City and SHR?

Constraints – We spent less time focused on the various constraints, but as we identified a number of them nonetheless, including many of the usual ones: political pressures, scarce resources for public health and fierce competition for resources between public health and health care, too little time, education and training - "we weren't trained to 'do' governance"

I want to highlight a couple of quite interesting constraints:

One of the project participants indicated: "*we are in this era of administration in which collaboration is expected*". There is this public expectation and peer pressure that tends to encourage collaboration and discourage go-it-alone approaches.

The other constraint relates to the provincial public health legislation, which tends to be prescriptive. It says a lot of 'thou shall' do this and 'thou shall' do that. Combined with either conditional funding or the fact that resources for public health are generally quite few, and it means that you generally do the things that 'thou shall do' and not other things. I think the planning legislation is also somewhat prescriptive, but perhaps not to the same extent.

One of the senior planner's in the City had a quite interesting comment though – "*We are on the front line of issues that are very new to us. They are important to the sustainability of those neighbourhoods, to their integrity... If that's what the neighbourhood needs, ... that is my mission.*"

This approach if very different from responding to what is prescribed in legislation.

The take-away from all of this is that there is a rich system of governance, even if many people never thought of it in those terms – there are sites where are influenced or made, and methods and tools for influencing, and there are all sorts of constraints that limit what both City and SHR can and can't do.

The question is: does this system provide for good governance?

The answer is probably yes, sometimes, in some ways, and to some extent, but there is certainly room for improvement.

There is a clear recognition amongst participants of the opportunity/need to improve on the existing governance context, to the benefit of all. In particular, for a variety of reasons, there is less communication and collaboration between the City and SHR than there might otherwise be.

They developed some ideas for how they could improve communications and collaborations. The figured that a more formalized system for promoting coordination and collaboration would be valuable. More specifically, there was a proposal to have the Boards of the respective organizations meet once a year to agree on common priorities and projects, and then to create various forums for exchange and collaboration between the two organizations at various levels.

SHR really emphasized the desire to align the SHR and City, so that they could then go out and jointly engage the community.

Now interestingly, at the same time we were doing the Good Governance project, SHR was doing a pretty major study on health disparities in and around Saskatoon. The final product was a 350-page report that describes the extent and causes of health disparities, but importantly, presents 46 evidence-based policy options to reduce those disparities.

But before they published the report, they shopped it around to their partners in the City and in the community and elsewhere, to get their buy-in on the work. And they invited letters of support from various people in the community, including the Mayor and all of the councilors and several senior municipal staff as well. When the report was finally released, there was remarkable acceptance of it.

Interestingly, one of the policy options was to increase the City funding to affordable housing. Just BEFORE the report was released, the City doubled its funding for affordable housing. Now there is so much demand for building affordable housing that the bottleneck in the system is in the City's permitting process – they can't process the applications fast enough. And since the report has come, there have been several provincial government initiatives that look remarkably familiar to proposals in the disparities report. The report is unlikely to have had nearly the impact it did were it not for the early engagement with partners on the project and the strong support for it they provided.
DWN