A "Health in All Policies" Evolution in New York City's PlaNYC

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Recommended Citation

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Abstract

Background: Health in All Policies (HiAP) is a framework requiring that the promotion of health be embedded in all substantive policy areas to have a comprehensive approach to the health and well-being of local citizens.

Purpose: To determine the extent to which the Bloomberg Administration in New York City used an HiAP approach to promote attention to health outcomes in peer agencies (outside the Department of Health and Mental Hygiene) within the city bureaucracy.

Methods: Document analysis was completed on a hallmark sustainability plan in New York City, called PlaNYC: the 2007 PlaNYC report, 2011 PlaNYC update, and PlaNYC progress reports from 2008 to 2013. Two coders, using standard qualitative techniques, coded the reports in March and April 2014. The reports were analyzed to gauge the extent to which peer city agencies incorporated health as a policy justification or planned outcome into their initiatives.

Results: The analysis shows that New York City has stimulated attention to health outcomes in peer agencies implicitly more than explicitly, that the extent to which peer agencies reference health has increased over time, and that every policy area in PlaNYC has some stated health relevance and health outcomes. Further, New York City appears to have progressed from early to later stages in the maturity model, indicating embedded HiAP.

Implications: The results illustrate the feasibility of a comprehensive HiAP initiative and could provide inspiration and direction for other jurisdictions.

Keywords

sustainability, health policy, Bloomberg

Cover Page Footnote

INTRODUCTION

During his tenure as mayor of New York City, Michael Bloomberg undertook a series of sweeping health initiatives that, despite controversy, "created a healthier city" according to the *New York Times*. In addition, policies with indirect health relevance were also initiated, such as the city's comprehensive, cross-sector sustainability plan: PlaNYC. Announced in 2007, the 127-initiative plan aims to prepare the city for an additional million residents by 2030 while mitigating the impacts of climate change, and in so doing, "defining what sustainability means to New York City and explaining how everything is interconnected—economic development, the environment, climate, and public health."[1]

According to Gase, Pennotti, and Smith "differences in health care account for as little as 10% of the variability in premature deaths, whereas social, environmental, and behavioral factors account for 60%."[2] Recognizing incidental impacts of non-health policies on public health, many officials now advocate a Health in All Policies (HiAP) approach, by which cross-sector action necessitates attention to health outcomes in peer agencies with other service foci. This study evaluates New York City's sustainability plan by asking: To what extent did New York City use a HiAP approach in PlaNYC?

METHODS

The 2007 PlaNYC report, 2011 PlaNYC update, and PlaNYC progress reports from 2008 to 2013 were coded independently by two reviewers, using standard qualitative techniques and consensus coding. The coding scheme measures attention to health considerations among city agencies in both rhetoric and practice, through two tiers.

The first tier indicated explicit or implicit health justifications and outcomes, and the second tier indicated key characteristics of the maturity model set forth by Storm et al.[3] For the first tier, explicit health relevance was operationalized as any passage justifying a policy with explicit connections linking the policy problem, health determinants, and the health of people. For example, passages relating air pollutants to asthma rates to justify air quality policies were coded as having explicit health relevance. Implicit health relevance was operationalized as policy justifications relating to health determinants, but without explicit language connecting the policy to the health of people, rather it is implied. For example, passages justifying a policy on the basis of cleaner air were coded as having implicit health relevance.

Similarly, direct health outcomes were operationalized as policy outcomes with explicit connections between the policy intervention, health determinants, and the health of people, and indirect health outcomes were operationalized as policy outcomes relating to health determinants, but without explicit connections to the health of people, such as miles of bike lanes installed, or reduction in water contaminants measured. The second tier follows the coding scheme laid out in Storm et al.,[3] which operationalizes six stages of maturity for HiAP at the local government level with 14 key characteristics (Table 1). This model was selected because it evaluates HiAP at the municipal level and was tested on diverse sectors, including environmental and spatial planning, similar to the agencies implementing PlaNYC. Broadly, the model assesses the extent to which health considerations are embedded in government structures and processes.

Table 1. Health in All Policies maturity model stages and key characteristics*

Key Characteristics	Maturity Levels					
	Stage 0 *Unrecognized*	**Stage I** *Recognized*	**Stage II** *Considered*	**Stage III** *Implemented*	**Stage IV** *Integrated*	**Stage V** *Institutionalized*
	There is no specific attention for the problem, in this case the problem of health inequalities.	Municipalities recognize the problem and the solution of HiAP and there is clarity which activities will alleviate the problem.	There are preparatory HiAP actions on parts of the problem.	HiAP investments in several problem areas exist. Non-health sectors are involved in the policy making process as well as in the process of policy implementation to reduce health inequalities.	Quality processes are an integrated part of HiAP.	There is a systematic improvement of HiAP quality and HiAP is considered at every municipal policy cycle.
1 Importance of HiAP recognized to reduce health inequalities 2 Visible which activities of sectors contribute to (determinants of) health inequalities	–	+	+	+	+	+
3 HiAP described in policy documents 4 Collaboration with sectors present (project-based) 5 Collaboration on health inequalities is started 6 Activities of sectors contribute to determinants of health inequalities	–	–	+	+	+	+
7 Concrete collaboration agreements 8 Structural consultation forms present 9 Key person HiAP is present (role is clear) 10 Working from sectors on health inequalities (policy basis)	–	–	–	+	+	+
11 Broad, shared vision on HiAP (political and strategic) 12 HiAP results visible (both content and process)	–	–	–	–	+	+
13 Political and administrative anchoring of the HiAP approach 14 Continuous improvement of integral processes and results on the basis of the achieved results	–	–	–	–	–	+

Adapted from Storm et al.[3]   * darker shading indicates a greater presence of key characteristics

RESULTS

Implicit and Explicit Distribution of Health in All Policies. All of the PlaNYC policy areas—housing, open space, brownfields, water, transportation, energy, air quality, and climate change—had implicit or explicit health relevance, but not all policy areas mentioned indirect or direct health outcomes. Implicit health relevance appeared most frequently in the land policy areas—brownfields, housing, open space, and parks—largely due to efforts to increase recreational spaces. Policies relating to air quality had the second most implicit health relevance and the most explicit health relevance. For this area especially, statements on health relevance and outcomes were more explicit and direct than in other policy areas, likely as a means of political justification.

References to explicit and implicit health relevance, and indirect health outcomes increased over time, while references to direct health outcomes remained the same. In total, there were 322 explicit health references, as compared to 203 counts of implicit health relevance; and 59 direct health outcomes, as compared to 83 indirect. From 2007 to 2013, references to both implicit and explicit health relevance doubled, mentions of direct health outcomes remained the same, and references to indirect health outcomes marginally increased from zero in the first report. The analysis illustrates that health considerations were represented implicitly more than explicitly, that attention to health has increased over time in peer agencies, and that every policy area in PlaNYC has some stated health relevance and health outcomes.

Extent to which PlaNYC Embeds Health in All Policies. Table 2 shows the presence of key characteristics of the maturity model for each report year, with the code count as a proportion of report length, to allow for comparison over time (otherwise longer reports would appear to have greater maturity). For visual ease, cells are shaded relative to the presence of these key characteristics; from the lightest gray at 0.1 through to the darkest at ≥0.6.

PlaNYC exhibits maturation with advanced key characteristics in later years, and the presence of existing characteristics increasing over time. As a notable exception, the 2009 report has high relative presence of key characteristics three through ten. The 2009 progress report focused particularly on efforts to overcome budget problems associated with the 2008 recession; as such, it had greater emphasis on collaboration and inequalities.

Arguably, PlaNYC itself embodies a collaborative, shared vision, though individual initiatives may not. The sustainability indicators demonstrate broad, shared vision on HiAP (Characteristic 11), in that all of the agencies working on the sustainability plan would refer to these benchmarks, and that there was visible progress on content and process (Characteristic 12). In all, the low presence of 11 and 12 when coded seems to be an interesting deviation from what is seen in the overarching approach. Everything considered, New York City appears to have progressed from Stage II to Stage V, indicating embedded HiAP.

IMPLICATIONS

PlaNYC shows unequivocal, overarching development in creating attention to health in peer agencies. Interestingly, PlaNYC did so without much direction from the health department, at least as characterized in reports. New York's HiAP approach matches characterizations set forth

by Gase et al.,[2] and Storm et al.,[3] among others, in that the plan features intersectoral action, explicit consideration of health, proactive change, and serves multiple social goals.

Table 2. Analysis of HiAP maturity model in PlaNYC

Key Characteristics		PlaNYC Report Years						
		2007	2008	2009	2010	2011	2012	2013
1	Importance of HiAP recognized to reduce health inequalities	0.3	0.2	0.5	0.3	0.5	0.6	0.5
2	Visible which activities of sectors contribute to (determinants of) health inequalities							
3	HiAP described in policy documents	0.3	0.2	0.9	0.3	0.7	1.0	0.6
4	Collaboration with sectors present (project-based)							
5	Collaboration on health inequalities is started							
6	Activities of sectors contribute to determinants of health inequalities							
7	Concrete collaboration agreements	0.1	0.4	0.9	0.2	0.5	0.7	0.6
8	Structural consultation forms present							
9	Key person HiAP is present (role is clear)							
10	Working from sectors on health inequalities (policy basis)							
11	Broad, shared vision on HiAP (political and strategic)	0.0	0.0	0.0	0.0	0.2	0.1	0.2
12	HiAP results visible (both content and process)							
13	Political and administrative anchoring of the HiAP approach	0.0	0.4	0.2	0.2	0.5	0.6	0.5
14	Continuous improvement of integral processes and results on the basis of the achieved results							

Many researchers cite the challenge of embedding health into all policies in the long-term.[4] Though PlaNYC is certainly the result of strong political leadership,[1] its focus on creating new bureaucratic structures to implement cross cutting policies could lend institutional durability over time.[5]

LIMITATIONS

Importantly, our sole use of document analysis tends to undercount several important elements of a comprehensive approach to HiAP such as: policies couched within greater economic rather than contextual focus; less-specific policies; universally targeted policies; and/or peer agencies that hire public health experts internally. Use of other techniques, like interviews, may have provided a richer perspective.

SUMMARY BOX

What is already known about this topic? The Health in All Policies approach to policymaking addresses disconnects between traditional health fields and health determinants through strategic, cross-sector collaboration among government agencies, though many researchers cite the challenge of embedding health into all policies in the long term.

What is added by this report? This paper applies a maturity model developed by Storm, Harting, Stronks, and Schuit to assess the development of health in all policies in New York City's sustainability plan over its first 6 years of planning and implementation.

What are the implications for public health practice, policy, and research? The results illustrate the feasibility of a comprehensive HiAP initiative and could provide inspiration for other jurisdictions.

REFERENCES

1. ICLEI. The process behind PlaNYC: How the city of New York developed its comprehensive long-term sustainability plan. ICLEI; Local Governments for Sustainability USA and The Mayor's Office of Long-Term Planning and Sustainability, City of New York, 2010.

2. Gase LN, Pennotti R, Smith KD. "Health in All Policies": Taking stock of emerging practices to incorporate health in decision making in the United States. J Public Health Manag Pract 2013;19(6):529–40. doi: 10.1097/PHH.0b013e3182980c6e.

3. Storm I, Harting J, Stronks K, Schuit AJ. Measuring stages of health in all policies on a local level: The applicability of a maturity model. Health Policy 2014;114(2–3):183–91. doi: 10.1016/j.healthpol.2013.05.006.

4. Greer SL, Lillvis DF. Beyond leadership: Political strategies for coordination in health policies. Health Policy 2014; 116(1):12–7. doi: 10.1016/j.healthpol.2014.01.019.

5. Isett KR, Laugesen MJ, Cloud D. Learning from New York City: A Case Study of Public Health Policy Practice in the Bloomberg Administration. J Public Health Manag Pract 2015 21(4): 313–22. doi: 10.1097/PHH.0000000000000225.