Exploring Peel Region's "Healthy Development Assessment" Healthy Built Environment Tool and Policy-Making Process: Critical Lessons for Future Research and Policy

by

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AUTHOR'S DECLARATION

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners. I understand that my thesis may be made electronically available to the public.

Abstract

The purpose of this thesis is to contribute to the critical literature on "healthy built environment" planning policy-making. It applies the theories of post-politics and policy mobilities against a case study of Peel Region's Healthy Development Assessment, to understand how the concept of "health" is defined and operationalized in practice. Health-based policy tools in planning are a burgeoning area of focus, and one that is becoming particularly influential in Ontario. Peel Region was an early adopter of the initiation of a healthy development tool process to monitor potential health outcomes of private developments. This process began in 2005 and continued until the development of the Healthy Development Checklist in 2016. As a growing field, there is a little research conducted on how "health" is defined in these processes, who gets to define health, and what limitations there are to more broad definitions of health.

This study used qualitative research methods and semi-structured interviews with 11 research participants involved with Peel's policy-making process. The results highlight that with post-politics, there are barriers to the conditions in which policy-making takes place that discipline practitioners from exploring wider definitions of health that are in line with post-political planning: the use of "health" as an empty signifier to advance an uncritical pro-growth agenda that is politically neutral. With policy mobilities, the study explores local contingencies that enabled the strategic advancements Public Health used to insert itself into conversations with decision-makers in planning, transportation and engineering, and to give it a voice that - while defining health more narrowly than preferred - still allowed the

department to be part of the conversation on planning priorities, and positioned to develop its voice in future policy decisions affecting built form. The thesis concludes with recommendations on future research and policy actions.

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Dedication

I dedicate this thesis to my parents, Russ and Irene Godfrey, for believing in my potential throughout life despite many discouraging false starts, wayward paths and dead ends; and to my loves Sarah and Ellis, for whom this work was written.

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Chapter 1

1.0 Introduction

Planning and public health have been increasingly intersecting over the past several decades (Corburn, 2004; Harris et al., 2017; Rydin, 2012). These concerns have been driven by the growing health consequences of urban sprawl development and 'obesogenic environments' – political, socioeconomic, cultural and physical factors that impact health - especially among medical and health professionals (Freestone & Wheeler, 2015). However, up until recent years past studies in planning have neglected the growing importance of health in planning policy tools, despite the enormous evidence supporting the importance of health-based interventions in planning. In addition, public health has an emerging influential direction-setting agenda in planning (Harris et al, 2017; Kent et al., 2018). The design of cities and urban places can create avoidable health iniquities, and critical policy research can bring into sharp relief the difficulties in creating urban environmental justice, especially following the leadership of public health and the Healthy Cities programme (Corburn, 2017; Sarkar, 2014). When planning research and practice examine health within the context of the city, opportunities are opened for exposing barriers to social justice. If the complexities of achieving health-based outcomes in cities are not fully examined, minority and marginalized groups are put at higher risk for potentially life-threatening health conditions that could be prevented through policy and research initiatives (Corburn, 2017).

Prior research has also neglected to conduct case studies evaluating the efficacy of healthy-built environment policy-making and policy tools, and whether these tools have achieved

their goals (de Leeuw, 2011). This is especially true in Ontario where little critical research has been done regarding the ways in which healthy built environment policies are advanced and implemented, raising questions regarding why this is so and what barriers may be in place despite the value of designing our cities to support greater health outcomes and reduce health iniquities.

Peel Region's healthy built environment policy tool - a joint effort between the Region of Peel's planning and public health departments - is one of the first to be implemented in Canada, and therefore offers the opportunity for deep exploration of the decision-making process surrounding its creation and design. The critical insights of post-politics and policy mobilities research can offer a fuller understanding of the politics of the concept of health in planning as it is deployed in practice: the former in describing the post-political landscape in which planners operate; the latter as tool to unpack how planners receive "best practices" and deploy them in local context.

Broader critical theories in planning that place ideas of "health" of urban form and "healthy built environments" within their locus are understudied within the planning literature, despite a strong evidence base for the importance of health-based interventions (Kent et al., 2018). At the same time, despite the growing multiplicity of competing planning concerns, health has re-emerged as an important direction-setting discipline for planning (Corburn, 2013; Freestone & Wheeler, 2015; Kent et al. 2018; Sakar et al. 2014; Thompson, 2015). As planning and public health have begun to join in intersectoral collaboration in some

jurisdictions, Peel Region is a unique example of a close working relationship between planning and public health in designing a policy tool to support a healthier built environment. Understanding how health has been defined and operationalized is important in creating policy tools.

One of the most important global forces linking planning and public health has been the World Health Organization's Healthy Cities Programme (Freestone & Wheeler, 2015), bringing community participation and empowerment, intersectoral partnerships, and participant equity to the fore of city governance (de Leeuw, 2011; WHO, 2019). However, the effectiveness of the Healthy Cities Programme as policy remains to be answered, and as pointed to by de Leeuw, V. (2011), evidence of effectiveness relies upon large-scale controlled trials with highly homogenized control and experimental groups, asking questions such as "Does it work; what is in it for the people; what political gain can be established?" (de Leeuw, 2011, p. 218).

1.1 Planning In Context

It is important to understand how planning practice has evolved over the decades in order to determine the state of current planning practice. Post-war planners envisaged themselves as impartial experts providing counsel to elected representatives with professional planners planning for the public interest with rational, impartial guidance (Campbell & Marshall, 2012). However, this modernist narrative began to unravel in the 1960s as the concept of a

broad, unifying “public” was criticized as having no meaningful definition in a pluralistic society, instead becoming multiple publics with diverse and often competing interests (Davidoff, 1965; Schon, 1983; Scott, 2012). Instead, planning was positioned as a process characterized by some theorists as “muddling through” where desirable mutual outcomes were reached through incremental, mutual adjustments to respective competing interests (Fainstein S., 2010; Lindblom, 1959). The difficulty in defining the public - and therefore the public interest - in the growing pluralism of western democracies deepened, as the plurality of objectives and plurality of politics made it difficult to aspire to unified goals. As well, so too did realizations that a general theory of planning would be insufficient to confront the challenge of “wicked problems” facing planners in defining a general theory of planning (Rittel & Webber, 1973). “Wicked problems” are the opposite of “tame problems”: they are a realization that social policy and its resultant problems are much more difficult to definitively describe and solve than relatively straightforward technical problem-solving exercises, therefore taking the adjective “wicked” to summarize the inability to arrive at definitive or objective answers that seem possible in the natural (and applied) sciences (Rittel & Webber, 1973).

The complication of planning in an increasingly pluralistic society - and the unravelling of the sense of the planners role in defending a stable, agreed upon definition of what is in the public interest during the 60s and 70s - led towards an increasingly normative stance where planners saw their role as ameliorating the most disadvantaged, buoyed by economic growth. The idea of economic growth within this framework also had positive connotations: the

possibility for greater concern for social justice and environmental well-being. However, by the 1980s, and the advent of neoliberal economics reforms and the rollback of the welfare state, economic development began to become a prominent rationale behind planning practice, and so did a growing mandate to promote new investment, jobs and competitiveness (Hackworth, 2007; Sager, 2011). Promoting growth began to challenge the prior planning precepts of reform, regulation and the welfare state, which led to a form of planning where it has been argued that planners became dealmakers rather than regulators. Planning's scope became challenged by planning within a neoliberal system that privileges market-oriented outcomes amidst rising inequality, interlocal competition and increased insecurity (Campbell & Marshall, 2012; Filion et al., 2016; Tasan-Kok, 2012). One method of reintroducing a conception of the public interest has been through the rediscovery of planning's roots in public health, and planning for better health outcomes, as exemplified in the World Health Organization's "Healthy Cities" movement (de Leeuw & Lin, 2017).

Planning's emergence as a formalized discipline came partly from its roots in 19th century public health, architecture, landscape architecture and engineering, though as these disciplines professionalized, planning fragmented and diverged from public health - encapsulated in early 20th debates over planning's role in social justice, and the unequal distribution of urban health vs. efficiency and aesthetics (as represented by the City Beautiful Movement and its discontents) (Corburn, 2009). Local governments required new governance structures to deal with the nascent pressures of industrialization-led population

growth, which had been creating anxieties around poor sanitation, physical and moral ill-health (Hall, 2014).

Planning emerged alongside public health, offering a more holistic consideration of urban environments than had been found in the traditional disciplines of engineering, surveying and architecture (Freestone & Wheeler, 2015). The issue of solving health problems through introducing greater standards for sanitary norms began to solve the former sanitation-driven urban crises, and as this problem found a solution so too did planning and public health begin to diverge (Hebbert 1999; Freestone & Wheeler, 2015). These solutions included open drainage and sewer systems, systemized waste disposal, and public baths constructed to limit contamination, as well as public housing and designed parks and playgrounds (Sarkar, 2015).

Throughout the 20th century, the divergence between public health and planning continued, particularly following the first World War. Public Health followed a largely biomedical model that focused on the health of the individual and modifying human behaviour rather than social determinants to redress health iniquities, while planning sought to distinguish itself as a specialized profession and pursued a direction of specialized technical problems, such as spatial orderliness, convenience, community and aesthetics (Freestone & Wheeler, 2015). As the century progressed, the primary program for planning after the post-war boom was managing market-driven a (Freestone & Wheeler, 2015). Some attempts were made to re-link planning and public health in the 60s, with the WHO being a primary driver, linking

growing research into environmental issues and health-related problems (Freestone & Wheeler, 2015).

One of the trends that would lead to a closer re-establish the links between planning and public health was the New Urbanist movement in the early 1980s, and its advocacy for pedestrian-friendly, transit-oriented neighbourhoods. Similarly, the 'smart growth' movement in the 1990s was another trend that allowed planners to bring new ideas to planning around sustainability and health that countered the conventions around sprawl (Freestone & Wheeler, 2015).

A more complete piece to the reestablishment of links between planning and health was the launch of the WHO's Healthy Cities Programme, started by two health physicians: Trevor Hancock and Leonard Duhl. Its purpose was the raise the profile of issues of public health to the attention of decision-makers (Freestone & Wheeler, 2015). The premise of this movement was to bring focus to the continual improvement of the physical, social and political environments of cities and to bring about the realization of people's maximum potential (Corburn, 2009).

However, as planning has begun to rediscover and incorporate its public health roots, new policy and governance tools that sought to redress public health concerns within planning's traditional ambit began to emerge (Corburn, 2009; de Leeuw & Lin, 2017). Alongside this re-engagement with public health have been questions relating to how health is defined in

planning, who defines health, and how cities are reproduced according to this definition of health. This questioning has a long-standing history in fields outside of planning, in particular within medical literature (Leonardi, 2018) where definitions of health swung between definitions built upon narrowly defined, technology-based medical and public health interventions; and definitions of health as a social phenomenon, requiring complex intersectoral policy actions (Solar & Irwin, 2010); but only more relatively recently have these concerns begun filtering into planning debates through the World Health Organization's "Healthy Cities" movement which began in 1987, a long-term development project to put health on the agenda of cities (Barton, 2000; Tsouros, 1995). The Healthy City was defined through this programme as "one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and developing to their maximum potential" (WHO, 1998 p. 13).

One prominent direction in planning for the public interest in Ontario has been this re-establishment of links between public health and planning (CIP, 2010; Miro, et al. 2015; OPPI, 2007) and framing the city as a structural determinant in health through its formal and informal institutions (Corburn, 2017). While the benefits of healthy cities are apparent, the influence of local decision-making and the importance of place on circulating or preventing best practices for developing better cities is an understudied phenomenon. Two occasionally overlapping research agendas - post-politics and policy mobilities - are recent approaches to providing critical understanding of the barriers to advancing more progressive health

outcomes, clarifying the planner's role in constructing urban governance regimes and urban spaces within the current political landscape.

1.2 Post-Politics & Policy Mobilities

Policy Mobilities is concerned with the tracing of sites and the movements of policies as they cross boundaries and are implemented locally. This trend had been linked to the rise of neoliberal globalization, and is often used to analyze urban policies that have a transnational appeal and origins. Local policy choices are described in this literature as composed of policy borrowings that are drawn from wider policy flows in order to serve certain purposes and for certain reasons, predicated upon relations of power and local factors that support the choices of what to adopt and for what reasons (McCann & Ward, 2013; Temenos & McCann, 2013; Temenos & Baker, 2015). This resonates with Peel Region, and its seeming adoption and mutation of a healthy built environment tool in the form of an adapted HIA.

Post-politics focuses on the suppression of democratic choice beneath technocratic decision-making that removes or defers the possibility of true political disagreement to a managed status quo that leans towards a neoliberal pro-growth agenda, and sheds light on the political-economic considerations that may hinder planning decisions (Beckett, 2018).

As health in planning policy tools become operationalized, the politics surrounding the decision-making behind how these tools are created and deployed is a phenomenon worth

studying to better understand barriers to more progressive application of healthy-built environment planning tools.

Research on post-politics and the post-political condition have looked at the governance and policy-making process of planning subjects ranging from urban regeneration, (Baeten, 2009), the structure of the UK planning system (e.g. Allmendinger & Haughton, 2012, 2015), urban discourse (Tunström & Bradley, 2014) mega project development (Legacy, 2015; Neo, 2010; Raco, 2014a), Football- related city branding (Makarychev & Yatsyk, 2014), 'Big Box' retail development (Rosol, 2014), 'ghost estates' (O'Callaghan et al, 2014), new urbanist developments (MacLeod, 2013) and sustainability-related Regional development policies (Hilding-Rydevik et al, 2011).

However, there is a gap within the post-political literature on studies that examines the politics of decision-making regarding healthy built environment related development and planning tools, and how the influence of the post-political condition may be affecting planning outcomes. This is especially true in the context of Ontario, where there is a lack of critical policy studies on the emerging prominence of health planning tools. Similarly, in the policy mobilities literature, there is a gap in studying the movement and influence of healthy built environment policies distilled from international policy networks, specifically the healthy cities movement and the WHO's Health Impact Assessment (HIA). This gap seemingly exists because of the relative newness of public health and planning joining together in collaborative efforts in recent decades.

Moreover, there is a gap in exploring how this policy was drawn from wider policy circuits and implemented in Peel Region, and what sorts of work was involved in this process. Case studies of policy mobilities research have ranged across a number of subjects, from policy tourism (Cook, Ward & Ward 2014; Cook, 2017; Gonzalez, 2010), smart cities (Crivello, 2015), to green urbanism (McCann, 2017). However, there is a gap in using case study methodology in analyzing healthy cities/healthy built environment policies, especially as they are operationalized at the local level once drawn from broader policy networks. This gap is significant because of the growing importance of health in planning, as it shifts towards a more primary focus of planning practice. As an example, OPPI have put out numerous documents emphasizing the importance of health in planning, recently issuing "Healthy Communities and Planning for the Public Realm: Call to Action" (OPPI 2016a). Similarly, the Canadian Institute of Planners recently issued "Policy on Healthy Communities Planning" (CIP 2018). This highlights how the practice of health in planning is growing in significance and moving into planning's parlance.

This studies offer critical tools to better understand the policy-making process and how Peel Region's healthy built environment policy tool came to be adopted, and what has limited its scope in consideration of health concerns.

1.3 Research Questions and Objectives

This thesis uses Peel Region's policy-making process as a case study to gain insight into the planning process and operationalization of health. Given the continual need for planners to re-evaluate their role in planning processes and social outcomes, this thesis addresses the question: *What influences led to the creation of Peel Region's Healthy Development Assessment tool?*

These influences range from best practices, to institutional influences, place, local history and other contingencies that may have affected the development the policy-making process.

1.4 Implications For Planning

This research may provide insight into the reflexive practice of planning, what Donald Schon calls "reflection-in-action", where planners are forced to make quick decisions as they navigate a terrain of being spokespeople, strategists or technical staff for interest groups participating in the regulatory process, while creating policies seemingly off-the-cuff (Schon, 1984). Understanding broader political trends and trajectories could help the practicing planner gain insight into their own processes and pursue normative outcomes in a difficult landscape constrained by levers of power beyond the practice's competencies. In particular, in being critical of the 'all things to everyone' definitions of terms like 'health' - without cross-pollinating that definition with a finer grained approach to the 'who' and 'where' targeted by these broad definitions of 'health' - could help planners find more exacting tools

and definitions. In addition, this study also offers suggestions for operationalizing solutions to bring broader health policies into action.

1.5 Thesis Outline

The structure of the thesis presents the Introduction, followed by a thesis, concluding with the main findings. Summaries of the sections of this thesis are provided below, with the ethics package, and coding scheme found in the appendices.

Chapter 1: Overview

The overview situates health in planning within the broader space of planning theory. This section also introduces Peel Region as the case study, and the rationale for choosing it as a focus of attention.

Chapter 2: Literature Review

This section introduces the Healthy Development Assessment, and the literature review section situates this research within the broader mobilities paradigm, aligning it with policy mobilities' critique of policy studies, as well as the post-politics literature.

Chapter 3: Research Methodology

This section discusses the qualitative, exploratory case study research design, and the justification for chosen methodology.

Chapter 4: Results and Findings

This presents the results from the interviews and document analysis. It then presents a summary of the findings of the results, situating them within the post-politics and policy mobilities literatures and confirming or contradicting those literatures precepts.

Chapter 5: Conclusions and Recommendations

This section presents the summary of key findings of the research; contribution to planning by this study; the limitations of the study; future research directions; and a conclusion.

Chapter 2
2.0 Literature Review

2.1 Why urban policy?

Within the hierarchy of political jurisdictions in Canada, the question "how much does urban policy matter?" arises. Whether or not urban policy matters comments on what the outcomes of that policy have on the well-being of the population under the jurisdiction of that local government (Wolman, 2012). Local policy analysis has received comparatively less focus than federal and provincial policy making, and therefore less is known about the effects of local policy on well-being, with there being in particular a lack of comparative studies to lead to broader generalizations of local policy-making outcomes (Henstra, 2015; Wolman, 2012). Similarly, there is a gap in how and why land-use governance regimes take on health concerns within the planning process (Harris et al., 2015).

2.2 Policy Transfer & Policy Mobilities

Policy mobilities is an emerging research agenda that offers a way of understanding the ongoing practices, institutions and ideas in the formulation and application of local urban policy; the why, how and what of decision-making around policy formulation. It does so by unpacking the creation and influences of local policy decisions, (Temenos & McCann, 2013, p. 345). This literature assumes a constructivist epistemology, in contrast to policy literatures - particularly in studies of policy transfer - that often assume a positivist epistemology

(McCann & Ward, 2012; Marsh & Evans, 2012). Epistemological constructivism posits that there could be an external reality independent of a subjective construction of it, but that it is impossible to know that reality unless through those constructions. Studying those constructions therefore is necessary to understand something about the world (Coghlan & Brydon-Miller, 2014). This contrasts with positivist epistemology, which states that there is an objective reality that exists, and it has a universal, essentialist nature that is experienced by everyone in the same way (Coghlan & Brydon-Miller, 2014).

The policy mobilities literature can generate insights about the importation of policies that come from international policy streams - such as Peel's seeming adoption and mutation of an HIA- and the factors at play when these tools are adapted locally. This research stream that seemingly resonates with Peel Region's Healthy Development Assessment, which initially was based upon similarities to the more common HIA but changed during formulation implementation. This is especially insightful for the Healthy Development Assessment, as it is a policy in the process of becoming: it has shifted and continually shifts across policy cycles and is not yet a mandatory policy required of the development process (Peel Region, 2019).

The broader 'mobilities' literature developed from the work of a small group of British researchers, and primarily the work of Mimi Sheller and John Urry (2005). The mobilities turn in social sciences concerned with examining the "constitutive role of movement within the workings of most social institutions and social practices." (Sheller & Urry, 2016). These

relationships contain varied connections that may be either at a distance or face-to-face. It also focuses on the complex combinations of the different modes of mobilities. These can range from “corporeal travel of people; physical movement of objects; virtual travel often in real-time transcending distance; communicative travel through person-to-person messages; and imaginative travel” (Sheller & Urry, 2016 p. 11). Social institutions and practices are implicitly “contingent assemblies” of these different manifestations of mobility (Sheller & Urry, 2016 p. 11).

As well, mobilities encourage unique research practices in order to capture and represent the different types of mobilities movement and related practices and institutions. Mobile methods utilize diverse research approaches that include both qualitative and quantitative methods, as well as visual and experimental approaches (Sheller & Urry, 2016). The mobilities research agenda implies a complex assembly of both movements and “moorings” - or “immobile infrastructures” - within these mobility forms. Mobilities are organized in and through systems and these mobility systems assume “immobile infrastructures” where things happen (Sheller & Urry, 2016 p. 12). This stream also highlights how social practices can emerge through “unintended consequences” that result from how these systems are used, combined and innovated. Finally, mobilities paradigm questions the idea of “space” as a container for social processes, and involves analysing “networks, relations, flows and circulation, and not fixed places” (Sheller & Urry, 2016 p. 12).

Policy mobilities then grew from the mobilities approach as a critique of "policy transfer", a policy studies research field from within orthodox political science literature that is defined broadly as "a process in which knowledge about policies, administrative arrangements, institutions etc. in one time and/or place is used in the development of policies, administrative arrangements and institutions in another time and/or place" (Dolowitz & Marsh, 1996). This field developed from the increasing internationalization of the world economy as national jurisdictions became more intertwined by technologies of communication and connection with various "elsewheres", which created new opportunities for learning from the policy experiences of others (Howlett et al., 2009; Marsh & Evans, 2012).

Researchers within policy transfer largely operate within a realist ontological and a positivist or critical realist epistemological position (Marsh & Evans, 2012). Policy-making as studied within the "policy transfer" approach looks at accounts of "rationally selected best (or better) practices moving across jurisdictional lines", and considers the movement of these policies as transactions or transfers conducted by rational actors hemmed only by the constraints of bounded-rationality (Peck & Theodore, 2015, p. 6).

Policy mobilities researchers draw from the mobilities paradigm, and as a critique of policy transfer, to study the movement of policy best practices to reveal the explanatory social practices and infrastructures that enable and sustain the movement of policies. In doing so, this work unpacks the multiplicities and socio-spatial complexities of these policy

movements and how and why they move where they move. Policy mobilities researchers understand these movements as power-laden social processes full of contingencies, course corrections and adaptations that imprint themselves upon these moving policies as they cross spatialities (McCann & Ward, 2013; Pecker & Theodore, 2015; Temenos, & Baker, 2015).

Moreover, the policy mobilities approach also analyzes policy invention as part of this economy of policy ideas. Critically, policies in this sense are not imported off-the-shelf as fully-formed, stable objects as depicted in policy mobilities' critique of policy transfer literature, but are instead "assemblages" (Baker et al., 2016; McCann & Ward, 2013). The concept of "assemblage" is a complex, slippery term deployed in order to incorporate questions of structure, agency and contingency in an existing policy.

An "assemblage" can be variously defined as "a gathering of heterogeneous elements consistently drawn together as an identifiable terrain of action and debate" (Baker & McGuirk, 2017 p. 428) and "human and non-human materials arranged through the active but often unpredictable manipulation of those materials and often narrativised as an organic whole" (Prince 2016 9. 336). In short, an assemblage creates the thing under research that has been narrativized by actors into a particular policy. Peel Region's resultant "Healthy Development Assessment" would be considered such an assemblage; as in an operationalized form it becomes narrativized by its creators and subsequently a 'thing' that can be observed and studied. Studying assemblages is to seek to place the policy in an empirically rich

account of the contexts in which they take place and how and by whom they are created (Baker, & McGuirk, 2017).

In addition, an assemblage is also processual; an observation that uncovers the processes of "arranging, organizing, fitting together of disparate actors, objects, techniques, organizations, representations" (Baker & McGuirk, 2017, p. 431). As a process, an assemblage is provisional and always morphing under the influence of changing relations, the addition or removal of elements, but always in a process of becoming. Assemblage thinking interrogates how this works, and the machinery underneath (Baker & McGuirk, 2017). Third: assemblage thinking uncovers the labours of assembling, with the understanding that policy requires labour and it is through that continued labour of human effort that policy-making is conducted. Assemblage methodologies analyze how those actors are advantaged or disadvantaged within their respective contexts, and how they are able to mobilize resources to facilitate change (Baker & McGuirk, 2017). Finally, assemblage thinking is committed to an auto-critical disposition and methodological openness and flexibility: an approach that opens the research process to uncertainty, risk, and acknowledges the underlying fragility within an assemblage's construction (Baker & McGuirk, 2017). The three factors in assemblage thinking, namely multiple logics, processuality and labours, were key in informing the coding for policy mobilities.

These pieces are then assembled in particular ways and for particular interests and purposes, and research unpacks those purposes to provide a clearer understanding of the limitations of

progressive policy-making (Baker, et al. 2016; McCann & Ward, 2013). Landed policies grow from and derive their legitimacy from pre-existing constructions and the accompanying assemblages of actors, processes and technologies that help it become an object of study - or a "spatialized social formation" - which are the key to constructing what is understood as legitimate and appropriate policy knowledge (Temenos & Baker, 2015 p 842). It is not a clear transfer of a policy from another site, but is instead always an emerging process, based in practice, and composed of dissimilar elements and parts (Baker & McGuirk, 2017).

2.3 Critiques of the Policy Mobilities Approach

However, some aspects of the policy mobilities approach (Peck, 2011) have been critiqued as focusing too strongly on the explanatory power of neoliberal political economic transformation and state restructuring (Bunnell T., 2015) and resulted in methodological circularity (Jacobs, J. 2012): in looking for the presence of neoliberal processes, more complicated histories and trajectories may be overlooked, and in looking for policy presence of neoliberalism then the research is liable to find only the presence of that neoliberalism (Bunnell, 2015; Jacobs, 2012). In an example showing the relevance of this point, Clarke, N. (2012) points to the work of Georges Saunier's historical study of the Transnational Municipal Movement as an historical method of exchanging best practices in urban policy before the advent of neoliberalism, pointing out that urban policy circulations are not solely the result of neoliberalism - as though nothing existed before.

As well, focusing solely on policy successes may miss out on the various gradations within policy-making, such as policy failures or policy course corrections (Jacobs, 2012). Stein, C. et al. (2017) builds on this point and argues that it is more instructive to study failed policy mobilities, as those constraints and resistances that prevent policy mobilization underscore the different social contexts within each territory, and can offer a more nuanced view of how neoliberalism manifests; that a seemingly vital policy of neoliberalism in one area can be opposed by agents of neoliberalism in another. Neoliberalism is broadly the rejection of the Keynesian welfare and egalitarian liberalism, where the government's only role is the protection of free exchange. It is an ideology that has led to the dismantling of the welfare state and the push to advance market discipline, competition and commodification throughout society, and the value placed upon (Hackworth, 2007; Peck et al., 2009; Peck et al., 2013).

Local contingencies - described as events related by chance or accident, or as a more complex way through a sequence of incidents or processes (Olsen, 2012) - that seemingly operate in contrast to the assumed precepts of neoliberalism, offer a richer understanding of conditioning environments: the local histories, local dynamics, and qualities of place that affect the circulation of urban policies . In studying the failure of a policy, it is possible to uncover the complex and contradictory processes (Stein, 2017), undermining the idea that neoliberalism is a hegemonic linear process (Peck et al., 2013), but instead an uneven, irregular one.

More recently, policy mobilities researchers have sought to analyze "how" policies are mobilized and territorialized, the labour that is involved in the construction, circulation and translation of a mobile policy's territorialisation, and the 'conditioning fields' that enable a policy's grounding (Cook et al., 2015). Robinson, J. (2015), proposes that instead of tracing what is moving when a policy circulates, to instead investigate *how* policymakers compose and receive their ideas, and the labours involved in policy-making. This is a key rationale for this study and the case study of Peel, and how the Region arrived at the policy tool it did.

Expanding on the "how" of policy construction, McCann, E. (2017) has argued that urban built environments are the product of labour, and that the purpose of policy mobilities research is to pay attention to the labour of assembling and reassembling the sociomaterial practices that make up urban regimes: the buildings, infrastructures, and policies (McCann, 2017). The labour of these innovations is the intellectual, practical, and political acts that require the compelling storytelling of policy-making, and attempts to make abstract, incommensurable things - like sustainability or health - commensurable, which involves the labour of metric-making and market-making, the creation of comparative technologies, and competitions about data, details, and expertise. Policy-making is this sense is part experiment, and relies upon combination and circulations of ideas, and is a process that is always unfolding, contingent and dynamic, never staying still long enough to be a singular, unified object (McCann, 2017).

Case studies of policy mobilities research have ranged across a number of subjects. These have addressed historical policy tourism (Cook, 2017; Cook, Ward & Ward 2014) (Gonzalez, 2010), smart cities (Crivello, 2015), creative cities and ad hoc networks (Cohen 2014), policy-making in decentralized Indonesia (Phelps et al., 2014), heritage policy in Hong Kong (Barber, 2014), Growth and Development Strategy in Johannesburg (Robinson, 2015) moving towards "world city" status (Bunnell 2015), New South Wales' "Housing First" model (Baker & McGuirk, 2017), corporate policy mobilization (Bok & Coe, 2017), public health drug strategies (McCann 2008), urban policy in the OECD zone (Theodore & Peck, 2011), Business Improvement Districts (Stein, C. et al., 2015) and green urbanism (McCann, 2017).

However, there is a gap in the literature in "healthy built environment" policies distilled from international policy networks, specifically the "healthy cities" movement and the WHO's HIA. Moreover, there is a gap in exploring "how" this policy was drawn from wider policy circuits and implemented in Peel Region, and what sorts of labours were involved in this process. Peel Region is a key case study in this literature as it regarded itself as an innovator in distilling and adopting a healthy built environment tool, and one of the first to explicitly do so in Ontario.

2.4 Post-Politics

In recent years, there has been growing literature on a "post-political moment" in planning (Allmendinger, 2017; Allmendinger & Haughton, 2012; MacLeod, 2013), and in geography

(Clarke, 2012; Fuller, 2013; Kennedy 2016; MacLeod, 2011; MacLeod & Jones, 2011; McCann, 2017; Rancière, 2001; Swyngedouw, 2011), and its analysis of the politics and decision-making of urban governance. It is largely based upon the work of theorists Slavoj Žižek, Jacques Rancière and Chantal Mouffe (Mouffe, 2005; Rancière, 2006; Žižek, 1999).

This body of literature posits that public policy has become non-ideological and diminished to questions of science and technology at the expense of conversations about value and priority: in short, avoiding bubbling conflict and presenting a surface consensualism that has been linked to the contemporary drive towards right-wing populism (Clarke, 2012; Mouffe, 2005). As planning is political and necessarily about political decisions, it is implicated in this process, and in order for urban policy-making to be a more fulsome process - it is argued - municipalities as democracies must be more than a negotiation between local politicians, staff, national or international politicians, bureaucrats, consultants and researchers: they must also involve local citizens, groups, movements and organizations and involve dissent and debate (Clarke, 2012b, p. 34; Kennedy, 2016). Clarke, N. (2012) has argued that it is post-politics that sustains the mobility of policies across political boundaries and shapes the resultant policy formations.

The following is a short introduction to understanding the basics of post-politics to provide clearer context for this point, and then how it manifests in planning. The post-political condition is characterized by a distinction between ‘the political’ on one hand, and ‘politics’ on the other: mutually exclusive states. In this sense, ‘the political’ is the opening up of

possibilities and alternatives that must arise in any society over choices of political futures (Ranciere, J. 2004). Another way of defining the political is as a "democratic agonistic struggle over the content and direction of socio-ecological life" (Swyngedouw, 2010 p 225). Finally, the political can be understood as "the space of power, conflict and antagonism within human societies" (Mouffe, p 9). The disagreement or struggle of the 'political' is not merely a dispute over the solutions to a situation, but rather a dispute over the nature of the situation itself and the spectrum of possibilities and alternatives to it (Rancière, 2004).

In contrast to the understanding of 'the political' as the raw force of alternative ways of doing things, 'politics' is merely the power play between political actors within the established system, and the routine choreographies of policy-making within that tamed and safe institutional and procedural configuration (Allmendinger, 2017). 'Politics' is the dynamics of power between these political actors within this existing institutional configuration and the attempt to enclose, reduce, and institutionalize the social field into a reductionist singular. This reductionist singular is located in narrowing terms such as 'the community', 'the people', 'partnership', 'governance', 'consensus' and are used to create the appropriate arenas for the proper doing of 'politics' (Allmendinger, 2017).

By its nature, 'politics' seeks to reduce 'the political', and the emergent possibilities contained within the unfolding of 'the political.' Complex political demands are reduced to safe technocratic exercises, managed by experts, and transformed into technocratic project outcomes that convert social and economic processes into discernible objects. Once

converted, these objects can then be more easily managed, accounted for, and contractualised. These in turn can be contracted out to actors with specialized expertise in order to implement new models of policy, which in turn create new elite networks of private actors that manage contracts aligned with positive, all-embracing concepts that are hard to disagree with by people outside the process, especially once those all-encompassing, fuzzy terms have been defined and operationalized (Allmendinger, 2017; Raco, 2014). An example is the term "sustainability" which has been broadened and watered-down.

Within the post-political public space, frames of consensus are formed around a neoliberal governance regime. Neoliberalism in this sense is an extension of market values into all institutions and social actions, in addition to being a set of economic policies favouring lowering trade barriers, promoting competitiveness and foreign investment, and deregulating and shrinking the nation state (Wilson & Swyngedouw 2015). The conflict over possibilities of this state of things is deferred through the use of vague and positive objectives, such as "sustainability" or "the creative city", or partnership-led approaches based upon consensus (Allmendinger, 2017; McCann, 2017; Swyngedouw, 2009). Managerial logic and expert opinion define the parameters of "proper" political participation, and participation for those with conflicting views is minimized by framing debates in technical terms - expert reports, indicators - while appearing to expand involvement (light public consultation meetings) and making appeals for consensus over pre-defined choices (Allmendinger, 2017; Allmendinger & Haughton, 2012; McCann, 2017; Swyngedouw, 2010).

With the shift towards post-political, Allmendinger (2017) is heavily critical of the current nature of a trend in planning and notes five points that have begun to characterize contemporary planning practice in order identify its qualities that link it with post-political theory. The first characteristic is a broadening and fuzzying of planning objectives, following which is a vagueness over what planning is able to achieve. This shift is intentional, as this vagueness blunts opposition to uncritical pro-growth neoliberal narratives by creating ambiguous objectives such as "sustainable development" (Allmendinger, 2017 p. 207).

The second characteristic is the shift from more openly antagonistic politics preceding the advent of Thatcher/Reagan/neoliberalism to consensus-based politics: creating consensus around growth and planning's role in delivering it and presenting choice but not around the consensus supporting growth and competitiveness. The third shift concerns the nature of planning and professional self-identity, as the nature of the profession shifted from reactive regulation to proactive facilitation, using an increasing 'empty signifier' vagueness that does little to present alternatives to an uncritical pro-growth consensus. This is described by Allmendinger as leading to a diminution of trust and confidence in planning and planners, as serious political questions remain but are hidden within the managed processes. A fourth shift into post-political planning is the adoption of managerialism and managerial tools that transform political questions into technical ones. The fifth shift is the intensification on delivery, and the search for tools and strategies that find cheaper systems to provide greater certainty around development strategies and decisions (Allmendinger, 2017 p. 209-210).

Whether or not this critique is substantiated in the findings, aspects may shed light on the constraints throughout the planning process. Moreover, it may help understand how 'health' is defined in the contemporary city, and what parameters are deemed appropriate for defining health within a pervading neoliberal landscape that has removed spaces of true political dissent over the order of things. In this way, proper political choice over defining health would be described by Chantal Mouffe as an 'agonistic confrontation' where competing visions of a different socio-ecological order are allowed to clash. In her view, the inclusion of this antagonistic conflict without violence is crucial to channeling the emergence of right-wing populism, and the hardening of non-negotiable ethnic, religious and nationalist identities (Mouffe 2005). This political antagonism is foreclosed through the creation of choices that can be 'managed' through dialogical consensual practices (Mouffe, 2005; Swyngedouw, 2010).

Post-political researchers instead would argue that alternative formulations of problems and solutions must be achieved through agonistic, conflictual engagement across markedly differing perspectives, and that political processes must be designed to offer this possibility (McCann, 2017; Mouffe, 2004). In contrast, the communicative or collaborative planning model (Forester, 1989; Healey, 1993, 1996, 1997; Innes & Booher, 2010), by suppressing this conflict, risks its emergence with more force at a later date. As is being borne out by current events, the rise of right-wing populist parties across the Western liberal democracies, formed around nationalist, ethnic and religious identity, (Nagan & Manausa, 2018) is making

the agonistic model of post-politics more prescient in its prediction of the consequences of exclusion. And so, while not being a cause of this nascent suppressed anger, how the right to health of the city is defined by policy-makers using models of decision-making that remove the political dimensions of defining health: the value and priority over what that means, and the varied ways health can and has been defined.

2.5 Health Impact Assessment

The HIA was developed in the World Health Organization headquarters throughout the 1980s and 90s out of a need to control vector-borne diseases without the use of chemical means for water projects (Dora, 2013 p 286). Over the past three decades, the HIA has matured and been used to influence the development of public policy outside the health sector (Harris, 2014) and its methods and approaches have expanded (Roxas-Harris et al., 2012). While sharing some superficial similarities to the Environmental Impact Assessment (EIA), the HIA has a distinct evolution growing out of public health professional movements aimed at promoting health at the policy level, as well as ameliorating health impacts. The distinct strands that emerged with HIA are “environmental health”, “the wider determinants of health” and “health equity”: all three are linked by a broader though generally incremental engagement by the public health sector with non-health sector activities. (Harris-Roxas et al., 2012).

A Health Impact Assessment (HIA) has also been variously defined as a method that "seeks to estimate the probable impact of a policy or intervention in non-health sectors, such as agriculture, transportation, and economic development, on the health of the population." (Brownson 2010, pg. 16). A Health Impact Assessment (HIA) is also defined as "systematic, evidence-based decision support tool that considers how a proposal may alter the determinants of health prior to implementation and recommends changes to enhance positive and mitigate negative impacts" (Pennington 2017, pg.56). Key to the definitions of the HIA are two essential features:

- To predict the future consequences of health if possible decisions
- To inform decision-making (Kemm, 2013).

2.6 Summary

In summary, urban policy outcomes are comparatively less research than federal and provincial policy. Policy mobilities and post-politics are research concepts that offer critical insights into the policy making process, in particular into the understudied healthy-built environment policy-making landscape. This field of practice is particularly relevant given the growing importance of healthy planning policies.

Policy mobilities is concerned with the movement of urban policies across jurisdictions from international sources and the how and why of those policy movements. It builds off of earlier

mobilities research, as a critical tool for unpacking the increasing fluidity of social institutions in an increasingly globalized world. Post-politics looks at the decision-making around local politics, and the dominance of an ascendant apolitical neoliberalism in determining planning outcomes. Both provide insight into the planning process, especially the decision-making of planning policy tools. However, both have not been applied to healthy-built environment policies, offering the opportunity to provide critical insight into an understudied phenomenon in Ontario that has been growing in significance within planning practice. The next chapter will discuss the research methodology used to answer the proposed research question.

Chapter 3
Research Methodology

3.1 Introduction

When designing a research program, it is necessary to make explicit how knowledge is created and processed. The following chapter will outline the research methodology followed for this thesis. I sought to better understand the factors and influences that can be discerned in the final product, which is Peel Region's HDA (2016). In order to unpack those influences, an exploratory case study approach was used to examine the healthy-built environment policy-making process in Peel Region.

In 2005, Peel Region began the process of searching an evidence-based tool to aid in identifying potential health impacts from built form and development, resulting in 2016's Healthy Development Assessment. This study of Peel Region's Healthy Development Assessment tool and the policy-making process seeks to uncover how and why a seeming 'Health Impact Assessment' was arrived at and what influences, local factors and course corrections influenced the creation of the tool. This is a crucial subject of study, as health and healthy cities are becoming an influential turn in planning (OPPI, 2007; CIP, 2010; Miro et al. 2015), and the emergence of healthy built environmental policy tools is an understudied phenomenon at a time when planning and public health departments are increasingly joining in intersectoral collaborations over shared goals in health (OPPI, 2014; OPPI, 2016). Key is the way in which health is defined in these emerging policy tools, and how to study the

effectiveness of these tools, as well as political barriers that must be resolved in order to provide for more holistic definitions of health.

3.2 Research Setting: Introducing Peel Region and Peel Region's Healthy Development Assessment

This master's thesis presents a case study of Peel Region's "Healthy Development Assessment" tool. In particular, this study is focused on Peel Region's decision-making process, and what influenced the policy process, led to Peel's definition of "health", and how it was deployed and mutated throughout the policy process.

In 2005, Peel Region began the process of designing a tool to control development applications to ensure healthier built form and better health outcomes for the population-at-large, as well as to mitigate high rates of diabetes among the South Asian population (Moloughney, et al. 2014). This was the first tool to have been adopted in Ontario (Dunn, 2009). The eventual policy-making process resulted in the development of the Healthy Development Assessment, a proposed development checklist for new housing developments (Peel Region, 2016). This process would result in a closer working partnership between Peel's planning and public health departments and the inclusion of health and health outcomes within a planning framework, which resonates with one of the main tenets of WHO's Healthy Cities: intersectoral partnerships (WHO 2019a).

Peel Region is a municipality within the Greater Toronto Area, and second largest municipality by population in Ontario after Toronto, at 1,296,809 million to Toronto's 2,731,571 million (Statistics Canada 2016d). It comprises three lower-tier municipalities: Mississauga (population 721,599), Brampton (593,638) and Caledon (66,502). Mississauga represents 52.2% of Peel's population, where Brampton and Caledon represent 43.0% and 4.8%, though both Brampton and Caledon saw the highest share of Peel's population increase between 1996-2016 (Statistics Canada 1996; Statistics Canada, 2016). The population figures are represented in Table 1:

Table 1

Population of Peel Region

Population	**1996**	**2016**	**% Change**
Peel Region	852,525	1,381,739	62%
Brampton	268,250	593,638	121%
Caledon	39,890	66,502	67%
Mississauga	544,380	721,599	33%

(Statistics Canada 2006; Statistics Canada 2006a; Statistics Canada 2006b; Statistics Canada 2016a; Statistics Canada 2016b; Statistics Canada 2016c; Statistics Canada 2016d)

Peel Region's population is also diverse, with 51.5% of Peel's population immigrants, which has more than doubled since 1996 by 108.3%. As well, Peel has the highest percentage of visible minorities in the Greater Toronto Area. This number is particularly high in Brampton, where 73.3% of the population are visible minorities (Peel Region, 2017). This is depicted in Table 2:

Table 2

Visible Minorities in the GTA

	Percentage
Durham	27.1%
Halton	25.7%
Peel	62.3%
Toronto	51.5%
York	49.2%

(Peel Region, 2017)

Within this diverse population, the largest share of Peel's immigrant population is South Asian, the largest and second largest coming from Indian and Pakistan respectively:

Table 3

Countries of Birth for Peel Immigrants

1. India	25.7%
2. Pakistan	7.8%
3. Philippines	6.1%
4. Jamaica	5.0%
5. China	3.7%
6. Poland	3.7%
7.United Kingdom	3.0%
8. Sri Lanka	3.0%
9. Portugal	3.0%
10. Guyana	3.0%

(Statistics Canada, 2016d)

Peel Region's economic activity is largely made up of service jobs, representing 86.7% of businesses in Peel, compared with around 12% goods producing businesses (Statistics Canada, 2016).

Table 4

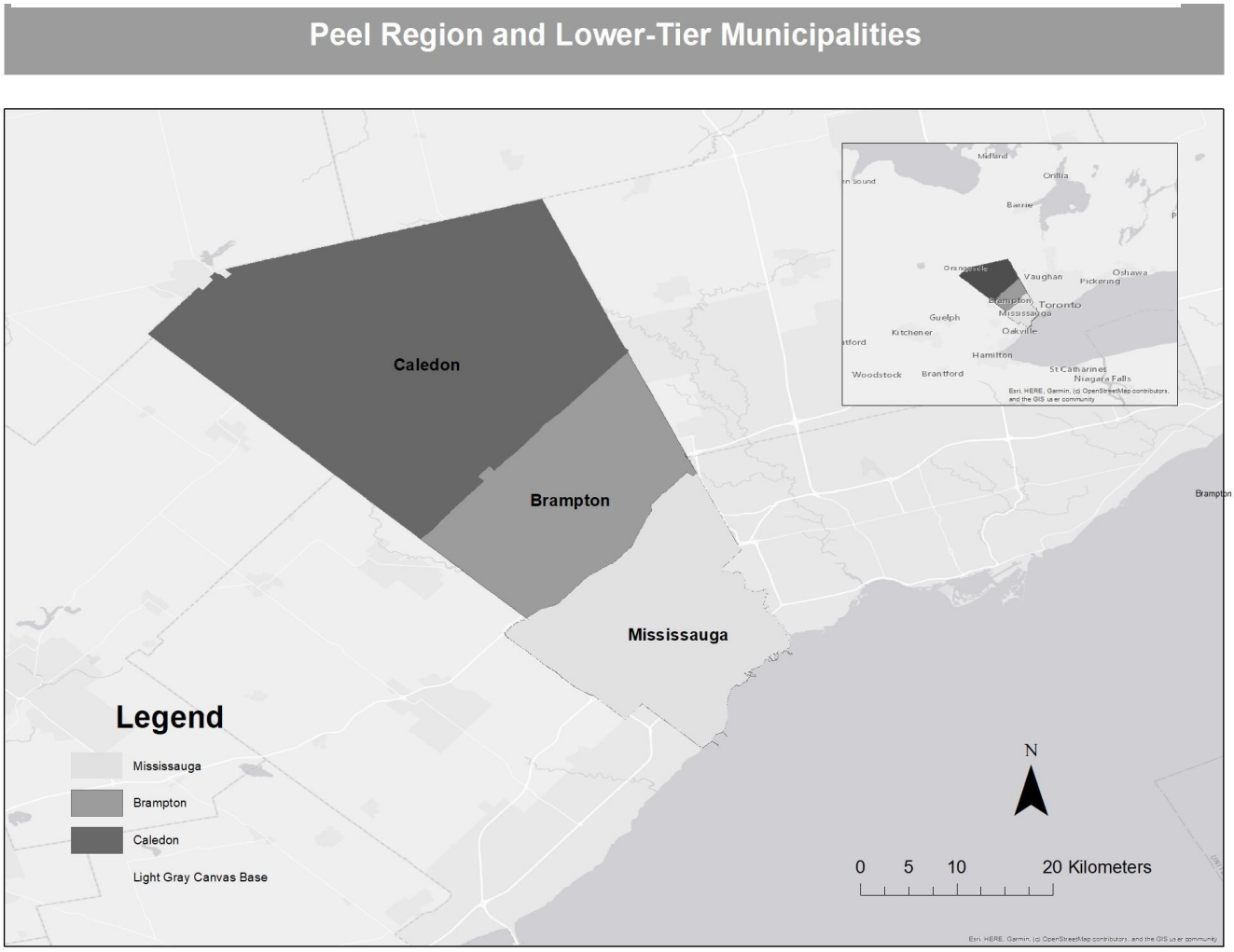
Top 5 Labour Industries in Peel

	Total	**Percentage**
Manufacturing	90490	12%
Retail trade	85425	12%
Transportation and warehousing	69920	10%
Professional, scientific and technical services	61500	8%
Health care and social assistance	59265	8%

(Statistics Canada, 2016d)

Peel Region's present governance structure resulted from a series of Regional amalgamations conducted by Ontario during the 1970s that stitched together urban and rural units of government. Peel Region was amalgamated in 1973, uniting Mississauga, Brampton and Caledon into a single administrative unit, though with jurisdictional competencies delegated to the lower-tier governments. Presently, Peel Region is predominantly urban in Mississauga and Brampton, while Caledon remains largely rural with many new large-tract suburban developments close to its border with Brampton (Meligrana, 2004; Drackley. et al. 2011; Peel Region, 2018). The current boundaries of Peel Region are depicted in Figure 1:

Figure 1



(Statistics Canada, 2016)

There is currently an upper-tier level of government of elected representatives from the constituent municipalities, and three lower-tier levels of government represented by the municipalities of Caledon, Mississauga, and Brampton. The upper-tier government's planning responsibilities are focused on broader, Regional planning issues, including: age-

friendly planning; agriculture; climate change; greenlands systems planning; growth management; health and built environment; housing; transportation; water resources. The lower-tier municipalities are primarily responsible for more specific land use responsibilities, including zoning, site plan applications and urban design (Drackley et al., 2011; Meligrana, 2004; Peel Region, 2018).

3.3 Policy Process

Peel Region's Healthy Development Assessment Tool was created over a decade-long process that went through numerous iterations and learning processes. In 2005, Region of Peel Council endorsed the "State of the Region's Health Report 2005 - Focus on Overweight, Obesity and Related Health Consequences in Adults." This report provided scientific evidence on the linkages between the built environment and its effects on physical health. At this time, Council directed Public Health to provide commentary on development applications that came to the Region (Peel Region, 2005).

The tool would have required evidence-based criteria to aid in identifying potential health impacts which necessitated the adoption of a tool. This process eventually resulted in the creation of Peel Region's "Healthy Development Assessment" tool: a checklist to assess health outcomes in development applications. This tool was voted upon by Council and enacted in 2016 as a development tool to guide applications, but which was only applicable to Caledon, as both Brampton and Mississauga decided not to adopt it and pursue their own

policy directions (Peel Region, 2016). Figure 2 outlines the time of the major policy documents:

Figure 2

Timeline of Healthy Development Assessment Policy Process

3.4 Study Design

The research is exploratory and deductive in character, oriented towards the exploration and discovery of themes (Patton, 2015), which were subsequently refined upon during an

examination and deductive application of critical policy studies in policy mobilities and post-politics. Exploratory studies are premised on examining unknown territories of research to formulate future research questions that can be addressed in subsequent studies (Neuman, 2012; Pajo, 2018). Exploratory research is less well-defined in the steps followed during research design and requires the researcher to be open-minded and flexible and take on an investigative attitude (Neuman, 2012). In contrast to descriptive - which answer questions of *what, where, when and how?* - and explanatory, which answers *why?* questions (Babbie & Benaquisto, 2002; Neuman, 2012) - exploratory research is suited to asking "what?" questions, such as "What is this social activity really about?" (Neuman, 2012, p. 16). In this case, Peel Region was chosen as a case study for its involvement in early adoption of a healthy development tool, seemingly drawn from larger policy trends in health impact assessment, but which in form became a different type of policy tool. The "what?" of this process is what were the influences and processes that led them to arrive at the final iteration of their healthy-built environment policy tool?

3.5 Qualitative Research

The value of qualitative research lies in its ability to uncover the richness and detail within Peel's policy-making process, and to extract as much meaning in the process as possible from the participants. Qualitative research is often defined in contrast to quantitative research, and the difference between non-numerical/idiographic and numerical/nomothetic explanations. Qualitative research generally falls within idiographic explanations: an

approach to research that attempt to create descriptions of a single case, seeking to exhaustively describe as many possible explanations of that case. Qualitative research relies primarily on non-numerical data, such as words, pictures, sounds, visual images or objects (Babbie, & Benaquisto, 2002; Neuman, 2012).

Qualitative research's strength is to increase depth and richness of description of a case or cases, using the power of words to convey meaning that purely numerical descriptions can lack. Its strength is also its weakness, as the depth of meaning ascribed to this approach can lead to ambiguity and lack of generalizability to findings (Babbie, & Benaquisto, 2002). Qualitative research also suffers from the difficulty of replicating research (Bryman, Teevan & Bell, 2009).

This compares with nomothetic explanations, which attempt to arrive at generalizable statements of a class of events, often using only one or a few explanatory variables (Babbie & Benaquisto, 2002; Neumann, 2012). Quantitative research relies heavily upon analyzing numerical data with mathematically-based methods, strict methodology, deductive research design, and the confirming/falsifying of established theories (Bajo, B., 2018; Mules, D., 2004). Qualitative research then relies primarily on non-numerical data, such as words, pictures, sounds, visual images or objects (Babbie, & Benaquisto, 2002; Neuman, 2012). The strength of quantitative is in the ability to generalize findings to broader cases, that while potentially lacking the descriptive richness of qualitative research can be applied to other cases more readily (Babbie, & Benaquisto, 2002; Neuman, 2012). Two methods were used to

understand the case study: content analysis and semi-structured interviews. The next section will address case study research.

3.6 Case Study Approach

This study used a case study approach for its ability to draw out a large amount of information. Case study research is when single or small number of cases - usually a program, event, activity, process of or one of more individual - are carefully examined by a researcher to draw out as many details as possible. The study is typically restricted by time and activity, and data is gathered over an extended period (Creswell 2014; Neumann, 2012). The strength of case study in research design is the ability to gather rich, detailed data about a particular case and the ability to conduct a more intensive investigation of a social phenomenon (Babbie & Benaquisto, 2002), which is suited to this study and the exploration of Peel Region's policy-making process. However, a criticism of case study research is that research may be conducted under the presumption of a particular bias, with the researcher setting out to find what they initially set out to find (Yin, 2018). Moreover, case study research receives the same criticisms of qualitative research in general, which is that it is less scientific than quantitative research and the inability to generalize findings. However, these potential problems can be mitigated as addressed in s 3.8 Limitations. The next section will discuss constructivism.

3.7 Constructivism

In this thesis, a constructivist approach was followed. Constructivism assumes that individuals construct subjective meanings of their experiences which are applied to objects and things, and because these meanings are varied and a multiple can lead to a complexity of views (Creswell, 2014). These subjective meanings taken on by participants are often socially and historically constructed and received through negotiation and interaction with others (Creswell, 2014). This study presumes that the social construction of reality through the participants' and researcher's value framework, following the lead of the broad direction in policy mobilities case studies that design their approach as an exploration of social processes and the relational, contextual understanding of the world and reality (Creswell, 2014; McCann & Ward, 2013.) The following section will explain content analysis.

3.8 Content Analysis

Peel's policy documents were analyzed using content analysis. Content analysis is the study of patterns of symbolic meaning within text, audio, visual, or other communicative materials (Neuman, 2012). Manual coding was used to analyze Peel Region's major policy documents related to the development of the policy tool, looking at both manifest and latent meaning. Manifest meaning is content that is in plain sight and easily agreed upon in meaning, while latent requires looking at the overall context to find meaning that may not be immediately on the surface (Pajo, 2018) The benefits of content analysis in this study is that it is flexible and

unobtrusive method. However, the disadvantage is that it is only as strong and reliable as the materials under analysis (Bryman, Teevan, Bell 2009). In this case, the documents analyzed by Peel have been officially released by the Region. The next section will explore qualitative research with interviews.

3.9 Interviews

The exploratory qualitative case study relied on in-depth semi-structured key informant interviews with questions written to uncover an empirically rich account as possible to investigate the policy-making process of Peel Region. The benefit of semi-structured interviews is that they are flexible and allow pursuing unexpected leads in the direction of interviews (Pajo, 2018). They are also useful for drawing from interviewees how they interpret and make sense of issues and events (Bryman, Teevan, Bell 2009). The downsides to semi-structured interviews is in their flexibility, which impairs comparability between responses, and which may lessen reliability (Bryman, Teevan, Bell, 2009).

The study is focused on Peel Region's planning and public health policy-making process which occurred primarily at Peel's main locations at 10 Peel Centre Drive, Suite A and B in Brampton, Ontario, and 7120 Hurontario Street, in Mississauga, Ontario. However, the policy process also occurred across multiple sites, that in addition to the physical locations of their departments in Brampton and Mississauga, also occurred in Toronto (the Health Background Study was a joint document with the City of Toronto), Hamilton (The Healthy

Development Index was developed by a team based out of McMaster University in Hamilton but was hired through Dr. Richard Dunn's role at St. Michael's Hospital in Toronto, Vancouver (the Lawrence Frank document was produced by a University of British Columbia professor), as well as international conferences which are alluded to in interviews but not named.

Respondents were asked questions (Appendix F) chosen to broadly explore the policy-making process and capture as much information as possible within a short timeframe. These questions relate to the labour of policymaking, influences on the policymaking process, and barriers and opportunities to more fulsome understandings of "health" in the planning process. Semi-structured interviews were chosen for the flexibility of uncovering unforeseen threads and narratives at the time of the questions' design.

Participants were stakeholders involved in Peel Region's policy-making environment and included eight former and current Peel staff members in addition to one lower-tier municipality staff member, one elected representative, and one planning consultant. Interviewees were recruited through purposive sampling, with four interviewees reached through direct purposive, and seven through further snowball sampling through these initial contacts.

The sample was recruited using direct emails for the purposive sampling phase which targeted respondents who were publicly associated with Peel's documents through author

names, or as main contacts for their department sections on Peel's website. Purposive sampling relies upon the judgement of the researcher to select cases, mainly to reach unique, particularly informative cases and gain a deeper understanding of an issue (Neuman, 2012). Next, snowball sampling through those direct email contacts who referred their colleagues. Snowball sampling is used to identify and sample cases in a network, using the analogy of a snowball that the respondent pool becomes larger as the process continues. It is useful when sampling an interconnected network of people or organizations, and useful in this case to reach respondents who may not have been publicly affiliated with the policy-making process through public authorship of documents (Neuman, 2012). The University of Waterloo Office of Research Ethics approved this study. (See Appendix A for ethics-related material).

In total, N=11 participants responded to these two stages of recruitment, out of N=23 attempted recruitments: 3 are current planners with the Region (two are health planners that work with both Planning and Public Health), two are former planners with the Region (one is a former health planner), one is a planner with a lower-tier municipality, and 1 is a private consulting planner. 2 are current public health employees, and one a former public health employee. Finally, 1 is an elected representative from a lower-tier municipality and Regional Councilor. Of the interviewees, 4 are male, while 7 are female. The length of employment and work on the Region's tool is represented in Table 5:

Table 5

Employee Timeline

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Planner 1														
Health Planner 2														
Public Health 3														
Health Planner 4														
Public Health 5														
Health Planner 6														
Planner 7														
Public Health 8														
Planner 9														
Planner 10														
Elected Rep 11														

The next section will introduce the data analysis process.

3.10 Data Analysis

The gathered qualitative data from the interviews and policy documents were coded. Coding is the step of converting raw qualitative data into a standardized form for further analysis. In doing so, the data are organized with accompanying tags to better convey ideas and concepts within the data, that can then be refined during further analysis (Babbie & Benaquisto, 2012; Bryman et al., 2002). Coding is often exploratory, discovering themes and patterns within the

data which can be subsequently refined upon a cross-checking of the literature (Patton, 2015).

When compared with quantitative data where statistical knowledge is applied against data, qualitative research relies upon coding of raw information for further analysis. The purpose of coding qualitative data is to convert it into another form for analysis, such as transforming raw notes or transcripts to codes or conceptual terms (Neuman, 2012; Pajo, 2018). The first step in coding was open coding, where the data was condensed into preliminary analytic categories for further analysis. The next step was axial coding, where the data was organized into codes, and links are found between the codes and then placed into analytic categories (Neuman, 2012). The last pass of coding was selective coding, where the previous codes were used to illustrate data in support of the of the conceptual coding categories that were created over the preceding steps (Neuman, 2012).

In addition, Peel Region's major policy documents leading to the creation of their *Healthy Development Assessment (2016)* were deductively coded, based upon Peel's own working definition of "health." The deductive coding process of the policy documents followed Peel Region's conceptualization of health as it was understood across the documents and traced the shifting working definition as it was understood in text. Key Peel Region documents were coded with regard to how they defined 'health', 'healthy communities' and 'health outcomes' and what they hoped to achieve by instrumentalizing 'health' in general.

The coded themes were determined through occurrence across multiple interviews, as well as resonance with the literature. In particular for policy mobilities themes, McGuirk & Baker's (2017) conception of assemblage methodology and its recommended attunement to the labours, processes and multiple logics of policy assemblage when conducting critical policy research was useful in coding the interviews. In particular, multiple logics, processuality and labours were specifically used for major themes organizing the codes. Second, Allmendinger's characteristics of post-political planning were insightful in unpacking the themes of post-politics across interviews and coding. The themes are presented in the order first for coding for health in order to depict the shifting definition. Next, the themes were presented in order according to policy mobilities research, and then themes resonant with post-politics. The next section will present the limitations of this thesis.

3.11 Limitations

In order to overcome the weaknesses of qualitative research, there are methods which can be used to ensure the rigour of gathered data and thereby enhance the trustworthiness of findings (Bryman, Teevan, Bell, 2002; Given, 2008). Criteria for evaluating qualitative research were used to ensure rigour of findings. For credibility to ensure that there is an authentic representation of participant experience, strategies used to attempt to satisfy these criteria were purposeful sampling, followed by peer debriefing of the semi-structured interview results, and detailed quotations. As well, member checking was used with the completed

transcripts of each recorded interview with participants to ensure the accuracy of and approval of the transcriptions.

Again, to enhance transferability of the qualitative research findings and that the research findings could fit contexts outside the study situation, the study context has been described as completely as possible, as well as how themes and hypotheses were developed, and what they mean. Third, to practice dependability to minimize the idiosyncrasies of interpretation, peer examination was used by a graduate research advisor. Finally, to enhance the confirmability and the extent to which biases, motivations, interests or perspectives of the inquirer have influenced the interpretations, an audit trail by a graduate advisor was used to read over draft versions of data analysis, and advised on decisions over respondent selection, methods used, and data interpretation techniques (Baxter & Eyles, 1996; Creswell, 2014; Pajo, 2018).

There are limits to this study based upon some criteria for establishing qualitative rigour. For credibility, prolonged engagement was not possible within the timeframe given for graduate study, both in terms of financial and time constraints. Similarly, there is a to the transferability of the findings owing to the limits imposed by the research timeframe and recruitment of participants necessary to provide full empirical account of the entire process, and every participant involved. Further, the limitation in the dependability of the study is that multiple researchers nor participant researchers were used to minimize idiosyncrasies in interpretation. Finally, the limitation to confirmability and the extent to which biases,

motivations, interests and perspectives influenced the research is that a thick description of the audit process was not conducted, nor an autobiography or journal/notebook (Baxter & Eyles, 1996; Creswell, 2014; Pajo, 2018).

3.12 Summary

In summary, this chapter outlines the research methodology used to approach the research question: *What influences led to the creation of Peel Region's Healthy Development Assessment tool?* This study used qualitative exploratory research design with constructivist approach, using semi-structured interviews with 11 respondents, and content analysis of 5 policy documents. These were then manually coded to uncover themes, as well as for resonance from the broader literature on policy mobilities and post-politics. The next chapter will discuss the research findings.

Chapter 4
Results and Findings

4.1 Introduction

This chapter presents the results of the content analysis and interviews. The content analysis is presented first to show the shifting conception of health across the policy documents, while the interviews are presented afterwards to offer some explanatory evidence for the nature of those definition shifts. In analyzing the primary healthy built environment documents released by Peel, they were deductively coded, based upon their depiction of "health." As mentioned in the methodology chapter, this was conducted in order to understand how this conception of health potentially shifted and mutated across the documents. Key Peel Region documents were coded for how they define their working conception of 'health', 'healthy communities' and 'health outcomes' and what they hope to achieve by instrumentalizing "health" in general. This is important for the later interviews in understanding to unpack what may have been behind the possible drift in definition. The interviews were coded for their resonance with the policy mobilities and post-politics literatures, showing detection of the influence of both theories upon the policy-making process. In particular, the coding relied upon the themes of assemblage thinking from McGuirk and Baker (2017), using multiple logics, processuality and labours as overarching coding themes. As well, post-politics drew in particular upon the work of Allmendinger (2017) and his core characteristics of post-political planning for coding themes.

4.2 Document Analysis Results: Policy Process

In 2005, Peel Region began the process of designing a tool to control development applications to ensure healthier built form and better health outcomes. The Region of Peel Council endorsed the "State of the Region's Health Report 2005 - Focus on Overweight, Obesity and Related Health Consequences in Adults" (Moloughney, 2015; Peel Region, 2005). This report provided scientific evidence on the linkages between the built environment and its effects on physical health. At this time, Council directed Health Services to provide commentary on development applications that came to the Region. This required evidence-based criteria to aid in identifying potential health impacts which necessitated the adoption of a tool.

The first series of documents published relating to the tool are "An Evidence & Best Practices Based Review for the Development of a Health Assessment Tool: Applying Research Evidence to Land Development Decisions to Increase the Health-Promoting Ability of Built Environments" by *Lawrence Frank and Company (2008)* and "Evaluating the Public Health Impacts of Land Development Decisions in Peel" by *Lawrence Frank and Company (2009)*.

In 2008, Regional Council then endorsed "Health Assessment Tool Initiative to Provide Quantifiable Comment on Neighbourhood Development Proposal" and hired Vancouver BC-

based Lawrence Frank and Company Inc to develop a model for Peel Region. Lawrence Frank and Company Inc submitted two reports to the Region: “An Evidence & Best Practices Based Review for the Development of a Health Assessment Tool: Applying Research Evidence to Land Development Decisions to Increase the Health-Promoting Ability of Built Environments” in November 2008, and “Evaluating the Public Health Impacts of Land Development Decisions in Peel” in January 2009 (Lawrence Frank & Co., 2008; Lawrence Frank & Co., 2009). These reports conducted reviews of the relevant literature on the impacts of built environment on an emphasis on physical activity-based health outcomes, these reports led to the recommendation of adoption of a modelling platform called as I-PLACE3S1, which allows to collection of data to build regression models that allow for inclusion of socio-demographic data to capture and understand data on unique age, income, gender, and ethnicity groups.

There is not explicit definition of ‘health’ or ‘healthy’, but these documents do class health outcomes as “Physical Activity & Body Weight, Air Pollution Exposure, Pedestrian Safety from Traffic, and Mental Health.” In addition, the report adds “Recommendations for supportive policy development”, whose latent meaning implicitly stretches beyond a primarily obesogenic definition:

1. Prioritize social inclusion and affordability.
2. Encourage close-in, infill and brownfield development.
3. Limit greenfield development.
4. Encourage compact, mixed-use development.

5. Encourage healthy food sources in close-in and low-income areas.

6. Invest in parks, trails and other recreational facilities.

7. Invest aggressively in pedestrian, bicycle and transit infrastructure.

8. Coordinate development with existing or planned transit.

9. Avoid locating sensitive land uses near sources of air pollution or noise [health definition] (Lawrence Frank, 2009 p. 7)

This definition, stretching to encompass social inclusion and affordability, as well as environmental and mental health, retains a broader working definition than the narrower, more obesogenic definition that will be found in later iterations. Finally, as will be key for its absence in later iterations of the policy-making process, there is special mention of addressing 'vulnerable populations', and recognition that "low-income households are generally less healthy than the population at large."

The second document analyzed was the *Healthy Development Index* (2009). In 2009 Peel Region retained a research team from St. Michael's Hospital Centre for Research on Inner City Health based in Hamilton, ON to build a tool to assess health impacts of development proposals, calling their tool the Healthy Development Index. The resulting index was meant as a framework to provide consistent, quantifiable standards to inform planning decisions (Dunn et al., 2009; Moloughney, 2015). This report does not mention the prior research conducted by the Lawrence Frank and Company Inc report, as is more restricted to a definition of health that is based upon encouraging physical activity.

The initial HDI provided seven core elements of the built environment associated with health:

Density

Service proximity

Land use mix

Street connectivity

Road network & sidewalk characteristics

Parking

Aesthetics & human scale (Dunn, et al., 2009)

Ultimately, the research team behind the HDI recognized that the tool faced barriers in existing zoning by-laws, and that "Many of the measures in the Index are largely prescribed by existing municipal, regional, provincial, and transportation standards and by-laws that do not currently allow the Index's health targets to be achieved; therefore, developers cannot meet the health requirements under existing standards," (Dunn et al., p. 12). As well, design standards that limit health-promoting development are an additional barrier, stating "existing Urban Design Guidelines, which dictate new zoning and by-laws, may have been developed with priorities other than health in mind; so, even new standards are not necessarily directed towards healthy development" (Dunn, et al., p. 13).

A further barrier was perceived as the lack of a collaborative approach with all sectors of government and departments, and that lacking a "common, agreed upon goals with other sectors and levels of government in the development process" would hinder "effective

implementation of all measures" (Dunn et al., p. 13). Conflicts with transportation and road design standards were listed as another barrier, such as classes between "auto safety vs. pedestrian and cyclist safety; increased vehicular collisions vs. increased activity-friendliness", and that they would "need to be reconciled and a process put in place to reconcile differences between various departments within municipal planning" (Dunn, et al., 2009 p. 13). A further barrier is political, that: "the Index needs to show that the health requirements will translate into wider benefits (e.g., public safety, economic, environmental) in addition to walkability" (Dunn, et al., 2009 p. 13). An additional barrier identified by the team is the need to build flexibility into the tool to respond to different development intensity, such as:

> [S]maller, intensification redevelopment (characterized by Mississauga) and larger greenfield subdivision development (characterized by Brampton and Caledon)" (Dunn et al. 2009, p. 13). Finally, the last primary barrier identified is of communicating the value of the HDI For some measures, "to show that the health requirements will translate into wider benefits (e.g., public safety, economic, environmental) in addition to walkability
>
> (Dunn, et al., 2009, p. 13).

The *Healthy Development Index (2009)* primarily defined health as physical activity outcomes, focusing on "chronic disease, obesity, and change in physical activity {health definition}" (Dunn et al, 2009, p. 9). There is no mention of the more expansive definition of health in the Lawrence Frank (2009) document that included social inclusion, vulnerable populations, or use of socio-demographic data into its metric.

The third document analyzed is the *Health Background Study Framework (2011)*. This step in the policy process was managed by The Planning Partnership and was a collaborative partnership between Region of Peel Public Health and Toronto Public Health Department. This process led to the development of the Health Background Study (HBS), which was found necessary in order to present the content of the HDI in a manner that was compatible with existing planning profession tools (Moloughney, 2015).

While the elements within the HDI were found to be comprehensive and feasible, what was in question for this iteration of the policy was how policies and standards could be strengthened to meet desired health outcomes. In addition, it was found that areas that related to environmental quality (air, water, noise, vibration, odour), mental health, access to healthcare, safety concerns and cultural considerations could also be considered in the creation of the HBS.

When interviewing stakeholders - public health and planning officials in Peel Region and Toronto - the document authors found that there was little consensus among potential users, i.e.) the development community, in terms of the purpose, content, applicability and implementation, with the development industry being extremely concerned, public health officials being highly supportive, and Toronto planners being ambivalent, while Peel planners were more supportive (Gladki, 2011; Moloughney, 2015).

The summary of recommended improvements to the HDI were as follows:

- Establish a format for the HBS that is simple, standardized and instructive to applicants with an explanatory implementation guide.
- Utilize a checklist to evaluate the success of new developments in achieving standards supportive of community health.
- Identify how to adapt the HBS to different levels of planning.
- Address overly prescriptive aspects.
- Allow more narrative description of how design elements are to be addressed. (Planning Partnership, 2011) (Moloughney, 2015).

In coding this document, its definition of health was described in relation to health as chronic illnesses, taking only three determinants from Public Health Canada's Social Determinants of health as relevant to its framework: social environments, physical environments, and health services. The report then states that built environment also impacts health through air pollutants and greenhouse gases, water quality, levels of physical activity, social cohesion and rates of crime, and rates of injuries and fatalities for motorists, pedestrians and cyclists. This definition is broader than that found in the *Healthy Development Index* (2009), including environmental health and social cohesion within its definition.

The fourth document coded for analysis was the *Healthy Development Index - Recommendations Report 2011).* For this iteration of the process, the Region then retained the services of Gladki Planning Associates in association with Du Toit Allsopp Hillier, who

were retained by the Heart and Stroke Foundation of Canada to assist in the refinement, evaluation and implementation of the HDI. As well, Peel Region in partnership with the City of Toronto, also retained the services of the Planning Partnership in order to assess the HDI and determine a mechanism to integrate considerations of health considerations of health impacts into the land use development approvals process. The latter project was made possible by a financial contribution from Health Canada through the Canadian Partnership Against Cancer (Gladki, 2011; Moloughney, 2015).

The process led by Gladki sought to explore "refinement and implementation of the HDI" and that their "recommendations present a framework for strengthening the HDI as an assessment tool and integrating its principles into the policy-making, planning and development process" (Gladki, 2011 p. 1).Their report tested the HDI on two existing and three proposed communities in Peel based on current conceptions of good planning. Their recommendations addressed improvements that would make the HDI both a useful description of what characteristics define a healthy development/community; and a practical and appropriate tool for evaluating the presence of these characteristics. After assessing three proposed developments and two existing developments, Gladki found that the HDI had issues in terms of practicality, usefulness of results, and appropriateness of the indicators (Gladki, 2011; Moloughney, 2015).

Regarding practicality, the report's authors found that the data were not always available to complete a full assessment, and "[t]he kinds of information that were available varied greatly

between study areas, resulting in different methodologies for assessing individual indicators" (Gladki et al., p. 9). In addition, collecting and analyzing the data took much longer than anticipated, raising questions for how practical the tool would be for Regional and area municipal staff to incorporate into the existing planning process. In particular, they stated that "[c]reating similarly formatted maps from different sources was time consuming and in the final analysis not feasible" (Gladki et al., p. 10).

The authors of the report also state that the number of indicators included in the HDI are so numerous that scoring was not possible, and therefore the process should be refined and simplified. Assessing the usefulness of the results, the authors found that much of the needed data was incomplete and therefore comparing developments using the tool was not feasible, that:

> [t]he information needed to complete the situational assessments was not all readily available from existing documents and data sources. It was necessary to combine an analysis of secondary plans, community design plans, plans of subdivision, zoning by-laws and other documents with requests to area municipalities for further information and mapping. The kinds of information that were available varied greatly between study areas, resulting in different methodologies for assessing individual indicators
>
> (Gladki et al., 2011 p. 9)

When examining the appropriateness of the indicators, the authors found that the weighting of the indicators needed revision over which aspects of the index weighed more than others, as they believed the current tool did not make sense in their analysis, and "required a level of

spatial assessment that was not possible given current levels of data and mapping capabilities" (Gladki et al., 2011 p. 10).

Finally, they found that many prerequisites within the development checklist were not met by the reviewed developments (Gladki et al., 2011; Moloughney, 2015). These findings were then brought to an Advisory Committee for a workshop and feedback in June 2011, and the results were that:

> The HDI is a valuable tool.
>
> The HDI should be carefully tailored to the Peel context and the various circumstances in which it will be used.
>
> The HDI is currently over-prescriptive and not sensitive to local context.
>
> Numerical scoring is of limited use.
>
> A qualitative component should be incorporated into the HDI.
>
> The HDI is a tool that must be adapted for different purposes. (Gladki, et al., 2011, p. 12-13).

The *Healthy Development Index - Recommendations Report (2011)* continued the refinement of health towards something more concise and generalized - less specific to populations based upon criteria of vulnerability and socio-economic status:

> What do we mean by a healthy community? In this instance, a healthy community is one that promotes and enables physical activity (other issues related to health, such as air quality, public

> safety, climate change adaptation [health definition]" (Gladki, 2011, p. 4).

There was an intermediary tool called *The Healthy Assessment Checklist* that only lasted several months before being cancelled and was only revealed in interviews and is not publicly accessible.

The final coded document was Peel's developed the Healthy Development Assessment (HDA), which is an adaptation of the Health Background Study Framework's work on the Healthy Development Assessment. This tool was designed to provide much clearer direction to developers and act as a much simpler checklist for the interpretation and use by the development community. The HDA's core elements are based upon the HDI's, conflating health primarily with physical activity outcomes. In the final version, the healthy features are:

> Density
>
> Service Proximity
>
> Land Use Mix
>
> Street Connectivity
>
> Streetscape Characteristics
>
> Efficient Parking (Peel Region, 2016, p. 7).

The final iteration of the tool became a simplification of previous iterations, and primarily a checklist of healthy built environment features that resembled more of an urban design checklist than a HIA.

In coding this document, the final definition of health in its current iteration of the policy-making process is an even more narrow definition of health than was explored in earlier iterations. The *Healthy Development Assessment (2016)* states:

> The Region of Peel is committed to creating healthy, supportive environments that enhance the health-promoting potential of communities. A healthy and complete community is compact, pedestrian-friendly, and transit-supportive; contains a mix of uses that support daily living; and, enables physical activity through active transportation. This User Guide provides background information and instructions for completing the Healthy Development Assessment (HDA). It is intended for use by anyone who has a role in the planning, design and approval of development. [health definition]
>
> (Peel Region, 2006 p. 1).

The HDA aims to assist planning and development stakeholders in creating healthy, supportive environments for Peel residents. It measures the health-promoting potential of a planning or development proposal by producing a score to communicate the achievement of design standards that are essential to building healthy and complete communities. The final definition for determining health is found it its checklist: Density; Service Proximity; Land Use Mix; Street; Connectivity; Streetscape Characteristics; Efficient Parking.

This process is consistent with the "multiple logics" of assemblage and the dynamics of policy mobilities, that the processuality is non-linear dynamic full of contingencies and

course corrections, that encompassed various commitments throughout the negotiation of an understanding of "health." The process started with a broader, more encompassing definition of health - closer in consistency with definitions found in wider policy flows - and then refined that definition to one consistent with a view to standard development procedures in Ontario.

4.3 Summary: Document Content Analysis

In summary of the timeline and coding of the documents, the Region began initial steps in creating a policy tool with the document *Evaluating the Public Health Impacts of Land Development Decisions in Peel (2009)*. This step required evidence-based criteria to aid in identifying potential health impacts which led the Region to look at developing a tool. The next step was the *Healthy Development Index (2009)*, which was a broad review of comparable policies in other jurisdictions and led to the development of a potential land-use tool. The *Health Study Background Framework* and *Healthy Development Index* evaluated the practicality and usefulness of the *Healthy Development Index*, and the *Healthy Development Assessment* was the policy response to that process: a formalized development checklist that simplified the *Healthy Development Index.*

4.4 Interview Results

The research interviews (See Appendix F and G for interview questions and supporting literature) suggest that the conceptual tools from the policy mobilities literature in assemblage thinking - tracing the multiple logics; processuality; and labours in particular - offer critical insights into the policy-making process in Peel Region. There is also evidence of the mechanics of policy boosterism at play in the Region's policy-making process, and how the Region's sense of advancement in its policy invention led it to turn away from policy examples towards its own in-house processes, but which also created a stronger role for Public Health in the planning process, albeit one constrained by the tenets of pro-growth development. However, counter to the idea that neoliberalism is a dominant explanatory factor, other facets of the process unraveled that provide insight into how planning and public health can collaborate in other jurisdictions.

4.5 Multiple Logics

The concept of *multiple logics* draws from the notion that neoliberalism is argued to not have a unitary logic or possible point of completion. Instead, it is understood as an evolving series of processes containing historical and geographical specificity and contingencies, and urban politics, are therefore formed by the ways in which neoliberal policies and techniques combine and mutate with different forms and styles of governance in urban - and national -

contexts (McFarlane, 2011; McGuirk, 2011). These local circumstances are the pieces and explanatory narratives to be uncovered through research.

The multiple logics of the policy-development process is highlighted by the fact that successive waves of staff worked on the tool, many of whom were not in contact with earlier iterations or were not familiar with earlier versions of the policy-making process.

> There has been a lot of staff turnover in terms of people taking this on {multiple logics}[1]. (Planner 10)

Another example is that many participants were not familiar with the Lawrence Frank (2009) iteration of the tool. One participant who was familiar with the tool only knew that it was not paid attention to:

> And there was a consultant who was hired for that. And he looked at those documents too, the Lawrence Frank one. And was told not to pay too much attention to them. So, I don't know what the behind the scenes rationale was, but it was just kind of shelved unfortunately {course correction}. (Public Health 8)

As well, some of the policy's initial champions - Dr. Oliver Mowat and others - had moved on and no longer worked at the Region during the interview process, though the policy-making process on the tool still continues, though in a form that more resembles an explicit urban design tool with an even slimmer definition of health.

[1] {Bracketed words} represent codes developed from the policy mobilities and post-politics literatures. These codes have been used to illustrate the connection between the data (interview transcripts, documents), analysis (codes), and final results (themes presented here).

However, as echoing the multiple logics rather than linearity of the process, the Region - through newer employees - began to incorporate elements of elsewhere into their tool, as displayed by the following conversation, particularly in shifting towards looking at tools with a less explicit health focus, like LEED and Toronto Green Standard, rather than towards health-explicit tools. This in turn turned the tool into a very planner-friendly urban design checklist, as described in a joint interview with Planner 1 and Health Planner 2:

> We're perhaps inspired by similar types of tools - so City of Toronto has Green Building Standards, that has maybe not as much of a health focus but a similar intent in terms of what a tool is trying to achieve through a development process. We've looked at Brampton's Sustainability guidelines, which were influenced by the HBSF. (Health Planner 2)
>
> What about LEED? (Planner 1)
>
> Yeah LEED's a good example {policy influence}. At the same time, I guess what we're trying to achieve from a health perspective was not really replicated anywhere else in Ontario, so that's where you see a lot of the trial and error {policy invention}. But I don't see the trial and error as such a bad thing, because in any kind of policy evolution you write the initial policies, and you develop your strategies and you implement them, but if you don't have - like you're saying -those best case examples then you have to be adaptive. You have to be self-critical and say what's working and what's not working. I think there's been a lot of that, and that's where you see the course correction {policy mobilities}. And that's why I think - you know - 4, 8 or 6 years or however many years later we're much more effective than we were in 2008. We took that time to be self-critical, we did self-evaluations {processuality}. (Health Planner 2)
>
> Yeah I don't think we were rushed. I think it was iterative, and consulted upon, and it involved a lot of different players to get it right {assemblage} and still evolving obviously {processuality}. (Planner 1)

> Yeah, and not being shy to still be involved without it being perfect {assemblage}. So, we were involved in the development process quite early on but less so. And we've ramped that up. But you know, we're still learning and we're still applying those course corrections {assemblage}, they're just less major corrections that they were in the past. (Health Planner 2)

The preceding conversation between Planner 1 and Health Planner 2 describes the process of influence and creation, and how the resulting policy became an assemblage, containing multiple logics and pieces of elsewhere, as well as a series of inventions to suit local contingencies. This suggests that the policy mobilities literature may have some explanatory power in describing the dynamics of the policy-making process and framing how Peel adapted and created their HDA from an initial HIA that was then shaped to suit local needs.

4.6 Processuality – The Process of Becoming

Assemblage thinking has been used to describe the process of "unity across difference" in a policy, in a trajectory that is indeterminate, emergent, turbulent and in the act of becoming something else (McCann, et al., 2013). This was captured in several of the interviews, where those pieces of processuality - the act of becoming - were captured in interview dialogue:

> Yeah I don't think we were rushed. I think it was iterative, and consulted upon, and it involved a lot of different players to get it right and still evolving obviously {processuality}. (Planner 1)

This is further reinforced with a comment by Public Health 3, describing the processuality of the tool, emerging from a need and kicking off a process of invention and iteration. The following quote highlights the inspiration for the tool, and the subsequent snowballing relationships that began to coalesce and turn it into a policy invention; that not only did it involve Peel staff, but the process brought in academics:

> Knowing the importance of making sure the built environment was health supportive, [Dr. Mowat] came up with the idea that we have all these other assessments for development applications. Why isn't there one that I can tell where something was healthy or not? {policy invention} And that's where the idea was born {emergent policy}. And then through relationships with academia and Healthy Development Index, that's where that went - to try and quantify the health promoting potential of a development application. (Public Health 3)

After an initial searching process where the Region was looking for a policy to adapt, they decided to invent their own tool, which occurred sometime after the Lawrence Frank and Company (2009) report. During the McMaster University's research process, they conducted a broad searching process of the literature, but thereafter Peel began to increasingly turn inward and instead refine its tool without reference to other places which was fed in part by its own sense of innovation and experimentation, though leading towards a tool that adopted a narrower working definition of health and health outcomes. The following quote highlights the step towards policy invention, where an initial search process led to the necessity of creation. Public Health 8 explains the Region's perspective on seeing the lack of healthy built environment tools to draw likeness from:

> At the time I didn't know anyone else who was doing [creating the HDI tool] {policy invention}. And York was interested, as well as Hamilton {policy extroversion}. I remember presenting to Hamilton at one point about their process and history. And they had the planning, the policy, the public health groups at the table to hear about the experience {policy teaching}. (Public Health 8)

This shows that what began as an extrospective process for something like a Health Impact Assessment turned into something more novel: an assemblage; an emergent process based upon local contingencies and trajectories. The tool in its current form bears a certain resemblance to a Health Impact Assessment: "systematic, evidence-based decision support tool that considers how a proposal may alter the determinants of health prior to implementation and recommends changes to enhance positive and mitigate negative impacts" (Pennington, A. 2017, pg.56); and as "a means of assessing the health impacts of policies, plans and projects in diverse economic sectors using quantitative, qualitative and participatory techniques" (WHO, 2018). However, the tool that was finalized did not use participatory techniques; instead, it relied primarily on quantitative information, and it did not anticipate health impacts beyond those influenced by walkability.

Peel Region's connection to international policy networks is suggested in senior figures at the Region discussing joining the "Healthy Cities" international movement and participating in knowledge-exchange conferences in London and New York City, using those networks to amplify and bolster their own policy-making efforts as existing at the cutting edge of planning.

> [Dr. Mowat's involvement] led us to join the Healthy Cities {international policy flow}. [He] attended conferences in London, England and New York City several times where [Peel] presented our Peel programs and received feedback. We learned so much from others during these sessions and the walkability and the healthy neighbourhoods were key to our moving forward. {international policy learning}. (Planner 11)

That knowledge exchange was described as continuing through numerous conferences as learning opportunities and that informed the knowledge translation between planning and public health. A meeting with New York's healthy built environment team was highlighted as particularly significant, linking Peel to international policy circuits. This process showcases both Peel's confidence in its policy development and initial involvement in international policy influences, as well as eventual shift from policy invention to policy boosterism:

> Quite a lot of knowledge translation occurred from the Healthy Development Assessment and the Healthy Development Index. Right from the beginning, Dr. David Mowat and Gayle Bursey were presenting at - I couldn't even list all the conferences they've been to {extrospective policy}. For example, [Peel] had a forum where they invited the key team from New York city who were doing the whole program in NYC, Health By Design, and they had a half-day forum in Mississauga and they invited all the key people in the areas {international policy exchange}. That kind of thing: often you don't find Health departments doing that. (Public Health 3)

As this process expanded, Peel Region began to consider itself a leader in policy development and experimentation. While they had initially participated in these broader policy exchanges, at some point it was decided that what the Region was doing had more to

offer other places than the reverse. The following quote shows their pivot towards the policy boosterism of their own program for healthy cities and healthy built environment planning:

> The policy-making process became more [in-house], as Peel was so ahead of the curve in terms of what they had done in terms of their work {extrospective policy}. There weren't a lot of examples of places we could steal. People were stealing more from us than we could steal from {policy extroversion}. (Health Planner 4)

Public Health 8 and Public Health 3 echoed this, describing the boosterism at play in Peel showcasing its policy tool and process for other regions to emulate. The Region still maintained a curiosity to what other areas were doing, but had begun to realize that the Region's process had more to offer and less to learn from other jurisdictions:

> There was a monitoring component to get a sense of what was happening with others, but if anything, a lot were looking more towards us for guidance {policy extroversion} (Public Health 8)

> There tended to be a lot of interest from other Public Health departments. They ask about process {policy extroversion}. (Public Health 3)

By the time of the creation of the HDA, the policy process became more an in-house exercise created by Region staff. As noted, previous iterations involved consultants, academics, and outreach to developers. In addition, the HDI was a broad, searching process in terms of looking for influence and inspiration. By the time of the HAD, the Region was merely refining what they had already drafted, looking inward to local context and place:

> The HDI is really the evidence - empirical evidence of what creates a healthy built environment, but the tool is meant to be locally adapted {local contingencies} so that it applies to the Peel context. And I think that's where the variation in tools and adaptation in tools, but the same concepts and standards, but where that mixes come. (Public Health 3)

The positioning of this posture then shifted to policy boosterism: ways to advertise the Region's involvement in policy experimentation in healthy planning. In addition, this trajectory also resonates as well with McGuirk & Baker's (2017) theme of processuality: catching the tool in the process of becoming something, which in this case was viewed by some participants almost as a Trojan horse to bring Public Health into a more authoritative voice in planning. This sentiment is expressed by Public Health 3:

> Here we've tried to bring in planners to the public health work. I think that's where we see Public Health going forward in a variety of topic areas, so many of the levers in terms of public policy are outside of health's control {transformation}. (Public Health 3)

> From what I understand, strategically walkability was received with the least resistance and there was an opportunity to advance the walkability, with the idea that the tool could be revised with the appropriate evidence-base at a later time {transforming}. (Public Health 3)

This section shows the snapshot of where the policy tool is, and the tensions altering its course, as well as opportunities in becoming something else: a more expansive tool. It unfurled over its iterations through a process that was not linear at the outset but shifted according to local contingencies and place dynamics.

4.7 Labours

McGuirk & Baker describe the labours of assemblage as "an inductive strategy that grapples with the situated articulation of multiple interacting processes and labours that produce socio-spatial phenomena such as policy" (McGuirk & Baker, p. 434). In this coding, evidence of that labour of assemblage was explored for insights. In this case, the labours of the policy-making process were not an a-to-b drafting of policy, but the work done towards a more strategic positioning of the policy tool as a means to bring Public Health - long ostracized from planning decisions - more firmly into the decision-making fold, albeit with a reduced scope of their general mandate. This process was initiated by a strategic choice to conflate health with walkability:

> From what I understand, strategically walkability was received with the least resistance {strategy} and there was an opportunity to advance the walkability, with the idea that the tool could be revised with the appropriate evidence-base at a later time. (Public Health 3)

This work continued as well with the consideration that walkability was perceived as the only viable means to advance the case of health considerations into planning outcomes. In this quote, one respondent explains how Dr. Mowat specifically supported a narrower definition of health in order to make the tool more strategically effective. A broader definition would

have been too cumbersome to advance the likelihood of the tool's advancement during the policy process:

> Often questions that Dr. Mowat would get would be why walkability and why not health overall in terms of making a change and having policy amendments around, why is it just addressing walkability, and his big thing was that he wanted to keep it focused in one area to demonstrate the impact {strategy}. And then once that was achieved then let's talk about air quality and food environment. Mental health. Then opening it up to other topic areas. But he really wanted to first get - by adding other topic areas right from the get-go you're diluting the effect that you wanted to achieve. So, he wanted to demonstrate first that you can make an impact on walkability then open the door to other areas {strategy}. (Public Health 8)

Those tensions were also fed into the process by Planning and Public Health. There were problems between the two departments over language use, and what sort of exclusion criteria to use as well as how exacting to make the tool. Public Health wanted fewer exclusions written into the policy than did Planning, who wanted to create a tool that allowed more exceptions to the development process and potential applications:

> There was some tension around language of the policy, so Integrated Planning wanted more exclusions written in the policies about what the Healthy Development Assessment would not apply for. Health wanted all-encompassing language, and then those exclusion criteria could be adopted or changed later as need be, but [Integrated Planning] didn't want them written in the policies. So that was a tension point. Once they understand we'd be establishing exclusion criteria for those applications that did not need to undergo a health assessment, then working with the local municipalities to decide what those would be, they came around, so those policies do have that broad language. So that was a tension. (Public Health 3)

Peel used “health” and “healthy cities” in this political process of “knowledge translation, discursive framing, and the framing of certain problems and policy responses” (Temenos & McCann, 2012 p. 1391) to advance its agenda. In this case, the Region framed the problem around the urgency of “diabetes”, and that formed the basis in which to advance a greater role for Public Health in Planning debates.

> So, went to Council and said way back - 2004ish - here’s the data related to our major health issues {framing problem}. Diabetes is about to go through the roof - ⅕ is going to ⅓, because of the South Asian community. If we’re dealing with this problem, we need to deal with planning and transportation {framing problem}. And as you sometimes do with policy - you put in more than you think you’re going to get {strategy}. (Public Health 5)

The urgency around diabetes and rationale for its use in framing the problem to advance the tool was echoed by Planner 9 in relation to Peel’s suburban built form. The built form was viewed as an implicit structural determinant of health, and a factor in the high rates of diabetes owing especially to Peel’s demographics. The lack of walkability in particular combined with Peel’s demographics was an urgent problem:

> [Diabetes] was a wakeup call to say, ‘why is the Region of Peel so bad?’ There are some demographic issues associated with the higher incidence {framing problem}. I think they were looking at the fact that more and more - none of our subdivisions or communities are really that walkable. Seeing that that lifestyle is not conducive to a healthy person. But it’s just that the headline that Peel’s is the highest incidence of diabetes is alarming {framing problem}. (Planner 9)

Again, this was voiced by Health Planner 6. Not only were the high rates of diabetes in general a problem in and of itself, but these high rates were also believed to be affecting hospital wait times. This is a problem framing beyond just the target demographic, but also attempting to expand the rationale to show how it affects people without diabetes as well by adding to hospital wait times and subsequently health care burdens:

> In Peel it was the diabetes and it was a huge concern. And you always hear complaints about hospital care and how long it takes to be seen, and a lot of that is because our residents aren't healthy and a lot of it can be mitigated through the built environment {framing problem}. (Health Planner 6)

Finally, in conversation with Planner 1 and Health Planner 2, Peel's ethnically diverse population was considered partly the reason for the high rates of diabetes. In particular, Brampton's high South Asian migrant population was considered the primary location for Peel's healthy built-environment structurally determinant effect on health:

> Because when you look at Peel it has the youngest population in the GTA - so, it's really ethnically diverse, it has a lot of things going for it, which also pose a lot of challenges so I think that really forced Peel staff to push forward thinking --- (Planner 1)

> --- and of course, the challenge - diabetes rates in Brampton are the highest {framing problem}. (Health Planner 2)

> --- and that goes with the demographics as well {framing problem}. (Planner 1)

The Region created a health planner position that could liaise with developers and area municipalities in order to advance policy and to build capacity within Public Health to have a stronger voice in the policy-making process. However, "walkability" was the piece that gave Public Health the opportunity to move into the planning realm based upon the perceived urgency of diabetes; framed as both a public health and economic crisis.

> Then we sent the Chief Medical Officer - he was a good speaker and had a strong presence, and he had that same message - that you can't do something with less walkability as healthy - you can't have my endorsement - and I'm telling you you're going to have rates of diabetes you will not be able to deal with. You will have problems in terms of your economy and blah blah, so he said all that and it changed how they voted {problem framing}. (Public Health 5)

The "labours" that are key in this translation were to craft a definition of health that broadened Public Health's participation in planning, while reducing the broader working definition of health. So while this process was a narrowing of "health" in the broad sense - limiting it to health outcomes from participating in physical activity - it was a strategic piece to give Public Health a more recognized and legitimate voice in the planning process, contrary to a strictly neoliberal interpretation; or the neoliberalisation of public health in order to be able to participate in decision-making processes outside the traditional ambit of their competencies. As explained by one participant:

> [My job was to] create capacity building on public health's side, as public health was trying to get planning to incorporate more of this

> research they had done and ideas they had {knowledge translation}. But they weren't necessarily speaking the planning language and couldn't demonstrate why that was necessary in a way that planning understood and was interested in taking on board. That was my role to be that bridge {knowledge translation}. (Health Planner 4)

This work is highlighted again by Public Health 5, displaying the work necessary to bring Planning and Public Health into concert. There was a period in which a primary relationship had to be established in which both parties could begin to translate each other's knowledge and capacities to each other in order to strategize from a common position. This was particularly challenging because of the lack of power Public Health felt they had in influencing decision-making in general, as it was felt like those abilities to affect decisions were beyond their scope:

> A lot of firsts happened. Aside from relationship-building and capacity-building, both parties had to learn each other's language and how to function {knowledge translation}. But then together we had to figure out how do we do this slightly different kind of policy as a component of health that happens in planning {strategy}. And health cannot just help out but strategically advance it {strategy}. (Public Health 5)

> Just that it's a really interesting work to be a part of, as a Public Health professional you don't necessarily have expertise in the processes you're trying to influence. So as an individual practitioner in this work, trying to as Public Health, we're accountable for the health of our population, but the levers to influence are often outside public health {power}, so the personal stories and individuals involved are often quite interesting. On our team, the makeup - people with sociology backgrounds, nutrition backgrounds, nursing backgrounds, disciplines who have to learn very specific plan and transportation processes. I find that a fascinating aspect of the work. Here we've tried to bring in planners to the public health work {knowledge translation}. I think that's where we see Public Health

> going forward in a variety of topic areas, so many of the levers in terms of public policy are outside of health's control {power}. (Public Health 3)

However, problem framing was a means by which to advance that relationship's strategic goals. Planner 7 describes the work of problem framing necessary to advance the goals of public health in planning, especially in confronting the institutional power of the development community in determining planning outcomes. Developers here are perceived as the weightier influence in the hierarchy of power:

> Good planning looks out for the health and welfare for people over the longer term and health is a huge component and a lot of that is tied back to the way we design and build communities. It's funny because since then I really have not heard much pushback - sometimes private developers, when you're reviewing a plan and say - here's the hierarchy of walking distances, and public health considerations - they kind of scratch their heads {power}. But once you explain it to them they understand. It's just a natural fit {problem framing}. (Planner 7)

Again, Public Health 5 describes the power structure and necessity of problem framing to include Public Health within planning decisions. The art of framing a problem was a means by which to show the urgency of considering that the built-form has adverse impacts on health that are beyond what was being considered:

> [The HDI] became a step in our Environmental Assessment at the Region. And the reason it was helpful is that it was based on

> scientifically proven relationships between physical activity and land use elements, so mix in Healthy Development Index - the 8 of those elements in Healthy Development Index - they all had a scientific link to increasing physical activity {problem framing}. I'd like it to have been more than that, like linked to heart disease and diabetes, or linked to what people ate, but that was state of the literature at that point, it was the only empirical evidence - but at least it could stand up to the Ontario Municipal Board. That was our goal. And we hoped it would get challenged at the Ontario Municipal Board, but it never happened. We wanted it so that even if we lost we'd get some face time with people who needed to think about these issues. (Public Health 5)

Planner 7 reaffirms the power structure that kept public health from a role in planning decisions. Public Health had been an outsider to these processes, and required a more authorial, charismatic figure to help bring it to a place of influence. Those linkages between health and planning were not as legitimate without that push for inclusion by Dr. Mowat:

> I was contacted by the Chief Medical Officer of Health Dr. David Mowat, and he was asking some questions about this relationship, so we set up an informal meeting one evening and we went through his objects: he had my perspective on urban design and the linkage. It was interesting, he said - you know the Public Health practitioners - we've not been at the table when big decisions are being made on new communities and built form, but they affect Public Health and I want to get back at the table {power}. I said - absolutely. You should be at the table. (Planner 7)

In addition, the labours of this knowledge translation and problem framing took on a gendered component, as the perception that Public Health was female, and other more technical disciplines were male, played a role in the power dynamics of knowledge

translation between planning and public health, especially regarding the more technical aspects of planning: engineering and transportation.

> Personally I never felt like more of a feminist than beginning built environment work {female labour}, even in terms of layering on culture and ethnicity - and who are the power-holders that design our communities that influence all of us, historically it's been white men designing our communities for not just white men. It's a fascinating sociological phenomenon {power}. (Public Health 3)

This was reaffirmed by Health Planner 4, that there was an aspect of female labour to positioning public health to a position of influence. It was seen as women doing the work of trying to bring health promotion and consideration of health goals in planning, in particular butting against a more male-oriented perception of planning:

> To me planning is a little bit more balanced than engineering, but still male-dominated. So that never - never really something that bothered me I guess, so not something I focused on and quite honestly, one struggle I did find in Public Health is that it was very much female focused {female labour} and coming from planning I struggled with that {maleness}. So, when have one gender balance different than other than changes dynamic. Didn't feel like 'you're a woman then I'm not going to listen to you' I think for engineering and planning, and always that push and pull, more that you're a planner you're not an engineer {power} - more technical knowledge than a gender thing {power}{male labour}. Never something that bothered me, so maybe never bugged me. (Health Planner 4)

Again, Health Planner 6 depicted the necessity of female labour to push public health's narrative, and the surprise at women - in particular nurse-trained women - should be able to speak planning

language:

> You know a lot of the public health professionals - you spoke with one of our health planners. She's a nurse {female labour} and man can she speak about planning. She picked it up fast. And she's a nurse {female labour}. She's not everybody. She's very good. And likable. (Health Planner 6)

While in its current state Public Health staff would like to see the tool increase in its application of "health", the process was a strategic advancement of Public Health in the planning conversation. In addition, it is considered by decision-makers as strategically placed to further health goals in the future.

> Yeah - we're trying to embed health as a criteria. Sustainable criteria. So, in order to do that we have to make it easy, user-friendly, not time-consuming, not scary, because we want everybody to do it. Then we'll make it mandatory {future labour}. (Health Planner 6)

In summary, this section highlights the labour of policy-making and what conditions led to the eventual outcome of the policy tool. Significant problem framing was undertaken in order to push the tool to the attention of decision-makers, as well as confrontations with the power dynamics of the development community in order to have considerations of public health appear as legitimate and worthy of inclusion within planning discussions. At times, this took on a gendered component, as public health was seen as a female domain, whereas planning was perceived as more technical and therefore more male.

4.8 Legitimacy in the Role of Planning

One theme of note that emerged through its frequency was the subject of 'legitimacy' and the view by planners and public health staff of themselves that both planners and public health staff felt their work was not always received as credible or legitimate within the system in which planning operates. This perception of the relatively low prestige held by public service staff by decision-makers and the public reflects the literature on post-politics and the public's malaise and disengagement with government and officials (Allmendinger, 2017), as well as a diminution of trust and confidence in planning and planners as the profession shifted towards a greater emphasis on growth and consensus, and promising all things to all people, becoming in the process an empty signifier (Allmendinger, 2017).

> I mean he's the Chief Head Medical Officer [legitimate authority] – he has a little more weight than [a planner/illegitimate authority]. It did help us move forward with the project for sure [political agency][charisma]. (Planner 6)

The results suggest that a medical doctor still commands respect and authority that could partially transcend this post-political condition, possibly owing – as it was noted – by the maleness of a doctor within a more perceived feminine perception of Public Health. As one respondent put it, regarding Dr. Mowat's influence and authority:

> An urban designer [illegitimate authority] can go and say all the exact same things, and say - yeah those are all nice guidelines, that's

> nice - but because a doctor is evidence-based [legitimate authority] , and that's really been our angle. (Health Planner 6)

At the same time, a doctor fits within the post-political reduction of policy to questions of science and technology, which may suggest why this combination works of authority coinciding with pure scientific expertise. Another respondent echoed this observation:

> If you get a Doctor [legitimate authority] to stand up there and defend the planning applications, it speaks bold. Whereas a planner can only make recommendations [weakened authority]. And sometimes our Council [elected decision-makers] decides against planning expertise, which is fine because it's part of the democratic process. But from our perspective, we're trying our best to provide the best advice. (Planner 10)

This 'best advice' echoes the idealized impartiality of planning - its noted strength in being wisdom imparted through education and study - though dwindling in esteem in the post-political landscape (Allmendinger, 2017). However, the perceived prestige of Peel's Chief Medical Officer of Health, Dr. David Mowat was used strategically by public health and planning staff:

> If we had faced [an obstacle] or felt that we had faced that, we would have gotten Dr. Mowat [legitimate authority] to go and talk to them. (Planner 4)

This self-perception of decision-makers also extended to self-policing on behalf of planners and public health staff that conformed to the parameters of the post-political consensus, and

the removal of the political in order to refine their policy-making process as apolitical and not associated with any particular political orientation (Wilson 2014), attaching to the more neutral credibility of Mowat's prestige as a doctor:

> So when we were first going to present to Brampton {lower-tier municipality} - it was doom and gloom [political vs. politics = tension/policy failure] - then it was maybe we could embed the index inside something else so it doesn't come out as some sort of left-wing thing [technocratic consensus] - then it was all it's not going to work [political] - then the commissioner went - what if an Medical Officer of Health spoke first [legitimate authority], not too long, right at the beginning of Council [elected decision-makers]. (Public Health 5)

With respect to the involvement of Dr. Mowat, he was described across the board as a key stakeholder in pushing the conversation on "healthy built environment", and a primary champion in maintaining the momentum throughout successive staff turnover. Dr. Mowat's involvement highlights the influence of charisma and legitimacy as well on processes, and the necessity of that figure in pushing forward policy visions.

> Then we sent the Chief Medical Officer - he was a good speaker and had a strong presence {charisma}, and he had that same message - that you can't do something with less walkability as healthy - you can't have my endorsement - and I'm telling you you're going to have rates of diabetes you will not be able to deal with. You will have problems in terms of your economy and blah blah, so he said all that and it changed how they voted {legitimate authority}. (Public Health 5)

What these points suggest is that there is a diminished sense among public health planning of its value to the process of city-building whenever it seems to extend beyond a status quo-oriented mandate, being careful not to seem 'political.' Instead, it is figures like a male doctor that would seem to hold more respect in the decision-making process, especially within the technical, profession-oriented practices of city-building such as engineering and transportation planning.

4.9 Defining Health

The definition of "health" in practice was slimmed down into a narrow category which resulted in an implicit removal of the "political", which then closed-off discussions of value, priority and democratic engagement. (Clarke, 2012). To begin with, the Region did not consult on its policy-making process when coming to an understanding of health, whether intentionally or not, foreclosing the possibility of conflict over their activities, and only doing focus group among planning, public health, and developers. In response to whether public consultations were conducted Public Health 8 responded:

> [With] the HDA [pause] no. But with the HDI [pause] no. And with the HBSF [pause] no. The closest we got with the HDI and the HBSF was stakeholder interviews. (Public Health 8)

This narrow definition of health was a conscious decision by a perceived legitimate authority, as established in the prior section, to reframe health as walkability, and reduce complexity of

the definition focusing it on one area of agreement that would fit within the post-political consensus of neutrality and something that does not fundamentally challenge the status quo:

> Often questions that Dr. Mowat [legitimate authority] would get would be why walkability [narrow definition of health] and why not health overall in terms of making a change [broad definition of health] and having policy amendments around it, why is it just addressing walkability [narrow definition of health]. And his big thing was that he wanted to keep it focused in one area [post-political consensus] to demonstrate the impact. And then once that was achieved, then let's talk about air quality and food environment. Mental health. Then opening it up to other topic areas [broad definition of health]. But he really wanted to first get - by adding other topic areas right from the get-go you're diluting the effect that you wanted to achieve [broad definition of health]. So, he wanted to demonstrate first that you can make an impact on walkability then open the door to other areas. (Public Health 8)

This statement resonates with the deferral of the political in the post-politics literature , that difficult decisions are displaced to the future where they could theoretically be addressed but are continually deferred to that point in the future. This point is voiced by Health Planner 4, explaining the Region's process of deferring more difficult political questions to the future, being happy with modest immediate gains:

> We were so happy with just happy with anybody being responsive [to the HDA] {power of status quo}. Like Public Health was so happy with anyone being responsive to being open to trying anything that we were willing to water things down and knowing that – we can start things - baby steps - we can get things in and build from there {post-political consensus}. (Health Planner 4)

And again, Public Health 7's comments highlight the feel-good nature of the definition Peel arrived at was without significant challenge or confrontation. Instead, it is more of a vague, fuzzy signifier as noted in the post-politics literature; a definition that can mean many things without representing a challenge to the status quo:

> You can [build consensus around health] - and it's a logical discussion. [...] Because everyone has someone in their family who has some kind of issue on health-related issue, mental health related issues, aging, etc. {signifier}. And if they can understand what children can get to, what seniors can get to, people start to begin to stop thinking about the project, and start thinking about the way they live, and the other people in their lives {all things to everyone}. (Public Health 7)

While Peel may have intended their policies in inter-sectoral collaboration to be a broad, expansive strategy, it resulted in a constraint to remove the possibility of conflict. Strategically then, the Region pushed forward with a definition of health that in practical terms was 'walkability', a choice that reduces discussion over how broad and encompassing health should be and constraints choice over the terms of any possible debate.

Interestingly, planners relied on Public Health staff in this process for their evidence and scientific consensus to lend their own work greater techno-managerial legitimacy from a scientific point of view, which was paired with at the same time a dismissal of the more fulsome social demands of Public Health on the profession, which meant that Public Health seemed to be strategically useful while not always practical, necessarily limiting their contributions and narrowing that definition of health. This echoes the broader health debate

where definitions of health have oscillated between definitions built upon narrowly defined, technology-based medical and public health interventions; and definitions of health as a social phenomenon, requiring complex intersectoral policy actions (Solar & Irwin, 2010):

> [...] as planners we always look to public health staff for scientific evidence {reliance on Public Health staff}. For instance, in our official plan policies, we require buffer zones for sensitive land uses to be away from highways, but we don't specify how much that buffer should be. Like a distance requirement. So one of the things my director says – you know what we need something from Public Health, they need to look into the literature to tell us the range, because without that specific range it makes it hard for the policy implementers like us to tell a developers this is the range. If you can just say - you need a buffer - well tell us what that buffer is. (Planner 10)

In addition, there was also skepticism of the role of public health's value to the process of even including 'health' within decisions, despite reliance on its evidence-based work, again suggesting a contributing factor to the narrowing of health: skepticism of advancing broader health goals in a planning tool, and a damping force on broadening that definition of health by a techno-managerial mentality - found in the idea of technical expertise - such as the technical transportation and engineering side of planning:

> I would say there's a resistance to Public Health being at the table {illegitimate voice}, particularly on the transportation side {legitimate voice}. If you attend an environmental assessment meeting for a road project, and you're Public Health, it's like why are you here and why are you telling me to do my job differently {illegitimate voice}. We don't influence their budgets or are part of their professional designation as part of engineers {legitimacy}. (Public Health 3)

This skepticism of the value of public health's influence was described by other participants, where planners in some respects appear pre-disciplined to accept the inculcation of market values as delivered by the development community. In this sense, the developers are the more persuasive and weightier influencers on the process, while Public Health's concerns were described as "wordy":

> So, part of my job was when I was in Public Health was trying to let them know what the planning process is, but really getting them to concentrate on what value they're bringing to the process {post-political value}. As we're finding that sometimes they provide very extensive, more essay-like comments, which the planners have trouble interpreting into conditions for local municipalities, which they would then pass on to the developers to address {post-political conditioning}. (Planner 10)

> [Public Health] would send long wordy letters about health [...] and not be applicable.{post-political values} (Planner 2)

> There was some tension around language of the policy, so Integrated Planning wanted more exclusions written in the policies about what the Healthy Development Assessment would not apply for {post-political values}. Health wanted all-encompassing language {broad definition of health}, and then those exclusion criteria could be adopted or changed later as need be, but [Integrated Planning] didn't want them written in the policies {politics}{post-political values} {weakened authority}. So that was a tension point. Once they understand we'd be establishing exclusion criteria for those applications that did not need to undergo a health assessment, then working with the local municipalities to decide what those would be, they came around, so those policies do have that broad language. So that was a tension. (Planner 3)

In the end, this narrowing of health was given from the top, squeezed further by the perceived lack of seriousness taken by planning staff regarding public health's involvement, and then implemented based upon political expediency, reflective of the conditions placed upon planning by post-politics.

4.10 Small Things: Incrementalism

The construction of choice with the policy tool around walkability created a tool that when brought to stakeholders - planners, developers, public health staff, and elected representatives - became one of the "small things" agreed upon by self-disciplined professional stakeholders (Clarke, 2012); i.e.) "politics": the routine administrations within institutional arrangements. In conversation with a stakeholder being asked about their view of the policy tool and proposed changes:

> [The changes] were minor {small things}. As opposed to 800 metres they had 1000 metres proximity to basic amenities, those kind of little tiny --- it wasn't philosophical changes {politics vs. the political}. So sometimes we were a little more stringent, and sometimes they were a little more stringent. It just went back and forth. {politics vs. the political}. (Planner 9)

The limit to the "small things", representing the shift from planning away from regulation and into active facilitation, was voiced by one participant: that planners' self-perception of their role is constrained by the philosophical terrain of planning in Ontario, and of the planners' role to manage choice and reduce conflict:

> That's where you get into a very tricky situation. Because planning as it operates in Ontario, philosophically {post-political planning} it's really about choice and the Healthy Development Assessment - that's the approach that it takes - it's about increasing different choices, opportunities to walk, to bike, and not so much about constraining or restricting certain things {politics vs. the political}. (Health Planner 2)

However, while hamstrung by the political culture, professionals within Peel nevertheless saw their work as progressive and an incremental advancement to make the implementation of a healthy built environment review process mandatory.

> We're trying to embed health as a criteria. Sustainable criteria. So, in order to do that we have to make it easy, user-friendly, not time-consuming, not scary, because we want everybody to do it. Then we'll make it mandatory. {deferring the political} (Health Planner 6)

> I'd like [The HDA] to have been more than [walkability], like linked to heart disease and diabetes, or linked to what people ate, but state of the literature at that point, it was the only empirical evidence - but at least it could stand up to OMB was our goal. [deferring the political]. (Public Health 5)

Finally, that the tool cleared the decision-making process is evidence of its relatively apolitical nature. There was not significant pushback during the decision-making process, as explained by participants.

> We hoped it would get challenged at the Ontario Municipal Board - but it never happened [post-political values: value neutral]. We wanted it so that even if we lost we'd get some face time with people who needed to think about these issues. (Public Health 5)

> So, went to Council and said way back - 2004ish - here's the data related to our major health issues. Diabetes is about to go through the roof - ⅕ is going to ⅓, because of the south Asian community. If we're dealing with this problem we need to deal with planning and transportation. And as you sometimes do with policy - you put in more than you think you're going to get. And surprisingly that report didn't get cut. So, we thought – this is great - we can go through all these applications with planners - first it was to comment, then it grew to be stronger." (Public Health 5)

What this suggests is that the tool was designed from the outset to not upset the status quo more than necessary to push a true political challenge, and the criteria for a post-political process was internalized by decision-makers throughout its design. It was not consulted upon with the public and did not meet significant push-back from developers to warrant significant change, other than making a non-mandatory application process easier for developers.

4.11 Summary

In summary, the document analysis and interview results suggest some overlap with the policy mobilities and post-politics. The first key finding from the document content analysis was that as Peel explored operationalizing a health tool, they went from something that

flirted with a broader definition of health that seemingly included discussion around health equity, towards finalization as a tool that kept a very narrow, confined definition of health that conflated health with walkability with the *Healthy Development Assessment.* Each iteration of the tool whittled away at the definition. This is echoed throughout the interviews, where the process unveiled the workings of the creation of an 'assemblage'; the multiple logics, processuality and labours involved in narrativizing a policy into a 'thing', at once seemingly stable, but shifting in meaning and purpose across its creation.

What once seemed to be an HIA, turned into a narrower urban design checklist following local contingencies and trajectories. For example, in the labours of creating the policy tool, the charisma and persuasiveness of the Region's Chief Medical Officer of Health was key in pushing forward the policy-process, and which had the spin-off of institutionalizing the relationship between Public Health and Planning. This relationship had been negligible prior to this process, with Public Health's contributions to decision-making being seen as less valid than the more technical disciplines like engineering and transportation planning. However, as this capacity-building process advanced, strategic problem-framing advanced the goals of health further than they had been, though

What is key is that counter to a narrative in the literature that presumes a policy tool that would passively follow the precepts of neoliberalism as the harsher critiques of post-politics presumes, the collaborative process between planning and public health enabled public health to have a much more influential role in the policy-making process, and positioned to continue

as an influential partner in the decision-making process. The next chapter will look into these findings in closer detail.

Chapter 5
Discussion, Conclusions and Recommendations

5.1 Introduction

This chapter discusses the results of the document content analysis and the interview analysis. It begins with a summary of key findings, progresses to a discussion of limitations of the study, then delving into a section on policy mobilities and then post-politics. This chapter concludes with recommendations for planning and ideas for future research. Largely, this research found that within that restrictive landscape of planning barriers, Peel Region was able to advance the working partnership of Planning and Public Health to begin to advance considerations of health within planning decisions, becoming more firmly entrenched within planning decisions. This suggests a more complicated dynamic than that predicted by the more broadly cynical tenets of post-politics. This study showed that key decision-makers strove to advance health in planning across successive staff turnovers to continue the direction of the policy tool.

The *HDA* tool was assessed through the policy mobilities and post-politics research streams, and this research suggests that both fields have some insight into the decision-making process around the healthy planning process, though some shortcomings as well. Peel Region's suite of healthy planning land-use policies suggest the barriers present in the post-political landscape on policy-making. This landscape is defined by the management of conflict and choice in order to remove the political from politics and policy-making,

becoming instead an apolitical practice that leaves basic questions about the underlying assumptions about the value and priority of decisions within ostensibly positive though vague terms like ‘sustainable development’, ‘creative cities’, and in the case of this study - ‘healthy cities’ - that disguise an unquestioning advancement of pro-growth policies.

This exploratory research pursued the tool’s origins and development to de-situate the official narrative to uncover the hidden workings beneath the policy adoption, unpacking its adaptation to local contingencies that showed in some sense it was a policy failure that become something new entirely. The tool went from a loosely adhered to Healthy Impact Assessment in its initial formulations - a tool to anticipate health outcomes of property development - to something resembling more of an urban design checklist, and the shifts and course corrections along the way highlight a learning process that introduced Public Health into a stronger decision-making role in planning decisions, albeit with a restrained role. These key findings will be discussed in depth below.

5.2 Summary of Key Findings

This study was guided with reference to two key concepts: policy mobilities and post-politics. The findings suggest that they have some explanatory power to unpack the decision-making process of healthy planning policy-making, while having some shortcomings found in the harsher aspects of its critique of planning practice.

There are several key takeaways from this research. First, that policy mobilities has insightful explanatory power in understanding the dynamics of policy adoption, in particular the shift of a loosely defined HIA into the much different HDA, particularly with the way a broad conception of health was slimmed down. Narrower understanding of health that while restrictive, still managed to advance consideration of health in planning therefore proved a strategically useful step to set-up future advancements of broader considerations of health within planning.

A second key finding would be that the post-political landscape may condition policy choices in Ontario consistent with the theories of post-politics, impeding broader health equity interventions. For example, while the conception of the tool during the Lawrence Frank (2009) iteration was much broader, the current iteration resolved mainly as a development checklist that focuses on walkability as a conflated definition of health.

Finally, a third key finding includes recommendations for future studies. Proposed studies would follow the continued development of Peel's healthy-built environment processes, as well as refine the applicability of these two concepts: policy mobilities and post-politics. The first follow-up research study would further investigate Public Health's involvement within planning's decision-making processes, as well as to pursue whether the tool develops a more mandatory aspect in development. Future research would also draw more comparative studies of healthy built environment policy-making in other Regions and municipalities in

Ontario, as well as comparative studies across political boundaries into other provinces, or countries.

The second follow-up studies would pursue the two critical theories: policy mobilities and post-politics. Policy mobilities was a particularly insightful lens into the decision-making process, prompting a wide-angle view of how and why policies are imported/exported and adapted for particular needs, and the local factors at play that shape those policies. However, it does not necessarily have a particularly strong causal approach beyond a broad critique of neoliberal. Similarly, post-politics sheds light on the conditioning factors of neoliberalism that might impede policy decisions but may be too strong in its approach and overlook other explanatory factors. Though Clarke, N. (2012) states that the reason policies moves and are so fluid across borders is because of the state of post-politics, and the essential sameness of this system across regimes and jurisdictions. This thesis would state that may be true to an extent, but there are other factors - local histories, interpersonal politics, and even something as quotidian as personal charisma - that enabled the success and shaping of the growing influence of health on policies in seemingly relevant ways as well.

The restrictions imposed on this policy tool follow post-political theory; namely, that the definition of health arrived at was a broad, fuzzy all-things-to-everyone operationalization of health that does little to challenge a pro-growth status quo, and conflated health with walkability. In addition, this process was not open to a consultation process, but was decided top-down by perceived experts. For example, a term like “healthy built environment” is

adapted and then supported with metrics in order to displace the political under a barrage of analyses and expert reports (Allmendinger & Haughton, 2011). The question: “how do we know that the built environments we are capable of building under this planning regime contribute to health?” is not asked but is instead assumed as a consensual goal and turned into a technical exercise with supporting assessment techniques and indicators.

5.3 Limitations of the Study

This study was limited by time constraints, as well as the small scope of the study. Future studies would benefit this research direction by looking at broader geographic range, a broader comparative suite of implemented policies - or failed policies - and include a broader network of actors as research participants. For example, including a larger research sample that factored in the participation by policy decision-makers, but as well as private sectors actors not only within consultancies, but the development sector, or civil society stakeholders, like NGOs and citizen groups. As well, research was limited by access to confidential documents that would have shed further light on the research, such as emails, internal documents, and similar pieces of evidence, that were unavailable at the time of research.

Limitations to this study are also based upon the limitations in general to qualitative research in general. In particular, this was a limited case study of a single phenomenon, and therefore it is not necessarily valid to present generalizations drawn from this research. In addition, the

inclusion of semi-structured interviews and the guidance of the interviewer may have introduced lack of comparability between results, as well as interviewer bias while guiding questions (Babbie & Benaquisto, 2002; Neuman, 2012; Creswell, 2014; Pajo, 2018). As well, rigor is more difficult to maintain and assess, though accurate transcripts of all interviews were reviewed by graduate supervision.

5.4 Policy Mobilities

As shown in the results, Peel's process moved throughout each iteration of the policy process from an outward, extrospective searching process that resembled the outlook of a Health Impact Assessment (HIA), in a process of learning and consuming best practices, towards an internal, more insular process of policy innovation and experimentation that shifted the Region's policy boosterism: something to advertise and broadcast. In this way, the policy process featured aspects of a failed policy transfer of an HIA. Stein, C. et al. (2017) argue that it is more instructive to study failed policy mobilities, as those constraints and resistances that prevent perfect policy mobilization underscore the different social contexts within each territory, and can offer a more nuanced view of how operate in contrast to the assumed precepts of neoliberalism - that the market operates in conflict with progressive planning such as health planning - and offers a richer understanding of conditioning environments, and opportunities for further progress.

In this way, Peel Region did not adopt a perfect edition of a Health Impact Assessment (HIA); variously defined as a method that "seeks to estimate the probable impact of a policy or intervention in non-health sectors, such as agriculture, transportation, and economic development, on the health of the population." (Brownson, 2010, pg. 16). Health Impact Assessment (HIA) is also defined as "systematic, evidence-based decision support tool that considers how a proposal may alter the determinants of health prior to implementation and recommends changes to enhance positive and mitigate negative impacts" (Pennington, 2017, pg. 56). The tool under consideration contained the essential features that would define it as an HIA:

- To predict the future consequences of health if possible decisions
- To inform decision-making

Instead, as the process continued, the Region arrived at a definition of health that was much less fulsome than that found in wider policy circuits of health policy, such as the healthy cities movement and the World Health Organization's best practices - distilled to an understanding of "healthy cities" as a dynamic process and more a commitment to continually improving the well-being of populations, places and policymaking processes with the goal of reducing overall health inequities (Corburn, 2009), which the Region evidently found non-workable crystallized in a policy tool. Instead, their definition moved towards one that fit neatly with a working definition that aligned with pro-development growth policies. However, what is crucial is that despite not operationalizing a broader definition of health, it

brought the Region's Public Health into a more authoritative role in the planning process, as well as establishing a strategic attempt to pivot towards further decisions by Public Health. What had been two departments operating in isolation became a unified partnership to bring health considerations - however narrowly defined - into an established process with room to grow regarding involvement with future decisions.

This suggests that for planning to present broader conceptions of health, a more multi-sectoral approach is necessary; a reaching out across siloed divisions to bring other voices of policy-making into conversation. In this case, it was planning that brought public health into the fold and elevated it into a more equal partner in planning decisions. This was a proactive initiative that perhaps could give guidance for how planners could act in practice in order to broaden the expertise of their discipline.

5.5 Post-Politics

Peel was able to advance its 'healthy built environment' planning agenda in this post-politicized landscape, as one of the primary voices advancing the health policy was a doctor; a credible voice of persuasion and influence and a perceived institutional cornerstone. Within Peel's system, the Public Health department initially struggled to be taken seriously or feel an equal partner in planning decisions where traditionally technical disciplines such as engineering, held greater perceived legitimacy. Public Health was able to slot into this conversation through the invitation of Peel's Development Services department, the team

responsible for reviewing development applications within the Region's purview. Initially, Public Health's role was advisory, without the ability to pull the levers of decision-making authority on how built-form was developed. However, by participating in a slimmed down version of health, they were able to participate in conversations of legitimacy with managerial elites, but in ways that limited the value of democratic participation through public consultation (Raco, 2014). This approach would seem to echo the post-politics literature that legitimacy comes from those vested institutional interests benefiting from guiding policies, while radical and reformist approaches are either ineffective or generally merely advance the post-political order (Beveridge & Koch, 2016).

The arrival at 'walkability' and its conflation with 'health' can be described in post-political analysis as echoing how fundamental questions about policy decisions seem to have been agreed upon 'somewhere else' by managerial elites (Raco, 2014) - not in public debates - and pursuant to a general interest decided upon by senior figures and using definitions which no one "in his [or her] 'right mind'" would reasonably disagree with (Allmendinger, 2017 p 192). 'Health' as 'walkability' then could be argued as having become a "consensualist centrism" (Swyngedouw, 2010 p. 615) that removes 'the political' to confine, organize and enclose debate around questions of power and value (Gill, Johnstone, Williams, 2012).

In this sense 'health' is not political, but instead a technical term, and opening its definition up to more political considerations - more fine-grain socio-economic conceptions - is eliminated. Health became a smaller, narrower concept, one that fits within the description of

'politics' from post-political literature; something that maintains the status quo agreement to a developer defined city without complications or tensions over who health is for, and how to understand health as a spatial phenomenon. The "small things" of disagreement is to say that the areas of agreement that do exist are within an area of safely defined technical choices made by self-disciplined experts (Gill, Johnstone, Williams, 2012). The role of the planner in this realm is not to challenge vested interests and ask broader political questions like "what is health?", but to agree to the technical specifications in a development checklist, where the most contested things have been removed (Beveridge & Koch, 2016). This is a glimpse into the techno-managerial process as described in the post-politics literature (Cook & Swyngedouw, 2011), that fundamental disagreement was not a sticking point during some of the glimpses emergent in the interviews of the negotiation process because the political decisions were not part of that process, and that process was not open to broader critique by the public.

Health is no longer a 'wicked problem' with complex facets and determinants, but is instead a non-ideological, pragmatic tangible project outcome, conceived by experts who "know best" (Raco, 2014 p. 26). This is a key point that asks then what else could result from such an institutional arrangement, and could health be more broadly conceived, or do these institutional arrangements in a sense sew shut possible alternatives. This impacts on the nature of planning, and the contradiction of planning for neoliberal forces, where bottom-up approaches are seemingly encouraged but stymied as a result of pressure from market forces (Tasan-Kok, 2012).

5.6 Recommendations for Planning

While not necessarily a conscious choice of its decision-makers, there is evidence that post-politics reduced the scope in which 'health' could be considered in its broadest definition: a definition that would have brought forward voices that articulated health needs beyond the spaces of government policy-making, though whether or not opening that process to greater engagement would have enhanced its progress is an open question.

The existence of this state would limit the scope of interventions planners can engage in, while they are at the same time pressured to take on issues that are seemingly beyond redress at the urban level; issues like climate change and true real estate affordability and social and affordable housing at levels to meet demand. In addition, it would pursue a more normative suggestion of:

- "What *should* a health tool look like?" and given these strictures;
- "What *can* a health tool look like?"

Corburn et al. (2014) has also recommended a method by which to resolve democratic deficiencies in urban policy-making: coproduction; participatory processes to create policy tools, joining lay people scientists, governments experts, to generate a pairing of socially and technically sound public policy (Corburn et al., 2014). In this approach, a pairing with the concept of "targeted universalism" delivers a broad equity-based approach to population

health while recognizing that some vulnerable groups and particular locations required specific, targeted policies (Corburn et al., 2014).

This would invite a conversation about the proper place of "the political" in planning for health and in urban policy-making, and whether planners can challenge vested interests and current conditions in ways that advance health considerations beyond very safe, technocratic questions, in addition to whether and to what extent planning can be rational and value-free.

This research also invites research into whether this be done at the municipal level without support from provincial policies. These are questions that planners should consider when they practice, to challenge the prevailing restraints of decision-making based on strict market logic, and to fend off potential questions of legitimacy from a resurgent right-wing populism that could question the fundamental disconnect from planning in closed circles, and planning for people beyond non-mandatory technical documents. Peel Region could explore bringing in voices from the community regarding how it defines health: not only something decided upon within professional policy circles, but inviting the public into those conversations to see if there are aspects of a policy tool that could be designed to suit challenges not perceived or apprehended by planning and public health staff.

These recommendations also extend into expanding the circle of expertise planners draw from in making decisions. In this case study, planning invited public health into the decision-making process and empowered their expertise for inclusion at the table as decision-makers.

This sort of interdisciplinarity, and breaking down of barriers between siloed departments, is an example of how planners can advance practice and strive towards advancing the cause of Healthy Cities, echoing the WHO's recommendations of both empowerment - of public health - and intersectoral collaboration (WHO, 2019). To further this cause would also include greater public participation and participant equity.

Operationalizing this work would suggest several key points for professional practice. While statutory and provincial policy changes are beyond the domain of municipal planners, there is nevertheless room for managerial/operational learning. This thesis highlights the importance of inter-departmental relationship-building, and the subsequent knowledge translation that occurred between planning and public health departments. However, rather than stop at merely a meeting of disciplines as happened in Peel, there is room for further cross-pollination between departments to embrace a broader goal of achieving harmonized health outcomes, resonant with a "Health In All Policies" approach (Clavier, 2016). This relationship-building and networking across departments is deliverable without legislative or policy changes, and requires examples such as those conducted by Peel, where departments across policy sectors and across interests, institutions and understandings of a policy found ways to broach their institutional divides. Examples from this case study include Peel's planning department running 'Planning 101' crash courses for public health in order to bring professionals with primarily nursing and medical backgrounds to be able to speak comfortably with planning vernacular.

Finally, this case study is an example to other comparable jurisdictions of the strategies for success and possible barriers to creating a similar policy tool for their region. Similar pitfalls may be present within the predominant pressures of a neoliberal governance structure, but that with collaborative strategies it is possible to elevate public health and broader considerations of health within planning discussions.

5.7 Future Research

Being a snapshot in time, this study would benefit from a follow-up that continues to follow the development of the policy, and whether it becomes mandatory with more, or less, stringent criteria and consideration of health. Future research would enhance the validity observations presented in this paper. In particular, this research area would deepen with:

- A broad study of the involvement of Regional Public Health units in Ontario - and in other areas of Canada - and their engagement with the political process. Studying engagement with political decision-makers would provide further empirical evidence whether that de/legitimizes efforts by public health to unite with planning concerns.
- A comparative study of policy-making processes of public health units and planning departments internationally.
- A follow-up on the ongoing policy-making process at Peel, and whether the strategic pivot of the tool was able to advance more normative health concerns, or if it is stifled

by the conditions of the post-political landscape; as well, whether it becomes mandatory with more or less stringent criteria and consideration of health.

Research could follow the continued trajectory of the Healthy Development Assessment as it evolves in Peel Region, and whether the policy-making process will be able to capture broader consideration of health impacts. In addition, it would include a broader geographic study within not only Ontario's healthy built environment policies, but nationally, as well as possibly internationally. For example, why has there not been a broader model such as that used in Richmond, CA - a "Health In All Policies" (HiAP) government model - been considered in Ontario, and how would a policy mobilities lens offer explanatory power to the reason why not? Corburn, J. et al. (2014) have advocated a HiAP approach, founded on the idea of 'co-production.'

A foundational objective of the notion of 'healthy urban governance' is democratic participation, and enhancing democratic participation in policy-making through the coproduction of policy tools, where stakeholders such as residents, non-governmental agencies, scientific and technical experts, participate in public decision-making processes to create policy decisions that run through all policies, not just land-use planning, but linking all policies through the urban government's policy outputs. The HiAP's key piece is advancing from simple acknowledgement of health equity problems - such as a health equity impact assessment. Instead, it advances ameliorating health equity impacts with action through inter-

sectoral response. Rather than a simple design checklist, the HiAP involves both the coproduction of knowledge and action strategies (Corburn et al., 2014).

5.8 Last Thoughts

This concern about post-political planning arises from the reduction of contemporary urban policy to 'small things' that are simple enough to build consensus around. Building consent around such easily agreed upon topics makes it easier to exclude those who engage in disagreement from the proper politics involved in planning and city-building. This is not to say that finding agreement over 'small things' is a bad thing, nor that it is not a valid goal, but that often that to push for goals like health equity, affordable housing and environmental sustainability, requires pushing against vested interests and not just debating within the parameters of safe terms that can be turned into vague objectives that are easily co-opted or re-directed through their vagueness (Clarke, 2012).

However, what is crucial is that despite not operationalizing a broader definition of health, this process brought the Region's Public Health into a more authoritative role in the planning process, as well as establishing a strategic attempt to pivot towards further decisions by Public Health. What had been two departments operating in isolation became a unified partnership to bring health considerations - however narrowly defined - into an established process with room to grow that commitment in future decisions.

As it stands, the current tool is a non-mandatory checklist that does not affect development in the majority of development applications in the Region, does not make-or-break development applications, and conflates health with walkability rather than a more fulsome definition. This study captures a snapshot of a tool in the process of becoming, but not yet arrived.

The way health is defined by policy-makers reflects how health is defined in our cities. A more comprehensive conception of health cannot be put into practice without vested interests being challenged and confrontation with the status quo. Understanding limitations in the terrain in which policy-making happens is key to posing compelling alternatives and imagining different ways of producing our cities.

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Appendix A

Letter of Information

Project Title: Exploring the Policy Mobility of Health Impact Assessment Best Practices with Peel Region's Healthy Development Assessment

University of Waterloo

Date

Dear (insert participant's name):

This letter is an invitation to consider participating in a research study I am conducting as part of my Master's degree in the Department of Planning at the University of Waterloo under the
supervision of Professor Dr. Jennifer Dean. I would like to provide you with more
information about this project and what your involvement would entail if you decide to take part.

This study is designed to analyze how best practice policies with transnational origins are mobilized and grounded in particular places. One such best practice that has not been analyzed within the policy mobilities research field is the Health Impact Assessment (HIA). This tool originated from the work of the World Health Organization in the early 90s, and the concept has since proliferated to numerous communities internationally for use in practice.

As a best practice with international origins, an analysis of the "how" the HIA assessment has been grounded in Peel Region as a "Healthy Development Assessment", and the "contingencies, failures, course corrections" and "deductions" from wider flows as it landed in Peel would provide insight into how best practices operate and are translated in the Greater Toronto Area. Of particular interest is the network involved in this policy, as both public and private sector actors were involved in the drafting of the policy.

Therefore, I would like to include you as one of several participants to be involved in my study. I believe that because of your knowledge of or because you were involved in the creation process of the Healthy Development Assessment, you are best suited to speak to the various issues in the development of this policy.

Participation in this study is voluntary. It will involve either a face-to-face interview of approximately 45-60 minutes in length to take place in a mutually agreed upon location. The interview may also involve a telephone interview of approximately 45-60 minutes in length. You may decline to answer any of the interview questions if you so wish. Further, you may decide to withdraw from this study by June 2018 without any negative consequences by

advising the researcher. With your permission, the interview will be audio recorded to facilitate collection of information, and later transcribed for analysis. Shortly after the interview has been completed, I will send you a copy of the transcript to give you an opportunity to confirm the accuracy of our conversation and to add or clarify any points that you wish. All information you provide relating to your identity will be considered completely confidential. Your name will not appear in any thesis or report resulting from this study, however, with your permission anonymous quotations may be used. While your identity will remain anonymous, there is the anticipated risk that due to the number of people involved in the project, a motivated individual may be able to ascertain your identity and therefore there is a risk of identification in participating in this study. Data collected during this study will be retained for the minimum retention period of 1 year in a locked office in my supervisor's lab. Only researchers associated with this project will have access.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE#22750). If you have questions for the Committee contact the Chief Ethics Officer, Office of Research Ethics, at 1-519- 888-4567 ext. 36005 or ore-ceo@uwaterloo.ca.

For all other questions or if you would like additional information to assist you in reaching a decision about participation, please contact me at XXX-XXX-XXXX or by email at ngodfrey@uwaterloo.ca. You can also contact my supervisor, Professor Jennifer Dean at 519-888- 4567 ext. 39107 or email jennifer.dean@uwaterloo.ca.

I hope that the results of my study will be of benefit to those organizations directly involved in the study, other voluntary organizations not directly involved in the study, as well as to the broader research community. Results from this research may be shared with the broader research community.

Sincerely,

Nicholas Godfrey, School of Planning, University of Waterloo
ngodfrey@uwaterloo.ca, XXX-XXX-XXXX

Dr. Jennifer Dean, School of Planning, University of Waterloo
jennifer.dean@uwaterloo.ca 519-888-4567 ext. 39107

Appendix B

Consent Form (Written)

Project Title: Exploring the Policy Mobility of Health Impact Assessment Best Practices with Peel Region's Healthy Development Assessment

By signing this consent form, you are not waiving your legal rights or releasing the investigator(s) or involved institution(s) from their legal and professional responsibilities.

I have read the information presented in the information letter about a study being conducted by
Nicholas Godfrey and Dr. Jennifer Dean of the School of Planning at the University of Waterloo. I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and any additional details I wanted.

I am aware that I have the option of allowing my interview to be audio recorded to ensure an accurate recording of my responses.

I am also aware that excerpts from the interview may be included in the presentations and/or publications to come from this research, with the understanding that quotations may be attributed to me using an anonymous identifier in my role as an expert.

I was informed that I may withdraw my consent by June 2018 without penalty by advising the
researcher.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE# 22750). If you have questions for
the Committee contact the Chief Ethics Officer, Office of Research Ethics, at 1-519-888-4567
ext. 36005 or ore-ceo@uwaterloo.ca.

For all other questions contact Nicholas Godfrey and Dr. Jennifer Dean.
With full knowledge of all foregoing, I agree, of my own free will, to participate in this study.
YES NO

I agree to have my interview audio recorded.
YES NO

I agree to the use of direct quotations in any presentations or publications that comes of this research.
YES NO

Participant Name: _____ (Please print)
Participant Signature: _____
Witness Name: _____ (Please print)
Witness Signature: _____
Date: _____

_____
_

Nicholas Godfrey
University of Waterloo
Department of Planning
XXX-XXX-XXXX
ngodfrey@uwaterloo.ca

Dr. Jennifer Dean
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519-888- 4567 ext. 39107
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Appendix C

Consent Form (Verbal)

Project Title: Exploring the Policy Mobility of Health Impact Assessment Best Practices with Peel Region's Healthy Development Assessment

By agreeing to verbal consent, you are not waiving your legal rights or releasing the investigator(s) or involved institution(s) from their legal and professional responsibilities.

I have listened the information presented in the information letter about a study being conducted by Nicholas Godfrey of the School of Planning at the University of Waterloo. I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and any additional details I wanted.

I am aware that I have the option of allowing my interview to be audio recorded to ensure an accurate recording of my responses.

I am also aware that excerpts from the interview may be included in the presentations and/or publications to come from this research, with the understanding that quotations may be attributed to me using an anonymous identifier in my role as an expert.

I was informed that I may withdraw my consent by June 2018 without penalty by advising the
researcher.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE#22750). If you have questions for
the Committee contact the Chief Ethics Officer, Office of Research Ethics, at 1-519-888-4567
ext. 36005 or ore-ceo@uwaterloo.ca.

For all other questions contact Nicholas Godfrey or Dr. Jennifer Dean.
With full knowledge of all foregoing, I agree, of my own free will, to participate in this study.
YES NO

I agree to have my interview audio recorded.
YES NO

I agree to the use of direct quotations in any presentations or publications that comes of this

research.
YES NO

Participant Name: _____ (Please print)
Participant Signature: _____
Witness Name: _____ (Please print)
Witness Signature: _____
Date: _____

Appendix D

Feedback Letter

University of Waterloo

Date

Dear (Insert Name of Participant),

I would like to thank you for your participation in this study entitled [insert "study title"]. As a
reminder, the purpose of this study is to understand how best practice policies are mobilized and become grounded in the policy-making process in southern Ontario.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE#22750). If you have questions for the Committee contact the Chief Ethics Officer, Office of Research Ethics, at 1-519-888-4567 ext. 36005 or ore-ceo@uwaterloo.ca.

For all other questions contact Nicholas Godfrey or Dr. Jennifer Dean.

Please remember that any data pertaining to your identity will be kept confidential. Once all the data are collected and analyzed for this project, I plan on sharing this information with the research community through seminars, conferences, presentations, and journal articles. If you are interested in receiving more information regarding the results of this study, or would like a summary of the results, please provide your email address, and when the study is completed, anticipated by June 2017, I will send you the information by email. In the meantime, if you have any questions about the study, please do not hesitate to contact me by email or telephone as noted below.

Nicholas Godfrey
University of Waterloo
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XXX-XXX-XXXX
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Appendix E

Snowball Sampling Email Forward

Dear (Insert Name)

I am writing you on behalf of Nicholas Godfrey who is conducting research on Peel Region's Healthy Development Assessment as part of a Master's degree in the Department of Planning at the University of Waterloo under the supervision of Professor Dr. Jennifer Dean. Attached you will find a letter of information with more details regarding the project.

Thank you for your time,

(Insert Name)

Nicholas Godfrey
University of Waterloo
Department of Planning
XXX-XXX-XXXX
ngodfrey@uwaterloo.ca

Dr. Jennifer Dean
University of Waterloo
Department of Planning
519-888- 4567 ext. 39107
jennifer.dean@uwaterloo.ca

Appendix F

Draft Interview Questions

Note: Questions to be asked only if relevant to area of expertise

We are interested in better understanding the way the Healthy Development Assessment was mobilized and grounded in Peel Region, as well as how the policy process involved in grounding best practices shape cities. I am going to ask you questions about this topic and then some more detailed questions about your role in the development of the Healthy Development Assessment.

Just as a reminder, I will be audio-recording this conversation. Is that okay with you?

Section 1: General Expertise
1. How long have you been working at (organization name)?
    a. In the field of X?
2. What is a typical day like for you?
3. What is the most interesting part of your job?

Construct	**Question**	**Prompt**
General	What is your current position? How would you describe your involvement in the Healthy Development Assessment process?	Policy planner, consultant, planning/health researcher?

Planning priorities	To your understanding, why did Peel want to develop this tool? What initiated Peel's interest in healthy cities/healthy built environment/healthy planning? What steps led to the Peel Healthy Development Assessment (2016), as work transitioned from the Health Background Study Framework (2011), the Healthy Development Index Refinement Study (2012), the Health and the Built Environment - Regional Official Plan Review Discussion Paper (2013)? What methods were used to discover best practices to inform this work? How are decisions about which best practices to use made? Were there points during its development that it could have been different?	Who? Why? Where? When? What sources/networks did you tap into? Why? What sources were used? By whom? Why or why not? How could it have been different?

Collaborations	Were collaborations part of the creation of the Healthy Development Assessment? What was the network of influence that enabled the creation of the Healthy Development Assessment?	Which ones do you work with most often? Who were most influential/not influential? Why or why not?
Future	Do you see the Healthy Development Assessment changing in the future?	Why or why not? What sort of approach to health?

Appendix G

Interview Questions and Supporting Literature

Research Question: *What influences led to the creation of Peel Region's Healthy Development Assessment tool?*	**Relevant Literature**
General Questions	
What is your current position? How would you describe your involvement in the Healthy Development Assessment process?	*n/a*
Planning Priorities	
To your understanding, why did Peel want to develop this tool? Prompt: Who? Why? Where? When?	"Why" a city arrives at a policy decision is crucial to policy mobilities and the study of policy, and finding the evidence "that multiple, often untraceable, influences [have been] brought to bear on even powerful circulating ideas in order to 'arrive at'

	distinctive responses to the specific challenges of a particular city." (Robinson 2015 p. 833). Those distinctive responses are the meat of this research.
What initiated Peel's interest in healthy cities/healthy built environment/healthy planning? Prompt: What sources/networks did you tap into? Why?	As stated by Prince, R. (2012) "networks are the boundary-crossing web of influences that shape political and policy decisions. They can include the political advisors and policy-makers who make day-to-day policy decisions, and the guiding hand of supra-national actors and foreign governments, as well as legitimating transnational epistemic communities of relevant experts."
What steps led to the Peel Healthy Development Assessment (2016), as work transitioned from the Health Background Study Framework (2011), the Healthy Development Index Refinement Study (2012), the Health and the Built Environment - Regional Official Plan Review Discussion	This question builds off the previous question to get a sense of the narrative of the timeline as it unfolded, and how the policy tool was narrativized. As stated by Peck, J. p. 26 "Depth interviews enable researchers to probe contending accounts and evaluate proto-explanations amongst a range of

Paper (2013)?	knowing interlocutors; they provide opportunities to excavate the social and political context of decision making, to delve into the `reasons for reasons', and to hand back circulating narratives and proto-explanations for verification, qualification, or rejection." Getting the 'circulating narrative' is key to unpacking and critically interrogating it through analysis.
What methods were used to discover best practices to inform this work? Prompt: Prompt: What sources were used?	Uncovering best practices and why they move is key to policy policies, as quoted by McCann, E. (2013) p. 344: "Certain governance strategies or policies, 'best practices', and 'received wisdoms' seem to be everywhere, and they resonate with us in their familiarity, even if we have not consciously studied them. They have 'gone viral'. They move around from place to place, and they hang in the air during discussions about how to govern places."

How are decisions about which best practices to use made? Prompt: By whom?	As framed in the policy mobilities literature, bringing to the table and resolving issues through collective decision-making "is integral to local policy-making." (Kennedy 2016, p. 99).
Were there points during its development that it could have been different? Prompt: Why or why not? How could it have been different?	Understanding course corrections of a policy and possible alternatives that never were is part of understanding how a policy is grounded, and "[w]ithout attending to the fine-grain of practice, critical policy scholars risk over-estimating the salience of influential actors and political projects, and under-estimating the contingencies, failures, course corrections, and re-directions that animate the making and implementation of policy" (Baker & McGuirk, 2017 p. 439).
Collaborations	
Were collaborations part of the creation of the Healthy Development Assessment?	
What was the network of influence that enabled	These questions build towards understanding

the creation of the Healthy Development Assessment?	the policy-making networks and collaborators, as policy mobilities studies looks at “key actors, ideas and technologies [that] are actively brought into productive co-presence in cities, [and] in how certain absences are also presences in policymaking, as actors in one place refer to models elsewhere as they construct 'local' policies” (McCann, 2011 p. 143).
Prompt: Which ones do you work with most often? Who were most influential/not influential? Why or why not?	
Future	
Do you see the Healthy Development Assessment changing in the future? Prompt: Why or why not? What sort of approach to health?	This question was designed to understand how employees conceive of health, and how a tool could possibly encompass those definitions, or be limited by practice.

Appendix H

Coding Schemes

Coding Scheme Post-Politics

Primary Theme **Secondary Theme**

Legitimacy Legitimate Authority

- Doctor
- Political Agency
- Charisma
- Leadership
- Elected Decision-Makers

Weakened Authority

- Planner
- Public Health

Politics vs. The Political Politics

- Policy Success
- Post-Political Values
- Technocratic Consensus

Political

- Tension
- Policy Failure

Defining Health Walkability = Health
Broader Definition of Health

Small Things Technocratic Consensus
Politics vs. The Political

- Deferring the Political
- Post-Political Planning
  - Post-Political Values

Coding Scheme Policy Mobilities

Primary Theme	Secondary Theme
Multiple Logics	Course Correction
	Transformation
	Transforming
	Contradictory Visions
	Assemblage
Processuality	Policy Invention
	Policy Influence
	Policy Teaching
	Policy Extroversion
	Assemblage
	Emergent Policy
	International Policy Flow
	International Policy Learning
	Local Contingencies
	Transformation
Labours	Strategy
	Framing Problem
Knowledge Translation	
Female Labour	
Future Labour	
Power	Male Labour
	• Maleness