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MOVING FORWARD HEALTH EQUITY: IMPLEMENTATION RESEARCH ON GOVERNANCE FOR HEALTH EQUITY AT LOCAL LEVEL

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Doctoral thesis by Anna Giné March

Directed by Amaia Bacigalupe and Bernard Cherubini

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Abstract

English abstract

BACKGROUND: Urbanization is one of the leading sociodemographic trends of the 21st century, which makes urban areas one the most important settings for tackling current and new global challenges. In fact, the importance urban health has been increasingly recognised for its central role shaping public health globally. In this context, an equity-promoting urban governance offers a window of opportunity not only to face these challenges, but also to be part of the solution. Policy coherence, accountability and social participation have been identified both as drivers of health equity and key dimensions of governance for health equity.

OBJECTIVE: The fundamental question that underlies this research is how local health strategies can drive forward an equity-promoting urban governance for health. This thesis aims to describe the urban governance for health context in three urban case studies, and to appraise and comparatively analyse how the key dimensions of governance for health equity have been incorporated within local health strategies. Moreover, the thesis assesses the main barriers and facilitators of the implementation of equity-promoting local health strategies.

METHODS: This is a qualitative-based implementation research, which employs a multiple case study method to deeply examine the local health strategies of Bilbao, Barcelona and Liverpool. Participant observation, document analysis and 27 in-depth semi-structured interviews among technicians, managers, decision-makers and other local actors were conducted. These key dimensions of governance for health equity were assessed: 1. Policy coherence was analysed using an adaptation of the Storm's Maturity Model for HiAP; 2. Accountability was assessed using the Ebrahim and Weisband's proposal and the corresponding domain of the PAHO Equity Commission's rubric for accountability; 3. Social participation was analysed using the Health Canada's Public Involvement Continuum model. To assess the barriers and facilitators of the implementation processes the Consolidated Framework for Implementation Research was used. In addition, to contrast and validate the comparative analysis results, 16 experts in the field of governance for health, health equity and implementation science were interviewed.

RESULTS: There were significant variations in the levels of maturity of policy coherence, accountability and participation across the local health strategies explored, being more developed in the cases of Barcelona and Liverpool, and somewhat more incipient in Bilbao. The heterogeneity of the governance for health strategies revealed that there is no one-size-fits-all type of strategy that fosters health equity. However, there are elements in common that can act as enablers of an equity approach.

Regarding policy coherence the results suggest that a democratic and socially progressive political environment supports the integration of health and equity as a shared value. Likewise, the establishment of legal and regulatory frameworks such as public health laws or strategic government plans can provide an umbrella for the institutionalization of a social model of health. Specifically with regard to local health strategies, these seem to be more operative when they involve multi-level policies. That is because they enable more easily the establishment of structures and resources for intersectoral action for health, the use of decision-support tools, and the development of individual and institutional capacities, which are key elements for its implementation. Building synergies with other programs and networks can also foster the implementation of policy coherence at the local level.

With regard to accountability, a human rights-based approach to health combined with structures, mechanisms and processes for accountable governance can foster transparency and answerability, but also compliance and enforcement. Accountability in local health strategies can be operationalized through Public Health Observatories with a technical profile and a sufficient degree of autonomy from the political level. Ensuring continuous and inclusive monitoring and evaluation, an availability of openly available disaggregated local data as well as the generation and transfer of applied knowledge are also key enablers of accountability at the local level.

Regarding social participation, a more horizontal model of governance involves promoting deliberative capacity and the decentralisation of power through the establishment of a variety of processes, mechanisms and instruments that encourage the participation of all social groups. It is essential ensuring an inclusive and representative participation and incorporate social participation as an essential part of the whole policy circle. Local health strategies should strive for leadership by and for the community, including specific actions for the development of participatory skills and capacities for both the population and local government.

CONCLUSION: The results highlight that progress in the implementation of equity-promoting local health strategies requires the inclusion of equity as a general value and as a specific policy objective through goals to reduce inequalities, but also through goals to strengthen and operationalise policy coherence, accountability and social participation. This implies moving from short-term, fragmented or isolated policies to a comprehensive set of policies that place equity at the centre. Effective policy action to respond to global challenges cannot fit into low-cost policy options that fit within electoral cycles. Health inequalities will only be reduced as a result of substantial political change; moving forward policy coherence, accountability and social participation into local health strategies can foster the creation of arenas to challenge the distribution of power.

Key words: *Health equity, Governance, Public policy, Health equity drivers, Policy coherence, Accountability, Social participation, Implementation research, Bilbao, Barcelona, Liverpool, Urban health*

French abstract

CONTEXTE: L'urbanisation est l'une des principales tendances sociodémographiques du XXIème siècle, ce qui fait des zones urbaines l'un des cadres les plus importants pour faire face aux défis globaux actuels et à venir. En effet, l'importance de la santé urbaine est de plus en plus reconnue pour son rôle central dans le façonnage de la santé publique au niveau global. Dans ce contexte, une gouvernance urbaine favorisant l'équité offre une opportunité non seulement de faire face à ce défis, mais aussi d'être une partie de la solution. La cohérence des politiques, la responsabilité et la participation sociale ont été identifiées à la fois comme des vecteurs d'équité en matière de santé et comme des dimensions clés de la gouvernance pour l'équité en santé.

OBJECTIF: La question fondamentale qui sous-tend cette recherche est de savoir comment les stratégies locales de santé peuvent faire avancer une gouvernance urbaine pour la santé intégrant l'équité. Cette thèse a pour but de décrire le contexte de la gouvernance urbaine pour la santé de trois études de cas dans des villes, ainsi que d'évaluer et d'analyser de manière comparative comment les dimensions clés de la gouvernance pour l'équité en santé ont été incorporées dans les stratégies locales de santé. En outre, la thèse évalue les principaux obstacles et facteurs facilitant la mise en œuvre de stratégies locales de santé intégrant l'équité.

MÉTHODES: Il s'agit d'une recherche qualitative sur la mise en œuvre de politiques publiques (implementation research), basée sur une étude de cas multiples pour examiner en profondeur les stratégies locales de santé des villes de Bilbao, Barcelone et Liverpool. L'observation participante, l'analyse documentaire et 27 entretiens semi-structurés approfondis auprès de techniciens, de gestionnaires, de décideurs et d'autres acteurs locaux ont été réalisés. Quatre dimensions clés de la gouvernance pour l'équité en santé ont été évaluées: 1. La cohérence des politiques a été analysée à l'aide d'une adaptation du modèle de maturité pour la santé dans toutes les politiques de Storm (MM-HiAP); 2. La notion de responsabilité a été évaluée à l'aide de la proposition d'Ebrahim et de Weisband et du domaine correspondant de la grille de responsabilité de la Commission sur l'équité de l'Organisation panaméricaine de la santé; 3. La participation sociale a été analysée à l'aide du modèle de continuum de la participation du public de Santé Canada. Enfin, pour évaluer les obstacles et les facteurs facilitant les processus de mise en œuvre, le cadre consolidé pour la recherche sur la mise en oeuvre (CFIR) a été utilisé. Par ailleurs, dans le but de contraster et de valider les résultats de l'analyse comparative, 16 experts dans le domaine de la gouvernance pour la santé, de l'équité en matière de santé et de la recherche sur la mise en œuvre ont été consultés.

RÉSULTATS: Des variations significatives existent dans les niveaux de maturité de la cohérence politique, de la responsabilité et de la participation à travers les stratégies locales de santé explorées, celles-ci étant davantage développées dans les cas de Barcelone et de Liverpool, et un peu plus embryonnaires à Bilbao. L'hétérogénéité des stratégies de gouvernance pour la santé a révélé qu'il n'existe pas de stratégie unique favorisant l'équité en matière de santé. Cependant, des éléments communs peuvent agir comme des leviers favorisant l'équité.

En ce qui concerne la cohérence des politiques, les résultats de cette thèse suggèrent qu'un environnement politique démocratique et socialement progressiste favorise l'intégration de la santé et de l'équité en tant que valeurs partagées. De même, la mise en place de cadres juridiques et réglementaires, tels que des lois de santé publique ou des plans stratégiques gouvernementaux, peut servir de cadre à l'institutionnalisation d'un modèle social de la santé. En ce qui concerne spécifiquement les stratégies locales de santé, celles-ci semblent être plus opérantes lorsqu'elles concernent des politiques à plusieurs niveaux, car elles permettent plus facilement la mise en place de structures et de ressources pour l'action intersectorielle en faveur de la

santé, l'utilisation d'outils d'aide à la décision et le développement de capacités individuelles et institutionnelles, éléments clés pour sa mise en œuvre. La création de synergies avec d'autres programmes et réseaux peut également favoriser la mise en œuvre de la cohérence des politiques au niveau local.

En ce qui concerne la responsabilité, une approche de la santé fondée sur les droits humains, conjuguée à des structures, des mécanismes et des processus de gouvernance responsable, peut favoriser la transparence et la responsabilité, mais aussi la mise en conformité et l'application. La responsabilité dans les stratégies locales de santé peut être opérationnalisée par des observatoires de santé publique dotés d'un profil technique et d'un niveau d'autonomie suffisant par rapport au pouvoir politique. La garantie d'un suivi et d'une évaluation continus et inclusifs, la disponibilité de données locales désagrégées à un niveau géographique, librement accessibles ainsi que la génération et le transfert de connaissances appliquées sont également des facteurs clés de la mise en œuvre de la responsabilité au niveau local.

En ce qui concerne la participation sociale, un modèle de gouvernance plus horizontal implique de promouvoir la capacité de délibération et la décentralisation du pouvoir par la mise en place d'une variété de processus, de mécanismes et d'instruments encourageant la participation de tous les groupes sociaux. Il est essentiel de garantir une participation inclusive et représentative et d'intégrer la participation sociale comme une partie essentielle au cours des phases du cycle des politiques publiques. Les stratégies locales de santé devraient s'efforcer d'être dirigées par et pour la communauté, en incluant des actions spécifiques pour le développement de compétences et de capacités participatives, tant pour la population que pour les gouvernements locaux.

CONCLUSION: Les résultats soulignent que les progrès dans la mise en œuvre de stratégies locales de santé sensibles à l'équité nécessitent l'inclusion de l'équité comme une valeur générale et comme un objectif politique spécifique. Ceci doit s’effectuer à travers des objectifs de réduction des inégalités, mais aussi via des objectifs de renforcement et d'opérationnalisation de la cohérence des politiques, de la responsabilité et de la participation sociale. Cela implique de passer de politiques de court terme, fragmentées ou isolées, à un ensemble complet de politiques plaçant l'équité au centre. Une action politique efficace pour répondre aux défis mondiaux ne peut s'inscrire dans le cadre d'options politiques peu coûteuses et adaptées aux cycles électoraux. Les inégalités en matière de santé ne seront réduites qu'à la suite d'un changement politique substantiel. En faisant progresser la cohérence des politiques, la responsabilité et la participation sociale dans les stratégies locales de santé, il est possible de favoriser la création d'arènes pour remettre en question larépartition inégale du pouvoir.

Mots clés : *Équité en matière de santé, gouvernance, politiques publiques, facteurs qui influent sur l'équité en matière de santé, cohérence politique, responsabilité, participation sociale, recherche sur la mise en œuvre (implementation research), Bilbao, Barcelone, Liverpool, santé urbaine.*

Spanish abstract

ANTECEDENTES: La urbanización es una de las principales tendencias sociodemográficas del siglo XXI, lo que convierte las zonas urbanas en uno de los principales escenarios para afrontar los desafíos globales actuales y futuros. De hecho, la importancia de la salud urbana ha sido cada vez más reconocida por su papel central en la configuración de la salud pública a nivel global. En este contexto, una gobernanza urbana que promueva la equidad ofrece una oportunidad no sólo para hacer frente a estos desafíos, sino también para ser parte de la solución. La coherencia política, la rendición de cuentas y la participación social han sido identificadas como impulsores de la equidad en salud y como dimensiones clave de la gobernanza por la equidad en salud.

OBJETIVO: La cuestión fundamental que subyace a en esta investigación es cómo las estrategias locales de salud pueden impulsar una gobernanza urbana por la salud que tenga en cuenta la equidad. Esta tesis pretende describir el contexto de la gobernanza urbana por la salud en tres estudios de caso, así como examinar y analizar comparativamente cómo se han incorporado las dimensiones clave de la gobernanza por la equidad en salud en las estrategias locales de salud. Además, la tesis evalúa las principales barreras y facilitadores de la implementación de estrategias locales de salud orientadas a la equidad.

MÉTODOS: Se trata de una investigación de implementación cualitativa, basada en un método de estudio de casos múltiples para examinar en profundidad las estrategias locales de salud de Bilbao, Barcelona y Liverpool. Se realizó observación participante, análisis de documentos y 27 entrevistas semiestructuradas en profundidad a técnicos, gestores, responsables de la toma de decisiones y otros actores locales. Se evaluaron las dimensiones clave de la gobernanza para la equidad en salud: 1. Se analizó la coherencia política utilizando una adaptación del Modelo de Madurez de Salud en Todas las Políticas de Storm (MM-HiAP); 2. Se evaluó la rendición de cuentas utilizando los dominios propuestos por Ebrahim y Weisband y la parte correspondiente a la rendición de cuentas de la rúbrica de la Comisión de Equidad de la OPS; 3. Se analizó la participación social utilizando el Modelo de Continuidad de la Participación Pública de Canadá. Para evaluar las barreras y los facilitadores de los procesos de implementación se utilizó el Marco Consolidado para la Investigación de la Implementación (CFIR). Además, para contrastar y validar los resultados del análisis comparativo, se entrevistó a 16 personas expertas en el campo de la gobernanza para la salud, la equidad en salud y la investigación en implementación

RESULTADOS: Hubo variaciones significativas en los niveles de madurez de coherencia política, rendición de cuentas y participación social en las estrategias locales de salud analizadas, siendo éstas más desarrolladas en los casos de Barcelona y Liverpool, y algo más incipientes en Bilbao. La heterogeneidad de las estrategias de gobernanza por la salud evidenció que no existe un único modelo de estrategia que fomente la equidad en salud. Sin embargo, hay elementos comunes que pueden actuar como facilitadores de un enfoque de equidad.

En cuanto a la coherencia política, los resultados sugieren que un entorno político democrático y socialmente progresista apoya la integración de la salud y la equidad como un valor compartido. Asimismo, el establecimiento de marcos legales y normativos como las leyes de salud pública o los planes estratégicos de gobierno pueden servir de paraguas para la institucionalización de un modelo social de salud. En lo que respecta específicamente a las estrategias locales de salud, éstas parecen ser más operativas cuando implican políticas multinivel, ya que permiten con mayor facilidad el establecimiento de estructuras y recursos para la acción intersectorial por la salud, el uso de herramientas de apoyo a la toma de decisiones y el desarrollo de capacidades individuales e institucionales, elementos clave para su implementación. La creación de sinergias con otros programas y redes también puede fomentar la instauración de la coherencia política a nivel local.

En cuanto a la rendición de cuentas, un enfoque de la salud basado en los derechos humanos, combinado con estructuras, mecanismos y procesos de gobernanza responsable, puede fomentar la transparencia y la responsabilidad, pero también el cumplimiento y la ejecución. La rendición de cuentas en las estrategias locales de salud puede hacerse operativa a través de Observatorios de Salud Pública con un perfil técnico y un grado suficiente de autonomía respecto al nivel político. Garantizar un seguimiento y evaluación continuos e inclusivos, una disponibilidad de datos locales desglosados y de libre acceso, así como la generación y la transferencia de conocimientos aplicados, son también factores clave para la rendición de cuentas a nivel local.

En cuanto a la participación social, un modelo de gobernanza más horizontal implica la promoción de la capacidad deliberativa y la descentralización del poder mediante el establecimiento de una variedad de procesos, mecanismos e instrumentos que fomenten la participación de todos los grupos sociales. Es clave asegurar una participación inclusiva y representativa e incorporar la participación social como una parte esencial en todas las fases del ciclo de las políticas públicas. Las estrategias locales de salud deben procurar un liderazgo por y para la comunidad, incluyendo acciones específicas para el desarrollo de habilidades y capacidades para la participación tanto de la población como del gobierno local.

CONCLUSIÓN: Los resultados ponen de relieve que el progreso en la aplicación de estrategias locales de salud orientadas a la equidad requiere la inclusión de la equidad como valor general y como meta política específica a través de objetivos de reducción de las desigualdades, pero también a través de objetivos de fortalecimiento y operacionalización de la coherencia política, la rendición de cuentas y la participación social. Esto implica pasar de políticas a corto plazo, fragmentadas o aisladas, a un conjunto global de políticas que sitúen la equidad en el centro. Una acción política eficaz para responder a los desafíos globales no puede encajar en opciones políticas de bajo coste que se ajusten a los ciclos electorales. Las desigualdades en salud sólo se reducirán como resultado de un cambio político sustancial; avanzar en la coherencia de las políticas, la rendición de cuentas y la participación social en las estrategias locales de salud puede fomentar la creación de espacios donde se ponga en cuestión la desigual distribución del poder.

Palabras clave: *Equidad en salud, Gobernanza, Políticas públicas, Impulsores de la equidad en salud, Coherencia política, Rendición de cuentas, Participación social, Investigación en implementación, Bilbao, Barcelona, Liverpool, Salud urbana*

"*Utopianism, the belief* ***that reality not only must but can be changed****, is one of the most vital impulses of feminist politics*"

Angelika Bammer

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berea ere badelako

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babes, mimo eta animoekin bide honetan lagundu nautelako,

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eta nire burua berreraikitzen lagundu zidatenei

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freer

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List of abbreviations and acronyms

ASPB	Agència de Salut Pública de Barcelona (Barcelona Public Health Agency)
BCE	Before the Common Era
CCG	Clinical Commissioning Groups
CEISH	Comité de Ética para las Investigaciones relacionadas con Seres Humanos (Ethics Committee for Research Involving Human Subjects)
CESCR	Committee on Economic, Social and Cultural Rights
CFIR	Consolidated Framework for Implementation Research
CiU	Convergència i Unió (Convergence and Union)
COMSalut	Comunitat i Salut (Community and Health)
CSB	Consorci Sanitari de Barcelona (Barcelona Health Consortium)
CSDH	Commission on Social Determinants of Health
EAJ-PNV	Euzko Alderdi Jeltzalea - Partido Nacionalista Vasco (Basque National Party)
ESAN	European Social Action Network
EU	European Union
GDP	Gross Domestic Product
GNHiAP	Global Network for Health in All Policies
HEiAP	Health Equity in All Policies
HIA	Health Impact Assessment
HiAP	Health in All Policies
HLPF	High-level Political Forum on Sustainable Development
IDACI	Income Deprivation Affecting Children Index
IDAOPI	Income Deprivation Affecting Older People Index
IRM-CMRP	Centre Montesquieu de Recherche Politique
ISGlobal	Barcelona Institute for Global Health
ISPED	Institut de Santé Publique, d'Epidémiologie et de Développement (Institute of Public Health, Epidemiology and Development)
LGA	Local Government Association
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
LOSC	Llei d'Ordenació Sanitària de Catalunya (Law on Health Organisation of Catalonia)

LSOA	Lower Super Output Areas
MM-HiAP	Health in All Policies – Maturity Model
NGO	Non-Governmental Organization
NHS	National Health Service
OPIK	Osasunaren Gizarte-Baldintzatzaile eta Aldaketa Demografikoari Buruzko Ikerketa-Taldea (Research Group on Social Determinants of Health and Demographic Change).
OBSIP	Observatori de Salut i Impacte de Polítiques (Observatory on Health and Impacts of Municipal Policies)
OSI-BB	Organización Sanitaria Integrada Bilbao-Basurto (Integrated Health Organisation Bilbao-Basurto)
PAHO	Pan American Health Organization
PAM	Pla d'Actuació Municipal (Municipal Action Plan)
PIAISS	Pla Interdepartamental d'Atenció i Interacció Social i Sanitària (Interdepartmental plan for social and health care and interaction)
PINSAP	Pla Interdepartamental i Intersectorial de Salut Pública (Interdepartmental and Intersectoral Public Health Plan)
PSE-EE	Partido Socialista de Euskadi-Euskadiko Ezkerra (Socialist Party of the Basque Country)
QCS	Qualitative Case Study
SDG	Sustainable Development Goal
SDoH	Social Determinants of Health
UB	University of Bordeaux
UDHR	Universal Declaration of Human Rights
UK	United Kingdom
UN	United Nations
UPV/EHU	University of the Basque Country
Urban HEART	Urban Health Equity Assessment and Response Tool
WHO	World Health Organization

BACKGROUND

Background

This background aims to situate the reader in the context of the thesis research. It describes the reasons behind the research questions, provides a panoramic view of the evidence on governance in urban health generated from different disciplines, and locates the specific context in which the research is carried out. The intention is to introduce the subsequent comparative analysis of the characteristics of governance for urban health equity in Europe, and specifically, in the cities of Bilbao, Barcelona and Liverpool

The introduction is structured in three parts; the first part briefly presents the researcher's theoretical and practical position that underlay and motivate this research. In the second part, the main concepts and theoretical frameworks that encompass urban health and health governance are critically reviewed. The third section, introduces the specific contexts in which this research is developed, that is in the cities of Bilbao, Barcelona and Liverpool.

1. Research statement

As this research aims to make a small contribution to the immense collective effort made in urban health research, it is appropriate to begin by acknowledging the long history of urban health research and the major contributions to this field that have been made by multiple disciplines. Throughout centuries, small and large scientific contributions have not only succeeded in improving urban health, but have also paved the way for current and future research. So this thesis research must be humbly situated on that long path on which it is based and on which it aims to build upon.

On the other hand, as crucial as it is to contextualize the research, it is also important to place the researcher in relation to the subject of enquiry. As the researcher's standpoint impacts on the research process[1,2], it is important to reflect on and explicitly recognize what that is. Therefore, this part is also a statement of the researcher's theoretical and practical position, a self-scrutiny of the lens through which the study of governance for urban health equity has been approached.

1.1. A brief long history of the study of population's health in cities

The way cities may shape health has been an important area of inquiry for centuries. The origin of the notion of "urban health" probably goes back to shortly after the Neolithic Revolution, at the very beginning of the formation of the earliest cities, around 7500 BCE in Mesopotamia. One of the first texts about the health of populations in cities dates back to over two millennia ago, in the 5th century BCE, when Hippocrates wrote about how local environment affects people's health, establishing a naturalistic approach to medicine and setting up the principles of ecological urban health[3].

While it is believed that ancient cities arose as trading centres, pre-industrial cities evolved to become political entities with their own economic and political functions. During the European Middle Ages, cities were often governed by their own laws, separate from the rule of lords of the rural area, so city residence offered freedom from customary rural obligations to lord and community[4]. The trade routes in the early modern era allowed certain European cities to grow

and become major urban centres, leading to a key historical period in which the study of urban health developed significantly.

From the second half of the 18th century onward, the growth of modern industry led to massive urbanization in Europe. This rapid growth of newly formed cities brought an exponential increment of safety and urban health problems. Indeed, epidemics in European cities or the pestilence within slums in the early Industrial Age became a major issue. The main cause of mortality among urban working-class populations were communicable diseases related to poor sanitation, and the cramped living conditions exacerbated the spread of tuberculosis, typhoid, and cholera. As overcrowding, poverty and unhealthy working conditions became permanent cores of disease, the local governments were required to develop knowledge for dealing with them.

This need of knowledge to deal with the unhealthiness of cities, triggered the onset of hygienism which is, according to Foucault, one form of social medicine that specifically developed as urban medicine[5]. Indeed, the hygienism not only operated on individual health, but also on general sanitation of urban spaces, such as the control of slaughterhouses and cemeteries, the location of fountains and drains, or the analysis of water and air circulation to prevent the accumulation of *miasma*[1(5)]. The fact that hygienism embraced all these domains entailed a progressive rapprochement of medicine to other related sciences, such as chemistry, physics, engineering or urbanism, which most certainly contributed to the scientific and technical progress of medicine. In turn this enabled a gradual paradigm shift, from miasmatic theory to early use of health statistics and other scientific advances. In this regard, it is worth mention a well-known urban health intervention that took place in 1854 in London, when the Broad Street pump handle was removed after observing differential attack rates for cholera. John Snow made a major contribution demonstrating the link between cholera and the contaminated drinking water, and even though his findings were not immediately accepted, they greatly influenced the construction of improved sanitation facilities[6].

Public hygiene, and its related scientific and political control of the urban environment, extended the power of medicine, which became, as well, a social agent of moralization. Indeed, at first the hygienism was strongly linked to a naturalization and moralization of poverty, considering pauperism a moral issue[7]. Hence, moral values (as temperance, effort or self-discipline), were embedded along with the social and health care for the poor. In this regard, it should be underscored that since its inception urban medicine has operated as a mechanism of social control and thus it has had critical part to play in the process of consolidation and reproduction of the capitalist system and in its interventions on people's bodies[5]. However, drawing on the work of Johann Peter Frank *The People's Misery: Mother of Diseases*, Rudolf Virchow refunded the concept of hygienism and laid the foundations of social medicine[7–9]. Virchow became a turning point in urban medicine when, in his Report on the *Typhus Outbreak of Upper Silesia*, he pointed to social roots of diseases, stating that the outbreak could not be solved by treating individual patients, but through political action to promote democracy, education, freedom and prosperity[10].

From the mid-19th century through the early 20th century, municipalities and councils began to progressively manage and improve sanitation measures, including paved streets, construction

[1] *Miasma*, also known as bad air or night air, comes from ancient Greek and means pollution. The miasmatic theory held that diseases and epidemics were caused by *miasma* emanating from rotting organic matter.

of sewers and disinfection of water. Other related factors, such as housing, nutrition, access to health care or epidemiological surveillance also were improved. This undoubtedly contributed to improve the health of urban residents and led to a dramatic decrease in infant mortality rates[11]. Thanks to this environmentally based public health the urban environment in many European cities had greatly improved by mid- 20th century, as had the health of urban populations[12].

During the last century global populations urbanized rapidly. In fact, urbanization is one of the leading global trends of the 21st century. Nowadays, Western and Central Europe is one of the most densely populated regions in the world, and about 78% of the population of the 27 member states of the European Union live in urban areas[13]. And as the world urban population grows, so does the academic interest in urban health. Indeed, the World Health Organization has been paying increasing attention to urban health development and living conditions in cities, developing technical programs such WHO Healthy Cities, which for more than 30 years has worked driving health high on the social, economic and political agenda of city governments.

Urbanization is irreversibly increasing around the world, in fact, it is estimated that by 2050 over 68% of the world's population will live in urban settings, cities, municipal governments and urban places[14], and it will have a significant impact on health and well-being. This sociodemographic trend points to cities being the predominant mode of living for the world's population, and thus makes urban areas one the most important settings for tackling current and new health and wellbeing challenges.

1.2. My own approach to urban health research

Urban health, as a field of study, can be defined as the analysis of urban characteristics that can influence health and disease in the urban context[15]. Up to now, most of the scientific literature on urban health has mainly focused on health risks and health inequities[16,17]. Hence, urban areas have often been presented as unhealthy places to live, characterized by pollution, noise, heat, heavy traffic, a lack of natural spaces, violence and social isolation. Here people experience an inequitable increase in rates of non-communicable disease, injuries, and alcohol and substance abuse. More recent studies, however, have shown that urban living can also be health promoting. Actually, the specific characteristics of cities, with their cultural and educational opportunities and better health and social services, can positively influence health. This research aims to embrace this *salutogenic approach*[2][18], looking at some of the enabling factors that drive cities to be healthier, more equitable and more resilient.

This research also encompasses a pragmatic approach and an action-driven focus. Because in this urbanized world, local governance increasingly equates to urban governance, this research aims to explore core elements of urban governance for health, and specifically, for health equity. This research focuses on case studies, aiming to explore real world contexts, focusing on feasibility, appropriateness and transferability of strategies developed to enable a healthy urban governance. It aims to extract all possible lessons learned to provide clues to current challenges in urban health. Because, ultimately, governance for health, as well as urban health, is made on a daily basis, in a daily context. Thus, urban settings present an immense opportunity to define and implement healthy public policy through governance innovation[19].

[2] Aaron Antonovsky developed the salutogenic model, which focuses on factors that support human health and well-being, rather than on factors that cause disease[18].

This research aims to gain understanding of how to further embed health equity in local governance for health through development and implementation of local health strategies. Joining a detailed and attentive approach of a case study and the broader perspective of comparative studies, the research aims to describe and compare the processes of development and implementation of local health strategies in the cities of Bilbao, Barcelona and Liverpool and comparatively analyse how the key dimensions of governance for health equity have been incorporated, identifying as well the main barriers and facilitators to further develop a health equity governance.

2. Introduction to urban governance for health

In this part, the main concepts and theoretical frameworks that conceptualize urban health and its governance are going to be presented and reviewed critically. An effort has been made to provide a panoramic view that brings together and integrates the evidence generated from different disciplines, particularly public health, sociology, medical anthropology (and more specifically, political anthropology of health[20]) and political science. Because, as Thomas Kuhn claimed, the history of science development in any scientific field happens when a *disciplinary matrix* is questioned, which allows shifting paradigms, and constructing new frameworks[21].

However, this introduction to urban governance for health equity does not attempt to be an exhaustive synthesis of the historical development of different theories, paradigms and concepts in these disciplines. Instead, it aims to provide a contextual basis for a better understanding of the current situation of urban health and the contemporary challenges and opportunities for local health equity governance.

2.1. Health, health determinants and health inequalities

Concerns about illness and health are universal in human life. Understanding the process of getting sick has been a challenge throughout history for health professionals and for communities in general, proving that health is an important value for people and societies. However, health is a complex concept to define, as it has multiple dimensions and meanings that have varied over time, societies, cultures, and streams of thought. The way to define and address health has set off an important theoretical discussion both among different disciplines and among the different ideological currents.

And what does this have to do with urban governance for health? Health is a complex phenomenon that can be approached from many angles. The conceptualization of health definition is important, because how it is conceptualized is paramount to understanding the boundaries and scope of responsibility of people's and population's health. Approaches to health oscillate between narrow health conceptualization, which entail vertical technology-based and medical campaigns targeting specific diseases, and social conceptualization of health linked health equity and social justice, which encompass complex intersectoral policy action. The way health is conceptualized is related to the type of urban governance that is sought and ultimately implemented.

2.1.1. The old and new biomedical model of health

Medicine, as a cultural system[22], calls for the search for models of understanding, interpreting and dealing with the disease. The biomedical model was instituted at the end of the 18th and early 19th century in European countries, along with the emergence of the working class and the industrial city[23]. During the First Industrial Revolution, a series of discoveries of the specific causal agents of infectious diseases, a contagionist turn in medical practice, greater authority for experimental laboratory methods, and the success of immunological products, led to significant shifts in ideas and practices in medicine[24]. This, in turn, ushered in the development of the biomedical model of health, characterized for its biologism, individualism, ahistoricity, mercantilism and pragmatic efficacy[23].

Since then, the biomedical model has gone established, and still nowadays, it is the hegemonic health model[23,25] in Western cultures. The biomedical model, also known as biomedicine, allopathic medicine, modern medicine or simply medicine, is based on physical processes and biological factors, and on values of scientific neutrality and objectivity. Within the biomedical model, health is considered the normal human condition, an equilibrium free from disease or pain. Conversely, disease is considered as a deviation from the norm, a loss of the natural equilibrium in biophysiological terms, hence disease is a state that needs to be diagnosed, quantified and treated.

From this biomedical perspective, the treatment of the disease is considered to be the exclusive preserve of medical knowledge. Based on medical knowledge, the role of health care is essentially to recover the biophysiological normality, which can be done through therapeutic interventions, drug prescription, or eventually even the promotion of healthy behaviours. As the biomedical model stresses the disease' diagnosis and treatment, it led to the development of medical theory and practice, which in turn, undoubtedly contributed to the increase of power and recognition of medical institutions[23].

However, the epidemiological transition[3] led to an increased prevalence of chronic diseases that could not be addressed from the mechanistic paradigm of the biomedical model, which was infectious diseases-based. Certainly, for the vast majority of chronic diseases no single external causative agent can be identified and therefore, from the single-causality approach of the medical model, no appropriate medical response could be given. So, the biomedical model based on the single-causality was reconceptualised to include the theory of multi-causality and individual risks. Still, these risks were only conceived on an individual basis, the relationship between the risk factors were not contemplated, and the mechanisms of production of the disease were disregarded. Hence, the biomedical model has been criticised, because the psychological, environmental, and sociocultural factors that influence health, when they are taken into account, are just marginally considered as part of the risk factors but not as a fundamental aspect.

In the mid-20th century, several academic and political currents denounced the processes of reductionism and naturalization of the biomedical model, starting the social medicine movement. It was considered that, from a biomedical approach, health care is provided from an individual, decontextualized, ahistorical, and often unicausal point of view, rendering this model unable to provide an adequate response to complex health problems. As the biomedicine model does not sufficiently take into account the political, economic, environmental, cultural and social context that people are part of, it tends to spur on a *sanitarization of the social*[20], that is to say, a healthcare translation of the societal issues. The social medicine movement disrupted proposing the processes of health-disease-care in terms of multiplicity and complexity, leading to the development of the social model of health, which are going to be presented later on.

Despite the biomedical paradigm being overcome on a theoretical level for more than half a century, it continues, in fact, to be the hegemonic health model[25] in many contexts, reinventing itself aligned with biotechnological and biomedical innovations. Indeed, the biomedical model is embedded in the innovative biotech-industries that have emerged worldwide under conditions of globalisation[26]. And it is no coincidence that public-private partnerships and

[3] The epidemiological transition is a theory which describes the change in disease patterns, fertility, life expectancy, mortality, and leading causes of death; where a pattern of high child mortality and infectious epidemics shifts to one with high prevalence of chronic and degenerative diseases[374].

privatisation tend to promote biomedical reductionism through predominantly technological solutions[27].

In the field of urban health, it should be noted that a significant part of the scientific research carried out, of the urban health assessments made, and of the health plans implemented have implicitly integrated this biomedical model. A specific example of that can be found in some of the "smart city" initiatives[4] that claim to be innovative by proactively addressing health and wellness simply by providing knowledge on healthy lifestyle habits through technology.

2.1.2. Broadening the health perspective beyond the biomedical model

The processes of being healthy, getting sick and accessing healthcare have social and cultural determinants that go beyond the classical biomedical reflections on the health-disease that, as stated above, do not consider what health means to an individual. Actually, being healthy means different things to different people. Often individual perceptions of their own health are relative to what it is expected given age, gender, socioeconomic status or context[28]. Indeed, health is frequently described in a pragmatic way, considering how disease interfere in people's everyday lives[29]. These particular perceptions can only be fully understood by recognizing the multitude set of interactions and influences that emerge out of the complexities of human experience.

From the medical anthropologic approach, for instance, there are three approaches to understand disease; *disease*, *sickness*, and *illness*. The first, *disease,* is the biological dimension of the disease, *sickness* is the subjective vision of the patient, and *illness* is the socio-cultural dimension of the disease. These different dimensions of disease, which are not considered in the biomedical model, bring greater richness to the understanding of the individual and populations' experiences of the triad health-disease-care. The medical anthropology approach aims to contemplate the entirety of people experiences[30], but it is not the only one that broadens the understanding of a biomedical model.

In 1948, health was defined in WHO's constitution as the "*state of physical, mental and social well-being and not merely the absence of disease or infirmity*"[31]. This understanding of what health is, also widened the health perspective, redefining it as a positive concept, and imbibing relativity, and social constructs in its approach. Within the context of health promotion, health has been considered as a resource that enables people to lead individual, social and economically productive lives. This approach emphasizes personal and social abilities and resources, considering health more as a resource for daily life than a goal of life. This perspective of health also embraces aspects of human experience, considering health a dynamic interplay of social structures and an embodied human agency.

The concept of social health recognises that individual health can be enabled or inhibited by social context. It recognises that the body is simultaneously social, psychological and biological,

[4] A "smart city" can be defined as an urban area that integrates different types of information and communication technology and electronic Internet of things. A recent systematic review on Smart Cities and Public Health concluded that although relevant arguments are made regarding the importance of smart cities' infrastructures to support public health, most of the articles do not report evidence about the evaluation of the applications in real environments, neither about their evaluation in the context of smart cities[375].

that health is cultural. It acknowledges that biomedicine and medical science is something but not everything. And, most importantly, that other voices matter[32].

2.1.3. Wider determinants of health, health inequalities, and determinants of health inequalities at urban level

Just as health must be understood from a broad perspective, so do the factors that determine it. The conditions in which people are born, grow, work, live, and age, and a broader set of forces and systems (as policies, social norms or economic and political systems), shape the distribution of money, power and resources, hence daily life, and health[33]. These conditions are known as Social Determinants of Health (SDoH).

In fact, as the SDoH are the conditions in which people are born, grow, work, live, and age, urban settings can be considered themselves a determinant of health[34]. However, to better understand the role of the urban environment in shaping the health of populations, the interconnections between urban settings and other health determinants should be taken into account[35]. Unemployment, unsafe workplaces, globalization and access to basic goods, but also gender, race and ethnicity, the socioeconomic status, level of education or the place of residence and an individual's status within it, just to mention a few, and the intersections between all them, condition people's health.

There are several frameworks that conceptualize the SDoH[36,37]. The following figure, the *Health map for the local human habitat*[38] (Figure 1)*, is* based on the Whitehead and Dahlgren's SDoH framework and eco-system theories, and it illustrate those wider determinants of health. In this model, people are positioned in the centre of the map, and all the different facets of a human settlement, set within its bioregion and the global ecosystem, are reflected in the series of spheres which move through social, economic and environmental variables. Broader cultural, economic and political forces are also considered.

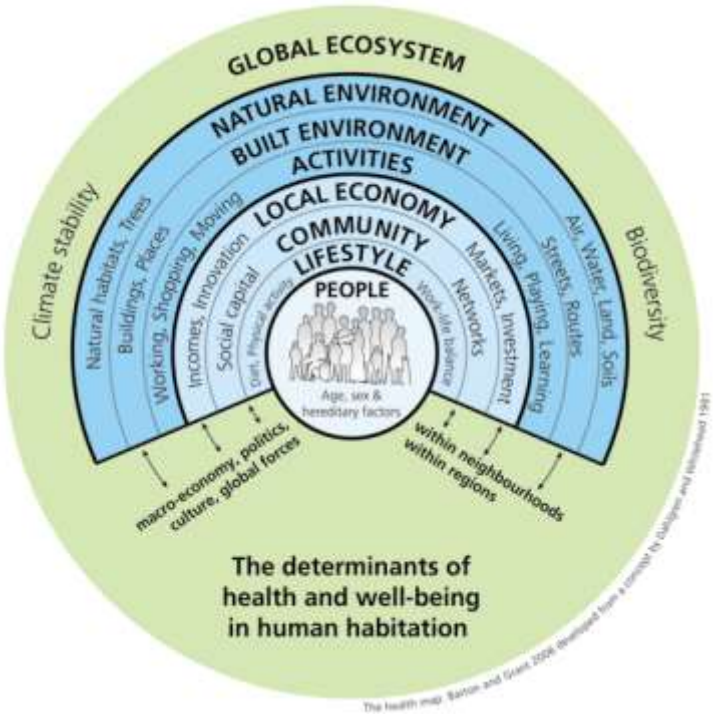


Figure 1. A health map for the local human habitat.

As mentioned previously, the SDoH and its distribution are linked to the opportunity to protect, promote and maintain health[39,40]. Extensive evidence demonstrates that the social, economic, and environmental conditions in which we grow up, live and work are major determinants of health and well-being across the life course[41]. These conditions are unequally distributed between individuals and societal groups, leading to inequities in health status within and between cities, by altering access to health-enabling resources, capabilities, and rights[39,42,43].

During the last decades, research has increasingly identified the SDoH at the root of inequalities in health, which are systematic, avoidable, and therefore unjust differences in health[44]. Evidence shows that the distribution of finance, education, housing, employment, transport, and health care, among others, do affect health and health equity. Indeed, in all those areas it is possible to identify a social gradient in health. Health inequalities are burgeoning and are recognized as one of the core challenges facing humanity and affecting population health worldwide[45].

There are different theoretical approaches that aim to explain the mechanisms driving health inequities, such us materialist, political economy, ecosocial theory, psychosocial, cultural, and life course theories. The materialist theories focus on effect of income inequality on health, highlighting the lack of access to resources and public infrastructures, for instance, how individual income determines good education, quality housing, environment or a healthy diet. Connected with this, the political economy approaches centre their attention on economic processes and how the distribution of power affects social relationships, provision of services, or quality of the physical environment. The ecosocial theory delves into how influences from the material and social world are biologically incorporated, developing the concept of *embodiment*. Psychosocial approaches explore the individual experience in unequal societies and its relation to stress and poor health outcomes, embracing the idea that psychosocial pathways are associated with relative disadvantage. Cultural theories focus on differences in beliefs, norms, and values and how people's behaviours are conditioned by those. Finally yet importantly, the life course approach acknowledges the influence of exposures within individual life course and across generations, emphasizing, as an example, how processes starting during childhood may condition mental and physical health later on.

The Commission on Social Determinants of Health (CSDH) framework (Figure 2), presented below, synthesizes the contributions of these different theoretical approaches, illustrating how the structure of societies affect population's health[46]. Underlying the SDoH inequities are structural determinants, which include the social, economic, and political context. The socioeconomic and political context comprises elements such as the labour market, the educational system, political institutions, and redistributive policies, but also societal and cultural values, for instance gender norms, roles, and relations. Didierichsen's work identifies the mechanisms that stratify health outcomes, which are at the base of health inequalities[47]; the structure of society, and social relations in society, create stratification, assigning different social class and gender divisions in society, and resulting in the socioeconomic position of individuals. In turn, this social stratification generates differential exposure, differential vulnerability and differential consequences to health conditions. Thus, these underlying SDoH inequities operate through a set of intermediary determinants, such as material circumstances, psychosocial circumstances, behavioural and biological factors, as well as the health system itself, which, ultimately, affect health outcomes.

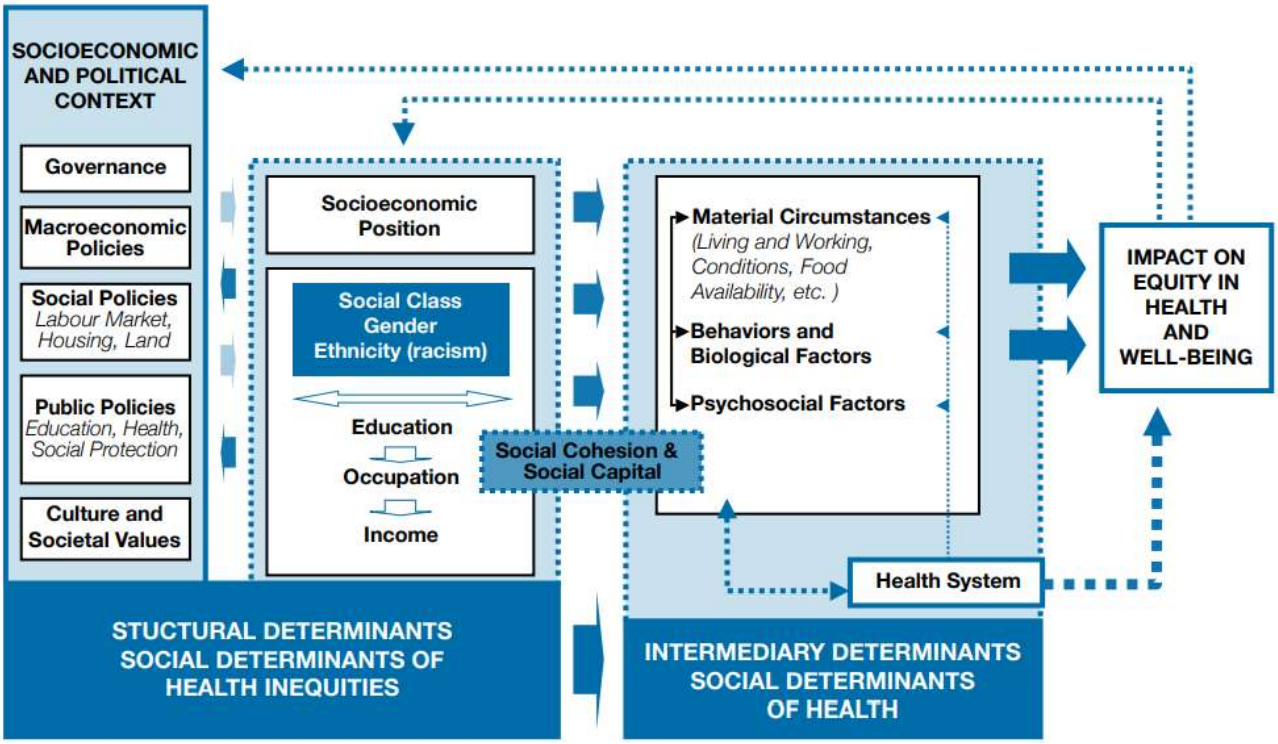


Figure 2. CSDH conceptual framework

This CSDH framework highlights that health, wellbeing and health inequalities are largely determined by wider social, economic, environmental, cultural, and political factors, that are regulated by policies and actions outside the health sector. It also underscores that health is not separated from the social, economic and political context, including policies, sociocultural values and governance, which are structural determinants of health.

Having shown the wider determinants of health and the mechanisms that generate health inequities, it is ultimately interesting to explore these as they are realised in practice at the urban level. The following theoretical framework illustrates the factors and processes influencing health inequalities in urban areas[48] (Figure 3). This framework links governance at the urban level, to physical environment (including natural context and other physical factors) and socioeconomic environment (including economic factors, employment and working conditions, domestic and family environment, public services and social transfers), with the specific settings, that is, where people create or solve problems related to health. One of the great contributions of this model is that it includes an intersectional approach, considering social axes of inequality (such as social class, gender, age or ethnicity/migration) and recognizing the underlying systems involving relations of power and domination.

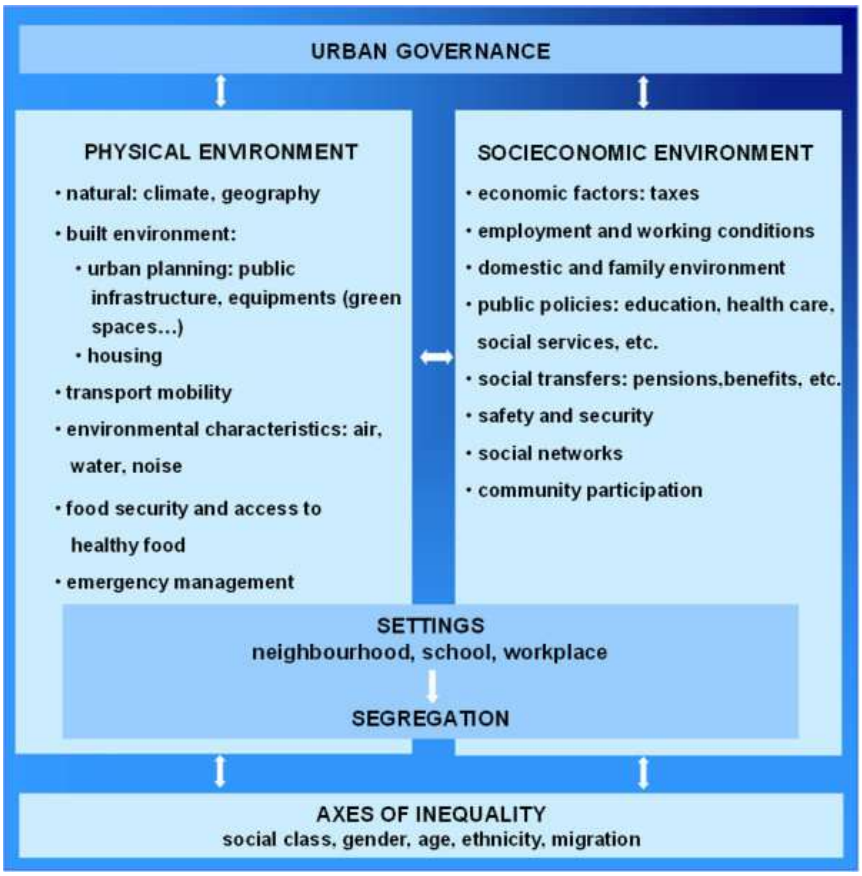


Figure 3. The conceptual framework for the social determinants of health inequalities in cities of Europe.

2.1.4. Health is political: A human rights-based approach

As stated at the 8th Global Conference on Health Promotion, "*The health of the people is not only a health sector responsibility; it is a wider political issue*"[49]. Indeed, framing health as a social phenomenon emphasizes health as a broad matter of social justice, and, consequently, health equity becomes a guiding principle. Health equity implies that everyone should have a fair opportunity to attain his or her full health potential, and that no one should be disadvantaged from achieving this potential. Health equity has been defined as "*the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification*"[46].

The positive effects of an expanded and pragmatic vision of health and human rights can be substantial[50,51]. However, in order to promote health equity, policies must not limit themselves to intermediary determinants, but must tackle the socioeconomic and political contexts, addressing the social mechanisms that systematically produce an inequitable distribution of the determinants of health among population groups. In fact, actions to address the unequal distribution of the SDoH are vital to promote health equity, and they require social protection, ensuring equal access to health and health services, and public health regulation that enables this further. It is also important to tack discrimination of different social groups (based on gender, ethnicity, race, sexuality, religion, age, or any other kind of discrimination) and maintain

a collective responsibility for health[52]. Indeed, socio-economic rights are indivisible from civil and political rights[51].

Political ideology strongly influences health and health equity[53]. For instance, identifying health differences as inequitable necessarily implies an ethical and political position[54]. Politics, and its derived policy choices, are guided by implicit or explicit values[55]. Working towards a human rights-based approach to health, entails the acceptance of guiding principles as equality, non-discrimination, inclusion, participation, universality, inter-relatedness, or accountability[45,46]. Contemporary philosophical, political, and public health paradigms have highlighted this link between health equity and fair governance[56,57], as well as the inherent complexity of implementing equitable health policies in practice[58].

The PAHO Equity Commission's conceptual framework also accounts for it (Figure 4)[59].

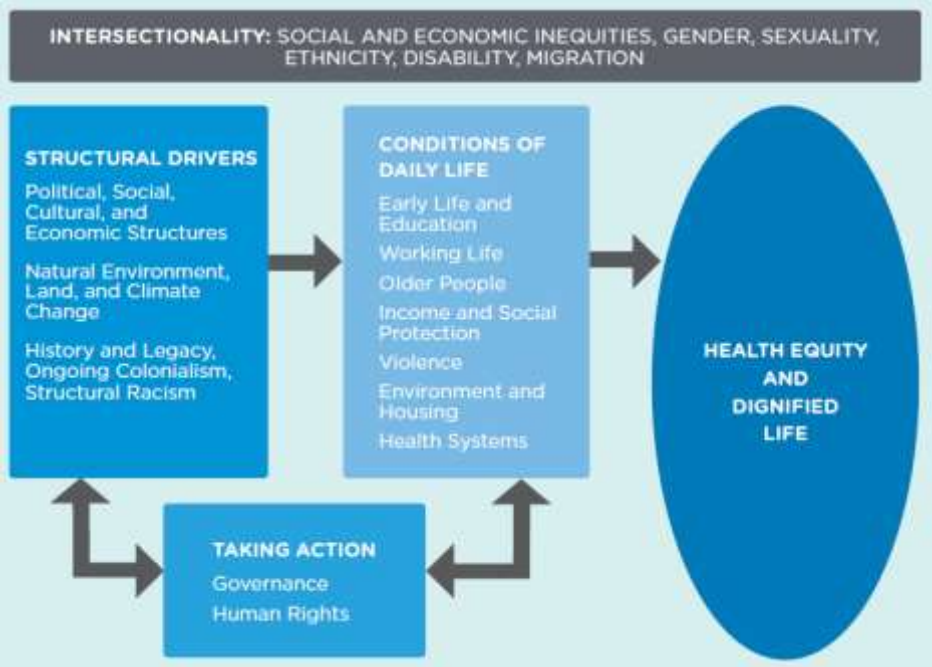


Figure 4. PAHO Equity Commission's conceptual framework

This conceptual framework is based on that of the Commission on Social Determinants of Health (CSDH) introduced in previous sections, but it goes beyond it. Hence, it is particularly interesting since it considers, as structural drivers of health equity, not only political, social, cultural and economic structures, but also other key aspects such as structural racism or climate change. This model also includes an intersectional perspective, recognizing that socio-economic position, gender, disability and ethnicity are significant grounds for discrimination. Furthermore, it has an explicit focus on governance mechanisms and human rights.

A human rights-based approach to health provides a framework for political influence to redress the unjust power relations, real and perceived discriminatory practices, and health inequalities[60,61], activating agency by those vulnerable to human rights violations[51]. In 1946, the WHO held that "*the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition*"[31]. In 1948, the Universal Declaration of Human Rights (UDHR) stated that "*Everyone has the right to a standard of living adequate for the health and well-being*

of himself and his family, including food, clothing, housing and medical care and necessary social services" (Art. 25)[62]. And in 1966 the human rights aspects of health were made more explicit when the Committee on Economic, Social and Cultural Rights (CESCR) defined it in its Article 12 as "*the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*", which realization is to be progressively achieved. The right to health has been subsequently assimilated into several treaties such as the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities, and the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families.

An essential aspect of this rights-based approach is the accountability mechanisms that it embeds, as the *right* to health provides an instrument for transforming diffuse social demands into political and legal claims[51,63]. Thus, the human rights approach to heath is a "*conceptual armature*"[46] connecting health, social conditions, and broad governance principles. As the progressive achievement of the right of health challenges all policies to be designed with the objective of improving that right and other health-related human rights, the approach also requires the intersectoral and participatory policy action to move forward. Equality and non-discrimination, participation, coordination between different levels and branches of government, a culture of human rights, and access to enforcement mechanisms are cross-cutting principles for public policies using a human rights perspective[64].

So, to sum up to this this point, health is a complex value-laden concept that can be approached from different perspectives. Health as a social concept is multidimensional, and it embraces aspects of overall wellbeing that are largely determined by wider social, economic, environmental, cultural, and political factors. These determinants of health are mostly regulated by policies and actions outside the health sector. The social determinants of health are inequally distributed, generating health inequalities. To address the complex and multidimensional mechanisms through which health inequities are produced, the human rights-based approach to health can provide a useful political and legal framework, connecting health outcomes, the social determinants of health, and governance processes.

2.2. Governance for health and equity

The previous section, presented governance as a structural determinant that affects health and health equity. Indeed, when health inequalities arise, social mechanisms have systematically produced an inequitable distribution of the SDoH and an unfair access to opportunities or basic goods, and ultimately this implies that governance processes have failed in one of their major responsibilities[53,65]. This section focuses on governance and directs the attention to the dimensions through which health and health equity may be fostered in social systems.

In this section, governance for health equity is introduced, and its main dimensions reviewed; policy coherence, accountability, as well as social participation and empowerment. All these dimensions are developed focusing on how they are carried out at the local level.

2.2.1. Governance, Governance for health, and Governance for health equity

This part aims to introduce the concept of governance for health equity. However, this requires in the first place knowing how some broader concepts, such as *governance for health*, *good governance* and *governance*, have been understood and conceptualized. The section does not aim to appraise the definitions of these concepts, but to give a general overview and contextualize them in order to better understand *governance for health equity*.

There is a widespread interest in the concept of governance, and a growing literature on governance and its impact on health[66,67]. However, no general agreement on its definition has been reached. Governance has been defined in several different ways, for instance:

> "*[governance] involves ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to systemdesign and accountability*"[68]
>
> "*The rules, processes, and behaviour by which interests are articulated, resources are managed, and power is exercised in society*"[69]
>
> "*A system of values, policies and institutions by which society manages economic, political and social affairs through interactions within and among the state, civil society and private sector. It is the way a society organizes itself to make and implement decisions"* and "*The exercise of political, economic and administrative authority in the management of a country's affairs at all levels*"[70]
>
> "*It is the ability of government to develop an efficient, effective, and accountable public management process that is open to participation and that strengthens rather than weakens a democratic system of government*"[71]
>
> "*Governance systems define who decides on policies, how resources are distributed across society and how governments are held accountable*"[72]
>
> "*Governance is the management of the course of events in a social system*"[73]
>
> "*[…] the traditions and institutions by which authority in a country is exercised. This includes the process by which governments are selected, monitored and replaced; the capacity of the government to effectively formulate and implement sound policies; and the respect of citizens and the state for the institutions that govern economic and social interactions among them*"[74]
>
> "*how society or groups within it, organize to make decisions*"[75]

> "*governance function characterizes a set of processes (customs, policies or laws) that are formally or informally applied to distribute responsibility or accountability among actors of a given system*"[76]
>
> "*an art, a dynamic process of collective social improvisation in which a plethora of actors are striving to organize matters for their own advantage*"[77]

These broad definitions of governance prove that it is a complex and multidimensional concept. Despite this fact, there appears to be consensus that governance not only encompasses but also transcends the collective meaning of government, including the processes of decision-making and decision-implementation. *Governance* also incorporates aspects such as systems of representation, power and institutional authority, rule of law, ownership, citizen engagement, or accountability. Henceforth, an integral part of the meaning of *governance* is the elements and principles underlying *good governance*[77]. *Good governance,* as a concept, has been in existence since the end of the Cold War and its meaning has been evolving[77]. Nowadays it is commonly defined in terms of practical values rooted in human rights and the principle that governors derive their authority from the people.

Good governance has been used as a model in contrast to *bad governance*, which it is usually defined as an unfavourable relationship which encompasses unfair policies, corruption, weak accountability, political instability, or deceit[78,79]. The other way round, *good governance* entails values such as fairness, participation, effectiveness, transparency, accountability, sustainability, and economic, social and cultural human rights[80–82]. In this sense, governance for health can be understood as a *good governance*, since it incorporates most of the above-mentioned values and regards health as a rights-based universal good. In practical terms, however, even if in the scientific and technical literature defining governance according to *good* or *bad* values seems to be quite common, this classification is hardly operational because it restricts the distinction of an ideal state of *good governance* from one that is "good enough"[83], hence it fails to support *good governance* practice. Moreover, what is considered *good governance* or *bad governance* depends to a large extent on the context, and some anthropological approaches have criticised the western ethnocentrism defining goodness[84].

In regard to governance related to health, some authors differentiate between *health governance* and *governance for health*. *Health governance* is commonly considered as the governance processes that focus on the strengthening of health systems. Conversely, *governance for health* is deemed to be a broader approach that refers to the joint action of health and non-health sectors, of the public and private sectors and of citizens for a common interest[76]. However, this distinction between *health governance* and *governance for health* appears to be rather inoperative from the point of view of the social model of health, moreover it does not consider that the limits of the health system are blurred, for instance, on issues such as community health. In this respect, a relatively recent literature review of health governance highlights the need for a more accessible understanding of health governance in an actionable way[76]. In this research, *health governance* and *governance for health* may be used interchangeably, but always refer to this second conception of governance, which goes within and beyond the health domain.

The concept of governance for health was first framed more than two decades ago[85]. Nowadays, one of the most widely used definitions of health governance is "*the attempts of governments or other actors to steer communities, countries or groups of countries in the pursuit*

of health as integral to well-being through both whole-of-government and whole-of-society approaches"[45].

It is worth highlighting some principles and elements that this definition encompasses, which are essential to understand how transformative this approach can be. In the first place, health is considered to be not only a central component of governance, but also a human right, an essential component of well-being, a global public good and an issue of social justice and equity[45]. It also takes the social inequalities and power asymmetries into account, both in the policymaking and in policy implementation processes. It also recognizes that as health is an emerging property of many societal systems, so governance for health requires structures and mechanisms that facilitate synergistic intersectoral policies and social participation. And last but not least, it implicitly implies that governance for health should integrate all levels of governance, from the global to the local[86].

Governance for health puts the spotlight on health as a key feature of a successful society and upholds health as a human right and as a matter of social justice, which somehow includes the principle of equity. However, it is important to point out that, whether a policy aim is to address determinants of health or determinants of health inequities, its policy objectives may need to be defined in a quite different way. For this reason, to improve both health outcomes and health equity, it is important to ensure an equity-based approach, so it is a requirement of governance for health equity[72,87].

2.2.2. Dimensions of governance for health equity

As discussed in the previous section, governance for health and the policies that derive from it, specifically target health determinants and, therefore, health outcomes. Even if governance for health implicitly embraces the value of equity, policies aiming to improve health may be different from policies focusing specifically on health inequities. Therefore, to ensure an equity-based approach, it is essential to assume explicitly equity as a core value, or in other words, a governance for health equity.

Barbazza and Tello conducted a literature review of governance for health's commonly used dimensions, identifying the following: accountability, partnerships, formulating policy/strategic direction, generating information/intelligence, organizational adequacy/system design, participation and consensus, regulation and transparency[76]. Since the importance of maintaining an equity-based approach was discussed above, it is appropriate to explore which of these dimensions of governance for health have been considered also dimensions of governance for health equity.

The WHO's report on *Governance for health equity* acknowledged the following functions of governance systems to address social determinants and reduce inequities in health: political commitment, intelligence, accountability structures and systems, policy coherence across government sectors and levels, involving local people, institutional and human resource capacity, modernized public health, and learning and innovation systems[72]. Although certainly all of them are important in governing for equity in health through action on social determinants, subsequent WHO's reports identified between them the most critical elements to drive health equity. Thus, it was then recognized the critical role of policy coherence[88], accountability[89] and social participation[90], as the key dimensions (Figure 5).

Action for health equity is accelerated where policies are coherent across sectors and different levels of government, accountability mechanisms are strong and there is inclusive and high-quality participation[91].

Figure 5. Health Equity Drivers

Indeed, policy coherence, accountability and social participation have a:

- Preventive role combatting discrimination and driving forward the protection and realization of rights for health equity and policy measures
- Promotional role driving focus, prioritization and action on health equity while working in intersectional areas, and
- Transformative role accelerating equity in participation in society' development and in the sharing of benefit of the gains of development.

Therefore, they are drivers of health equity on their own, but at the same time, they are common goods interacting with each other, that is to say, essential and interlinked dimensions of governance for health equity (Figure 6). Through their individual and collective effects, policy coherence, accountability and social participation move forward health rights-based approaches that underpin the delivery of laws, policies and programmes that enable health equity[92], fostering, in turn, the empowerment of people and communities to actively engage with decisions affecting their health and well-being[93].

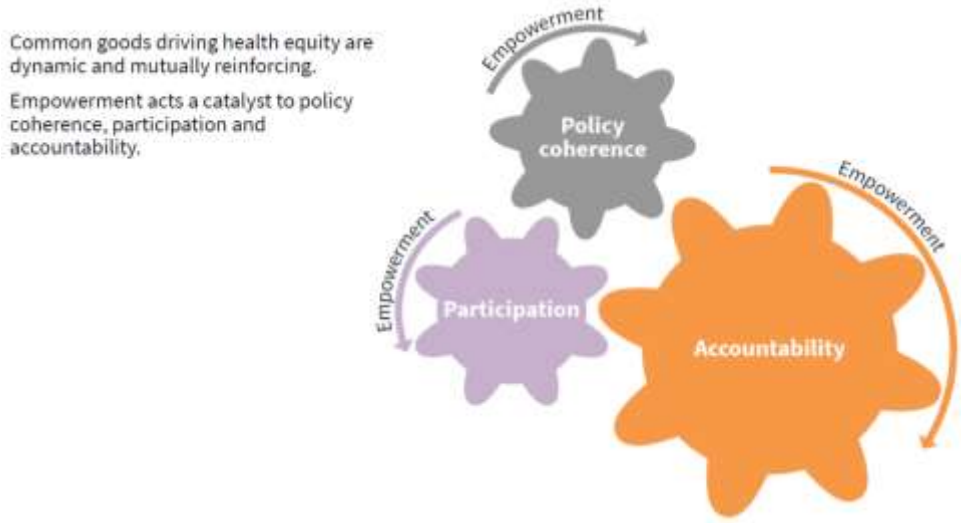


Figure 6. Driving forward health equity: the role of accountability, policy coherence, social participation and empowerment[92]

It should be highlighted that that each of these dimensions of governance for health equity is dynamic and that they interact with one another. In point of fact, when policy coherence, accountability and participation processes are present and integrated into actions, policies and interventions they are more effective and their impact is greater, extending sometimes beyond the specific measures targeted. Indeed, the interaction between them is particularly powerful in empowering people and communities to engage actively with decisions affecting their health and its determinants, and thereby reducing inequities in both[92].

> "[…] *where accountability mechanisms are strong, where policies are coherent across sectors and different levels of government, where there is inclusive and quality participation, and where people and communities are empowered, action for health equity is accelerated*"[92].

Likewise, it should be emphasised that these health equity drivers have to be considered throughout the policy cycle[94]. That means, in the process of agenda building, policy formulation, decision-making (adoption), implementation and evaluation.

Some authors have claimed that categorizing the health (and health equity) governance dimensions, and providing theoretically informed presumptions about causality links, allows to provide a greater explanatory power to governance analysis, increasing the empirical applicability[95]. In this regard, these three dimensions (policy coherence, accountability and participation) are particularly interesting, since they can be constructed as actionable processes to operationalize the function of governance itself, that is to say, are a practical assessment of current health equity governance processes and opportunities for improvement.

This section aims to delve deeper into these dimensions of governance for health equity, that is, into policy coherence, accountability and social participation. For each of these dimensions of governance, a theoretical definition and its link to population health and health equity are presented, at the same time that this theory is grounded at the operational level, displaying mechanisms, tools and good practices for the development of these dimensions in governance.

2.2.2.1. Policy coherence

Policy coherence is a key dimension of governance for health equity and a driver of health equity; it seeks to ensure integrated, complementary, and synergic policies while involving political commitment and leadership, as well as an across-government strategic long-term vision. This concept underpins terms such as intersectoral action for health or Health in All Policies. The main message of policy coherence is that systems for promoting health and well-being and preventing disease and ill health are less efficient wherever sectoral policies are unaligned. Modifying policies for health may also have co-benefits for other development objectives. This presents all sectors with new opportunities for assessing their contributions to people, planet, prosperity, peace and partnership. Thus, policy coherence as a health equity driver refers to the need to strengthen the coherence of policies and actions across sectors and stakeholders in a manner that increases resource flows to redress health inequities and integrate health equity concerns in other sectors. Therefore, it requires taking into account interdependencies and complexity, as well as a whole-of-government and whole-of-society coproduction of population health[72].

A whole-of-government approach represents the diffusion of governance vertically across levels of government, and horizontally throughout sectors. The activities within this approach are

multilevel, spanning local and global activities and actors, and increasingly involving groups outside the government (whole-of-society). It requires that all actors consider improved health and well-being as a social goal that can only be achieved by joint action[45]. Horizontal whole-of-government approaches strengthen coherence between government sectors (whether national, regional or local), and cover 'soft' dialogue-based transformative processes, as well as 'hard' shifts in constitutional accountability. And vertical whole-of-government approaches strengthen coherence between governmental levels, and between policy and its implementation[96,97].

As explained earlier in Section 2.1., health and health equity are mostly determined by wider social and political factors, these in turn are embedded in policies and actions outside the health sector. Therefore, many of the most pressing challenges that we face concerning health, wellbeing and health equity, involve multiple interacting causal factors which are not the responsibility of the health sector or of any single government department. Indeed, the health and health equity challenges of the 21st century are too vast to be tackled by one sector alone. And, moreover, the integration and coordination of actions across sectors delivers more appropriate and efficient services[45].

Significant evidence exists, including through gathering exercises undertaken as part of the European Review of Social Determinants and the Health Divide[41] and the Women's Health Report[98], of the impact of non-health policies and interventions on the health and well-being of individuals and communities across the European Region[99]. Therefore, coherent action across government is essential to improve health and health equity[72,99–102]. It is particularly important to driving health equity, as is often the unintended consequence of actions undertaken by sectors other than health that affect health equity. For example, where environmental, trade, or financial policies are not aligned with or working to contribute to health goals. In this regard, policy coherence itself can be a measure of effective intersectoral action, as intersectoral action and integrated governance are requirements to achieve policy coherence.

There are several levels or types of intersectoral relationships; information, cooperation, coordination and integration[103]. The first step in a process of intersectoral work is information, which focuses on the specific knowledge exchange between sectors. Cooperation entails the interaction between sectors in order to achieve greater efficiency in their own actions. Then, coordination, refers to a joint effort working towards the adjustment of actions, programmes, and policies of each sector to achieve more efficiency and effectiveness. And finally, integration, entails sharing responsibilities, resources and actions, and most importantly, sharing a common social goal rather than different sectoral objectives.

The literature underlines the fact that multilevel intersectoral coordinated action can effectively address health inequities, improving governance for social determinants of health across all levels of government, sectors and stakeholders[72,104–106]. However, intersectoral action alone without added incentives, leadership, common policy goals or vision is not a guarantee for policy coherence. Policy coherence requires rather strategic, systems-level work towards common agreed objectives that is enabled through the right mechanisms and incentivized in an appropriate way. Thus, policy coherence does not solely speak to action and integration between sectors but equally ensuring coherence across, national, regional, and local levels[43].

Key levers for policy coherence as a governance for health equity dimension include building partnerships across sectors to identify specific roles for long-term improvements in health and reduction of health inequities, and linking health equity objectives to existing strategies[107]. At the same time, policy coherence requires a coordinated delivery system embedded within structures and systems of society.

Coherence across all areas of public policy is important to realize health and well-being, because although it may be known which particular policy options are effective, they are more likely to have a greater impact on health if they are combined and coordinated across sectors, actors, institutions and levels of government. Policy coherence of actions across sectors and stakeholders is essential for improving health equity, since only where policies across the whole of government and society are aligned and integrated, can the societal goal of health equity be achieved. The lack of awareness within policy networks has been reported as a barrier for implementing coherent approaches[108,109].

Health in All Policies (HiAP) is a collaborative approach that recognizes that health is beyond the health sector and integrates health considerations into policymaking across sectors to improve health for all. HiAP was defined at WHO's 8th Global Conference on Health Promotion in Helsinki, as "*an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity*" [49]. HiAP provides a framework for regulation that combines health, social and equity goals with economic development, and manages conflicts of interest transparently[110], thus the HiAP framework provides governments with a practical means of enhancing a coherent approach.

Health Equity in All Policies (HEiAP) developed from HiAP recognizes that it is not possible to improve population health without addressing health inequities, and therefore seems to go beyond HiAP to focus policy, in a coherent manner, on the multiple mechanisms that produce or remedy health[88]. It is also a shift away from "health in all policies" based on a narrow health concept towards "health equity for all policies" based on a broader concept such as *sustainability*, that can improve ownership of health equity policy goals across sectors and stockholders[111]. Although in practice, HiAP is generally used to refer to both, including HEiAP. Similarly, in this research HiAP will always be used by embedding equity in its most inclusive dimension.

Although HiAP was not formally recognized until June 2013, at *The Helsinki Statement on Health in All Policies,* it builds upon a rich heritage of ideas, actions and evidence[49]. HiAP draws on the roots of the 1986 *Ottawa Charter* for Health Promotion, which identified intersectoral action and healthy public policy as central elements for the promotion of health, the achievement of health equity, and the realization of health as a human right[112]; the 2006 Finnish presidency of the European Union, which prioritized and advocated the importance of building healthy public policy through an intersectoral approach for health; the 2011 *Rio Political Declaration on Social Determinants of Health*, which paved key principles for health promotion action[107]; the 2013 publication of *Health 2020: European Policy Framework for Health and Wellbein*g, that highlighted the value of intersectoral action for health[113]. Subsequently, a series of conventions drafted and ratified health frameworks to anchor HiAP. These include; the 2016 *Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development*[114]*;* the 2016 *Shanghai Consensus on Healthy Cities*[115]*,* which will be will be seen in greater depth in Chapter 1.3.; the 2016 *Health and Climate Action Agenda*; the 2017 *Adelaide second Statement II from the International Conference Health in All Policies: Progressing the Sustainable Development*

Goals[116]; the WHO Thirteenth General Programme of Work 2019−2023 launched in 2018, the 2019 *Global Action Plan for Healthy Lives and Well-being for All*[117] or, most recently, the *WHO European Health Equity Status Report initiative*[91].

In 2017 the Global Network for Health in All Policies (GNHiAP) was launched. This was a network of government entities and institutions, international intergovernmental and non-government organizations, and academia committed to working collaboratively to strengthen HiAP practice internationally. The GNHiAP has seven objectives focusing on leading, providing and facilitating HiAP implementation in countries on a national, regional and local level. Thus, HiAP has been used widely; and examples of HiAP showed that health objectives can be furthered through policies that cut across several sectors worldwide, taking effective action on Social Determinants of Health[118].

However, despite progress on HiAP globally, there are many challenges to develop and sustain this comprehensive strategy to improve population health and health equity. On the *macro* level front, the often-unquestioned structures of power and the current socioeconomic development model, accompanied by a lack of the courageous political commitment required in order to re-orientate current social and macroeconomic policies to address equity-related challenges[119]. On *meso* level*,* there is a great need for an increased accountability and participation in governance[72,88], as well as a need for an improved health literacy of the public, the policy-makers, and the media[120,121]. And finally, on the *micro* level front, it is necessary to develop context-specific conditions, strategies, mechanisms and tools that effectively contribute to develop, implement and sustain HiAP in practice.

Policy coherence at the local level

As previously discussed, the importance of policy coherence as a governance dimension goes beyond the improvement of population's health and health equity. In fact, the 2019 EU Report on Policy Coherence for Development stated that policy coherence is key to ensure economic, social, environmental and governance dimensions of global sustainable development. In this regard, the WHO European Healthy Cities Network, in its second strategic goal approach, includes "*ensuring policy coherence at the local level*"[122] as a core dimension for healthy, happy and sustainable urban lives.

Policy coherence at the local level has closely been linked to the beginnings of sustainable development. Sustainable development can be understood as an integrated answer to a broad range of new social movements and initiatives. It started in the 1970s and included environmental movements, social rights movements and global justice movements. Sustainable development aims at analysing global problems in the triangle between economic, ecological, and social aspects and assesses the impact of policies on those three aspects. Sustainable development as a core strategy was already incorporated the first Local Agenda 21 processes resulting from the Rio UN Conference on Sustainable Development in 1992. However, it was not until November 2016, when WHO focused their Declaration on promoting health in the 2030 Agenda for Sustainable Development [114], that WHO connected both approaches in their central documents.

The 2030 Agenda for Sustainable Development comprises 17 Sustainable Development Goals (SDGs). Health has a prominent role within the 2030 Agenda, through the SDG 3 "*Ensure healthy lives and promote well-being for all at all ages*" [123]. Health equity, at the same time, is centrally positioned as "*Leaving no one behind*" is an overarching theme and addressing inequalities and

discrimination a defining feature. But most interestingly, the 2030 Agenda entails the development of coherent and integrated approaches and puts its emphasis on equity and multisectoral action. Actually, the SDG 17 explicitly recognizes the importance of partnerships to "*Strengthen the means of implementation and revitalize the global partnership for sustainable development*"[123]. Indeed, the Sustainable Development Goals (SDGs), link action to improve urban places, living conditions and social and economic conditions that can promote health equity. And by linking urban place and health inequalities, it also makes visible the challenges for local governance in promoting an urban ecosystem for health[124].

HiAP can facilitate a holistic and multi-stakeholder action to improve health and wellbeing at the same time advancing other SDGs goals. Thus, an effective way to achieve the SDGs is through HiAP, an approach that systematically takes into account the health implications of decisions in all sectors, involves an intersectoral action that deals with all determinants of health, and promotes the use of formalized governance structures to facilitate multisectoral action. For this reason, understanding the nature, strengths and challenges of current HiAP practice is vital to strengthen the capacity to act on SDGs. As Dr Tedros Adhanom Ghebreyesus, WHO General Director, highlighted "*Health is not only a critical outcome of the Sustainable Development Goals, it is also an important tool for achieving them*"[125].

The GNHiAP initiative was launched in 2017, by the governments of Sudan, Finland, Thailand, State of South Australia and the Province of Quebec in order to work jointly to strengthen, institutionalize, and facilitate the implementation of the HiAP approach. Enhancing HiAP development, the GNHiAP main aim is to help other governments to achieve health-related SDG targets, at national, subnational, and local level. In fact, the GNHiAP role is to support the implementation of the HiAP approach to progress towards the SDGs achievement. In this context, GNHiAP emphasizes that the local governments are the key for establishing local healthy public policies and implementing the SDGs, in other words, localizing the 2030 agenda.

The reason behind seeking to localize the agenda 2030 is that municipalities and cities are in a privileged position to implement coherent policies and focused action on the SDoH and equity, to ensure participative decision-making processes, as well as to monitor and evaluate processes to measure progress on the SDGs. It is down at the level closest to people where much policy action takes place. And certainly, health policies are implemented to a large extent at the local level, in the settings of everyday life, in cities and municipalities, in the neighbourhoods and communities where people of all ages live, love, work, study, and play[115].

Localizing the 2030 agenda means, in the first place, recognizing that making cities inclusive, safe, resilient and sustainable will promote health, wellbeing and health equity, or to put it another way, to acknowledge that there is a powerful link between SDG 3 "*Good health and well-being*", and SDG 11 "*Sustainable cities and communities*". Making cities sustainable means creating career and business opportunities, safe and affordable housing, and building resilient societies and economies. It involves investment in public transport, creating green public spaces, and improving urban planning and management in participatory and inclusive ways [123]. Local governments have the responsibility to act locally and collectively to do so because they bear the ultimate responsibility for the health of their citizens.

The HiAP approach can strengthen local governance for health in a coherent manner. Actually, the first governance principle of the Shanghai Consensus on Healthy Cities is to integrate health as a core consideration in all policies, to prioritize policies that create co-benefits between health and other city policies, and to engage all relevant actors in partnership-based urban

planning[115]. The HiAP approach is key for local decision-making processes and policy implementation, and therefore the HiAP is also critical to achieve SDG targets.

In fact, recent comprehensive Urban Health Framework (Figure 7) explicitly links urban health to the SDGs, demonstrating that a HiAP approach resonates with health as a determinant, outcome, as well as an indicator of sustainable development[126].

Figure 7. Conceptual Framework: Urban Health related SDGs within a HiAP approach

In short, policy coherence is a governance dimension that is needed to move forward health and well-being for all. It enables the prevention of unintended negative effects on health and health equity by ensuring integrated, complementary, and synergic public policies. It requires political commitment and leadership, as well as an across-government strategic long-term vision shared across actors, institutions, and levels of governance. Policy coherence mechanism must operate across a decision-making system, ensuring an intersectoral action that has a health equity focus, as it is the HiAP/HEiAP approach. Coherent policies are essential to ensuring progress on the SDGs and, at the same time, the SDGs provide a framework to strengthen policy coherence for (urban) health and health equity.

2.2.2.2. Accountability

Accountability, as a health governance dimension, seeks to achieve an effective control strategy of the actions required by all sectors in producing health and health equity results. There is a wide range of approaches to the conceptualisation of accountability[127]. In general terms, accountability includes elements such as transparency, which involves collecting information and making it publicly accessible, responsibility, which comprises justifying actions and decisions, compliance, through monitoring and evaluation of procedures and results, and the application of sanctions in case of deficiencies in compliance, responsibility or transparency[128]. Accordingly, accountability for health involves transparency, answerability, compliance and enforcement. Thus, accountability for health integrates elements related to explanation and compliance, that is, providing public, transparent, information and reporting of actions and progress guidance to achieve improved health determinants, and elements related to sanction, such as effective and accessible mechanisms for redress in the event of violations[129].

In previous sections it was asserted that health equity is a critical imperative not only because it is at the heart of our shared values of fairness, justice, and equal opportunity, but because it is impossible to have a sustainable health and social system without it[130–132]. Accountability is related to all these aspects and, moreover, the rights-based approach to health has as a core concept accountability, including accountability mechanisms within the health system and beyond it. In this regard, it is worth mentioning the rubric developed by the PAHO Equity Commission to analyse the inclusion of health equity in health policies, which, among other dimensions, measures specifically the inclusion of accountability mechanisms to redress violations of people's right to health[133]. Accountability for health has the purpose of reducing abuse, assuring compliance with procedures and standards, increasing performance, advancing implementation, and contributing to sound policymaking[134]. Thus, accountability has been defined as:

> *" […] the process which provides individuals and communities with an opportunity to understand how government has discharged its right to health obligations. Equally, it provides governments with the opportunity to explain what they have done and why. Where mistakes have been made, accountability requires redress. It is a process that helps identify what works, so it can be repeated and what does not, so it can be revised. Accountability is not the same as responsiveness, responsibility, answerability or evaluation, as none of these concepts include a legal compulsion to explain and provide remedies[135]".*

Accountability is therefore considered fundamental to governance and the rule of law. Other aspects that accountability encompasses are:

> *"It requires, as well, measures to ensure adherence to the principles of supremacy of law, equality before the law, accountability to the law, fairness in the application of the law, separation of powers, participation in decision-making, legal certainty, avoidance of arbitrariness and procedural and legal transparency"*[136]

There are many conceptualizations and models for considering the types of accountability. Brinkerhoff distinguishes between three types of accountability: financial accountability (compliance with laws, rules and regulations regarding financial control and management), performance accountability (performance measurement and evaluation, and service delivery improvement) and political/democratic accountability (equity, relationship between the state and the citizen, to discussions of governance, increased citizen participation, transparency and openness, responsiveness and trust-building)[134]. Accountability of health and health determinants is a political/democratic accountability necessary to address health inequities and ensure the health equity awareness and prioritization of the populations that face multiple barriers to achieve health outcomes[137].

Political accountability at the governmental level means holding the government accountable for violations of the health-related rights through the actions of political bodies[72]. Human rights generate state accountability for the values they protect, which can provide the basis for justifying the implementation of policies to tackle health inequities. Some of the key elements required for accountability as part of a rights-based approach to health relate to what the government is doing, how much effort it is expending and how it is going about this process[138]. However, as trans-national actors increasingly play a role shaping population's health, the duty bearer is not exclusively the government, and then sanction mechanisms are required, for instance to hold to account commercial actors[139,140]. Thus, accountability processes and mechanisms need to adapt to reflect continually evolving political, environmental, economic and social challenges[89].

Accountability of actors, governments, international actors, companies or even individuals is essential to realizing health equity. Although improved accountability is presented frequently as an answer for addressing wrongs in multiple arenas, including the health and social sectors, yet it often remains blurred and poorly understood[141]. Much work on understanding and improving accountability in health is rooted in the human rights-based approach to health, which without a doubt has helped to establish clearly the parameters of different governmental obligations.

The Lancet Oslo Commission on Governance for Health[142] identified weak accountability mechanisms as one of the five dysfunctions of the global governance system that allow adverse effects in global health to persist and that are the root cause of health inequities. There is also evidence of the link between low accountability, privatisation and increasing inequalities[143]. Looking at this the other way around, this means that accountability mechanisms can promote health equity by holding actors to account on their actions where these create inequities. Strong accountability mechanisms can also ensure compliance and implementation, for example of health policies by other governmental sectors. Where they exist, these mechanisms can also act as a deterrent for behaviour and policies that may affect health equity negatively and improve performance. For example, where companies fear redress through litigation and possible

compensation claims they are more likely to adhere to environmental health regulations and not pollute the environment.

Accountability mechanisms can be judicial (i.e. courts), quasi-judicial (i.e. human-rights offices), administrative (i.e. auditors, inspectors, controllers), academic (i.e. call for research) or political mechanisms (i.e. elected representatives, political parties, voters, media). International bodies also have an important role through international standards and oversight. Non-Governmental Organizations (NGO), citizens groups and the media can also advocate and lobby and through these activities have an important role in holding governments or other actors to account[138]. Indeed, media reporting focusing on whether a government has fulfilled its commitment to health equity or on government policy contributing to health inequities through policies, lack of investment and others, can act as a powerful accountability mechanism.

As noted above, in order to ensure effective accountability for heath and health equity it is necessary to deploy specific processes and instruments[41,135], such as laws or regulations, but also complaint mechanisms, media-based accountability mechanisms, legal counselling, empowerment services or participatory budgeting, among others. One type of mechanism for accountability is the *statutory governance boards* capable of holding all stakeholders to account and ensuring clear multi-stakeholder mechanisms for accountability[6]. Equally, required health impact assessments (HIA)[5] of policies can act as accountability tool for health[144–146], and on-going impact assessments of current policies are also critical to tackle social determinants of health[147,148]. In fact, a key recommendation of the CSDH, the Rio Political Declaration on Social Determinants of Health and of Health 2020, was the need for comprehensive, equity-sensitive monitoring of health and health determinants to increase accountability[107,149]. Indeed, monitoring of health and health determinants helps in the first phase to put the equity issues in the agenda and, in the second phase, keeping them active.

Accountancy mechanisms, such as observatories, agencies or institutions that evaluate and monitor the impact of policies on health and health equity are important, as data provides an evidence base for equity-oriented interventions[42,150,151]. The existence of a knowledge base on health inequities and their structural determinants, the monitoring of trends over time and the recommendations of feasible and effective policies for addressing health inequities are all key aspects of driving health equity through data and evidence. Monitoring is explicitly intended to have practical relevance for policymaking, so it should be linked to clear criteria and have policy relevance. Measurement of data is required on health equity within the health system, as well as across all domains of government, including all aspects of society. And by aspects of society, it refers, for example, to the measurement of social capital, community capabilities, and how these interact with individual and population health outcomes.

In the literature, accountability mechanisms are often classified on *invited spaces* or *autonomous spaces*[152]. Invited spaces include the institutionalised mechanisms operated by governments, which imply a top-down approach, for example municipal participatory budgeting. Autonomous spaces refer to social mechanisms generally created through collective action, implying a bottom-up approach, for instance informal local care networks. *Invited* and *autonomous* spaces should be developed, ensuring at the same time a real, effective, and

[5] HIA is a tool that systematically assesses the potential, and sometimes unintended, effects of a policy, plan, program or project on population health and its distribution within the population, identifying at the same time appropriate actions to manage those effects.

balanced division of powers. Both kinds of accountability mechanisms have to be promoted in order to move forward participatory accountability, which have a positive effect on citizens' trust in government, in citizen rights awareness, and in government responsiveness to citizen demands[153,154].

The last consideration to be made is that accountability for health is needed at all levels of governance; from global (international human rights treaties, SDG commitments, etc.) to local (city charter). This reflects the influence of stakeholders and decision-making beyond national borders such as global trade agreements and commercial interests which directly and indirectly shape different opportunities and risk for health across the population at the local levels[155,156]. In this regards, the 2030 Agenda, and specifically the target SDG 16.7, commits to "*ensure responsive, inclusive, participatory and representative decision-making at all levels*", in order to "*promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels*"… Even if this, seen critically, can be interpreted as a great incoherence, given that the follow-up mechanism for SDGs, the High-level Political Forum on Sustainable Development (HLPF), act as just such a political body and does not provide any kind of accountability[123,157].

Accountability at the local level

As stated above, accountability is essential to health governance and it is needed at all levels of governance. In other words, a governance for health equity clearly involves building better mechanisms within the government for transparency and accountability, and mobilizing some level of real power and independent decision-making at all levels, but particularly at the local level[158]. Local governments are an important point of contact between citizens, decision-makers, and service providers[159,160]. It is no coincidence that the decentralization processes have been considered an opportunity to make governance more responsive, to increase local input to policy design and implementation, and to promote public participation in local democratic structures, as well as a greater accountability[152,161].

Some authors argue that accountability at the local level is mainly about setting standards, sharing information, making judgements about appropriateness, and sanctioning unsatisfactory performance[162]. Other authors consider that the key element of local accountable governance ensures the flow of information about what governors do towards those who are affected, as well as the flow of information to and from those in a position to force bad governors to bear the costs of their misdeeds[161]. My specific approach about accountable governance at the local level is not only about responding to peoples' problems, environments, demands, with responsiveness and transparency, but also about ceding real decision-making authority to citizens.

This section describes some accountability instruments used at the urban level that have shown a positive and redistributive effect improving health determinants. It is not intended to be an exhaustive review, but rather an example of some good accountability practices developed at the urban level in order to ground this dimension of governance, which is somewhat abstract, in the actual practice of urban governance for health.

Indeed, having specified everything that local accountability can cover, the question arises as to which accountability mechanisms foster urban governance for health. The WHO European Healthy Cities Network, in its second goals of the strategic direction of Phase VII, considers "*promoting accountability for health and well-being by statutory and non-statutory local actors*" and "*ultimately acting as a guardian, facilitator, catalyst, advocate and defender of the right to the highest level of health and well-being for all residents and visitors*"[122]. However, it does not specify which tools, other than the sanctioning mechanism, can be used to promote accountability in cities and municipalities. One of the reasons for such an ambiguity may be that there is no one-size-fit-all basket of mechanisms to improve accountability at the local level. The specific context of local governments has a profound effect on their accountability mechanisms. For instance, particular accountability instruments in dense urban environments may not be ideal for rural dispersed villages. Here are some accountability mechanisms that have been implemented and showed positive effects in terms of health equity in medium sized cities, such as the ones studied in this particular research.

One of those accountability mechanisms is public expenditure management, also known as participatory budgeting or participatory public expenditure management. The local government budgets are often an accurate reflection of the government priorities, but frequently the resource allocation, the procurement processes, and the delivery of services lack transparency. In this context, the public expenditure management is set not only as a mechanism to improve transparency, accountability and effectiveness in public resource management, but also to reduce poverty reduction and to improve social equity outcomes for disadvantaged groups, as well as to promote citizen empowerment, to enhance confidence in public institutions, and more efficient budget, policy formulation and delivery[163].

The public expenditure management allows citizens to hold government accountable by voicing their needs in resource allocation, by judging whether public policies and budgets address social priorities, by fostering public awareness and administrative oversight about governmental actions and by appraising local governance performance regarding the delivery of public goods and services. These participatory budgeting mechanisms have been shown to have a clear redistributive effect, and therefore are effective instruments for tackling broader determinants of health, and for reducing inequality and poverty[164–166]. The Porto Alegre model may be the best known public expenditure management programme. It started in 1989 in the municipality of Porto Alegre, and since then it has spread to over 100 municipalities in Brazil. A quantitative assessment of the effects of participatory budgeting in Porto Alegre during the period 1989-2000 not only showed that a citizen-focused and citizen-controlled model is possible, but also that it has a positive impact on health determinants and equity[163].

The adoption of participatory budgeting can represent an open political challenge, because most cities that devolve actual control of the budget to councils with civilian participation see a clear redirection of their political priorities[167]. In this respect, participatory budgeting can be understood as a form of social empowerment that goes beyond the electoral process, since it creates new spaces to voice community members 'needs and to hold those in power accountable. However, whether city managers cede real power to citizens, is quite controversial. Some authors pointed out that in most of the cases cities' councils may formally submit to the decisions made at community-led meetings, but they retain the authority to partly or completely ignore them[166]. In those cases, participatory budgeting fails to mobilize real power but,

nonetheless, it gets to mobilize some degree of accountability ensuring access to the city's budgeting plan and asking communities about budgeting priorities.

Other instruments which can foster accountability in urban governance for health are health observatories, public health agencies or similar institutions designed to gather information about communities' health and monitor how public policies and other environmental and socioeconomic changes affect it. A good example of these can be the Agencia de Salut Publica de Barcelona (ASPB)[168], which promotes the evaluation of health impacts of municipal policies, synthesizing and systematizing information on the evaluations carried out, moving forward the transparency of city government. Moreover, the ASPB developed *Infobarris,* a support tool for the analysis of health and its determinants in the neighbourhoods of the city of Barcelona, which offers a set of indicators of physical and socioeconomic context, health, and behaviours related to health, as well as health services for the districts of Barcelona in open-access.

The literature consistently mentions the need for improving health information systems to document disparities in health outcome in a more comprehensive manner, incorporating better measurement of health and of determinants, as well as appropriate measures of health inequity[169–171]. Therefore, mechanisms that foster data and evidence drive health and health equity by highlighting areas for action, allowing informed policy-making, enabling accountability, and by measuring the impact of specific determinants and urban policies on health equity. Monitoring equity in health and its social determinants can effectively contribute to improve understanding of health inequalities in cities and municipalities, providing evidence for action, raising awareness, allowing informed policy-making and, above all, enabling accountability.

However, an indispensable element to effectively impact government accountability is being able to translate research findings into a language that is understood by all municipal stakeholders, so it can raise awareness of health and incentivize political action. Because, at the end of the day, public health is everywhere but often it remains invisible to policy-makers. Rapid assessment methods designed to produce health data in time to influence policy or HIAs, can be specific tools to promote healthy urban public policy. Evidence-based reports resulting from these tools can provide the rationale for actions, and demonstrate the potential, feasibility, and practicality of social actions in addressing health inequities. But for these to have a greater impact on accountability, the evidence must also be shared beyond policy-makers, informing, and engaging civil society, organizations or academic institutions, which can drive forward political commitments. It has to be guaranteed that civil society can fulfil its monitoring function, establishing a transparent regulatory framework through which civil society organizations can flourish[89]. And this closely relates to the next dimension of governance for health equity, social participation.

In summary, accountability is an essential in governance for health equity in that it plays a critical role in identifying and removing obstacles and barriers to achieve the right of health. Accountability processes and mechanisms can generate evidence for action, promote governmental transparency, explain governmental actions, engage civil society and other key actors, and hold those accountable where standards have been inappropriate. Accountable governance at the local level aim to respond to community problems, environments, demands, with responsiveness and transparency, and to cede real decision-making authority to citizens. In practice it can be promoted, for instance, through mechanisms such as public expenditure management, or health observatories designed to analyse information to promote and monitor healthy public policies.

2.2.2.3. Social participation

Previous sections have pointed out that participation is also a central aspect of a human rights-based approach to health. Linked to this, social participation, as a dimension of governance for health equity, is about participation of civil society in the policy process, including the need for a voice, or alternatively conceptualised as capabilities to enable meaningful participation. Thus, social participation is both, a means for, and a goal of, health equity. Social participation plays an important role in shaping social policy to advance health and health equity[102,172–174].

There are several conceptual models for considering the types of social participation. Participation can be classified, for instance, on its main function; nominal, instrumental, representative, and transformative[175,176]. The aim of functional participation is to enlist people to secure legitimacy, as well as compliance. The next level is instrumental participation, which enlists contributions and delegates responsibilities in order to promote efficiency. Then, representative participation aims to ensure sustainability by gathering people's views and ideas. Finally, transformative participation is about human rights, and undoubtedly is enhanced by empowerment.

If empowerment was intricately linked to all the dimensions of governance for health equity that have been exposed so far (policy coherence and accountability), this relationship is even stronger and more explicit when it comes to participation. Actually, empowerment and participation should be regarded as a binomial, as they have a symbiotic and complementary link[177,178]. This is because, participation can quickly become a token exercise or even a means of maintaining power relations without genuine empowerment and, without meaningful participation, empowerment can remain an empty, an unfulfilled promise[177]. But both of them together, empowerment and participation, are enablers of health and equity in health[179–182].

Empowerment and meaningful participation constitute one of the mechanisms for the redistribution of power, money and resources, which underlies health inequities. On the one hand, empowerment is the process that enables people to increase control over their lives, to gain control over the factors and decisions that shape their lives, to increase their resources and qualities and to build capacities to gain access, partners, networks, a voice, in order to gain control[182,183]. This implies a shift in focus from individual responsibility for health to community "*response-ability*" by refocusing on social determinants and healthy public policies[184]. On the

other hand, social participation, in its most transformative definition, is about an active, free and meaningful participation, which necessarily involves building critical consciousness, confidence and political capabilities in order to enable people to request their rights. In this regard, Francés and La Parra-Casado, stated that:

> *"The promotion of social participation is a key driver of health equity because it supports governance mechanisms that provide opportunities for greater health equality: raising awareness and recognition of the rights of groups with the highest level of health disadvantage; transforming so-called vulnerable groups into agents and protagonists of the policies and programmes that affect them; producing new collective knowledge that challenges dominant narratives; promoting coherence, responsiveness, transparency and the rule of law; facilitating the implementation and evaluation of strategies, programmes and activities; and promoting population consciousness of the private sector strategies used to promote products and choices that are detrimental to health"*[90]

There is extensive evidence that shows that participatory empowering strategies and interventions lead to improved health outcomes and reduced health disparities[72,185–189]. Most research in this area is focused on empowerment of groups facing social exclusion, since in fact, prioritizing the empowerment of vulnerable groups is key to addressing health inequalities. Indeed, ensuring that all people, including those who may be facing vulnerabilities, are able to participate in policy and decision-making processes that may affect their health is essential to improving both, health and health equity. Conversely, presenting a process as participatory when those have low inclusiveness, intensity, or influence (flawed participation), has great potential to produce health inequities[90].

Mechanisms of empowerment and participation should engage the intended beneficiaries of policies in decision-making processes, ensuring that the differential needs of marginalized and at-risk groups are recognized, and that they are involved in resource allocations, design, monitoring and review of policies, services and interventions[72,183]. In other words, in order to ensure a meaningful participation and promote social inclusion and social justice, participative processes must be inclusive and representative. In the end, inclusion and voice are core aspects of participation and empowerment, and both require non-discrimination as a pre-condition. Essential to meaningful participation are accessible mechanisms for participation and, equally, capabilities of individuals and communities[190].

Capabilities to participate meaningfully can be promoted at individual and community level. With reference to health, individual empowerment refers primarily to the individuals' ability to make decisions and have control over their personal life, for instance, health literacy. Community empowerment can be defined as individuals acting collectively to gain greater influence and control over the determinants of health and the quality of life in their community, through community action for health[191]. Both of them imply the achievement of a level of knowledge, skills, and confidence to take action to improve personal and community health, as well to organize and act to guarantee the political and social rights affecting health equity[181,192]. Therefore, to enable the required capacities is a critical issue to strengthen the "power to" and "power with" individuals and communities and to build influence and participation in decision-making processes.

In this connection, it should be noted that social capital, which can be defined as the degree of social cohesion that exists in communities[191] is closely related to community empowerment and community action for health, and in fact, cohesive communities have greater power to influence political decisions affecting the community. In turn, community empowerment and ownership contribute to build community resilience and community health[193–195].

An empowered community is more likely to apply their collective efforts to address health priorities and meet their respective health needs, providing social support, addressing conflicts within the community, and gaining increased political participation, and influence and control over the determinants of health[192]. Empowered communities are more able to challenge hierarchical power relations to take action on social, economic and political determinants of health and, in turn, social capital creates solidarity and stimulates the opportunity for fairer policies that aim to reduce health and social inequalities. Hence, it is essential to strengthen civil society participation in decision-making on health and social issues, from diagnosis to evaluation[192,196]. Strategies to improve population's health should build empowerment among communities and improve social participation processes through the whole policy process.

From a human rights perspective, the right to participation and consultation in public matters is established in various international instruments, such as Article 21 of the Universal Declaration of Human Rights, Article 25 of the International Covenant on Civil and Political Rights and Article 13.1 of the International Covenant on Economic, Social, and Cultural Rights. The right to participation involves the active, documented participation in the formulation, implementation, and monitoring of public policies.

Social participation at the local level

> *"Cities have the capability of providing something for everybody, only because, and only when, they are created by everybody"* [197]

Over the past two decades, local governance has been considered a way to promote the direct participation of citizens through partnerships and projects, to create more deliberative forms of formulating and implementing policies, and to empower civil society[126,198–200]. Social participation at the local level has been linked to several agendas, including democratic governance, sustainable development, and even neoliberalism, sometimes in a simultaneous way[201]. Social participation was also a central aspect of the Local Agenda 21 campaign and the WHO European Healthy Cities Network. And despite its long journey, it is still considered an innovative social practice.

In the previous section it was asserted that social participation could be applied in a variety of sectors at all levels of governance[90], however neighbourhoods, municipalities and cities, because of its closeness and everydayness, are undoubtedly some of the most appropriate settings for fostering social participation[202]. Local governments are closest to citizens' concerns and priorities, and have unique opportunities to partner with not-for-profit sectors, civil society and citizens' groups. This section focuses on local participatory processes and specifically on social participation for health and health equity in the European urban context.

Despite having different local government powers and relations to national authorities, diverse scales of operation, or different governance structures, local governments are often responsible for addressing many local needs. Among these needs, the need for a healthy city. Thus, local governments do share an excellent opportunity to influence intermediate pathways linking root environmental and social causes to health outcomes and inequities. Supporting social participation in urban governance, including priority-setting, planning and implementation, and monitoring of health outcomes and inequities, have been shown to be critical to address health inequities[166]. Ensuring that people participate in shaping the local policies and programmes that affect their lives is essential to moving forward health and health equity, but, as urban health is shaped by mechanisms that go beyond health interventions and policies, it is also necessary to support a broader agenda of community development and empowerment.

In this regard, the Copenhagen Consensus of Mayors, adopted at the WHO European Healthy Cities Network Summit of Mayors in 2018, commits cities to "*foster health and well-being through governance, empowerment and participation, creating urban places for equity and community prosperity, and investing in people for a peaceful planet*"[203]. Moreover, the promotion of greater participation and partnerships for health and wellbeing are a core theme of the WHO European Healthy Cities Network current phase VII[122]. The WHO envisions a healthy city being one that ensures community participation in decisions that affect peoples' lives, goods and services, that is, a city that engages the whole of society, encouraging the participation of all communities[204].

As participation at the local level relates to taking an active part in the context of public decisions that affect the health of the community, it enhances with community health[205], understood as the "*health of individuals and groups in a defined community, determined by the interaction of personal and familial factors and by the socioeconomic-cultural and physical environments*"[206]. Moreover, there is a growing literature that relates local governance and community health[200,207,208], linking those through a community approach to health based in an asset model that promotes community action and participatory population health interventions.

Social participation, also at urban level, should include both forms of participation; institutionalized (conducted through institutional channels and mechanisms), and non-institutionalized (carried out by other means and actors), because they mutually reinforce one another[209]. Despite this fact, when it comes to health governance for health at the local level, the most frequently seen is the participatory processes promoted almost exclusively by local administrative governments (institutionalized participation). However, in recent years, new local participation structures have emerged as spaces of local governance and networking, where social, technical and political levels converge[210].

The construction of community dynamics based on participatory democracy provides a new space for reflection, debate, and proposals on community health and public policies. However, these spaces are often limited to specific projects, which have become the main instrument of the governance in many European cities[211]. Although this phenomenon, known as a *projectification*, is still quite common, at the end of the day there are the different cultures of engagement that determine in each specific setting how participation for health is conceived and implemented. At institutional level, social participation depends upon more or less formal, reasonably durable institutions willing to adopt a participatory and more horizontal institutional

culture, including the whole population in the different stages of the health-policy process, establishing partnerships with other sectors, and developing an evaluation culture of participation[90,166].

In practical terms, however, too often local participation is merely symbolic[166], and unfortunately, social participation is often confused with actual social *party-cipation*. And I mean *party-cipation*, since at parties, who gets invited? The most frequent answer to this question is that invitations go to friends, to peers. That is why processes of local participation should be promoted from a critical perspective with the practices and norms that operate behind these processes, that is, taking the mechanisms of exclusion and the absent realities into account. When participation does not incorporate an intersectionality approach, systems of privilege and oppression are maintained, so that it is implicitly accepted that different perspectives may be ignored, and political decisions can favour the more advantaged social groups.

Promoting real representative participation is complex and challenging. It requires time, resources and an often uncomfortable institutional positioning. Emphasis must be placed on ensuring that everybody, including those who may be facing different discrimination processes, has the capacity to participate meaningfully. Including the neglected community's voices in the processes of decision-making, in priority-setting, and in monitoring provides a unique opportunity enhance accountability and legitimacy, and more importantly, to gain genuine input from the whole community. Certainly, an intersectional approach can serve to revise, in terms of equity, how public policies are defined and who participates in their elaboration and prioritization. Indeed, establishing participatory mechanisms that include an intersectional perspective are a clear opportunity to move forward health equity and social justice.

In a nutshell, social participation is an essential health equity governance dimension and key driver of health equity, which involves both population involvement in decisions that affect its health and community empowerment. Indeed, participative processes should give voice and promote capabilities to participate meaningfully, ensuring inclusivity, intensity and influence. At the local level, social participation enlaces with community health.

2.3. Local health strategies: Policies as a mirror of Governance

As discussed in above section 2.1.4, health and equity are complex value-laden concepts. Societies integrated ideological systems of meaning and practice that, in a given culture, guide the interpretation of daily life. Indeed, ideology plays a critical role in legitimizing and concealing social and political power structures, and this can have an impact on the invisibility of social inequalities as a whole, as well as on health inequalities in particular. Explanations of how health inequities arise and persist over time are shaped not only by scientific evidence and models but by political ideology and the interests of different stakeholders with access to decision-making arenas[72].

There are complex interactions between political traditions, policies, and public health outcomes[53]. Policies reflect ways of thinking about the world and acting upon it, they contain implicit models of social organization and visions of how individuals should interact in society[212]. Hence, ideology can be reflected both symbolically and operationally in policies; in the principles and values that underlie them, in their objectives and in their interventions. In this sense, Shore and Wright point out that policies are discursive formations through which social processes can be identified as they provide charters for action to guide behaviour and to legitimize narratives[213]. Policies can also be considered *technologies of governance*, vehicles through which institutions seek to act upon the world and to manage, regulate or change society[212]. Hence, there is an empirical link between governance, policies and health equity[214]; political parties with egalitarian ideologies tend to implement redistributive policies that affect population health indicators and health equity[53,215–219]. The explanatory mechanisms are complex, but point to the fact that the redistribution of material and immaterial resources discourages vertical power relations and promotes social cohesion and the well-being of society.

In light of this, policies can be a remarkable object of research enquiry. As policies can foster or hinder distribution of power, wealth and resources, they provide insight into the complex ways in which these value-laden concepts, government and other agents interact, either to consolidate structures of power or create new rationalities of governance. Hence, the local health strategies develop in Barcelona, Bilbao and Liverpool will be main object of analysis of this research, as a way of approaching governance.

Because of the transdisciplinary nature of this research, as well as the fact that it is developed in multiple settings, makes it even more pertinent to clarify concepts that may be used with different meanings depending on the context or theoretical perspectives. So, in the scope of this research, “strategy” is understood comprehensively, and therefore, a local health strategy is considered as any strategy, directive, policy or plan, or set of them, developed by the local government, that explicitly recognizes the aim to promote the health of population groups and communities.

Local health strategies are usually explicitly stated in a public document that describe guiding-principles, objectives to be achieved and the interventions to be carried out to achieve them, in other words, the *symbolic and operational content*[220,221] of local governance for health for a given period of time. Local health strategies are the result of the so-called *construction of a policy* and define the urban health issues and intervention proposals that have entered into the political agenda as a result of an interplay of interests and power of the different actors[222–224].

Policies are tools of governance that reflect ideology, implicit values and models of social organization. Its symbolic and operational content makes them an interesting object of research enquiry. Thus, in the scope of this research, local health strategies are used to approach governance. Local health strategies are understood as any strategy, directive, policy or plan, or set of them, developed by local government, which explicitly recognises the objective of promoting health.

3. Urban governance for health equity in global context

As pointed out in previous sections, local governments are particularly well situated to respond to local needs and to tackle wider determinants of health and equity in health. However, they are also placed within a wider context that creates the conditions that shape their ability to taking practical action. Governance processes operate at every level of human enterprise, may it be global, regional, national, municipal, and even at household level[225]. As Kickbusch and Gleicher stated, "*Wicked problems require systems approaches that involve a wide range of society and multiple levels of governance, from local to global, with increasing relevance of the local level*"[45].

This implies that urban governance for health equity goes beyond the territorial meaning of "urban", connecting local and global, and transcending boundaries. In this regard, the terms "*Glocal*" or "*Glocalization*" were introduced decades ago by Swyngedouw, and have been used to recognize and emphasize the complex and inseparable interface between global developments and local responses. They aim to capture these complex interactions between people, politics, power and perception[226–229]. Consequently, in order to understand some of the current challenges and opportunities of governance for health at the local level, the global trends must been considered, including their economic, political, and social dimensions. This section is going to briefly review some of these trends.

The importance urban health has been increasingly recognised for its central role shaping public health globally[230]. Indeed, one of the major global health challenges of the 21st century is to reconcile the growing proportion of the population that lives in urban settings with the goal of creating healthy cities[34]. In this sense, urban governance for health must respond to global trends (such as those set out below) but, at the same time, be able to influence regional, national and global governance through its local knowledge and capacity in order to promote the kind of economic and political conditions in which a city is most likely to thrive[166].

3.1. Urban health in context of neo-liberalization and globalization

At the end of the 20th century, the arrival of neo-liberalism led to a progressive economic liberalization, deregulation, privatization, reduction in government spending, and an increased presence of the private sector in the economy and society. It captured the political agenda at all levels of government, placing economic interests in a hegemonic position and reducing the power of governments to exercise their function safeguarding basic determinants of health and well-being. The interests of economic forces, business and market powers, have affected the ability of governments to promote and protect people's health and health equity [231]. In this context, urban governance for health faces great challenges that threaten people's right to health[232,233].

In his book *"Le Droit à la ville"*, written in 1968, Lefebvre highlighted the effects that capitalism had over the city and called social movements and grassroots organizations to action. Current urban challenges such as the acceleration of forms of privatization, the degradation of the urban setting or the exclusion of the poorest segments of the population, make his work completely relevant nowadays[234]. In fact, as neo-liberalism has accelerated and generalized injustices in the city, various urban social movements have spearheaded a *new* 'right to the city' movement.

The renaissance of the 'right to the city' reveals a collective awareness of these concrete urban challenges, as well as the willingness to rethink the cities in different ways.

In order to provide specific examples of the influence of the processes of globalization and neo-liberalism, below are some of the most currently relevant global challenges that urban health governance is facing.

Urban poverty and slums

Urbanization has been accompanied by an alarming increase in urban poverty, of which slums are the most visible manifestation. The rapid rate of urbanization has sometimes outpaced the capacity of local governments to manage the proliferation of slums. Thus slums represent a failure of governance at the local level, as the municipal government plays a crucial role mitigating and modulating the negative impact of urban poverty and slum growth. But slums also represent a failure at national and global levels of governance, as it is estimated that there are currently three billion people living in urban areas, and over a billion living in urban slums[235]. The "urbanization of poverty" is serious and largely unrecognised, partially due to the fact that it affects mostly, although not exclusively, low-income and middle-income countries[235,236].

Although there is no universal agreement on the definition of slum, there is consensus that they are characterized by a lack of basic services, substandard housing or illegal and inadequate building structures, overcrowding, unhealthy living conditions and hazardous locations, poverty and social exclusion, insecure tenure or informal settlements, and minimum settlement size. As a consequence, slums constitute a threat to physical, mental and social health, as well as to the well-being and quality of life of the populations living in them[235,237]. Moreover, people in slums are frequently marginalised and even stigmatised, with the result that they experience expropriation of property, displacement, and denial of access to basic services[238].

Gentrification and *turistification*

Neo-liberal policies shape urban spaces in that economic power pre-empts urban social needs and one of its consequences is the gentrification process. Gentrification can be triggered by direct intervention of global market, or driven by urban regeneration policies. Whatever the case may be, gentrification is a complex economic, housing and health issue related to the transformation of neighbourhoods which increase their economic value, causing involuntary displacement of lower-income residents. Gentrification entails shifts in the neighbourhood's characteristics, often from racial or ethnic composition and average household income, to higher-income households, new businesses and resources.

The relationship between gentrification processes and tourism is evident. Gentrified neighbourhoods generally host a significant volume of tourists and, at the same time, the presence of tourism reinforces the displacement of the resident population. Mass tourism also leads to property speculation, competing for resources with the citizens[239]. The *Turistification* phenomenon is also known as the "Venice syndrome"[6]. Although the gentrification trends are not systematically studied, they have been reported in many European cities other than Venice,

[6] The documentary "The Venice syndrome" was the winner of Best Documentary at the Urban festival TV. It explores the Venice gentrification process.

such as Paris and Marseille (France), Milan, Turin, Naples, Genoa and Rome (Italy), Barcelona and Madrid (Spain), Łódź (Poland), Lisbon (Portugal) or Berlin (Germany) to name just a few[239].

Gentrification is a matter of governance for health equity because it affects the essential character of the neighbourhood, its community's history and culture, and its social capital. Moreover, displacements have health implications and contribute to inequities among populations, in terms for instance of limited access to affordable healthy housing, healthy food choices, walking and bicycle paths, exercise facilities, transportation choices or quality schools[240]. Indeed, it is an issue of social and environmental justice regarding wider determinants of health[241].

Commercial Determinants of Health

Commercial determinants of health can be considered "*the double burden of neo-liberalism*"[242]. Defined as the "*strategies and approaches used by the private sector to promote products and choices that are detrimental to health*"[140], the commercial determinants of health are a global public health issue which relates to the political economy of globalisation. Products such as alcohol, sugar-sweetened beverages, and foods high in fat, sugar and salt, or tobacco are a big and lucrative business, despite the extensive evidence available linking them to the global burden of non-communicable disease[243].

Corporate activities are shaping urban environments, determining the presence, accessibility and promotion of these consumables[233]. Kickbusch, Allen and Franz, identified four channels whereby corporate actions influence the environment, the consumers and, ultimately, the people' health: marketing (including commercial sponsorships[244]), lobbying, corporate social responsibility strategies, and extensive supply chains[140]. Research has documented the corporate techniques used to appeal the most vulnerable population, such as children or adolescents[245,246].

Further aggravating this situation, non-communicable disease prevention strategies often focus on lifestyles and personal responsibility for addressing risk factors, ignoring the limited control that many people have over their circumstances and their exposure to the marketing activities of transnational corporations[242,247]. Constantly, urban residents are exposed to a wide variety of unhealthy products, unhealthy foods, tobacco, sugar-sweetened beverages or alcohol[248]. In this connection, and although it is not yet included in the scientific literature as a commercial health determinant, it should be noted that, in the past few years, betting agencies have proliferated exponentially in many cities, strategically located in neighbourhoods with a low socioeconomic level. Gambling is an increasing urban health problem, which entrails a high personal, interpersonal and community cost[249].

It is also worth noting that that these consumerist dynamics often not only pose a direct risk to the health of the population, but also indirectly through the environmental pressure that plastic bottles or packaging, for example, represent. Ill-health, damages to the environment, and health and social inequalities, might be better understood through a commercial determinant lens[250].

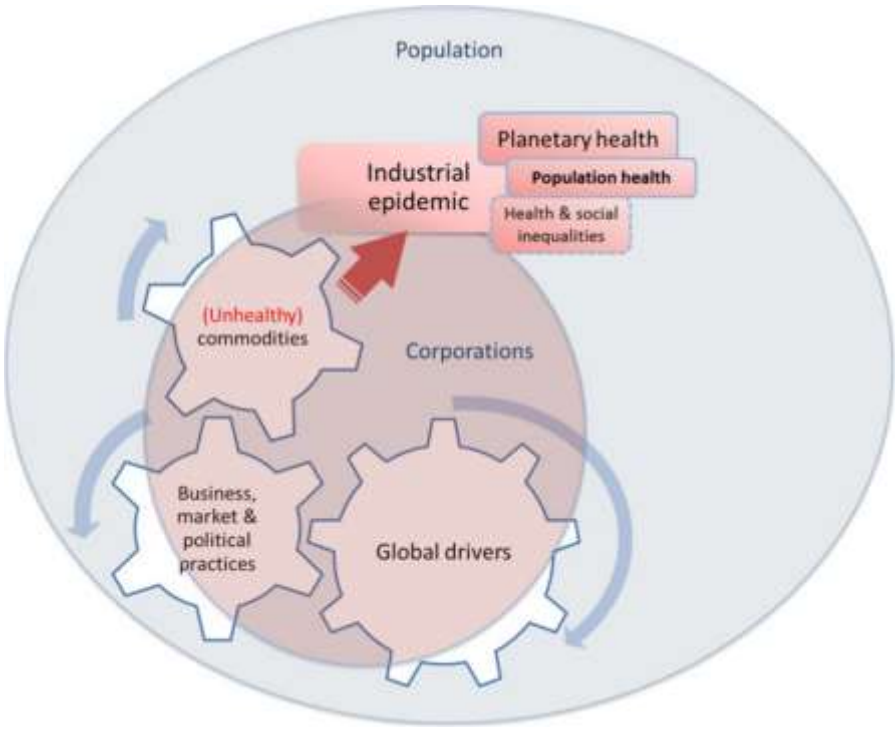


Illustration 1. Commercial determinants of health[250].

3.2. Urban health in the context of climate change, natural disasters and epidemics

The context of neo-liberalisation and globalisation is intrinsically related to the current context of environmental vulnerability. The harmful effects of human activity on the biophysical environment are already impacting population health, and are projected to drive the majority of the global burden of disease over the coming century, hitting today's most vulnerable and future generations the hardest[251]. In this regard, the emerging *planetary health* movement highlighted the interconnection and interdependency of all systems[252].

It should be considered that climate change, natural disasters and epidemics are occurring in the context of rapid urbanization, which emphasises even more the intertwined existence of humans and their environment. There is a growing awareness of the need for resilient urban environments that can protect and promote both, the health of ecosystems as well as population health[253,254].

According to WHO, the climate crisis is a human-caused disruption of the Earth's natural systems that threatens to both the planet and the health of the people who live on it[255]. The risks and challenges that climate change poses to cities are numerous: directly through stress, cardiovascular and respiratory illnesses, malnutrition, economic instability, vulnerable shelter and loss of homes and forced migration of populations; and indirectly via increased urban heat waves, degraded air quality, rising sea levels, food and water insecurity, more and more intense floods, droughts, earthquakes, volcano eruptions, tsunamis, hurricanes and storms, increased spread of diarrhoea, vector-borne and infectious diseases[256,257]. And, as mentioned before, these impacts will not affect in the same way the entire population of the world.

In fact, urban areas, and especially socioeconomically disadvantaged populations within urban settings, are at higher risk to the adverse effects of climate change[258,259]. Therefore, urban areas should prepare adaptation strategies to the effects of climate change and targeted resilience actions that prioritize the most vulnerable people and environments[260]. Climate change mitigation and adaptation must go hand in hand with efforts to achieve health equity through action in the social determinants.

The same applies to the recent COVID-19 epidemic, which has exposed the persisting health inequalities in our societies, bringing these inequalities into sharp focus, and showing the heaviest impact on the lives of people living in deprivation or facing difficult socioeconomic circumstances. On the one hand, it has been shown that some groups of population are at higher risk of being infected and dying from the virus than others, determined by factors such as gender, ethnicity and socioeconomic deprivation. On the other hand, measures taken to control the spread of the virus have also had unequal socioeconomic impacts which are likely to deepen health inequalities in the long term[261]. Moreover, the inequitable consequences of the pandemic have been exacerbated by the neoliberal policies, such as privatization of health services or politics of austerity and its subsequent cuts to social policy expenditures, that considerably weakened the capacity of the response to the coronavirus pandemic[262,263].

Urban settings offer a window of opportunity to improve resilience to climate change, natural disasters and epidemics, by not only strengthening prevention, preparedness and readiness, but also ensuring an inclusive and equity-promoting governance for health.

As an overview of this section, it is important to acknowledge that urban governments are placed within a wider context that influence local government's ability to promote and protect people's health and health equity. Neo-liberalization and globalization are processes in which cities are immersed, and they pose a threat to global health, which has to face new challenges such as the "urbanization of poverty" or gentrification. Market-driven economies and globalisation also drive unhealthy behaviours. Also, related to these trends, climate change is threatening the urban environment and urban health. In this context, an equity-promoting urban governance for heath offers a window of opportunity not only to face these challenges, but also to be part of the solution.

4. Putting cities in context

About 78% of European citizens live in cities, and most of them in medium-sized cities[13]. Compared to other parts of the world, urban regions in Europe have many polycentric structures, that is to say, metropolitan areas where several towns or cities are in close to one another. This urban structure is the result of elements that date back to the Roman Empire, where cities functioned as administrative centres and to the Middle Ages, when cities, often situated near a river or harbour, were relevant marketplaces and strategic locations along trade routes.

Demographic, political and economic factors made cities evolve in uneven ways throughout their history. Some periods were characterised by decline whereas in other periods cities thrived and expanded. Throughout the 20th century, many cities developed and spilled over into their surrounding regions. In fact, in recent years, the population has still been growing in most European metropolitan areas. At the same time, the population is becoming more culturally and ethnically diverse, fostered by the free movement of citizens within the European Union and the influx of migrants and asylum seekers from non-EU countries[13].

However, this section will not analyse European cities as a whole, but specifically the case study cities on which this research focuses. In this third part of the background, a brief historical overview of Bilbao, Barcelona and Liverpool's development is given, so they can be better understood. Thus, this section is intended to briefly introduce the historical, political, demographic, and economic factors that have built and characterised the cities we know today. The specific aspects related to urban health and governance, including the structure and political-administrative features of their local government, will be presented in later sections.

4.1. Bilbao

Bilbao is located near the northern edge of the Iberian Peninsula, about 16 kilometres from the Bay of Biscay (Figure 8). Although the Ibaizabal-Nervión estuary, where it is placed, was probably already populated before its foundation, it was in 1300 when the Villa of Bilbao was founded by Diego López de Haro. A decade later, María Díaz de Haro, granted a new town charter that further extended the trade privileges of the Villa, making it a strategic location along trade routes and an obligatory passage for all trade from Castile towards the sea. The economic, social and urban development of Bilbao was based on trade, on the port, on the weekly market and on the iron from *Miravilla*.

From the 15th century onwards, Bilbao consolidated its commercial position, becoming the most important economic centre in the Seignory of Biscay. This economic growth involved a major increase in population, leading to the Old Quarter (Casco Viejo) being created by expanding the three original streets, to *seven streets*, the name used nowadays to refer to the historical centre of Bilbao. During the 15th and 16th centuries, exchanges with other European ports were strengthened and trade was established with the American colonies. In 1511, the Consulate of Bilbao was constituted and Bilbao became the main port on the Bay of Biscay.

Despite the crisis that affected the European economy in the 17th century, Bilbao-Bizkaia managed to maintain its growth because of the large English and Dutch commercial ties of iron, wool and its merchant fleet. During the 17th and 18th centuries, two floods and a fire devastated the city in less than forty years. After these events, an extensive urban renewal began, the

original city wall was removed and the new buildings were built in stone instead of wood. It was in this new area that the wealthy bourgeoisie and English and Dutch merchants settled.

In the 19th century, specifically in 1808 in the context of the Napoleonic invasion, the city changed hands several times. Later on, during the Carlist Wars that confronted Liberals supporters of the Spanish regent Maria Christina and Carlist, supporters of the late king's brother Carlos of Borbón, targeted Bilbao for being a liberal and economic bastion. Baldomero Fernández-Espartero Álvarez de Toro took the city in 1836. Finally, during the Third Carlist War, Bilbao was liberated by General Concha, in 1874. Despite all those upheavals, Bilbao continued to develop. The railway reached Bilbao in 1862, consolidating the importance of Bilbao as a financial and economic centre. In fact, from 1875 onwards, there was an unprecedented era of development, based on the nearby mines, trade and port activity. Bilbao experienced heavy industrialisation and became known for its important iron, steel, and ship-building industries, the key drivers of its economic growth. This economic expansion was followed by a period of urban development, and Bilbao and its surrounding area underwent a radical transformation. Bilbao spread towards the Abando area and embarked on other expansion projects; tree-lined avenues, straight streets and promenades were built and the new architecture marked the start of modern Bilbao.

In the early 20th century, Bilbao was the economic powerhouse of the Basque Country and one of the most important cities in Spain. In 1900, the Euskalduna shipyards were founded and in 1902, Altos Hornos de Vizcaya started operating, which was the largest company in Spain for much of this century. The spectacular growth of Bilbao was accompanied by a significant cultural development, which was dramatically disrupted by the Spanish Civil War (1936-1939). Franco's forces bombed and destroyed Bilbao into submission and overcame the so-called "Iron Ring" that surrounded Bilbao. This led to the end of the Basque Government's jurisdiction and the Francoist dictatorship, which was followed by a long post-war period for the city under the Francoist dictatorship.

With the war over and after a hard post-war period, the city developed and became a beacon for many immigrants that came to work in Bilbao's booming industry. With this rapid expansion, the industrial and urban landscape of the city changed again resulting in a sprawling urban area that spread into the neighbouring municipalities, on both banks of the River Nervión, creating the metropolitan area known as Gran Bilbao. However, at the end of the 20th Century, a deep crisis in the iron and steel industry forced the City to rethink the basis of its economic development. In 1988, the emblematic Euskalduna shipyards closed, and with it the Bilbao shipbuilding industry, resulting in major negative economic and social consequences. Bilbao was forced to tackle the difficult industrial restructuring, and the City embarked on urban rehabilitation projects and building infrastructures, including new bridges, the metro, airport and tram.

At the end of the 20th century and early 21st century, as a result of this industrial restructuring, Bilbao progressively transforms its industrial economy. It became a service city, and positioned itself as a tourist destination[(264)]. The Guggenheim Museum is seen as an icon of the city's international outreach and of the urban and social transformation of recent year of which the museum has been part. Indeed, Bilbao was chosen the Best European City 2018 at The Urbanism Awards 2018.

Figure 8. Satellite view of Bilbao

Currently, Bilbao has a population of approximately 350,000, and Gran Bilbao, its metropolitan area, has about one million inhabitants. The city is divided into eight districts, which are further subdivided into 34 neighbourhoods (Figure 9).

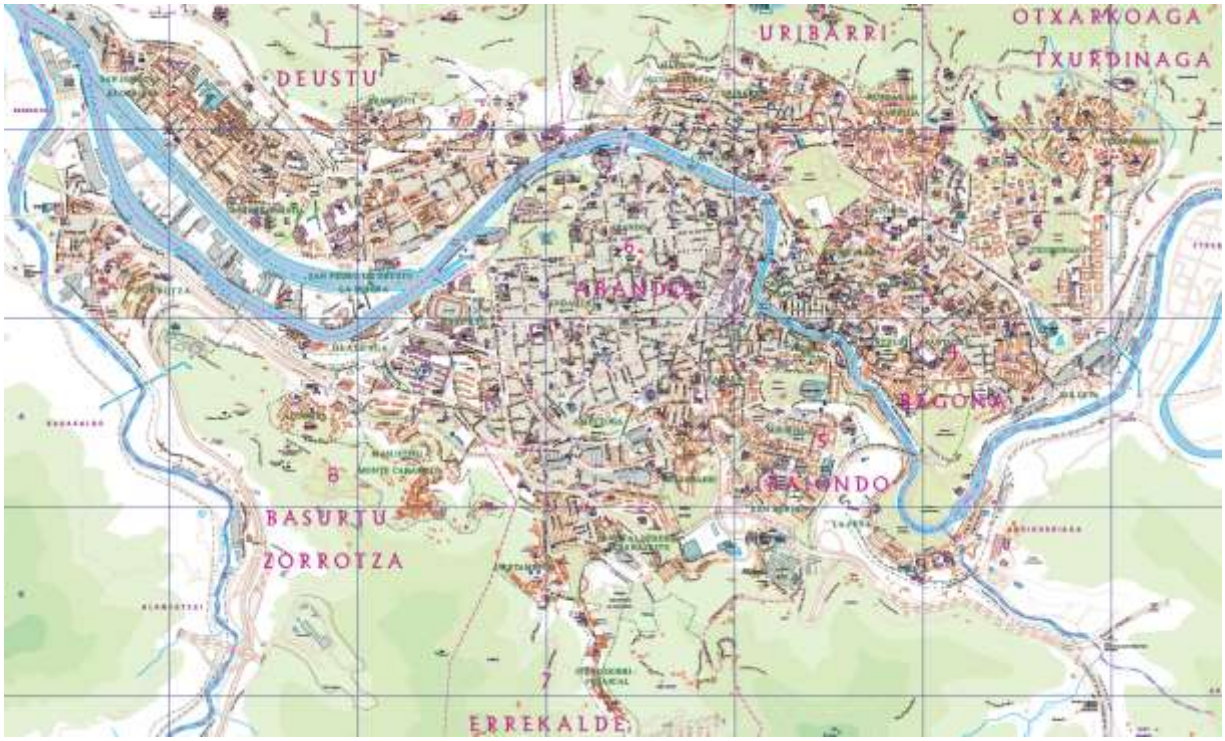


Figure 9. Districts and neighbourhoods of Bilbao

4.2. Barcelona

The origins of present-day Barcelona (Figure 10) are not entirely clear; it is believed that the first human settlements may date back to Neolithic times although there seems to be a greater consensus that the city was founded by the Romans at the end of the 1st century BCE and named *Colonia Julia Augusta Faventia Paterna Barcino*. In the time of Augustus, *Barcino* had some thousand inhabitants, but it grew rapidly. During the 3rd century, the Roman colony was partially destroyed by Germanic tribes and then reconstructed and its wall rebuilt and fortified.

In the 5th century the Western Roman Empire came under attack from various Germanic tribes, and the Visigoths took control of the invaded Hispania. At that time, *Barcino* became an important centre of the Visigothic kingdom, and it remained controlled by the Visigoths for three centuries. At the beginning of the 9th century, after the Muslim conquest in the 8th century and the subsequent expulsion of the Arabs from the Iberian Peninsula by the Franks, the territory was organised into counties based on territorial divisions from the Visigothic period, becoming a county of the Carolingian Empire and a regular residence of the Crown of Aragon. In this way, the Roman-founded town developed over the centuries into an important medieval capital.

Barcelona was by far the largest settlement under the Crown of Aragon. In the 11th century Count Ramon Berenguer I promulgated the first Catalan legislative text, *Usatges de Barcelona*, the fundamental laws and basic rights of Catalonia which sought to resolve the legal problems of the new feudal society. Later in the 12th century, under the jurisdiction of King Alfonso I, the Principality of Catalonia was made up through the union of the various counties of the Catalan lands. In this way, Barcelona gained political and commercial relevance and experienced a period of great economic, social and cultural splendour. In 1249, King James I instituted the municipality of Barcelona, stipulating that it would be governed by five *Consellers* and by the *Consell de Cent*, a municipal government structure, consisting of 128 jurors, which lasted until 1714.

As mentioned above, medieval Barcelona established itself as an important economic and political centre, which led in turn to its growth. Thus, in the 12th century, a new wall was built to extend the city, integrating the Ribera and Sant Pere de les Puel·les neighbourhoods on one side, and reaching as far as the Rambla on the other. Later on, in the 14th century, the wall was extended to include the Raval neighbourhood and the present-day Paral·lel, and its final boundary was the sea itself. Within these walls, the city continued to grow and prosper until 1333, when famine and epidemics killed thousands of people, as it did the Black Plague four years later. Epidemics continued and the situation worsened due to a severe economic crisis in the 15th century.

From the 15th century onwards, Barcelona entered a period of decline and having been an important political, economic and maritime power, gradually lost its importance. This was because, on the one hand, the Crown of Aragon became part of the new Spanish monarchy and was transferred to Castile and on the other hand, because with the conquest of America, much of the trade was diverted towards the Atlantic. Throughout the 16th and 17th centuries, tensions with the central power increased. In 1640, the Catalan people rebelled against the economic burden that Philip IV imposed on the counties of the Principality of Catalonia to finance the war against France. The Feast of Corpus Christi, historically known as Bloody Corpus, marked the beginning of the *Guerra dels Segadors*, a war that lasted 11 years during which Barcelona was besieged for 14 months. Finally, in 1659, France and Spain signed the Treaty of the Pyrenees.

In 1701, when Charles ll of Spain died without leaving a legitimate heir, the War of the Spanish Succession unleashed. Castile was in favour of the Bourbon Philip V and Europe was split between those who supported it and those who favoured Archduke Charles III of Austria. As the Bourbons wanted to establish an absolute monarchy, Barcelona, and Catalonia as a whole, together with England, Portugal and the Seven United Provinces of the Netherlands, were on the side of the Archduke of Austria to maintain its own statutes. In 1713, Spain and England signed the Treaty of Utrecht, recognising the Bourbon as the king of Spain. Barcelona, left on its own, suffered another 14 months siege, and eventually the city fell to the Bourbon troops on 11 September 1714. Following the war, the Catalan governmental institutions were abolished and Catalonia's rights and privileges were suppressed.

Although Barcelona was severely weakened after the War of the Spanish Succession, new commercial and industrial activities began to develop. The six kilometre medieval walls surrounding Barcelona, which allowed the city to resist seven sieges between 1641 and 1714, limited, at the same time, a necessary urban expansion. Throughout the 18th century, and particularly the first part of the 19th century, the city experienced a significant demographic growth, which raised the population from 115,000 inhabitants in 1802 to 140,000 in 1821. The population density challenged the sanitary and social situation of Barcelona, which lacked of sewage and running water infrastructures. Furthermore, the streets were narrow, dark and lacked ventilation. These precarious sanitary conditions contributed to a yellow fever epidemic in 1821 and several cholera epidemics in 1821, 1834, 1854 and 1865 in the city.

Despite this dire health and social situation inside the walls, the attempts to expand outside the walls were repressed by the Ministry of War, the Central Government in Madrid, due to the military consideration of Barcelona and Ciudatela as a strategic stronghold. In 1841, the Barcelona City Council called a contest to promote the development of the city and it was assigned to Dr. Pedro Felipe Monlau, a physician and hygienist. He wrote the work *"Abajo las murallas"*[265] (Down with the walls), a report on the advantages that the demolition of the city walls would bring to Barcelona, which had broad social support. The need to grow outside the walls became more and more noticeable.

The Industrial Revolution worsened the unhealthy living conditions in Barcelona, as the new factories within the city walls affected the environment and, in turn, living conditions. In this context, there were various strikes, riots and demonstrations against the misery and the terrible working and living conditions that the proletariat had to face. At the same time, the Industrial Revolution also raised the interest of the Catalan bourgeoisie in investing in infrastructure and technology and, eventually, in the expansion of the city according to more modern standards. So finally, the central government was put under pressure to agree on the demolition of the medieval walls, which took place between 1854 and 1856[266].

The Plan for Barcelona's *Eixample* was commissioned to Ildefons Cerdà, and it was quite visionary, adapting the city planning of Barcelona for its development in later centuries. The *Pla Cerdà* was a Plan of the city expansion organized in a regular orthogonal grid and in blocks of 113 square meters. These blocks had the buildings and sidewalks cut at 45º angles at all corners to achieve greater visibility and mobility, with a small central square that made intersections play a prominent role in the structure of the city[266]. This configuration, even today, is one of the iconic features of the city of Barcelona.

Although Barcelona experienced a turbulent period throughout the 19th century, with various military conflicts and the confrontation between liberals and conservatives, the period of

stability at the end of the century brought economic, social and cultural resurgence. In this period of *Renaixença*, a new bourgeoisie enriched by the rise of industry built notable modernist buildings in the streets of an embellished Barcelona. This period also heralded the recovery of the Catalan language and culture, which had been suppressed at the end of the War of the Spanish Succession.

In the early 20th century Barcelona, the industrial activity and the working class continued to grow. The appalling working conditions of the workers led to a general strike in 1909, which resulted in a popular revolt, and led to the introduction of the eight-hour working day. While the city's industry and population were growing, the Spanish Civil War and the long period of dictatorship that followed set the tone for a time of upheaval. Barcelona, which supported the Republican side in the Spanish Civil War, was bombed by Franco's Italian air force, which indiscriminately bombed the civilian population. At the end of the War, the dictatorship established by General Francisco Franco subjected the Catalan people and culture to severe repression. The Generalitat was abolished and President Companys was executed by firing squad. The subsequent post-war economic hardship lasted until mid-20th century.

From the second half of the 20th century onwards, a protest movement began demanding democracy and the return of lost rights, but it was not until after the death of General Franco in 1975 that democracy was established. In 1977, with the restoration of the Generalitat, Barcelona become again the capital of Catalonia and in 1979, Barcelona had, for the first time after 40 years of dictatorship, a Mayor who was democratically elected by the people of the city. Thus, progressively, Barcelona started to recover its own governance, culture and identity.

Like any other city, Barcelona has adapted to population changes throughout its history, creating the necessary infrastructure and carrying out urban renewal programs. Some of these major urban renewal programs include the aforementioned *Pla Cerda* to cope with the population growth, the renewal project for the 1992 Olympic Games, the urban renewal to adapt to the immigration wave of the 1990s and, or more recently, the revitalization of down town areas Ciutat Vella district and Raval neighbourhood to promote tourism.

Barcelona is still today the capital and largest city of Catalonia and the second most populous city of Spain. With a population of 1.7 million within city limits, and around four million people in its urban area that extends to numerous neighbouring municipalities, it is also one of the most populous urban areas in the European Union.

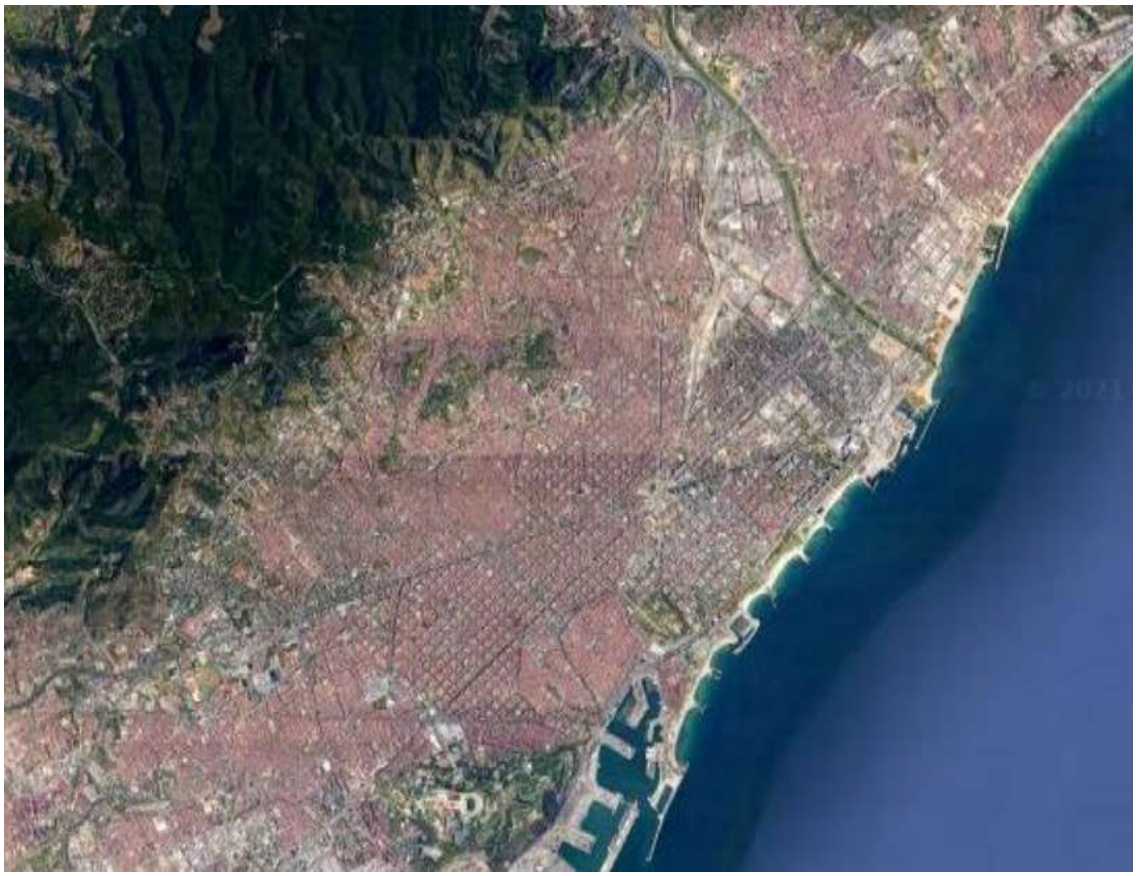


Figure 10. Satellite view of Barcelona

The need to know the city and the characteristics of the parts of its territory led at the end of the 19th century the Municipal Administration to establish a division of districts. After the 1960s and 1970s social and urban transformations, in 1984, a new territorial division of the city of Barcelona was approved dividing the city of Barcelona into 10 Municipal Districts. The current territorial division of the City is based on the same division, in addition to a new division of 73 Neighbourhoods approved on 2006. Thus, the current territorial division consists of Municipal Districts and Neighborhoods, but also Basic Statistical Areas and Census Sections[267] (Figure 11):

- The 10 Municipal Districts are the largest territorial unit within the municipality of Barcelona and they have official numerical and nominal denomination.
- The 73 neighbourhoods are territorial delimitations of Municipal Districts significant from the urban and social point of view. They represent a territorial framework for the development of urban actions and the provision of local equipment and services.
- The 233 Basic Statistical Areas are uniform territorial areas between the Neighborhoods and the census sections.
- And finally, the 1068 Census Sections are areas within the Basic Statistical Areas with an approximate number of electors of 1.000.

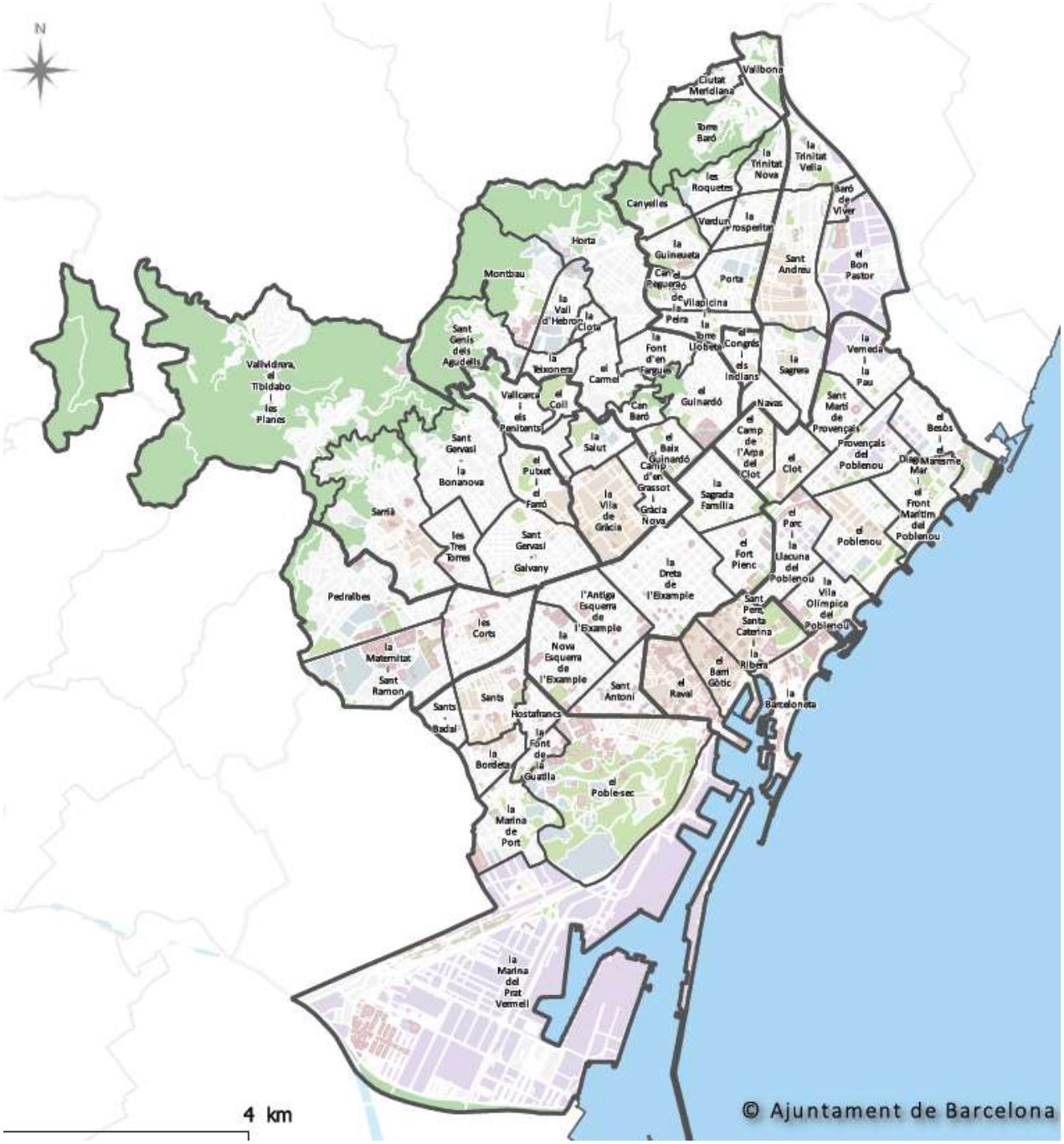


Figure 11. City of Barcelona, by neighbourhoods

4.3. Liverpool

Although there is some debate about the origin of the name of the city of Liverpool, the vast majority of hypotheses refer to a common element; a place with water. One of the most widely held hypotheses is that the name comes from the Old English; liver, meaning muddy or thick, and pol, meaning a creek or pool. Thus, it is thought that the original reference was to a pool or tidal creek, now filled up, into which two streams drained, since the city began as a tidal pool of the River Mersey.

There is archaeological evidence of the existence of settlements in the area around modern-day Liverpool since the Iron Age. Prior to the Roman presence in about 70 BCE, the region was inhabited by Brythonic, Cornovii, Deceangli and Setantii tribes. Chester was a major Roman fortress, although after the withdrawal of the Roman troops, this area continued to be inhabited by native Britons. Afterwards, this area was the scene of fighting between four medieval kingdoms; the Anglo-Saxon kingdoms of Mercia and Northumbria, as well as the Celtic kingdoms of Powys and Gwynedd.

Even though there may have been a small hamlet before, the origins of the city of Liverpool date back to 1207, when King John issued letters patent announcing the creation of *Livpul*, a new borough. King John divided the land at Liverpool into burgages on which people could build houses, inviting settlers to come and take up holdings there. In 1229, the King granted the merchants the right to form themselves into a guild to protect their interests. And, as in many medieval towns, in Liverpool the Merchant's Guild also ran the city on a day-to-day basis. The earliest mention of a mayor of the city of Liverpool, elected by the members of the guild, dates back to 1351.

In the 13th and 14th Centuries, medieval Liverpool basically comprised seven streets and Liverpool Castle and it probably had a population of about one thousand inhabitants, mainly farmers, fishermen, craftsmen and tradesmen. By the early fifteenth century, a period of economic decline set in which, together with the feuds between the Stanley and Molyneux families, led to a population decline to around 600 inhabitants by the middle of the 16th Century.

During the second half of the 16th and in the 17th Centuries, Liverpool started to grow and expand, reaching a population of over two thousand inhabitants. Liverpool's population probably reached 2,500 at the time of the Civil War, in part due to English troops being transported from the port of Liverpool to Ireland to put down rebellions. The Civil War between king and Parliament began in 1642. Liverpool, which was initially in Royalist hands, was taken by Parliamentarian soldiers 1643. The Royalists' troops re-attacked but could only retain Liverpool for a matter of weeks. In 1644 the Royalists lost the battle of Marston Moor losing, along with it, Liverpool and the whole of the North of England. After this turbulent period, Liverpool continued to expand at a quick rate, and the town had reached a population of approximately five thousand inhabitants by the beginning of the 18th Century.

The port of Liverpool, which had been gaining in importance, established Liverpool as recognised a port and commercial city. Thus, in 1715 the first commercial wet dock was built, and substantial profits from the slave and tobacco trades enabled the city prosper and continue to grow rapidly. The merchants of Liverpool made huge profits from the triangular slave trade, but it should be noted that several local people, such as William Rathbone, Edward Rushton and William Roscoe, were at the forefront of the local abolitionist movement. The industry also experienced significant growth in the 18th century; sugar refining, rope making and shipbuilding became flourishing industries, as well as manufacturing such as watchmaking, ironworking and

pottery, which also prospered. Despite economic growth, many of the poorest people in Liverpool lived in dreadful hygienic and sanitary conditions with overcrowded houses and filthy streets without sewers. By the mid-18th Century, the population had risen to 20,000.

Although the American War of Independence in 1776 disrupted trade from Liverpool, by the start of the 19th century, Liverpool had the largest and most advanced port in the world and became one of the world's richest cities. At the time, the population already exceeded 80,000 inhabitants. The large volume of trade passing through Liverpool, the construction of major buildings and infrastructures, such as the intercity rail link, reflected this wealth. Many Irish and Welsh migrants, as well as Scandinavians and Dutch, came to live in Liverpool. As a result, the population increased dramatically, reaching a peak 376,000 inhabitants by the middle of the 19th Century, coinciding with the Irish potato famine of the 1840s.

Like other towns of that time, Liverpool was unsanitary, and there were cholera epidemics in 1832 and 1849. The physician and medical officer of health William Henry Duncan, drew attention to the correlations between the disease and environment and highlighted the deplorable sanitary state of the labouring classes in Liverpool. In fact, he believed that Liverpool was "*the most unhealthy town in England*". Duncan submitted evidence to an inquiry into the Corporation of Liverpool and to the House of Commons' select committee on the health of towns. His influence and subsequent actions of the council, for instance supplying piped water, resulted in a significant improvement in environmental hygiene.

Liverpool officially became a city in 1880. And, a few years later, in 1888, under the Local Government Act, it was one of the cities to become a County Borough, and thus independent of its shire county of Lancashire. In the early 20th century, the population of Liverpool had reached 685,000, and Liverpool continued attracting immigrants and expanding, which ultimately led to a shortage of houses.

In the early 1930s, the Great Depression hit Liverpool badly, leaving thousands of people unemployed behind. This was partially combated by a large amount of housing being built by the local council, creating jobs and coping with the overcrowding and the slum housing. During the Second World War, Liverpool was heavily bombed by the Germans because of its critical strategic importance, killing thousands of people and causing damage to almost half the homes in the metropolitan area. Then, significant rebuilding followed the War, but this also entailed the destruction of significant historic parts of the city that had not been damaged.

In the 1950s and 1960s, in a context where the local economy was booming, Liverpool redeveloped central areas of the city and overspill towns were built nearby at Kirkby and Skelmersdale. Later on, in 1974, due to urban expansion and the accretion of a large metropolitan area, the City was made a metropolitan district of the metropolitan county of Merseyside, and the council reconstituted as Liverpool City Council. In the late 1970s and 1980s, Liverpool, as in the whole of the United Kingdom, suffered from the recession and became an unemployment blackspot loaded with social and economical issues.

Then, in the last years of the 20th century, Liverpool progressively boosted its local economy promoting tourism based on its heritage as an attraction. By way of example, Mathew Street is one iconic tourist attraction related to the Beatles. In the 21st Century, Liverpool is still thriving and was ranked one of the most visited cities in United Kingdom. Several areas of Liverpool city centre were granted World Heritage Site status by UNESCO in 2004, and it was designated the European Capital of Culture in 2008. However, Liverpool remained one of the most deprived local authorities in England.

Figure 12. Satellite view of Liverpool.

Liverpool city currently has a population of almost 500,000 inhabitants (Figure 12). The city forms the urban core of the recently devolved Liverpool City Region, which has a population of about 2.25 million, and conglomerates the nearby local authority districts of Halton, Knowsley, Sefton, St Helens, and Wirral.

Liverpool is organised in thirty different wards; Allerton and Hunts Cross, Anfield, Belle Vale, Central, Childwall, Church, Clubmoor, County, Cressington, Croxteth, Everton, Fazakerley, Greenbank, Kensington and Fairfield, Kirkdale, Knotty Ash, Mossley Hill, Norris Green, Old Swan, Picton, Princes Park, Riverside, Speke-Garston, St Michael's, Tuebrook and Stoneycroft, Warbreck, Wavertree, West Derby, Woolton and finally Yew Tree (Figure 13).

Figure 13. Liverpool's wards

RESEARCH QUESTIONS
OBJECTIVES AND HYPOTHESIS

5. Research questions, objectives and hypothesis

Throughout the Introductory sections, the theoretical and conceptual foundations of governance for health have been presented, the key dimensions of governance for health equity have been explored, and the importance of the local level of governance and the local health strategies has been discussed. The three cities that serve as case studies in this research have also been contextualized. All this sets the necessary basis for exploring how to integrate health equity into local health governance through the development and implementation of local health strategies in the cities of Bilbao, Barcelona and Liverpool. In this section, the questions, objectives and hypotheses are defined

5.1. Research questions

The fundamental question that underlies and motivates this research is how can local health strategies drive forward an equity-promoting urban governance for health, particularly in the three case study cities. From this concern, three specific research questions are derived:

1. *What is the context in which local health strategies have been developed in Bilbao, Barcelona and Liverpool?*

2. *How have the key dimensions of health equity governance (policy coherence accountability and social participation) been incorporated into the local health strategies of Bilbao, Barcelona and Liverpool?*

3. *What are the barriers and facilitators of the implementation of equity-promoting local health strategies in Bilbao, Barcelona and Liverpool? And what are the new implementation-related challenges and opportunities in the current context of the COVID-19 pandemic?*

5.2. Aim and objectives

In alignment with the research questions stated, the general aim of this thesis is to gain an understanding on how further embed equity in the local governance for health by looking at how to strengthen the key dimensions of governance for health equity in the implementation of local health strategies.

Thus, the specific objectives are:

1. *To describe the urban governance for health context, including population's health, the local government structure and trajectory, and the health strategies developed by the local government, in the cities of Bilbao, Barcelona and Liverpool.*

2. *To appraise and comparatively analyse how the key dimensions of governance for health equity (policy coherence, accountability and social participation) have been incorporated in the local health strategies of each of the cities.*

3. *To assess the main barriers and facilitators of the implementation of equity-promoting local health strategies, and particularly the implementation-related challenges and opportunities that the current context of COVID-19 raises, in the three cities.*

5.3. Theoretical assumptions and research hypothesis

This section aims to make explicit the general assumptions and the hypotheses behind the stated research questions and objectives.

5.3.1. Theoretical assumptions

Based on the evidence set out in the background section, it is considered that the local level of governance is the sphere that has the most direct and important influence on health equity. It is also implicitly assumed that it is precisely at this level where the change can occur most easily, and therefore it makes sense to focus on it from an implementation research point of view.

It is also assumed that the local health strategies, as public policies, can actually foster or hinder distribution of power, wealth and resources. In other words, that the local health strategies can having an impact in equity. Another assumption is that the symbolic content (values and principles guiding the strategy) and the operational content (concrete proposals) of local health strategies are a reflection of the characteristics of local governance for health, and thus can provide a valid approximation of the degree of awareness and interest in acting on health equity.

On the other hand, it is assumed that the Barcelona and Liverpool case studies have had a governance for health trajectory enough to enable the identification of the barriers and facilitators related to the implementation of their local health strategies in a pre-COVID-19 pandemic context. Also that the COVID-19 pandemic has disrupted the implementation processes of the local health strategies in the three case studies and, in the current context, cities may have been forced to rethink and/or adapt their local health strategies to respond to the pandemic. Thus, even though it may be premature to examine the implementation barriers and facilitators of the local health strategies in a scenario in which they are being questioned and/or redefined, it is a good moment to examine the implementation-related challenges and opportunities that this new COVID-19 pandemic context poses for the advancement of governance for health equity.

Confirming or refuting these assumptions is beyond the scope of this research.

5.3.2. Research hypothesis

The hypothesis linked to the first objective is that the local health strategies in Bilbao, Barcelona and Liverpool are different in terms of content, mechanisms and actors involved. It is also expected that the specific historical background and the political and institutional context, structure and dynamics play a determining role in the definition of these strategies.

The hypothesis behind the second objective is that the key dimensions of governance for health equity (policy coherence accountability and social participation) are explicitly included in the local health strategies and that specific instruments or mechanisms have been developed to put them into operation in Bilbao, Barcelona and Liverpool. It is also hypothesised that these dimensions of governance for health equity vary in their degree of development and institutionalization among the different settings.

Finally, the hypothesis linked to the third objective is that, in the pre-COVID-19 pandemic scenario, the barriers and facilitators to the implementation of equity-promoting local health

strategies were context-dependent and, therefore, specific and different across case studies. It is also hypothesized that the current context of COVID-19 pandemic has significantly disrupted the implementation processes of local health strategies, creating difficulties and challenges, as well as new opportunities.

METHODOLOGY

6. Methodology

The methodology is the fundamental epistemological and ontological view embodied in the research, the related assumptions and propositions that orient the analytic focus of the research. To consider and make explicit the methodological position, it is critical to undertake high-quality research[268]. Having previously established the objectives and hypotheses of this research, this chapter logically focuses on the methodology, defining the study design and methodological approaches, as well as the methods and techniques employed.

This chapter is structured in five sections: in the first one the design and methodological perspective of the research are specified and the most relevant elements of qualitative-based implementation research are explained. Then, the research methods are introduced, which refer to multiple qualitative case study method. The third section describes the data collection techniques after which the data analysis of the research is presented. The last section of the methodology comprises the ethical issues of the research, including of course trustworthiness and ethical reflexivity. The methodological limitations, though, will be presented in a subsequent chapter.

6.1. Study design and methodological perspective

This study is a **qualitative-based implementation research**. Given that it has an action-oriented vocation, a methodological approach that could answer the research questions previously exposed providing actionable knowledge has been sought. One of the ultimate challenges facing urban governance for health globally is how to take assets, instruments, interventions or strategies to move health equity forward and implement them in the real world. Qualitative-based implementation research is an appropriate methodological perspective, as it provides a basis for the context-specific, evidence-informed decision-making, needed to facilitate effective deployment in practice, to improve implementation and, eventually, also to enhance equity[269,270]. Therefore, this study is a qualitative-based implementation research that, taking elements from the critical paradigm[7], stems from an explicit pragmatic and transformative ethos[271].

In order to deepen the design and methodological perspective of this research, this section introduces, on the one hand, the most relevant aspects of implementation research and, on the other hand, the most relevant features of qualitative methodology.

6.1.1. Implementation research

Implementation research has its origins in several disciplines and research traditions and, basically, it attempts to solve implementation problems related to policies, programs, projects or interventions. Thus, it is a conceptual umbrella that aims to improve the understanding of the challenges faced in confronting the real world by broadening and deepening the understanding

[7] The ontological, epistemological and methodological way of approaching research establishes the paradigm that encompasses it. The critical paradigm posits that science, and in particular social science, cannot be completely value-free or objective, and deliberately focuses on the study of inequality and power, aiming not only to understand or explain it, but rather to change society. It therefore operates from the perspective that research should seek to create actual positive social change.

of these real-world factors and how they influence implementation. Implementation research can overlap with other types of research and the distinctions are not always clear cut[272].

Implementation research can be defined as an integrated concept that links research and practice to accelerate the development and delivery of public health approaches[273]. Interest in the approach has grown exponentially over the last few decades; the WHO has call for an increase the use of implementation research to bridge the gap between research, policy, and practice to improve health outcomes[274–276].

> "*Implementation research is the scientific inquiry into questions concerning implementation—the act of carrying an intention into effect, which in health research can be policies, programmes, or individual practices*" [272].

Implementation research encompasses the scientific study of the processes used in the enaction of initiatives as well as the contextual factors that affect these processes[272,275,277–279], and has high aspirations to be transformative. The knowledge arising from implementation research consolidates the corpus of knowledge of implementation science[278], which stems from the struggle of translating science into action and, therefore, it has as its ultimate goal to address contextual barriers to enhance innovation uptake[277].

The WHO identified four key characteristics of implementation research, which are systematic, multidisciplinary, contextual, and complex[274] (Figure 14).

Characteristic	Summary/description
Systematic	The systematic study of how evidence-based public health interventions are integrated and provided in specific settings, and how resulting health outcomes vary across communities. Balances relevance to real life situations with rigor, strictly adhering to norms of scientific inquiry.
Multidisciplinary	Analysis of biological, social, economic, political, system and environmental factors that impact implementation of specific health interventions. Interdisciplinary collaborations between behavioural and social scientists, clinicians, epidemiologists, statisticians, engineers, business analysts, policy makers, and key stakeholders.
Contextual	Demand driven. Framing of research questions is based on needs identified by implementers in the health system. Research is relevant to local specifics and needs, and aims to improve health care delivery in a given context. Generates generalizable knowledge and insights that can be applied across various settings. Mindful of cultural and community-based influences.
Complex	Dynamic and adaptive. Multi-scale: occurs at multiple levels of health systems and communities. Analyses multi-component programmes and policies. Non-linear, iterative, evolving process.

Figure 14. Key characteristics of implementation research

Implementation research not only relies on qualitative methodology but also on quantitative or mixed methods. And yet, implementation-related questions are often addressed by qualitative methodology, as it is particularly well-suited to provide insight into the dynamism and complexity of implementation issues[280,281].

6.1.2. Qualitative methodology

In a research context, the term *qualitative* often refers to the process of trying to understand the qualities of something, and it is usually defined to contrast with *quantitative,* understood as the process of collecting and analysing numerical data. However, this distinction between *qualitative* and *quantitative* is only partially helpful and often problematic, as sometimes attending to qualities might involve quantifying aspects of, for instance, an experience[282–284].

Qualitative methodology emerged from human and social sciences and tend to focus on approaches for studying behaviours and experiences, individually and within collectives. It is frequently used when the potential answer to a research question requires an explanation, focusing usually on *how* and *why* something works, to build understanding[281,285]. Hence, qualitative methodology is an umbrella covering several forms of inquiry to understand and explain the constructed meaning of social phenomena, as part of a particular context[285,286]. One of the core characteristics of the qualitative methodology is that the researcher is, generally, the primary instrument for data collection and analysis and usually it involves fieldwork. In this regard, it could be said that "*qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry*", as stated by Norman and Lincoln[287].

The attributes of qualitative methodology are particularly salient for implementation research because of its focus on understanding how implementation processes influence and are influenced by dynamic contextual factors[280,281]. Indeed, qualitative methodology in implementation research is not only a valuable approach to help to answer these complex questions, but it is oriented toward supporting practice and problem-solving. For instance, it is particularly useful revealing contextual elements, organizational and interpersonal dynamics, or stakeholder's perceptions affecting implementation[288].

6.2. Research method

There are different types of qualitative research methods as well as several possible classifications. Perhaps the most widely used classification is ethnography, narrative, phenomenological, grounded theory and case study[282,289]. This research employs a **multiple qualitative case study** method, which is a research method common in social science. One could briefly say that a case study is an in-depth examination of a single case, which could be, amongst others, a policy, implementation process or intervention site. Multiple case studies cover two or more cases in a way that produces more generalizable knowledge, allowing comparison within and across contexts.

Before delving into multiple case study method, let's first review what a Qualitative Case Study (QCS) actually is. A QCS enables a complex phenomenon to be described or explored using a variety of data sources[290]. The QCS is considered particularly suitable for answering *what*, *how* and *why* questions of implementation, for covering contextual conditions relevant to the phenomenon under study and when the boundaries are not clear between the phenomenon

and context[291]. For this reason, QC Studies have been widely used in implementation research[288], although they have also been used across a variety of approaches and disciplines. Within implementation research QCS is considered an optimal tool to examine complex issues, and involve an up-close, in-depth and detailed examination of a particular case or cases, within a real-world and contemporary context.

The underlying methodological basis that guides the QCS research was primarily built by Robert Stake[292] and Robert Yin[293], seeking to ensure that the topic of interest is exploredin depth on a constructivist paradigm which, built upon the premise of a social construction of reality, recognizes the importance of the subjective human creation of meaning but does not reject outright some notion of objectivity. Among the different types of case studies proposed by Stake and Yin, this research focuses on exploratory and instrumental case studies. *Exploratory case studies,* because it is aimed to explore situations in which the strategies being evaluated have no clear, single set of outcomes[291,293], and *Instrumental case studies* because at the same time the selected cases aim to provide insight into an issue and to refine an implementation theory[292,294].

As stated above, this research uses a multiple case study method, which can be used to either predict similar results or contrast results but for predictable reasons[293]. Moreover, multiple case studies, as are grounded in a variety of empirical evidence, allow a wider exploration of research questions and a deeper review of theory[291]. Indeed, case findings may corroborate or completely reject the theoretical baseline, or may create brand new hypothesis that commences the construction of new frameworks[291,295].

Within the scope of this research, three case studies will be analysed; Bilbao, Barcelona and Liverpool. These case studies have as specific object of study their local health strategies. Examination is carried out, for each case, on 1) the process of development and implementation of local health strategies, 2) how the key dimensions of health equity governance have been incorporated in these strategies, and 3) what the main barriers and facilitating factors have been for its implementation. The selection on these settings involved a purposive process, which sought the selection of diverse cases that provide variation along the dimensions of theoretical interest (causal leverage)[296]. In this way, it has sought to combine incipient local health strategies, as in the case of Bilbao, with others with a long track record, as in the cases of Barcelona and Liverpool. Therefore, Barcelona and Liverpool are case studies illustrative in focus.

Analytic generalisation of case studies results must be done carefully, with great concern and accuracy, as there is a risk of the cases not being representative[295]. Limitations regarding the generalisation of qualitative research and case study inference will be further developed in later sections. Yet, in order to strengthen the degree of generalisation of the case studies findings, interviews were conducted with international experts in the field of governance for health in addition to the multiple case study method.

6.3. Data collection techniques

Qualitative research requires robust data collection techniques. In this regard, a hallmark of QCS methods is the use of multiple data sources to enhance data credibility. Thus, this research has sought to obtain information from multiple sources, using different data collection techniques such as in-depth semi-structured interviews, participative observation and document analysis.

- In-depth semi-structured interviews: In-depth interview is a discovery-oriented qualitative research technique to explore a respondent's perspectives and experiences which can uncover valuable insights. Semi-structured interviewing, in-between both structured and unstructured interviewing, uses a blend of open-ended questions based on a framework of themes to be explored, providing more comparable qualitative data than in-depth interviews[297].

  A non-probabilistic purposive sampling through the "snowball" technique[8] was employed to invite to participate:

  a) People involved in the development and/or implementation of local health strategies in Bilbao, Barcelona and Liverpool. In order to capture different perceptions of these processes, efforts were made to include different profiles (technicians, managers and decision-makers, as well as economic and social actors) in each case study.
  b) Experts in the field of governance for health, health equity and implementation science, seeking to compare, contrast and validate the global result of the cases studies. These experts were linked to WHO European Health Equity Status Report Initiative, WHO European Healthy Cities Network, UK Healthy Cities Network, Global Network for Health in All Policies and Academy. Gender balance has been taken into account when inviting to participate experts.

  All of them were initially contacted by e-mail, which explained the objective of the research and invited them to participate in an interview. Those who gave their informed consent were contacted again to arrange a suitable time. The interviews were conducted face-to-face when possible, or alternatively by videocall or telephone. Interviews were conducted from October 2019 to May 2021. The approximate duration of these interviews was 60 minutes, lasting between 38 and 97 minutes. All interviews were digitally recorded and transcribed verbatim for analysis. The required measures were taken to preserve the anonymity of the participants.

  Ultimately, 43 interviews in-depth semi-structured interviews were conducted, 27 to key informants related to the development and/or implementation of local health strategies in Bilbao, Barcelona and Liverpool, and 16 to international experts. The interview guides can be found in the study Annexes.

[8] Snowball sampling, also known as chain sampling, chain referral sampling or referral sampling, is a non-probability sampling technique that uses an initial small group of key informants to identify from their social networks other eligible participants who eventually could contribute to the study. The term *snowball* reflects an analogy with a snowball growing in size as it rolls downhill.

- Document analysis: Analysis of organisational and institutional documents are a staple in qualitative research, often being used in combination with other qualitative research methods as a means of triangulation. Document analysis can be defined as a systematic procedure that entails finding, selecting, appraising and synthesising data contained in key documents, including printed, computer-based and Internet-transmitted materials[298]. Document analysis is particularly applicable to QCS[292,293], because documents provide background information, historical insight and context, and they can also be a source of qualitative empirical data.

  In relation to this research, a methodical search for relevant documents was performed in all three case studies. The document analysis comprised minutes of meetings, strategic plans, annual and special reports, policy documents, laws and regulations, background papers, newsletters, press releases, multimedia material, scientific sessions, conferences, dissemination materials and content of institutional websites.

- Participant observation: Participant observation is one type of qualitative data collection method typically used in ethnography, which involves an intensive and usually extended immersion with a given group, a particular community, an organization or institution. As the name suggests, it is a process that enables researchers to learn about the activities of the people under study in the natural setting through observing and taking part of those the day-to-day activities. Participant observation involves a range of data collection techniques which, in the scope of this research, were direct observation, natural conversations and informal interviews, collective discussions, moderate participation, analyses of fieldwork notes and documents produced.

  In Bilbao, the participant observation was carried out over a period of nine months and comprehensively covered the all policy-development process. The degree of participation was *participant as observer*[299], specifically in the process of validation of the local health strategy' general objectives, and the subsequent process of intersectoral policy-making. Participant observation could only be carried out in Bilbao's case study, the reasons for this are detailed in the limitations chapter.

A summary of data collection techniques are presented in the following tables. Table 1 shows data collection techniques by case study and research objective, Table 2 presents interviews conducted, by type, stakeholder and case study and Table 3 lists the documents included in the local health strategies, by case study.

Table 1. Data collection techniques by case study and research objective.

Specific research objectives	Bilbao	Barcelona	Liverpool
1. To describe the urban governance for health context, including population's health, the local government structure and trajectory, and the health strategies developed by the local government, in the cities of Bilbao, Barcelona and Liverpool.	Participant-observation In-depth semi-structured interviews Document analysis	In-depth semi-structured interviews Document analysis	In-depth semi-structured interviews Document analysis
2. To appraise and comparatively analyse how the key dimensions of governance for health equity (policy coherence, accountability and social participation) have been incorporated in the local health strategies of each of the cities.	In-depth semi-structured interviews Document analysis	In-depth semi-structured interviews Document analysis	In-depth semi-structured interviews Document analysis
3. To assess the main barriers and facilitators of the implementation of equity-promoting local health strategies, and particularly the implementation-related challenges and opportunities that the current context of COVID-19 raises, in the three cities.	Participant-observation In-depth semi-structured interviews	In-depth semi-structured interviews	In-depth semi-structured interviews

Table 1 shows that, for the first research objective, the data collection techniques included participant- observation, which could only be carried out in Bilbao, in-depth semi-structured interviews and document analysis. For the second research objective, in-depth semi-structured interviews and document analysis were conducted in all three settings. Finally, the third research objective entailed participant- observation in Bilbao and in-depth semi-structured interviews in all settings.

Table 2. Interviews conducted, by type of interview, stakeholder and case study

Interviews conducted, by type of interview, stakeholder and case study			
Case Study	**Local technicians and decision-makers related to local health strategies**	**Other local actors related to local health strategies**	**Total num. of interviews**
Bilbao[9]	8	-	11
Barcelona	5	-	6
Liverpool	7	3	10
International experts			16
OVERALL INTERVIEWS			**43**

Table 2 shows that a total of 43 interviews were conducted to 39 people, this divergence is due to the fact that occasionally more than one interview was conducted to the same person. In the three case studies, 27 interviews were carried out; in Barcelona and Bilbao, interviews were conducted among technicians, managers and decision-makers involved in the development and implementation of local health strategies, but in Liverpool, a few interviews were also conducted to other local actors from the social sector and the University. Additionally, 16 interviews were carried out with international experts.

Table 3. Documents included in the local health strategies and other documents analysed, by case study

Local health strategies analysed, by case study	
Bilbao	• I Plan Municipal de Salud de Bilbao (2019-2023)[(300)]
Barcelona	• Pla de Salut de Barcelona (2016-2020)[(301)] • Programa d'Actuació Municipal (2020-2023)[(302)]
Liverpool	• Liverpool Health and Wellbeing Strategy (2014-2019)[(303)] • City Plan (2020)[(304)]

Table 3 shows the core policy documents of the local health strategy in force for each of the cases studied. These documents were identified by managers and technicians of the local government at the time that this research was carried out.

[9] Out of the eleven interviews conducted to local managers or technicians from the Bilbao City Council, three interviews were carried out by a colleague from Opik Research Group with an extensive experience in qualitative methodology, Maite Morteruel. The reason for this was a concurrent research project on HiAP involving the same key informants from the Bilbao City Council. The script of these interviews was developed jointly, ensuring the inclusion of all the dimensions of analysis of this research.

6.4. Data analysis

The interviews, participant observation, and document analysis provided a great amount of qualitative data. In order to manage and analyse it, transcriptions, documents, field notes, etc. were computerized, processed and subsequently analysed through a computer-aided qualitative data analysis software, namely NVivo.

The type of data analysis carried out is a qualitative data analysis, more specifically, a **thematic analysis.** A thematic analysis involves a iterative process of *qualifying*[305], a non-linear procedure of interpretation, classification and integration of manifest and latent thematic contents. Thus, it is a detailed and systematic study of a set of interviews or other documents whose ultimate object is the identification of common threads that extend across the texts. Therefore, even though thematic analysis has an intrinsic subjective component, it is also an empirical and methodical procedure. Thematic analysis is a commonly used analytic approach to qualitative data in implementation research[280].

As indicated, thematic analysis consists of a qualification process in which, based on the data, themes are conceptualized. Depending on the object of study and the research question, different support instruments, models or frameworks can be used as summary themes to guide and assist this qualification. In this way, coding involves allocating data to the pre-determined themes through an eminently deductive analytical process.

Using instruments, models or frameworks for describing and summarizing qualitative data is interesting because it facilitates the systematization of the thematic codification and the subsequent comparison of contexts. Thus, for the purposes of this research, the data was coded and thematically analysed, through an iterative process, according to themes predetermined by different instruments and frameworks, on the basis of a codebook-type analytical approach (see in Annexes). This guided thematic analysis can be applied to different qualitative data sources and, in this research, it has been applied to interview transcripts, documents and field notes, taking the specific features of each source into account. More specifically, the assessment of the key dimensions of governance for health equity was carried out essentially on the key documents of the local health strategies (strategic directives, policies or plans). On the other hand, the analysis of the barriers and facilitators of the implementation of these strategies was mainly conducted on the interviews transcripts and other data from participant observation.

The following sub-sections detail the different instruments and frameworks used as a lens through which to organise, code and interpret data. In addition, a dedicated section was devoted to discussing the analytical generalization of the results of multiple qualitative case studies.

6.4.1. Key dimensions of governance for health equity assessment

There is no consensus on which instruments or models should be used to measure governance dimensions. This is also true for the dimensions of governance for health and, particularly, for policy coherence, accountability and social participation, the key dimensions of governance for health equity. Therefore, in order to facilitate a systematic and cross context analysis, it has been necessary to review, select, and even adapt, the most suitable instruments or models for assessing the integration of these dimensions into local health strategies.

This section introduces the selected instruments and models, that is, an adaptation of the Storm's Maturity Model for HiAP[306] for policy coherence, the Ebrahim and Weisband's core components of accountability[128] and the accountability domain of the PAHO Equity

Commission's rubric[133] for accountability, and the Health Canada's Public Involvement Continuum[307] for social participation.

Policy coherence

In order to assess the extent to which policy coherence has been incorporated into local health strategy, an adaptation of Storm's Maturity Model for HiAP[306] has been used.

The Maturity Model for HiAP (Figure 15) was develop to assess HiAP growth processes, and it has been applied to municipal policies on health inequalities within 16 municipalities in the Netherlands. This model consists of six maturity levels, based on fourteen related characteristics. These maturity stages are:

- Stage 0 - *Unrecognized*: There is no specific attention for the problem, in this case the problem of health inequalities.

- Stage I - *Recognized*: Municipalities recognize the problem and the solution of HiAP and there is clarity which activities will alleviate the problem (characteristics 1–2).

- Stage II - *Considered*: There are preparatory HiAP actions on parts of the problem. For example, HiAP is described in the local health policy document as a means to reduce health inequalities, collaboration between health and non-health sectors is started (project-based), and there are preparatory actions and activities to influence determinants of health inequalities (characteristics 3–6).

- Stage III - *Implemented*: HiAP investments in several problem areas exist. Non-health sectors are involved in the policy making process as well as in the process of policy implementation to reduce health inequalities. Collaboration agreements are made between sectors. Structural consultation with others sectors and the presence of a key person for HiAP are available (characteristics 7–10).

- Stage IV - *Integrated*: Quality processes are an integrated part of HiAP. There is a broad, shared vision on how to reduce health inequalities by HiAP, and there are visible milestones (both content and process) (characteristics 11–12).

- Stage V - *Institutionalized*: There is a systematic improvement of HiAP quality. There is political and administrative anchoring of the HiAP approach and HiAP is considered at every municipal policy cycle (characteristics 13–14).

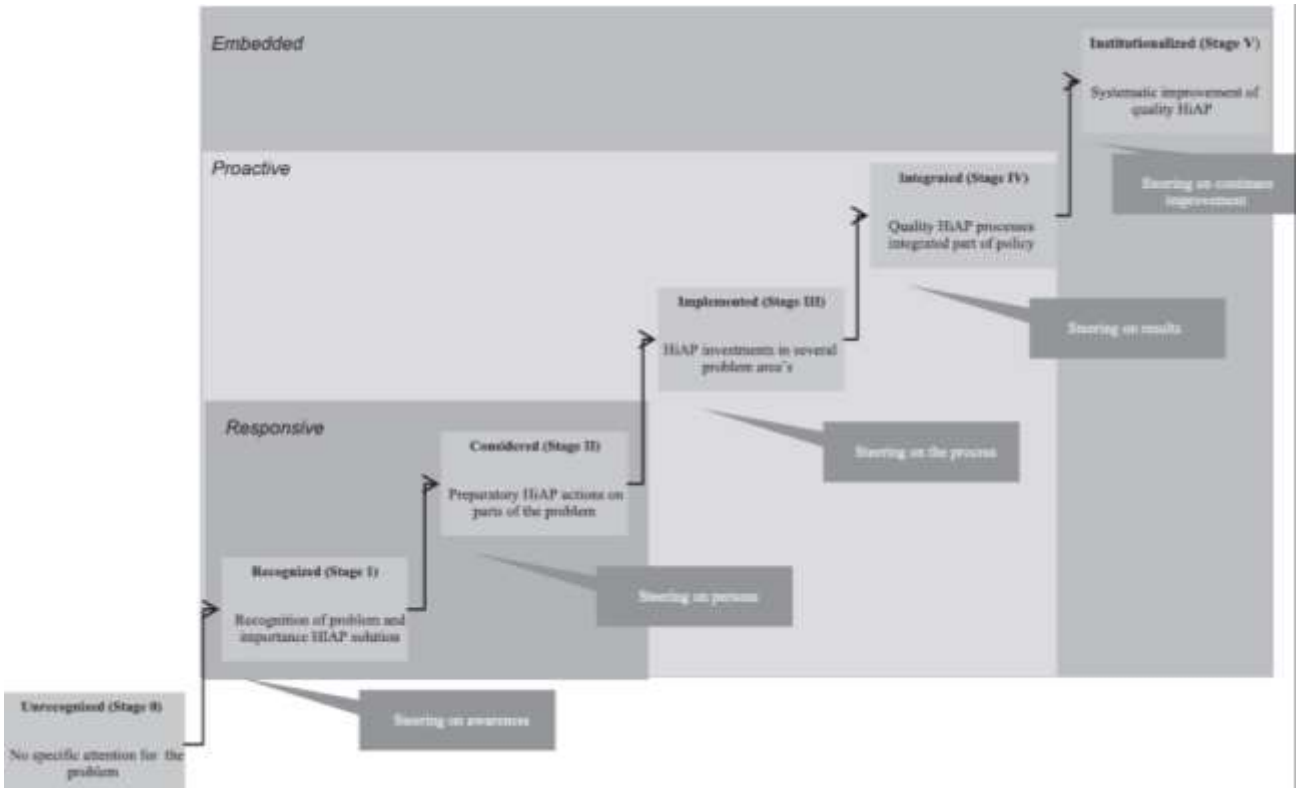


Figure 15. Maturity Model for HiAP[306]

The adaptation of this Maturity Model for HiAP has sought to broaden the HiAP scope, including aspects of the whole-of-government approach, to comprehensively assess the policy coherence dimension of governance for health equity. This adaptation of the Maturity Model for HiAP, resulting in fourteen policy coherence characteristics, has driven the identification, organisation, coding and interpretation of the data.

Accountability

In order to assess accountability, the thematic analysis was based on the four core components of accountability in global governance identified by Ebrahim and Weisband[128] and the accountability domain of the PAHO Equity Commission's rubric[133].

The Ebrahim and Weisband' four core components of accountability[128] are the pre-determined general themes which have guided accountability analysis of the local health strategies. Those are:

- Transparency, which involves collecting information and making it available and accessible for public scrutiny.

- Answerability or justification, which requires the provision of clear reasoning for actions and decisions, including those not adopted, so that they may reasonably be questioned.

- Compliance, through the monitoring and evaluation of procedures and outcomes, combined with transparency in reporting those findings.

- Enforcement or sanctions for shortfalls in compliance, justification, or transparency. For numerous observers, this is what underlies the power of accountability mechanisms.

In addition, to ground these general themes of accountability within the health policies, the guiding questions of the accountability domain of the PAHO Equity Commission's rubric have been applied, aiming specifically to assess the inclusion of mechanisms to redress violations of people's right to health.

The PAHO Equity Commission's rubric was developed to code and analyse health policy environments' inclusion of health equity, and it is based on a review of literature and practice in health equity. The PAHO Equity Commission's rubric has ten domains, one of which is accountability, and a set of specific questions linked to these domains. All these questions receive a score, four being the total score for the accountability domain (Table 4)[133].

Table 4. Accountability PAHO Equity Commission's rubric

	PAHO Equity Commission's rubric	**Question score**
Accountability	Does the health plan include mechanisms to redress violations of people's right to health?	
	• Does the health plan include mechanisms for educating people on their right to health?	1
	• Does the health plan include mechanisms for reporting right to health violations?	1
	• Does the health plan include mechanisms for enforcing people's right to health?	1
	• Does the plan include mechanism for investigating and reducing fraud and corruption?	1
	OVERALL SCORE	4

Social participation

The *Health Canada Policy Toolkit for Public Involvement in Decision Making* is an exceptional publication that seeks to provide principles, guidelines and information for the effective involvement of citizens in government decision making on health issues[307]. In this document the *Health Canada's Public Involvement Continuum* model (Figure 16), which has been used to assess the governance for health equity dimension of social participation, is presented. This way, social participation is classified according to the five levels of the Health Canada's public involvement continuum throughout the phases of the political cycle[94]. These levels of public involvement are:

- Level I - *Inform/Educate*: When factual information is needed to describe a policy, program or process; a decision has already been made or no decision is required; the public needs to know the results of a process; there is no opportunity to influence the final outcome; there is need for acceptance of a proposal or decision before a decision

may be made; an emergency or crisis requires immediate action; information is necessary to abate concerns or prepare for involvement; or the issue is relatively simple.

- Level II - *Gather Information/Views*: When the purpose is primarily to listen and gather information; policy decisions are still being shaped and discretion is required; or there may not be a firm commitment to do anything with the views collected.

- Level III - *Discuss or Involve*: When two-way information exchange is needed; individuals and groups have an interest in the issue and will likely be affected by the outcome; there is an opportunity to influence the final outcome; there is a willingness to encourage discussion among and with stakeholders; or input may shape policy directions/program delivery.

- Level IV – *Engage*: When there is a need that citizens talk to each other regarding complex, value-laden issues; there is a capacity for citizens to shape policies and decisions that affect them; there is opportunity for shared agenda setting and open timeframes for deliberation on issues; and options generated together will be respected.

- Level V – *Partner*: When there is a willingness to empower citizens and groups to manage the process; citizens and groups have accepted the challenge of developing solutions themselves; there is a readiness to assume the role of enabler; and there is an agreement to implement solutions generated by citizens and groups.

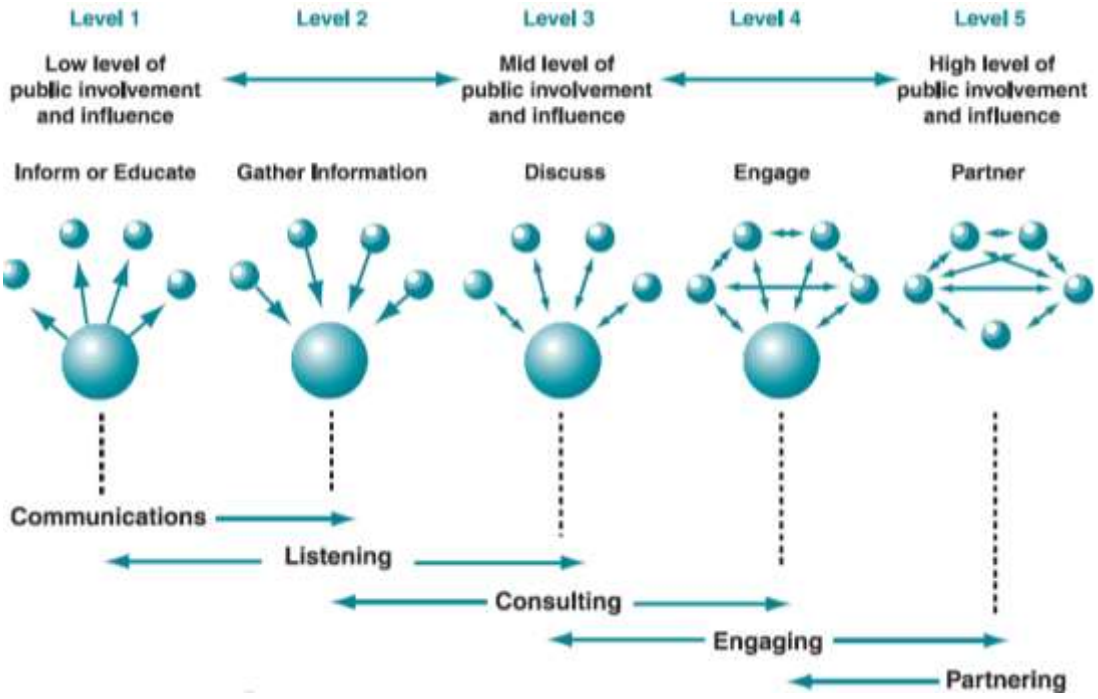


Figure 16. Health Canada's Public Involvement Continuum

6.4.2. Implementation barriers and facilitators assessment

In implementation research, the barriers and facilitators of implementation process usually are analysed using a framework to drive data collection and analysis[280,288]. Implementation frameworks describe loosely structured constellations of theoretical constructs that provide a common language by which to guide systematic approaches for studying implementation contexts[308]. One of the most widely used implementation frameworks is the Consolidated Framework for Implementation Research (CFIR)[309,310], which has been selected to assess the barriers and facilitators of the implementation processes of local health strategies in Bilbao, Barcelona and Liverpool.

Consolidated Framework for Implementation Research

The Consolidated Framework for Implementation Research (CFIR) is a determinant framework that aims to provide a pragmatic organization of constructs that appear to influence the process of implementation within general domains, in order to help to identify and explain factors that influence implementation. The CFIR offers a structure for approaching complex, interacting, multi-level, and transient states of constructs in the real world by embracing, consolidating, and unifying key constructs from published implementation theories. Many of the implementation frameworks have been developed for use in the context of the healthcare system; however the CFIR domains consider factors at organizational and broader societal levels, making it applicable to wider contexts. Thus, the CFIR offers an overarching typology to promote implementation theory development and verification about what works where and why across multiple studies and settings.

The CFIR is systematized into five domains based on context (intervention, outer setting, inner setting, individual and process), and these domains in turn have a number of related constructs. This framework has been widely used to examine implementation barriers and facilitators. In this research the CFIR will be used as a guide for the implementation analysis, without seeking to limit the analysis to its scope or to have to use all the suggested constructs (Figure 17). The CIFR codebook template can be found in Annexes.

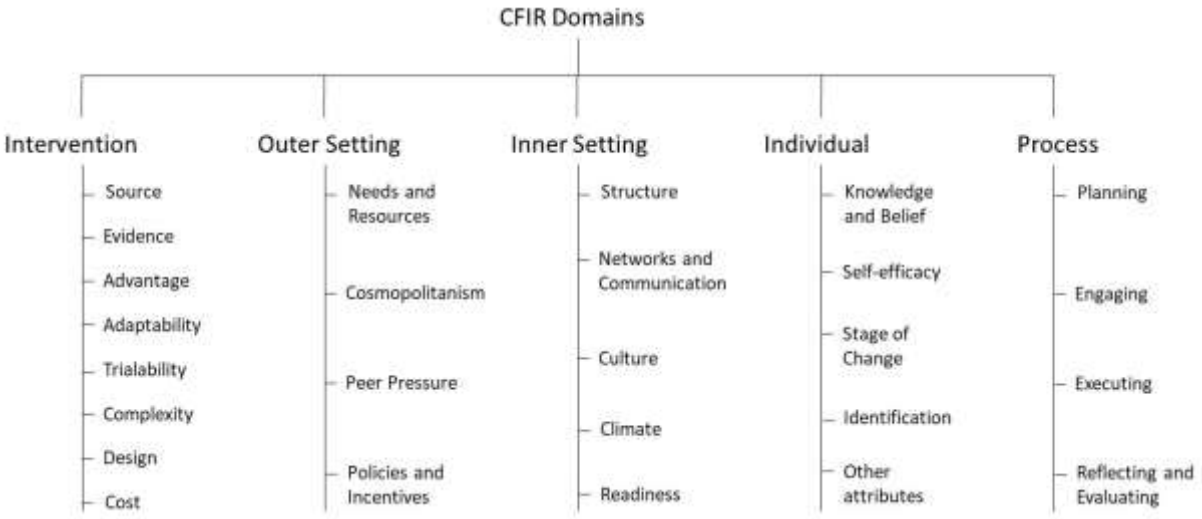


Figure 17. CFIR Domains

Data was thematically coded according to emerging themes and these CFIR framework domains. As the analysis is to some extent informed by CFIR framework, it involves a deductive reasoning, which at the same time facilitates a comparative analysis of the implementation of the strategies for governance for health implementation across case studies. However, in this case, the framework-driven analytic approach is explicitly open to findings that may not fit into the pre-set constructs, embracing at the same time an inductive approach that enables developing thematic constructs on implementation barriers and facilitators. It is worth noting that inductive and deductive are not mutually exclusive approaches[288].

Finally, it should be noted that, as this is a multiple qualitative case study design, a data analysis has been carried out within each of the case studies and also between cases or, in other words, a cross-case analysis.

6.4.3. Analytic generalization

Generalization can be defined as the general statement or proposition made by drawing an inference from observation of the particular. The extent to which qualitative data can explain phenomena outside and beyond the specific domain of a particular case study is one of the methodological and analytical controversies associated with the selected method. The research method has often been criticized for generating results that are less generalizable than those of large-sample quantitative methods[295].

However, going beyond this narrow statistical interpretation, case studies can have theoretical implications that go well beyond the particular places or events under investigation when conducted properly[295,311]. That is known as *analytical generalisation,* which is essentially a theoretical generalization that consists of an ideographic comparison of the case study research results with the existing theoretical knowledge in order to either test the existing theory or to develop novel theories[291]. In this way, multiple case studies provide a stronger basis for theoretical generalization than a single-case study, but the reason for this is not for the sake of having a larger sample, but that multiple case studies allow easier separation of the generalizable theoretical relationships found, from the idiosyncrasies associated with a specific case more easily.

Thus, in order to strengthen the degree of generalization of the results of the case studies, use has not only have been made of the above mentioned instruments, models and frameworks to systematize the thematic analysis and the comparison between contexts, but also interviews with international experts were carried out. Experts in the field of governance for health, health equity and implementation science have provided knowledge that goes beyond the boundaries of the case studies, which has been used to compare, contrast and validate the results of the multiple qualitative case study.

6.5. Ethics and reflexivity

The Ethics Committee for Research Involving Human Subjects, CEISH-UPV/EHU, assessed the proposal for this research (reference M10-2019-248) and issued a favourable report on 12/12/2019 considering that:

- The research is justified because its objectives will generate an increase in knowledge and a benefit for society that makes the foreseeable inconveniences and risks acceptable.
- The capacity of the research team and the available resources were adequate to carry out the research.
- It was planned according to the methodological and ethical requirements necessary for its execution, in accordance with the criteria of good practice in scientific research.
- It complied with the regulations in force, including the authorisations, agreements or conventions necessary to carry it out.

However, beyond this ethical approval, the process of ethical consideration is an ongoing necessity that continues long after approval has been granted. This is particularly true in qualitative studies, where the dynamics of human interaction pervade, and therefore require a reflexive approach in which the researcher's questioning of assumptions and interests is required[312].

Reflexivity is an awareness of the researcher's role in the practice of research and the way this is influenced by the object of the research. In other words, it is being aware that the researcher contributes to the construction of meanings throughout the research process and acknowledges the impossibility of remaining outside of their one's subject matter. It should go beyond a simple reflection on the research process and outcomes, considering the complex relationships between the production of knowledge (epistemology), the processes of knowledge production (methodology), and the involvement and impact of the knowledge producer or researcher (ontology)[2].

In the section "*My own approach to urban health research*" of the background chapter, the motivation for undertaking this research was stated and the underlying values and preconceptions were acknowledged. Likewise, in the chapter "*Theoretical assumptions and research hypothesis*" the research questions, the assumptions and hypotheses behind them are made explicit. Thus, the methodological and ontological reflexivity are briefly presented in this section.

Methodological and ontological reflexivity is critical in qualitative methodologies and particularly when, as it is the case in this research, participant observation is carried out. Reflexivity is essential in participant observation, since the instrument for data collection is the researcher who has this dual role of "observer" and "participant". Participant observation involves being both an outsider and an insider, and the boundary between these two roles is not always obvious. Throughout the participant observation fieldwork, a shifting position between an observer as participant and a participant as observer has been adopted, thus the researcher's knowledge, insights and experience has directly interacted with the object of study. This is also true for other data collection methods, such as interviews, and for other stages of the research, such as data analysis.

As qualitative research is contextual, describing the contextual intersecting relationships between the research and researcher should deepen the understanding of the work and increase the creditability and trustworthiness of the findings[1,2,313].

RESULTS

7. Results

This chapter describes the results of this research. It is structured in two large blocks; in the first block, corresponding to sections 7.1, 7.2 and 7.3, the particular results of each case study are presented. In the second block, which corresponds to section 7.4, the results of the cross-case analysis enriched with the analysis of the interviews made to international experts in the field of governance for health.

Qualitative case study results

This section presents the results of the research conducted in the three case studies; Bilbao, Barcelona and Liverpool. The results of each case study have been organized in the same subsections, which are the following:

1. Urban governance for health context
    a) Overview of demographics and social determinants of health and health in the city
    b) Local government
    c) Governance for health trajectory
    d) Local health strategy
    e) COVID-19 pandemic and governance for health

2. Analysis of key dimensions of governance for health equity in the local health strategy
    a) Policy coherence
    b) Accountability
    c) Social Participation

3. Analysis of factors affecting the local health strategy implementation
    a) Implementation barriers and facilitators of the local health strategy in pre-pandemic context
    b) Implementation-related challenges and opportunities of the COVID-19 pandemic context

All these subsections are interconnected and linked to the research objectives.

BILBAO CASE STUDY

7.1. Bilbao

7.1.1. Bilbao governance for health context

This section describes the context of governance for health in Bilbao. It includes; a) a profile of its demographics and social determinants of health and health status, b) an overview of the local government powers and structure, c) a summary of its governance for health trajectory, d) the description of the current local health strategy and, finally, e) a brief reference to local governance for health in the context of the COVID-19 pandemic.

7.1.1.a. Overview of demographics and social determinants of health and health in Bilbao

In 2020 Bilbao had 350,184 inhabitants, and a population density of 8.536 habitants/km^2[314]. Bilbao metropolitan area, which comprises 25 municipalities that make the Comarca of Greater Bilbao plus ten other surrounding municipalities, has about one million inhabitants and it stands as the fifth most populated urban area in Spain.

Bilbao has a relatively stable population, with a higher number of deaths compared to births but a positive migratory flow. The size of the 35-54 age group stands out, being it almost twice the size of the 5-24 age group. 20% of men and 28% of women are aged 65 or over, a percentage which has increased in recent years, while the percentage of young people has fallen[315] (Figure 18). The foreign born people are about 13,5%[314].

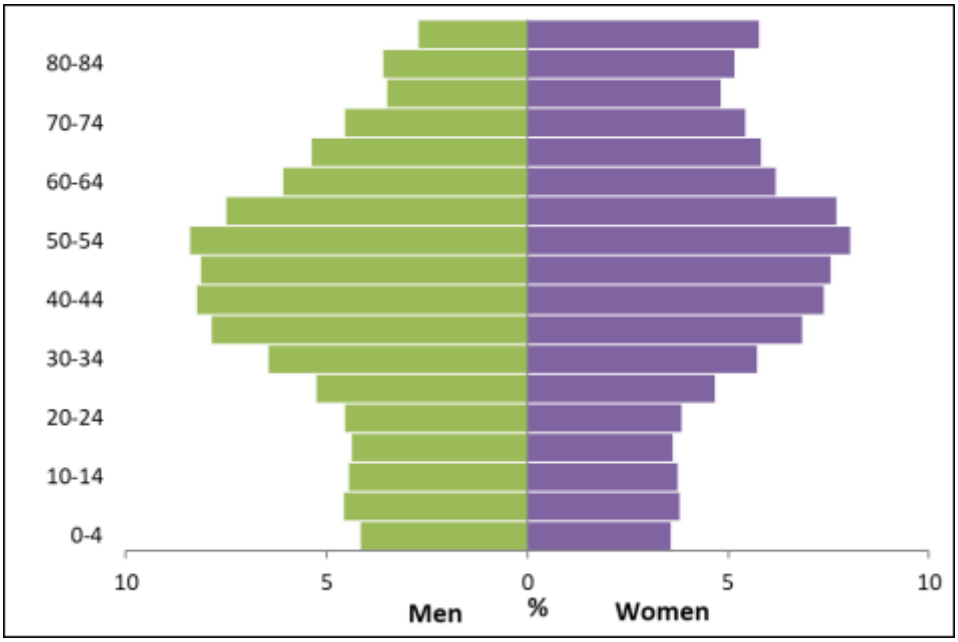


Figure 18. Pyramid of the population of Bilbao 2017. Source: Bilbao Health Diagnosis[315].

The main environmental perceived problem is related to noise, more than half of the population is exposed to noise levels that are harmful to health. On the other hand, about 63% of the inhabitants do not perceive that the surroundings of their homes are lacking in green areas. The quality of the air is good, as it is the quality of drinking water. People living in more disadvantaged areas of the city report more environmental problems around their homes.

Between 80-90% of the inhabitants of Bilbao live in an environment that is conducive to healthy eating and physical activity. It is therefore not surprising that the majority of the inhabitants have quite healthy behaviours. The availability of spaces for physical activity is high both in terms of facilities (79%) and the general environment (82%), and 80% of men and 68% of women are physically active. The vast majority, 92%, of the population say that they have good access to fruit and vegetables in their living area which is considerably more than access to fast food (66%), and so 64% of men and 74% of women say that they consume fruit or vegetables on a daily basis. The high presence of bars stands out, 75% of men and 86% of women do not have a risky alcohol consumption although excessive alcohol consumption remains one of the main addiction-related public health issues. In relation to the consumption of other toxic substances, 73% of men and 84% of women do not smoke. Sedentary lifestyles, obesity and tobacco consumption follow a clear socio-economic pattern, so the lower the level of education, the higher the rate. Hence, although there are generally fairly healthy behaviours, there are certain groups with significant potential for improvement.

In relation to the social environment, more than 80% of people have good social support, although 11% of the Bilbao inhabitants do not have a sufficient network of people willing to provide support in situations of vulnerability. On the other hand, around 60% do not perceive crime as a problem in their environment. It is also worth noting that more than 20% of elderly people live alone, a percentage that is higher in Bilbao-La Vieja and Casco Viejo.

With regard to housing, Bilbao has slightly higher indicators of housing problems than the other Basque cities. On average, about 17% of dwellings in Bilbao have no lift, 30% have no heating, 5% have a low comfort index and 10% are empty-houses, but these indicators vary considerably depending on the neighbourhood. Thus, in terms of percentage of homes without lifts by neighbourhood, Uretamendi-Iturrigorri-Peñascal (68%), Casco Viejo (48%) and Otxarkoaga (47%) stand out; without heating, Uretamendi-Iturrigorri-Peñascal (63%), Otxarkoaga (53%) and Arangoiti (49%); and in the case of empty homes, Zurbaran-Arabella (28%), Abando (18%) and Casco Viejo (15%). The family houses average usable surface is 82m^2.

In Bilbao, prior the COVID-19 pandemic, the GDP per capita was over €35.000 and the personal average income €17.685, being Services being the main economic activity (90.8%)[314]. Gender inequalities in income are evident, with women having consistently lower income levels. About 55% of the population of Bilbao makes ends meet easily or fairly easily, while 18% do so with difficulty or a great deal of difficulty. Most difficulty is experienced by younger people and those with lower levels of education. Educational level established clear social inequalities in the capacity to make ends meet with disposable income. The 2020 unemployment rate was about 12%[314]. While 86% of employed men and 83% of employed women have a permanent contract, The more advantaged social classes showed more job stability and job satisfaction. About 8% of men and 10% of women take care of a dependent person, and there are significant gender inequalities in the distribution of domestic work.

Life expectancy is quite high and has been increasing, being around 86.4 years for women and 79.6 years for men. Despite their longer life expectancy, women have a worse state of health at any age. The magnitude of inequalities in life expectancy between neighbourhoods in Bilbao is significant: 6.4 years for men and 5.9 years for women. The impact of inequality in mortality is particularly evident in certain neighbourhoods and in the case of men. 79% of men and 69% of women say they are in good or very good health, 90% of women and 84% of men have no limitations in daily life activities. Despite a good general state of health on average, significant

health inequalities exist, with health status and mortality worsening with decreasing educational level, social class, gender and neighbourhood of residence.

Bilbao city has had a relatively stable population of about 350,000, and is situated in an important urban area of about one million inhabitants. Although in general terms the population of Bilbao is fairly healthy, the city of Bilbao presents inequalities on the social determinants of health, resulting in significant inequalities in health indicators by educational level, social class, gender and neighbourhood of residence within the city. Thus, for example, inhabitants of the most disadvantaged areas have more environmental and housing problems, as well as worse working and economic conditions, less healthy behaviours, more chronic diseases and shorter life expectancy.

7.1.1.b. Stakeholders relevant to local governance for health in Bilbao

Bilbao City Council

Bilbao City Council is the institution in charge of governing the city of Bilbao. Local government is elected every four years by universal suffrage. Since the first elections in 1979, the Basque Nationalist Party EAJ-PNV, a centre-right political party, has been in power. Thus, Bilbao' City Council has been under the rule of EAJ-PNV for more than four decades, Currently it governs with a coalition agreement with the Socialist Party (PSE-EE) and Juan Mari Aburto is the present Mayor of the city. This fact has marked a political idiosyncrasy that hinges on economic development.

> "*Bilbao has economic means and a social drift that well... I think is quite acceptable, although it also has shortages and great needs. At the political level? Well, we have a conservative municipal government that has a government agreement with a party supposedly less conservative. But the fact is that here economic development, as the driving force of the whole society and of the municipality, is a fundamental pillar*" City Council member from outside the Health and Consumer Affairs Area.

Bilbao City Council is made up of a Municipal Executive body and a Municipal Plenary with regulatory functions. The former is constituted by the Mayor and the so-called Governing Board of the City of Bilbao, a Board that collaborates in the political management function of the Mayor and exercises executive and administrative functions. On the other hand, the Municipal Plenary is the body of maximum political representation of the citizens in the municipal government and is made up of 29 councillors and chaired by the Mayor. It is a body for debate and the adoption of major strategic decisions through the approval of organic regulations and other general rules, municipal budgets, urban development plans, forms of service management, etc. It is also in charge of the control and supervision of the government bodies. The government and administration of the Bilbao City Council are regulated by Organic Regulations which were approved in a plenary session in 2004.

In addition to the aforementioned separation of functions between the Plenary and the Municipal Executive, the municipal organisation includes the General Secretariat of the Plenary, Cabinets reporting to the Mayor, and Coordination Units for policy action and Government Areas (see Bilbao' General municipal organisation chart on Annexes). There are also eight Districts whose political direction is exercised by the corresponding Presiding Councillors and management by the District Municipal Centre Directors. Coordination is carried out by the Area of Citizen Attention and Participation and Districts. There are also Sectoral Boards which are advisory, participatory and consultative bodies for specific municipal policies, allowing a dialogue between the political-technical sphere and social organisations. Lastly, the Bilbao City Council comprises different municipal entities.

The Basque Law on Local Institutions reinforces and guarantees a great degree of municipal autonomy in the management of many of certain social determinants of health[316]. In this way, the City Council' areas are ultimately responsible for managing the municipalities' competencies on employment, social policies, mobility and environment to name but a few. Bilbao City Council therefore has many responsibilities for the social determinants of health at the urban level and can constitute a critical arena for health promotion. However, health promotion has been a competency that has largely been allocated at the Basque Government level and, to a large extent, it was not considered a proper responsibility of the City Council until quite recently.

The Health and Consumer Affairs Area is under the umbrella of the Mobility, Environment, Urban Regeneration and Healthy Development Policy Coordination Unit. The Health and Consumer Affairs Area is structured in two functional and operational sub-areas, as its name indicates. On the one hand, it has a sub-area that performs public health functions related to health protection and health promotion. On the other hand, it has a legal-administrative function related to Consumer Affairs, which also provides legal support for all the activities of the health area. Its public health functions are mainly related to health protection, and more recently also to health promotion and community health. Its health protection activities include animal, pest and zoonosis control, food safety, environmental health and urban hygiene. Its health promotion activities include activities such as prevention of drug and other addictions, promotion of healthy behaviours and it also carries out some activities related to community health.

Other stakeholders relevant to local governance for health

The Bilbao-Basurto Integrated Health Organisation (OSI BB) is a healthcare provider organisation created on 2014 as a result of the integration of two previous Health Service Organisations, the Bilbao Primary Care District and the Basurto University Hospital. It is one of the 19 Service Organisations belonging to *Osakidetza*, the Basque Health Service, and it comprises the Basurto University Hospital, 22 Primary Care Units, 3 Continuous Care Points and a peripheral administrative centre. Community health activities, among other types of health promotion activities, are often coordinated by the Bilbao City Council.

In addition to OSI BB, the Health and Consumer Affairs Area of the City Council has partnership for specific issues with the Basque Government, and particularly with the Department of Health, at the regional level. This is usually coordinated through the Territorial Health Delegation of Bizkaia and the Sub-directorate of Public Health and Addictions of Bizkaia.

At the supra-municipal level, the Health and Consumer Affairs Area of the City Council has partnership for specific issues with the Vizcaya Provincial Council which, in addition to the

ordinary powers exercised by the provincial councils of the other provinces of Spain, exercises specific powers derived from the Statute of Autonomy and the 1983 Law on Historical Territories. At the local level, it has links with other stakeholders, mainly third sector organisations with which it coordinates the work with a predominantly executive and operative nature.

Bilbao City Council is the administrative and governing body of the city of Bilbao, and it is made up of a Municipal Executive body and a Municipal Plenary. The municipal organisation includes the General Secretariat of the Plenary, Cabinets reporting to the Mayor, and Coordination Units for policy action and Government Areas, which have a great degree of autonomy in the management of some social determinants of health. Thus, there are possibilities to foster health promotion at the local level, but public health, and particularly health promotion, has not been considered to be a core competence of the City Council. The Health and Consumer Affairs Area is under the umbrella of the Mobility, Environment, Urban Regeneration and Healthy Development Policy Coordination Unit. This Area coordinates its work mainly with the Bilbao-Basurto Integrated Health Organisation, which is a healthcare provider that falls under Osakidetza - Basque Health Service. It also coordinates with the Department of Health of the Basque Government and with various third sector organisations and other institutions working at local level.

7.1.1.c. Governance for health trajectory in Bilbao

During Franco's regime, public health was based on a charitable-paternalistic philosophy in its dual repressive-assistance dimension. This disregarded the social dimensions and the new conceptions of epidemiology and health administration that began to develop during the Republic. The competencies in health and social services were largely centralised and, through a series of laws, the municipalities were relegated to carry out resulting necessary assistentialist activities, such as healthcare and child protection and school healthcare, assistance and repression of begging, or care provision in shelters for transients[317,318].

The Basque Country regained competencies over health after the democratic restoration in 1987. However, this transfer from the national to the regional level did not entail a handover of competences related to health promotion to the local level in the Basque Country. Municipalities continued to carry out largely the same health activities as under Franco's regime. Thus, Bilbao City Council continued to carry out tasks of a predominantly healthcare nature. These activities constituted a very important part of the functioning of the Health and Consumer Affairs Area which, for example, was in charge of a School Health programme in which it carried out health check-ups and vaccinations of children, as regulated by the School Health Law of 1984. It was not until well into the 2000s that this type of activity was taken over by Osakidetza, the Basque Health Service.

This reorganisation of healthcare provision under the Basque Government's Department of Health resulted in a centralisation of health competencies at the regional level, which practically relieved the municipalities of their health-related responsibilities. The transfer did, however, give greater capacity to the Health and Consumer Affairs Area to take on new tasks and rethink the approach to health promotion.

After the progressive reduction of healthcare activity, the reformulation of the Area's public health-related activities faced some resistance from the technical staff that worked in the Area, most of whom were nurses and doctors. Rethinking the approach to health promotion entailed questioning the biomedical model, which was strongly rooted.

> "*It was difficult to make this transition, because the concept of health based on care was one in which we had been anchored for decades*" City Council member of the Health and Consumer Affairs Area.

This reluctance among the technical staff was also shared by the politicians, who considered these new health promotion functions less important than the healthcare ones. In addition to this, the Mayor of Bilbao from 1999 to 2014, Iñaki Azkuna Urreta, former general director of Osakidetza-Basque Health Service and advisor in the Department of health of the Basque Government, was a staunch advocate of health-related activities, including health promotion, being managed at the Basque Government level. In consequence, the Area of Health and Consumer Affairs was relegated to its most basic activities and for years it remained an undervalued area within the City Council.

A slightly greater integration of public health functions at the local level was fostered in 2011 by the *draft Law on public health and food safety of the Autonomous Community of Euskadi*[319], which recognised, at the regional level, the public health competences of the local administration. The draft Law was rooted in the strategic objectives set out in Ecoeuskadi 2020 to move towards a new model of sustainable progress and, within it, health equity was established as a cross-cutting, explicit and practical axis in all public health activities and plans, in the health system and in other policies with an impact on the social determinants of health. This draft law also embraced the HiAP strategy.

Although this draft Law was never submitted for approval by the Basque Government, it did provide a basis that somehow contributed to counteracting the aforementioned reluctance to change the health model in the Bilbao City Council' Health and Consumer Affairs Area. It made it possible to begin to open up the focus of healthcare, including other public health activities like environmental health, and also to drive the integration of health promotion activities. This reorientation process could only be achieved through the involvement and leadership of strongly committed people working in middle management, who were able to overcome resistance from both staff and politicians.

Thus, under the umbrella of this important draft Law, the activities developed in the area of environmental health, food safety and animal and pest control were consolidated and new community health and health promotion activities were developed.

> *"We worked on the first draft Law on public health and food safety of the Autonomous Community of Euskadi, in which we could already see that environmental health was there as a part of public health activities. And I think everyone knew we [Health and Consumer Affairs Area of Bilbao City Council] were there, doing that, right? So you see yourself sheltered in an umbrella, and I think that helped a lot"* City Council member of the Health and Consumer Affairs Area.

> "*I would like to think that the municipal government is becoming aware of its influence on health, let's say, on health promotion, and that it goes beyond disease prevention. So while we all believe that health is essential, and that it is a city objective, it is more... a discourse. But this is a step forward, because before there was no health discourse at all,*

and therefore I understand that progress has been made" City Council member of the Health and Consumer Affairs Area.

On the other hand, there was also a certain reorientation of the activities of the Consumer Affairs sub-area, which continued to carry out consumer health protection functions, but progressively integrated tasks related to education on responsible consumption.

The participation of the Bilbao City Council's Health and Consumer Affairs Area in the process of drafting the *Law on public health and food safety of the Autonomous Community of Euskadi* served to begin to consider health promotion strategies with a broader vision. Likewise, and even though it was not finally approved, it did serve to raise the need to draw up a Municipal Health Plan in accordance with that of the Basque Government.

"*And that is why we saw the need to draw up a Plan, somewhat in accordance. I mean, although we are a municipality, we work very much in agreement with the Basque Government, of course, with all that this implies for us, the laws, what they say and so on... So, it was like coming down to the municipality, and that is how we began to see the need to develop the Municipal Plan as a necessity*" City Council member of the Health and Consumer Affairs Area.

However, the lack of a Public Health Law at the Basque Country level has meant that there has been no formal framework to provide coverage for local health promotion competencies. This lack of legislation has hindered the implementation of pioneering approaches such as HiAP, both at regional and local level, and may have contributed to the delayed development of the *Municipal Health Plan*.

After many years in which the Area of Health and Consumer Affairs was largely disregarded within the City Council, the process of developing a *Municipal Health Plan* aiming to implement the HiAP approach served to breathe life into both the Area within the City Council and the competencies of the local government in the social determinants of health. In fact, prior to the formulation of the *Municipal Health Plan*, intersectoral action in health was rather scarce. Specific interactions revolved around the sectoral plan roundtables, in which areas other than the promoters were only involved to a greater or lesser extent. This was significantly strengthened during the process of developing the first *Municipal Health Plan of Bilbao*.

"*We have taken an important step in raising awareness, but we are still far from having all the policies or programmes that may be developed at the municipal level incorporating Health. We are going step by step, changes take time. But, nevertheless, I believe that with the Plan we have taken a major step forward*" City Council member of the Health and Consumer Affairs Area.

Despite these steps, the road ahead for advancing towards a governance for health is a long one and faces considerable resistance, some of it still within the Health and Consumer Affairs Area itself and perhaps more importantly, some political resistance.

"*I think it would be essential for our political government to believe in this, yes, I am talking about political will. That it believes in it, and makes it a priority*" City Council member of the Health and Consumer Affairs Area.

The formulation of a *Municipal Health Plan* of this nature was only possible thanks to the personal involvement and leadership of people in middle management. With the turnover of some of these people, governance for health and equity in the city of Bilbao has been left metaphorically shipwrecked, but with a roadmap to be implemented.

The trajectory of health governance in Bilbao City Council is marked by a certain resistance to change that has hindered the institutionalisation of a social model of health and has resulted in a belated introduction of internationally recognised approaches, such as the salutogenic approach or HiAP. The lack of a Public Health Law at the Basque Country level has meant that there has been no formal framework to provide coverage for local health promotion competencies. In fact, in Bilbao health promotion activities start timidly to be developed from the 2000s onwards. Since then, two milestones have marked steps to move towards a governance for health; the draft Law on Public Health and Food Safety of the Basque Autonomous Community (although this draft law was never submitted for approval) and the process of developing the first Municipal Health Plan of Bilbao. These steps, although quite modest, have been relevant in Bilbao's governance for health trajectory as they entailed facing up to and coping with resistances both within the Health and Consumer Affairs Department itself and at city government political level. Changes in the Area's sub-directorate open up an uncertain panorama, with an approved Municipal Health Plan that represents a strong commitment to governance for health equity, but an institutional context that is not conducive to its implementation.

7.1.1.d. Bilbao's local health strategy

Bilbao's health strategy is mainly based on the *I Bilbao Municipal Health Plan* (I Pan Municipal de Salud de Bilbao 2019-2023). The *Mandate Plan* (Plan de Mandato 2019-2023)[320] explicitly mentions and frames the *I Bilbao Municipal Health Plan* within the policies of the municipal government and, likewise, the *Bilbao City of Values* project includes health as a shared value of the city and its *Development Plan* alludes to it.

The *Mandate Plan*[320] is a document that sets out the ten major City projects and priority actions of the City's government for the coming years. Its main lines of action are 1) Economic activity and employment, 2) Social policies, 3) Transport, mobility and accessibility, 4) Youth, values, education and training, 5) Culture and sport, 6) Coexistence and safety, 7) Sustainability and urban transformation, 8) Development of neighbourhoods, 9) Bilbao euskaldun and 10) Transparency, participation, rigour and good management. The *I Municipal Health Plan* is included as a specific measure within the Social Policies line of action.

Bilbao City of Values (Bilbao Balioen Hiria)[321] is a project aiming to foster a framework of shared values in the city of Bilbao. After a process of citizen participation, the Plenary of the City Council approved the *Bilbao Charter of Values* on 2018, which encompasses the following 17 collective values: Respect for Human Rights, Social Justice, Gender Equality, Solidarity, Diversity/inclusion, Commitment, Environmental Sustainability, Participation, Trust, Creativity, Coexistence, Identity, Effort, Co-responsibility, Honesty, Enthusiasm and Health. In 2018 the *Bilbao Values Development Plan* was approved, which refers to the *I Municipal Health Plan* to develop the value of Health in the city.

Despite these references to the *Municipal Health Plan*, the *Mandate Plan* and the *Values Development Plan* they do not constitute policies of governance for health and, therefore, they have not been considered part of the local health strategy by the technicians and managers of the Bilbao City Council.

Plan Municipal de Salud de Bilbao

During the last City Council mandate period the development of the first *Municipal Health Plan of Bilbao* for the period 2019-2023 was requested. The process of drafting was carried out in different phases between 2017 and 2019 and it was led by the Municipal Health Plan' Leading Group, a multidisciplinary group made up of the management and technical staff of the Bilbao City Council's Health and Consumer Affairs Department, as well as research staff from the OPIK Research Group of the University of the Basque Country[322].

The first phase of the process of drawing up the *Municipal Health Plan* comprised carrying out a Health Status Report in order to find out the health status of the population of Bilbao and its connection with the social determinants of health. This was carried out through two parallel and coordinated processes; a quantitative assessment of the state of health and the determinants of health of the population of Bilbao[315] and a participatory process to incorporate the perspective of the general public, the associative fabric, and the professionals from different fields related to health and its determinants[323–325].

Based on the results of this Health Status Report, and taking into account the results of a scientific literature review and other legislative documents review, the Municipal Health Plan Leading Group sketched out the strategic lines and general objectives of the Health Plan. Then a participatory validation process was carried out in which public health experts and municipal technicians complemented and endorsed these strategic lines and general objectives, resulting in the final version of the main structure of the *Municipal Health Plan.* This structure was afterwards presented and substantiated to different municipal political agents, including the Mayor, Governing Board, spokespersons of the opposition political groups, etc (Figure 19).

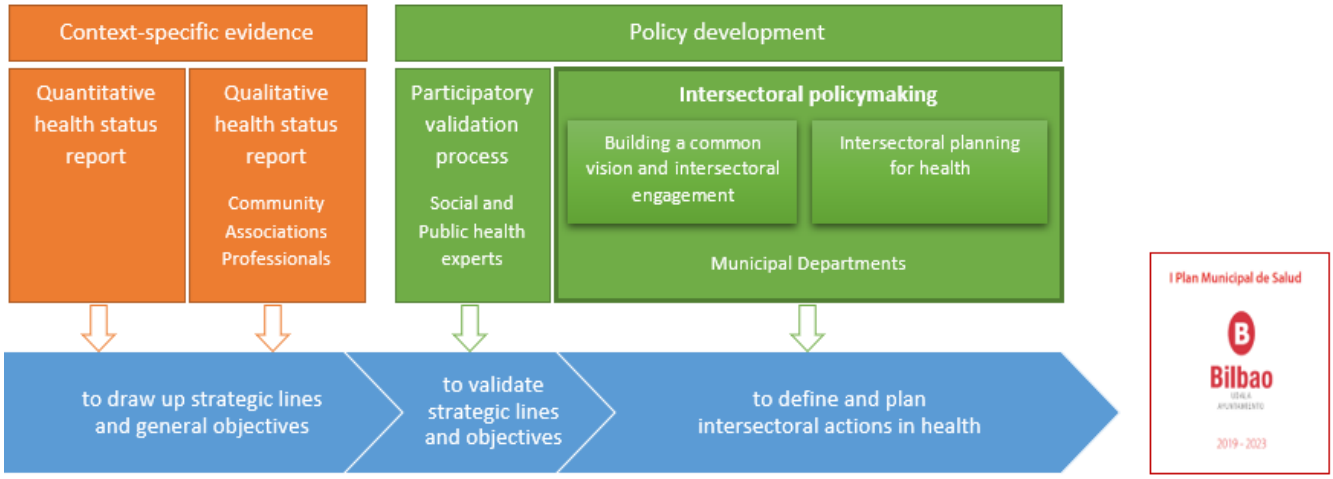


Figure 19. Development process of the first Municipal Health Plan of Bilbao.

In the phase of policy development, the Directorates of the different Municipal Areas were involved to ensure an intersectoral policymaking of the first *Municipal Health Plan*. Firstly, the strategic lines and general objectives structure and the main results of the Health Status Report were presented to them. A work plan to formulate the actions to feed the Plan was also proposed to the Directorates of the different Municipal Areas.

In the early stages of the formulation of the Municipal Health Plan, given that the social model of health was not institutionalised, it was considered essential to raise awareness among the City Council's Areas of the impact that each of them could have on the health of Bilbao's citizens using context-specific evidence (based on Health Status Report). Hence the sub-directorates and technical staff of each of the municipal areas were engaged in 12 workshops, in which 16 areas with competencies in the social determinants of health participated. In these sessions, the importance of the social determinants of health in which each Municipal Area had competencies to respond to the health needs identified in the Health Status Report was emphasised.

Each of these municipal areas was asked to identify actions, current or new, that could respond to the general objectives. The actions proposed by the Municipal Areas were, for the most part, incorporated following the formulation proposed by the Areas or reformulated in search of synergic actions between different municipal areas. The final formulation of the set of actions was then validated by the municipal areas.

> "*I find it interesting that it has been opened up to all areas of the City Council. There are many actions that can have an impact on health, like us. It has helped us to be more aware of the health impact of the mobility area [...] At the beginning we didn't understand anything, what are they asking us? But I think it's a question of talking about it, and it's interesting that our actions are there. But well, I also think that in the Plan there are too many actions, too many, to manage the indicators and to monitor... I think it's going to be complicated*" City Council member from outside the Health and Consumer Affairs Area.

The *I Municipal Health Plan of Bilbao* (Figure 20), although it is led by the Area of Health and Consumer Affairs, incorporates actions from most areas of the City Council. It is an ambitious plan conceived to boost governance for health equity at the municipal level, institutionalising a social model of health and the HiAP approach. It was approved by the Governing Board in March 2019, and entered into force in October 2019.

Figure 20. I Pan Municipal de Salud de Bilbao 2019-2023

> "*I have a very positive opinion of the approval of the Plan, and of the whole process of drawing up the health plan. We have not reinvented the wheel either, eh? But I believe that it puts us on a higher level than we were before, in a better starting position for a future plan, which can be much more focused on certain issues. It is a necessary step, and this step had to be taken with such a broad perspective as the health Plan has*" City Council member of the Health and Consumer Affairs Area.

The I Municipal Health Plan of Bilbao (2019-2023) seeks to give continuity to the Health and Consumer Affairs Department's actions for the protection, prevention and promotion of health, while also integrating the perspective of the social determinants of health. It has two main aims, improving the health of the population of Bilbao and reducing social inequalities in health between men and women, social groups and neighbourhoods of Bilbao. And it is articulated around six strategic lines, 22 general objectives and 236 actions (Figure 21). It also recognises four transversal axes, which are equity, gender perspective, a positive vision of health, and citizen participation.

In a rather reluctant institutional context, a Municipal Health Plan of this nature could be formulated thanks to the strong personal commitment to move forward governance for health equity and the leadership of people in the middle management of the Health and Consumer Affairs Area. However, the approval of the Plan was concurrent with changes in the Directorate of Health and Consumer Affairs Area, resulting in a less enthusiastic view of this strategic orientation and, therefore, also of the Plan's implementation prospects.

> "*And how do I see the plan? When I first read it, it really made me feel… overwhelmed. It overwhelms me [...]. So many actions, uff.... It seemed to me, it still seems to me complicated, complicated, complicated to deploy. How could we have committed to do all this?*" City Council member of the Health and Consumer Affairs Area.

This reluctance within the Health and Consumer Affairs Area itself is not new to Bilbao City Council. This fact, together with a lack of clear political will and commitment, calls into question the actual implementation of the Municipal Health Plan.

> "*Well, frankly, I have some doubts. I leave it there... I don't know... I mean, only time will tell. For now I don't see much interest in doing something substantial, eh? But hey, it's also the first Plan, I don't know. We have to give it a chance to see how it develops. But for the moment I don't have the feeling that it will be one of those plans that, well, that is going to make a decisive mark on municipal policy*". City Council member from outside the Area of Health and Consumer Affairs.

The Municipal Health Plan defines its evaluation and monitoring processes, identifying the main outcome indicators that evaluate the fulfilment of its aims. These procedures include the requirement to carry out a mid-term evaluation of its implementation process in 2021. This mid-term evaluation has not been issued at the time of this research, so the degree of implementation of the Plan remains unmonitored at this point.

Figure 21. Municipal Health Plan of Bilbao' strategic lines and general objectives

The local health strategy of Bilbao is mainly based on the Municipal Health Plan 2019-2023, which is the first Health Plan of the Bilbao City Council and in the development of which several Areas of the City Council have been engaged. The Municipal Health Plan is referred to in the Mandate Plan and in the Development Plan of the Bilbao City of Values project, policies that, however, do not constitute part of the local health strategy. The first Bilbao Municipal Health Plan is quite ambitious; it is articulated around strategic lines, one of which integrates the HiAP approach, as well as around transversal axes, which encompass equity and citizen participation. The mid-term evaluation of the Plan has not been conducted in the period covered by this research, so it is not possible to know the actual degree of implementation of the Plan's actions.

7.1.1.e. COVID-19 pandemic and governance for health in Bilbao

In the Basque Country, Epidemiology competences, as well as healthcare provision, are mostly centralised at regional level, in the Basque Government's Department of Health and Osakidetza-Basque Health Service respectively. Therefore, the city of Bilbao has played a relatively minor role in terms of monitoring and providing medical assistance during the COVID-19 pandemic. It has been the primary responsibility of the local government, however, to supervise curfew hours, control public concentrations, capacity limits and limitations in the hospitality sector, enforce the correct use of masks, adapt public spaces, transport and services, as well as put in place measures to minimise the social and economic impact of the pandemic.

The SARS-CoV-2 virus emerged in China in January 2020 and entered Europe via Italy. In Spain, the first imported case was reported at the end of January and the first locally transmitted infections were confirmed at the end of February. A few days later, in early March 2020, the Basque Government also confirmed the first cases of coronavirus in Bizkaia. In March, the escalation of cases was dramatic, hospitals were overflowing and the lack of protective equipment meant that healthcare workers suffered of a high rate of infection. On 19 March, the first Osakidetza healthcare worker to die of COVID-19 died in Basurto Hospital.

The epidemiological situation led the Government of Spain to approve the declaration of a State of Alarm, which was initially approved for 15 days, with measures to severely restrict the movement of people and economic activity on 14th March 2020. Two days later, the land borders closed and the Basque elections were suspended. On 29th March the national Government approved the suspension of non-essential activities until 9th April and established a compensatory paid leave for the affected workers. The *Copa del Rey* final between Real Sociedad and Athletic Bilbao was postponed. On 18th April, a new extension of the State of Alarm was announced until 10 May with new measures, such as allowing children, who had experienced the greatest restrictions, to go out on the streets during certain time slots from 27 April. In May, all people were allowed to go out on the streets under time slots conditions, and there was also a gradual return to face-to-face teaching, with the mandatory use of face masks and other safety measures. Once the first wave of COVID-19 had passed, the State of Alarm, which lasted 96 days, was lifted and the so-called process of de-escalation began on 21st June. The de-escalation involved the progressive withdrawal of confinement measures and restrictions on mobility and the entrance into the so-called *new normality*.

After this relaxation of the measures, a new COVID-19 wave began in July 2020. To try to slow down the spread of the virus, the use of masks in open spaces was made compulsory. However, the incidence of COVID-19 continued to increase during the summer, so a health emergency was declared in the Basque Country, and the Basque Government once again implemented restrictions. The COVID-19 pandemic has led not only to direct mortality from SARS-CoV-2 infection, but also to indirect mortality and morbidity exacerbated by the socio-economic consequences of the pandemic. These consequences have increased with each subsequent wave of the epidemic. In this sense, pandemic fatigue is especially visible when analysing mental health data.

Throughout these pandemic waves, Bilbao City Council was mainly concerned with carrying out a series of information campaigns and guidance services, commemorative events, and to developing economic aid for trade and tax incentives for companies. The Bilbao City Council also carried out two studies, one on COVID-19 and de-escalation in Bilbao[(326)], and the other on COVID-19 and its evolution in Bilbao during the second wave[(327)]. These studies evaluated, among other aspects, the public's perception of the municipal government's management. Although in these studies the City Council's epidemic management had a slightly positive assessment, the equity perspective in the measures put in place have been quite weak. In this regard, it is noteworthy the absence of desegregated data on COVID-19 incidence and mortality, as well as impact in social and economic terms, by neighbourhood and by inequality axes in the city of Bilbao. Information that has not been considered a priority to obtain, and which should be at the basis of the development of equitable policies.

> "*We know that the epidemic is increasing inequalities here, because it is happening everywhere. But we don't really know it, we intuit it and we kind of see it indirectly through the increased demand from the most vulnerable groups [...]. But I don't think the major measures have taken this into account, no. I don't even know if anyone is analysing this. In fact, if you ask which groups are the most disadvantaged, they may answer hospitality, commerce, tourism… which, you know, up to now is what has been prioritised. Well, there is this training for migrant women to become awareness-raisers, but beyond that…*" City Council member of the Health and Consumer Affairs Area.

As for the Health and Consumer Affairs Area, which was leading a governance strategy for health in which equity is a transversal axe, the COVID-19 epidemic disrupted an implementation process that was just beginning to unfold. Moreover, the epidemic has placed an overload of work on the Health and Consumer Affairs Area which, together with reduced funding, puts a strain particularly on the implementation of health promotion activities.

> "*The epidemic at the budgetary level means a terrible reduction, terrible. And at the level of the Health Area, when it comes to cutting back, there are actions just that cannot be cut [...] And where do you cut back? Well, we have cut back on those issues that were in full development, that were not yet consolidated. A lot of health promotion programmes*" City Council Member of the Health and Consumer Affairs Area.

In this context, the arrival of vaccines at the end of December 2020 opens a new horizon, but it also leaves many challenges in terms of the unequal social, economic and health consequences in the city.

Given that health responsibilities in the Basque Country are largely centralised in the Basque Government's Department of Health, the local government of the city of Bilbao has played a minor role in the monitoring and management of the COVID-19. It has however had the responsibility to handle the social and economic consequences of the pandemic. In this context, Bilbao's City Council has mainly carried out a series of information campaigns and advisory services, commemorative events, and developed financial support for commerce and tax incentives for businesses, which lacked an equity focus. The City Council has neither collected data on health and social determinants of health disaggregated by neighbourhoods and other axes of inequality that could have helped to develop more equitable measures in the city of Bilbao. Besides, the COVID-19 epidemic disrupted the process of implementing the local health strategy, particularly affecting health promotion and community health activities.

7.1.2. Analysis of key dimensions of governance for health equity in Bilbao's local health strategy

This section of Bilbao's case study results analyses the extent to which policy coherence, accountability and social participation are incorporated into the current local health strategy. To assess these key dimensions of governance for health equity, the following tools have been used; an adaptation of the Storm's Maturity Model for HiAP[306] for policy coherence, the Ebrahim and Weisband's core components of accountability[128] and the accountability domain of the PAHO Equity Commission's rubric[133] for accountability, and the Health Canada's Public Involvement Continuum[307] for social participation. These tools were used to examine the content of the Municipal Health Plan of Bilbao, and, in a complementary way, the interviews with key informants of the local health strategy in Bilbao were also analysed.

7.1.2.a. Policy coherence

Policy coherence is one of the key dimensions of governance for health equity. In order to assess the extent to which it has been incorporated into the local health strategy of Bilbao, an adaptation of Storm's Maturity Model for HiAP scale[306] has been applied to Municipal Health Plan of Bilbao (Table 5). The table below summarises the degree in which policy coherence have been considered.

Table 5. Policy coherence in Bilbao's local health strategy

Bilbao's local health strategy		
Stage	**Policy coherence components**	
Recognition	Importance of policy coherence recognized to reduce health inequalities	In the prologue, the Bilbao Municipal Health Plan states that "*This Plan aims to give continuity to a large part of the health protection, prevention and promotion actions promoted by the Health and Consumer Affairs Department, integrating the perspective of the different municipal areas with an impact on health determinants"* and "*It is the materialisation of the commitment of each and every one of the municipal areas to work transversally and jointly with the aim of having a positive impact on the health of the people of Bilbao*". In this way, the impact that actions of each of the City Council's areas have on health is acknowledged, as well as it is the need of a synergic and coherent municipal action for health.
	Visibility of which activities of sectors contribute to (determinants of) health inequalities	
Consideration	Policy coherence / Intersectoral action described in policy documents	The Bilbao Municipal Health Plan includes the perspective of the social determinants of health and sets out the progressive incorporation of the HiAP strategy. Thus it does not involve exclusively the Health and Consumer Affairs Area, but integrates

	Collaboration with sectors present (project-based) Collaboration on health inequalities is started Activities of sectors contributing to determinants of health inequalities	different actions of municipal areas with an impact on health determinants (housing, employment, equality, environment, etc.). And, in fact, the first strategic line of action is intended to put *"health at the heart of municipal policy"*. It claims to be a Plan led by the Mayor's Office, although at the same time it recognises that "*for a realistic and sustainable start, the Health and Consumer Affairs Area assumes its role as a driving force in the progress of the HiAP strategy at municipal level, adopting a role of support and accompaniment for the rest of the municipal areas in their task of incorporating the perspective of health and equity in their actions*". Therefore, consideration has been given to how to incorporate health and equity into municipal plans, programmes and projects. Moreover, the mechanisms for the HiAP implementation have been considered. For example, specific actions 1.2.1 and 1.2.2 include the creation of structures such as an Inter-Municipal Health Working Group made up of technicians and technicians from the different municipal areas or the formation of a group of people belonging to the Health and Consumer Affairs Area to accompany the municipal areas in the incorporation of the health determinants perspective.
Implementation	Concrete collaboration agreements Structural consultations forms present Key person or group ensuring policy coherence (role is clear) Working from sectors on health inequalities (policy basis)	The first Bilbao Municipal Plan establishes specific commitments in terms of intersectoral actions for health with several municipal areas, made jointly during the policy formulation process. These commitments were made during the process of drawing up the Plan. However, given that it is the first Municipal Health Plan and that since its approval in 2019 it has had a relatively short, and constrained by the COVID-19 pandemic, implementation trajectory, it may be too early meaningfully assess this stage. It is interesting to highlight, however, that within the Health and Consumer Affairs, a team of six people has already been set up to monitor the municipal areas that are committed to carrying out specific actions for health. Thus, each person in this team is the interlocutor and reference person for some of the municipal Areas. This is a first step in the establishment of specific functions to reinforce intersectoral action and support the fulfilment of the commitments established in the Plan.
Integration	Broad, shared political and strategic vision Policy coherence results visible (both content and process)	At symbolic level health may seem to be a central value for the City Council, for instance, Bilbao City of Values explicitly incorporates Health among its core values. However, there is no other commitment beyond the rhetorical intention to implement the Municipal Health Plan, which has not received clear political and institutional support. The Municipal Health Plan embraces the HiAP approach but as there has not yet been a relevant deployment of such strategy, this cannot be yet considered a direct and reliable reflection of an integrated policy coherence.

Institutionalization	Political and administrative anchoring of the HiAP approach	There is no political or administrative anchoring of the social health model or the HiAP approach. The local health strategy has only recently incorporated these elements, which may explain its lack of institutional consolidation. Furthermore, it is not possible to refer to any continuous improvement of procedures, as the implementation process has only just begun and no evaluation has yet been carried out.
	Continuous improvement of integral processes and results on the basis of the achieved results	

In order to provide an enriched view of policy coherence in Bilbao's health strategy, the results presented in this table are complemented and further developed with the results of the thematic analysis of interviews with key informants involved in the local health strategy development and/or implementation.

Bilbao's local health strategy recognises the importance of policy coherence to reduce health inequalities and makes visible the contribution of other municipal areas to improve health and health equity. The first Municipal Health Plan incorporates commitments to intersectoral collaboration, adopting the HiAP approach. However, its implementation is still very early days and the work of the municipal sectors has not yet been sufficiently developed nor evaluated.

> "*I think the strategic lines are the right ones. I think this is where we have to continue, or well, to start, particularly in line one, the one about health in all municipal policies*" City Council member of the Health and Consumer Affairs Area.

> "*Health is not an issue that concerns us directly in our Area, although in a tangential or indirect way, yes, of course. But yes, I think it is something that is being taken more and more into account in the municipal work in general and in our activities*" City Council member from outside the Area of Health and Consumer Affairs.

In this context of the very recent consideration of policy coherence for health, there are both optimistic and reluctant views on its implementation. Thus, although the need for synergic, coordinated and coherent action is widely recognised, reticence about the mechanisms to move towards it can also be found. It is perceived that the City Council works operatively in silos and that the intersectoral action may lead to an overload of work and a loss of oversight of the Area's activities.

> "*It is not easy to work on sectoral aspects that we don't know well [...] Often these require specific expertise, such as HIAs. And we are being required to specialise to such an extent that we end up hiring consultants who do this. And then you lose a little bit of perspective and you become a sort of contractor. It ends up becoming a bit of a formality that has to be fulfilled... And I don't know to what extent this added workload really adds up*" City Council member from outside the Area of Health and Consumer Affairs.

In relation to intersectoral action on health, one element that has emerged repeatedly is the need for the municipal areas to have the close support and leadership of the Health and Consumer Affairs Area in order to be able to implement the intersectoral actions for health to which they committed themselves in the Plan. At the same time, the need to frame the local health strategy under the higher umbrella of the Mandate Plan is also recognised. It is

considered that if the coverage and guidelines come not only from the Health and Consumer Affairs Department, but rather from the City Council as a whole, it would be easier for all municipal areas to shoulder their responsibility for health.

> "*In the end, what is in the Health Plan is not necessarily seen as a priority in our area. Making plans together always joins up, it can ally a bit.... But it is just enough that it comes from above, as the Mandate Plan does, to make it considered an imperative*" City Council member from outside the Area of Health and Consumer Affairs.

The policy coherence of Bilbao's local health strategy can be placed at the Stage II, *Considered*, of the V stages that the MM-HiAP has. The first Municipal Health Plan of Bilbao includes the perspective of the social determinants of health and health equity. Thus, it integrates different actions of municipal areas with an impact on health determinants and it establishes mechanisms for the HiAP implementation. The local health strategy of Bilbao has only recently incorporated the HiAP approach, which may explain its lack of political and institutional consolidation. Indeed, its implementation still in its very early days and the intersectoral work has not yet been sufficiently developed nor evaluated. Although there is certain reluctance about the concrete mechanisms for developing a coherent municipal governance for health, there is a fairly widespread view that it requires both leadership from the Health and Consumer Affairs Area and explicit political endorsement from the government in power.

7.1.2.b. Accountability

Accountability is key dimension of governance for health equity and it is particularly important for the success and sustainability of local health strategies. To assess how accountability has been incorporated into Bilbao's health strategy two tools are used; the four core components of accountability identified by Ebrahim and Weisband[128] (Table 6), and the guiding questions of the PAHO Equity Commission's accountability domain[133] (Table 7). The results from these tools for analysing accountability are then complemented and further developed using the results of the thematic analysis of interviews with key informants involved in the development and/or implementation of the local health strategy.

Table 6. Accountability in Bilbao's local health strategy (Ebrahim and Weisband's components)

Ebrahim and Weisband's Accountability component		**Bilbao's local health strategy**
Transparency	Collecting and making available and accessible for public scrutiny information that is "actionable" to citizens	Bilbao City Council participates in the *Open Government Partnership* programme to evaluate and develop mechanisms to promote a more open, accountable and responsive governance. As part of this project, it has developed a *Transparency Portal*[328] within the City Council's website which provides access to public information derived from the transparency obligations established by current legislation and other information that the local government wishes to provide albeit not legally obliged to do so. Thus, it provides public access to information on different areas of municipal management, such as issues related to recruitment, regulations, subsidies, human resources or other information related to the municipal government itself. It also has the *Bilbao Open Data*[329], an initiative to open up the data of the city of Bilbao. It should be noted, moreover, that information related to health and social determinants of health is rather scarce and is not disaggregated, and is therefore of little utility from a health equity perspective. In addition, the different sectoral plans and reports are also published, but this information is often rather unfriendly and not readily actionable. "*What happens with the reports is that they are unreadable, at least ours. I mean, the activity of the Area is collected, but even too much, there is a lot of data and I don't think many people will actually bother to read it*" City Council member of the Health and Consumer Affairs Area. As far as the local health strategy is concerned, the first Municipal Health Plan, as well as the Participatory Health Diagnosis and the Quantitative Diagnosis are available in open access on the City Council's website. It should be mentioned that "*Strengthening transparency and accountability in municipal health policies*" is one of the specific objectives of the first general objective of strategic line I.

Answerability	Providing justification for decisions so that they may reasonably be questioned	The strategic lines and objectives of the first Bilbao Municipal Health Plan are based on the Health Diagnosis that used participatory methodologies to capture the different perspectives of diverse city's stockholders and citizens. Indeed, the use of participatory processes in Bilbao's health diagnosis helped to complement quantitative approaches in order to better identify population's needs as well as health assets[324]. And yet, although specific actions were included in the first Municipal Health Plan to meet the outputs of the participatory process, the feedback to the participants after the formulation of the first Municipal Health Plan was quite poor. "*Well, the Plan was sent when it was already done to some of the entities that had participated, but a bit like 'this is the result', the truth is that we didn't make a great effort to validate it with them either*" City Council member of the Health and Consumer Affairs Area. On the other hand, it has not been possible to evaluate the Answerability dimension in the framework of the implementation of the local health strategy, since at the time of this research the mid-term evaluation planned for 2021 has not yet been issued.
Compliance	Monitoring and evaluation of procedures and outcomes	In terms of the overall management of Bilbao City Council, it is worth mentioning the *Bilbao Responsible* platform[330], which provides access to information on the fulfilment of the commitments made by Bilbao City Council for public scrutiny. With regard to Bilbao's health strategy, it is worth highlighting the strategy line VI of the first Bilbao Municipal Health Plan, which seeks to generate knowledge through research, aimed at improving effective municipal action for health. Accordingly, general objective 6.1. calls for the open-data monitoring of health and its social determinants in order to improve understanding of the state of health of the population and health inequalities. Besides, the evaluation and monitoring of the Plan itself foresees that "*the results of the interim and final evaluation will be published and disseminated internally within the City Council, as well as to the general public*" to enhance compliance.
Enforceability	Sanctioning for shortfalls in compliance, answerability or transparency	Bilbao City Council obtained the highest score in the Transparency Index of City Councils in 2017, in fact, it obtained an outstanding rating since the first edition in 2008[331]. In 2015 the Plenary of Bilbao City Council approved the *Code of Conduct, Good Governance and Commitment to Institutional Quality of Bilbao City Council*. This Code determines the principles and standards of conduct to be followed by the political representatives of Bilbao City Council, by holders of municipal management bodies, as well as by holders of senior management contracts for municipal instrumental entities, and it establishes some enforceability measures. The Bilbao's health strategy, however, does not contain or refer to these or other enforcement mechanisms.

At the local government level, accountability is quite good in the dimensions of transparency and compliance and enforceability, and acceptable in the dimension of answerability. The City Council of Bilbao, involved in the *Open Government Partnership programme*, has developed mechanisms to enhance an accountable governance such as the *Transparency Portal*, *Bilbao Responsible* or *Bilbao Open Data*. It also has approved a *Code of Conduct, Good Governance and Commitment to Institutional Quality*. All this has led it to the achievement of high scores in the Transparency Index of City Councils. Despite the fact that Bilbao City Council's accountability is relatively good there is, however, room for improvement.

> "*The overall situation is quite good, but we have little culture of evaluation, and we do it simply because it's time to do it. In other words, the Plan ends and we have to evaluate. What for? It doesn't matter, because it's time. We don't have a culture of continuous evaluation, of learning from what we are doing as we go along. Are we going to keep doing something poorly until it is evaluated at the end of the year? It's really a bit like that*" City Council member from outside the Area of Health and Consumer Affairs.

Paradoxically, the relatively good accountability performance of the city government does not necessarily translate into the local health strategy. Thus, for example, the information available to citizens in relation to the social determinants of health and health status is, beyond the Bilbao Health Diagnosis, practically non-existent. This should be understood in the context of the incipient process of implementing the Municipal Health Plan.

The Municipal Health Plan considers accountability as a principle of governance for health and proposes specific actions to move towards an accountability-based governance for health. For instance, the creation of interactive tools for the visualisation of health data, which enable the identification of health inequalities. However, at the time of writing this research, the accountability mechanisms envisaged in the Municipal Health Plan have not yet been developed.

> "*In terms of accountability, we are trying to work on something that is more tangible, that is more understandable, that can be more interesting to the society, to our own politicians and to the rest of the municipal areas. We are working on it but we are still in the process of developing it, it's still very early days. We are going slowly*" City Council member of the Health and Consumer Affairs Area.

In the first Municipal Health Plan of Bilbao accountability is somehow linked to the right to health. It is stated "*Bilbao City Council considers health and well-being as a fundamental right that must be guaranteed and places people at the centre of its policies and actions*". Nevertheless, the Municipal Health Plan does not include specific mechanisms to redress violations of people's right to health beyond a proposal for monitoring health inequalities. Below is the PAHO Equity Commission's rubric for the Bilbao's health strategy (Table 7).

Table 7. Accountability in Bilbao's local health strategy (PAHO Equity Commission's rubric)

	PAHO Equity Commission's rubric	Question score
Accountability	Does the local health strategy include mechanisms to redress violations of people's right to health?	
	• Does the local health strategy include mechanisms for educating people on their right to health?	0/1
	• Does the local health strategy include mechanisms for reporting right to health violations?	0/1
	• Does the local health strategy include mechanisms for enforcing people's right to health?	1/1
	• Does the local health strategy include mechanism for investigating and reducing fraud and corruption?	0/1
	OVERALL SCORE	1/4

Although Bilbao City Council incorporates the accountability dimensions of transparency, responsibility, compliance and enforceability reasonably well, this does not yet translate into the local health strategy. This fact must be understood in the context of the incipient implementation of the Municipal Health Plan, which does include accountability as a fundamental principle and which proposes specific actions to move towards an accountable governance for health. However, the Municipal Health Plan does not include, beyond a proposal to monitor health inequalities, mechanisms to redress violations of people's right to health, and that is why it scores 1/4 on the PAHO Equity Commission's accountability rubric.

7.1.2.c. Social Participation

Social participation is one of the key dimensions of governance for health equity. To assess its incorporation into Bilbao's local health strategy, the Health Canada's public involvement continuum[307] has been used to qualify social participation's degree throughout the phases of the policy cycle[94]. These results are summarized in the following table (Table 8).

Table 8. Social participation in Bilbao's local health strategy

Social participation		**Bilbao's local health strategy**
Policy cycle phase	*Level*	
Health and social determinants of health needs assessment (agenda building)	IV - Engage	The first Municipal Health Plan of Bilbao is based on the Health Diagnosis which included a participatory process that aimed not only to listen to and gather the perceptions of different actors, but also to engage them and to create a space for discussion and exchange (details of the participatory process of the Bilbao Health Diagnosis can be found in the annexed paper). Despite its limitations, contributions derived from this participatory diagnosis were taken into account in the policy formulation stage, and these proposals influenced the Municipal Health Plan by adding specific actions.
Local health strategy policy-making (policy formulation and adoption)	Level II - Gather Information	The process of developing the Municipal Health Plan involved a participatory validation process with experts from the social and public health fields, which complemented and endorsed the strategic lines and general objectives, resulting in the final version of the main structure of the Municipal Health Plan. Then, there was intersectoral policymaking work involving several municipal areas. The Municipal Health Plan, once formulated and internally validated, was released to the public following the usual legal procedures.
Local Health Strategy execution (implementation)	Not yet evaluatable	The degree of inclusion of social participation in the implementation and monitoring stages of the Bilbao local health strategy cannot yet be evaluated, given that these phases have not yet been completed. However, the content of the Municipal Health Plan does contemplate the dissemination of the evaluation reports, so, if this is done as established, it would be at level I - Informing citizens to make the results of a process known. The Municipal Health Plan recognises participation as a transversal axis; "*it is acknowledged that citizens need to become leading agents in defining and shaping their own health, transcending their role as mere recipients of services. The spaces and channels for developing a fully participatory democracy, together with progress in municipal transparency and accountability, will consolidate the achievement of this principle of the first Municipal Health Plan*". It is therefore striking that greater levels of social participation have not been envisaged in these phases of the political cycle.
Local Health Strategy monitoring (evaluation)	Not yet evaluatable	

The following spider graph summarises the levels of social participation in Bilbao's local health strategy in the phases of the policy cycle that could be assessed at the time of undertaking this research (Figure 22).

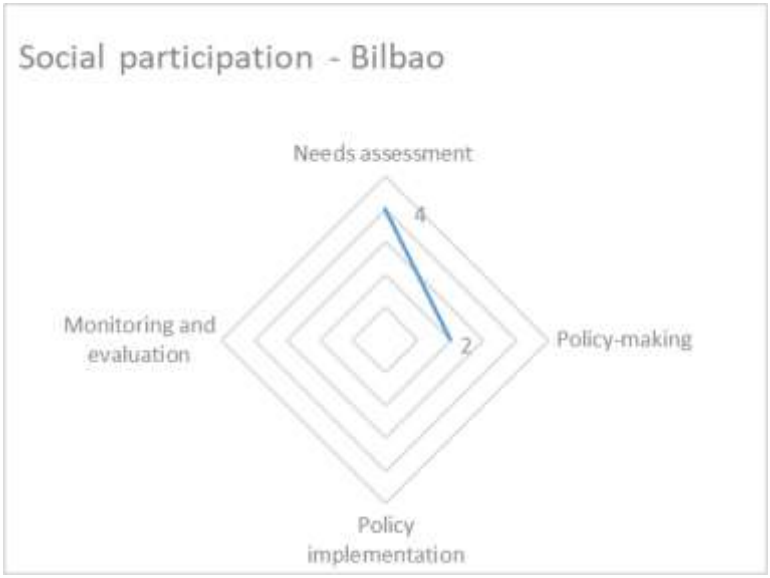


Figure 22. Levels of social participation in Bilbao's local health strategy

In order to provide an enriched view of social participation in Bilbao's health strategy, the results of the Health Canada's public involvement continuum are complemented and further developed by the results of the thematic analysis of interviews with key informants involved in the development and/or implementation of the local health strategy.

The participatory processes that the Bilbao's local health strategy were intended to encourage discussion among and with citizens and stakeholders. This space gave individuals and groups interested in urban health the opportunity to discuss and influence the input for the Municipal Health Plan and, in fact, their input contributed to shaping it.

> "*I think they were interesting processes, to allow citizens to have a voice, and to ask them questions. Participation seems to me to be interesting. I believe that we must always listen to the citizens, not only in this, but in any other Plan that we may propose. And then, those dynamics that we did, I think it was quite enlightening. It was a bit of a reflection on what health is, that it is not only the absence of illness, and I think we all agreed on that*" City Council member of the Health and Consumer Affairs Area.

Although the importance of participation is widely recognised, the difficulties inherent to the development of these participatory processes are also acknowledged. Among the barriers that have been pointed out for the inclusion of social participation to a greater extent are the lack of technical capacities, the cost and time that participatory processes imply, as well as the low culture of participation at both the institutional and social levels.

> *"But these participatory processes, while very fashionable, are very expensive, time-consuming and difficult. Including the participatory process that was done for the elaboration of the Plan.... The reality is that about 170 people participated, which maybe is a great success, but I don't know... And that counting associations, citizens and*

professionals. So, well, those few are who took part, and all that with a terrible effort" City Council member of the Health and Consumer Affairs Area.

"I think participation is necessary, but I think it costs a lot. It costs a lot because citizens don't want to participate, and because it is difficult for us as an institution to organise" City Council member of the Health and Consumer Affairs Area.

The perceptions of this participatory process among the technicians and managers of the Bilbao City Council are very heterogeneous and evidence a very incipient participatory culture, which has not yet significantly permeated the institution. In spite of this, Bilbao City Council recognises, at least at the discursive level, participation as a value of governance and it has conducted some participatory processes, including participatory budgeting.

"*We are still at a very early stage, at all levels. That is to say, I believe that the City Council is committed to encouraging participation, or at least that's what they say, but it is still more of an idea than a reality, we don't have a participatory culture*" City Council member from outside the Area of Health and Consumer Affairs.

The first Bilbao Municipal Health Plan establishes participation as a transversal axis, giving it value and visibility. Within the Municipal Health Plan, social participation is tangentially articulated in its general objective 5.2. "*Promote community health as a working tool for health promotion in the neighbourhoods*", which aims to promote community processes in the neighbourhoods by incorporating the health perspective into them. However, the Municipal Health Plan does not foresee the establishment of mechanisms to facilitate participation in the process of defining, monitoring and evaluating the local health strategy itself. There is also a certain gap between the symbolic content, which gives great weight to social participation, and the operational content, which barely has concrete actions for its articulation. This fact may hinder the practical development of social participation in Bilbao's health strategy. Moving towards a greater participatory culture is perceived as a shared responsibility between the institution and society.

"*Well, one of the transversal axes of the plan is participation. The participation of the whole of society [...] But I find these participatory processes difficult, and I understand that they are necessary. So, I think that, well, we professionals ourselves have to make progress first*" City Council member of the Health and Consumer Affairs Area.

"*I think that there is a lot of posturing, a lot of covering up. I think that in order for citizens to really participate, fuck, we have to have a society that is more engaged, aware... I don't know, it's something more on a social level*" City Council member of the Health and Consumer Affairs Area.

Bilbao City Council has an embryonic participatory culture that has not yet taken root in the institution. The barriers that have been pointed out for a greater inclusion of social participation are the lack of technical capacities, the cost and time required, and the scarce culture of participation at both institutional and social levels. The Municipal Health Plan recognises participation as a transversal axis and includes actions that intend to foster community processes, however, it does not foresee mechanisms to facilitate participation in the process of defining, monitoring and evaluating the local health strategy itself. This gap between its symbolic and operational content may hinder the inclusion of social participation in practice. As the full implementation and evaluation of Bilbao's local health strategy has not yet been carried out, it has not been possible to assess the degree of inclusion of social participation in these phases.

7.1.3. Analysis of factors affecting the local health strategy implementation in Bilbao

This section presents the barriers and facilitators identified in the processes of developing and implementing Bilbao's local health strategy in the pre-pandemic context (Table 9), as well as the challenges and opportunities related to the local health strategy in the current COVID-19 pandemic context (Table 10). These elements have been analysed using the domains of the CFIR framework, and the results are summarised in the following tables.

7.1.3.a. Implementation barriers and facilitators of the local health strategy in pre-pandemic context in Bilbao

Table 9. Implementation barriers and facilitators of the local health strategy in Bilbao: Pre-pandemic context

CFIR		**Implementation barriers and facilitators of the local health strategy in Bilbao: Pre-pandemic context**
Outer setting	Needs and resources of those served by the local government	Bilbao's health strategy is based on the Health Diagnosis and includes those elements that citizens and social agents highlighted in the participatory process, however, the perception that it fully responds to the public health needs of the city is not shared by everyone, even within the Health and Consumer Affairs Area of the City Council. "*If you ask here, well, people think that it is the Plan made by and for community health, because the rest of the activities that we do hardly have any importance within the Plan*" City Council member of the Health and Consumer Affairs Area.
	Cosmopolitanism	Given that public health, and in particular health promotion, have largely been taken over at regional level, the degree of networking between the Health and Consumer Affairs Department of the City Council and other local organisations is relatively low. Even so, coordination roundtables have been held with the Bilbao-Basurto Integrated Health Organisation and different projects have been developed with various third-sector organisations working at the local level.

	Peer Pressure	It seems to be a kind of mimetic pressure to advance towards innovative approaches on urban health. There is a positive regard towards other cities that have a longer trajectory in governance for health equity, as well as an interest in learning from these experiences. "*And we had also set up processes of training and sharing. We had contacted Javier Segura from Madrid and a person from Barcelona City Council who were going to share with us their experience of working in neighbourhoods to promote health, and the integrated action they are carrying out in the neighbourhoods*" City Council member of the Health and Consumer Affairs Area. "*We are currently looking at how we can join the Healthy Cities Network, which is one of the things that were included in the actions of the health plan*" City Council member of the Health and Consumer Affairs Area.
	External Policy	The lack of a Basque Government' Public Health Act to give legal coverage to the City Council's health promotion competences has been one of the recurrent barriers identified. "*I think that these issues that have to do with health plans, with equity... I wish they had legal coverage, I wish they were compulsory by law. Because everything that is not compulsory by law, well, we can develop activities, we can do things, but it is hard to pull it off*" City Council member of the Health and Consumer Affairs Area.
Inner setting	Structural characteristics	One of the barriers identified for the Plan's implementation is the structural reorganisation of the City Council Areas following the electoral process, as well as the turnover of the management and technical staff. On the other hand, a team of people was created within the Health and Consumer Affairs Area to provide support and follow-up to the actions that other municipal areas had committed to implement within the Municipal Health Plan. This group, although still lacking a formal structure, has been identified as a facilitating mechanism for the implementation of the local health strategy.

	Networks and communications	Difficulties linked to communication and networking within the City Council have been identified as a significant barrier to implementation. Work is carried out in silos both within the municipality and within the municipal areas. "*Many times, and this is very common in the public administration, we work in silos, even within the area itself. It is an endemic problem. It happens not only that one area does not know exactly what the other area does, but also that within the area itself, much of the activity is completely unknown for other people*" City Council member of the Health and Consumer Affairs Area.
	Culture	The Bilbao Charter of Values includes Health within its 17 collective values, and so it may come as a surprise that this has not been identified as an enabler. Conversely, the lack of political and institutional commitment towards a governance for health has been identified as a barrier to the implementation of the Municipal Health Plan. "*Yes, I am talking about a lack of political will, a lack of will to act beyond the discourse*" City Council member of the Health and Consumer Affairs Area.
	Implementation climate	The Municipal Health Plan is considered a roadmap for progress towards health equity, and is perceived as both a challenge and an opportunity. At the same time, it is recognised that the capacity for change and the degree of support for innovation are not the most appropriate for the implementation of the Plan and are likely to hinder the achievement of the objectives set out in the established period.
	Readiness for implementation	There are no clear signs of a high degree of commitment to the implementation of the Municipal Health Plan in terms of available resources or leadership capacity. However, there are some champions within the Health and Consumer Affairs Area who could facilitate implementation and counteract to some extent the resistance to change. "*Well, it's going little by little. You know we are an administration and it takes time to change things here. We are very slow and it's hard for us to adapt. And we often end up adapting, as I said, but it's hard for us. We professionals ourselves have to adapt and that's why it's difficult sometimes, because we do many things and leaving our usual work, our comfort zone, is difficult. But, well, I think we are working on it*" City Council member of the Health and Consumer Affairs Area.

Process	Planning	The process of policy formulation, involving other sectors, has been considered tedious and complex but at the same time enriching and meaningful. It is also perceived that this intersectoral policy-making process can be a facilitator for the implementation of the local health strategy. "*The process of drafting the plan was so long… It was complex but, well, it was very enriching. We have had collaborations with other areas, but not to this extent, and I think it was important to do it this way for the Plan*" City Council member of the Health and Consumer Affairs Area.
	Engaging	The formulation and implementation of the Municipal Health Plan has so far involved actors mainly at the institutional level (whole-of-government). This engagement was done through a series of sessions in which the social model of health was introduced and subsequent meetings to discuss the possibilities of advancing health and equity in the social determinants of health under the competence of the different municipal areas. The whole-of-society approach was largely overlooked. Although at this stage it is considered too early to be assessed, it is expected that these alliances will contribute to the implementation of the local health strategy. "*Because, many times we have great, good, intentions and then little by little they start to fade, particularly if you face it alone.... So, well, we have started to build collaboration ties and we hope that this will help to prevent this from happening*". City Council member of the Health and Consumer Affairs Area.
	Executing	The execution of the Municipal Health Plan is still at an rather incipient stage. The activities that were being carried out within the Health and Consumer Affairs Area and that were included in the Plan have continued to develop normally, but the new activities have not yet been fully developed. It should be highlighted, though, that a group has been created to follow up on the intersectoral actions for health, establishing referent interlocutors within the area of Health and Consumer Affairs for the other municipal areas. Although the activity of this group has not yet materialised, it is considered that it can strengthen intersectoral work and thus the implementation of the Plan.
	Reflecting and evaluating	The Municipal Health Plan has not yet been evaluated. One of the difficulties encountered in terms of monitoring and evaluation is the establishment of indicators that are meaningful, practical, easy to obtain and shared between municipal areas.

Intervention	Innovation source	There is a high degree of ownership of the local health strategy within the Area of Health and Consumer Affairs which decreases considerably when the other municipal areas are asked about it, despite the intersectoral policy-making process carried out.
	Evidence strength and quality	In general, it is agreed that the Bilbao's local health strategy is evidence-based and incorporates the guidelines recommended by the WHO and other international organisations. It was also pointed out that it could have had a more explicit link with the SDGs which could have facilitated its implementation. "*I think that it would help if there were other international issues that could also lead the way, such as the Sustainable Development Goals. Those kinds of things that could also pull health-related issues*". City Council member of the Health and Consumer Affairs Area.
	Relative advantage	While the Municipal Health Plan is seen as an ambitious policy in relation to the local government's starting point, it is considered a necessary step forward rather than a final destination. The relative advantage over other approaches is not clearly perceived. "*We have not reinvented the wheel either, eh? But I believe that it puts us on a higher level than we were before, in a better starting position for a future plan, which can be much more focused on certain issues. It is a necessary step, and this step had to be taken with such a broad perspective as the health Plan has*" City Council member of the Health and Consumer Affairs Area.
	Complexity	The complexity of implementing the plan has emerged repeatedly as a barrier. This complexity is attributed to the many cross-sectoral actions that the Plan integrates, the implementation of which depends to a large extent on the work of other municipal areas. As far as the Health and Consumption Area is concerned, the complexity of developing the new interventions specified in the Plan, without more resources, has also been pointed out. "*So many actions, uff.... It seemed to me, it still seems to me complicated, complicated, complicated to deploy. How could we have committed to do all this?*" City Council member of the Health and Consumer Affairs Area.

Individuals	Knowledge and beliefs	Although cross-sectoral action is widely recognised as being necessary and relevant, the individual attitude towards its practice is often rather negative. It is regarded as a mere procedure which generates work overload. "*I mean, it's always the same people who do it. Everything that is related to other areas, they always put it on me [...]. So, I give and receive a lot of hassle. I'm asking for data all day long*" City Council member from outside the Area of Health and Consumer Affairs.
	Self-efficacy	The degree of confidence of the Health and Consumer Affairs Area' staff in its own capacities to implement the actions of the Municipal Health Plan is, in some aspects, relatively low. It should be taken into account, however, that it is the first Plan, and that it includes many actions and responsibilities that are entirely new to them. "*It seems to me that first we need to be trained, because there is a lot to do, and of course, we have to do it well, right? We have to give support to other areas to... for example, carry out HIAs, but we don't even know how to do it ourselves!*" City Council member of the Health and Consumer Affairs Area.
	Individual stage of change	The predisposition to change is, in general terms, not very enthusiastic. *"Adding up these issues is difficult, in the daily routine... but this doesn't mean we have an unfavourable attitude, nor a negative one. It simply has to be done, and sometimes it is a pain in the ass, to put it colloquially, but well, anyway, it gets done*" City Council member from outside the Area of Health and Consumer Affairs.
	Individual identification with organization	One of the barriers identified in this regard is a lack of identification with the institution as a whole, has been identified linked to the aforementioned silos working model. "*I think that what is really missing is the philosophy of working as a whole, that we are not compartmentalised areas, but that the City Council is the City Council, that this is not my area and I do my own thing*" City Council member from outside the Area of Health and Consumer Affairs.

The main facilitators of the implementation of Bilbao's local health strategy in the pre-pandemic context were a certain mimetic pressure to move towards innovative approaches to urban health implemented in other cities, the existence of champions within the Health and Consumer Affairs Area, the formulation process of the Municipal Health Plan involving other municipal areas from the very beginning, and the establishment of referent interlocutors within the Health and Consumer Affairs Area to follow-up intersectoral actions. The main barriers to the local health strategy' implementation were the lack of a Basque Government Public Health Act to provide legal coverage and foster the City Council's health promotion competences (outer setting); a silo working model, with frequent structural reorganisations and staff turnover, and a lack of political commitment (inner setting); a complex and ambitious Municipal Health Plan considering the starting point in terms of governance for health of Bilbao's government, and difficulties related to the establishment of meaningful and shared indicators to assess its implementation and its impact (intervention); as well as an attitude towards change and innovation quite lukewarm (individuals).

7.1.3.b. Implementation-related challenges and opportunities of the COVID-19 pandemic context in Bilbao

Table 10. Implementation-related challenges and opportunities of the COVID-19 pandemic context in Bilbao

CFIR		Implementation-related challenges and opportunities of the COVID-19 pandemic context in Bilbao
Outer setting	Needs and resources of those served by the local government	The City Council acknowledged the impact that the pandemic, the measures implemented for its management, and the indirect consequences of those measures, have had on the health and equity of the population of Bilbao. Yet, it was assumed that the pandemic management rested primarily on the Basque Government, and therefore the role of the Bilbao City Council was essentially to facilitate it. It was deemed a responsibility of the city government to enforce regional guidelines, inform citizens, and respond to the increased demand for social services resulting from the social and economic impact of the pandemic. "*Areas that already had a more disadvantaged situation are going to see a greater increase, and this inequality is going to be more evident, [...] Inequalities in all areas, which means that there are going to be inequalities in health, it's obvious, right?*" City Council member of the Health and Consumer Affairs Area. "*We have a new city reality to which we must respond*" City Council member from outside the Area of Health and Consumer Affairs

	Cosmopolitanism	Communications, cooperation and coordination with the Department of Health, and with the OSI-BB of the Basque Health Service were strengthened to support and facilitate the management of the pandemic.
	External Policy	In the Basque Country, a large part of health competencies, including epidemiological surveillance, are centralised in the Basque Government's Department of Health, so that municipal administrations were relegated to play a minor role in the COVID-19 pandemic management.
Inner setting	Structural characteristics	For the Health and Consumer Affairs Area the pandemic has meant a substantial increase in workload, mainly linked to the execution of regional directives, the technical support provided to other municipal areas and the reorganisation of work within the Area itself to adapt to mobility restrictions and social distancing. But it also meant a significant cut in funding. All of this poses a major challenge for the development of the local health strategy. "*Well, not only is it going to be difficult for us to adapt to this new reality and reinvent ourselves, but we are going to have a smaller budget, so we will have to be more creative in order to be able to carry out the programmes*" City Council member of the Health and Consumer Affairs Area.
	Networks and communications	Communication with other stakeholders was reinforced by the overwhelming need for coordination, which has been identified as an opportunity to foster joint work. However, as far as specific programmes are concerned, the adaptation of the face-to-face mode remains a challenge which affects the most vulnerable population groups. "*We were still in the process of adapting to this new reality. A lot of the activities were face-to-face, the activities at school, with the elderly.... And it can't be done like we used to, right now it can't be done. And yes, we have to adapt to online, but with certain groups it just can't be done, particularly with the most vulnerable*" City Council member of the Health and Consumer Affairs Area.

	Culture	Although at a rhetorical level it has been repeated that "*we will get out of this situation together*", in practice the measures developed by the Bilbao City Council have lacked a perspective of equity, which mirrors the low degree of mainstreaming of the value of equity in the institution. "*Inequalities are there, but you have to want to see them, and then act, and I wouldn't say that this has been the case […] In fact, if you ask which groups are the most disadvantaged, they may answer hospitality, commerce, tourism… which, you know, up to now is what has been prioritised*" City Council member of the Health and Consumer Affairs Area.
	Implementation climate	The Health and Consumer Affairs Area considers that the COVID-19 pandemic has represented a major setback for the implementation of the Municipal Health Plan and, in particular, for activities related to health promotion. Paradoxically, other municipal areas see it as an opportunity for the Health and Consumer Affairs Area, as it has been given a greater visibility and influence within the City Council.
	Readiness for implementation	Despite the pandemic and the temporary halt it caused in the development of Bilbao City Council's activities, the implementation process of the Municipal Health Plan has continued. "*Well, we are working on it, but the reality is that we are lagging a long way behind with the Plan. It will be done, I think it will be done as much as possible*" City Council member of the Health and Consumer Affairs Area.
Process	Planning	One of the challenges that has been pointed out is the lack of disaggregated data by neighbourhood or other axes of inequality for the city of Bilbao, which could have contributed to a better understanding of the situation and to better planning from an equity perspective.
	Engaging	The context of the pandemic has favoured the emergence of several community networks, for example the informal care networks that have sprung up in different neighbourhoods. Networking with these new social actors in the city offers an opportunity to contribute to the development of community health. "*New networks have emerged. Here there were already networks that we worked with, but some have been strengthened and new ones have been created. This is our great opportunity, to know how to make the most of these networks, in order to precisely address actions that we had already contemplated in the Health Plan*" City Council member of the Health and Consumer Affairs Area.

	Executing	As far as local government is concerned, Bilbao City Council has mainly carried out information campaigns and commemorative events, and has also developed fiscal and financial programmes to support commerce and businesses. On the other hand, the Health and Consumer Affairs Area has concentrated on implementing the directives of the Basque Government's Health Department, on providing technical support to other municipal areas and on reorganising its internal work. Although the City Council has not played a prominent role in the management of the pandemic, this context is seen to have given relevance to the work carried out on the Health and Consumer Affairs Area.
	Reflecting and evaluating	The COVID-19 context has been identified as an opportunity to further develop community health, by positioning the neighbourhood level as a key level for municipal action, and by taking into account its health assets and its community networks. "*But looking at the positive side, we are also more aware that everything we do must be directed more towards the neighbourhoods, more a community-based way of acting. Probably we must also have to reinvent ourselves a little bit in this context, and we are in the middle of this process, and this COVID issue has given us a boost*" City Council member of the Health and Consumer Affairs Area.
Intervention	Innovation source	Although new functions have been taken over as a result of the COVID-19 pandemic context, the Municipal Health Plan has continued to be considered the cornerstone of the local health strategy.
	Adaptability	Due to the pandemic, Bilbao City Council, which had shown a certain degree of resistance to change, has had to adapt to new ways of working at many levels and in a relatively short period of time. This has shown a greater capacity for adaptation and change than was previously perceived in the institution. "*Because we were just starting to implement the Plan, we had just started and... this COVID thing came along and broke all our plans. But, well, we had to reinvent ourselves and we have done so*" City Council member of the Health and Consumer Affairs Area.
	Complexity	In addition to the perceived complexity of the Municipal Heath Plan itself, there is the added difficulty of developing the actions in the context of the required social distancing, which is perceived to be even more challenging. "*Now it is undoubtedly more complex to develop certain actions, and we also have more actions that are not included in the Plan that we are also in charge of*" City Council member of the Health and Consumer Affairs Area.

Individuals	Self-efficacy	Although it is acknowledged that the COVID-19 context has been stressful at various levels, being able to cope and adapt to new ways of working is perceived positively. "*At first I thought... What's coming crashing down on us? And in fact were complicated months, of a lot of work, of a lot of uncertainty... But hey, better or worse, we've been doing what we could, which is actually not little*" City Council member of the Health and Consumer Affairs Area.

The management of the pandemic was primarily placed in the hands of the Basque Government, with Bilbao City Council playing a secondary facilitating role, essentially by complying with and enforcing regional directives and responding to the increased demand for its services arising from the social and economic impact of the pandemic. In this context, the Health and Consumer Affairs Area has faced the dual challenge of responding to a substantial workload increase and coping with a major cut in funding, while reorganising these processes internally. Although the Municipal Health Plan has continued to be considered the cornerstone of the local health strategy, it has suffered a setback in its implementation. In the city, the context of the pandemic has led to the emergence of several community networks, which is seen as an opportunity to further develop community health despite all these challenges.

BARCELONA CASE STUDY

7.2. Barcelona

7.2.1. Barcelona governance for health context

This section describes the context of governance for health in Barcelona. It is structured in five parts; a) an introduction to the demographic characteristics and social determinants of health and the health status in the city; b) a description of the local government; c) its governance for health journey; d) a review of the current local health strategy and lastly; e) an overview of the governance for health in the context of COVID-19 pandemic.

7.2.1.a. Overview of demographics and social determinants of health and health in Barcelona

The beginning of the 21st century is characterized by a relative demographic stability in the city of Barcelona, with a slight general increase in population following the upward trend. In January 2020 the number of inhabitants of Barcelona city reached 1,666,530 people within the administrative limits, the highest number since 1990[(332)]. That makes Barcelona one of Europe's most densely populated cities with a mean population density of about 16,000 people per square kilometres and an average of 2.51 persons per household. Furthermore, the Barcelona metropolitan area has a population of more than 5.6 million, which is the largest on the Mediterranean Sea[(333)].

The average age of the population of Barcelona remains quite stable at 44 years, but there is an increase in the number of elderly people and the number of centenarians in the city has reached an all-time high; 863 people in 2020[(332)]. The gender structure of the population registered in Barcelona shows a slight global female superiority that increases within the older population (Figure 23).

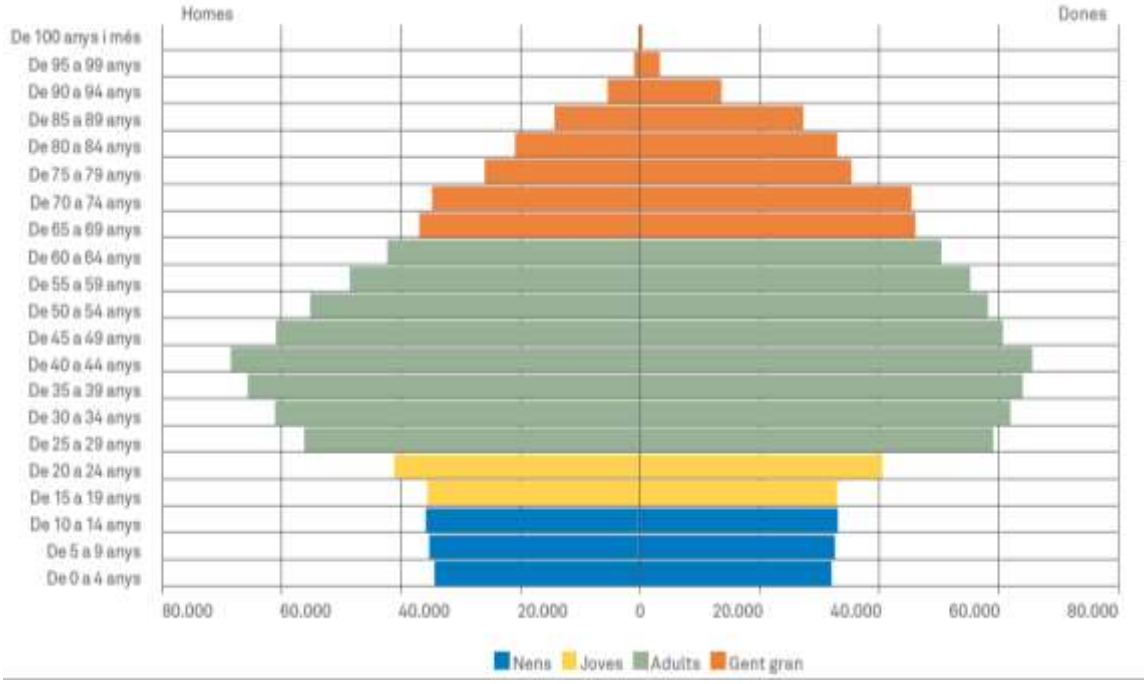


Figure 23. Pyramid of the population of Barcelona 2020. Source: Statistical Yearbooks of the City of Barcelona

A peculiar fact is that Barcelona has significant demographic daily fluctuations due largely to residents from the metropolitan region or broader Catalonia commuting for work, study or other reasons, but also due to the popularity of Barcelona as a tourist destination. Prior to the pandemic, over 9 million people visited the city annually in a clear upward trend[333].

The migratory movement in Barcelona is mainly driven by young adults leaving the city and going to other parts of Catalonia in the case of departures and by young adults coming from other countries in the case of arrivals. In fact, in recent years, Barcelona has experienced an increase in the number of registered residents of foreign nationality, which account for 21.7% of the total population[334]. In 2020, for the first time in the city's recent history, more than half of Barcelona's residents have been born outside the city. Indeed, the diversity of origins continues to be a distinctive feature of Barcelona city, with residents of about 180 different nationalities[332]. Those residents mainly come from Italy, Pakistan, China, France, Morocco, Colombia, Honduras, Venezuela, Peru, the Philippines and Argentina[334]. There is a heterogeneous special distribution of the foreigners, Ciutat Vella is the district with most foreigners both in absolute and relative terms.

Every day around 7.2 million journeys are made by people living in the Barcelona Metropolitan Area. The majority of accidents with injuries or deaths occurred during journeys on motorbikes[335]. It should be noted that in the past few years the Barcelona Superblock model[10] has recovered public space for pedestrians reducing traffic significantly in several neighbourhoods. Despite this, more than half of the city's population is exposed to levels of traffic noise above those recommended by the WHO[335].

Moreover, based on 2019 data, the quality of the air in the city of Barcelona is not particularly good, the concentrations of nitrogen dioxide exceed the recommended levels in the city's traffic areas, while the concentrations of suspended particles exceed the WHO recommended levels throughout the city. Indeed, air pollution is one of the main health problems in Barcelona, and it is estimated that the excess of air pollution with respect to the WHO recommendations causes 1,000 deaths annually. However, it is worth noting that during the COVID-19 lockdown period along the first epidemic wave, Barcelona experienced temporal but significant improvement in air quality[336].

With regard to housing, households located in Ciutat Vella, Nou Barris and Sant Andreu have the fewest square metres per person. In addition, one out of every ten households in Barcelona suffers from 'energy poverty', that is, having difficulty paying for electricity, water or gas. These households are mainly located in Ciutat Meridiana, Baró de Viver and Vallbona[335]. In 2016 Barcelona had a Disposable Household Income per capita estimated at €20,800. The recession widened the territorial inequalities, and the value of the disposable household income per capita per district ranges between the index 182.4 for Sarrià-Sant Gervasi and 55.0 for Nou Barris[333].

[10] The Barcelona Superblock model is an innovative urban and transport planning strategy that aims to reclaim public space for people, reduce motorized transport, promote sustainable mobility and active lifestyles, provide urban greening and mitigate effects of climate change. The Barcelona Superblocks were estimated to help reduce harmful environmental exposures, such as air pollution, noise, and heat, while simultaneously increase physical activity levels and access to green space, and thereby provide substantial health benefits[376].

Concerning work and labour conditions, serious and fatal occupational injuries have increased in Barcelona in 2019; half of these injuries were caused by accidents during the transfer from home to work, although occupational diseases related to mental health are also noteworthy. Before the COVID-19 pandemic there was a decrease in unemployment and an increase in temporary contracts[337]. Although updated employment statistics are not yet available for Barcelona in the current context, a major increase in unemployment is expected. Indeed, in economic terms, Barcelona entered 2020 with dynamism, generating employment and other economic indicators with a clearly positive trend. However, when the COVID-19 pandemic broke out in March 2020, all this dynamism came to a standstill. The paralysis of non-essential economic activity led to a 19.8% drop in Barcelona's GDP in the second quarter, especially marked in sectors such as construction, industry or services.

The city of Barcelona has great economic and social heterogeneity between neighbourhoods, with areas with a high level of well-being and other areas with significantly worse physical, economic and social conditions. In these latter areas is where the most disadvantaged and vulnerable population is concentrated, resulting in unhealthy environments and therefore creating territorial health inequalities.

With regard to life expectancy of people living in Barcelona, pre-pandemic data show an increase, standing at around 83.7 years for men and 87.3 for women. There is, however, an important variability according to districts; Ciutat Vella has the lowest life expectancy in the city while Les Corts has the highest. This difference in life expectancy by neighbourhood is over two years for women and five years for men. In 2019, perceived health slightly worsened, and also reveal differences between population groups; women had worse perceived health than men, and there were also differences by social class, so that people with more resources reported better perceived health than people with fewer resources[335]. This underscores the fact that health inequalities remain an unresolved issue in the city.

Half of the population of Barcelona has multiple chronic illnesses. The main chronic disorders among the population are high blood pressure and high cholesterol, followed by chronic back or neck pain, anxiety, depression and addictions. Alcohol is the leading cause of treatment for drug use[335,338]. In 2018, around 1,300,000 Barcelona residents used primary care services, hospital care, emergencies, social and health services, mental health or addiction services[335].

Barcelona is a highly populated city that has a growing population of over 1.6 million inhabitants within its administrative boundaries, as well as a large transient population. Inequalities in the physical, economic and social environment between neighbourhoods are important in the city of Barcelona. This in turn generates territorial inequalities in health, which are still an unresolved matter in the city.

7.2.1.b. Stakeholders relevant to local governance for health in Barcelona

Barcelona City Council

Barcelona City Council is the administrative and governing body of the municipality of Barcelona. The Mayor is elected by the members of the plenary among its members for a 4-year mandate duration the day the new municipal corporation is formed after the local election.

After the restoration of democracy in the mid-1970s, the first democratic municipal elections were held in 1979. From then until 2011, the Barcelona City Council was governed by a coalition of parties led by the Socialist Party of Catalonia. After a mandate from Convergence and Union (CiU), since June 2015 the Barcelona Mayor is Ada Colau, from the citizen municipalist platform *Barcelona En Comú*. She is the first woman to hold the office.

Barcelona City Council is organised according to a specific law, the Municipal Charter. A first version of this law was passed in 1960 and amended later, but the current version was approved in March 2006. The Municipal Chapter sets out the guidelines for the functioning of Barcelona City Council. It provides the local government a special relationship with the Spanish government, giving the Mayor wider prerogatives by the means of municipal executive commissions. It also expands the powers of the City Council in areas like telecommunications, city traffic, road safety and public safety. Besides, it recognises a special economic regime to the city's treasury and it gives the council a veto in matters that will be decided by the central government, which needs a specific favourable report from the council.

The Municipal Chapter also determines an organisational structure, differentiating between two levels, the political and the executive. On the one hand, the political level defines the strategy for the city, and is constituted of the councillors who are responsible for the deliberative functions of planning, programming and control. It is organised by governing bodies, which are the City Council, the Mayor, and the Government Commission (see Barcelona' Government Bodies on Annexes). On the other hand, the executive level is responsible for carrying out specific policies to meet the objectives set. The executive structure is composed of municipal managers who are in charge and coordinate the several municipal areas and districts, bringing day-to-day municipal management closer to the city's 73 neighbourhoods.

In addition to this structure, there is another level of local government competences, the Districts. Each District has its own political and administrative centre, functioning as a political entity with its own powers that helps to decentralise city politics. Barcelona is organizationally divided into ten districts, which not only allows an administrative decentralisation, but also encourages participation of citizens in decision-making by meeting the specific needs of each area of the city.

The City Council has created a range of subsidiary entities with their own legal identity, such as independent bodies, municipally owned business entities and municipal trading companies. Furthermore, the local government has direct or indirect holdings for the purposes of participating in decision-making in areas where it may be affected or collaborating with other authorities or private entities in areas of mutual interest or shared jurisdiction. The City Council can participate in these holdings to different degrees and in different proportions according to the undertakings. Barcelona City Council is also represented in several consortiums, foundations and associations (see Barcelona' Subsidiary Entities Organization on Annexes).

As far as health is concerned, the Counsellor for Health, Ageing and Care is the political head of the Health Area, and defines the political priorities related to health in the Municipal Action Plan (Pla d'Actuació Municipal – PAM). The Counsellor holds the presidency of the Barcelona Public Health Agency and the vice-presidency of the Barcelona Health Consortium, entities that are to be presented below. Gemma Tarafa is currently the Counsellor. On the other hand, the Directorate of Health Services promotes the City Council's health policies and the reduction of health inequalities. The Health Department promotes different city plans, programs, strategies and campaigns.

Other stakeholders relevant to local governance for health

In terms of public health, there are quite strong institutional links between the Barcelona City Council, the Public Health Agency of Barcelona, the Department of Health and the Public Health Agency of Catalonia, with mutual accountability through officer participation on governing boards. Territorial links with direct funding of territorial functions are also evident.

Thus, in the city of Barcelona governance for health involves different actors beyond the City Council.

> *"Municipal health has two main actors: the Barcelona Public Health Agency, which is responsible for public health, and the Barcelona Health Consortium, which is responsible for healthcare. These are mixed between the City Council and the Generalitat [Government of Catalonia], with different proportions in terms of both budget and representation"* City Council Member.

The Public Health Agency of Barcelona (Agència de Salut Pública de Barcelona - ASPB) is an autonomous body established to manage public health and environmental services in the city. In these areas it concentrates the responsibilities and resources of the City Council of Barcelona (60%) and the Department of Health of the Generalitat de Catalunya (40%) in a single consortium. It was created in 2002, when the Municipal Institute of Public Health was integrated in the Barcelona Territorial Laboratory of the Department of Health. Hence, the Barcelona City Council centralized its public health services and responsibilities in the Public Health Agency of Barcelona, which has the responsibility for public health services that in the rest of Catalonia are carried out by the regional services (the ASPB organization chart can be found in Annexes).

The Observatory on Health and Impacts of Municipal Policies (Observatori de Salut i impacte de polítiques - OBSIP[338]). It was created in 2016 by the Health Directorate of the Barcelona City Council and the Barcelona Public Health Agency as a tool aiming to foster accountability of public policies. The OBSIP is located within the Public Health Agency, and its main purpose is to monitor the state of health and health equity in the city, as well as the impact on health of specific public policies implemented by the City Council.

The Barcelona Health Consortium (Consorci Sanitari de Barcelona - CSB) is a public body of the Generalitat de Catalunya (60%) and Barcelona City Council (40%), and it is attached to the Catalan Health Service. The Barcelona Health Region is divided into two territorial areas, the Metropolitan area and the Barcelona City area, the latter being managed by the Barcelona Health Consortium.

Besides these, there are other bodies and entities in which the City Council, and particularly the Health Directorate has representation in their governing bodies. These are; Parc de Salut Mar,

Hospital de la Santa Creu i Sant Pau, Consorci de Salut i Social de Catalunya, Assemblea Local de la Creu Roja, Parc de Recerca Biomèdica de Barcelona, Fundació IS Global and Fundació Pasqual Maragall. All these entities, as well as others in which the City Council has no formal representation are involved in the city's governance for health, although they play a relatively minor role in relation to the above-mentioned stakeholders.

Barcelona City Council is the administrative and governing body for Barcelona city. It is organised according to the Municipal Charter, a specific law that expands the powers of the City Council which encompass most of the wider determinants of health. The Counsellor for Health, Ageing and Care is the political head of the Health Area, and she holds the presidency of the Barcelona Public Health Agency (ASPB) and the vice-presidency of the Barcelona Health Consortium (CSB). These are core stakeholders for local governance for health, both mixed bodied between the Barcelona City Council and the Catalan Government.

7.2.1.c. Governance for health trajectory in Barcelona

Barcelona has a long history of local governance for health, which can be illustrated by reports on population health and its determinants such as the medical topography[11] of Laureano Figuerola, later taken up by Idefonso Cerdà in his General theory of urbanisation[339]. Yet, a key milestone for local health governance, and the starting point for this analysis, is the recovery of municipal democracy in the late 1970s.

In the context of devolution enacted by the 1978 Spanish Constitution and initiated with the first transfer of competencies from the central government to the Government of Catalonia, the city of Barcelona made public health a political priority[340,341]. This facilitated the establishment of geographic health information systems, the implementation and consolidation of the Health Interview Survey which is carried out every 5 years, as well as the publication of the Annual Health Report of Barcelona. Thus, studies on the health of the city were promoted, documenting not only the state of health of the populations but also highlighting the causes of the problems.

Throughout the 1980s, the Councillor for Health, epidemiologist Joan Clos had a significant political influence in the local governance for health. He played a major role promoting actions for developing the autonomous health service in the city, seeking to ensure that preventive interventions of proven effectiveness would reach the entire population, reducing social inequalities in health and developing a comprehensive information system that would make it possible to detect problems and intervene in them. He also sought to introduce elements of intersectoral action in health, although this was only partially achieved.

Already at that time, Barcelona stood out as a pioneering example of how to combine the analysis of health inequalities with political action. A paradigmatic example of this was the comprehensive program to increase access to health and social services for pregnant women and for the children implemented in the low income District of Ciutat Vella. The evaluation of this program showed a significant reduction of infant and perinatal cumulative mortality rates

[11] Medical Topographies are studies of specific geographical locations and their populations, which are approached from a hygienic-sanitary perspective, to prevent disease and promote local health. These studies usually include a physical description of the place and its biological environment, the historical background, the temperament and moral character of its inhabitants, customs, living conditions, demographic movements, prevalent pathologies and patterns of disease distribution.

between Ciutat Vella District and the rest of the city, before (1983-86) and after the intervention (1987-89, 1990-92)[342]. Barcelona also demonstrated its leadership in urban health by promoting the creation of the WHO Healthy Cities Network, which was launched in 1988 with the presence of the city from the outset.

In 1990 the Parliament of Catalonia approved the Catalan Healthcare Order Act (LOSC), a legislation landmark that redefined the roles of planning, purchasing and provision of health care, calling to create the Catalan Health Service and making the Health Plan the main health planning tool[343]. The first Catalan Health Plan was formulated in 1993. According to the LOSC, regional health councils must approve and adopt regional-adapted versions of the health plan. Health regions are the first level of territorial organization in health administrative terms, and sub-regional levels (municipalities and counties) have a less clear function concerning the implementation of the health plan activities except for capital cities where municipalities play a major role in collaboration with the regional authority as in Barcelona[343]. Hence, throughout this period, the institutional collaboration with those responsible for planning the regional health service in the city was also established. Barcelona also monitored the implementation of the Health Plan activities broken down by the city's 10 districts and 66 basic health areas, and this description made it possible to highlight the inequalities in health within the city.

In 1998, the Municipal Institute of Health became the Municipal Institute of Public Health and a few years later, in 2002, it became the Public Health Agency of Barcelona (ASPB). As an autonomous body concentrating the responsibilities and resources of the City Council of Barcelona and the Department of Health of the Generalitat de Catalunya in the City, and its foundation certainly marked a landmark in Barcelona's leadership of governance for health equity. Throughout all these years, Carmen Borrell, current manager of the ASPB, has been an essential contributor to the consolidation of the study and intervention on the wider determinants of health, building internal capacity and promoting culture change.

It is interesting to mention that in 2004 the left-wing tripartite government of the Generalitat de Catalunya launched the *Neighbourhoods Law* (Llei de barris)[344], which involved an urban renewal program aimed at improving the physical and social conditions of neighbourhoods in Catalonia, financing 12 low socio-economic neighbourhoods in the city of Barcelona. The *Neighbourhoods Law* also had two complementary programs; *Work in the Neighbourhoods* and *Health in the Neighbourhoods* (Barcelona Salut als Barris)[345]. The evaluation of these urban renewal policies in the city of Barcelona showed an improvement in terms of perceived health and mental health as well as health equity[346].

Indeed, among all the actions, programs and initiatives carried out by the ASPB, the above-mentioned community health the program *Barcelona Health in the Neighbourhoods* deserves special attention. This program was launched in 2007 and for the past fourteen years it has been implemented in the Barcelona's most vulnerable neighbourhoods in order to reduce social inequalities in health. Initially it was funded by a research grant and the funds were maintained during the economical crisis and were tripled when the programme became a political priority in the last municipal government[347]. It is also partially funded by the Department of Health of the Generalitat de Catalunya. The programme was expanded from 12 to 25 city neighbourhoods with the creation of the *City Neighbourhoods Act* at the beginning of the Colau government's term of office. Until now more than 500 people, organisations and public services have participated in this initiative[335].

Since the creation of the ASPB, the data on health inequalities in Barcelona has also greatly improved, however this did not always necessarily lead to a prioritization in the political agenda.

In 2015, coinciding with the arrival in government of a new left-wing party (Barcelona en Comú), the reduction of health inequalities was pushed up the political agenda[340].

> "*The current government is different, but before certain visions were limited, for example, those related to the study and promotion of interventions with a perspective of inequalities. Before it was not possible to move in that direction because there was a political constraint. I think that has changed radically since 2016, and it has been very noticeable in terms of the scope of public health in municipal action*" ASPB member.

It was at this time when the Observatory of Health, Inequalities and Impacts of Municipal Policies (OBSIP) and was set up by the Health Directorate of the Barcelona City Council and the Barcelona Public Health Agency. The OBSIP is one of the concrete actions included in the Government's Joint Action Measure for the Reduction of Social Inequalities in Health 2015[348].

It was also about that time that the Urban HEART could be used, which is a tool that allowed to identify urban inequalities in the city of Barcelona and to include health inequalities in the public debate[349]. This also allowed to reinforce the community health programme Health in the Barcelona Neighbourhoods as well as other city programmes aimed at reducing health inequalities.

Since then, the combination of political will, technical capacity and the impulse of citizens have enabled the development and implementation of policies to tackle social inequalities in health in the city of Barcelona[340]. Hence, in order to reduce the social inequalities in health that still exist in the city of Barcelona, the Health Department collaborates with other areas of the City Council and social actors in the city. Likewise, the City Council also works closely with the Barcelona Health Consortium to improve the quality and accessibility of healthcare.

> "*The Health Directorate of the City Council used to be just a person... Now they are a whole team. The Councillor for Health has a very important weight in the new government team, and this is noticeable*" ASPB Member.

With this favourable backdrop, Barcelona has made significant progress in tackling health inequalities through measures such as the aforementioned Government's Joint Action Measure for the Reduction of Social Inequalities in Health 2015[348], but also reviewing the different sectoral plans to determine points of convergence and impact on health (2016-2017), the ASPB's Plan for tackling inequalities[350], or the Barcelona Strategy for Inclusion and Reduction of Social Inequalities 2017-2027[351].

Since the recovery of municipal democracy, public health has been one of the city's political priorities. Barcelona was one of the founding cities of the WHO Healthy Cities Network and, over the years, has developed a comprehensive information system that has enabled better detection, monitoring and planning of actions to intervene in health inequalities. The leadership of the ASPB moving health equity forward in the city of Barcelona, and a political commitment to tackle health inequalities, which has been particularly noticeable since 2015 should be stressed.

7.2.1.d. Barcelona's local health strategy

In the Barcelona local health strategy two levels of policies can be distinguished. On the one hand there is the Barcelona Health Plan (Pla de Salut de Barcelona), which is based on the Catalan Health Plan and incorporates a set of specific actions to respond to the political priorities of Barcelona's local government. On the other hand there is the Municipal Action Programme (Programa d'Actuació Municipal), a strategic policy of Barcelona City Council, which takes a broad approach to health and its determinants.

Pla de Salut de Barcelona

Given that the Barcelona Health Plan[301] is an adaptation of the Catalan Health Plan[352], to properly understand the Barcelona Health Plan, it is necessary to contextualise health planning in Catalonia.

As indicated in the previous section, the Catalan Healthcare Order Act (LOSC) established the Health Plan as the main strategic health planning instrument for health interventions[343]. Up to now, seven consecutive health planning cycles have been completed (Figure 24). The Catalan Health Plans define the strategic guidelines that are implemented in the different health regions, thus the Barcelona Health Plan is fully aligned with the 2016-2020 Catalan Health Plan[301,352].

Period	Description	Planning cycle	Health plans	Duration (years)
1979-1990	Devolution of health competencies	–	None	-
1991-2001	First health plans	0 1 2 3	1991 1993-1995 1996-1998 1999-2001	3 years
2002-2010	Consolidation of health planning	4 5	2002-2005 2006-2010	4 years
2011-2015	Oriented to health services	6	2011-2015	5 years
2016-2020	Oriented to health services and health policy	7	2016-2020	5 years

Figure 24. Catalonia's Health planning timeline[343]

It should be emphasised that throughout these periods there has been an increasing focus on health equity in the Catalan health planning, at least at the level of values (symbolic content). Following the approval of the Interdepartmental and Intersectoral Public Health Plan (PINSAP)[353][12] of the Public Health Agency of Catalonia on 2014, the 2016-2020 Health Plan[352]

[12] The Interdepartmental and Intersectoral Public Health Plan (PINSAP) is an initiative of the Public Health Agency of Catalonia to promote HiAP and to encourage the reorientation of the health system towards health promotion and community health. It also seeks to tackle health inequalities and to promote healthy public policies at the local level.

incorporated for the first time an explicit commitment to strengthen strategic health policy to address the social determinants of health through intersectoral action. The 2016-2020 Catalan Health Plan[352] is set around 12 strategic lines, priority areas and specific projects (Figure 25).

Figure 25. Catalan Health Plan 2016–2020 strategic lines[343,352]

The leadership, monitoring and evaluation of the development and implementation of these lines in the city of Barcelona falls mainly to the CSB. But all stakeholders of Barcelona health governance play a role not only monitoring the implementation of the health plan activities, but notably in health planning. Thus, the Barcelona Health Plan 2016-2020[301] has, in addition to the lines set out in the Catalan Health Plan, a set of specific actions to respond to the political priorities in the city of Barcelona.

> "*The Catalan Health Plan always goes alongside the Barcelona Health Plan […]. The Generalitat sets a lot of the Health Plan, what the health regions have to do... And in Barcelona, we are looking for room to stand out and make a difference. That is our role as an Agency*". ASPB Member.

The development of the 2016-2020 Barcelona Health Plan (Figure 26) began in November 2014, in the 4th annual meeting of the Health Plan. It brought together 400 participants from the health administration, health care providers, scientific societies and professional associations, industry, patients' associations, different departments of the Government of Catalonia, universities and the local community to assess the 2011-2015 Health Plan and to define the priority issues to be

incorporated in the new Health Plan. After the establishment of the strategic guidelines a period for comments and reviews via a dedicated website was opened.

At the start of a new legislature in January 2016, the proposal was revised in line with the new priorities of the current Government, which strengthened aspects such as the fight against inequalities in health, citizen participation and intersectoral work, among others. The health region also participated in drawing up the Health Plan. In addition, the Barcelona Health Plan was validated by the territorial participation councils and the Department of Health. Finally, it was submitted for approval by the Executive Council of the Government of Catalonia and presented to the Health Committee of the Parliament of Catalonia.

Figure 26. Pla de Salut de Barcelona (2016-2020)[301]

As a result of this joint work between the Barcelona City Council, the ASPB and the CSB, the 2016-2020 Health Plan sets out 10 specific measures for the city of Barcelona. The leadership, monitoring and evaluation of the development and implementation of these measures in the city of Barcelona falls mainly to the ASPB. These are the following:

1. Reduce inequalities in health, prioritising actions in the neighbourhoods identified as having the worst socio-economic and health indicators.

2. Include the community approach to improving health by reorienting the primary health care model to promote the community dimension and by considering public health actions as part of a strategy of networked work and community participation.

3. Guarantee universal, equitable and quality public health care.

4. To guarantee integrated social and health care.

5. Introduce actions aimed at improving sexual and reproductive health and the prevention and care of sexually transmitted diseases.

6. Define actions aimed at improving the mental health of the population as well as care for people affected by mental health problems, including addictions.

7. Improve the model of prevention, detection, care and recovery of gender violence, children and the elderly.

8. Reinforce actions to improve environmental health. Control and analysis of the different elements that make it up and establish mechanisms for communication and dissemination to the population.

9. Advance in occupational health actions in order to improve the health and well-being of people in relation to work and contribute to creating a working environment that protects health, facilitates and reinforces healthy choices and ensures respectful and fair treatment.

10. Advance in the improvement of information systems using technological tools to enable health monitoring, prioritisation and evaluation of interventions and better and transparent communication of results.

These ten strategic measures of the Barcelona Health Plan are priority areas to be worked on in coordination with other city stakeholders. They are therefore closely linked to another Barcelona's key policy for the city's governance for health strategy, the Municipal Action Programme. It also connects with other specific operational Plans related to health in Barcelona.

> "*The Barcelona Health Plan draws from the Catalonia Health Plan, and is written by the Consortium together with the Agency. In the latter plan, a special effort was made to formulate a section that consisted of ten specific actions for the city of Barcelona. This section was quite inspired by the Municipal Action Plan*" City Council member.

> "*The Health Plan is the umbrella for other specific operational plans, such as the Mental Health Plan, the Drug Addiction Plan, the Sexual Health Plan, the Community Health Plan...*" ASPB Member.

Programa d'Actuació Municipal

The Municipal Action Programme (Programa d'Actuació Municipal - PAM) (Figure 27) is the strategic policy document that sets out planning for municipal action over the coming years and establishes the key actions and projects to be carried out during the municipal term of office.

The current 2020-2023 PAM+[302] is a somewhat atypical PAM, shaped by the need to respond to the pandemic. Indeed, the health crisis caused by COVID-19 led to the interruption of the ordinary process of developing and approving the renewal of the previous PAM, which covered the period 2016-2019. Thus, the PAM 2020-2023, which was pre-approved, could not be ratified due to the pandemic and it was put on hold for ratification throughout 2020. However, as it was formulated, this PAM turned out to be less suitable for its purpose. The new context highlighted the need to redefine and reformulate the priorities of the mandate in accordance with the new needs arising from the pandemic. Thus, the previously established priorities were reviewed and updated in a new 2020-2023 PAM+, that was finally ratified in February 2021.

Figure 27. Programa d'Actuació Municipal de Barcelona 2020-2023(302)

The process of developing the PAM usually begins with an initial proposal drawn up between the Councillors, the Directorates and the technical part, the result of a process of technical-political contributions. Then, this document is opened to a participative process, through the platform *Decidim Barcelona*[13] and through several participative sessions held in the different Districts. This participatory process provides input, generally in the form of support for existing initiatives that have already been formulated by the government team or in form of new proposals. These inputs return to the governing team, which can either validate and incorporate the new proposals, as they have been formulated or as a nuance within an existing proposal, or it can reject them and explain why these were not included. This document then returns to the Government, and must be approved by the Plenary.

The exceptional circumstances of the pandemic significantly altered this process, both in terms of the participatory processes and in terms of its political approval. Nevertheless, the 2020-2023 PAM+ is a Plan in force and a core component of Barcelona's health strategy.

> *"The new PAM of the City Council [PAM 2020-2023] had a difficult birth… A difficult birth because there was the initial proposal of the government team, the participatory process had begun and then the pandemic arrived... And in the end, we ended up making an adapted PAM, which was a kind of mixture between the initial one, the one adapted to the circumstances [of the repercussions of the pandemic] and the Pact for Barcelona*[14] *that the parties had made during the pandemic... And that's how it turned out. […] I think that with all these COVID issues the current PAM was not even approved by the Plenary,*

[13] *Decidim Barcelona* is Barcelona City Council's digital participation platform that aims to build a more democratic city. It is a collaborative project based on open code, which means that any citizen can see how it is built, reuse it or improve it. This platform was launched as part of the development of the Municipal Action Plan 2015-2019 and involved the participation of 40,000 people.

[14] In July 2020, in order to respond to the consequences of the COVID-19 epidemic, the municipal political groups of Barcelona City Council promoted a process of dialogue and consultation between the city's main actors in order to formulate a city Pact. The resulting *Pact for Barcelona* aims to give new impetus to the city in all areas in order to achieve social and economic recovery. It is a large consensus on immediate priorities that allows synergies and joining talent and resources beyond the city's municipal competencies.

it was said… well, this is the result, and it remains like that, as a strategic document" City Council member.

The 2020-2023 PAM+ aims to consolidate the process of transformation of the city by focusing on the strategic challenges that can function as levers of change for recovery[302]. The document is structured in six main axes:

1. *Recovering the economy by making it stronger, more resilient and more diversified*. This first axis includes elements of Economic promotion, creative industries and competitiveness, Green and circular economy, Social economy, Employment of quality, Trade and markets, consumption and food, and Tourism. This axis is a commitment to strengthen the economic fabric, particularly focusing on local commerce and innovative sectors, promoting the internationalisation of creative and cultural industry, and quality and diverse tourism, and creating quality and sustainable employment.

2. *Strengthening care and resources for social inclusion*. This second axis integrates interventions in the areas of Social inclusion, Elderly people and ageing, Disability, Health and care, Feminism, Childhood, Adolescence and youth, Migration and reception, Sexual and gender diversity, LGBTI, Combating loneliness. It aims to protect social rights by reinforcing the social and health care model, focusing on the most vulnerable people, placing care at the centre of political action, and strengthening social and health services in the city.

3. *Accelerating the ecological transition against the climate crisis*. This third axis addresses issues such as Sustainable and safe mobility, Urban green and biodiversity, New energy model, Ecological transition and Zero waste. It seeks the implementation of an urban model with a human dimension that prioritises environmental health through clean, sustainable and safe mobility, the extension of the urban green, the rehabilitation and energy efficiency of buildings, and decarbonisation.

4. *Strengthening an educational, cultural, scientific and sporting city*. This axis includes elements of Education, Science, Culture, Sports, Democratic Memory, Interculturality and religious pluralism, as well as Citizenship Rights. It aims to promote the right of citizens to access and participate socially, communally and professionally without discrimination, articulating the associative and professional fabric with public programmes.

5. *Making a friendlier and safer city from the neighbourhoods and with a metropolitan vision*. This axis is the umbrella that encompasses *Pla de barris*[354], Coexistence, civility and safety, Housing, rehabilitation and combating gentrification, Urban regeneration and Metropolitan actions. It seeks a model of a city on a neighbourhood-scale, that is a closer and more human, cohesive and healthy city not only where to stay but also where to live, reclaiming public spaces by and for the community.

6. *Promoting an open city, with a digitised administration*. This last axis includes elements of governance such as Public administration close to the people and solvent, Digital transition and technological innovation, Gender mainstreaming, Transparency and good

governance, Participation, community action and democratic innovation, Global justice and Agenda 2030. Thus, this axis seeks a modern administration and an accessible, transparent and participatory governance, with an international commitment and aligned with the SDGs.

Barcelona's current health strategy consists mainly of two strategic documents, the Barcelona Health Plan and the Municipal Action Programme (PAM). The Barcelona Health Plan follows the lines, priority areas and objectives of the Catalan Health Plan, but also incorporates a set of specific actions to respond to the political priorities of Barcelona's local government. Thus, in the Barcelona Health Plan 2016-2020 aspects such as the health equity, citizen participation or intersectoral work have been strengthened. In addition, there is the Municipal Action Programme, which is a strategic policy of Barcelona City Council that adopts a broad approach to health and its determinants. The current 2020-2023 PAM+ was shaped by the need to respond to the pandemic.

7.2.1.e. COVID-19 pandemic and governance for health in Barcelona

In Barcelona, the Public Health Agency of Barcelona (ASPB), and specifically its Epidemiology service, is the responsible entity for the surveillance and control of communicable diseases. At the end of January 2020, the epidemiology service of the ASPB was responding to an increase in calls from professionals who were concerned about the return of citizens residing in Barcelona from the Chinese New Year, which was celebrated on January 25th. On January 27th, the Department of Health held its first meeting of the Committee for the analysis and monitoring of high-risk emerging communicable diseases. A few days later the first confirmed case of COVID appeared in Spain, one month after the first cases were detected in China. After considerable discussion the Mobile World Congress, an annual major event for the city of Barcelona, which was scheduled to be held in February, was cancelled. On 25th February the first case of COVID-19 was identified in Barcelona.

Two days after the first case of COVID-19 in the city of Barcelona, on February 27th, a Crisis Committee was created at the ASPB. The functions of the Crisis Committee were mainly to manage reinforcements for COVID-19 epidemiological surveillance, to coordinate work with different institutions and levels of government, and to lead external communication in relation to COVID-19 through web-based dissemination of relevant information[355].

As COVID-19 cases spread, so did the workload of the Epidemiology Service which continued to increase exponentially. Initially their teams were reinforced with five nurses and one doctor but, not much later, the Epidemiology Service had to be reinforced with staff from all the agency's services.

On March 14th, the Government of Spain announced a state of alarm in response to the spread of the COVID-19. At that point, coordination committees were set up at various levels: the inter-institutional crisis committee, the ASPB's internal crisis committee, the technical office for the management of COVID-19 in Barcelona, the technical office for residences and the EduSalud-Barcelona office.

There were 12,927 diagnosed cases of COVID-19 during the first wave in Barcelona. One group that was particularly hard hit were the elderly people living in nursing homes. On June 22nd the alarm status ended, but in July there was once again an increase of cases. The second wave arrived in October 2020. At that time, the local government was in a better position to cope with it than during the first wave. Indeed, reinforcements were already organised in the Epidemiology Service, contingency plans were established, individual protection materials were available, 18 hotels were adapted to handle quarantine and health care for uncomplicated COVID cases, the capacity of hospitals was expanded with municipal pavilions adapted for healthcare, etc. And yet, the second wave in its wake left 48,645 diagnosed cases of COVID-19.

> "*When the second wave hits, which is from the summer onwards, things have already changed quite a lot; we already have a contract with Atento to be able to call all the COVID sick people, we have new staff to reinforce the epidemiology service, the Generalitat de Catalunya has set up the contact-tracers, and we are also about to start a new service, a new COVID surveillance program in which up to 30 people participate*"
> ASPB Member

Although it became evident from the beginning of the pandemic that some of the consequences of COVID-19 had an unequal impact on the population, these social health inequalities were particularly accentuated in the second wave. An analysis carried out by ASPB highlighted the existence of social inequalities in the incidence of COVID-19 by age group, gender, geographical area, and income in the city of Barcelona[356].

The following chart (Figure 28) shows the evolution of confirmed cases of COVID-19 in the city of Barcelona practically since the beginning of the epidemic. It displays the first two waves mentioned above, a third wave at the end of January 2021, as well as a less important fourth wave at the beginning of April.

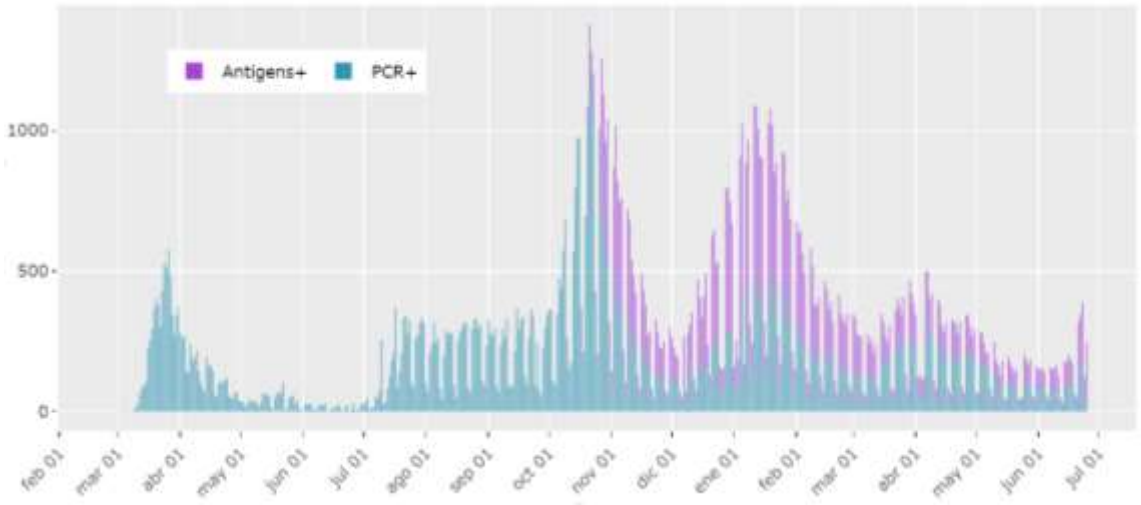


Figure 28. Evolution of confirmed cases of COVID-19 in the city of Barcelona[355]

The COVID-19 pandemic has generated a major health crisis in Barcelona, which has affected especially people living in residential centres and on the elderly, overstretching the capacity of the city's health and social services to respond in the most critical moments. From the start of the pandemic until October 2020, excess mortality in the city exceeded 3,600 cases.

The city's local government is aware that the consequences of the epidemic are not exclusively health-related, but also socially and economically, and that these consequences disproportionately affect certain groups of the population. Interventions in response to the crisis have sought to integrate this equity perspective. This is shown by the fact that Barcelona City Council has articulated a response to the social and health needs of the population which focus particularly on the needs of the most vulnerable population. Moreover, in October 2020 Barcelona City Council allocated €35m to the Social Shock Plan (Pla de Xoc Social)[357] to tackle the most pressing needs of the citizens. This plan focused particularly on the most vulnerable populations.

The start of vaccination has marked a turning point (Figure 29) and has enabled a New Normal. However, this social, economic and health crisis has forced the local government to rethink long-term priorities.

Figure 29. Evolution of the percentage of men and women with complete COVID-19 vaccination in Barcelona

Although the vaccination strategy in Barcelona was conceived as a universal campaign, for everyone and at no cost, it did not take an equity perspective from the outset, generating inequalities between territories in the city. Once again, the analysis of the data made it possible to bring these inequalities to light and to establish measures to correct them, evidencing once again the importance of proportional universalism.

Like many other cities, Barcelona was not prepared to deal with an epidemic of this scale. Despite this, the ASPB, as the main body responsible for public health in the city, led the health response to the COVID-19 crisis in Barcelona responding quite quickly and coordinating with other actors. Since data from the pandemic began to be available, the impact of COVID-19 proved to be uneven across the population, increasing health inequalities. It also became evident that the social and economic consequences of the pandemic exacerbated the already existing inequalities in the city. Several political measures were taken by the Barcelona City Council to try to deal with this situation, notably the Social Shock Plan.

7.2.2. Analysis of key dimensions of governance for health equity in Barcelona's local health strategy

This section analyses the extent to which the key dimensions of governance for health equity, have been incorporated into the current local health strategy of Barcelona. In order to do so, an adaptation of the Storm's Maturity Model for HiAP[306] has been used to asses policy coherence. Accountability has been assessed using the Ebrahim and Weisband's core components of accountability[128] and the accountability domain of the PAHO Equity Commission's rubric[133]. As a final point, the Health Canada's Public Involvement Continuum[307] has been applied to asses social participation. The local health strategy' documents analysed with these tools were the Barcelona Health Plan and the Municipal Action Programme. To provide an enriched view of policy coherence, accountability and social participation in Barcelona's local health strategy, this assessment was complemented by a thematic analysis of the interviews.

7.2.2.a. Policy coherence

The following table summarizes how the components of policy coherence have been included in Barcelona's local strategy documents, using an adaptation of Storm's Maturity Model for HiAP scale[306] (Table 11).

Table 11. Policy coherence in Barcelona's local health strategy

Barcelona's local health strategy		
Stage	**Policy coherence components**	
Recognition	Importance of policy coherence recognized to reduce health inequalities	Barcelona's health strategy recognises the importance of an intersectoral approach to improving health and equity, and this is stated in both the 2016-2020 Health Plan and the 2020-2023 PAM+. Already in the *Inspiring principles* Section of the Barcelona Health Plan it is explicitly mentioned: "*Improving the health of a community and ensuring that this improvement is achieved in an equitable way does not depend solely on the health system. A multilateral focus is needed with an approach known as Health in All Policies*". In fact, one of these principles is "*Establish the social causes as the main factors that determine health inequalities in a community*". The MAP also takes up this idea, albeit implicitly; all the main operational lines have at least a set of actions linked to SDG3 - Health and well-being, SDG10 - Reduced inequalities, SDG11- Sustainable cities and communities, and SDG17 - Partnerships for the goals.
	Visible which activities of sectors contribute to (determinants of) health inequalities	
Consideration	Policy coherence / Intersectoral action described in policy documents	Line 12 of the Health Plan specifically addresses *Interdepartmental and intersectoral policies* as a key mechanism for guaranteeing health equity. Likewise, within the specific strategic actions for the city of Barcelona, it is worth

	Collaboration with sectors present (project-based) Collaboration on health inequalities is started Activities of sectors contribute to determinants of health inequalities	highlighting point 1.1, which seeks the *Coordination with other areas of government to tackle social inequalities in health*. The PAM itself has an interdepartmental nature, gathering actions from different areas of the City Council for "*a city that is friendlier, healthier and more resilient*", and it also seeks to involve social and economic local actors. Besides this, the ASPB has developed a plan for tackling inequalities[350] which includes interventions to mainstream equity across ASPB's services. There is no similar plan in the City Council of Barcelona.
Implementation	Concrete collaboration agreements Structural consultations forms present Key person or group ensuring policy coherence (role is clear) Working from sectors on health inequalities (policy basis)	The aforementioned line 12 of the Health Plan aims to reinforce the tools to support the incorporation of the HiAP approach and it comprises intersectoral collaboration agreements such as the Interdepartmental Public Health Plan (PINSAP), the Interdepartmental Plan for Social and Health Care Assistance and Interaction (PIAISS), or community health projects such as COMSalut, to name just a few. Among the mechanisms for implementation stated in the Health Plan, the Health Impact Screening Test (TestSalut) should be noted within this line 12, and the *Observatory of Health, Inequalities and Impacts of Municipal Policies* within the strategic actions for the city of Barcelona. On the other hand, the PAM is a kind of more generic document and does not go as far as detailing the mechanisms for implementing policy coherence. Neither there is a structure for intersectoral action for health within the City Council, nor are staff specifically assigned to this task. Meetings for intersectoral work for health within the institution take place on a more informal basis, usually to discuss specific issues.
Integration	Broad, shared political and strategic vision Policy coherence results visible (both content and process)	Despite the lack of structure for sectoral action for health, the local government of Barcelona has a clear political commitment and strategic vision to move forward health equity. This is particularly evident in the ASPB' activities. In fact, the first strategic action for the city of Barcelona established in the Health Plan is "*Reducing inequalities in health, prioritising actions in the neighbourhoods identified with the worst socio-economic and health indicators"*. In turn, the PAM incorporates, in a more or less explicit way, an equity focus in all of its strategic axes. The way in which the PAM is developed and monitored, entailing the participation not only of different sectors within the municipality but also of other local actors and civil society, may indicate that policy coherence does indeed go beyond the symbolic content.
Institutionalizat	Political and administrative	There is no doubt that health and equity are values ingrained in the current local government of the city of Barcelona, and this

	anchoring of the HiAP approach	is reflected in both the Health Plan and the PAM. The analysis of the impact of policies in terms of reducing health inequalities is also quite systematised, in particular through the ASPB's work. This facilitates processes of continuous improvement and action-oriented policies with an equity perspective.
	Continuous improvement of integral processes and results on the basis of the achieved results	

In order to provide an enriched view of policy coherence in Barcelona's health strategy, the results set out in the table are complemented and further developed by the results of the thematic analysis of interviews with key informants involved in the development and/or implementation of the local health strategy.

The Barcelona Health Plan and the PAM are a fair reflection of the high degree of policy coherence in the local health strategy in Barcelona.

> "*In Barcelona, when we talk about public health planning, the Health Plan and the Municipal Action Plan come together. The Municipal Action Plan, which is the municipal government's plan, also has health objectives and, in the end, we have to integrate both of them ensuring synergies*" ASPB Member

Both documents are based on the social model of health, recognise the existence of inequalities, and the need for coherent intersectoral policies to combat health inequalities. However, even though in terms of symbolic content policy coherence is evident in Barcelona's health strategy, there are also some reservations about its operational content and translation, particularly with regard to the *Quality of care* lines of the Health Plan (general lines 3-7) and its practice within the healthcare system.

> "*The Health Plan is still much more like a healthcare plan.... And yes, it includes equity and action on social determinants in the introduction, but then we have to see, in specific actions, how this is reflected and actually put into practice*" ASPB Member

Beyond the healthcare system, albeit the symbolic and operational content seems to be more aligned, not all municipal areas and their staff address inequalities with the same impetus. Besides, a lot of work is still done in silos, which does not facilitate the health mainstreaming in the local government. The complexity of the City Council's organisational structure seems to hinder rather than enhance intersectoral work.

> "*Integrating health or any other issue is not easy in institutions that are complex... For decades, over time, the City Council has become more complex, segmented, sectorialised... And all of this goes against, to a certain extent, the exercise of cross-mainstreaming*". City Council Member

In this regard, the role of public health in leading the reduction of health inequalities in Barcelona has been particularly relevant, but even within the ASPB itself, the acknowledgement and sensitivity towards health inequalities is quite variable. The ASPB's Plan for tackling inequalities[350] seeks to mainstream equity across ASPB's services, but there is no similar plan in the City Council of Barcelona.

Considering these difficulties, the absence of a formal structure for intersectoral action for health within Barcelona City Council may seem surprising. But the fact is that, despite lacking

formal structure and mechanisms, the MAP explicitly includes interventions to improve health and the social determinants of health while integrating a focus on equity.

> "*Some years ago we drafted a measure that was... A bit like a social epidemiology manual, you know, intersectoral action for health and so on. And that measure envisaged the creation of a commission for the reduction of health inequalities. But then we saw that the government plan, the PAM, already included many actions on the social determinants of health [...]. And after having seen that the City Council is full of committees, and more committees, we realised that having another committee for intersectoral action for health would not add to the government's action for equity in health*" City Council member.

However, this institutionalisation of health equity can be rather fragile as it depends to a large extent on the political momentum, which can shift with any political government change.

> *"Four years ago the [local] government, which at that time governed in minority, did not achieve the political approval of a majority on its PAM. This can happen when there are flexible political majorities"* City Council member.

The policy coherence of Barcelona's local health strategy can be placed at the *Stage V - Institutionalized* of the MM-HiAP, the highest level of the scale. Indeed, Barcelona has an extensive experience describing health inequalities and designing coherent interventions to reduce them. Although with different emphasis depending on the City Council's areas, the health equity approach seems to be quite well integrated, and politically and operationally entrenched through the PAM. Although well established since 2015, this institutionalisation lacks of a structure with established mechanisms, and it does not envisage a long-term plan to mainstream health and equity in all areas of the City Council. Therefore, it is highly dependent on political momentum and that makes it potentially vulnerable to political changes in power.

7.2.2.b. Accountability

With the aim to assess the degree to which accountability is formally established in the Barcelona's health strategy, the core accountability components identified by Ebrahim and Weisband[128] (Table 12), as well as the mechanisms to redress violations of people's right to health[133] (Table 13) are going to be assessed in the Barcelona 2016-2020 Health Plan[301] and the 2020-2023 PAM+[302]. Then, the results from these tools for analysing accountability are complemented and further developed using the results of the thematic analysis of interviews with key informants involved in the development and/or implementation of the local health strategy.

Table 12. Accountability in Barcelonal's local health strategy (Ebrahim and Weisband's components)

Ebrahim and Weisband's Accountability component		Barcelona's local health strategy
Transparency	Collecting and making it available and accessible for public scrutiny information that is "actionable" to citizens	Barcelona City Council has made a clear commitment to transparency. This is evident, for example, in the *Open Data BCN* portal on its website, where it is possible to access both health data and data on the determinants of health, often disaggregated by gender, neighbourhood, etc. These data, as well as evaluations of different programmes, can also be found in the *Observatory on Health, Inequalities and Impacts of Municipal Policies*[358]. The ASPB also publishes its reports, sessions, etc. Thus, the information is easily accessible on the web, although this information very often lacks of an adapted format for people with special needs. In this regard, it is worth to recall the workshops on *Transparency and Communicative Effectiveness: The right to understand*, organised by the City Council in December 2020. The PAM is published on the City Council's website. Line 6 of the MAP states the objective of moving towards "*a more efficient management model, linked to the evaluation of results, accountability, transparency and efficiency in the administration of public goods*". In line with this, on the *Transparency* website of the City Council, the monitoring tool of its actions can be accessed. This website displays information for the purpose of accountability and actions related to the Health Directorate can also be monitored there. The Barcelona Health Plan is also publicly available on the CSB website. An evaluation of the former Health Plan can be found in this document, but information on the monitoring and evaluation of the current Health Plan is not that easily accessible. Addressing transparency issues is one of the challenges guiding the Health Plan (line 9). In the introduction to this line it is stated "*Today's demand for transparency and accountability requires that information obtained be made available to the public in all formats, including open data*", but this recognition does not clearly link to concrete actions to improve transparency.

Answerability	Providing justification for decisions so that they may reasonably be questioned	In terms of accountability of the city's governance, the *Consells de Salud de Districte*[15] and particularly the *Barcelona Decidim* platform are relevant. It allows making proposals, following up on them, and getting feedback from the City Council. Thus, it is a useful tool to operationalise answerability. On the other hand, as far as the Health Plan is concerned, there are no such mechanisms in place. The Health Plan includes an analysis of the health situation and the challenges identified, which serve as justification for the development of its objectives and actions. "*For the accountability of the Health Plan an internal evaluation of the previous plan has been carried out, but little more... It is a very technical document. [...] As for the MAP, accountability is done through the Decidim Platform*" City Council Member
Compliance	Monitoring and evaluation of procedures and outcomes	The PAM is monitored quarterly, using a tool that indicates the degree of achievement of each action. These process indicators are made public, so it is possible to monitor compliance through the city council's *Transparency* website. However, the degree of evaluation and monitoring that the MAP has is far from that of the Health Plan, for which not even an annual evaluation has been carried out. This undoubtedly has an impact on the achievement of the objectives. "*The City Council does much more monitoring of all their plans, they request the process and result indicators of this plan or the other one... But there are no serious interim evaluations for the Health Plan. The priority lines that are not the specific to Barcelona I don't even know who follows them*". ASPB Member "*The problem is when you haven't done any mid-term evaluation in four years. If you don't do it, when you get to the end you realise that there are things where nothing has been done, whereas if you do some mid-term evaluation it's easier to move things forward*". CSB member. Although it is not directly connected to the Health Plan, the ASPB carries out the Barcelona Annual Health Report to monitor the state of health and its determinants in the city.

[15] *Consells de Salut de Districte* (District Health Boards) are the body for community participation for health in the city of Barcelona.

Enforceability	Sanctioning for shortfalls in compliance, answerability or transparency	Barcelona City Council obtained the highest score in the Transparency Index of City Councils 2017[331]. In the same year, the Plenary of the Municipal Council approved a *Code of Ethics and Conduct* that regulates the guidelines for conduct as well as the monitoring and enforceability mechanisms. The local health strategy documents do not mention this measure or any other specific measures to be applied in the health strategy.

Barcelona City Council has deployed a number of accountability mechanisms, including the *Barcelona Decidim* platform or the *Open Data BCN* and the *Transparency* website. With regard to the accountability related to the local health strategy, in addition to the mechanisms previously mentioned, the role of the ASPB as an autonomous body, and particularly the *Observatory on Health, Inequalities and Impacts of Municipal Policies*[358] should be highlighted. All these mechanisms ensure that the local government has a strong capacity of account-giving. This is particularly evident in the dimensions of transparency, answerability and compliance.

However, a more in-depth assessment of the health strategy accountability reveals substantial differences on the level of accountability between the MAP and the Health Plan. This can also been noted within the Health Plan, between the 12 general lines of the Catalan Health Plan and the specific 10 lines for the city of Barcelona. Although these differences can be found in all accountability dimensions, it is in the monitoring and evaluation of procedures and results where they are more evident. Thus, the Health Plan monitoring has room for improvement in compliance.

> "*I am aware that in the previous Health Plans had a kind of monitoring matrix for the follow-up, but in this latest Plan, the one for the period 2016-2020, we have encountered a number of obstacles... The people who were doing this work changed positions and other incidents have not allowed us to make a proper progressive evaluation of the Plan development*" CSB member.

Although the weak compliance of the 2016-2020 Health Plan may have been caused by extraordinary circumstances, there is a fairly generalised perception that accountability at the regional level is less strong than it is at the local level in terms of the follow-up of the Health Plan. This perception is aligned with the findings of a study that assessed the accountability of health policies in the autonomous communities of Spain, rating Catalonia with a meagre 32% on the Accountability Index for health policies[143].

Another element affecting the compliance of the Health Plan is its scant recognition as a directive tool for action in the healthcare system. This hinders the implementation of the proposed interventions and, ultimately, the achievement of the objectives it envisages.

> "*One of the weaknesses I see the Health Plan has is that, in the healthcare system, they don't even know it exists. For public health it is an important document, but in the healthcare sector... For healthcare it doesn't feel like an instrument that implies action. I don't think so*" ASPB Member

Despite this, Barcelona's local health strategy has well integrated accountability, a fact that has been highlighted by the main actors involved. One of the most remarkable elements of accountability in Barcelona is the comprehensive, equity-sensitive monitoring of health and social determinants of health. This data and evidence have effectively contributed to improve

the understanding of health inequalities in the city, providing evidence for action, raising awareness and allowing informed policy-making.

> "*Another key element has been public health data intelligence, to be able to say 'ok, we have data that proves that there are health inequalities', to be able to make this problem visible*". City Council member.

> "*We find inequalities, because we try to identify them, because we take a look at them.... This is happening with the vaccination coverage data, we want to see if there are differences or not, territorially, by gender, by socio-economic level*". ASPB Member

> "*Barcelona has had a very social and equity-oriented approach, and I mean an approach not only in the detection of inequalities, but also in designing municipal interventions to address them*" CSB Member

In relation to accountability for the right to health described in Barcelona's local health strategy documents, the PAM states "*The city model must respond to the defence of citizens' rights and health*", linking health to the fulfilment of other social rights. In addition, one of its actions is "*Monitoring health inequalities in the city of Barcelona from a rights and gender perspective"*. On the other hand, the Health Plan refers to the "*Charter of rights and duties in relation to health and health care*", which could be considered an implicit reference to the right to health.

However, the Barcelona local health strategy main documents do not go as far as to develop the mechanisms for educating people on their right to health, reporting right to health violations and investigating and reducing fraud and corruption. It should be mentioned that this does not mean that these mechanisms are not implemented in the local government, but rather that they have not been addressed as part of the local health strategy.

Below is the PAHO Equity Commission's rubric for the Barcelona health strategy.

Table 13. Accountability in Barcelona's local health strategy (PAHO Equity Commission's rubric)

	PAHO Equity Commission's rubric	**Question score**
Accountability	Does the local health strategy include mechanisms to redress violations of people's right to health?	
	• Does the local health strategy include mechanisms for educating people on their right to health?	0/1
	• Does the local health strategy include mechanisms for reporting right to health violations?	0/1
	• Does the local health strategy include mechanisms for enforcing people's right to health?	1/1
	• Does the local health strategy include mechanism for investigating and reducing fraud and corruption?	0/1
	OVERALL SCORE	1/4

The local health strategy of Barcelona has fairly integrated the accountability components of transparency, answerability and compliance. The Barcelona health strategy includes different mechanisms for account-giving, such as the *Barcelona Decidim* platform, the *Open Data BCN* and the *Transparency* website, the *Public Health Agency of Barcelona* and particularly the *Observatory on Health, Inequalities and Impacts of Municipal Policies*. Its comprehensive, equity-sensitive monitoring of health and social determinants of health have effectively contributed to improve understanding of health inequalities in the city, providing evidence for action, raising awareness and allowing informed policy-making. One aspect that could be improved, however, is the Health Plan compliance dimension of accountability. The mechanisms to redress violations of people's right to health are not made explicit in the local health strategy documents, being 1/4 the accountability punctuation of the PAHO Equity Commission's rubric.

7.2.2.c. Social Participation

In order to assess how social participation has been incorporated into Barcelona's local health strategy, the Health Canada's public involvement continuum[307] has been used. The table below presents the synthesis of the level of social participation in each phase of the political cycle (Table 14).

Table 14. Social participation in Barcelona's local health strategy

Social participation		**Barcelona's local health strategy**
Policy cycle phase	*Level*	
Health and social determinants of health needs assessment (agenda building)	V - Partner	Barcelona has established channels to recognise citizens as active subjects, listen to their voices and initiatives, and create spaces for dialogue and the collective construction of proposals. In Barcelona the participation system is regulated by the Citizen Participation Regulation, which specifies three types of channels: a) participatory processes, b) participation bodies and c) citizen consultations. All of them can be activated by initiative of the City Council or by citizen initiative. Therefore, citizens have the possibility to present normative proposals or to activate the agenda of the City or District government bodies by proposing points on the agenda of their sessions. The structure of participation in health has, at its base, the *Consells de salut*, in each of the ten Districts of Barcelona.
Local health strategy policy-making (policy formulation and adoption)	IV - Engage	With regard to the PAM, a participatory process was launched in parallel to the public exhibition process for the presentation of objections to the initially approved document. Although the participatory process was interrupted by the declaration of the state of emergency, 13,512 people participated. On the other hand, the platform *Decidim Barcelona* received a total of 3,344 citizen proposals that were technically studied in order to evaluate their inclusion to de PAM.

		In the Health Plan, the Barcelona component did not have any public participatory process, as only technicians and managers participated in it. In contrast, the Catalan Health Plan component did have participatory sessions and it includes as a priority area the development of strategies to guarantee social participation for health.
Local Health Strategy execution (implementation)	I - Inform	The City Council has a Citizen Participation Department that supports community action. In some neighbourhoods there are community action groups that participate in the implementation of certain interventions, however this is not done in all neighbourhoods of the city nor is it systematically carried out as an integral part of the local health strategy. Thus, although the *Cosells de Salud* and the community health network play a certain role in the implementation of specific community actions, at this stage of the policy cycle the position of local government is in general more informative, reporting the results of the implementation processes.
Local Health Strategy monitoring (evaluation)	II - Gather Information	In neighbourhoods where there are active community networks, evaluations of the implementation of interventions are commonly carried out, and these evaluations often involve a participatory component. But again, this is not done in all neighbourhoods of the city, nor is it systematically carried out as an integral part of the local health strategy. Although there is not yet a high degree of social participation in the evaluation phase, there is an effort to incorporate people's perceptions in addition to quantitative indicators in many intervention assessments. *"There is a strong participation in the development of the PAM.... But is there a participatory follow-up or a participatory evaluation? I am not aware of any such thing being done, neither in the Health Plan"* City Council member

The following spider graph summarizes the levels of social participation of Barcelona's local health strategy at the main phases of the policy cycle (Figure 30).

Figure 30. Levels of social participation in Barcelona's local health strategy

In order to provide an enriched view of the social participation in Barcelona's health strategy, the results of the Health Canada's public involvement continuum are complemented and further developed by the results of the thematic analysis of interviews with key informants involved in the development and/or implementation of the local health strategy.

The progress that the government of Barcelona has made in terms of social participation over the last years is remarkable. Thus, for the first time in Barcelona, participatory budgets were set up to decide part of the municipal investment in the districts. Mechanisms have also been established to promote citizen initiatives, to debate through participatory processes, to co-produce through different participatory bodies, and to encourage citizen decision-making through citizen consultations. Likewise, *Decidim Barcelona* has established itself as a useful platform fostering citizen collaboration, allowing for programmatic participation in public policy and ensuring transparency of municipal actions.

The Citizen Participation Regulation as well as the multiple participatory processes developed reflect this political will to promote social participation. This willingness to advance social participation in governance was also demonstrated implementing measures such as the telematics participation councils and bodies during the pandemic.

That being said, the mainstreaming of social participation at the local government level is somewhat less clear when it is translated into the local health strategy, although both the MAP and the Health Plan explicitly include participation among their objectives. There is room for improvement, for instance in the degree of citizen involvement in the Health Plan's specific lines for the city of Barcelona formulation.

> *"In the Health Plan the Barcelona component did not have any public participatory process, we were only technicians and managers. In the Catalonian Health Plan there were some participative sessions... Yes, there was more participation, but this was not the case in Barcelona"* ASPB Member

Participation could also be further enhanced in the implementation and evaluation phases of the local health strategy. Although the *Consells de Salud* and the community health network play an important role in the implementation of local health strategy actions there is a perception that they are somehow not sufficiently taken into account and engaged in these phases of the policy cycle.

> *"Community networks are key and perhaps sometimes it has not been sufficiently taken into account..."* ASPB member

The government of Barcelona has taken important steps in terms of participation and democratic innovation. The Citizen Participation Regulation, *Decidim Barcelona* and other participatory mechanisms, as well as the multiple participatory processes developed, reflect this political will to foster participation. This active promotion of social participation, which is strong at the local government level, is somewhat less clear when translated into the local health strategy. There is room for improvement in the Health Plan's specific lines for the city of Barcelona formulation, and in the implementation and evaluation of the local health strategy as a whole.

7.2.3. Analysis of factors affecting the local health strategy implementation in Barcelona

The following barriers and facilitators identified by the agents involved in the processes of implementation of Barcelona local health strategy are going to be presented; firstly the barriers and facilitators of implementation in the pre-pandemic context, followed by these in the current COVID-19 pandemic context. These barriers and facilitators have been analysed using the CFIR framework domains, and the results are summarised in the following tables (Table 15 and Table 16).

7.2.3.a. Implementation barriers and facilitators of the local health strategy in pre-pandemic context in Barcelona

Table 15. Implementation barriers and facilitators of the local health strategy in Barcelona: Pre-pandemic context

CFIR		Implementation barriers and facilitators of the local health strategy in Barcelona: Pre-pandemic context
Outer setting	Needs and resources of those served by the local government	There is a widespread perception that Barcelona's local health strategy is not only adapted to the needs of the population, but is also a pioneer in addressing health inequalities. There is a shared recognition of the progress made in recent years in terms of health equity. Likewise, there is a positive perception of the medium and long-term strategic vision that the current local health strategy entails. This is seen as an enabler for its implementation and development. "*There is a clear vision of where we want to go, sometimes even a bit idealistic, because well, then it has to be put into practice... But when you look back you see how far we have come*" CSB member.
	Cosmopolitanism	Barcelona City Council is networked with other external organisations with which it creates synergies, facilitating the implementation of the local health strategy. Most of these have been mentioned as stakeholders in the local governance for health, but it is worth pointing out that the City Council also networks with other social and economic actors. This is regarded as a facilitating factor. "*It also helps to have the Institute for Global Health [ISGlobal] in Barcelona, which is a cutting-edge institute, and which for example has made an assessment of the health impact of the public bicycle system in the city, without even having to ask for it*" City Council member.

	Peer Pressure	ASPB has routinely integrated benchmarking elements into the organisation's annual evaluation, which enables identifying best practices in other organisations with similar characteristics. The consolidation of benchmarking is perceived as an asset for the improvement of public health management.
	External Policy	The local health strategy, and specifically the Health Plan, is strongly influenced by the strategic guidelines set by the Catalan Health Plan at regional level. However, an effort has been made to ensure that it is adapted to the Barcelona reality with specific actions intended to also meet the political guidelines of the PAM. In this sense, the co-ordination between the local and regional levels is considered fairly good, enabling a local health strategy that is more responsive to the reality of the city. "*In the Barcelona Health Plan we have tried to include the priority actions for the city beyond what is established in the Catalan Health Plan*" ASPB member.
Inner setting	Structural characteristics	The main barrier identified in this domain refers to the lack of resources and capacities that exist in the Healthcare system. Although the lack of human resources and technical capacity has been a barrier acknowledged by all actors involved in the implementation of the local health strategy, it has been identified to a lesser extent as an issue within the ASPB and the City Council. "*We have a system that is precarious, a little at a technical level, but above all in terms of the number of professionals [...]. In the primary care centres there are many things that are done, for example at the community level, but the priority is always healthcare provision. These other types of activities, like community health, are based to some extent on the goodwill of the professionals... And that wears them down and it's not sustainable"* CSB member.

	Networks and communications	Establishing effective communication and cooperation systems has been identified as a challenge across institutions and agencies. Working in silos is an important barrier to enable effective communication, but difficulties related to communication have been identified even within the City Council's Health Directorate. "*Communication is very important and I think at the moment it's one of the things we don't do very well. Sometimes we find out that things that are being done have already been done by someone else, or that the same thing is being done twice at the same time. And sometimes we work twice, but not even in the same direction…*" CSB member "*A stronger collaboration between public health in primary health care must be promoted, primary health care has an enormous penetration in the territory and we barely work together, more synergies must be sought*" ASPB member "*It happens a lot in the City Council that one doesn't know what the other one is doing, in general the City Council works quite compartmentalised..."* City Council member
	Culture	The values of the local government are strongly conditioned by the political party in power. There is a shared perception that left-wing governments have prioritised health and equity over other interests. In this sense it is understood that the continuity of a given political party means that these values permeate the institutional culture, and ultimately this can be seen in municipal management practices. The current government of Ada Colau has been identified as a facilitating factor for the implementation of an equity-focused local health strategy. "*The political option obviously impacts on health equity. The political option is important because if it impacts on equity in several areas of municipal action, it ends up impacting on health equity*" City Council Member
	Readiness for implementation	There is organisational commitment to implement an equity-focused local health strategy. However, the lack of information and knowledge on how to mainstream equity/health into the work of "*the less sensitive sectors*" has been identified as a barrier. "*Sometimes the health perspective is not implemented, not because of bad faith, but because there is a lack of knowledge to do so.... Because there are many perspectives at stake, and we all need to learn to be able to bring them into our practice. So training is needed, in every area, in every policy... Training on what it means to integrate an equity approach or a health approach*". City Council Member

Process	Planning	One element that has been recurrently identified as an enabler to plan interventions to address them is public health data intelligence. This refers not only to data, such as the health survey, but also a sensitive approach to inequalities in the design and analysis of these data. "*Making policies to reduce health inequalities, taking them into account when planning, requires first of all having detected them.... Inequalities are sometimes not seen if you don't look at them, and the Agency [ASPB] is very good at that, at looking at inequalities and saying 'something needs to be done about that', so let's work on it together*". ASPB member.
	Engaging	Other sectors within the City Council are involved in the local health strategy through the MAP's cross-sector measures, driven by a strong political will without the development of any structure or specific mechanisms (such as commissions for the reduction of inequalities in health, HIA or others). At ASPB's level the ASPB manager has been identified as a champion in promoting an equity-sensitive approach to public health. Moreover, in the context of the development of the *Plan for tackling inequalities*, the ASPB has developed trainings to mainstream equity across its services. "*Carme has been training generations of people who now have a very keen awareness of health inequalities, and this can be felt in the Agency's work*" ASPB member. In relation to the healthcare system, one barrier is the lack of recognition and ownership of the Health Plan as an operational instrument to guide action. The Health Plan is considered as not being operational in terms of the action that can be taken at the health facility level by healthcare workers. This results in a low level of engagement with regard to the implementation of the Plan. It is worth mentioning that the Health Plan is not activated through the Catalan Institute of Health, which may hamper this appropriation.
	Executing	The execution of the 2016-2020 Health Plan, and specifically the execution of the general guidelines coming from the Catalan Health Plan, have been insufficiently monitored. This has been identified as a barrier to the effective deployment and implementation of the Plan's actions. "*The problem is when you haven't done any mid-term evaluation in four years. If you don't do it, when you get to the end you realise that there are things where nothing has been done, whereas if you do some mid-term evaluation it's easier to move things forward*". CSB member.

	Reflecting and evaluating	The overall perception of the local health strategy in Barcelona is rather positive. Coordination between local and regional level strategies and between different actors in the city are highlighted as key facilitators. There are specific reflections regarding the Health Plan beyond the previously mentioned need to reinforce monitoring. These include the importance of linking the next Health Plan to the objectives of the 2030 Agenda. But at the same time, the need to critically question the function of the Health Plan as such a highly strategic document, and thus not very operative, for the governance for health in Barcelona has been pointed out.
Intervention	Innovation source	There is a perception of internal development and ownership of the local health strategy by key stakeholders. "*Both the Barcelona Health Plan and the PAM are the policies that lead the city's institutional action for health*" City Council member.
	Evidence strength and quality	The perception that policies have a measurable impact on the population is certainly a facilitating factor for local health strategy implementation. This has been highlighted by all the main actors involved. *"It's about making a real change in inequalities. And there have already been evaluations that have shown that it's possible to reduce health inequalities through the right policies".* City Council member.
	Complexity	The need for a broad, comprehensive, and complex local health strategy is assumed. "*Health cannot be sought only in the healthcare system because, as you know, it is everywhere. That is why acting to improve is complex and requires action from all sectors. A Health Plan that only serves the healthcare system would not have a meaningful impact on the population's health*" CSB member.

Individuals	Knowledge and beliefs	Overall there is a fairly positive perception that work is being done to address health inequalities, although not all staff to the same degree. Public health training and awareness-raising about health inequalities has been highlighted as an enabler. "*In the end it's about values, about what kind of society we want to live in. And it's easier to work when you see your values reflected in your work activities, in what you do*" ASPB member. "*I believe that the actual implementation of equity-oriented interventions requires people who are trained and sensitive to the issue of inequalities*" ASPB member. "*In many cases, training in public health is not required or is not sufficiently valued, which means that some of these human resources do not have the necessary training, or the necessary awareness to tackle inequalities*" CSB member.
	Individual identification with organization	The way in which the organisation is perceived varies depending on whether it is the CSB, the ASPB or the Barcelona City Council. Aspects related to bureaucratisation and technical-political disagreements are barriers identified in this dimension. Aspects related to continuous learning and process improvement have been identified as enablers. "*[The City Council] It's a rather bureaucratic and hierarchical institution. Dealing with politicians is not always easy, sometimes at the technical level we are aware of how things should be, but then our voice has… a relative weight, you know what I mean*" City Council member. "*It's not perfect, but we learn in the process. And well, somehow we are a reference in the Spanish State in terms of tackling health inequalities. I am proud to work here [ASPB]"* ASPB member.

The main facilitators of Barcelona's local health strategy implementation in the pre-pandemic context are related to the positive perception that it does impact tackling health inequalities. The local government's political will is judged to be the main driver of the Barcelona's equity-focused strategy. Coordination between the local and regional levels is considered to be fairly good, allowing the local health strategy to be better adapted to the reality of the city. Other factors facilitating the implementation of this strategy relate to networking with external organisations, creating synergies. The generation of equity-sensitive public health data is seen as an asset generating evidence for action, and as a means of engaging "*the less sensitive sectors"*. Public health training of staff in charge of implementation has also been identified as an enabler. The main implementation barriers for the local health strategy were related to communication difficulties and silos working (inner setting). Barriers were also identified with regard to the lack of coordination public health-primary health, the engagement of the healthcare system staff, and with regard to the monitoring and evaluation of the Health Plan (process).

7.2.3.b. Implementation-related challenges and opportunities of the COVID-19 pandemic context in Barcelona

Table 16. Implementation-related challenges and opportunities of the COVID-19 pandemic context in Barcelona

CFIR		Implementation-related challenges and opportunities of the COVID-19 pandemic context in Barcelona
Outer setting	Needs and resources of those served by the local government	The COVID-19 pandemic disrupted the City Council's usual way of working, creating an uncertain and complex context in which not only the way of working had to be restructured, but also there were increasing demands from citizens. This led to an initial halt in the process of formulating the new PAM, as well as the suspension of Health Plan activities considered non-essential. Efforts were focused on trying to respond to new and more immediate needs, and therefore the implementation of the local health strategy was somehow side-lined. "*The COVID situation has led the City Council to modify the usual way of working or providing services under normal circumstances, and has also demanded an immediate response from us. […] We had a context of great uncertainty, complexity, volatility and ambiguity, against which we had to respond*" City Council member.
	Cosmopolitanism	There is the perception that the urgent need for a prompt response to the outbreak and its consequences has facilitated coordination and joint action between different bodies and actors of the city, as well as between the city government and other governmental levels. "*We have created four technical offices or committees, for public health, nursing homes, schools and vaccinations, which allow us to coordinate the work with other agents in the city, the Catalan Institute of Health, the Barcelona Health Consortium, the Department of Health… with the actors involved in the epidemic*" ASPB member. "*The pandemic has shown that things can work if we work together in a coordinated way. I believe what has happened in this unexpected situation is that we realised that it was not the time to beat about the bush.... We were able to reach a consensus quickly and to find quick and favourable solutions*" CSB member.
	External Policy	Overall there is a positive perception of the epidemic control measures implemented. However, a deeper analysis reveals a certain degree of confrontation between multiple public health needs. "*We have been advocating for the continuation of community activities, we argued that it is essential to continue to act on these other determinants of health.... Isolation can be as negative as the virus*". ASPB member.

Inner setting	Structural characteristics	One of the challenges that has consistently emerged is the lack of structural preparedness to deal with the pandemic, including public health under-funding and particularly the lack of trained public health workforce. "*When the COVID-19 epidemic hit, public health services were totally underfunded. Public health is at less than 2% of the entire health budget, and so those services were not ready... It hit us like a tsunami*" ASPB member. "*In March all the healthcare staff was called to strengthen the epidemiological surveillance. We divided them into five working groups that we considered to be priorities. Initially it was only the healthcare staff, but later the epidemiological surveillance was also reinforced with non-healthcare staff*" ASPB member.
	Networks and communications	Challenges have been identified in relation to both internal and external communication systems but, at the same time, the epidemic has been identified as an opportunity for *forcible* improvement. This refers, for instance, to information systems that were outdated, but also to mechanisms to cope with social misinformation and fake news around COVID-19. "*The information systems in general, and particularly in relation to disease reporting, were obsolete and insufficient. Now they have forcibly improved, for the management of COVID, and this has been a lesson learned*" ASPB member. "*From the point of view of communication, it is also important to better manage the role of social networks to avoid the spread of false information... Public health needs fast systems to counteract misinformation*" CSB member.
	Culture	One opportunity identified is the more prominent position that health has taken in the context of the global pandemic. However, it has also been pointed out that, although health has been given a central role, it has often been from a biomedical and hospital-centric standpoint. Being able to reveal health inequalities has enabled some countering of these visions towards a social model of health. "*One opportunity that is clear is that with the pandemic the area of Health has become more central to the policies of all administrations… And this is also the case here in the City Council*" City Council member "*I think, and this is my perception, that with the whole issue of the pandemic, and the fact of being able to show data disaggregated by neighbourhood... that it has somehow popularised health inequalities to some extent*" City Council member

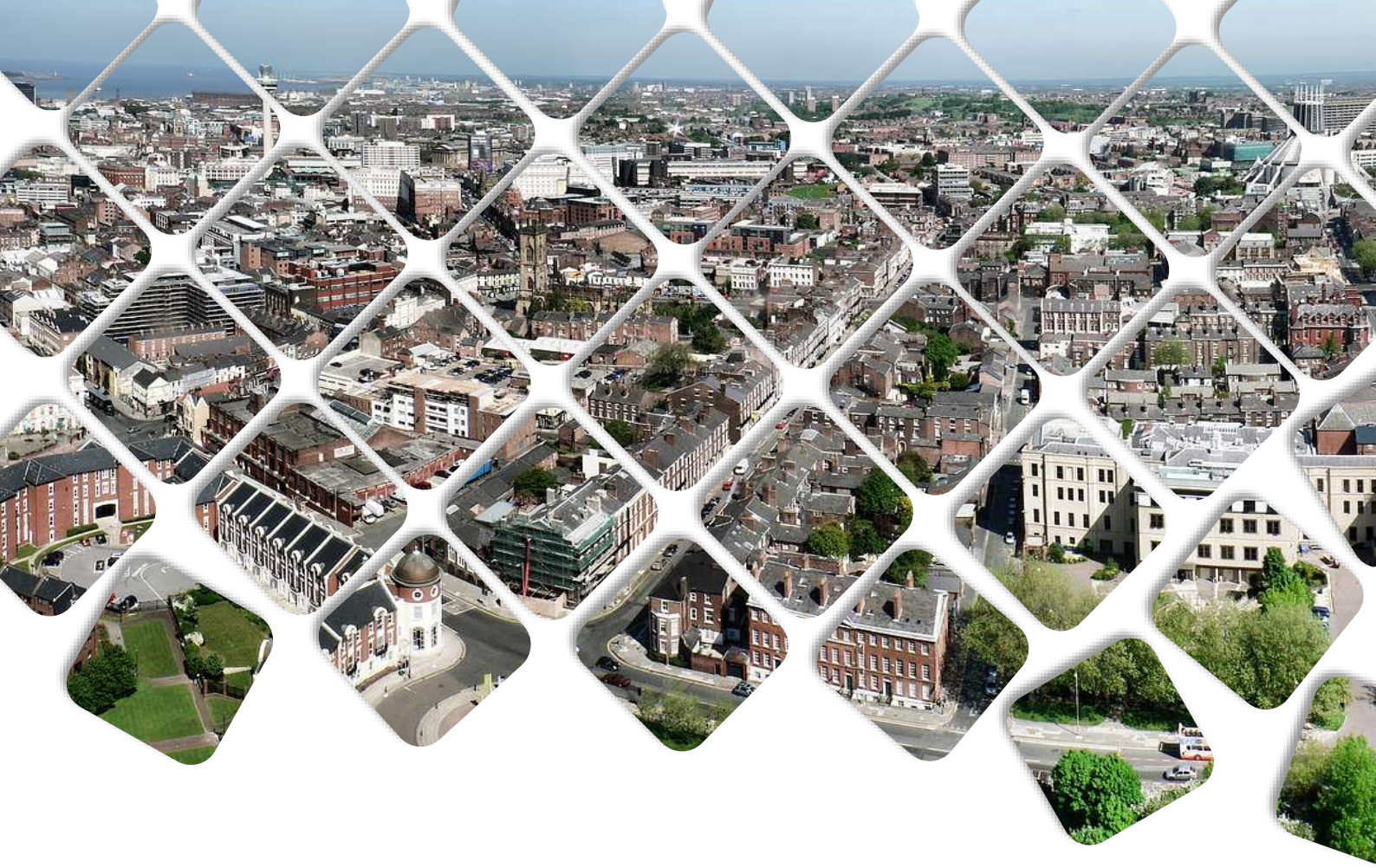
	Implementation climate	The pressing imperative to respond to the COVID-19 context has led to an eminently technical and shared leadership, considered to be more resolute. "*The working environment was really stressful, we did not have a clear response at the management level to handle an epidemic of these characteristics, but there has been committed and flexible leadership... And this is very important to be able to respond to the situations that have arisen*" ASPB member. "*One of the things that has facilitated a response to the pandemic is that politicians have asked us what needs to be done and let us, the technicians, do our work*" CSB member.
	Readiness for implementation	At present, the imperative need to respond to the COVID-19 context, which has created the aforementioned opportunities, has been prolonged over time. This, in turn, has been an obstacle to the implementation and development of other health activities unrelated to the pandemic but also deemed as relevant. "*One barrier that is holding back the implementation of the Health Plan is that the Generalitat's health directorate, at least in the Barcelona region, is focused almost exclusively on COVID*" CSB member.
Process	Planning	The challenges related to planning have been several; from planning the response to the COVID-19 epidemic itself, with virtually no time, to the challenge of planning health and social activities in both the medium and long term. "*A huge challenge was to plan, without time, how to confine 16,000 people, which is the core of the municipal group, and at the same time ensure that the City Council would continue to serve the citizens*" City Council member. "*Well, with all this COVID stuff, we haven't even had time to think about the next plan... So yes, the 2016-2020 plan has been extended. Before the pandemic, things were being started, but... Now I don't know if anyone is working on the next Health Plan*". ASPB member.

	Engaging	To engage with informal and community networks has been identified as an enabler and an opportunity to respond to the social and health needs arising from the pandemic. So has the creation of a volunteer pool, an initiative implemented in Barcelona City Council. "*It was thought that the volunteer pool was a motivational tool that could provide a response to the challenges we faced as a City Council, outside the contractual framework of the employees, but as volunteers. We mobilised 1,056 people, of which we activated about 400 in different projects to respond to the demands of the different services; accompaniment calls to the elderly, preparation of food lots and its distribution, preparation of school kits, distribution of masks on public transport, access and public space control, and so on*" City Council member. "*At the time of strict lockdown, having a community health structure, especially in the most vulnerable neighbourhoods, was very useful to be able to provide a response and help the collectives that most needed it. And the community network itself has greatly facilitated this*" ASPB member
	Executing	The COVID-19 pandemic has provided an opportunity to test the government's capacity for change, flexibility and responsiveness. "*We had the feeling that we were really facing a crisis of a magnitude that could not be dealt with by the usual systems of the municipal government*" City Council member. "*With the pandemic we have seen that society is capable of making changes for the sake of health. And also, in a very extreme case, it has been shown that we, as administration, are capable of pushing other interests into the background for the sake of health*" City Council member.
	Reflecting and evaluating	After the most immediate response, there is a perceived need to assess both the public health conditions prior to the pandemic and how the response to it has been. Likewise, it is perceived necessary to reflect on opportunities to better respond to such an event. "*At the beginning, there was no time for reflection but only for action, and this has had an effect on the response […]. But now public health researchers have spoken out about the need for evaluation, to identify what has worked and what we need to improve in order to deal better with other similar situations*" ASPB member.

	Adaptability	The initial response to COVID-19, which involved practically all ASPB services, entailed an act of adaptation and flexibility from the technical staff who, once the first wave had passed, began to call for the resumption of the activities that had been put on the back burner. *"Staff at the Barcelona Public Health Agency were concerned about the feeling of having abandoned their daily work to devote themselves to COVID. This affected both the staff who came from different services to reinforce epidemiological surveillance, and the staff of the Epidemiology service itself, who had to devote almost 100% of their time to COVID and could not take time to work on other communicable diseases"* ASPB member. There is a fairly widespread perception of an active involvement of the city's social and economic actors, as well as different agencies and institutions, in the co-creation of the response to the COVID-19 crisis. "*We went to the neighbourhood teams and set new paradigms for action, and that has meant that we now have up to 30 informal groups that are still active and continue to provide support in each district, helping to solve many, many problems… An important part of the municipal services has worked to reinforce this network of co-creation to face the crisis*" City Council member.
	Complexity	The complexity of having to deal with such a large-scale and unprecedented pandemic, and particularly the conflict over competing health, social and economic interests, and the lack of resources to cope with the multiple and growing needs, have been highlighted as challenges encountered by the main stakeholders involved in the local governance for health in the city of Barcelona.
Individuals	Knowledge and beliefs	There is the perception that the epidemic has raised awareness on the vulnerabilities and inequalities that pervade society, and that equity is a value that has been stressed in the response measures to the COVID-19 situation. "*This epidemic has shown once again, but in an even more glaring way, the inequalities in our society. I believe that we have become more aware of this*" ASPB member

	Self-efficacy	At the beginning of the epidemic there were concerns about not being able to deal with such a situation. The lack of preparedness to respond to this kind of emergency meant that skills and learning had to be developed along the way. "*When the epidemic started, suddenly a manager of the City Council got sick, and in a matter of hours, around 30 people in the management area fell ill, and I thought... We're not going to be able to cope with this. [...] Now I think that not only we have done more than we thought we could, but also that we have learned a lot along the way*" ASPB member
	Individual identification with organization	There is a positive perception of the degree of commitment of Barcelona City Council workers in the response. It is also felt that the local government has tried to provide an adequate (though not necessarily sufficient) response to the pandemic. "*I feel that an internal work has been done which has given meaning to the values of the organisation, you know, proximity and community… The public service vocation of the city council's workers has been largely demonstrated*" City Council member

The COVID-19 pandemic set an uncertain and complex context in which the usual way of working had to be restructured at the same time that citizens' demands were increasing. The structural underfunding of public health, as well as the conflicting health, social and economic interests, were huge institutional challenges for managing such a situation. However, these challenges provided, at the same time, an opportunity to put the government's capacity for change and responsiveness to the test. Efforts focused on trying to respond to the COVID-19 crisis through coordination and joint action between different stakeholders and actors in the city, including community networks. Lessons have been learned throughout the process, although there is still a need to step back and reflect on the necessary medium- and longer-term challenges to face. One clear opportunity identified is the increased social and political awareness of the health inequalities in Barcelona.



LIVERPOOL CASE STUDY

7.3. Liverpool

7.3.1. Liverpool governance for health context

This section describes the context of governance for health in Liverpool. It includes; a) an overview of demographics and social determinants of health and health in the city, b) a description of the local government, c) a description of its journey on governance for health, d) the presentation of the local health strategy and, finally, e) a brief reference to local governance for health in the context of the COVID-19 pandemic.

7.3.1.a. Overview of demographics and social determinants of health and health in Liverpool

Liverpool is a city and metropolitan borough in Merseyside, North West England, which currently has a population of almost 500,000 inhabitants in the city, and a population of about 2.25 million in its metropolitan area. Liverpool is the largest settlement in the region and the sixth largest in the United Kingdom, and the population projection suggest that it will increase in the coming years.

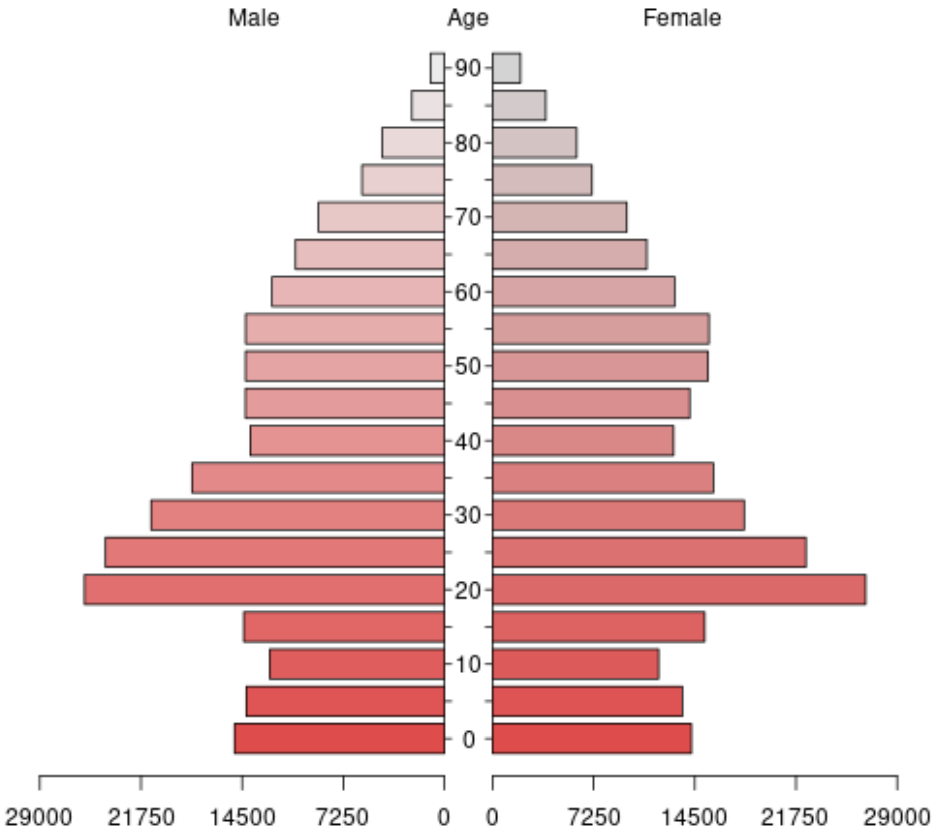


Figure 31. Demographic pyramid Liverpool 2019. Source: www.iz.sk

The city has a relatively young population, with an average of 37.6 years. According to the 2021 Census, there are 86,954 inhabitants aged 0-15 (17.5%), 337,574 inhabitants aged 16-64 (67.8%) and 73,514 inhabitants aged 65+ (14.8%) (Figure 31). The Office for National Statistics project a substantial population increase in Liverpool over the coming decade, particularly in the number of children and people aged over 60 years; the population forecast by 2030 is 531,000.

Liverpool has a large and very diverse population. This is shown by the demographics statistics in 2021 in which the population breakdown by ethnic group was; White British 84.8%, Asian or Asian British 4.2%, Black or Black British 2.6%, White Irish 1.4%, other White 2.6%, Mixed ethnicity 2.5%, and other ethnicities 1.8%. The vast majority of Liverpool's ethnic minorities live within the inner city area.

According to the Index of Multiple Deprivation[16] 2019(359), Liverpool was the third most deprived local authority out of 317 English local authorities for average score. It was ranked as the fourth most deprived in 2015, and previously the most deprived in 2004, 2007 and 2010. When considering the proportion of Lower-layer Super Output Areas (LSOA)[17] in the most deprived 10% nationally, Liverpool is ranked second most deprived. Currently, about 48% of Liverpool's residents and 57% of Liverpool's children live in these LSOA, although not all of these people may be experiencing deprivation. This unfortunately results in the fact that one in three children are classed as living in poverty in Liverpool (one in five in England as a whole), and more than half the children live below the poverty line in four of Liverpool's electoral wards.

The following image shows the level of deprivation and inequality for the whole of Liverpool and across the city. It can be noted that Liverpool's most deprived LSOAs are in the neighbourhoods in the north of the city, with those around the inner core, Belle Vale and Speke-Garston displaying the highest levels of deprivation.

[16] The Index of Multiple Deprivation measures relative deprivation across small areas called Lower-layer Super Output Areas. It is based on seven different domains of deprivation; income, employment, education, health, crime, barriers to housing and services, and living environment. In addition to the seven domain-level indices above, there are two supplementary indices: the Income Deprivation Affecting Children Index (IDACI) and the Income Deprivation Affecting Older People Index (IDAOPI), which are subsets from the income deprivation domain. Although the Index of Multiple Deprivation is fairly complex, it could be interpreted broadly as a lack of resources and opportunities.

[17] The Lower-layer Super Output Areas (LSOAs) are areas of relatively even size, around 1,600 people. There are 32,844 of these areas across England, including 298 in Liverpool. Thus, Liverpool has 30 Council Wards and 298 LSOAs, but it should be noted that sometimes the LSOA boundaries cross Council Wards. Each LSOA is given a score based on a basket of indicators and can then be ranked and compared with all other areas across England.

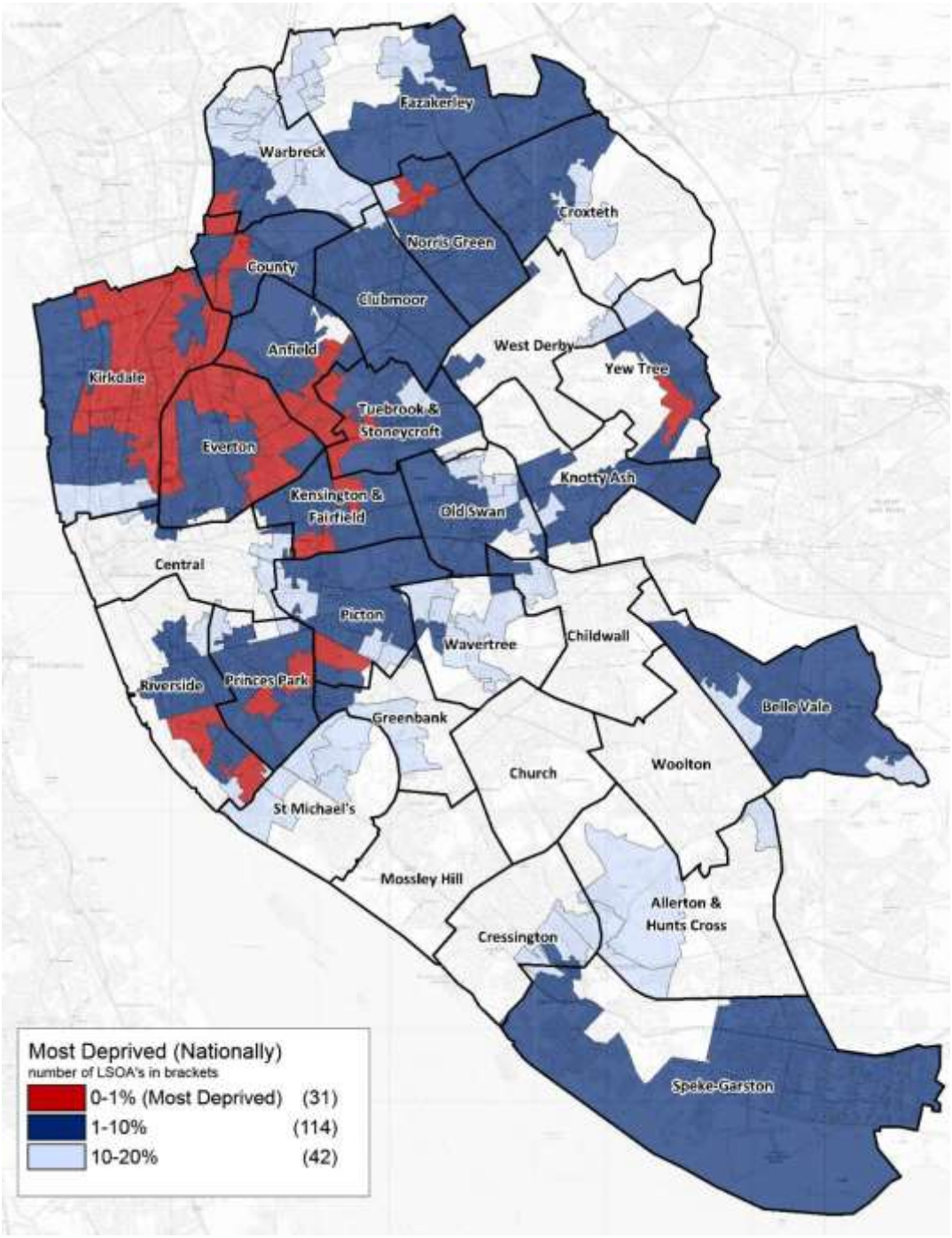


Illustration 2. Spatial pattern of Deprivation across Liverpool on the Index of Multiple Deprivation 2019 by LSOA[360]

This spatial pattern of deprivation is evident in most of the domains of deprivation. And so, unsurprisingly, there is a similar spatial distribution of Health Deprivation and Disability domain across Liverpool by LSOA [359].

The health of people in Liverpool is generally worse than the England average. The gap in average life expectancy for Liverpool compared with the England average being 3 years. This can be further evidenced by comparing some health indicators such as under 18 conception rate, infant mortality rate, breastfeeding initiation, childhood obesity, percentage of inactive adults, percentage of adults with overweight or obesity, admissions episodes for alcohol related

conditions, emergency hospital admissions for intentional self-harm, hospital admissions for violence, including sexual violence, life expectancy at birth for both male and female, under 75 mortality rate from cancer, from cardiovascular diseases or from all causes.

As noted above, Liverpool has some LSOAs considered highly deprived areas in England, so it is not surprising that it has, likewise, Liverpool also has one of the greatest health inequalities in the country. Major inequalities in health can be observed, for instance, in health indicators such as inequality in life expectancy for both male and fame. By way of example, it should be mentioned that in 2019 life expectancy was 11.1 years lower for men and 8.9 years lower for women in the most deprived areas of Liverpool than in the least deprived areas.

The COVID-19 pandemic has also significantly affected the city of Liverpool; by the end of 2020, 28.933 cases of COVID-19, 4.055 hospital admissions and 988 deaths had been recorded. This means up to 6% of Liverpool residents tested positive for COVID-19 in 2020 and, among these, up to 3% of cases died[361].

Liverpool has a very diverse population of almost 500,000 inhabitants, and population projections suggest that this is set to increase in the coming years. Liverpool is one of the most deprived cities in England, ranking third out of 317 English local authorities by average score. The city has huge socio-economic inequalities between the city's wards, as well as significant health inequalities, which follow a clear spatial pattern.

7.3.1.b. Stakeholders relevant to local governance for health in Liverpool

Liverpool City Council

Liverpool City Council is the governing body for the city of Liverpool. It comprises 90 locally elected councillors, three for each of the city's thirty wards. It is also one of six local authorities that integrate a bigger administrative area known as Liverpool City Region, a combined authority of six Merseyside councils. It is controlled by the Labour Party and currently led by directly elected Mayor Wendy Simon.

As one of the most deprived areas in the UK. Liverpool City Council has shouldered a disproportionate level of deprivation and spending cuts enforced from central government, which has surely influenced its particular political idiosyncrasies even beyond the socio-economic, political and cultural North-South divide in England[362].

> *"Well, the northwest of the country, is a very deprived part of the country, and has always really been strong labour territory"*. City Council member.

> *"Liverpool sees itself as... A kind of almost... like an island. Politics in Liverpool is quite different than national politics, so we've never had a conservative MP. We kind of... I suppose, a bit like some parts of Spain, kind of get on better within the city than we do with national bodies, its a tribal loyalty"* Third sector representative.

Regarding the jurisdiction and competencies of Liverpool City Council, it has managerial responsibilities for areas such as economic development, employment, transport, housing,

infrastructure, culture or tourism. Health and determinants of health are managed through the services it commissions and delivers, through its regulatory powers, through community leadership and through its well-being power[363].

Organizationally within the Liverpool City Council, the competencies related to health are located in the Public Health Directorate and in the Health and Welfare Committee. The Public Health Directorate that has as primary functions: sexual health provision, immunisation and screening plans, National Childhood Measurement Programme, NHS health check assessments, drug and alcohol programme, school nursing and health visitor service, deliver health care advice and statistical analysis. The Director of Public Health is the principal adviser on health-related issues, and a statutory member of the Health and Wellbeing Board. Given the relevance of the Health and Wellbeing Board to the governance for health in Liverpool, it is detailed below.

Liverpool's Health and Wellbeing Board

Public health became a function of local government in 2013, and since then City Councils took on responsibility for public health and Health and Wellbeing Boards took on their statutory role[364]. The Health and Wellbeing Boards are at the centre of setting the strategic direction of the local health and care system and, as it will be developed later, were established in Councils with adult social care responsibilities in 2013 through provisions in the Health and Social Care Act 2012[365]. Broadly speaking, it can be said that Health and Wellbeing Boards are intended to be a forum for collective decision-making, and they sit at the centre of a complex matrix of local, regional and national relationships.

> "*So the Health and Wellbeing Board's function is to do that, about joining up, like commissioning plans and delivery of those commissioning plans. […] Our function is to forge those relationships and help manage them if you like, encourage them*" City Council member.

Health and Wellbeing Boards have council officers and other non-councillors as full constituent members, characteristic that distinguishes them from other Council committees. Indeed, statutory members of Health and Wellbeing Boards are made up of representatives from a number of organisations; one or more council elected members, at least one representative from each Clinical Commissioning Group (CCG) in the area, directors of adult social services, children's services and public health, a representative from local Healthwatch and, when required, a representative of NHS England. Further details on these stakeholders are provided later on.

Actually, the Chair of the Health and Wellbeing Board is the Mayor of Liverpool. Its internal structure includes: the Integrated Care Partnership Group, which is co-chaired by the Chief Executive of the City Council and the Chief Executive of Liverpool CCG; an Integrated Care Partnership Group, which is co-chaired by the Chief Executive of the City Council and the Chief Officer of Liverpool CCG; the Local Safeguarding Children Board and the Local Adults Safeguarding Board. In Liverpool's case citizens are formally represented through Healthwatch, and the Board has members of the public present at Board meetings.

Other local stakeholders relevant to governance for health

There are other actors relevant to local governance for health that work closely with Liverpool City Council; these partners are the NHS Liverpool Clinical Commissioning Group, the Champs

Public Health Collaborative, Liverpool Healthwatch, or the Local Government Association, as well as other public health teams and partners across Liverpool City.

The NHS Liverpool Clinical Commissioning Group (CCG) is responsible for planning and buying a part of NHS services for the people of Liverpool, including the hospital and community clinics health care. Since April 2015 it has also had responsibility for general practitioners services in Liverpool.

The Champs Public Health Collaborative is a long-standing collaborative led by the nine Directors of Public Health of local authorities in Cheshire and Merseyside. The Liverpool Public Health group coordinate public health programs such as antimicrobial resistance, cancer screening, high blood pressure and cardiovascular disease prevention, suicide prevention or COVID-19 response, to name a few examples.

Liverpool Healthwatch, on the other hand, is a community-led organisation, made up of local representatives and other local organisations, which aims to ensure that the needs of local communities are heard and understood, but also that these voices have a real influence on policy making.

Liverpool is part of the Local Government Association (LGA), which is a politically led and cross-party national membership body for local authorities. Its purpose is to be an interlocutor with the national government in order to secure funding and powers for local governments and the communities they serve. The LGA is explicitly committed to provide support to Health and Wellbeing Boards.

Liverpool City Council is the governing body of the City of Liverpool, and has management responsibilities for wider determinants of health such as economic development, employment, transport, housing, infrastructure, culture and tourism. Since 2013, public health has been a function of the City of Liverpool, setting up the Health and Wellbeing Board. This Board is a statutory forum that brings together political, clinical, professional and community leaders from across the health and care system. Thus, on governance for health, Liverpool City Council works closely with the NHS Liverpool Clinical Commissioning Group, the Champs Public Health Collaborative, Liverpool Healthwatch and the Local Government Association, as well as other public health teams and local partners.

7.3.1.c. Governance for health trajectory in Liverpool

Having presented the main actors of governance for health in Liverpool, we shall briefly review its historical development. The local responsibility for health and wellbeing has a long history in Liverpool. Indeed, from the Victorian Public Health Acts, the local government held the principal responsibility for population health, tackling infectious diseases but also improving sanitation, living and working conditions.

In fact, it could be said that the "*new* environmentally-based public health" was born in Liverpool in 1847 with the appointment of the first full-time city Medical Officer of Health, Dr William Henry. He was a prominent member of the Liverpool branch of the Health of Towns Association and it was largely due to his work that the Corporation of Liverpool promoted the Liverpool

Sanitary Act 1846, which established a public health service as an essential activity of local government. Thus, medical officers of health worked closely with sanitary inspectors and borough engineers, supported by legislation such as the above-mentioned Liverpool Sanitary Act of 1846 and national Public Health Acts in 1848 and 1875[12]. At the time it was considered that the local government was clearly best placed to take the lead in these matters, and to a certain extent this has been the case since then[12,363].

> *"And well, until 1974, the medical officer of health was concerned entirely with what these days we would consider to be public health, which is, social determinants of health, in other words, health promotion, as it used to be understood, and also infectious disease control and environmental health"* University professor.

While the development of effective treatments for disease and the creation of the National Health System (NHS) led to the establishment of a biomedical and hospital-centred model, the main determinants of health have been, and continue to be, inextricably linked to the work of local councils. After 1974, public health moved into the NHS, and three administrative levels were introduced; districts, areas and regions. Hence, health services management became part of the role of Community Medicine at district level, which dealt with public health issues and commissioning health services.

In 1980, the Thatcher government merged the districts and the areas, so Liverpool became an area called Liverpool Health Authority. Despite these restructurings, it seems that the awareness of the impact that social, economic and environmental determinants have on health and equity has remained deeply rooted in Liverpool.

> "*In 1980s the only people that talked about social determinants of health, like housing and health, or racism and health, patriarchy and health… You know, were socialist. And most conventional doctors were uninterested, or actively opposed, to focusing on the social determinants of health. […] There were no plans on social determinants of health; I was able to persuade my health authority to have a Women's Health, because I'm a feminist. I did a lot of work with women at the community, of course. We opened the first day-care centre, the first abortion unit… And I had to do this work outside the official job*". University professor.

> "*When Mrs. Thatcher was Prime minister, we weren't even allowed to talk about inequalities in health, so, public health had to talk about variation in health, rather than inequalities. So that changed, and to be fair, I think, it became quite an important part of any health plan. It was particularly the case at Liverpool, where there is a lot of deprivation, and there is an awareness on how this deprivation, poverty... Impact on life chances and health*" City Council member.

Having so embedded that the city is a place that shapes the health of those living in it, it is not surprising that Liverpool was one of the driving forces behind the WHO Healthy Cities Programme. The WHO Healthy Cities Programme was initiated in 1986 with the original intention of bringing together a small number of European cities to collaborate in the development of urban health promotion initiatives and to share models of good practice, and Liverpool was among these first cities (Figure 32).

"*The initial headquarters of the WHO Healthy Cities Project was at the University of Liverpool. […] It started off with 11 cities, and one of the 11 cities was, of course, Liverpool*". University professor.

Figure 32. Program for Liverpool Healthy Cities Conference in 1988

John Ashton, who was the first director of the Healthy Cities Project in Liverpool, also set up Liverpool Public Health Observatory in 1990 in order to provide intelligence to Merseyside Health Authorities, later Primary Care Trusts, and currently Local Authority Public Health Departments. So, the Liverpool Public Health Observatory provided all of them with epidemiological information and research support with the health needs assessments.

"*Public health got a new life in 1990, because of the introduction of the internal market into the NHS, you know, because it had this new focus on providing information for the new contract culture, as it were, if you understand, health needs assessment and so on"* University professor.

Later on, the Health and Social Care Act 2012[365] led to the transfer of the public health function back from the National Health System (NHS) to local government, which took place in 2013. Then, the responsibility and funding for many public health services were progressively transferred from NHS to local authorities, which entailed one of the most significant extensions of local government powers and duties in decades[363]. In this Act, the national Government set out a vision for the leadership and delivery of public services, where decisions about services should be made as locally as possible, involving people who use them and the wider local community[364]. This way, Health and Wellbeing Boards became established to act as the principal forum for local health improvement and partnership[363,364].

"*The 2012 Health and Social Care Act, which was written by McKinsey and the management consultants, and was very much about introducing privatization in a really big way… Despite that, public health moved back to local government*" University professor.

This move of public health to councils included the transfer of funding and commissioning for health services such as sexual and reproductive health, drug or alcohol treatment and the responsibility for 0-5 health visiting. Despite a difficult economic context and the national austerity policies, which put local governments in a quite challenging position, the return of public health enabled the use of all of local government powers and functions to improve health and reduce the inequalities that still exist. Over these years, local public health developed its approaches, widened its tasks, and established partnerships.

Since then there has been a growing recognition of the importance of prevention and an acknowledgement that health, and particularly health equity, is everyone's business. Actually, progress has been made, for instance, in embracing the HiAP approach, which is remarkable, especially considering that it has been achieved at the time of austerity and rising demand for health and care services.

In the last decade, Liverpool Council's budget has been cut by about 65%, and that has had significant impacts on its governance, forcing a reduction in funding for educational programmes and social care and more than 2,500 redundancies, etc[366]. Public health budget has also been significantly hit, and Liverpool Public Health has lost a number of posts. Seeking to cope with the need for welfare provision among the city's most vulnerable, Liverpool local government has been selling off assets and outsourcing public services to private investors[367], which has not contributed to improving its fragile socio-economic situation.

Liverpool has a long history of local governance for health equity, being a forerunner in a number of initiatives such as the WHO Healthy Cities Programme. However, Liverpool City Council faces considerable challenges arising from more than a decade of funding cuts and austerity measures which, together with privatisation processes, challenge the effective implementation of health equity policies.

7.3.1.d. Liverpool's local health strategy

The Liverpool City Council has embraced health and wellbeing across all its functions and services, and works on major themed interventions to improve health. Within the current city health strategy, we can distinguish two levels. On the one hand, there are the *Joint Strategic Needs Assessment*[368] and resulting *Joint Health and Wellbeing Strategy*[303], led by the Health and Wellbeing Board. On the other hand, there is also the *City Plan*[304], led by City Council and the Team Liverpool, a network of the city's largest public sector organisations, as well as private and third sector.

Liverpool Health and Wellbeing Strategy

The Health and Social Care Act 2012, introduced duties and powers for Health and Wellbeing Boards in relation to the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy, which aim to be a locally owned processes for service decision-making, strategic assessment and planning to improve the health and wellbeing of the local community and reduce inequalities. The outcomes of these processes are in the form of evidence and the analysis of needs in the case of the Joint Strategic Needs Assessment, and in the form of agreed priorities for the Health and Wellbeing Strategy. All of them combined, are intended to establish what kind of actions local authorities, the local NHS and other partners need to take in order to meet health and social care needs, and to address the wider determinants of health. So, one could say in simple terms that the Joint Strategic Needs Assessment identifies the need and the Health and Wellbeing Strategy outlines how that need will be addressed.

The responsibility for undertaking the Joint Strategic Needs Assessment comes through the Health and Wellbeing Board, where elected councillors, directors of public health and clinicians also have critical roles to play. The Joint Strategic Needs Assessment is an on-going evaluation process rather than a standalone document. It uses a range of techniques from quantitative and qualitative evidence to appraisals of the health and social care needs, resulting in annual reports, which provide a foundation to help commissioners shape services to address local needs. The process assessment includes a consultation process with stakeholders and civil society in order to develop an understanding of what is important to local people, involving a range of groups and organisations across the city. Liverpool Charitable and Voluntary Services, as well as HealthWatch, actively participate in its organisation and realisation.

> "*We met with every influential person in the city. So, every director in the local authority, and the chief exec of the NHS in the northwest, and we met with all the chief execs of the health trust, hospital trust... We met with the fire service, the police, and we worked with the local community, Voluntary Service... In meetings, and basically said, 'this is what we want, you know, we're trying to develop health and well being in the city and we want to know what you think'. And so we have quite long meetings to understand what their thought were their priorities for the city*" City Council member.

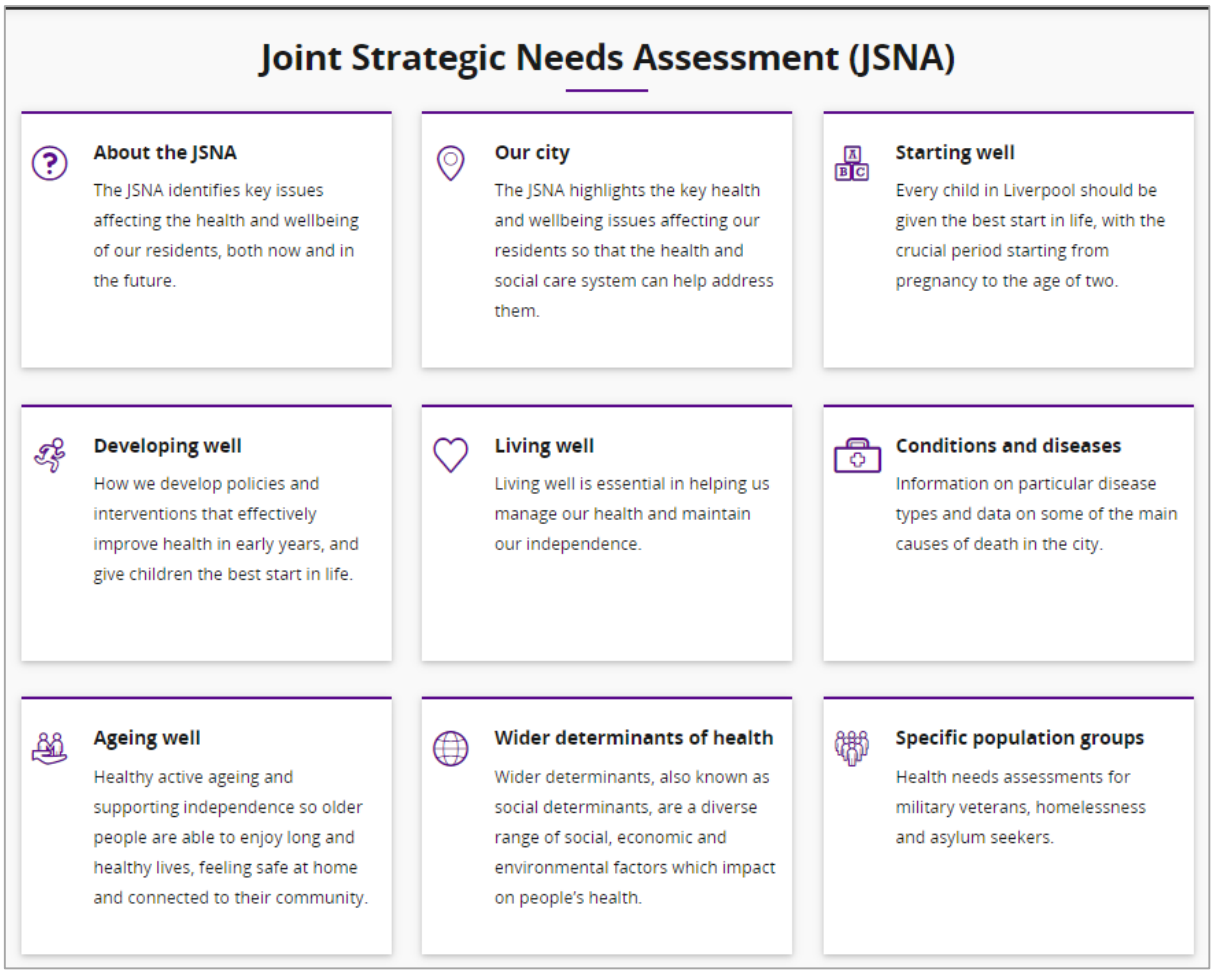


Illustration 3. Liverpool's Joint Strategic Needs Assessment[368]

The Liverpool's Health and Wellbeing Strategy[303], also known as the Joint Health and Wellbeing Strategy, is a governance for health strategy for Liverpool City. It is based on the Joint Strategic Needs Assessment and on-going engagement with partners and local communities, and it has a vision of creating a *Fairer, Healthier, Happier Liverpool*. The Health and Wellbeing Strategy focuses essentially on the four following aims:

- Giving children and young people the best start in life
- Health and independence for all
- Liverpool's citizen's engaged in improving health and wellbeing
- Building resilient and safe communities

Illustration 4. Liverpool Health and Wellbeing Strategy 2014-2019[303]

Surprisingly, the strategy does not detail objectives or concrete actions that could indicate how to advance these general aims beyond rhetoric. Thus, it is apparently intended to be a roadmap or a blueprint, rather than an operational strategy document; it does describe the general objectives and values (*symbolic content)*, but not the specific objectives and the interventions to achieve them expressed in concrete terms (*operative content*).

The first strategy that was developed is the one covering a five-year period, specifically from 2014 to 2019. The outbreak of the COVID-19 epidemic has made it difficult to elaborate and approve the strategy for the next period in time; however, it is currently being developed and it is likely to be published in the next few months.

City Plan

On the other hand, under the slogan *A thriving, sustainable, fair city for everyone*, the Liverpool's City Plan[304] offers a whole-of-government (and purportedly whole-of-society) strategy that explicitly considers health as a fundamental axis. It focuses on six priority areas; health, education, neighbourhoods, economy, culture and climate. Beyond these core axes, the City Plan also embraces the seventeen SDGs and explicit commitments to a collaborative leadership, community empowerment and equity promotion.

Illustration 13. City Plan Aims[304]

The City Plan is more operational than the Health and Wellbeing Strategy. It does feature specific objectives and indicators, but not linked to each other. So, in a down-to-earth manner, the City Plan aims to improve a set of indicators related to socio economic inequalities (health, education, skills and employment, etc.), healthy life expectancy, infant mortality, premature mortality rates for chronic conditions, mental health and wellbeing, educational attainment at all key stages, skills rates, housing quality, homelessness prevention and reduction, community safety and pride of place, re-offending, people and families in poverty, jobs and employment rate, diversity of the city's workforce, workers earning above the real living wage, higher value and clean growth sectors, good business practice, CO2 emissions and air quality, community cohesion, the social impact of public anchor organisations, neighbourhood coproduction of local services.

The City Plan is led by *Team Liverpool*. This is a network of the leaders of the city's largest public sector organisations and private and third sector, including; University of Liverpool, City of Liverpool College, Liverpool Chamber of Commerce, Torus, Merseyside Police, Merseyside Fire and Rescue Service, Liverpool Charity and Voluntary Services, Liverpool Clinical Commissioning Group, Mersey Care NHS Foundation Trust or Liverpool University Hospitals NHS Foundation Trust, in addition to, of course, the Liverpool City Council.

Even though the Health and Social Welfare Council participated in the review of the Municipal Plan, it is recognised that the scope of action of this Council needs to be broadened with a more comprehensive Plan, both in terms of objectives and the actors involved.

> "*No doubt that the City Plan will have a greater impact on the social determinants of health, because it does not stem from the Health and Wellbeing Committee, you know, which is there and does its things, but... Well, you know what I mean... The City Plan is led by the City Council and organisations across the city, you know, public sector organisations and private, and third sector*". Third sector representative.

This City Plan was approved in 2020 and therefore intended to be a blueprint to respond to the new challenges arising from the COVID-19 pandemic.

The Liverpool City Council has set, within the current city health strategy, the *Joint Health and Wellbeing Strategy*, which is based on the *Joint Strategic Needs Assessment* and led by the Health and Wellbeing Board and, on the other hand, the *City Plan*, which is led by City Council and a network of the city's largest public sector organisations, as well as private and third sector. The first one aims to create a "*Fairer, healthier and happier Liverpool*". It is a roadmap that states the importance of giving children the best start in life, of engaging citizenship or building resilient communities to improve health and equity, but which does not define specific objectives or concrete interventions to achieve this overall goal. On the other hand, the City Plan is a more operational document which aims to build "*A prosperous, sustainable and just city for all*", and embraces a whole-of-government approach along six broad axes: health, education, neighbourhoods, economy, culture and climate.

7.3.1.e. COVID-19 pandemic and governance for health in Liverpool

In 24th February 2019, a patient was treated at the Royal Liverpool hospital for Coronavirus and, in 2nd March, the first case of COVID-19 was confirmed. Actions were quickly initiated to try to respond to the looming health crisis. After this first case of COVID-19 cases in Liverpool gradually increased, leading to a peak in hospital admissions and deaths a bit later.

> "*When COVID first came to the UK, when we have one or two cases, nationally, you know, we were very quick to respond. We immediately held the Health and Wellbeing Board to see what we needed to put in place. And that was actually covered on national news, that we've done that, you know, because at the time, people weren't reacting as quickly to it as we were in Liverpool*". City Council member.

Then, on 16th March, social distancing measures were announced; shops in Liverpool closed and, two days later, the schools did as well. A national lockdown was introduced from the 23rd March 2019 to May 2020. At this peak, COVID-19 lockdown saw 64,900 of Liverpool residents furloughed.

Liverpool Health Protection Board was established as a sub-committee of the Health and Wellbeing Board in July 2020. It was chaired by the Director of Public Health and had broad membership across NHS, primary care, social care, higher education, children's services, faith and voluntary sector, Healthwatch, business sector, emergency planning, etc. The Liverpool Health Protection Board lead the governance requirements locally for COVID-19 control, and developed and has oversight of the implementation of the Liverpool COVID-19 Outbreak Management Plan. This Plan aims to be a whole system response to reduce spread of COVID-19 infection and prevent and contain outbreaks, taking into account local priorities and risks, and using local assets and new developments including vaccination, rapid testing and improved intelligence. It is worth noting that, in the Liverpool COVID-19 Outbreak Management Plan, inequalities are considered in almost every aspect of the response.

The introduction of screening tests made it possible that, from May to September 2020, lockdown began to be lifted and restrictions were progressively lowered. Targeted asymptomatic testing began; in fact, Liverpool made headlines for being the first local government in the country to approve a locally-made protective screen for taxis and private hire vehicles. The NHS contact tracing system went operational, and schools began to reopen as well as non-essential shops and other venues. However, after a quite stable summer in Liverpool, the number of cases went up again in September and October 2020, when there was a second COVID-19 peak. Consequently, restrictions were reintroduced. A second national lockdown was established in November, which was then followed, in Liverpool, by an asymptomatic mass-testing pilot supported by the Army. From 28th September 2020, the government introduced payment for people on low income who needed to self-isolate and could not work from home.

The incidence of COVID-19 cases dropped for a few weeks, but rebounded again in mid-December and early 2021. Despite this third peak, the discovery of vaccines against COVID-19 augured a new and more hopeful scenario. If the Pfizer Vaccine was approved on the 2nd of December 2020, on the 8th of December Liverpool started the vaccination campaign, being one of the first cities to vaccinate in the United Kingdom. In early 2021, the vaccination programme is well underway, but new variants of the virus continue to pose an ongoing threat.

Since the beginning of the pandemic, Liverpool Public Health, within the Health and Wellbeing Board, has been at the centre of measures to tackle the spread and impact of COVID-19.

Obviously, the Health and Wellbeing Board has not worked in isolation from the rest of stakeholders. It has worked with partners across local government, the NHS, the voluntary and community sectors, and beyond, to co-produce a coordinated team response.

However, local analysis revealed that, by the end of 2020, there were 28.933 cases of COVID-19, 4.055 hospital admissions, and 988 deaths. Moreover, this impact has varied by ward, ranging from 410 per 100.000 people in the relatively prosperous Yew Tree to 73 per 100.000 in Central, displaying an increase in the gap in life expectancy between the highest and lowest wards to 13 years[361]. Indeed, like many other contexts, in the city of Liverpool health inequalities have been exacerbated during this pandemic, with those already worse off experiencing the most severe impacts of COVID-19.

> "*I think what has struck people here is the inequality. People are starting to realise inequality, people who are dying are ethnic minorities, and they are poor people... I think, people are starting realise that the children who are missing school are the poor children, the ones who are disadvantaged who haven't got a computer. I think some of those things are actually getting people quite upset. They didn't haven't recognised it in such a clear way before that*". City Council member.

So, even though before the pandemic tackling health inequalities was a priority in Liverpool's city governance, these unequal consequences of the pandemic make even more relevant and necessary an integral objective to address the long-term systemic challenges facing the city to *build back fairer*[361]. In fact, different local stakeholders have shared unanimously this view:

> "*After this last year with COVID, what the pandemic has exposed in terms of the gaps, and the problems in local social and health services… There might be an opportunity now to say, we have to consider the social determinants of health, and actually public health should be there right in the middle. Then, maybe, they'll start funding it in a way that it should be funded*." City Council member.

Although the public health area was only partially reinforced, there seems to be an awareness that actions with a key focus on a proportionate universal response that strengthens preventive action on the social determinants of health across the life course are needed. In fact, some of the envisaged measures form the Liverpool Health Protection Board focused specifically on early years, poverty, deprivation, employment or housing. In general terms, it can be said that this response has been data-led and based on a whole population approach. Liverpool's response to the pandemic, from the outset, focused on protecting health and social services, identifying education as an important priority. There was also a clear will towards a transparent and accessible communication. It also has been a multi-agency partnership response, led by the local government working with partners at local, regional and national levels.

The post-vaccination scenario raises new social and economic challenges. For instance, currently there are over 10.700 people unemployed in Liverpool and further increases are expected when furlough is withdrawn. This puts a strain on the Liverpool City Council which has already had to respond to an increase of more than 82% in people claiming benefits[361]. But the COVID-19 pandemic has not only brought enormous challenges at the local level, it has also brought some opportunities that are worth underlining. New technologies in work, health and business have been harnessed and, perhaps more importantly, it has become increasingly clear the crucial need for working in constant partnership, and focusing on local, community-led, bottom-up approaches.

"In the first wave of the pandemic we learned the importance of community engagement: not treating our people as helpless victims, but considering them as a potential community asset. Since then we have collaborated with our local communities and watched in awe as community initiatives have added to the support we are offering. Our experiences have shown the community spirit and trust that exists in Liverpool, and highlighted the power of a community-led response, giving us the power to respond quickly and proactively. We need to nurture the relationships we have built with our communities during this time, remembering to give and take at all times, not just when we need it". City Council participant in the local health strategy, on the Public Health Annual Report 2020: Liverpool's Covid-19 Journey[361]

The COVID-19 pandemic has led to a shift in both the needs of the population and the priorities of Liverpool City Council, which responded quite swiftly. The Health and Wellbeing Strategy and its renewal for 2020-2025 was put on hold, prioritising the development and implementation of the COVID-19 Outbreak Management Plan. From the earliest data analysis flagrant health inequalities were revealed, thus the local government tried to provide an equity-based response, both in terms of health and socio-economic measures, yet it was overtaken by the sheer demands and needs. Improved coordination between different actors and the active involvement of community networks were key in trying to respond to these needs beyond Liverpool City Council's capacities and recognised as being so.

7.3.2. Analysis of key dimensions of governance for health equity in Liverpool's local health strategy

This section analyses the extent to which the key dimensions of governance for health equity, that is, political coherence, accountability and social participation, are incorporated into Liverpool's local health strategy. In order to asses policy coherence an adaptation of the Storm's Maturity Model for HiAP[306] has been used. To asses accountability, the Ebrahim and Weisband's core components of accountability[128] and the accountability domain of the PAHO Equity Commission's rubric[133] were applied. Finally, social participation has been assessed using the Health Canada's Public Involvement Continuum[307]. These tools for assessing key dimensions of governance for health equity have been applied to the text of Liverpool's Health and Wellbeing Strategy and Liverpool's City Plan documents, and this analysis was complemented with a thematic analysis of the interviews to give an enriched view of Liverpool's local health strategy for each of the three dimensions.

7.3.2.a. Policy coherence

In order to assess the extent to which policy coherence has been incorporated into Liverpool's local health strategy, an adaptation of Storm's Maturity Model for HiAP scale[306] has been applied to Liverpool's Health and Wellbeing Strategy and Liverpool City Plan (Table 17). Thus, the following table summarizes how the components of policy coherence have been included in Liverpool's local strategy documents.

Table 17. Policy coherence in Liverpool's local health strategy

Liverpool's local health strategy		
Stage	**Policy coherence components**	
Recognition	Importance of policy coherence recognized to reduce health inequalities	In both, the Health and Wellbeing Strategy and the City Plan, it is explicitly recognized the importance of intersectoral action and policy coherence in addressing health inequalities and improving the wider determinants of health. For instance, it is stated; "*A united effort is required to bring about sustainable change in health and wellbeing, address the wider determinants of ill health and reduce health and social inequalities*" and "*We will work together to tackle health inequalities and respond to what matters most to people in improving health and wellbeing*", respectively. On the other hand, the contribution of a number of sectors to health is explicitly recognized in the Liverpool's Health and Wellbeing Strategy, "*The challenge here is to address the root causes of poor health such as low-income levels, housing, education and employment.*"; and implicit in the City Plan, under the recognition of the actions of different sectors to the population' wellbeing and happiness.
	Visible which activities of sectors contribute to (determinants of) health inequalities	

Consideration	Policy coherence / Intersectoral action described in policy documents Collaboration with sectors present (project-based) Collaboration on health inequalities is started Activities of sectors contribute to determinants of health inequalities	Although the Health and Wellbeing Board has internal documents that refer to HiAP or intersectoral work, within the Liverpool City Council policy coherence is generally denoted with other terms, such as whole-of-government or whole-of-society. But specifically in the Liverpool's local health strategy documents, these terms are *Collaborative leadership* or *Whole systems level.* The City Plan and the Health and Wellbeing Strategy are roadmaps that are not intended to detail specific intersectoral actions for health, and yet both make constant reference to the other sectors' activities to improve health and reduce inequalities. By way of example, in the City Plan it is stated; "*Creating and maintaining safe and accessible public places, local facilities and green infrastructure, in partnership with our communities: To reduce health inequalities and improve health and wellbeing through maximising the use of local public assets, including parks*".
Implementation	Concrete collaboration agreements Structural consultations forms present Key person or group ensuring policy coherence (role is clear) Working from sectors on health inequalities (policy basis)	Policy coherence is articulated through the Liverpool City Council's Health and Wellbeing Board, which includes the directorates of different sectors and is chaired by the Mayor. It has a person in charge of ensuring intersectoral collaboration, not only between different departments within the City Council, but also with other stakeholders. Collaboration agreements are reflected in the minutes of the Board meetings. The Health and Wellbeing Strategy, and particularly the City Plan, are themselves policies based on intersectoral action for health.
Integration	Broad, shared political and strategic vision Policy coherence results visible (both content and process)	In the City Plan is stated "*A thriving, sustainable, fair city for everyone*", and "*A fairer, healthier, happier Liverpool*" in the Health and Wellbeing Strategy. These are declarations of intent that certainly reflect a shared vision of the importance of health and equity. How these strategies have been developed, involving broad sectors of society beyond the City Council, may indicate that policy coherence is not only expressed in terms of content, but also in the process.
Institutionalization	Political and administrative anchoring of the HiAP approach Continuous improvement of integral processes and results on the basis of the achieved results	Liverpool's local health strategy focuses on addressing the determinants of health as a means to improving the health and wellbeing of the city's population. Both, the social model of health and the health equity, are quite embedded in the strategy. In the same way, health and equity are values that are solidly anchored in the Liverpool City Council. However, the last component of institutionalizing policy coherence, relating to continuous improvement based on results achieved, is not entirely well established. Although the Annual

		Public Health Report somewhat supports the continuous process of evaluation and policy development, neither the Health and Wellbeing Strategy nor the City Plan progress reports have been released.

In order to provide an enriched view of policy coherence in Liverpool's health strategy, the results set out in the table are complemented and further developed by the results of the thematic analysis of interviews with key informants involved in the development and/or implementation of the local health strategy.

Therefore, it could be stated that Liverpool's local health strategy integrates well this important dimension of governance for health equity. Liverpool's long trajectory in governance for health has enabled a political and administrative anchoring of the social model of health and the health equity, both at whole-of-government and whole-of-society level.

> *"We have had some bits of partnership working, but it was never a total thing, until recently. […] And I think that, in this health and wellbeing strategy, is the first time that... That really they [the social determinants of health] have been a fairly significant part of the strategy".* City Council member.

Although there is no doubt that there is an institutionalized policy coherence for health and equity, a critical examination unveils some doubts about how this institutionalization actually impacts on the improvement of health equity.

> "*Structurally, social determinants of health model is totally institutionalized. They have been institutionalized at least for… 20 years, probably. It's so institutionalized that even conservative governments take for guaranteed that inequality is a bad thing, although that's not down of a kind of hegemony of equity, if I can put it that way. […] But, in a different sense, in a functional sense, in terms of what actually goes on, in terms of what it does… You can see that is not as institutionalized as it could be*". Third sector representative.

Policy coherence appears to be fully embedded both at a discursive level and in terms of the mechanisms that operationalize it in Liverpool's local government. However, as far as the reduction of health inequalities is concerned, there is no evidence of its effective translation.

This relates to the continuous improvement of integral processes and results on the basis of the achieved results, which is a MM-HiAP component of the Institutionalized Stage. In this aspect of policy coherence institutionalization Liverpool has room for improvement. There is a lack of monitoring and evaluation of the progress of the local health strategy, as well as a lack of linkage between the progress of such strategy and health and health equity outcomes. Progress in this area could lead to a more effective and visible translation of policies in terms of sustainable equity and health results.

The policy coherence of Liverpool's local health strategy can be placed at the *Stage IV - Integrated* of the MM-HiAP. This means that the social model of health and the health equity approach are quite embedded, and therefore they are politically and operationally quite entrenched. However, as the continuous improvement of integral processes on the basis of the achieved results is not yet fully achieved, its effective translation in terms of its impact on health equity remains unclear.

7.3.2.b. Accountability

To try to provide insight into how accountability has been incorporated into Liverpool's local health strategy, the four core components of accountability identified by Ebrahim and Weisband[128] are assessed (Table 18), as well as the inclusion of accountability mechanisms to redress violations of people's right to health, using the guiding questions of the PAHO Equity Commission's accountability domain[133] (Table 19). In order to present the information related to accountability in the Liverpool's Health and Wellbeing Strategy and Liverpool City Plan in a clear and structured manner, the following summary tables are presented, one for each specific assessment tool used. Besides presenting these findings in the tables below, these results are further explored and extended using the results of the thematic analysis of interviews with key informants that have participated in the development and/or implementation of Liverpool's local health strategy.

Table 18. Accountability in Liverpool's local health strategy (Ebrahim and Weisband's components)

Ebrahim and Weisband's Accountability component		Liverpool's local health strategy
Transparency	Collecting and making available and accessible for public scrutiny information that is "actionable" to citizens	Both the Health and Wellbeing Strategy and the City Plan are available on the City Council website, so are the Public Health Annual Reports. Although this information is not available in formats adapted to specific needs, the following is indicated; "*If you require further support or an alternative format, please email publichealth@liverpool.gov.uk*". It should be noted that even though this information is available, the strategies do not define concrete actions linked to indicators that could facilitate citizen's scrutiny. The agenda and minutes of the Health and Wellbeing Committee meetings, and more recently, also the meeting recordings, are publicly available. The meetings include a 'declarations of interest' to provide an opportunity for Members/Officers to declare any pecuniary or significant prejudicial interests they may have in any item on the agenda, as well as a question time for inquiries that may be posed by any person or organization "*any question submitted in writing, either prior to the meeting via post or email, or by presenting to the Committee Clerk prior to the start of the meeting*". Thus, the level of transparency is quite decent, with fairly straightforward access to information and open contact channels. That being said, it is equally true that there has been no social communication effort. "*Accountability… Well, purely from Public Health, we produce an annual health report, which comment on the good things that happened and the bad things. It is accessible, but maybe not widely read by the population*". City Council
Answerability	Providing justification for decisions so that they may reasonably be questioned	In general terms, the objectives are intended to respond to the health and health equity concerns perceived and identified in the Public Health Reports. At the same time, there is an explicit willingness to meet citizen expectations on local policies and respond to local citizens' feedback. In this sense, mechanisms have been established to encourage feedback, besides the participatory processes; "*The Joint Strategic Needs Assessment is an ongoing process. If you have any comments on the information available, or would like to work with us to develop these or other reports further please contact us*".

Compliance	Monitoring and evaluation of procedures and outcomes	The monitoring and evaluation of procedures is certainly an area for improvement, in fact, a corruption scandal has recently been revealed and a criminal investigation led to the arrest of several public officials. This scandal also involved the Health and Wellbeing Board. However, following this scandal, an internal assessment has been made and actions to improve compliance have been identified. It should be noted that there was no independent accountability mechanism that could monitor procedures and outcomes. "[Regarding the Health and Wellbeing Strategy] *There's nothing here that anyone can disagree with, but I'm not optimistic about their chances of delivering... Where are the funds? And where are the details?*" Third sector representative. On the other hand, although Public Health Reports are issued annually, this is not the case for the Health and Wellbeing Strategy's implementation and performance follow-up reports. On the contrary, the City Plan commits "*to provide accountability and transparency for the achievement of our shared outcomes, with progress monitored and reported annually*". At the time of this investigation, one year has not yet passed since its approval and therefore the report has not yet been issued.
Enforceability	Sanctioning for shortfalls in compliance, answerability or transparency	No enforcement mechanisms other than legal sanctions are contemplated.

To a certain extent, Liverpool local health strategy incorporates accountability mechanisms that go beyond a simple airing of citizens' grievances and exposing governments' justifications. They promote collective action to influence policymaking, service provision and resource allocation. However, it is necessary to strengthen these mechanisms, especially those related to accountable compliance.

> "*I will choose my words carefully…. The accountability of the City Council has recently had an inspection from the government, and changes to accountability were recommended as part of this government's inspection… Some procedural matters needed to be addressed, so that's been developed at the moment*". City Council member.

Despite recent corruption cases, there appears to be a widespread feeling that accountability at the local level is stronger than at other levels of government. In this connection, there is the perception that, at higher levels of management, citizen's power to influence policy and monitor policy implementation become more distant and less accessible.

> "W*e've got a potentially new system, so the government is getting rid of Clinical Commissioning Groups and then moving to a different system, which is a Merseyside and*

Cheshire based partnership. And there's going to be some decision making made at that level, and that hasn't got necessarily at the moment any engagement, capacity, or any democratic accountability structure. It's all a very new structure, but I think it's much easier to have a commitment to the local community and a commitment to engage the local community on the Liverpool level" Third sector representative.

On the other hand, with regard to specific mechanisms that enhance accountability of governance for health, it is noteworthy to mention the work that the Liverpool Public Health Observatory has been carrying out for decades. The activity of the Observatory, developing for example Health Impact Assessments, seems to have reinforced an independent external monitoring and evaluation that, with the integration of these functions into the Liverpool City Council's Public Health Department, may have been weakened.

"*One thing that the Observatory did… It did research and intelligence work that would not have been done by the health authorities themselves. So, in that sense, it put more information about health impacts and public policy into the public domain, and sometimes that forced people to act when they may not have done that in other ways, and that obviously is about accountability […] I do think that the observatory was helpful to accountability*". University professor.

If we focus on analysing accountability specifically linked to the inclusion of mechanisms to redress violations of people's right to health, using the guiding questions of the PAHO Equity Commission's accountability domain[133], the result is rather bleak. Although, as mentioned above, certain accountability mechanisms do exist, there is no explicit mention of these mechanisms linked to the right to health, neither in the Health and Wellbeing Strategy nor in the City Plan. It should be noted, however, that the Health and Wellbeing Strategy does state "*health is a fundamental right of every human being, to be enjoyed at the highest attainable standard*", although without linking it to any accountability mechanism. This may be due to its rather symbolic, and not quite operational, nature of the strategy content.

Table 19. Accountability in Liverpool's local health strategy (PAHO Equity Commission's rubric)

	PAHO Equity Commission's rubric	Question score
Accountability	Does the local health strategy include mechanisms to redress violations of people's right to health?	
	• Does the local health strategy include mechanisms for educating people on their right to health?	0/1
	• Does the local health strategy include mechanisms for reporting right to health violations?	0/1
	• Does the local health strategy include mechanisms for enforcing people's right to health?	0/1
	• Does the local health strategy include mechanism for investigating and reducing fraud and corruption?	0/1
	OVERALL SCORE	0/4

When assessing the four basic components of accountability identified by Ebrahim and Weisband, Liverpool's local health strategy appears to have a fairly acceptable level of transparency and answerability, while gaps have been identified in monitoring and evaluation of procedures and results, as well as in the effective sanctioning of non-compliance. Regarding the evaluation of the accountability dimension according to the PAHO Equity Commission, the result is discouraging (0/4). It should be noted, however, that accountability mechanisms exist to redress violations of the right to health, although there is no reference to them in the content of the Health and Wellness Strategy or in the City Plan.

7.3.2.c. Social Participation

In order to qualify how this key dimensions of governance for health equity has been incorporated into Liverpool's local health strategy, social participation is classified according to the five levels of the Health Canada's public involvement continuum[307] throughout the phases of the policy cycle[94]. This tool has been applied to Liverpool's Health and Wellbeing Strategy and Liverpool City Plan and the results are summarized in the following table (Table 20).

Table 20. Social participation in Liverpool's local health strategy

Social participation		**Liverpool's local health strategy**
Policy cycle phase	*Level*	
Health and social determinants of health needs assessment (agenda building)	V - Partner	The Joint Strategic Needs Assessment has an explicit will to empower the community, and the City Council assumed the role of enabler. In this phase of the political cycle, citizens and other social groups accepted the challenge of developing solutions themselves, although this degree of engagement may have been somewhat watered down over time. Despite this, it is noteworthy the opportunity for shared agenda setting and open time frames for deliberation on issues that affect them.
Local health strategy policy-making (policy formulation and adoption)	IV - Engage	The City Plan has as a shared commitment "*create a partnership culture where risks are shared and bold decision-making is enabled*". On the other hand, the Health and Wellbeing Board stated, "*The Joint Health and Wellbeing Strategy needs to be part of everyone's core business related to health and wellbeing across the city. It is influenced through, and by, its on-going engagement processes therefore promoting ownership of the strategy and its achievements*". It is true that there have been processes to involve citizens and social agents in the formulation of local policies and strategies, but this relationship has not

		been entirely horizontal. Despite this, there is certain degree of capacity for citizens to shape policies and decisions that affect them.
Local Health Strategy execution (implementation)	II - Gather information	The fact that both the Health and Wellbeing strategy and the City Plan are intended to be living documents necessarily opens up the implementation process. Thus, there is a certain degree of dialogue between the actual proposals and the implementation. Although there is not a firm commitment to do anything with the views collected, individuals and groups may have an opportunity to influence the outcome. Having said this, it is also true that, as the provision of services is quite outsourced, once the projects are funded, operational capacity to modify the intervention is certainly limited, even for the City Council.
Local Health Strategy monitoring (evaluation)	II - Gather information	Part of the assessment is based on the perception of citizens and social agents, and this qualitative approach allows getting an insight into the experiences and meanings of the population. However, there is still a long way to go, since there is no social participation either in the design of evaluations or in their conduct, just to mention a couple of examples.

The following spider graph summarizes the levels of social participation of Liverpool's local health strategy at the main phases of the policy cycle (Figure 33).

Figure 33. Levels of social participation in Liverpool's local health strategy

In order to provide an enriched view of social participation in Liverpool's health strategy, the results of the Health Canada's public involvement continuum are complemented and further developed by the results of the thematic analysis of interviews with key informants involved in the development and/or implementation of the local health strategy.

The city of Liverpool has a deep-rooted culture of social mobilization and participation, which has undoubtedly facilitated this strong social participation in the needs assessment and policy-making processes, the phases of the policy cycle in which there has been an explicit commitment to engage with the community. In other phases of the policy cycle, such as implementation or evaluation, where participation has not been so actively promoted, the degree of involvement is clearly lower.

> "*As you would imagine, Liverpool is renowned for its politics. So, there was a lot of involvement from local people already, because we have a very strong volunteering at third sector in Liverpool, very very vocal... So very much involvement there. So, you know, involving them in the strategy was really important*." City Council member.

In general terms, the engagement of the community and other stakeholders in the local health strategy has been fairly high. Although this participatory culture is not yet fully embedded in local government, there does seem to be a certain degree of political will to strengthen it. Among the initiatives to advance on social participation in health, it is worth mentioning that the Liverpool City Council has participated in the European Social Action Network.

> "*We've had a variety of different ways of engaging. I think some Councillors would say that, because the councils are elected to some extent they represent very local areas in the city, so they are the voice of the local population, because they've been voted to do that. Having said that, we have set up lots of other things. For example, an important participatory process to talk about primary care services, where they should be situated, but also what they wanted and how they wanted it to be run…*" City Council member.

> "*We were part of a political movement in health and in generally in social mobilization, an organization called European Social Action Network, ESAN. Liverpool were the only city in England who were members, we're no longer members, because unfortunately we're no longer in Europe. […] We were the only people who were there under the umbrella of public health and health improvement*" City Council member

Thus, although the level of social participation in Liverpool is relatively good and there is some willingness to strengthen it, a closer examination reveals the acknowledgment that making social participation and community health transformative and empowering is, in practice, very complex. On the one hand, there are challenges related to previous experiences of poorly executed participation processes, scepticism about the difference participation will make, and lack of confidence in the actual capacity of the local government to respond to social needs. Concern was also raised about the instrumental use of participatory processes. And, specifically, the concern that the local government was shifting responsibilities onto the community in the current context of austerity as public services were hollowed out.

> *"I think people have maybe been engaged in the past, but they feel like anything's changed. It's like… Well, people in my neighbourhood still die really young… What difference is this going to make? […] It's not easy, I think making the best of the opportunities that we've got, and making people feel that their voice counts... and it would be easier if there was money. So if people actually believed there was money to*

address the issues, to deal with them, to provide new services... Then, people would be more willing to engage then, because they will believe it was going to make a difference. But they know the local authority has got no more money, they know that health has got no money. So there's a limit to what they can do to improve things" Third sector representative.

On the other hand, challenges related to the possibilities of participation were identified, recognizing that there are absent voices and difficulties to effectively engage certain groups. Challenges with respect to the ability to participate in a relevant and meaningful way were also identified. And lastly, difficulties related to the willingness to participate were noted, suggesting a certain degree of fatigue resulting from multiple participatory processes.

"*If you're living a really chaotic life, if you've got so many other things going on in your life, you might not necessarily expect to be heard, or be listened to... or have the time to engage*" Third sector representative.

"*The more concrete it's an issue about, the more likely you can get members of the public involved. But public health... As much as I'm a fan of engaging with the public, when we stop to reflect on it, it's such a difficult, nebulous subject... Most people don't know what public health is other than in the context of COVID infection protection"* City Council member.

"*There are other things going on out there in people's day-to-day lives… It became so overwhelming, there are a lot going on… A lot of… And it's so difficult to engage in every issue at the same time*". Third sector representative.

All of these challenges may explain why, despite the entrenched culture of social mobilization and participation in the city of Liverpool and the apparent willingness to embrace it within local government, there is a perception that in the end social participation remains more utilitarian than transformative.

"*We didn't do enough, I don't think, around getting people to be involved in bigger or wider policy things. And if we did, it was very easy for it to become tokenism..."* City Council member.

Social participation has been incorporated into Liverpool's local health strategy in an unequal manner in the different phases of the policy cycle. Thus, in health needs assessment and policy formulation there is a medium-high level of public participation and influence, while policy implementation, monitoring and evaluation have a medium-low level of participation. But beyond the fact that the level of social participation is not high in all phases of the political cycle, several barriers have been identified that may explain the perception that social participation ends up being, in practice, more utilitarian than transformative.

7.3.3. Analysis of factors affecting the local health strategy implementation in Liverpool

This section presents the factors affecting the local health strategy implementation in Liverpool identified by the agents involved in the processes of implementation of local health strategies. On one hand, the barriers and facilitators of implementation in the pre-pandemic context (Table 21), and on the other hand, the implementation-related challenges and opportunities of the current COVID-19 pandemic context (Table 22). These factors have been analysed using the domains of the Consolidated Framework for Implementation Research framework as a guide for the implementation analysis.

7.3.3.a. Implementation barriers and facilitators of the local health strategy in pre-pandemic context in Liverpool

Table 21. Implementation barriers and facilitators of the local health strategy in Liverpool: Pre-pandemic context

CFIR		Implementation barriers and facilitators of the local health strategy in Liverpool: Pre-pandemic context
Outer setting	Needs and resources of those served by the local government	Overall, there is a fairly good perception of how responsive Liverpool's local health strategy is to the perceived needs of the population. This is largely attributed to the participatory processes in both the Joint Strategic Needs Assessment and the development of the Health and Wellbeing Strategy and the Liverpool City Plan "*So the strategy didn't belong to the city council, it belonged to Liverpool. And the message was very clear from the start, 'if you want this city to survive to thrive, you have as much responsibility as anybody out. Yeah, everything you do... You have to ensure that you embed health in all your business plans, because if you don't, you're not going to get what you want, what you expect. So it's your responsibility too'. So that was kind of how we developed the Health and Wellbeing Strategy*". City Council member.

	Cosmopolitanism	Liverpool City Council has networked with other external organizations, particularly UK Healthy Cities Network and the European Social Action Network. Although belonging to these networks has been identified as a facilitating factor for the implementation of the local health strategy, some actors recognize at the same time that this entails an additional workload that is not necessarily reflected in health and equity results. "*Many of the cities that have been involved in the European healthy Cities program, for many years, still have high levels of inequality, and high levels of poverty. So in the UK, that's definitely true, you know, for Liverpool, but also for Glasgow, and others. It isn't as if being part of healthy cities has necessarily closed that equity gap. And I think what that shows is that is that healthy cities is about a process, a journey, not about reaching an end point*" University professor.
	External Policy	Any approach to urban governance must be considered in the context of national (and international) influences, and this is particularly true for external policy. The Health and Social Care Act 2012 and its associated reorganization of public health within local government is widely recognized as a factor facilitating the implementation of governance for health. However, other national policies, such as the austerity policies that were imposed following the 2008 financial crisis, have been identified as a major obstacle to the actual delivery of the responsibilities that the Health and Social Care Act placed on local councils. "*Public health was for a long time under the NHS, and… Well, when finally, the Health and Social Care Act brought public health back to… to where it should have always been. Well, that change coincided with the terrible financial crash. Local governments lost millions and millions of pounds, because austerity meant the national government really really squeezed lots and lots of money out of local services. That rundown quickly impacted the services accounts, that become rundown services, because they couldn't afford any more to run*". City Council member.
Inner setting	Structural characteristics	The Health and Wellbeing Board has been identified as enabler for intersectoral work for health, so the Liverpool City Council has a full-time dedicated person to facilitate its work. Given that both the City Plan and the Health and Wellbeing Strategy are based on a whole-of-government approach, it can be inferred that the Health and Wellbeing Board acts as a facilitator not only of intersectoral action for health within the City Council, but also as a facilitator of the implementation of Liverpool's local health strategy as a whole.

	Networks and communications	Communication between public health professionals and those in other fields can sometimes be difficult and, in fact, has been identified as a bottleneck to implementation. Acting on the social determinants of health implies conveying the need for complex actions that have long-term results. In this sense, one of the main difficulties identified has been precisely to communicate the importance of acting when the impact on health is not easily measurable in the short term. On the other hand, there are also communication barriers between technical experts and civil society representatives and, in this sense, the need to adapt the language to create a common understanding has been highlighted. "*I sat at the top table in the council, so, I sat with the chief executive the directors I was around that table talking, but I felt... They didn't take my ideas as seriously as the other directors. The director of social care or the director environment, had very concrete ideas of what they wanted, for instance to build five houses or to build a new roof. And my things... I could contribute to much more long term, nebulous, difficult to account, important but not urgent issues. I always felt... We lost out to some extent*" City Council member. "[…] *often the experts are so ingrained in their own little bit of the puzzle that they don't think of... Well, not everybody is like me. Not everybody understands this. And we take that for granted*" Third sector representative.
	Culture	The fact that health and equity are institutionalized values in Liverpool City Council has been identified as a facilitating factor. However, at the same time, a potential exploitation for political ends has been pointed out, which could hinder the implementation of effective measures for health equity. "*So there is quite a lot of political involvement in Liverpool. The politicians like to be involved in anything that's getting a lot of attention. And, of course, when public health run campaigns, they all put the hands up and say, I'm responsible for that. So, you know, whether they're interested or not is another matter, but it certainly gets them a lot of kudos for that very reason"* City Council member.

	Implementation climate	Generally speaking, there seems to be a positive perception of the climate for implementation, both within the local government and in relation to other local actors. The constant changes in people and structure have been identified as a barrier that can be overcome. "*The health service and public health has been reorganised lots and lots of times every few years. The government reorganise itself and we change every time that the government changes... The partnership meetings, the names, and whatever change... But the partnerships get to continue with different names over the years"* City Council member.
	Readiness for implementation	Looking back to the pre-pandemic period, there did not seem to be a major need for change within the institution, which followed its own rhythms in the processes of developing the local health strategy and its implementation. Leadership engagement depended, to a large extent, on the elected Mayor. "*To some extent, the elected Mayors affect coherence between council policies. There was one that had a very clear view on what he thought was health, his interests were on things like drugs, alcohol... those kind of issues. So, we've had quite a lot of input into some of those kinds of policies and, working with other council directorates, we've got things through*" City Council member.
Process	Planning	A barrier identified is the different timeframes managed by the City Council Directorates and the stakeholders involved in the local health strategy, which seems to hinder the planning, implementation and monitoring of intersectoral actions for health. "*People might have... people work to different timeframes, if you see what I mean. So they have workloads on different times, I think sometimes they can struggle to get answers back from people or, you know, getting drafted, when the draft from plans... They may not get the cooperation that they need in the time that they needed, you know, so I think they can sometimes have problems hitting those deadlines*" City Council member.

	Engaging	The perception of how different actors, inside and outside local government, have been involved is generally perceived as satisfactory. This collaboration, and particularly the engagement of key people (champions), has been identified as a facilitating factor driving through the implementation process. "*All it's about… As I say, it's identifying the resources. And for me, the resources of people"* City Council member. In terms of engaging the citizenry, hurdles for participation to be empowering and transformative, beyond a merely symbolic participation, are also identified. This point has been developed extensively in Section 7.1.3.2.2.3.
	Executing	One of the barriers that has been made explicit is the challenge of tracking progress with a local health strategy that is intended to be a roadmap rather than an operational strategy. "*The objectives are so vast, so ambitious, that it's not easy to actually notice the progress.... You see it in small things, of course, but after so much effort you can't go and say, well that's it, we no longer have health inequalities! I mean... I doubt if we will ever be able to meet them*". City Council member.
	Reflecting and evaluating	In terms of evaluation, there are annual reports on the state of public health, but not on the process of implementing the local health strategy. This has been identified as a barrier to assessing progress. In this sense, there has been some thought about the relevance of setting up mechanisms that could facilitate not only the evaluation in terms of health impacts, but also of the overall performance of the municipality in terms of the population's wellbeing. "*I think that there can be value in having mechanisms, like health observatories or health impact assessments, but I think probably those will be stronger if they are integrated into looking at what is the overall function of our local government*". City Council member.

Intervention	Evidence strength and quality	There is a perception that the local health strategy integrates principles and values that allow addressing the social determinants of health and equity. Thus, the local health strategy is perceived as being well-founded on a conceptual and theoretical level. "*Do you know the Marmot Review? The Strategy incorporates Marmot's values. So... That was taken to our Health and Wellbeing Board, and that's where they formally adopted to make sure that any strategies and reports that come underneath the Health and Wellbeing Board would use those Marmot's says, social determinants of health, also health and all policies… So, to address the root causes of health inequities*". City Council member
	Complexity	The local health strategy is perceived as quite broad and comprehensive, as a long-term strategy. However, it has a relatively high level of abstraction that does not make it readily operational, hampering its implementation. In this sense, one of the implementation-related barriers that has repeatedly emerged is precisely the complexity of how to translate this integrated approach for health and equity into practice. "*[…] aims to act on all the determinants of health, throughout life, and… And with a special effort to reach the populations that need it most, you know? It is not a matter of promoting health through physical activity campaigns, but of improving health and well-being at the root causes"*. City Council member. "*The problem they have with a lot of those [strategies] is it's quite easy to get anybody to agree on what we want to move towards. So I can agree on a strategy that want to reduce health inequalities. Very few people will say that's not right... And how you go about making it happen, this is quite different*" Third sector representative.
	Cost	Although the local health strategy itself is not directly associated with high costs, the impact of the financial crisis and the austerity measures have repeatedly been raised as an issue for the implementation of the local health strategy. "A*usterity policies reduced the city's budget by seventy percent, and you can imagine the impact this had... health has been a priority for the city, but sometimes... it's hard to get to it all with so few resources*" City Council member.

Individuals	Self-efficacy	Since Public Health has become part of the local government's responsibilities, the public health team's capacity, skills and expertise have grown, being able to integrate and carry out new functions, including those related to the implementation, monitoring and evaluation of the local health strategy. "*Health Impact Assessments started, I think, with the university. And then again, Health Impact Assessments became a more routine thing, so any big policies that we would be developing ended up with a Health Impact Assessment, if you like, link to it. So, again, I think, the university was very good in terms of initiating these ideas and we took them forward*" City Council member.

The main facilitators of the implementation of the local health strategy in the pre-pandemic context were related to the strategy itself, which is seen as widely accepted and responsive to the needs of the population, the existence of operational mechanisms such as the Health and Wellbeing Board or the use of HIAs, and the high degree of institutionalisation -at least at the discursive level- of values such as equity, as well as Liverpool's long trajectory of local governance for health. The main barriers to implementation were mostly focused on aspects such as national austerity policies (outer setting), difficulties related to communication (inner setting), and the weak monitoring and evaluation of the local health strategy deployment (process).

7.3.3.b. Implementation-related challenges and opportunities of the COVID-19 pandemic context in Liverpool

Table 22. Implementation-related challenges and opportunities of the COVID-19 pandemic context in Liverpool

CFIR		Implementation-related challenges and opportunities of the COVID-19 pandemic context in Liverpool
Outer setting	Needs and resources of those served by the local government	It is explicitly recognised that the COVID-19 pandemic has led to a change in both the needs of the population and the priorities of Liverpool City Council. To a large extent, it was considered that the local health strategy, as it was defined, could not respond to the new challenges arising from the pandemic. Indeed, the update of the Health and Wellbeing Strategy 2020-2025 was put on hold, and the work of the Health and Wellbeing Board focused almost exclusively on managing the epidemic. "*I think COVID has meant that many organizations, including the local government, and health services, have had to direct their resources, both money and people to focus on COVID, which has meant that there's been very little space to focus on many of the other priorities"*. Third sector representative.
	Cosmopolitanism	In response to the demands arising from the COVID-19 pandemic, the Health and Wellbeing Board established the Health Protection Board as a sub-committee to lead the governance requirements locally for COVID-19 control and to oversight of the implementation of the COVID-19 outbreak management plan, which involved a co-ordinated response between national Public Health, NHS Trusts, emergency services, prisons, universities, local business and the Liverpool City Region among others. Despite the pressure to respond to new needs and priorities with existing resources, and perhaps because of this, the perception of the degree of collaboration with other organizations is positive. In fact, this collaboration has been identified as a facilitator of the response to the pandemic. "[…] *we could not act on our own, this has gone beyond the capacities of any organization... We have had to strengthen the collaboration to be able to respond to this [COVID-19 epidemic], and I have to say that it has been exceptional*". City council member.

	External Policy	The lockdown-related measures established at the national level have had a strong impact on both population health and the social determinants of health. And while the need for a population-based containment is not directly questioned, the absence of complementary measures to mitigate the foreseeable consequences of this enforced lockdown has been criticised. There is a perception that local government has been left somewhat on the sidelines of decision-making in terms of the health response to the epidemic, which has been mostly nationally led. And yet, it has had to shoulder the consequences of measures in which it has not been involved almost single-handedly. *"Certainly, in the UK, we've seen a dialogue about what level should the decisions be made around responding to COVID, and the public health responses to the pandemic. At times, that's been made by national government, and actually, there's been a very strong argument that it's local government that should be involved in those decisions to a much greater extent, because they are close to the people. They're the lowest level of governance. So I think it's really created a very kind of interesting debate about that role of local governance for health"*. University professor.
Inner setting	Structural characteristics	Changes in management positions have been identified as a possible difficulty for the continuation of the local health strategy implementation. Specifically, it is perceived that the new Directorate of Public Health has focused entirely on the response to COVID-19, without necessarily considering what elements of the Health and Wellbeing Strategy could have been retained and even used as part of this response. "*We have a Director of Public Health, he is only been in place for one year. And it's been quite a year for him... because he's been dealing with mainly one issue, obviously, of COVID*" City Council member.
	Networks and communications	Teleworking and virtual meetings within the City Council have been boosted in the wake of the epidemic. In terms of communication, there seems to be a paradoxical situation; while the intrinsic difficulty of an eminently virtual communication is recognised, there is a strong consensus that networks have been strengthened between City Council directorates, between different local organizations, and even between different levels of government. On the other hand, the capacity of the different local actors to networking and provide a coordinated response to this health, social and economic crisis has highlighted the critical role of the local level of governance, opening up a debate about at what level the epidemic should be managed in the first instance.

	Culture	The fact that equity and health, guiding principles of the local health strategy, were strongly anchored in the Liverpool City Council, has facilitated a response to the epidemic that took them into account. Thus, by way of example, the Liverpool's COVID-19 Outbreak Management Plan prioritized vaccination of the most vulnerable groups and communities, including Black, Asian and Minority Ethnic communities, communities of higher deprivation and poverty, vulnerable migrants and asylum seekers, Gypsy, Roma and Travellers communities or people who experience homelessness.
	Implementation climate	The context of the epidemic brought with it a sense of urgency, thus local government sought to respond to the emerging needs in a faster and more coordinated manner. *"In the past, it could take a long time to get something put into place. That's not been an option now, you've got to work together, you've got to make it happen, and to make it happen now"* City Council member.
	Readiness for implementation	The perception that there was a lack of preparedness to respond to such an epidemic is unanimous, and so is the perception that, despite being unprepared, the response to such an epidemic was actually quite prompt and efficient. The fact of having Public Health competencies established in the local government and having strong links with the university have been identified as facilitators for this. "*When COVID first came to the UK, when we have one or two cases, nationally, you know, we were very quick to respond. We immediately held the Health and Wellbeing Board to see what we needed to put in place"* City Council member.

Process	Planning	It has been emphasized that local public health was largely underfunded prior to the COVID-19 pandemic. In addition, there was no foreseen planning to cope with such a crisis, so the local health strategy was quickly overshadowed, and the Health and Wellbeing Board had to elaborate a specific Liverpool's COVID-19 Outbreak Management Plan. Currently a new plan beyond the emergency response to the COVID-19 epidemic is considered necessary. "*No one was prepared for this pandemic, which has exposed how little attention was paid to public health protection, infection control and environmental health. It has put the entire health and social care system, and especially public health, under huge huge pressure*" City Council member. "*As the city starts to open up, the current resourcing of COVID response is being reviewed to plan sustainable resourcing next year*" City Council member.
	Engaging	Concerning the engagement of other social actors, a paradoxical situation has arisen; although direct engagement with local government has certainly decreased, mostly due to the impossibility of face-to-face engagement and the urgency of the COVID-19 response, community networks have mobilized to try to reach those areas where the institution could not (indirect engagement). Having a vibrant community network has been seen as a key enabler for this. *"[...] especially during the last year when we've had the pandemic, of course, it has not been really useful to go and just start complaining that things aren't as we want them... But it was about saying, OK, understanding what they're doing and then trying to do what we can to help"* Third sector representative.
	Executing	In an attempt to respond to a pandemic situation that was far exceeding the capabilities of Liverpool City Council, efforts concentrated almost exclusively on pandemic control and management. Other public health activities, such as health promotion and community health, were suspended in most cases. As the vaccination campaign advances, attempts have been made to progressively restart these activities, but work overload, staff fatigue and lack of resources have been the main obstacles to the full re-establishment of these activities.

	Reflecting and evaluating	The COVID-19 pandemic has also been perceived as a kind of reset that has allowed reflection on the mean of implementation, questioning in some ways established priorities and values. The pandemic has brought glaring health inequalities to the fore and raised a greater awareness of the need to incorporate an equity approach in all public policies. However, whether actually this will help advance governance for health equity in the long run remains to be seen. *"I think, the responses to COVID in terms of the kind of community organizational responses, such as lockdown and curfews and so on, have meant that we've actually seen some opportunities, some kind of vision of what a society could look like if it was if it was run slightly differently with different priorities." University professor.* "*We have seen that COVID illnesses and death are have been concentrated in poorer communities […] I would hope that will have an impact into the future, in how we approach health and equity. But people have very short memories. So it may well be that we just get over the pandemic and we go back to what was before. I don't know, I hope not"* City Council member.
Intervention	Innovation source	In an attempt to tackle the COVID-19 epidemic, it was deemed that the local health strategy as it was formulated could not provide a response, so a specific plan was developed. This COVID-19 Outbreak Management Plan included several elements considered innovative, such as the pilot testing of asymptomatic tests and the use of data and soft intelligence to support the vaccination campaign. "*Liverpool's response has been probably the best in the country, and that's not just me saying that, you know what, I think we've led on many things. So we were the first city to do mass testing, asymptomatic mass testing as well*". City Council member.

	Complexity	The complexity of responding to rapidly evolving needs has been considered an important issue. The main barrier highlighted in this dimension is the rapidly changing epidemiological situation and the need to establish responses that are both systematic and flexible. The links with the university, which contributed to the strengthening of epidemiological surveillance, have been identified as a supporting element. On the other hand, another barrier highlighted in this dimension is the need to balance health, social and economic responses. "*We need to analyse data on a daily basis to understand how the infection is spreading, who is most affected and how this changes over time*" City Council member. *"People in poorer areas are less likely to self-isolate because they cannot afford to lose income, we do need welfare benefits... and here's the rub, where should resources go when they're limited?"* City Council member.
	Cost	Funding is a recurrent barrier, both for the response to the COVID-19 context itself and for the recovery of health promotion and community health activities programmed in the local health strategy. "*Effective implementation of the Plan will be dependent on funding, on a sustainable long-term funding for public health*" City Council member.
Individuals	Individual identification with organization	There is a high degree of individual identification, not only with regard to the Liverpool City Council, but with the city as a whole. And, in this regard, a facilitating factor identified has been a sense of belonging and solidarity that already existed in Liverpool, but which has been accentuated in the current crisis situation. *"In Liverpool, I think... it's such a caring city, people here are renowned for their friendliness and how they care. You know, the amount of volunteers, and food banks, and even people who haven't got a lot of money will always give. And that happens because… That was happening before COVID, you know? But what comes naturally to the city is for people to be together and to help each other. It's just who we are, as a city here"* City Council member.

There is a unanimous perception that local public health was underfunded prior to the COVID-19 pandemic and that this has been evidenced by a lack of preparedness to respond to an epidemic. Despite the lack of resources, the context of the epidemic brought with it a sense of urgency which prompted the local government to respond quickly, reinforcing coordination with other actors such as national Public Health, NHS Trusts, emergency services, prisons, universities, local business, and the Liverpool City Region among others. The fact that equity and health, guiding principles of the local health strategy, were strongly anchored within the Liverpool City Council, has contributed to a response that took them into account. Even so, the response was predominantly focused on the control and management of the outbreak to the neglect of health promotion and community health activities. Existing community networks in the city were an obvious health asset, stepping up their involvement to try to respond to the needs of people where the city council was not able to reach.

MULTIPLE CASE STUDY

Comparative analysis results

7.4. Comparative analysis of case studies

The comparative analysis results includes the findings of the comparative analysis of Bilbao, Barcelona and Liverpool case studies described in the previous section, enriched with the results of the analysis of the expert interviews in a contrasting and validating exercise. This section therefore presents the results of the cross-analysis for each of the key dimensions of governance for health equity and the enablers for each of these dimensions, which are the result of the analysis of implementation-related barriers and facilitators together with expert input. In this way, the knowledge and insights of experts in the field of governance for health, health equity and implementation science have yielded an interplay between theoretical knowledge, expertise and the findings of this multiple qualitative case study research, thereby providing the basis for a more robust analytical generalisation.

This section is structured in four subsections. The first three parts relate to the key dimensions of governance for health equity. Each of these three parts presents the results of the cross-analysis and the enablers that allow moving forward in their implementation. The fourth subsection summarises the facilitators of the implementation of policy coherence, accountability and social participation.

1. Moving forward policy coherence in local health strategies
    a) Cross-case analysis of policy coherence
    b) Enablers of policy coherence

2. Moving forward accountability in local health strategies
    c) Cross-case analysis of accountability
    d) Enablers of accountability

3. Moving forward social participation in local health strategies
    e) Cross-case analysis of social participation
    f) Enablers of social participation

4. Enablers of the implementation of governance for health equity

7.4.1. Comparative analysis of policy coherence

The result of the comparative analysis of policy coherence from the multiple case studies is presented below. Moreover the enablers for moving it forward, grounded on the barriers and facilitators found in the case studies and on the *know-how* and insights of the experts, have been identified.

7.4.1.1. Cross-case analysis of policy coherence

In order to assess the extent to which policy coherence has been incorporated into the local health strategies of Bilbao, Barcelona and Liverpool, an adaptation of Storm's Maturity Model for HiAP[306] has been used. This model consists of six maturity levels; Stage 0 – Unrecognized, Stage I – Recognized, Stage II – Considered, Stage III – Implemented, Stage IV – Integrated and Stage V – Institutionalized.

According to the analysis based on these maturity levels, the policy coherence in the Bilbao health strategy was classified in *Stage II – Considered*. For the first time, the Bilbao's local health strategy includes the perspective of the social determinants of health and health equity, integrating actions from different municipal areas. Bilbao Municipal Health Plan has a very incipient implementation and the intersectoral action for health has not yet been sufficiently developed, which explains the fact that a higher level of policy coherence has not yet been achieved.

The policy coherence of Barcelona's health strategy is at *Stage V - Institutionalised*. Barcelona has extensive experience analysing health inequalities and designing coherent interventions to reduce them, and its local health strategy is a clear reflection of this. It should be noted, however, that its institutionalisation lacks an established structure with set mechanisms.

The policy coherence of Liverpool's health strategy can be placed at *Stage IV: Integrated*. The social model of health and the health equity approach are well established both politically and operationally. Continuous improvement of integrated processes based on the results achieved is, however, an element that has yet to be achieved.

Barcelona's health strategy has reached the highest level of policy coherence maturity, while Liverpool is in the process of attaining it. Bilbao's strategy is steering on the process. But what is really relevant, beyond the classification established by this Storm's Maturity Model for HiAP tool, is how to make further progress. Therefore, the following section focuses on the regulations, structures, mechanisms and processes for moving towards more coherent local health strategies.

The following table (Table 23) and figure (Figure 34) summarise the characteristics of policy coherence in the local health strategies of Bilbao, Barcelona and Liverpool, and the degree in which each of them has been achieved.

Table 23. Cross-case analysis of policy coherence

Cross-case analysis of local health strategies' policy coherence				
MM-HiAP Stages	**Characteristics**	**Bilbao**	**Barcelona**	**Liverpool**
Stage 0 - Unrecognized	There is no specific attention for the problem, in this case the problem of health inequalities			
Stage I- Recognized	Importance of policy coherence recognized to reduce health inequalities	Fairly embedded	Fairly embedded	Fairly embedded
	Visible which activities of sectors contribute to (determinants of) health inequalities	Fairly embedded	Fairly embedded	Fairly embedded
Stage II - Considered	Policy coherence / Intersectoral action described in policy documents	Fairly embedded	Fairly embedded	Fairly embedded
	Collaboration with sectors present (project-based)	Fairly embedded	Fairly embedded	Fairly embedded
	Collaboration on health inequalities is started	Fairly embedded	Fairly embedded	Fairly embedded
	Activities of sectors contribute to determinants of health inequalities	Partially embedded	Fairly embedded	Fairly embedded
Stage III - Implemented	Concrete collaboration agreements	Fairly embedded	Fairly embedded	Fairly embedded
	Structural consultations forms present	Partially embedded	Partially embedded	Fairly embedded
	Key person or group ensuring policy coherence (role is clear)	Partially embedded	Poorly embedded	Fairly embedded
	Working from sectors on health inequalities (policy basis)	Poorly embedded	Fairly embedded	Fairly embedded
Stage IV - Integrated	Broad, shared political and strategic vision	Poorly embedded	Fairly embedded	Fairly embedded
	Policy coherence results visible (both content and process)	Poorly embedded	Fairly embedded	Partially embedded
Stage V - Institutionalized	Political and administrative anchoring of the HiAP approach	Poorly embedded	Fairly embedded	Fairly embedded
	Continuous improvement of integral processes and results on the basis of the achieved results	Poorly embedded	Fairly embedded	Poorly embedded

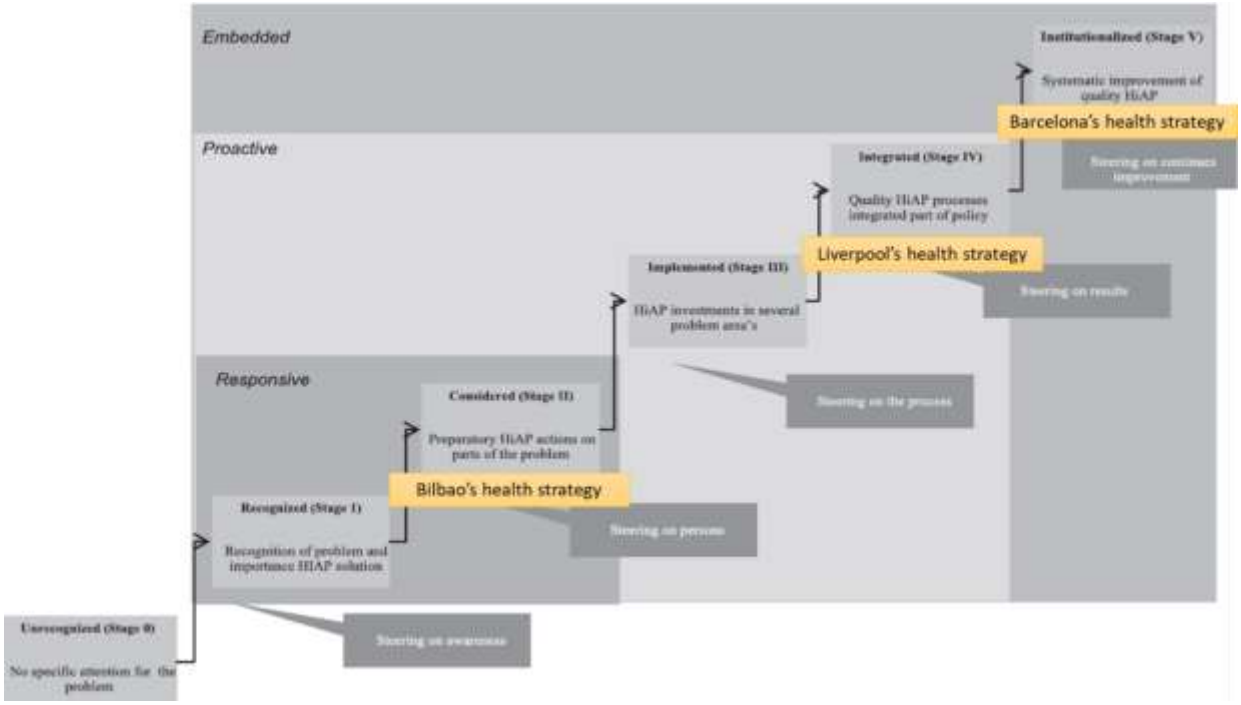


Figure 34. Cross-case analysis of Policy coherence (Storm's Maturity Model for HiAP)

7.4.1.2. Enablers of policy coherence in comparative perspective

Health policies can have a greater impact and tackle unintended negative effects on health equity by other sectors if they are coordinated across actors, institutions and levels of governance. While there is a consensus among experts that policy coherence should occur at all levels of governance, the **local level** has been identified as the one where it can be most easily, effectively and meaningfully implemented.

> "*The further down in the administrative and governmental level you go, the easier it is to make public health policies. At the local level, in the local governments, in the municipalities... That's where you can achieve intersectoral action in health, you can do HiAP or whatever you want to call it.... [...] And I firmly believe that, if you want to make healthy public policies, if you want to work for equity in health... It needs to be done at the local level*" Governance for health expert.

The results suggest that a **democratic and socially progressive political environment** can act as a catalyst in mainstreaming health and equity as a shared value and responsibility, providing the necessary political support for the formulation of equity-driven policies and seeking that these are implemented.

On the other hand, the establishment of public health laws, as well as strategic government plans, appears also to be a factor that facilitates the institutionalisation of a social model of health and joint action on the social determinants of health. These **legal and regulatory**

frameworks can recognise and formally integrate strategies that foster policy coherence, as is the case of HiAP, which in turn enables their operationalisation.

At the same time, results indicate that local health strategies that include **multi-level policies** to foster health and equity have a greater level of policy coherence. Thus, it appears to be effective to establish strategies for health that combine aligned, on the one hand, Health Plans belonging to the municipal Health Area or Health Department and, on the other hand, general City Council Plans. These multi-level strategies are more likely to set broad objectives that require input from different sectors, thus creating the imperative for intersectoral action for health. In this way, multi-level strategies trigger government action on the social determinants of health as a *whole*. At the same time, however, it is necessary to ground local health strategies in documents that are operational, so that all stakeholders can be effectively mobilised.

Related to this last point, putting health and equity at the heart of local governance must be backed by political will. It requires high-level political support, but it must also involve all middle managers and workers in a way that consolidates a **commitment across the institution**. The ASPB's Plan for tackling inequalities[350], with seeks to mainstream equity across ASPB's services, can be an example of good practice to this end.

> *"There is no single way to do it, of course, but sustainable HiAP deployment must be supported by leadership at a macro level, enabling the development of mechanisms and structures that facilitate its implementation. The more HiAP is institutionalised, the more likely it is that government will have regulated procedures"* Governance for health expert

Beyond policies, **structures and resources** are also needed to facilitate the implementation of policy coherence. Having a formal intersectoral structure and a specific budget line to support its intersectoral action for health seems to be an ideal scenario, however it is possible to develop coherent action for health and equity with more informal structures and with minimal financial resources. What really seems to be of crucial importance to start with is to have dedicated staff to build these intersectoral collaborative relationships and to provide spaces for cooperation to flourish. Then, structures and resources make intersectoral action for health more resilient to changes in the political and administrative landscape of institutions.

> "*Also resources are needed to support and sustain HiAP. I think it's essential to have dedicated staff to implement it. And well, having a dedicated budget it's ideal, but there are numerous experiences that show that it is possible to do so with almost no money"* Governance for health expert

The three case studies analysed show that the prevailing sectoral logic is one of the most important administrative and managerial difficulties to overcome, as it is a major barrier to the coordination and integration of actions for health. In this regard, the use of **health's decision-support tools** offers a structured approach to incorporate evidence into policymaking and facilitate the consideration of health and equity concerns in decisions made by other sectors. There are several health's decision-support tools, among the most widely used of which stand out the following; Health Impact Assessment, Health Matrix, Healthy Development Measurement Tool, Healthy Development Checklist, Health Background Study Framework, Health Economic Assessment Tool, and Health Lens Analysis. The choice of one tool or the other

will largely be determined by the institutional context and its appropriateness at the juncture of the policy cycle.

> "*Health in all policies is very helpful to improve health equity, at national and also at local government, because everything that a local authority does, impacts on health. But even now, the public tend to believe that health is all about health care, etc. So, having a systematic mechanism in a local authority, whether it is health impact assessment or having a kind of… or health analysis lent, or wherever, that looks at the impact on health of the local authorities, you know, housing policy, education policy, highways policy, finance policy… Is very important*" Health equity expert.

It should be noted, however, that while health's decision-support tools can facilitate the integration of health and health equity issues into decision-making processes, these tools have limited capacity to advance policy coherence on their own. They should therefore be considered **as part of a broader institutional strategy**.

> "*Obviously, anything that is institutionalised can become bureaucratised and so on… But, the bottom line is 'What do they do in Quebec or in Australia with the outputs of Health Impact Assessment?' That's the key thing. There is no point in doing Health Impact Assessment unless you are forced to look systematically at all Health Impact Assessment reports or outputs and to act on them*" Implementation science expert.

The implementation of policy coherence mechanisms also requires knowledge, abilities and skills, and therefore **building individual and institutional capacity** is necessary. This can be done through training for members of the health department as well as other areas or departments of the institution. But it is also necessary to establish spaces for trying out innovative forms of intersectoral work. Individual and organisational capacities are strengthened as experience is gained in practice.

Last but not least, **establishing synergies** with other programs, such as the Sustainable Development Goals (SDGs), and other local, national and international networks, such as the Healthy Cities Network or the Global Network for Health in All Policies (GNHiAP).

The 2030 Agenda for Sustainable Development calls for action on 17 SDGs, including the goals of improving health and equity. The SDG 17 is to revitalize the global partnership for sustainable development and it aims to promote them building on the experience and resourcing strategies of partnerships.

> *"Various elements drive the HiAP strategy, depending on the specific context. However, there are opportunities for synergies with other local, national and international agendas and priorities, for instance the SDGs"* Health equity expert

Participating in Networks such Healthy Cities or GNHiAP can act as a facilitator by establishing a public commitment to move towards better governance for health equity. In addition, enables sharing of lessons learned between cities facing similar challenges.

> *"The Healthy Cities Programme it's a part of the European program, but then there are wider national networks. There the idea is to share learning from those cities. And I think that's worked. That's works better in some places than others. And it's worked better in at some times than others. But it's been certainly been an important factor, I think, one of the important factors in shifting that focus, placing health and equity at centre stage in cities"* Health equity expert

Policy coherence in the health strategy of Bilbao was classified as Phase II - Considered of Storm's MM-HiAP[306], whereas Barcelona was classified as Phase V - Institutionalised and Liverpool as Phase IV: Integrated. But beyond this qualification, it is interesting to outline the factors that enable moving forward policy coherence at the local level, according to this comparative anaylisis: A favourable political context and institution-wide commitment, recognising health and equity as a fundamental cross-cutting goal. Regulatory frameworks, such as public health laws or government strategic plans, that enable the creation of norms, structures, mechanisms and processes to operationalise policy coherence. Multi-level local health strategies with broad objectives that call for intersectoral action for health. The use of health decision support tools to facilitate the consideration of health and equity concerns in other sectors' decision making. Developing individual and institutional capacity through training and "learning by doing". As well as establishing synergies with other local, national and international programmes and networks.

7.4.2. Comparative analysis of accountability

The result of the multiple case study' comparative analysis of accountability is presented below. It has been complemented with the enablers that allow moving forward in its implementation, resulting from the analysis of the case studies' barriers and facilitators and experts' perceptions.

7.4.2.1. Cross-case analysis of accountability

The four core components of accountability in global governance identified by Ebrahim and Weisband[128] and the accountability domain of the PAHO Equity Commission's rubric[133] were used to assess the degree of integration of accountability within the local health strategies main policy documents.

The Ebrahim and Weisband' four core components of accountability are transparency, answerability, compliance and enforcement. Table 24 summarises the inclusion of these Ebrahim and Weisband' accountability core components in Bilbao, Barcelona and Liverpool health strategies.

- With regard to the transparency component, this has been incorporated into the local health strategies of all three case studies in a fairly explicit way. Bilbao, Barcelona and Liverpool have all set out ways of collecting information and making it available to the public, including the local health strategy policy documents themselves. Although transparency is somehow present in all the case studies, there are differences between them in terms of the effort made to provide disaggregated data, as well as in terms of fostering close, effective and inclusive communication between local government and citizens.

- The answerability component assumes that citizens are well informed in order to be able to hold government accountable. It goes beyond the right to know and the right to understand, and refers to the materialisation of these rights through mechanisms of interaction between local governments and citizens. As for the answerability component within local health strategies, it is incorporated to some extent in all the cases studied, although its inclusion is often vague and through mechanisms that are not always identified in the policy documents. The rationale for the local health strategy itself is usually made on the basis of prior health needs assessments, and the justification for actions and decisions is often articulated through general mechanisms to encourage feedback.

- The compliance component is closely linked to the accessibility of information allowing for the monitoring and evaluation of public policies, decisions and actions that affect citizens. This component includes mechanisms for supervising and assessing both procedures and results, as well as mechanisms ensuring transparency in the communication of these results. The extent to which the compliance component has been incorporated into local health strategies is quite heterogeneous and has significant room for improvement, particularly in the case of Liverpool.

In the end, the strength of accountability mechanisms relies largely on enforcement or sanctions for deficiencies in transparency, answerability and compliance.

- While to a greater or lesser degree transparency, answerability and compliance components are found in the local health strategies examined, none of these explicitly addresses enforcement mechanisms. One of the reasons for this lack of reference to enforcement mechanisms may be that local health strategies are not conceived as the appropriate tool to articulate this accountability component, which could be regulated in other types of standards, regulations or laws. But beyond this, the establishment of sanction mechanisms for non-compliance with accountability is an exercise in recognising the government responsibility for any possible negligence on its part, which entails both an uncomfortable political position and a high degree of democratic maturity. The Table 25 summarizes the further exploration of the enforcement component, identifying the specific accountability mechanisms for guaranteeing the right to health embedded in the local health strategies of Bilbao, Barcelona and Liverpool. Any of the local health strategies explicitly include mechanisms to redress violations of people's right to health. The case of Bilbao and Barcelona refer to the right to health as a general framework, but go little further in developing specific enforcement mechanisms. The State has legally enforceable obligations responsibility to respect for, protection, guarantee, and fulfilment of the right to health. This State-level centralisation may explain why local health strategies do not include mechanisms to redress violations of people's right to health.

The local health strategies of Bilbao, Barcelona and Liverpool have room for improvement in terms of accountability across all of Ebrahim and Weisband's dimensions, but particularly in the dimensions of Compliance and Enforceability. The next section focuses on enablers that can enhance accountability of these health strategies.

Table 24. Cross-case analysis of Accountability - Ebrahim and Weisband's accountability core components

Cross-case analysis of local health strategies' accountability				
		Bilbao	**Barcelona**	**Liverpool**
Transparency	Collecting and making available and accessible for public scrutiny information that is "actionable" to citizens	Fairly embedded	Fairly embedded	Fairly embedded
Answerability	Providing justification for decisions so that they may reasonably be questioned	Partially embedded	Fairly embedded	Fairly embedded
Compliance	Monitoring and evaluation of procedures and outcomes	Partially embedded	Partially embedded	Poorly embedded
Enforceability	Sanctioning for shortfalls in compliance, answerability or transparency	Poorly embedded	Poorly embedded	Poorly embedded

Table 25. Cross-case analysis of Accountability - PAHO Equity Commission's rubric

PAHO Equity Commission's rubric - Accountability	Bilbao	Barcelona	Liverpool
Does the local health strategy include mechanisms to redress violations of people's right to health?			
• Does the local health strategy include mechanisms for educating people on their right to health?	0/1	0/1	0/1
• Does the local health strategy include mechanisms for reporting right to health violations?	0/1	0/1	0/1
• Does the local health strategy include mechanisms for enforcing people's right to health?	1/1	1/1	0/1
• Does the local health strategy include mechanism for investigating and reducing fraud and corruption?	0/1	0/1	0/1
OVERALL SCORE	1/4	1/4	0/4

7.4.2.2. Enablers of accountability in comparative perspective

Although the local health strategies examined hardly include accountability mechanisms linked to the right to health, experts have highlighted the relevance of taking the interlinkages between accountability, **a human rights-based approach** and health equity into account. A human rights-based approach can enhance accountability operating as a means for a non-discriminatory and equitable governance. At the local level, the integration of a culture of defence and respect for the right to health implies raising public awareness of this and other human rights through, for example, campaigns that promote a culture among citizens of the enforceability of rights. It also involves training public servants on and for a human rights perspective in order to foster institutional change, which is a long-term process.

> "*Accountability is critical to health equity... and in fact it is also a key element in the human rights-based approach to health. Accountability makes it possible to establish responsibilities for protecting human rights, focusing on the protection of groups most vulnerable to human rights violations and, more importantly, linking health to other civil, political and socio-economic rights*" Health equity expert.

These institutional changes to move forward health equity require a strong **governmental commitment to accountability**. But beyond political will, the commitment to transparent and accountable governance must be operationalised through the creation of **structures and mechanisms.**

> "*I think that aspect of having an accountability mechanism that involves citizens is really important in actually ensuring that local government is held to account for its decisions around health, wellbeing and sustainability*" Governance for health expert.

There are many possible models for this, one of which is **Public Health Observatories** with a technical profile and a sufficient degree of autonomy from the political level. In this sense, the work that the *Liverpool Public Health Observatory* has carried out for decades or the work that the *Observatory of Health, Inequalities and Impacts of Municipal Policies of Barcelona* is

currently undertaking could be highlighted. Indeed, health observatories have the potential to foster accountability by monitoring population health and health determinants at the local level, identifying gaps in information, identifying relevant areas for action, conducting health equity impact assessments, assessing the progress of local health strategies and their impact improving health and reducing inequality, and disseminating knowledge. Although these health observatories can be useful instruments for incorporating accountability in local governance for health equity, there are not one-size-fits-all recipes applicable. Statutory governing boards, participatory budgeting or required Health Impact Assessments can be equally useful mechanisms for strengthening accountability.

Continuous and inclusive monitoring and evaluation are key processes for advancing accountability for health equity. The assessment of the impact of local health strategies on both population health and the social determinants of health is essential to understand what has worked and why, as well as to identify areas for improvement. Actually, a weak ongoing assessment of health inequities and social determinants trends can explain why interventions are not delivering intended results. Assessments should look at both process and outcomes, and should be designed from a holistic approach that combines quantitative and qualitative methodologies and includes participatory processes to capture different community perspectives and knowledge. Indeed, assessments that explore the experiences and perceptions of individuals and groups provide essential insights for the formulation of public policies that respond more effectively to the needs of the population, bringing government closer to society.

> "*Accountability is a means to understand the discomforts of our society and the relevance of the policies that are implemented, to bring government and society closer and to build trust*" Governance for health expert.

Related to this last point, another essential element of accountability for health equity is the availability of local **disaggregated data**, which can highlight the specific needs hidden in regional and national statistics. Improving disaggregated data collection is a critical requirement for an intersectional analysis, and therefore is fundamental to enable better assessment and evaluation of the impacts and benefits of policies and interventions to reduce health inequities. To have local data disaggregated by sex, income, disability, ethnicity, age group, neighbourhood, etc. also allows for the generation of evidence for action, thus linking the governance for health equity dimensions of accountability and policy coherence. Strengthening, in turn, intelligence for health equity.

> "*We must encourage our governments to be accountable, and one way to do this is to demand disaggregated data from our institutions. Disaggregated data makes possible to visualise health experiences of communities that face intersectional forms of discrimination, making them identifiable and able to be considered in interventions*" Public health expert.

The **generation of applied knowledge** seems to be an element that, in addition to promoting more equitable health strategies in a specific context, also fosters innovation and leadership. Too often, evaluations of local health strategies remain internal documents for institutional use and lessons learnt are not drawn from them.

Lastly, it is just as important to carry out inclusive evaluations of local health strategies and to generate applied knowledge, as it is to **transfer of information and knowledge** from them. This

not only increases transparency and answerability towards society, but also allows for a decisive contribution to the generation of knowledge for action. The dissemination and transfer of applied knowledge should ideally encompass from the scientific community to civil society, including decision-makers and politicians. In this regard, it is necessary to recall that access to information does not necessarily imply its understanding. Therefore, it is essential to provide not only accessible information, but also understandable and actionable information for different groups. This include ensuring the use of clear language and providing relevant documents in an accessible format and/or alternate formats.

> "*The more health inequalities are analysed, the more they are addressed, and the more this process is monitored properly communicated both politically and socially... the easier it becomes. Over time, you build a way of doing things that not only improves government accountability, but also its trust and interaction with citizens*" Governance for health expert.

The local health strategies of Bilbao, Barcelona and Liverpool have room for improvement in terms of accountability in all of Ebrahim and Weisband's dimensions, but especially in the Compliance and Enforceability dimensions. The policy documents of these strategies do not include mechanisms to redress violations of people's right to health; this may be because local health strategies are often not conceived as the proper instrument to articulate this accountability component, which is often centralised at higher levels of government. Yet the local level has competencies over the social determinants of health and therefore has enforceable responsibilities to be accountable for. Adopting a human rights-based approach can foster accountability, but structures and mechanisms are needed to operationalise it. Public health observatories with a technical profile and a sufficient degree of autonomy from the political level are a model for deploying accountability at the local level, though there are no single recipes applicable. Continuous and inclusive monitoring and evaluation, availability of disaggregated data, and the generation and transfer of applied knowledge are also key enablers of accountability.

7.4.3. Comparative analysis of social participation

The result of the multiple case study's comparative analysis of social participation, as well as the enablers for its implementation, are presented below. The latter are the result of both the analysis of the barriers and facilitators of the multiple case study and of the experts' contributions.

7.4.3.1. Cross-case analysis of social participation

In order to assess the extent to which social participation has been incorporated into the local health strategies of the case studies examined, the Health Canada's public involvement continuum model[307] has been used. This model consists of five levels of public involvement, which are: level I - Inform/Educate, level II - Gather Information/Views, level III - Discuss or Involve, level IV – Engage and level V – Partner. These levels of the Health Canada's public involvement continuum model have been examined throughout the phases of the policy cycle[94]; agenda-setting, policy formulation and adoption, implementation and evaluation phases.

- In the agenda-setting phase of the policy cycle, the level of public participation and influence was quite high, *level IV* in Bilbao and *level V* in Barcelona and Liverpool. There has been a visible effort from local institutions engaging and partnering with citizens and other social and economic actors, trying to foster deliberation and seeking to set a shared agenda, which is important to ensure that the local health strategies are not mismatched to the realities of people's lives. Having said that, it is equally true that, being inclusion a key element to foster equity, the degree of heterogeneity of the population involved, selected or recruited is not always taken into account nor analysed. The mechanisms established to enable participation at this phase have been participatory diagnosis and other participatory processes, citizen consultations and different types of participatory bodies.

- In the policy formulation and adoption phase, Barcelona and Liverpool stand out at *level IV*, giving citizens the ability to shape the policies that affect them, and Bilbao lags somewhat behind with at *level II* of public involvement. The platform *Decidim Barcelona* should be mentioned as a particularly effective instrument for articulating social participation in this phase of the political cycle.

- The implementation phase could only be evaluated in the Barcelona and Liverpool case studies, given that these phases have not yet been completed in Bilbao. As the degree of public involvement in the implementation of the local health strategies remains limited to communicating and listening, Barcelona is situated at a *level I* and Liverpool in *level II*. Although there are community networks that can participate in specific activities of these local health strategies, this participation is far from being a cross-cutting element in their execution.

- Finally, the evaluation phase could also only be evaluated in the Barcelona and Liverpool case studies. In these phase of the policy cycle seems that the participatory culture is less embedded, and both cases score *level I*. The eventual explanation for the lower inclusion of social participation in this phase may lie in the fact that evaluation are areas

where a more administrative, managerial and technical model prevails, hindering space for participation[369].

The following table and figure summarise the inclusion of social participation in the local health strategies of Bilbao, Barcelona and Liverpool (Table 26 / Figure 35).

Table 26. Cross-case analysis of local health strategies' social participation

Cross-case analysis of local health strategies' social participation			
Policy cycle phase	**Bilbao**	**Barcelona**	**Liverpool**
Health and social determinants of health needs assessment (agenda building)	Level IV Engage	Level V Partner	Level V Partner
Local health strategy policy-making (policy formulation and adoption)	Level II Gather Information	Level IV Engage	Level IV Engage
Local Health Strategy execution (implementation)	*Not applicable*	Level I Inform/Educate	Level II Gather Information
Local Health Strategy monitoring (evaluation)	*Not applicable*	Level I Inform/Educate	Level I Inform/Educate

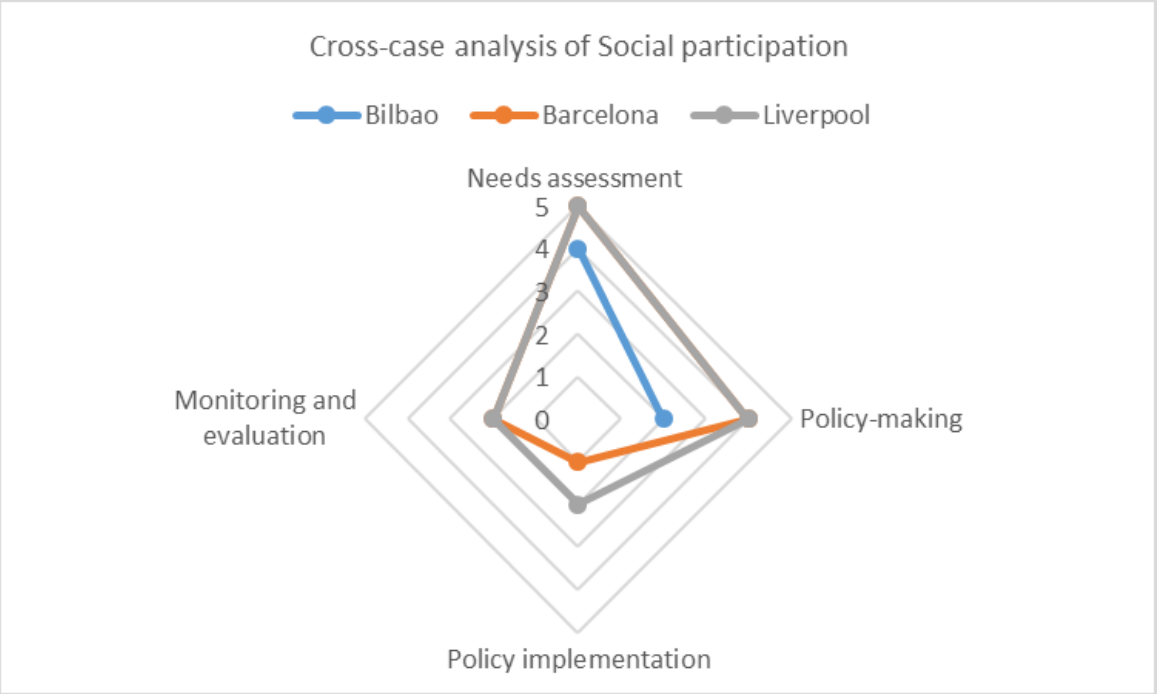


Figure 35. Cross-case analysis of local health strategies' social participation

The local health strategies of Bilbao, Barcelona and Liverpool show high levels of the Health Canada model of public participation in the agenda setting phase of the policy cycle. Barcelona and Liverpool also do so in the policy formulation and adoption phase. However, there is a clear area for improvement in the implementation and monitoring phases. The following section focuses on efforts to advance social participation in local health strategies throughout the policy cycle.

7.4.3.2. Enablers of social participation in comparative perspective

Social participation challenges the imperative of individualism, fostering social capital in favour of collective action, since often it implies a common purpose and agreement between various social actors and stakeholders. Thus, social participation is related to the principles of agency, autonomy, solidarity and equity, valuables spheres of human life. In this regard, experts agree that social participation is health-enhancing in and of itself, through effective political participation promoting the conditions necessary for health equity as well as through indirect pathways of enhanced social support and empowerment. Moreover, social participation feeds back, as **cohesive communities** have both greater power to organising themselves in to claim their rights and greater influence in policy decisions that affect the community.

The experts also agree that **social participation** in governance for health must be understood **beyond institutional participatory processes**, including community networks and social movements in their advocacy and political incidence role.

> "*One of the difficulties governments have with participation is that they often understand it in a very narrow way, you know? As something that happens only when and how governments propose it. Participation though happens at all levels... Often as a confrontation of social groups with the government itself. This is also social participation, and should be understood and valued as such*" Health equity expert.

To move forward social participation is essential the redefinition of the role of local governments, embracing a **participatory institutional culture** that promotes deliberative capacity and decentralisation of power. The explicit definition of the intended governance model and the role that participation should play in it can act as a roadmap, facilitating progress.

> "*Network governance or horizontal governance are somewhat utopian as models, but they are useful as a benchmark because they do help to move towards more participatory and deliberative forms of governance*" Implementation research expert.

The results suggest that social participation requires a genuine commitment by the local governments, because creating space for social participation of all social groups is complex, but key to advancing health equity. To operationalise a more horizontal governance model, it is necessary to establish **processes, mechanisms and instruments that encourage participation** to foster the active participation and engagement of communities. These can be divers, such as participatory committees, open public budgeting, planning meetings, community hearings to support participation and capacity building for citizens and community organizations in budgeting, and participatory planning and participatory implementation and evaluation activities or other tools of deliberative democracy.

In this regard, the platform *Decidim Barcelona* could be mentioned as a particularly effective mechanism for articulating social participation in policy formulation. It should be mentioned, however, that although technologies have the potential to increase opportunities to actively participate in the management and monitoring of local health strategies, differences in socio-economic and skills and knowledge related to the use of technologies may lead to inequitable access to digital communications worsening inequalities[370]. Meaningful participation must be inclusive and representative, thus **seeking out possible missing voices**. A first step is to become aware that certain population groups may not be participating. The next step is to take this into account and establish mechanisms to compensate for these biases which are ultimately the result of social inequality.

> "*Yes, there are innovative tools for participation, and of course they are great, they have expanded forums... But we need to ensure meaningful participation as well, because it's the participation of those who have the least voice that leads to health equity. We must not forget that we move in a society shaped by huge inequalities, and participation in society is also shaped by these. And trying to counteract this imbalance of power... I think this is the biggest challenge for a meaningful participation*" Health equity expert.

Indeed, the social capacity to engage in public policy depends to a large extent on the institutional context, which must be conducive to the establishment of mechanisms that encourage the participation of all social groups, the community and civil society organisations. But, to a certain extent, it also depends on the **appropriation of these participatory mechanisms** by social actors.

> *"Because participation it's something that should be appropriate for different people's life and level of interest*" Governance for health expert.

It is important to deeply integrate the experiences of communities as an **essential part of the entire policy circle**, tailoring these processes, mechanisms and instruments of citizen engagement to the goal and the specific policy circle phase. Therefore, it is required to build institutional capacity in the use of different participatory methodologies and tools. While the use of adapted participatory methodologies encourages participation, it is critical at the same time being sufficiently flexible to evolve and be responsive to new issues or concerns that could arise during the participatory process. Maintaining an open attitude is essential to **avoid an instrumental use of social participation** as a means of merely obtaining information, making it easier to empower communities and promoting a participatory democracy.

> "*I think that it has been very important encouraging cities to have that kind of lens of 'how our governance process is enabling participation by citizens and by communities?' and 'how deep is that participation?' Because one of the things we found was that there would be some cities that were comfortable with consultation, you know, they would come up with the ideas and then they would send out those ideas to citizens and ask what did the citizens think. But there are other cities that had moved much further along a spectrum. So that they were they're actually trying to involve citizens in decision making, so, as co-creators of policy*" Governance for health expert.

Social mobilization is key in the search for empowerment in the implementation of equitable social policies and more democratic and more participatory forms of governance. Moreover, open and inclusive policy-making not only drives innovative and more equitable solutions, but

also generates greater trust in governments, greater compliance with decisions and better health equity outcomes. Participation and engagement can be facilitated through **building skills and capacity** within the population and across government, in turn building awareness and resilience among communities and fostering commitment to action on the determinants of health inequities.

Local governments can play a role building community "*response-ability*"[184], that is community capacities to take action on health and reduce health inequities through local health strategies led by and for the community. In other words, local health strategies that move away from individual approaches of health promotion and focus on acting on the social determinants of health, taking into account **community health** assets as well as local health needs. At the same time, local governments can play a facilitating role in connecting people to local community resources, which is another way of seeking to ensure that no one is left behind.

It should be underlined finally that, in the absence of institutional commitment and mechanisms for participation, **social participation can be socially enforced**. The community has the capacity to demand the establishment of participatory mechanisms, to control over these participatory processes and to appropriate the assets generated.

> "*A lot of public health people think they have good ideas and overwhelming evidence, and they complain, because they say that without political will nothing can be done. But that's not true. I studied political science, and I know that political commitment can be built, that we cannot externalise this responsibility, and fortunately the logos of control is not only held by the politician... We, as individuals, communities, organisations, or as institutions, create opportunities for political will*" Health equity expert.

The level of social participation was quite high in the agenda-setting phase, although attention has not always been paid to ensuring an inclusive and equitable participation. In the policy formulation and adoption phase, Barcelona and Liverpool stand out giving citizens the opportunity to somehow shape the policies that affect them, while Bilbao lags behind. The implementation and evaluation phases could only be evaluated in the Barcelona and Liverpool case studies and in these phases of the policy cycle both score relatively low levels. This fact may be due that implementation and evaluation are areas where a more administrative, managerial and technical model prevails, hindering space for participation. To move forward a governance for heath equity, social participation must be present in the entire policy circle, tailoring method of public engagement to the specific goal. Social engagement can be facilitated establishing mechanisms that encourage the participation and building skills and capacity within the population and across government.

7.4.4. Enablers of the implementation of governance for health equity

The enablers of the implementation of the key dimensions of governance for health equity may have arisen from the case studies of Bilbao, Barcelona and Liverpool both as an facilitator element and/or as a barrier (lack of the enabler). Other enablers of implementation were not identified in the multiple case studies, but were identified by the experts. The following table (Table 27) summarises the enablers of governance for health equity implementation, identifying the source of information.

Table 27. Enablers of the implementation of the key dimensions of governance for health equity

Governance for health equity dimension	Implementation enabler	Source/s of reference			
		Bilbao	Barcelona	Liverpool	Experts
Policy coherence	The local level				X
	Democratic and socially progressive political environment mainstreaming health and equity as a shared value and responsibility	X	X	X	X
	Legal and regulatory frameworks (public health laws, strategic government plans, etc) providing an umbrella for the institutionalisation of a social model	X		X	X
	Local health strategies that include multi-level policies	X	X	X	X
	High-level political support and commitment across the institution	X	X	X	X
	Structures and resources for intersectoral action for health	X		X	X
	Use of health's decision-support tools			X	
	Building individual and institutional capacity	X	X	X	X
	Establishing synergies with other programs and networks		X	X	X
Accountability	Human rights-based approach				X
	Strong governmental commitment to accountability		X	X	
	Establishing structures, mechanisms and processes for accountable governance				X
	Public Health Observatories with a technical profile and a sufficient degree of autonomy from the political level		X	X	X
	Continuous and inclusive monitoring and evaluation		X		X
	Availability of local disaggregated data	X	X	X	X
	Generation of applied knowledge		X	X	X

	Transfer of information and knowledge		X		X
Social participation	Cohesive communities, community networks and social movements			X	X
	Participatory institutional culture that promotes deliberative capacity and decentralisation of power		X	X	X
	Establishing multiple processes, mechanisms and instruments that encourage participation of all social groups	X	X	X	X
	Inclusive and representative participation, seeking out possible missing voices				X
	Embedding social participation as an essential part of the entire policy circle				X
	Avoiding an instrumental use of social participation			X	X
	Building skills and capacity within the population and across government				X
	Local health strategies led by and for the community – Community health approaches	X	X	X	X

DISCUSSION

Discussion

8. How can governance for health equity be moved forward at the local level?

8.1. Main findings

The heterogeneity of the governance for health strategies analysed in the context of the three study areas reveals that there is no one-size-fits-all type of strategy that fosters health equity. However, there are elements in common that can act as facilitators in the inclusion of equity as a core element in the strategies. Notably, there needs to be acknowledgment of equity as a general value and as a specific aim of policies. Objectives and targets need to be set for reducing inequalities as well as overall goals to improve policy coherence, accountability and social participation.

Although there were significant variations in the levels of maturity of policy coherence, accountability and participation across the local health strategies of the case studies, their importance for advancing health equity was well acknowledged among the actors involved in both the development and implementation of local health strategies. Moreover, its importance for advancing health equity has been widely endorsed among experts.

Policy coherence

Although the local level may be an appropriate arena for articulating policy coherence, it must attempt to do so in the face of external barriers over which it has little control. Policy coherence cannot be taken for granted. Examples such as Bilbao illustrate that health is often perceived from a biomedical perspective. From this standpoint other municipal departments may not be aware or feel concerned about how their actions influence the health of the population.

Working in silos is part of the structure and functional dynamics of municipalities, which can lead to frustration for those seeking to promote coherent approaches such as HiAP. On the other hand, mechanisms for integrating health into the policies of other sectors (whether they be decision-support tools such as HIA or intersectoral committees) may lead to unnecessary bureaucratisation and administrative overload. In turn this can eventually trigger resistance from the non-health sectors involved. And the absence of formal intersectoral structures for health, as is the case in Barcelona, can make coherent policy approaches more vulnerable to political change.

A shared challenge in all three case studies, which was explicitly highlighted in Liverpool, is the inherent difficulty in moving from symbolic and discursive policy coherence to operational policy coherence and from this to concrete and measurable outcomes in terms of population health and equity.

The results suggest that a democratic and socially progressive political environment supports the integration of health and equity as a shared value and responsibility. Likewise, the establishment of legal and regulatory frameworks such as public health laws or strategic government plans can provide an umbrella for the institutionalization of a social model. Specifically with regard to local health strategies, these seem most likely to include an equity

perspective when they involve multi-level policies. That is, strategies that include policies that cut across local government responsibilities should have high-level political support as well as institution-wide commitment. The policies that result within the health department itself will be more firmly rooted to better enable implementation. Multilevel strategies more easily enable the establishment of structures and resources for intersectoral action for health, the use of decision-support tools, and the development of individual and institutional capacities, which are key elements for its implementation.

Building synergies with other programs and networks can foster the implementation of policy coherence at the local level. However, institutional changes in terms of policy coherence tend to be very slow and the first fruits obtained are often not so tangible such as improvement of intersectoral communication, which may lead to the reformulation of particular sectoral policies to better include health and equity. Therefore, while it is important to measure results in terms of population health and equity, it is equally important to measure and value the *process* of strengthening policy coherence.

Accountability

The relatively good accountability performance of the city government does not necessarily translate into the local health strategy. For example, in the case of Bilbao, although the overall accountability at institutional level appeared to be adequate, the information available to citizens in relation to the social determinants of health and health status at neighbourhood level was, beyond the Bilbao Health Diagnosis, practically non-existent. Another challenge in terms of accountability is highlighted in the case of Liverpool, which shows that the assimilation of the monitoring and evaluation functions of local health strategies by the institution can weaken the external capacity for advocacy.

One of the key levers for enhancing accountability, such as the human rights-based approach to health, is a framework that is virtually unrecognised at the local level, and where it is acknowledged, it is not put into operation. The findings indicate that the human rights-based approach to health lays down a solid framework that can foster governmental commitment to accountability. However, it is necessary that the rights-based approach to health does not remain at a discursive and symbolic level. It needs to be translated into action by establishing structures, mechanisms and processes for accountable governance in terms not only of transparency and answerability but also compliance and enforcement.

Of course, there is no single model for accountability implementation, which is highly context-dependent. Nevertheless, the case studies analysed show that Public Health Observatories, with a technical profile and a sufficient degree of autonomy from the political level, can act as a catalyst for accountability as part of local health strategies. Beyond the way in which accountability is implemented, what is really important is to ensure continuous and inclusive monitoring and evaluation, an availability of disaggregated local data that is openly available, as well as the generation and transfer of applied knowledge.

Social participation

Social participation is often understood by local governments in a reductionist and somewhat utilitarian way; a necessary process to be institutionally-driven. Moreover, social participation is perceived as expensive and time-consuming, and not very efficient. There are also barriers

related to previous experiences of poorly executed participation processes, scepticism about the difference that participation will make, and lack of confidence in the actual capacity of the local government to respond to social demands and needs. As a result, there is a considerable gap between the symbolic content of policies, which in general terms give great weight to social participation, and the operational content, which barely has any concrete actions for its articulation. In the three case studies, the community health action focuses on the implementation of certain programs or projects. It is hardly linked to the phases of the policy cycle that favour processes of social transformation and empowerment. Thus, social participation at the local level remains more utilitarian than transformative.

Social participation essentially takes place outside the institution undertaking it and therefore it is critical to recognise, value and actively promote cohesive communities, community networks and social movements able to participate meaningfully. A more horizontal and networked model of governance necessarily involves creating a participatory institutional culture that promotes deliberative capacity and the decentralisation of power. This can be pursued through the establishment of a variety of processes, mechanisms, and instruments that encourage the participation of all social groups. To promote equity it is essential to realize that uncritical social participation replicates social inequalities. It is therefore vital to ensure participation is both inclusive and representative, with possible missing voices being positively sought out. It is also important to incorporate social participation as an essential part of the whole policy circle and to avoid an instrumental use of social participation.

Local health strategies should be focused on community health, and within this focus must incorporate specific actions for the development of skills and capacities in the population as well as in the government. Nevertheless, the essential point is to recognise that local health strategies must be led by and for the community.

8.2. Implication of findings

Perhaps one of the most relevant points in terms of implementing an equity approach is to understand that the development of each of these key dimensions of governance for health equity has a positive and cumulative impact on the other key dimensions. Therefore, in order to advance health equity, it is pertinent to consciously and explicitly try to integrate policy coherence, accountability and social participation into the strategic governance. The results of this study provide some clues on how these key dimensions of governance for health equity can be operationalised at the local level. The mechanisms and processes of policy development need to consider delivery systems and must be adapted to the current context of institutions. Strategy development needs to be integral to core institutional arrangements, working within existing systems but also encourage the adaptation of these to improve their capacity to deliver equity results across sectors and determinants.

Local health strategies must also be flexible enough to evolve in the face of political, social, economic and environmental challenges as these arise. The COVID-19 pandemic has evidenced a lack of awareness and preparedness of local governments to respond to global challenges. At the same time, however, it has shown that in the case studies where key dimensions of health governance were more established, the response was more equitable, timely and comprehensive.

The Background section explored the major global challenges that urban governance is facing, such as urban poverty, gentrification, commercial determinants of health, climate change, natural disasters and epidemics. All these issues not only have serious negative impacts on population health but also generate inequality. In fact, inequalities in terms of wealth and power are not only maintained but are intensifying. Moreover, under the hegemonic policy paradigm that prioritises economic growth over social and environmental issues, the potential for local innovation to address health inequalities effectively seems very limited.

In this social, political and economic conjuncture, governments can commit to reducing health inequalities, but can they realistically propose actions to substantially change the structural determinants of health and well-being? The research has revealed the obvious confusion of values that underlies current policy commitments to reduce health inequalities. The same governments that embrace the rhetoric of health equity are often dismantling public sector mechanisms to support disadvantaged populations. How then can governance for health equity be moved forward?

Effective policy action to respond to these challenges cannot fit into low-cost policy options that fits within electoral cycles. Health inequalities will only be reduced as a result of substantial political change. Thus new political scenarios and new strategies that seek to engage substantively with power inequalities must therefore be created. Scott-Samuel and Smith have already pointed out that within the confines of neoliberalism and a political paradigm that prioritises only economic growth, a *fantasy paradigm*[371] is created in which proximal, downstream, easily tackled exposures are posited as potential solutions to health inequalities. This research moves away from such approaches by embracing Levitas' notion of *utopia as method*[372] in order to approach health equity research from a different and potentially useful angle. Levitas developed conceptualised the *utopia as method*[372] which turning the positivist method on its head in order to find a way towards *utopia*. The results of this research intend to contribute to the construction of the utopian path to health equity, where the evidence is not yet strongly consolidated, but where it is necessary to move forward in order to build it.

The results highlight the need to move from short-term, fragmented or isolated policies to a comprehensive set of policies that put equity at the centre. Policies, programmes, projects and interventions are most effective when the actions needed to create the conditions for health equity are coordinated in a transparent and inclusive policy environment. Thus, sustainable and inclusive development strategies need greater policy coherence within and across sectors, greater accountability and greater social participation. However, the ultimate purpose of including and deploying these health equity drivers within local health strategies is not so much to produce a roadmap to equity, but rather to develop possible future scenarios in which the causal pathways that lead to unequal distribution of power, income, and wealth could be challenged.

Achieving health equity necessarily requires a global paradigm shift, without which the formulation of strategies that address the root causes of health inequalities seems an unattainable goal. Building on the utopian vision of a society in which health is more egalitarian, one of the necessary changes to realise this vision may be more coordinated, transparent and inclusive local health strategies. In the same way, in order to build greater societal resilience to face the fore mentioned global challenges, long-term structural transformations are needed to change the way we think about priorities. The question is, from do we start? Considering this complex and inseparable interface between global and local responses, can change be initiated at the local level?

8.3. Strengths and weaknesses of the research

This research has strengths but also limitations that are discussed in this section. Perhaps the most obvious element that has limited the development of the research as intended is the epidemic that hit the case study areas in the early 2020s. The COVID-19 pandemic has affected not only the circumstances of the case studies selected but also the research itself. By necessity, the pandemic has modified the research objectives. Over the past few decades there have been many public health challenges that have required research into the implementation of practices and policies worldwide, but perhaps none as global as the current pandemic. This research has sought to respond to the new demands for knowledge generated by the current pandemic situation, including the exploration of the challenges and opportunities generated by the pandemic in the implementation of local health strategies as a new research objective.

The COVID-19 pandemic has also forcibly affected the development of the research. Due to the enforced mobility restrictions, it has not been possible to carry out the participant observation in Barcelona and Liverpool case studies as was originally planned. Instead has been necessary to compensate by conducting online interviews to key informants. As it was not feasible to interview all the actors involved in the design and implementation of local health governance strategies in each site, a targeted approach was taken, focusing on key informants through purposive and respondent-driven sampling. It is acknowledged that non-probability purposive sampling using the snowball technique is subject to biases, and also the COVID-19 epidemic has led to some of those key informants contacted not being able to participate due to work overload and sick leave. In order to try to address these limitations, a special effort has been made in the collection and analysis of documents.

Beyond the COVID-19 pandemic context, the research has some inherent limitations. Focusing the research at the local level was a strategic choice based on both the feasibility of conducting the study and the usefulness of the results, since the evidence points to a greater ability to implement at the local level. Although it was a conscious choice, the associated limitations it imposes are recognised. One of these limitations is the loss of territorial perspective, missing the relationship between rural and urban areas, which has not been explored. Another limitation is the loss of perspective of the relationship between the local, regional, national and international levels of governance, which has also not been the subject of this research.

It could be argued that the case study selection (Bilbao, Barcelona and Liverpool) is also a limitation of this research but they were purposively sampled, seeking the selection of illustrative cases that provide variation along the dimensions of theoretical interest[296]. However, it is acknowledged that all three of the sites were based in the high-income Global North, that no cities from the Global South or impoverished countries have been included in this research, and therefore this may affect the transferability of results.

The present research also has limitations inherent to the qualitative approach. Since in qualitative research the researcher is the main instrument of data collection and analysis, the researcher's biases, assumptions and personal values may affect its outcomes. Lincoln and Guba defined credibility, transferability, conformability, and dependability as good measures of trustworthiness in qualitative research[373]. The following table summarises how these elements have been taken into account and apply to this research (Table 28).

Table 28. Lincoln and Guba's trustworthiness model

	Meaning	In the context of this research
Credibility	To ensure that the object of study is accurately identified and described.	This research employs a multiple qualitative case study method, which is grounded in a variety of empirical data sources to enhance credibility. Thus, this research has sought to obtain information from multiple sources, using different data collection techniques such as in-depth semi-structured interviews, participative observation and document analysis. It has to be pointed out, however, that in this research interviews with key informants and experts were conducted in the following languages: Catalan, Spanish, French, and English, according to their mother tongue. These interviews were transcribed and analysed in the language in which they were conducted. Quotes of the interviews conducted in Catalan, Spanish and French were translated for the present report. There are no standards for translation of translinguistic qualitative research, which may be considered a credibility-related limitation. Moreover, the translation of these was not done by a professional translator. The use of tools, models or frameworks to describe and summarise qualitative data is interesting because it facilitates the systematisation of thematic coding and the subsequent comparison of contexts. The guided thematic analysis used for the assessment of the key dimensions of governance for health equity was essentially carried out on the key documents of local health strategies (strategic directives, policies, or plans). Several limitations arise from this. On the one hand, there has been no validation of the use of these instruments, models, or frameworks to assess policy coherence, accountability and social participation in local health strategies. On the other hand, the key documents of local health strategies may not always be a reliable and accurate reflection of the actual incorporation of these dimensions in local governance. In-depth interviews including comprehensive questions have sought to capture elements of governance beyond the strategy documents, thus enriching the analytical codebook approach.

Transferability	Making connections between elements of the study and contexts relevant to them.	When it comes to case studies, one of the most frequent criticisms relates to the transferability, external validity, and therefore generalisability of the results[295]. Indeed, the extent to which qualitative data can explain phenomena beyond the specific scope of a particular case study is one of the controversies associated with the method. While this has been taken into account in the analysis, it is also true that multiple case studies provide a stronger basis for theoretical generalisation than a single case study, as they make it easier to separate generalizable theoretical relationships from the idiosyncrasies associated with a specific case study. Moreover, the cross-case analysis was enriched with the analysis of the interviews to international experts in the field of governance for health in order to strengthen the degree of generalisability of the case studies' findings. The findings have been framed with caution and do not intend to provide a roadmap to equity applicable to all contexts. Instead, it is recognised that there is no one single kind of strategy to move towards health equity, but there are common elements that can act as enablers for the inclusion of an equity approach. Even these enablers do not pretend to be applicable to all cities, given that both the case studies analysed and most of the experts consulted belong to institutions of the Global North or wealthy countries.
Dependability	Reflecting on changes in the phenomenon and context studied.	The policies that constitute the local health strategies are highly dependent on electoral and political cycles, as well as having their own cycles of formulation, implementation, and evaluation. As was extensively developed in the case studies, the timing of the local health strategies when they were examined covered different phases and periods of time in each case study, which could be considered a limitation. On the other hand, one cannot understand human thoughts, feelings, and actions without understanding the setting and the contextual variables that are operating. In this regard, it has to be noted that the rapidly changing scenarios in which we have operated during the COVID-19 pandemic may have influenced the responses of the key informants that participate. One of the limitations of the study is that the interviews were conducted over a period of 20 months, during which time the epidemiological situation and the available scientific evidence has significantly changed, potentially bringing about changes in beliefs, experiences, values, and actions.

Conformability	Objectivity-control for bias of the research when analysing the findings.	For reasons of feasibility, it was not possible to carry out double coding that would have assessed the reliability of the data analysis. However, specific actions have been taken to enhance research trustworthiness and rigour, including triangulation of data, member checking and peer debriefing. Thus, data analysis was iterative and findings were discussed with key actors of the case studies, experts, and with research teams in which the PhD student is situated to ensure that the interpretations were challenged and properly reflected the data. Further considerations regarding how the research process and outcomes may have been influenced by the researcher are detailed in the section on Ethics and reflexivity.

8.4. Contributions to urban health research and new lines of inquiry

Most current research on health inequalities has focused on how to measure health inequities caused by social, economic and environmental determinants. Yet, in order to close the gap between values of equity and action, further knowledge is needed on how to develop and implement policy options. Furthermore, the relatively small amount of research that has addressed health inequalities from an action-oriented perspective has often done so from a substantially reductionist view, focusing on specific programmes or issues. Reducing health inequalities necessarily requires intervening in the causal pathways that lead to unequal distribution of power, income and wealth. Both the lack of practical recommendations to address health inequalities and the lack of effective ones have led to some frustration among policy makers and activists[371] and did not help to overcome rhetorical commitment to the reduction of health inequalities. The results of this research aim to contribute to filling this gap.

This research also aims to open up new research avenues to build healthier, more equitable and resilient cities. On one hand, the research has been based exclusively on case studies of cities located in the Global North, which is an important limitation in terms of the transferability of the results. It would be highly desirable to conduct research of a similar nature in cities in the Global South. Moreover, this limitation is critical in terms of global equity and research, so I hope that although I was not able to cover it, this study may open the door for others to do so. On the other hand, I also hope that this study can serve as a basis for opening the focus of urban health governance. One of the research's limitations is the omission of the relationship between rural and urban areas, and the relationship between local, regional, national and international levels of governance. These are the boundaries of this research but can be taken over as starting points for future research.

CONCLUSIONS

9. Conclusions

Health transcends medical healthcare and includes the social determinants of health; the conditions in which people are born, grow, work, live, and age. Health-disease processes can only be fully understood if the multiple factors and interactions that affect the human experience are recognised. The health of individuals and populations is strongly influenced by wider set of forces and systems shaping the conditions of daily life. These living conditions do not depend exclusively on individual choices, but are determined by socio-cultural, economic or environmental factors. The social determinants of health are unequally distributed, generating health inequalities. The magnitude of these inequalities is enormous, as it is their variability, which at the same time indicates that health inequalities can be modified by public policies that contribute to the reduction.

Equity in health is closely related to the conceptual thread of human rights and implies social justice that enables all people to have an equal opportunity to achieve the highest attainable standard of health and a life of dignity. Health is a human right that encompasses not only health care but also the social determinants of health that ensure dignified living conditions in order to achieve adequate levels of health and reduce health inequalities.

Local governments are able to respond to local needs by addressing the social determinants of health and health equity. However, they are also situated in a broader context that challenges and shapes their response capacity to uphold the right to health. The complex and inseparable interface between global developments and local responses poses a challenge for urban health governance, which must respond to global health threats such as the consequences of neo-liberalisation and globalisation processes, climate change, natural disasters, or pandemics. But this close interconnection between the global and the local also makes urban governance a potential arena of change. An equity-promoting urban governance for health offers a window of opportunity not only to face these challenges, but also to be part of the solution.

Governance is a structural determinant that affects health and health equity. A governance strategy for health equity considers health as a fundamental human right, as an essential component of well-being, as a public good, and as a matter of social justice. Policy coherence, accountability and social participation have been identified as the key dimensions both as health equity drivers on their own and as key dimensions of governance for health equity. Policy coherence enables the prevention of unintended negative effects on health and health equity by ensuring integrated, complementary, and synergic public policies. Accountability generates evidence for action, promotes governmental transparency, explains governmental actions and holds those responsible where standards have been inappropriate. Social participation promotes the transfer of real decision-making authority to citizens, giving them a voice and promoting capabilities to participate meaningfully, ensuring inclusivity, intensity, and influence.

There is an empirical link between governance, policies and health equity. The explanatory mechanisms are complex, but point to the fact that the redistribution of material and immaterial resources discourages vertical power relations promoting well-being of society. As policies can foster or hinder distribution of power, wealth and resources, they provide insight into how the value-laden concepts on which they are based influence the complex ways in which government and other agents interact, either to consolidate structures of power or create new rationalities of governance. In light of this, policies can be a remarkable object of research enquiry. As a way of approaching governance, the local health strategies, -understood as any directive, policy or

plan, or set of them, developed by the local government, that explicitly recognizes the aim to promote population health-, were the main subjects of analysis of this research.

The comparative analysis of the local health strategies of Bilbao, Barcelona and Liverpool showed significant variations in the maturity levels of policy coherence, accountability and participation. Although there is no one-size-fits-all type of strategy that fosters health equity, local health strategies seem to be more effective when the actions needed to create the conditions for health equity are coordinated in a transparent and inclusive policy environment. The importance of policy coherence, accountability, and social participation in advancing health equity was well acknowledged among the actors involved in the development and implementation of local health strategies as well as by experts.

The enabling factors identified for advancing policy coherence were: 1) favourable political context and a commitment by all institutional actors to recognise health and equity as a fundamental cross-cutting objective; 2) policy frameworks, such as public health laws or government strategic plans, that support the creation of rules, structures, mechanisms and processes to operationalise policy coherence; 3) multi-level local health strategies with broad objectives that call for intersectoral action for health; 4) the use of health-decision support tools to facilitate the consideration of health and equity issues in other sectors' decision-making; 5) the development of individual and institutional capacity through training and *learning by doing*; and 6) establishing synergies with other local, national and international programmes and networks.

The enabling factors identified for advancing accountability were: 1) a human rights-based approach; 2) structures and mechanisms and processes to operationalise accountability; 3) public health observatories with a technical profile and a sufficient degree of autonomy from the political level; 4) continuous and inclusive monitoring and evaluation; 5) availability of disaggregated data; and 6) generation and transfer of applied knowledge.

The enabling factors identified for advancing social participation were: 1) a participatory institutional culture that provides multiple processes, mechanisms and instruments to foster the participation of all social groups; 2) to seek for an inclusive and representative participation; 3) to integrate social participation throughout the political circle; 4) to build skills and capacities of the population and government; and 5) to promote transformative and empowering community health approaches.

The ultimate purpose of identifying these implementation-enabling factors is to facilitate the inclusion and development of policy coherence, accountability and social participation within local health strategies. In doing so, there is certainly no attempt to provide a recipe for health equity, but rather to open up possible pathways for the development of future scenarios in which the unequal distribution of power and its causes can be challenged. The results of this research may be a modest contribution to the study of public policy and urban health, but hopefully they can contribute to opening up new avenues of research and practice to build healthier, more resilient and more equitable cities.

ANNEXES

10. Annexes

Interview script

BASIC INTERVIEW SCRIPT	
General context of local governance for health	• Could you describe what competencies the City Council has in health and specifically in the social determinants of health? Are there other institutions/organisations involved in local governance? • Could you describe what the city's track record in governance for health has been like? • To what extent do you consider that the social model of health has been institutionalised, and the health equity approach?
Health equity drivers	• In relation to governance for health, to what extent do you think policy coherence (intersectoral action for health, health in all policies) has been developed (examples), through what mechanisms or instruments? What have been the main barriers and facilitators? • In relation to governance for health, to what extent do you think social participation has been developed (examples), through what mechanisms or instruments? What have been the main barriers and facilitators? • In relation to governance for health, to what extent do you think accountability has been developed (examples), through what mechanisms or instruments? What have been the main barriers and facilitators?
Opportunities Challenges	• How has the COVID pandemic affected health governance? • How do you think equity-promoting health governance could be developed in this context? • What would be the opportunities and challenges to be faced?
Other	• Is there any information that you consider relevant, that I have not explicitly asked you about, that you would like to share? • Do you know of any report, article, website, book... that you think could be useful to deepen this research? • Is there any other person that you think I should interview to go deeper into these issues? •

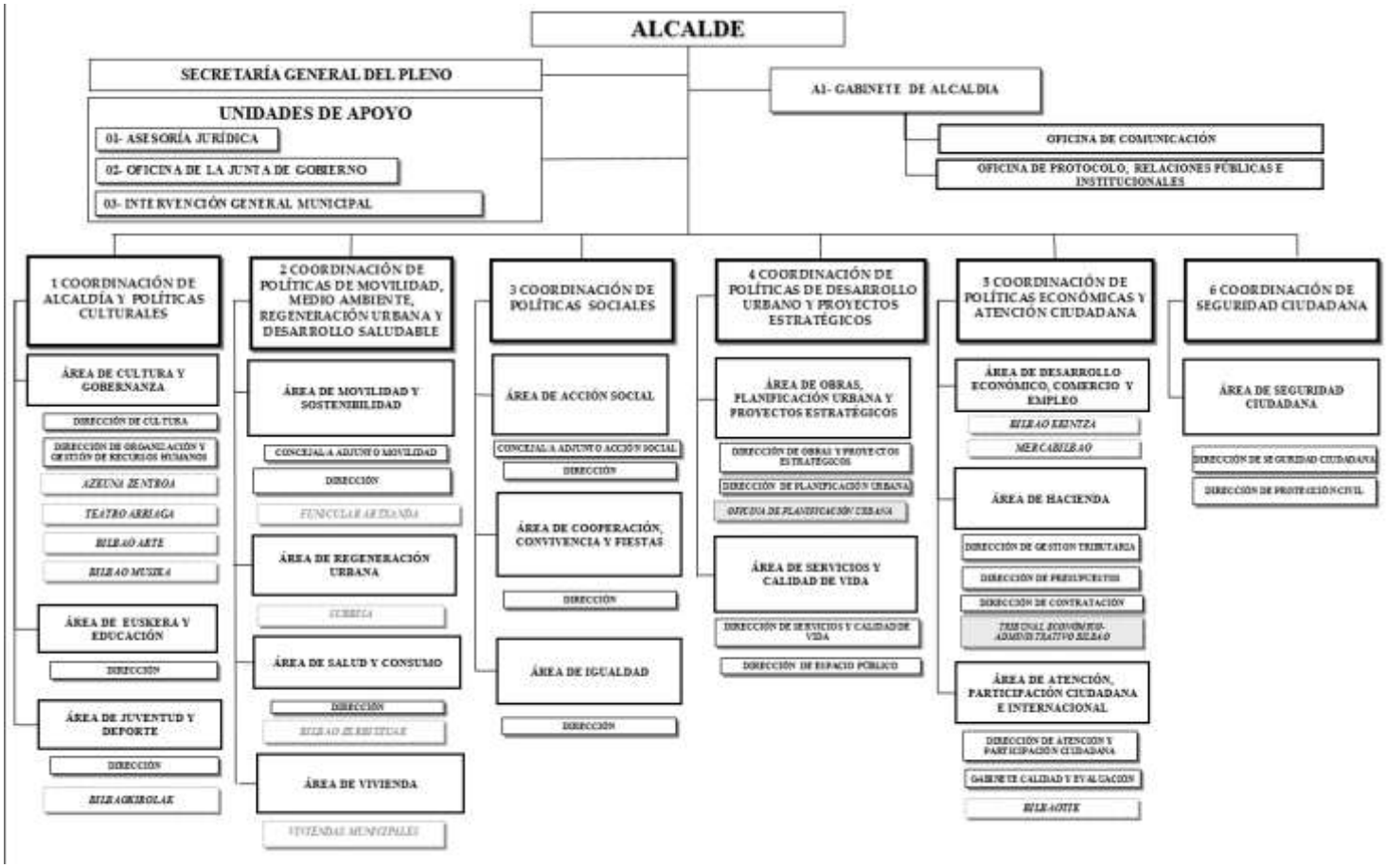
CFIR Codebook

CFIR Codebook		
Construct		**Short Description**
INTERVENTION CHARACTERISTICS		
A	Intervention Source	Perception of key stakeholders about whether the intervention is externally or internally developed.
B	Evidence Strength & Quality	Stakeholders' perceptions of the quality and validity of evidence supporting the belief that the intervention will have desired outcomes.
C	Relative Advantage	Stakeholders' perception of the advantage of implementing the intervention versus an alternative solution.
D	Adaptability	The degree to which an intervention can be adapted, tailored, refined, or reinvented to meet local needs.
E	Trialability	The ability to test the intervention on a small scale in the organization, and to be able to reverse course (undo implementation) if warranted.
F	Complexity	Perceived difficulty of implementation, reflected by duration, scope, radicalness, disruptiveness, centrality, and intricacy and number of steps required to implement.
G	Design Quality & Packaging	Perceived excellence in how the intervention is bundled, presented, and assembled.
H	Cost	Costs of the intervention and costs associated with implementing the intervention including investment, supply, and opportunity costs.
OUTER SETTING		
A	Patient Needs & Resources	The extent to which patient needs, as well as barriers and facilitators to meet those needs, are accurately known and prioritized by the organization.
B	Cosmopolitanism	The degree to which an organization is networked with other external organizations.
C	Peer Pressure	Mimetic or competitive pressure to implement an intervention; typically because most or other key peer or competing organizations have already implemented or are in a bid for a competitive edge.
D	External Policy & Incentives	A broad construct that includes external strategies to spread interventions, including policy and regulations (governmental or other central entity), external mandates, recommendations and guidelines, pay-for-performance, collaboratives, and public or benchmark reporting.
INNER SETTING		

A	Structural Characteristics	The social architecture, age, maturity, and size of an organization.
B	Networks & Communications	The nature and quality of webs of social networks and the nature and quality of formal and informal communications within an organization.
C	Culture	Norms, values, and basic assumptions of a given organization.
D	Implementation Climate	The absorptive capacity for change, shared receptivity of involved individuals to an intervention, and the extent to which use of that intervention will be rewarded, supported, and expected within their organization.
	Tension for Change	The degree to which stakeholders perceive the current situation as intolerable or needing change.
	Compatibility	The degree of tangible fit between meaning and values attached to the intervention by involved individuals, how those align with individuals' own norms, values, and perceived risks and needs, and how the intervention fits with existing workflows and systems.
	Relative Priority	Individuals' shared perception of the importance of the implementation within the organization.
	Organizational Incentives & Rewards	Extrinsic incentives such as goal-sharing awards, performance reviews, promotions, and raises in salary, and less tangible incentives such as increased stature or respect.
	Goals and Feedback	The degree to which goals are clearly communicated, acted upon, and fed back to staff, and alignment of that feedback with goals.
	Learning Climate	A climate in which: a) leaders express their own fallibility and need for team members' assistance and input; b) team members feel that they are essential, valued, and knowledgeable partners in the change process; c) individuals feel psychologically safe to try new methods; and d) there is sufficient time and space for reflective thinking and evaluation.
E	Readiness for Implementation	Tangible and immediate indicators of organizational commitment to its decision to implement an intervention.
	Leadership Engagement	Commitment, involvement, and accountability of leaders and managers with the implementation.
	Available Resources	The level of resources dedicated for implementation and on-going operations, including money, training, education, physical space, and time.
	Access to Knowledge & Information	Ease of access to digestible information and knowledge about the intervention and how to incorporate it into work tasks.
CHARACTERISTICS OF INDIVIDUALS		
A	Knowledge & Beliefs about the Intervention	Individuals' attitudes toward and value placed on the intervention as well as familiarity with facts, truths, and principles related to the intervention.

B	Self-efficacy	Individual belief in their own capabilities to execute courses of action to achieve implementation goals.
C	Individual Stage of Change	Characterization of the phase an individual is in, as he or she progresses toward skilled, enthusiastic, and sustained use of the intervention.
D	Individual Identification with Organization	A broad construct related to how individuals perceive the organization, and their relationship and degree of commitment with that organization.
E	Other Personal Attributes	A broad construct to include other personal traits such as tolerance of ambiguity, intellectual ability, motivation, values, competence, capacity, and learning style.
PROCESS		
A	Planning	The degree to which a scheme or method of behavior and tasks for implementing an intervention are developed in advance, and the quality of those schemes or methods.
B	Engaging	Attracting and involving appropriate individuals in the implementation and use of the intervention through a combined strategy of social marketing, education, role modeling, training, and other similar activities.
	Opinion Leaders	Individuals in an organization who have formal or informal influence on the attitudes and beliefs of their colleagues with respect to implementing the intervention.
	Formally Appointed Internal Implementation Leaders	Individuals from within the organization who have been formally appointed with responsibility for implementing an intervention as coordinator, project manager, team leader, or other similar role.
	Champions	"Individuals who dedicate themselves to supporting, marketing, and 'driving through' an [implementation]" [101] (p. 182), overcoming indifference or resistance that the intervention may provoke in an organization.
	External Change Agents	Individuals who are affiliated with an outside entity who formally influence or facilitate intervention decisions in a desirable direction.
C	Executing	Carrying out or accomplishing the implementation according to plan.
D	Reflecting & Evaluating	Quantitative and qualitative feedback about the progress and quality of implementation accompanied with regular personal and team debriefing about progress and experience.

Bilbao' City Council organisation chart



Incorporating narratives and perceptions into local health diagnoses: the case of Bilbao

Nota metodológica

Incorporando las narrativas y las percepciones en los diagnósticos de salud locales: el caso de Bilbao

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RESUMEN

La subjetividad de multitud de dimensiones que inciden en la salud requiere abordajes sistémicos, diseños de estudios que integren datos de salud poblacionales y las narrativas de la población, así como abordajes metodológicos específicos que permitan capturar la evidencia procedente de procesos sociales y comunitarios. El uso de metodologías participativas en los diagnósticos de salud urbana es clave para capturar las diferentes perspectivas y conocimientos del contexto local, contribuyendo a un análisis más completo de la realidad. Esta nota metodológica expone el desarrollo del proceso participativo realizado como parte del diagnóstico de salud de Bilbao: la identificación de agentes participantes y criterios de selección, la invitación a participar y las dinámicas desarrolladas. Compartir experiencias que hayan incorporado procesos participativos es necesario para favorecer su desarrollo metodológico, y así, impulsar su práctica.

Incorporating narratives and perceptions into local health diagnoses: the case of Bilbao

Keywords:
Social participation
Health situation diagnosis
Methods
Stakeholder participation
Urban health

ABSTRACT

The subjectivity of a multitude of dimensions that affect health requires systemic approaches, study designs that integrate population health data and the narratives of the population, as well as specific methodological approaches that allow the capture of evidence from social and community processes. The use of participatory methodologies in urban health diagnoses is key to capturing the different perspectives and knowledge of the local context, contributing to a more complete analysis of reality. This methodological note presents the development of the participatory process carried out as part of the Bilbao health diagnosis: the identification of participating agents and selection criteria, the invitation to participate and the dynamics developed. Sharing experiences that have incorporated participatory processes is necessary to foster its methodological development, and thus, to promote it practice.

Introducción

La subjetividad de multitud de dimensiones que inciden en la salud urbana requiere abordajes sistémicos, diseños de estudios que integren datos de salud poblacionales y las narrativas de la población local, así como abordajes metodológicos específicos que permitan capturar la evidencia procedente de procesos sociales y comunitarios. En las últimas décadas se ha desarrollado una amplia evidencia científica sobre los beneficios, en términos de salud y equidad, de incorporar procesos participativos en la formulación, el desarrollo y la evaluación de programas, proyectos, planes y políticas[1–4].

La incorporación de la participación ciudadana en la realización de diagnósticos de salud dirigidos a la planificación de políticas municipales constituye una oportunidad para exprimir el potencial salutogénico de los municipios y, a su vez, fomentar un modelo de gobernanza más participativo, transparente y transformador. En España han emergido interesantes experiencias de diagnósticos de salud vertebrados por procesos participativos; sin embargo, salvo remarcables excepciones[5], no se describe la metodología participativa de manera que pueda ser analizada y adaptada a otros contextos. Esta nota metodológica expone el proceso participativo desarrollado en el diagnóstico de salud de Bilbao.

Exposición del método

En el marco de la elaboración del *I Plan Municipal de Salud de Bilbao*[6] se realizó un diagnóstico de salud que integró, por una parte, una descripción cuantitativa de la salud y de los determi-

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Figura 1. Proceso de elaboración del *I Plan Municipal de Salud de Bilbao*.

nantes sociales de la salud[7], y por otra, un proceso participativo dirigido a capturar diferentes perspectivas acerca del concepto de salud y sus determinantes, así como de los activos y las necesidades de salud presentes en los barrios de Bilbao y en el conjunto de la ciudad (fig. 1).

El diagnóstico de salud participativo de Bilbao[8] fue desarrollado con la metodología que se expone a continuación.

Identificación de agentes participantes y criterios de selección

Se identificaron, por su complementariedad para identificar necesidades y activos de salud, los siguientes agentes clave: 1) ciudadanía asociada y no asociada, y 2) profesionales, relacionados/as con determinantes sociales de la salud, que desempeñan su trabajo en los barrios (tabla 1). La selección tuvo en cuenta criterios de representatividad socioeconómica y geográfica. Así, en el caso de los/las profesionales, se priorizó la representación de todos los distritos de la ciudad y, en el caso de los/las vecinos/as, la diversidad en cuanto al nivel socioeconómico del barrio. Como ciudadanía asociada se incluyeron las asociaciones vecinales y de barrio, así como otras asociaciones sociales no profesionalizadas, excluyendo asociaciones de pacientes. Igualmente se procuró una paridad de género.

Invitación a participar

La invitación a las/los profesionales se llevó a cabo a través de correo electrónico y por vía telefónica por parte del Área de Salud y Consumo del Ayuntamiento de Bilbao. La invitación para los talleres participativos con vecinas/os sin vinculación a asociaciones vecinales se hizo mediante carteles, difusión en páginas web y redes sociales del Ayuntamiento y contactos informales. Se contó con la colaboración del teléfono de información municipal para la gestión de la información a las personas interesadas y su registro. Asimismo, resultó clave el apoyo por parte de entidades socioeducativas y de los centros de salud. En la convocatoria se ofreció a las/los vecinas/os una gratificación en forma de vale para utilizar en la red de comercio local. El reclutamiento para el taller con ciudadanía asociada se realizó por correo electrónico y vía telefónica por parte del Área de Salud y Consumo del Ayuntamiento de Bilbao y del equipo investigador.

Dinámicas participativas

Se realizaron diferentes dinámicas participativas[9] (tabla 1), que tuvieron una duración de 1,5-2 horas y se desarrollaron en los centros municipales de distrito o en los centros cívicos de los barrios. Fueron conducidas por dos dinamizadores/as, pertenecientes al grupo investigador. Las personas participantes en todos los talleres dieron su consentimiento para la grabación de las sesiones, lo que facilitó la extracción de información y su análisis.

1) Talleres con profesionales que trabajan en los barrios

Estos talleres se desarrollaron en tres partes. En la primera, introductoria, se presentaron algunos datos relevantes en relación con la salud en Bilbao y se creó un espacio de reflexión y diálogo colectivos sobre las preguntas «¿Qué es la salud?» y «¿Qué cuestiones condicionan el que unas personas estén sanas y otras no?».

Posteriormente, se solicitó a las/los participantes que identificaran las necesidades y activos disponibles en la ciudad de Bilbao. Con los resultados obtenidos, el equipo dinamizador organizó los resultados en dimensiones que expuso y fueron validadas por el grupo.

En la tercera parte, en grupos reducidos, se priorizaron las dimensiones relativas a las necesidades en los barrios a través de un sistema de puntuación. Una vez elaborado el borrador del informe con los resultados obtenidos de estos talleres, se envió a los/las profesionales para que fuesen validados, se les pidió que realizasen una lectura crítica y que matizaran cualquier aspecto que considerasen oportuno.

2) Talleres con ciudadanía no asociada

Estos talleres tuvieron la misma estructura que los realizados con profesionales que trabajan en los barrios, con la especificidad de que las necesidades y los activos de salud se identificaron y priorizaron tanto para la ciudad como para el barrio.

3) *World café*[10] con ciudadanía asociada

Esta dinámica consistió en una primera parte introductoria, tras la cual las personas participantes debatieron en mesas de diálogo grupal en torno a las preguntas sobre activos y necesidades de salud de Bilbao planteadas. Se hizo una puesta en común en la que una persona portavoz de cada grupo expuso al conjunto de participantes las ideas más relevantes trabajadas. Finalmente, tras la recogida de todas las aportaciones grupales y con el apoyo de las/los dinamizadores, se consensuaron las principales conclusiones. Los activos en salud fueron identificados sobre un mapa físico de la ciudad de Bilbao por las personas portavoces de los grupos.

Tabla 1
Agentes y técnicas desarrolladas en el diagnóstico de salud participativo de Bilbao

	Profesionales que trabajan en los barrios	Ciudadanía no asociada	Ciudadanía asociada
Agentes	Profesionales de ámbitos de educación, acción social, salud, cultura y deporte	Vecinos/as sin vinculación a movimientos sociales o vecinales	Personas vinculadas a asociaciones vecinales y otras organizaciones no profesionalizadas (asociaciones de madres y padres, asociación de técnicos/as en integración social, asociación de mujeres gitanas, asociación de apoyo a la crianza, etc.)
Técnicas	8 talleres participativos en barrios de cada distrito 66 participantes	5 talleres participativos en barrios de diferente perfil socioeconómico 61 participantes	1 *World café* 14 participantes pertenecientes a 10 entidades
	Encuesta *online*		21 participantes

De forma adicional, se elaboró un cuestionario *online* accesible a la población general desde la página web del Ayuntamiento de Bilbao, instando a participar a las personas que no pudieran o no desearan hacerlo en alguna de las sesiones presenciales a las que se las había invitado.

Aplicabilidad

Cabe destacar las limitaciones relacionadas con la imposibilidad de los grupos de vecinas/os en barrios de todos los distritos de Bilbao, así como un posible sesgo de motivación, siendo más probable la participación de aquellas personas con mayores posibilidades de participar o más sensibilizadas. No obstante, el análisis de contenido temático ha mostrado que la captación de diferentes perfiles de población aportó una enorme riqueza al proceso, dado que los discursos, las necesidades y los activos identificados por los diferentes agentes fueron complementarios y permitieron un análisis más completo de la realidad.

Conclusiones

El uso de metodologías participativas en los diagnósticos de salud urbana permite capturar las diferentes perspectivas de los agentes comunitarios, así como su conocimiento cercano al contexto local. La realización de procesos participativos en los diagnósticos de salud contribuye a complementar las aproximaciones cuantitativas y puede ayudar a la construcción de un sistema de gobernanza local en salud más horizontal y que responda mejor a las necesidades humanas. Compartir experiencias que hayan incorporado procesos participativos es necesario para favorecer su desarrollo metodológico e impulsar su práctica.

Contribuciones de autoría

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Conflictos de intereses

Ninguno.

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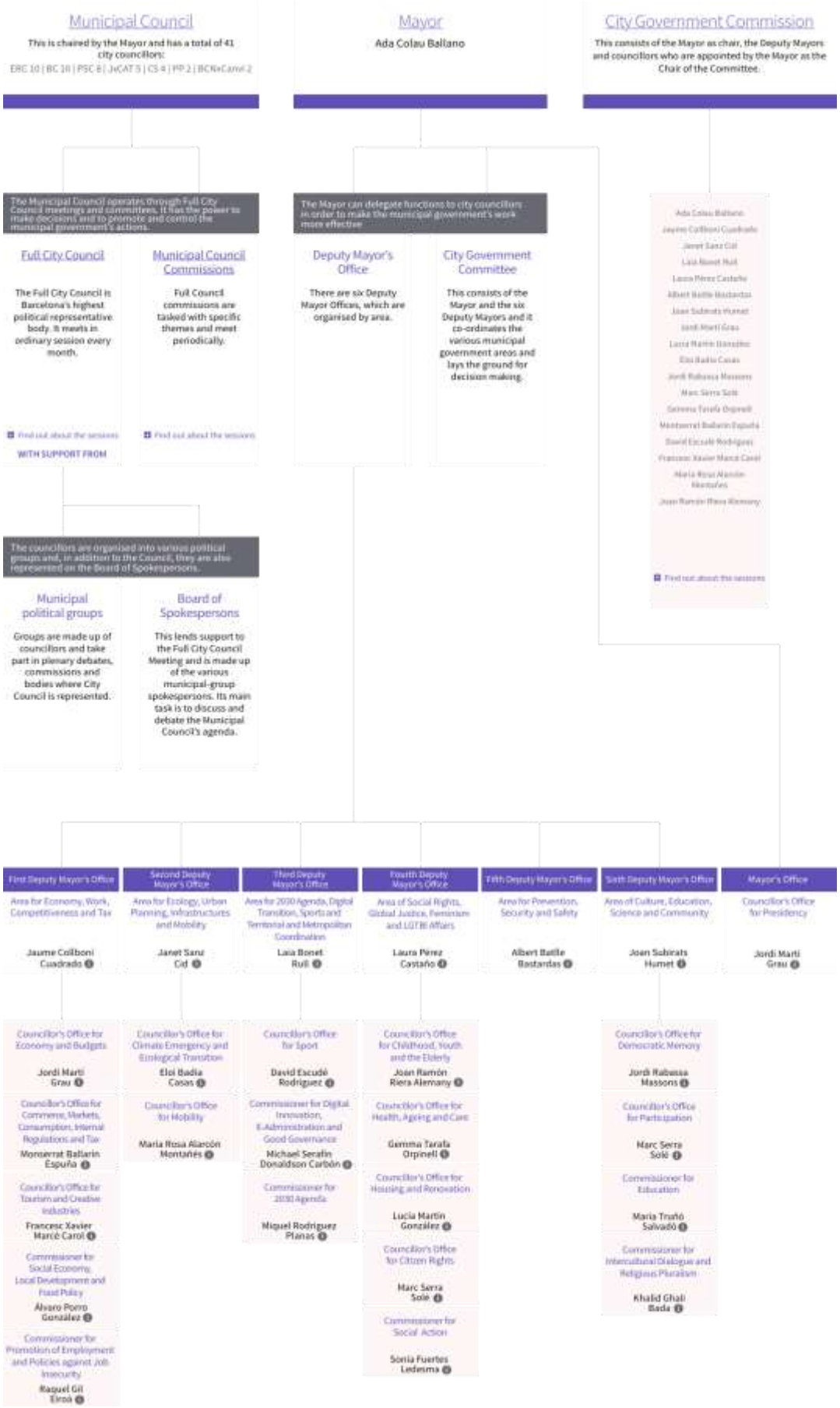
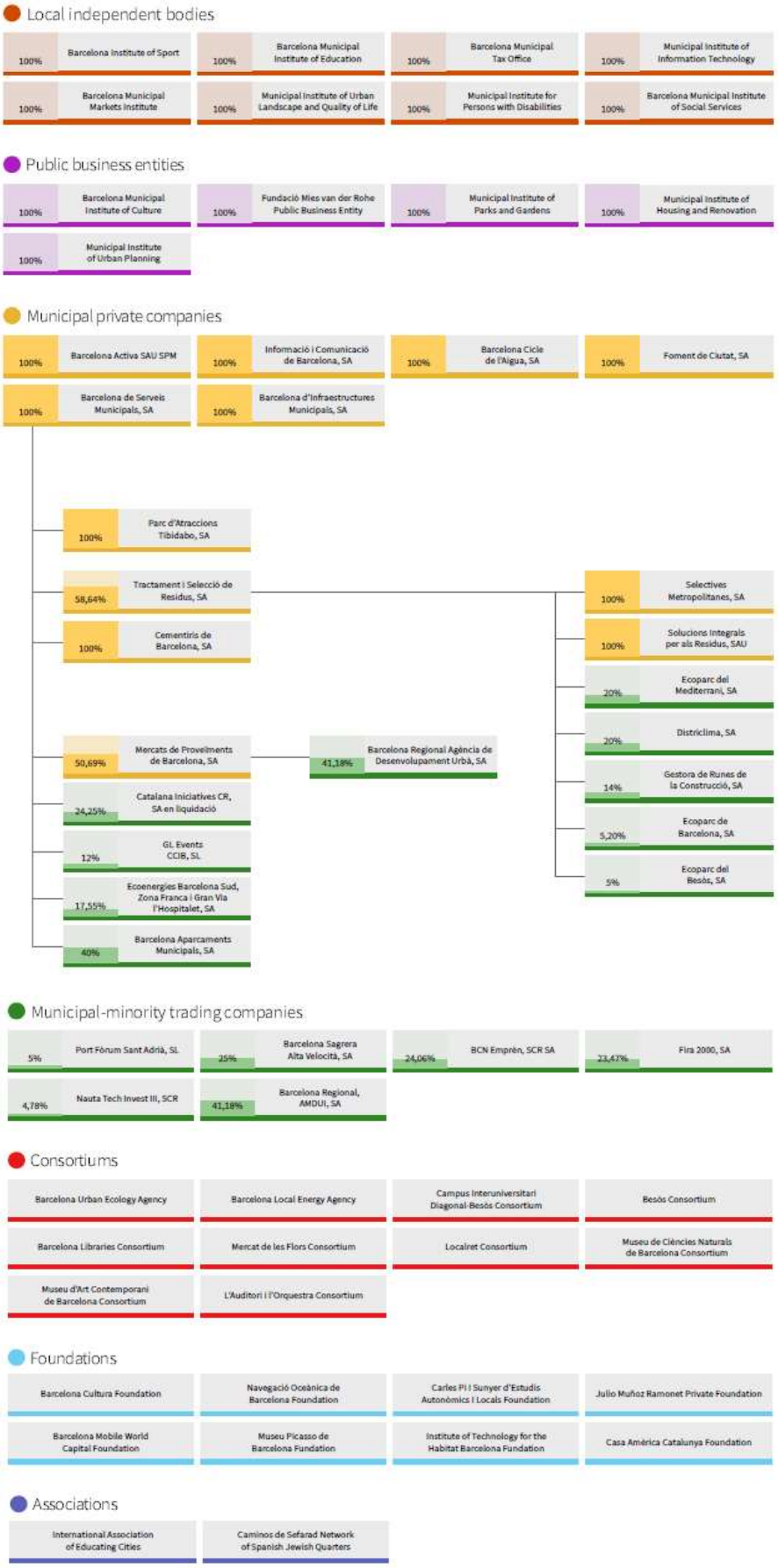
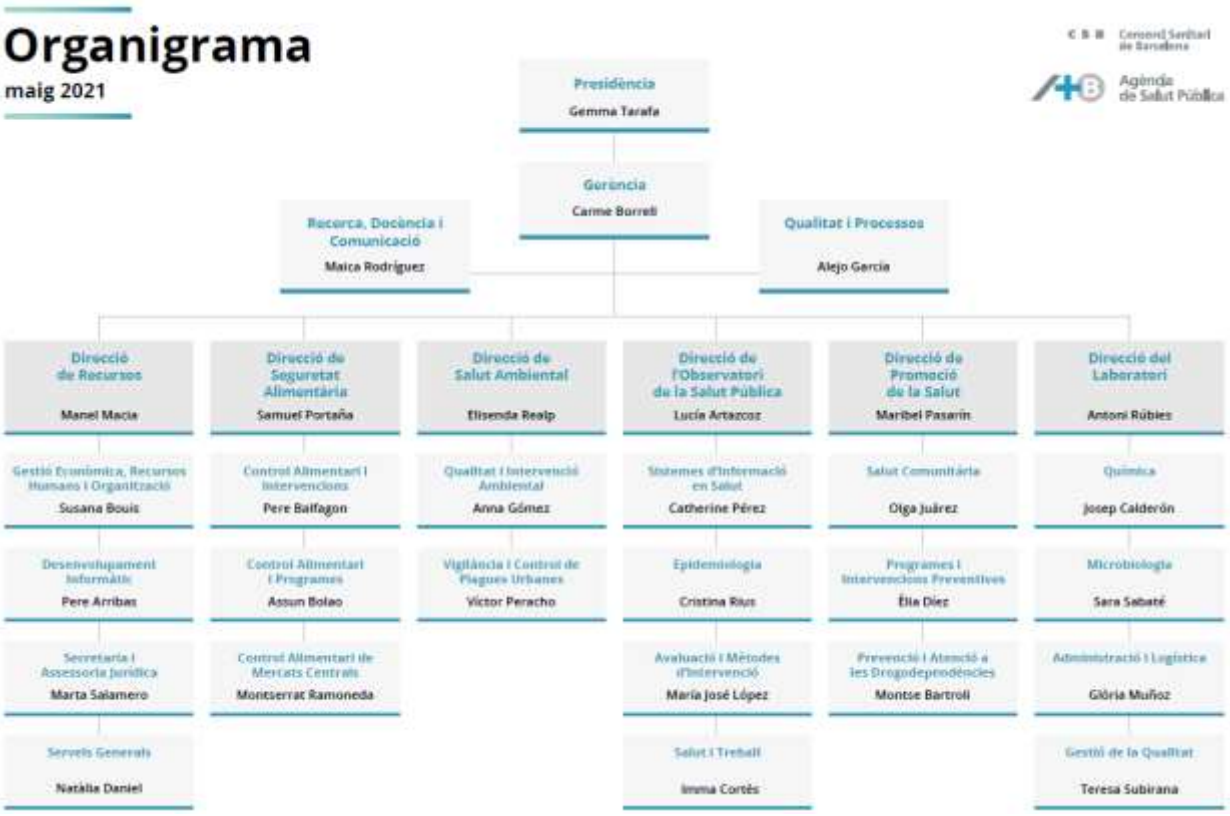
Barcelona' City Council organisation chart



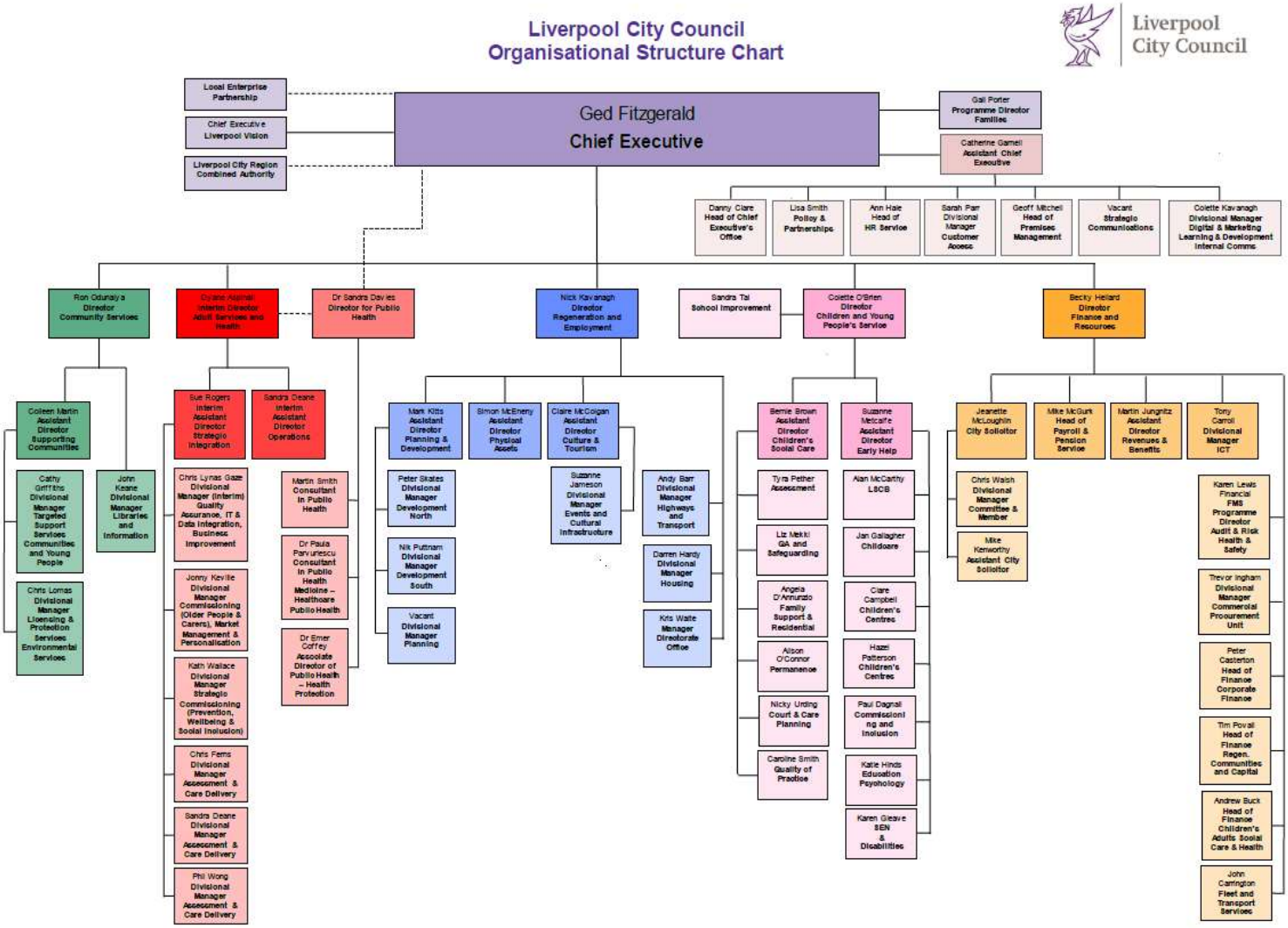
Barcelona' Subsidiary Entities Organization



ASPB' organization chart



Liverpool' City Council organisation chart



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