WHY CONSIDER A LOCAL PUBLIC HEALTH OBSERVATORY FOR YOUR CITY OR REGION?

Local governments require up-to-date, quality health intelligence about their population in order to make important decisions about policies and resource allocation. This is especially relevant for local governments with jurisdiction over large urban areas with a fluctuating population in a rapidly changing environment.

The World Health Organization (WHO) and United Nations Human Settlements Programme (UN-HABITAT) exposed the extent to which certain city dwellers disproportionately suffer from a wide range of diseases and health conditions (1) (Box 1). Such inequities exist in cities all over the world. They are a manifestation of differential social and living conditions, often resulting from unplanned urbanization, which can undermine progress in health development.

A key to both understanding the problem and applying the appropriate solution lies in the availability and utility of local health intelligence. In reality, though, routine information systems at regional and national levels often lack urban-level data (1).

URBAN HEALTH OBSERVATORIES: A POSSIBLE SOLUTION TO FILLING A GAP IN PUBLIC HEALTH INTELLIGENCE

A local public health observatory can provide urban policy makers with much needed health intelligence not found elsewhere. A recent study commissioned by the WHO Centre for Health Development identified good practice which is reflected in a new conceptual framework of an urban health observatory. Sufficient experience and knowledge have been accumulated by pioneering observatories to be shared with cities around the world wishing to establish one of its own. A city should first consider some key factors - political landscape, funding, current public health environment, scope of work, governance, partnerships and sustainability - to determine if and how an urban health observatory might provide a solution to their need for better local health intelligence.

BOX 1. HIDDEN CITIES

“Hidden Cities: unmasking and overcoming health inequities in urban settings” (1) sheds light on unfair differences in health status and health determinants that exist within cities, globally. It stresses the key role of local leaders and governments in promoting urban health equity.

Some of the policy options to achieve healthy urbanization were previously published in a report to the WHO Commission on Social Determinants of Health from the Knowledge Network on Urban Settings (2). A web-based platform created by WHO, Action: SDH supports the continued development of a knowledge base of actions to improve health equity through addressing the social determinants of health.

Properly understanding and responding to the issues highlighted in Hidden Cities requires a multisectoral approach which is informed by accurate data and information about specific social and health conditions at the local level.
They do not specify conditions in the urban areas, not to mention at the sub-urban, neighbourhood level, or by sub-populations in the city. Even when such information exists, it is often limited, fragmented, or is not translated into policy implications.

A type of public health institution that might offer a solution is the “public health observatory (PHO)” (3). It is a relatively new development in the provision of intelligence, different from other related types of institutions, like disease registries, academic centres or public health departments. PHOs produce and disseminate intelligence for their host area in order to inform policy. They are comparatively autonomous, have strong networks for accessing data, and provide high-quality intelligence that is tailored to the needs and timescales of local decision-makers. They reflect the increasing importance placed on health inequalities, on evidence-based “healthy public policies” and on cross-agency work to address the multifactorial, multisectoral influences on health. Several exemplary PHOs, mostly at national and regional levels, are found in Europe and in Latin America.

GOOD PRACTICE AND AN EMERGING CONCEPTUAL FRAMEWORK

The WHO Centre for Health Development commissioned a study at the recommendation of international experts to identify good practice among local PHOs serving a major urban area, or urban health observatories (UHOs), in different parts of the world. The Belo Horizonte Observatory for Urban Health in Brazil undertook the study to analyse the structural and functional characteristics of existing UHOs and other closely related institutions. The objective was to synthesize this information into a conceptual framework which can help guide the establishment and sustainability of UHOs, globally.

![Figure 1: A Working Conceptual Framework of an Urban Health Observatory](source: Belo Horizonte Observatory for Urban Health (Belo Horizonte, Brazil))
Seven institutions were purposively selected for the study to include internationally reputable UHOs (or, where one could not be found, an equivalent urban public health institution) as well as more recently established ones from low, middle and high income countries with consideration for geographic representativeness. Information about the institutions was collected from the Internet and a key informant survey conducted in 2011-12. This information combined with a review of the white and grey literature contributed to the development of a working conceptual framework of an UHO (Fig. 1).

On one hand, the observatories varied on many dimensions including years of existence; historical circumstances of their creation (politically driven, civil-society driven, etc.); host institution (government, university, civil society/NGO); scope of work (research, training, surveillance); and resource capacity, among others. On the other hand, they also shared “good practice” including:

- A primary focus on the urban setting and local priorities, using a social determinants of health approach
- Coordination across multiple sectors, disciplines and levels of government
- Collation of data which are disaggregated at the intra-urban (small area) level to reveal health inequalities
- Analysis and interpretation of data to understand health patterns in the city and their underlying causes, to detect gaps in existing policies and programmes, and to identify new priorities for intervention
- Production of relevant, timely, understandable and actionable local health intelligence to promote utilization of research evidence in strategic planning, policy formulation and performance review
- Dissemination and outreach to policy makers, the scientific community and the general public
- Research and capacity-building in urban health

The main strength of the UHO lies in its ability to mobilize multisectoral partnerships to process locally specific data and translate it into intelligence which can help policy makers effectively understand and address public health priorities in the city. Its legitimacy is derived from the quality of intelligence and the extent to which governance mechanisms and stakeholder relations are in place to ensure sensitivity to community interests and needs.

BUILDING UPON THE EXPERIENCE OF PIONEERS

Several public health observatories including sub-national urban health observatories in different contexts around the world have established legitimacy and demonstrated their ability to provide much needed health intelligence to inform local policy decisions. They effectively fill a gap left by other types of public health institutions and provide a more efficient solution for all. Sufficient experience and knowledge have been accumulated by pioneering public health observatories to be shared with others wishing to establish, strengthen or sustain their own observatory. The Belo Horizonte Observatory for Urban Health, for example, was modelled on the London Health Observatory (Box 2). In this respect, the value of the pioneering observatories should be viewed not just within their local context but also within the broader national, regional and global contexts in which they provide an important and scarce resource.

IS A LOCAL URBAN HEALTH OBSERVATORY A SUITABLE OPTION FOR YOUR CITY OR REGION?

The necessity to establish an urban health observatory, and the appropriate way in which to do so, will vary according to the context and objective. Some key factors to consider and related actions are briefly discussed below.

1. **Political landscape:** Gauge how receptive the policy-making body would be of intelligence produced by an urban health observatory. For example, determine the level of political commitment to improve health levels and equity by addressing the broader determinants of health through a multisectoral approach.
2. Funding mechanism: Many ways of securing funding are possible, including a membership approach, core funds from government or local entities, a consultancy model, etc. It is important to set up a funding mechanism that is sustainable and allows the observatory to be transparently rigorous in its outputs.

3. Public health environment: Assess data availability and current institutional capacity for producing local health intelligence (i.e. geocoded by small area). Determine whether gaps can be filled by mobilizing existing public health infrastructure, or a unique need and opportunity exist for an urban health observatory.

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**Example of Local Health Inequality spine chart for Westminster, London, released by the LHO in February 2012**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Local Authority Value</th>
<th>Regional Value</th>
<th>England Value</th>
<th>England Worst</th>
<th>Range</th>
<th>England Best</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health outcomes</strong></td>
<td></td>
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<tr>
<td><strong>Males</strong></td>
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<tr>
<td>Male life expectancy at birth (years)</td>
<td>83.8</td>
<td>79.0</td>
<td>76.6</td>
<td>73.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inequality in male life expectancy at birth (years)</td>
<td>16.9</td>
<td>7.5</td>
<td>8.9</td>
<td>16.9</td>
<td>3.1</td>
<td></td>
</tr>
<tr>
<td>Inequality in male disability-free life expectancy at birth (years)</td>
<td>17.0</td>
<td>9.1</td>
<td>10.9</td>
<td>20.0</td>
<td>1.8</td>
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<tr>
<td><strong>Females</strong></td>
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<tr>
<td>Female life expectancy at birth (years)</td>
<td>86.7</td>
<td>83.3</td>
<td>82.6</td>
<td>79.1</td>
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<tr>
<td>Inequality in female life expectancy at birth (years)</td>
<td>9.7</td>
<td>4.8</td>
<td>5.9</td>
<td>11.6</td>
<td>1.2</td>
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<tr>
<td>Inequality in female disability-free life expectancy at birth (years)</td>
<td>14.4</td>
<td>7.9</td>
<td>9.2</td>
<td>17.1</td>
<td>1.3</td>
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<tr>
<td><strong>Social determinants</strong></td>
<td></td>
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<tr>
<td>Children achieving a good level of development at age 5 (%)</td>
<td>55.0</td>
<td>59.5</td>
<td>58.8</td>
<td>49.5</td>
<td></td>
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<tr>
<td>Young people not in employment, education or training (NEET) (%)</td>
<td>4.9</td>
<td>5.7</td>
<td>6.7</td>
<td>12.3</td>
<td>2.6</td>
<td></td>
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<tr>
<td>People in households in receipt of means-tested benefits (%)</td>
<td>15.6</td>
<td>18.8</td>
<td>14.6</td>
<td>32.8</td>
<td>4.7</td>
<td></td>
</tr>
<tr>
<td>Inequality in percentage receiving means-tested benefits (% points)</td>
<td>39.7</td>
<td>27.2</td>
<td>29.0</td>
<td>55.1</td>
<td>4.6</td>
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</tbody>
</table>

Notes: From 1 April 2013, LHO is part of a new national body called Public Health England and no longer has a separate existence. The figure above was reprinted, with permission of the author, from UCL Institute of Health Equity and London Health Observatory (2012).
4. **Scope of work:** Based on the assessment of the public health environment, determine the most appropriate scope of work for your observatory. Issues to consider would include, for example, the extent to which the observatory would collect, manage and analyse routine population health information, engage in scientific research, provide training and capacity-building, or offer topic expertise.

5. **Organizational positioning and governance:** Various types of organizational positioning and governance are possible (e.g. academic institution, public health department, non-government organization). Consider the optimal setting for your observatory with regards to, for example, organization of government and health systems, sustainability of host organization, level of autonomy that would be granted to the observatory, level of resources and infrastructure already in place, and ability to mobilize additional resources.

6. **Partnerships:** The ability to engage multisectoral partners will be one of the crucial aspects of an urban health observatory. A careful stakeholder analysis should guide the development of strategic partnerships. The various objectives of a partnership may include: gaining access to data and technical skills; leveraging resources; strengthening political influence; establishing legitimacy; networking with other public health observatories for coordination, peer-learning, etc.; engaging other sectors; and ensuring sustainability.

7. **Sustainability:** All of the above-mentioned issues should be considered while keeping in mind their implications for sustainability in order to ensure uninterrupted operation of the observatory.

Finally, serious consideration should be given to labelling a public health institution, whether new or old, as an “urban/city health observatory”. It should be based on its actual or proposed substance vis-à-vis the working definition of a public health observatory (3) and the actual work of reputable observatories. This is to avoid risk of creating false expectations or diminishing the value of the label. At the same time, the advantages of an urban health observatory should be fully embraced; for example, being an evolving type of public health institution, it may be freed from some of the preconceptions of what local public health bodies should do, allowing it to innovate ways of improving urban health. Strong political and financial support, strategic partnerships, and a tactical role within the existing system are critical for local urban health observatories to both realize their full potential and be sustainable.

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**REFERENCES**

Urban health observatories: a possible solution to filling a gap in public health intelligence.

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