From projects to policy: ‘Healthy Cities’ as a mechanism for policy change for health?

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SUMMARY
One of the aims of the European Healthy Cities project was to contribute to the development of healthy public policy. This paper examines the evidence from ten cities in the Netherlands and the United Kingdom which are either part of the World Health Organization (WHO) Healthy City Project or part of their respective National Networks. Five key issues are identified based on current thinking in political and administrative science concerning change and policy-making. These provide a framework for the analysis of key informant interviews undertaken in the ten case studies. It was concluded that, at the time of the research, a substantive policy change had not taken place and in most cases the Healthy city initiatives were still projects rather than policies and, where plans or strategies had been developed, they were still insufficient in their impact in raising health as opposed to health care up the policy agenda.

Key words: change; Healthy Cities; policy

INTRODUCTION
For some years there have been attempts by those championing health promotion to influence the public policy agenda and develop what has come to be called ‘healthy public policy’. The World Health Organization (WHO) Healthy Cities Project now entering a second 5-year phase, is one such attempt to do this at the local level (Tsouros, 1991, 1995). An over-arching goal of the WHO Healthy Cities Project was to raise awareness on where and how health is created and to influence agencies other than those traditionally responsible for health in developing strategies which together create a supportive environment for health (Milio, 1986). Local authorities were seen as having a particularly important role to play (Blackman, 1995).

The purpose of this paper is to explore the experience of a sample of ten cities in the United Kingdom (Glasgow, Liverpool, Winchester, Sheffield and Newcastle) and the Netherlands (Rotterdam, Eindhoven, Groningen, Almelo and Tilburg) which have adopted the ideas of the WHO Healthy Cities Project. The emphasis is not on international comparison, but on the combined experiences of the individual case studies. The paper aims to assess the extent to which there is evidence for movement towards the broader goal of the creation of healthy public policies and/or a public health policy in these cities.

Having placed the European Healthy Cities project in context, the first part of the paper will briefly explore the relationship between projects and policy change. It will then examine the state of play in the cities selected, structured around five key issues. The evidence is based on
key informant interviews undertaken in 1993 and 1994, 6 years after the WHO Project was launched in Europe in 1987. As such, therefore, it is a cross-sectional and now historical view of a process that is still evolving and in which the participants are continually learning and developing.

THE WHO HEALTHY CITIES PROJECT—BACKGROUND

The Healthy Cities initiative was an attempt by WHO/EURO to implement at a local level the HFA strategy developed in the early 1980s (Curtice and McQueen, 1990). The resulting Healthy Cities Project, has had a major influence on the development of the settings approach to health promotion, and has taken root worldwide in a variety of forms. In 1996 it was the theme of World Health Day. In Europe, the official WHO Project is in its second 5-year stage, involving 36 Project cities. There are also large numbers of other initiatives, some quite well developed, that are connected by 26 national, provincial and regional networks, similar to the Healthy Communities initiatives found in North America (Poland, 1996). In this paper the term ‘Healthy Cities’ will be used as a noun to refer to well-developed Projects that adopt most of the principles developed by the WHO Project, but are not necessarily part of the official Project (Figure 1).

A further distinction has been made between individual health promotion ‘projects’ under the Healthy Cities banner within individual cities and the Project with a capital ‘P’.

THE FRAMEWORK OF ANALYSIS: THE NATURE OF PROJECTS, POLICY AND CHANGE

In this paper, policy development is considered to be an iterative and dynamic process involving a range of actors linked together through a network of activities, decisions and motivations (Considine, 1995). Policy is not a decision (Allison, 1971; Hogwood and Gunn, 1984), policy is produced in, with, and through negotiations between participants. Policy, therefore, is not an end product but a dynamic system of varying pace with no distinction between policy development and implementation (Lipsky, 1980). Much of what occurs in policy systems is continuous work on persistent issues, and each policy episode is shaped in part by the nature of the organizations involved and organizational mechanisms and processes. Changing public policy is notoriously difficult and, given a general reluctance towards change (Siler-Wells, 1987), policy maintenance is more the norm than policy change (Pettigrew et al., 1992). Any policy change that

Aims of the second phase of the official WHO/EURO Project

- To bring together a network of European cities to assist and support the implementation of local HFA efforts.
- To move health high on the political agenda.
- To move health on the public agenda and integrate the health aspect into economy, culture and city life.
- To develop city health policies.
- To foster the development of supportive environments (physical and social).
- To create action for health.
- To facilitate the development of networks and communication skills.
- To exchange knowledge and expertise.

Chief principles

- Intersectoral collaboration.
- Community participation.
- Equity.

Fig. 1: Aims and chief principles of the second phase of the official WHO/EURO Project.
does occur takes place by incremental steps, especially at local level (Nocan, 1989, in Curtis and Taket, 1996, p. 204).

Projects normally are short term in nature, usually small scale and involve limited financial risk. They are strongly associated with new innovations providing a vehicle for experimentation, a test bed of new approaches or new products. Such initiatives may be adopted subsequently throughout an organization or as a broader policy initiative or strategy. Having a fixed time limit, they are both controllable and flexible at the same time. They provide an opportunity to create a temporary organizational structure for problem-solving using a multidisciplinary team, horizontal communication channels, fast decision-making processes and delegated responsibilities (Handy, 1986).

In the context of organizations, Levy and Merry (1986) distinguish between first-order change, which consists of minor adjustments that do not change the core of an organization, and second-order change, which they describe as a multidimensional, multilevel, qualitative discontinuous radical organizational change involving a paradigmatic shift (see also Bartunek and Moch, 1987). These notions of two types of change provide a useful framework for understanding the development of ‘Healthy Cities’. Projects are characteristic of first-order change while a new policy agenda can be considered second-order change. A move to the latter depends on what Rist (1994) calls a window of opportunity for policy formulation, which, he argues, in the complex environment of policymaking is frequently very small and open for only a short time. Kingdon (1995) takes this idea further by identifying three streams that influence the agenda setting process: politics, problems and policies. By the coupling of these three streams, issues reach, or increase in, agenda status. A change in the political stream or a pressing problem in the problem stream opens a window. Advocates of policy proposals then press their solution or alternatives through this window and they become coupled to the events in the political stream or to problems that float in the problem stream. This coupling changes the political agenda. It is only when all three streams are coupled that an issue will receive a high place on the political and decision-making agenda.

THE KEY ELEMENTS OF POLICY CHANGE

The nature of policy environments, the dynamic interaction between power, influence, coincidence, argument, interpretation, and content make any analysis of policy change complex. In this paper we have limited ourselves to a selection of key elements to structure the findings from the case studies. Two elements relate to policy change in itself (Cobb and Elder, 1983; Pettigrew et al., 1992; Kingdon, 1995) and three elements are central to the question how projects relate to policy (Bowen et al., 1994).

Supportive national strategies

Even where individual cities may well be moving towards more comprehensive strategies, the flexibility with which they can shift resources depends on factors that are often beyond their control. A supportive national health policy, particularly where power and control are dictated by centralized fiscal policies, is therefore an important prerequisite.

Developing formal structures that see health as part of mainstream activity of all key organizations and departments

When working intersectorally, a prime characteristic of the Healthy City idea, structures are needed to define areas of accountability and provide a degree of domain consensus (Hudson, 1987) on the role of individual organizations and their contribution to health. In the case of the WHO/EURO Project, each city was required to have an intersectoral project team, representing all parties and organizations in the city. This team was responsible for the organization and implementation of the project activities at the operational level. A steering group, representing all parties and organizations in the city including the city government, was expected to monitor activities and take political responsibility. Both these groups are normally required to be supported by a project office and coordinator.

The existence of shared ownership and commitment by all organizations and communities involved

Responsibility should be a shared by everybody who participates, including the wider community. Such sharing between different types of people demands an emphasis on effective communication as well as new ways of working (Funnell et
Developing core activities within the organizations involved which create the capacity needed for healthy public policy development and implementation

While participating organizations have to identify their role in creating health they also need to develop the organizational capacity to achieve this. Making health a core activity of non-health organizations is therefore a central feature. So, implicitly, is long-term organizational development.

Agenda-building

A prerequisite for policy development and changing existing policies is that the issue in question should become part of the political agenda (Cobb and Elder, 1983; Kingdon, 1995). Concomitantly, one would expect that activities targeted at this issue will receive some form of political commitment.

RESEARCH METHODS

The evidence presented here was based on a qualitative research study which forms part of a broader study on health policy in local government (Goumans, 1995a, b). It drew on techniques commonly used in political science and organizational research (Cassells and Symon, 1994). A non-probability sampling technique called snowball sampling was used to identify key informants, since access to the sample was dependent on local knowledge. While positivists would question the reliability and validity of the data generated in this way, we felt that it was more appropriate to the questions we were asking to gather specific information from specific informants who were knowledgeable about the process under consideration. We were also interested in a holistic perspective based on a number of different experiences. The sample was drawn from five cities in the United Kingdom (Glasgow, Liverpool, Winchester, Sheffield and Newcastle) and five cities in the Netherlands (Rotterdam, Eindhoven, Groningen, Almelo and Tilburg). A number of criteria were used to select the sample cities including visibility as a Healthy City within their own national networks and the length of time they had been involved in the initiative. Willingness to participate also was a factor. Only two cities in each country are, at the time of writing, official WHO Project cities. Snowball sampling generated an average of ten key informants, reflecting different categories of organizations: the statutory (health and local authority); the voluntary sector; independent organizations; and the community. Semi-structured interviews with open-ended questions were used and the transcripts subject to content analysis. Each participant received a copy of the final analysis for verification and validity check.

THE EXPERIENCE OF THE TEN CITIES IN THE NETHERLANDS AND THE UNITED KINGDOM

Having a supportive national strategy

Persuading national governments actually to take action within the basic Health for All (HFA) principles has proved to be difficult (Curtis and Taket, 1996). The political ideology of many European governments does not acknowledge the role played by socio-environmental conditions in determining health, which forms the chief focus of the HFA strategy. Expenditure on health care, rather than health promotion and sickness prevention, is deeply entrenched in existing systems. This is despite the evidence presented by McKeown (1976) and more recently by Wilkinson (1996) that the gains in health achieved during the twentieth century were more a by-product of factors such as higher incomes, better housing and a general rise in welfare and living standards than expenditure on health care. Nota 2000 is often regarded as the Netherlands government’s response to HFA2000. However, the document did not receive wide acceptance (de Leeuw, 1989), although inequalities in health are part of a major national research programme. In the UK, the national government’s white paper Health of the Nation (1991) is seen as the tardy British response to HFA. However, both the policy and subsequent local action have been criticized for being too limited and selective in their targets, focusing on disease and neglecting the social model of health and inequalities (Rathwell, 1992, in Curtis and Taket, 1996, p. 268).

Differences in the organization of the national...
health systems and the administrative organization of local government result in differences in the formal responsibilities for public health of local government between the United Kingdom and the Netherlands. In the Netherlands, the health authority (GGD) is under the jurisdiction of the local authority from which they receive their finance. Some health authorities have contractual agreements with several local authorities in an area. The GGD in the Netherlands has a specific remit for prevention and public health at community level, with little or no involvement in institutionalized care. Formal responsibility for the prevention of public risks is required through the Act on Collective Prevention (1989).

In the United Kingdom, the health authorities are part of the National Health Service, receiving their money directly from the national government. Their responsibilities cover prevention, cure and care of disease, illness and disability. Local government, which is separate, has a formal responsibility for community care through the Community Care Act of 1990. The power of local authorities in the UK has greatly diminished during the last few years. In the Netherlands, local control has increased due to the decentralization of policy-making (Hupe, 1990).

At the time of the research reported in this paper, these differences in administrative structure between the two countries did not appear to have had an impact on local policy development, as variations between cities in this study were greater than between countries. If anything, there was a greater move towards an attempt at strategic planning in UK cities, where, paradoxically, the power to effect change that comes from flexibility in shifting local resources was more limited.

The development of structures to ensure that health was part of the mainstream activity of key organizations and departments

In their early stages of development, most cities in the study had the structure laid down by WHO/EURO of having so called ‘steering groups’. The disadvantages of these soon became apparent and some were eventually abolished. Agendas tended to focus on issues of structure, ownership and lines of accountability rather than the broader issues of common goals, philosophy, values, ideology and vision. Indeed, in some cases the latter issues were never discussed at all. Representatives of organizations were drawn mostly from middle management, chiefly heads of services. Real collaboration between agencies and organizations in most cities was most common at operational level rather than at managerial level, since in task-driven organizations it was easier to focus on specific action. At both levels the involvement of either the project coordinator or a demonstration project manager was needed to bring the parties together. In one case study, however, the creation of a joint public health team within existing joint planning frameworks has encouraged intersectoral collaboration at the policy level. Increasing budget cuts and the widespread recognition of the value of working with other organizations to make effective use of local resources, has been utilized to great effect by the Healthy Cities coordinators as a stimulus to collaboration:

We started to speak a common language and we underestimated I think how important that is. You just assume that you can work with a completely different organization, with completely different beliefs and bureaucratic processes. Healthy Cities has been enabling in that sense. I could not quantify how much of the change would be, what percentage would be theirs and what percentage would be central policy change itself. There was no doubt that it [Healthy Cities] played a part. (Management, Health Authority)

All cities had a coordinator in some form or other. In four of the Dutch cities, coordinating ‘Healthy Cities’ was just one of their regular tasks, but in one Dutch case study and all the UK cities there was someone specifically dedicated to ‘Healthy Cities’, four of whom had specifically dedicated offices rather than one integrated within an existing department. In all cases, coordinators are either employed by the local health authority or the local authority. All were skilled networkers and facilitators, holding the many skills identified as crucial to effective change agency (Kingdon, 1995; Moon, 1995), resulting in a relatively high profile within the local authority and organizations in the city.

‘Healthy Cities’, however, was still often perceived generally as something additional to mainstream activity, largely running projects and encouraging communication. The existence in most cases, except one, of separate Healthy Cities structures and project groups, reflects this. However, some cities have attempted to integrate the initiative into mainstream structures. In one case study in the Netherlands, the management team of the health authority became
directly responsible for the development and maintenance of health policy, integrating ‘Healthy Cities’ development into existing systems within the city council, thus retaining ultimate responsibility and ensuring commitment. Each member of the management team had responsibility for a certain geographical area and an identifiable person with responsibility for the development of health policy in that area of the municipality. Similar structural changes are apparent in a UK city, where ‘Healthy Cities’ has been integrated into the joint planning structures under the umbrella of the Joint Consultative Committee through the creation of a Joint Public Health Team (JPHT). Traditionally, joint planning arrangements have concentrated on planning care and services; however, there has always been legislative provision for looking at broader issues. Few such joint planning arrangements in the United Kingdom have actually done so. The JPHT was made up of representatives of the city council and the health authority, the trades council, the chamber of commerce, the voluntary sector, and the universities. Reporting to this team was a network of task groups which were established on a short-term basis to develop the City Health Plan (Costongs and Springett, 1997). Significantly, however, although the ‘Healthy Cities’ coordinator was a member of the JPHT, the post was not permanent and was financed out of short-term budgets.

Ownership and commitment
Political commitment for Healthy Cities was made visible mainly through the provision of working structures, regular meetings, the development of projects and logistic support in terms of employment of Healthy City staff. This alone, however, is not enough since such support is more often symbolic than tangible and rather precarious. In fact, not all the seats of special Healthy City committees were taken up and Healthy Cities was often left out of political negotiations. Most solid was the commitment to ‘Healthy City’ demonstration projects, but support for the philosophy and ways of working was more symbolic, expressed by a formal letter from the city council or from the board of directors of an organization.

A specific role of ‘Healthy Cities’ is to increase understanding of what creates health. It has stimulated politicians to reflect on their roles with regard to public health. It has stimulated activities and provided some evidence through demonstration projects:

Healthy City people are pioneers. They seek relationships between health and other council responsibilities which the council has never paid attention to. In that way it influences policy making and the council’s thinking. (Politician)

We [Local authority, MG] make people ill, because we have awful housing, we cannot provide them with jobs, we knock them down on the roads, we pollute them; all the things the Health Authority has no influence over at all. (Management, Local Authority)

Shifts in thinking tended to be at the level of the individual politician, and so dependent on that individual remaining in the political arena.

Overall participation in ‘Healthy Cities’ activities could be divided into basically two kinds. ‘Core group’ participants were those who had an intrinsic belief in ‘Healthy Cities’ ideas as a valuable concept to promote the health of the city and its inhabitants. These participants are the prime movers or change agents (Pettigrew et al., 1992) involved in raising the ‘Healthy Cities’ profile and using some its core principles of intersectoral collaboration and community participation to persuade others to become involved. Members of the core group became involved in projects and activities regardless of their content. Their roles varied from ordinary group member to chairperson, facilitator or advisor in different contexts and depending on their background—professional or organizational.

The ‘peripheral group’ were those whose support and participation depended on whether the activity reflected their specific interests. Examples include: the specific content of a project; visibility; establishing international linkages; congruence with national governmental requests; problem areas in the city; whether they had been asked to participate or not; their skills and experience; their contacts; their resources; the availability of project money; or avoiding redundancy.

Involvement for both types of participants could change over time, leading to some marginal movement between categories. For core participants, it often depended on how they were involved. For the peripheral participants, it depended on both whether and how they were involved. In the final analysis, however, ‘Healthy Cities’ at the time of the research was not owned by organizations, but rather by a network of committed individuals:
Healthy Cities has not been owned by mainstream organizations, and I think that has been one of the major drawbacks. If you have not owned Healthy Cities as the core business inside your whole organization and mainstream money gets squeezed by the government and other pressures, it was easier to say ‘nice to have tried that one’. . . . And I think that was what was happening. (Management, Health Authority)

It is also questionable whether the majority of steering committee members were truly representative of their respective departments and organizations, or how much their own personal learning was fed back into those organizations. In one case study, the Healthy Cities team asked all middle managers to write a paper on how they thought their work related to health. These papers were then discussed in meetings, enabling the managers to learn from each other. In some cities, senior managers have signed up to some form of a city health plan or strategy:

By giving the lead to others, one assumes that it will get into the hearts and minds. (Employee, Health Authority)

The plans identify the role they play in creating health and areas of responsibility for the promotion of health in their city:

What Healthy Cities did do what normal interagency working didn’t do, was saying here was a very visible commitment to health and future welfare. It was very useful to have Healthy Cities in that sense and to continue to have it. (Employee, Health Authority)

However, it was clear that the majority of people working in city administration and in local organizations, as well as the general public, still had little notion of the Healthy City idea. The development of a City Health Plan in some cases had started to change this, if somewhat slowly:

We are trying hard to change people’s habits and that was not going to change overnight. But people show a great interest in what we are trying to do. I expect the quality of life to improve over the years. The HC plan should create an awareness that people’s well being was improved by other things than the health board and hospitals. (Politician)

While community participation has been a main feature of the rhetoric of Healthy Cities, the reality has been variable. When it comes to policy development, there was very little evidence of much being achieved. Community participation was regarded by policy-makers as a ‘noble idea but a mission impossible’. Community participation had only taken place within specifically funded community development projects, the majority of decision-makers and politicians finding it difficult to incorporate community participation into their mainstream activities:

Their idea was going into this community, develop a blue print, go away after three years and they are independent. A total misconception, total lack of understanding. (Community Development Worker)

Lack of experience and the structures to enable community participation in decision-making, fear, and power issues were all cited as reasons. It was felt that community development projects under the ‘Healthy Cities’ banner had helped to bring such approaches to the attention of the city council and local organizations. In one case study, a separate ‘Community Support Unit’ was a key part of the Healthy Cities Unit, its sole remit being community development and associated activities. This included work to raise long-term and secure funding for community development.

Core activities of Healthy City Projects

Within all ten case studies the chief focus of work was the implementation of the key aims of community participation, intersectoral collaboration, developing political commitment and reducing inequities. These rather nebulous ideas mean little to those not directly involved in health promotion and ‘Healthy Cities’. Demonstration projects were the main vehicles used to change this. These involved a range of events covering a wide span of different subjects targeted at an equally wide variation in groups from children to older people and at-risk groups to the general public (Figure 2).

Unlike traditional projects, ‘Healthy Cities’ projects were explicitly set up to demonstrate something and not just as a vehicle for testing out an idea before putting it into practice. At the same time, most local coordinators feared so-called ‘projectism’ with a ‘Healthy City’ Project being regarded as just another project with a limited life. Unfortunately, efforts systematically to evaluate activities have been very limited and virtually non-existent in some cases. The impact of demonstration projects can be very short term as the following quotation illustrates:

But the thing that we did learn was that if you have a range of pilot projects there that piloting something means nothing if it did not enter the mainstream thinking of the organizations. So the pilot projects could have been wonderful and they could have been
wonderfully successful, but when they came to an end that was it. Nothing then happened it just finished, fizzled out. (Member, Local Authority)

Despite this example, the general consensus amongst key informants was that demonstration projects are needed in order to give substance to the Healthy Cities concepts and ideas, whilst providing an opportunity to learn what is likely to work locally. Demonstration projects also raise awareness, creating a receptive environment which will facilitate the further development of health policy.

Making health a core activity of non-health organizations was being tackled in a variety of ways and at a variety levels (Healthy Sheffield Development Unit, 1993; Glasgow Healthy City, 1995; Liverpool Healthy City 2000, 1996). Some cities were beginning to move away from projects and put more fundamental changes into place (Lyon, 1993). In one city, for example, health was already an explicit part of the housing strategy (City of Liverpool Housing and Consumer Services Directorate, 1995). The involvement of managers in strategic planning, to which reference has already been made, is another indication of change. In another city which had a number of demonstration projects, a new managerial structure and way of working was created and based on:

projects at all, because all the projects which should happen should happen not in Healthy Cities, in the structure there, but in between the organizations who are actually influencing things. So within the council or in the Health Authority or in the hospitals, or within the voluntary sector, within the business sector and where necessary they would collaborate with each other. (Member, Local Authority)

Organizational development, which is crucial in moving health on to the agenda of organizations who do not see it as part of their domain or statutory duty, was not an early priority for any of the case studies, but again there were signs it was receiving more attention in a number of cities.

Health as part of the broad political agenda
There were a wide variety of reasons why cities originally adopted the ‘Healthy City’ idea. Key individuals played a large role, which is not uncommon in the development and communication of innovations (Rogers, 1983). All key informants felt, however, that political support was necessary for ‘Healthy Cities’ to survive competition with other initiatives. It was a requirement of the WHO Project for both the chief executives and the politicians from each city officially to sign up, declaring their commitment to Healthy Cities, but this does not guarantee anything (Davies and Kelly, 1992). Nor can one easily assume that a formal political commitment to ‘Healthy Cities’ means that health has a place on the political agenda and is taken into consideration when developing public policy.

At the time of the research the political agenda status of ‘Healthy Cities’ was generally low. Health as opposed to health care policy still had a low priority in policy decision-making, particularly when it came to negotiation over resources. Those seeking to push the health agenda had therefore emphasized health in issues that were of high interest, such as quality assurance, safety, inner city problems or economic regeneration. There is no evidence to suggest that this strategy had yet paid off in gaining a permanent place for health on the agenda. This can best be illustrated by looking at the impact of municipal elections, where in some instances ‘Healthy Cities’ was elevated further up the agenda, while in others it was relegated. Significantly political colouring appears not to be a determining factor, although political stability was a contributing one.

Health education issues, e.g. heart health, AIDS.
Environmental issues, e.g. air pollution.
Infrastructural issues, e.g. transport planning and road safety.
Economic issues, e.g. industrial development and health promotion at the workplace.
Housing programmes and shelters for the homeless.
Leisure issues, e.g. recreation and sports.

Fig. 2: Range of subjects in demonstration projects.
In one case, a city had been successfully participating for some years in the WHO Project, achieving visible and concrete outcomes and the mayor and the city council having signed up for a further 5 years in the WHO Healthy Cities Project, when a change of government halted the process. By contrast, in another city, following the demise of ‘Healthy Cities’ after an election, the former Healthy Cities Coordinator became part of the city political administration and was able to champion its incorporation into existing structures under the new regime. It thus has now been established as an integral part of the municipal business.

Key informants had their own explanations both as to this variation and what prevented ‘Healthy Cities’ gaining a sustainable place on the political agenda, citing unrealistic expectations and limited understanding amongst politicians, high workloads and the failure to make ‘Healthy Cities’ an integral part of organizational goals. It was just a matter of time, for gaining experience and for learning by the actors involved. However, this dependency on the efforts of key individuals to keep health on the agenda in whatever form does not generate any confidence in long-term sustainability. Ambitious and inspiring people tend to move on, managers change jobs, enthusiasm may fade away and politicians may not be re-elected.

To some extent, low priority in itself can be explained by the relative newness of Healthy Cities as an idea. New issues always have difficulty in achieving agenda status, unless these issues reflect a short-term crisis (Cobb and Elder, 1983; Pearson, 1991). The notion of a Healthy City, by contrast, reflects a longer-term vision about the relationship between health and society. Thus, like other initiatives, Healthy City demonstration projects remain floating in the so-called policy stream, ‘softening up the system’ (Kingdon, 1995) through the use of persuasion and the diffusion of new ideas. Occasionally, ‘Healthy Cities’ can be attached to other policy options that float in the policy stream and which are more likely to receive political attention, such as unemployment, or attached to an influential individual or a short-term crisis. The importance of entrepreneurs continually waiting for the opportunities where they can push an issue forward in this way was stressed by Kingdon. However, the window of opportunity for any real change in the political agenda to occur has yet to be opened for ‘Healthy Cities’.

What has been the contribution of the Healthy Cities Project in the ten case studies?

Perceived relevance and value can be regarded as indicators of success as much as objective indicators (Maarse, 1995), so key informants were asked whether ‘Healthy Cities’ has actually made a difference.

In terms of content of activities, it was felt that little difference had been made. Old activities quite often continued under a new label. Some new activities were initiated, but probably would have been started as a logical consequence of existing policies and activities. A few interviewees suggested that ‘Healthy Cities’ was merely a convenient label:

Healthy Cities as such does not mean anything to me. It was a flag to make people enthusiastic. The point was however that you have to undertake activities. The label can thereby be Healthy Cities, but also something different. (Management, Health Authority)

This was not the prevailing view; on balance, Healthy Cities was perceived as having added value. This was mostly defined in terms of facilitation. Involvement in Healthy Cities provided a meaningful framework, which drew people together around health issues who otherwise never would have met, whether it was the different chief executives of organizations in a municipality, or people from the grass roots and decision-makers. By developing linkages between people, coordinators and their associated units established an engine role for Healthy Cities, and for health:

If we did not participate in Healthy Cities, nobody would coordinate public health issues. I mean there are a lot of people who work to make [city] a better place, but they do not see their activities necessarily in relation with health. (Healthy City Team Member)

Through the efforts of core participants the process of learning to understand where and how health was created and what can be done by each individual and organization to promote health in an urban context was speeded up. In that sense, ‘Healthy Cities’ functioned as a key to innovation:

It has been an enabler that has convinced the parties that things can work. It has been a key that opened the door to new thinking. You must have as well the motivaters, the people that take an interest in that. I can give encouragement to them, but I cannot do their job. (Politician)

Eleven interviewees agreed that health gains...
were not self-evidently part of the criteria for judging activities and policies. Rather, having ‘Healthy Cities’ increase the focus of attention on health, bringing together people who share a common responsibility for the health of the population of a municipality. In one specific case study, participation in ‘Healthy Cities’ helped to free the city from isolation. It brought new knowledge to the city. In all cases, it brought an element of glamour to health activities and it also helped to attract resources from outside. Most of all, involvement helped to create a common language and what was considered valuable experience of working together across organizations with very different beliefs and structures.

However, while interviewees agreed that ‘Healthy Cities’ made a difference, they were unable to say by how much, nor were they able to isolate the possible policy benefits. The general consensus was that long-term policy-making had been lacking and had been discussed largely in terms of developing a health plan:

It was difficult to show the policy benefits of Health for All on short term. For example, how can you measure the direct result of the time spent on inter-agency meetings? (Senior Officer, Local Authority)
could have done without, but would not have been that successful. (Public Health Professional)
if we had not been involved in Healthy Cities, we would have to invent something like it. (Management, Health Authority)
I could not quantify how much of the change would be [due to Healthy Cities, ], what percentage would be theirs and what percentage would be central policy change itself. There was however no doubt that it played a role. (Management, Health Authority)
I don’t know how much Healthy Cities contributed. A lack of funding drove people together, it could be a result of governmental changes, it could be that using multi-facet submissions of funding for a geographical area encourages people to think about health gain and changes. (Coordinator)

THE IMPLICATIONS FOR POLICY CHANGE

The picture presented here is only a snapshot of a continual process of change that was at the time taking place in cities in the United Kingdom and the Netherlands which had taken on board the Healthy Cities idea. What does it imply about the nature of change in the context of healthy public policy?

All the cities referred to have achieved some level of ‘first-order’ change; in other words, minor adjustments that have not changed the core of organizations in municipalities (Levy and Merry, 1986) These first-order changes are the result of the various activities and demonstration projects that have been carried out under a Healthy Cities label:

Without Healthy Cities none of the health policy development would have happened at all. It has been an impetus to develop HFA principles . . . but still it has a long way to go. (Healthy Cities Team Member)
Without Healthy Cities the Health Authority would still regard care as the one and only priority and the LA [local authority] would not go any further than their statutory functions. This means that little or no preventive or health promotion work would be done. The beauty of Healthy Cities was that it brings many organizations together and gets a lot of small groups together. A thing what would not have happened without HC. (Coordinator)

A few cities of the sample of ten cities are struggling towards ‘second-order’ change. At the time of the research, local health strategies in the form of a Health Plan were just becoming a focus of Healthy Cities work. However, Pettigrew et al. (1992) have argued that writing a policy document is not by itself sufficient. Top-down strategies cannot succeed unless bottom-up action takes place and small-scale projects cannot have an impact without a strategic framework that moves the resources that support the change. It is still therefore an open question as to whether this move towards second-order change is sustainable, or whether Healthy Cities projects and ideas will become a short-term enthusiasm of like-minded people as has happened, for example, in Australia (Whelan et al., 1992) or, as in many other places, remain a label attached to a few small-scale projects (Farrant, 1991).

Even if projects do not automatically result in policy, they can facilitate the policy-making process. What influences political decision-making is not the practical outcome of a project, but is quite often the cumulative process of participating in and seeing the consequences of a series of projects. This is particularly true if policy-making is considered as a system of innovation and learning amongst a web of linked actors continuously exchanging information and skills (Considine, 1995; Radaelli, 1995):
Real change takes ages. We can only facilitate some changes and some preconditions that may have a positive influence on health. (Healthy Cities Team Member)

None the less, Healthy Cities was too dependent on certain individuals. Although perceptions of health are changing, the process, on the evidence of these case studies, is not yet far enough down the road to be permanent (Drucker, 1991).

CONCLUSION

Building healthy public policy is a time-consuming process, because it involves developing a new infrastructure supportive to health promotion and it requires a critical mass of people to hold in their consciousness the vision involved. ‘Healthy Cities’ is asking for a radical change and this change is only beginning to happen in a few places. Health, as opposed to health care, still does not have solid place on the political agenda. It is hardly discussed, it is not problematic, and it is not politically interesting. Strategies need to be developed to change this or ‘Healthy Cities’ will continue to be largely professionally driven (Baum, 1993) and will remain vulnerable to political whim.

However, policy development is not only about vertical and horizontal interaction and negotiation it is also about learning (Sabatier, 1987; Howlett, 1994; Jenkins-Smith and Sabatier, 1994). The current focus on organizational development evident in the older and more established Healthy Cities, together with the continuing work on community development could facilitate a rise in awareness of the role of public policy in health promotion. Thus, moving forward is most likely to be accomplished by a pragmatic approach rather than one focusing too much on the word ‘health’. If second-order change were to take place at an organizational level, health promotion would automatically be part of the domain of public policy at the local level. However, movement towards this broader goal of healthy public policy is still tentative and its prospect fragile.

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