Healthy Cities: urban social entrepreneurship for health

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SUMMARY
Social entrepreneurship is key to the success of health promotion and Healthy City development. An overview of entrepreneurship skills is provided, and a policy change model in which social entrepreneurs play a key role is described. The model has been tested in a selection of 10 European, officially WHO-designated, Healthy Cities.

Recognition by the entrepreneur of the components of the model, and subsequent strategic action, indeed influenced urban policy agendas. However, the two cities that were most effective in doing so also had institutionalized their entrepreneurial capacities. This seems therefore the next challenge in health promotion.

Key words: health policy; Healthy Cities; social entrepreneurship

INTRODUCTION
Social entrepreneurs will be vital for the future development of health promotion, as they offer a way of tackling the social determinants of health and disease through community-based action (Catford, 1998). Social entrepreneurship, therefore justly, is considered an essential part of Healthy City development. In this article we will identify characteristics of the urban social entrepreneur for health, and assess whether such entrepreneurs in a sample of Healthy Cities have been successful in opening windows of opportunity towards policy innovation. In addressing the latter question, we will use the model provided by Kingdon (1995), identifying components of the policy development ‘spiel’. An inevitable inference from our findings will deal with the question whether social entrepreneurship may be institutionalized in order to make drives towards innovation sustainable and less dependent on individual capacities.

SOCIAL ENTREPRENEURS
Social entrepreneurship is considered an important ingredient of modern policy initiation. Catford (1997) has described the social entrepreneur as a person that is capable ‘... to analyse, to envision, to communicate, to empathize, to enthuse, to advocate, to mediate, to enable and to empower’ a wide range of disparate individuals and organizations. In order to effectively (and efficiently) act as Catford prescribes, a social entrepreneur needs to direct scarce resources towards activities with the highest potential gain.

Entrepreneurship seems to be a hype of the 1990s. Numerous studies have identified characteristics of the entrepreneurial role in commercial organizations. Such entrepreneurs are typically considered leaders in stable environments. However, the social entrepreneur by definition operates in community environments that are dynamic and to some extent unpredictable. Selsky and Smith (1994) describe the assumptions...
under which entrepreneurial roles in business organizations have been studied and identified:

- leadership research assumes stable, hierarchical structures and unitary normative patterns;
- such studies emphasize the ability to control the environment, including the internal symbolic environment of the organization;
- they magnify the importance of individual, heroic, entrepreneurial action; and they focus on narrow situational contingencies.

Social change, being one of the important foci of health promotion and Healthy Cities, obviously does not have a fit with these assumptions. Social entrepreneurs in health promotion and Healthy Cities primarily act outside their own organization (if any at all) rather than within, and are in those roles more often seen as individuals rather than organizational representatives. Such a position would lead to a new field of studies into entrepreneurship emphasizing the subjective experience of the craft. Selsky and Smith (1994) categorize the various inventories of entrepreneurs’ capacities and skills into the following. What they call community entrepreneurs should have qualities in the following areas.

- The multiframe perspective. Entrepreneurs appreciate different perceptions of the complex and diverse range of issues and stakeholders among actors in their domain.
- Proactiveness. Entrepreneurs broker commitments of resources into networks of commitments to address the issue domain, and can anticipate expectations and desired outcomes of the collaborative enterprise.
- Reflectiveness. Entrepreneurs are able to reflect on their continuously changing positions and those of stakeholders in their domain. They are able to learn, question existing norms and move beyond preconceived mental maps (e.g. the creation of policy ontologies, cf. Milewa and De Leeuw, 1995).

The role of social entrepreneurs in setting policy agendas has long been ignored. Studies of entrepreneurship mainly focused on personal and interpersonal characteristics of the entrepreneur (e.g. Duhl, 1995). Also, agenda building in policy development was either considered a democratic exercise (romantic), or a battle between organizational entities (cynical) (de Leeuw, 1999). Kingdon (1995) empirically ascertained the role of social entrepreneurs in policy change (Figure 1). He found that the policy context could best be described as consisting of three more or less independent streams of development in which different stakeholders each play their role.

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**Fig. 1:** A visual representation of Kingdon’s stream model (1995) in which a window of opportunity (right) is opened.
According to Kingdon, there is a continuous stream of problems floating around in the policy context. In his conceptualization, problems are there just to be connected with solutions. In policy development, stakeholders in the game will try to connect their favoured solution with an already existing problem.

Second, there is a stream of political development. The political environment is in constant flux, not just in terms of formal elections (capital P Politics), but also in terms of the continuous struggle to determine who gets what at which time (politics). Both types of politics are merely interested in medium-term survival, and manoeuvre between stakeholder interests and contextual developments in the other streams.

Third, policy (even when it seems a fixed agreement to use specified resources towards specified ends) is dynamic in itself. It may have to be adjusted to new conditions, abandoned, or require complete overhauls. Policies must be regarded as being a constant state of evolution; only the highest fit with perceived reality will survive.

In each of these streams, stakeholders, or participants, as Kingdon calls them, are active. They may be actors (individuals or organizations) that have openly and explicitly associated themselves with problem issues, political endeavours and policy development. Some of these visible participants have formal competencies in those areas; they may be consultants (problem stream), elected politicians (political stream) or bureaucrats involved in policy preparation and execution (policy stream). On the other hand, there are invisible participants in the game as well. They may consist of scientists in a particular domain (problem stream), pressure group or community representatives (politics), and bureaucrats defending their turf (policy stream).

Kingdon’s thesis is that societal issues will only reach policy agenda status (i.e. are under explicit consideration for policy development) if a window of opportunity is opened between the three streams. This can only be accomplished if a social entrepreneur is aware of the dynamics of each stream, and of the stakes both visible and invisible participants in them (cf. the three capacity areas identified by Selsky and Smith, 1994). The social entrepreneur will then negotiate, advocate, explain, connect, prove and convince those participants of the added value of trying something new. This is called the process of ‘alternative specification’. The effective social entrepreneur will never stick to one version of her ‘truth’. Truth is contextual and can be sold in different ways to different stakeholders. Particularly when the social entrepreneur already has access to resources that would support her specification of alternatives, windows of opportunity may more readily be opened.

Two issues are worth further emphasis here. First, the role Kingdon ascribes to the social entrepreneur is that of a change agent. The social entrepreneur, in his view, is not necessarily concerned with the management of change. There is a marked difference between the two designations. The change agent would primarily act as a catalyst of change, whereas the manager of change would be involved in change processes themselves (i.e. the monitoring and supervision of resources and visions towards desired changes). This observation closely relates to the second issue. A social entrepreneur is not necessarily to be considered as being part of an organization; she is explicitly referred to as an individual. Such an assertion creates an inevitable analytic tension. Supposing that such an individual is based within an organization, much of the effort to change policies and infrastructures (and therefore society) will require strengthening of the position of the entrepreneur within her own organization first. We could thus distinguish between internal (intraorganizational) entrepreneurship, and external (interorganizational) entrepreneurship. In our inquiries, we have assumed that intraorganizational entrepreneurship is de facto: the mere presence of a Healthy City office in a town would indicate that the social entrepreneur’s change agenda is in concordance with her most proximal organizational unit. However, as municipal organizations can be considered complex professional bureaucratic environments, the other organizational units with that apparatus were considered part of the ‘outside world’ in which the dynamics described by Kingdon are prevalent.
HEALTHY CITIES POLICY EVALUATION

Since the beginning of the Healthy Cities Project there have been less or more successful efforts at evaluation of the achievements of the network cities and the Project as a whole (for review, see Tsouros, 1994; Curtice, 1995). Research for, with and in Healthy Cities over time has become an important issue in the movement. There is no conference, seminar or meeting where the research issue has not been debated (de Leeuw et al., 1992). Currently, there still is very little empirical work on Healthy City evaluation, work by Werna and Harpham (1995, 1996) being the exception rather than the rule.

Evaluation efforts will always have to take into account what the original objectives of the intervention were; ideally, an evaluation mode is built into the original intervention plan, either as a strategic and implicit focus (often remaining abstract) or as an applied and explicit research endeavour.

In this section, we will argue that the original Healthy City Project intervention has been restricted—in its primary and formulated goals—to policy dimensions of the application of Health for All—principles on the local level.

The WHO Healthy Cities project is a long-term international development project that seeks to put health on the agenda of decision-makers in the cities of Europe and to build a strong lobby for public health at the local level. Ultimately, the project seeks to enhance the physical, social and environmental well-being of the people who live and work in the cities of Europe. The project is one of WHO’s main vehicles for giving effect to the strategy for Health for All (HFA). (Tsouros, 1994: 1)

The strategic objectives for the second phase include the speeding up of the adoption and implementation of policy at city level based on the European HFA policy and its targets; strengthening national and subnational support systems; and building strategic links with other sectors and organizations that have an important influence on urban development. (Tsouros, 1994: 11–12)

These statements regarding the objectives of the project are important, as they distinguish between policy-related objectives and HFA target-related objectives. We will focus on the former, as evaluation of the latter objectives has been dealt with elsewhere, and is largely a (relatively simple) numerical exercise.

In the realm of policy-related objectives, WHO seems to be quite straightforward: health is to be put on political agendas (decision-makers in the cities of Europe) and on social agendas through a communicative process (a strong lobby for public health at the local level) leading to specified and ‘hard’ policies (the adoption and implementation of policy at city level). The Healthy Cities Project itself has—although this is not spelt out in public documents—over the years become one of the most important political vehicles of the WHO European Regional Office (EURO), and implicitly the maintenance and strengthening of this role is another objective of the project. Embedding the project (i.e. EURO) in a variety of structures and institutions would extend the viability and relevance of both the project itself as well as EURO. Developing, embedding, and linking those structures and institutions is another policy objective (building strategic links with other sectors and organizations that have an important influence on urban development).

It is clear that whatever kind of evaluation is to take place, its main focus should be on policy (development), and not (as has been the case in the recent past) on mere structures, processes, singular case studies or hardly structured collections of ‘models of good practice’. These well-intended perspectives have so far only provided isolated and circumstantial evidence of the obvious success of Healthy Cities (Price and Tsouros, 1996).

Policy is the expressed intent of an institution (government, corporation, volunteer group, etc.) to act strategically towards the attainment of specified goals (De Leeuw, 1989). Policies do not necessarily identify intervention instruments, implementation strategies (including their required resources) or quantified—or quantifiable—objectives. However, once the evaluation decision has been taken by whichever actor with a legitimate interest in the policy, at least some of those factors, instruments and resources must have been operational and allocated in order to assess the policy process. Policy evaluation does not just focus on the results of the policy, but more importantly on the (choice) processes that have determined operationalization and allocation of resources and instruments.

METHODS

Our original policy investigation focused on a range of issues in local policy development (de...
Leeuw et al., 1998), using sociological theories on the attribution of causality and ownership of public problems (Gusfield, 1981), Kingdon’s perspective on social entrepreneurship in opening windows of opportunity for policy change (1995), and a model describing processes of intersectoral and interorganizational collaboration (Gray, 1985, 1989). Further, based on pilot studies among all European WHO-designated Healthy Cities (cf. Milewa and de Leeuw, 1995), we were interested in the relations between city motivations to join the international project, the richness and diversity of resources for healthy cities, and the reliance on short-term projects (‘projectism’—Goumans and Springett, 1997) on one hand, and capacities of Healthy City Projects to change urban health policy on the other. In this article, we will focus exclusively on the issue of social entrepreneurship.

Selection of cities to be visited was more or less arbitrary. The WHO Healthy Cities Project is a programme of the European Regional Office of the Organization. Cities from all member states have been eligible for application in both the first and second phase (as will be the case in the third phase); in the second phase of the project (1992–1998), 38 cities from across the region were designated. However, this research endeavour being financed by the European Union, only cities from one of the 15 member states of the Union could be investigated. Further, resource allocation by the Union permitted extended visits to 10 cities only. Selection of these cities was therefore more or less superficial. No two cities from one member state were to be selected; a reasonably even distribution of cities in population size was preferable; geographically, selected cities were to be evenly spread over the Union’s area; both cities with a longer tradition in the project as well as ‘newcomers’ were to be selected. Finally, cities would have to be committed to the evaluation objectives. Even though this is a WHO requirement, not all cities were unequivocally enthusiastic about the idea of being evaluated. The final group consisted of Amadora (Portugal), Bologna (Italy), Dresden (Germany), Dublin (Ireland), Glasgow (UK), Horsens (Denmark), Liège (The Walloon part of Belgium), Rennes (France), Turku (Finland) and Vienna (Austria).

In order to address the wide range of policy issues and theories we intended to use, Healthy City co-ordinators were requested to organize a number of meetings with as many stakeholders as possible. The response is described in Table 1. Cities were visited for at least four working days each. The context in which respondents were interviewed depended very much on the preference and set-up created by each city co-ordinator. In some cases, interviews acquired the character of focus-group sessions (on one occasion the research team was exposed to a group of ~50 community representatives). Alternatively, we also had the opportunity to engage in lengthy face-to-face debates with individual partners.

<table>
<thead>
<tr>
<th>City</th>
<th>Total</th>
<th>Healthy City staff</th>
<th>Politician</th>
<th>Local senior bureaucrats</th>
<th>Local junior bureaucrats</th>
<th>Other bureaucrats</th>
<th>Volunteer community activists</th>
<th>Paid community activists</th>
<th>Researchers</th>
<th>NGO executives</th>
</tr>
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<tr>
<td>Amadora</td>
<td>41</td>
<td>2</td>
<td>3</td>
<td>8</td>
<td>0</td>
<td>11</td>
<td>15</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Bologna</td>
<td>20</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>11</td>
<td>15</td>
<td>1</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Dresden</td>
<td>20</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>0</td>
<td>11</td>
<td>15</td>
<td>1</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Dublin</td>
<td>31</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>15</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
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<td>25</td>
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<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Horsens</td>
<td>12</td>
<td>3</td>
<td>5</td>
<td>3</td>
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<td>1</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>Liège</td>
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<td>9</td>
<td>12</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>3</td>
<td>18</td>
<td>5</td>
</tr>
<tr>
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<td>5</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Turku</td>
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<td>6</td>
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<td>6</td>
<td>4</td>
<td>1</td>
<td>8</td>
<td>9</td>
<td>0</td>
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<tr>
<td>Vienna</td>
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<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
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<td>5</td>
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<tr>
<td>Total</td>
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<td>45</td>
<td>24</td>
<td>46</td>
<td>25</td>
<td>32</td>
<td>41</td>
<td>25</td>
<td>21</td>
<td>44</td>
</tr>
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</table>

Categories turned out to be mutually exclusive to a limited extent. In some cases, respondents had to be assigned to one category only, whereas they maintained themselves to represent two or more categories. Generally, however, the numbers adequately show the number and types of respondents.
The interviews covered all our research questions; in the interview segment dealing with social entrepreneurship, we asked respondents to identify components of Kingdon’s theory, i.e. we asked questions regarding existing problems, politics and policies in the city, respondents’ perceptions of the presence and capacities of social entrepreneurs within and outside the local Healthy City domain, and examples of alternative specification during the life of the local Healthy City Project. We did not present respondents with a definition or description of the concept of social entrepreneurship, as we feared that such a statement would prompt respondents to present us with answers that would be ‘socially desirable’, thus causing potential response bias. We also assessed the degree to which urban policies had changed over the course of the period in which the municipality had been part of the international Healthy City movement. This information was yielded from study of local policy documents and reports to the WHO Healthy City Project Office. In order to ascertain that policy changes were justifiably attributed to a city’s decision to take part in the Healthy City Project, we used the following criteria: (i) a salutogenic health perspective had not previously been part of the municipal mainstream political agenda; and (2) the mainstream political health agenda referred to Healthy Cities or Healthy City activities as either a source of inspiration or an evidence-based toolbox. As to the latter criterion, it should be kept in mind that political decisions and policy-making are based more on perception than on rational considerations (de Leeuw, 1993).

Our visits were concluded by a debriefing session with the staff of the Healthy City Project offices, in which we discussed our preliminary findings and highlighted some of the conceptual issues we purposefully had not introduced before. The role and scope of social entrepreneurs were highlighted in these sessions; they thus acquired the character of both a brief consultancy as well as a validation of our findings.

FINDINGS

Figure 2 positions the 10 cities within the Kingdon model. The figure represents the degree to which visible participants

![Diagram of Kingdon's stream model]

No social entrepreneurship beyond the confines of the direct partners of the Healthy City Project

Social entrepreneurship related to visible participants beyond HCP

Recognition of three streams as well as visible and invisible participants. Window not yet opened

Window opened

Fig. 2: Social entrepreneurs positioned within Kingdon’s stream model.
Healthy City social entrepreneurs (i.e. project co-ordinators and individuals closely associated with them) were aware of, and active in, the three streams, and communicated with both visible as well as invisible participants in those streams.

Two cities were able to open windows of opportunity; one city was aware of the three streams and recognized the presence of visible and invisible participants in the policy game, but had not yet reached the stage of sufficient alternative specification to effectively open a window of opportunity; three cities did recognize the three streams and the presence of visible participants but could not yet connect sufficiently with invisible participants in order to start the process of alternative specification; four cities were in the process of recognizing the existence of the three streams and were limited in their entrepreneurial activities to the formal partners of their Healthy City endeavour.

Social entrepreneurs were found to be present in all cities investigated. However, in some contexts they were more effective than in others, partly because in some cases their entrepreneurial focus was in conflict with that of other entrepreneurs. For instance, there were cities in which activities in the field of sustainable development (so-called ‘Local Agenda 21’ activities) were not considered to be part of the Healthy City vision. Even though at face value sustainable development and urban health promotion seem to pursue the same ends, conflicting entrepreneurial activities could ensue. Also, some entrepreneurs were embedded in the local bureaucracy to the extent that they were not at liberty to allocate resources towards their entrepreneurial activities. In those cases where Healthy Project Co-ordinators had to run a project on their own, the day-to-day administration of the activities of the project turned out to consume most of their time, and their entrepreneurial skills could hardly be used.

The six cities that fall within the model had been more effective in changing local policy agendas than the others. To our surprise, the two cities that had effectively opened windows of opportunity were also the cities that had institutionalized their entrepreneurial activities. In Horsens (Denmark) this institutionalization has taken the shape of a Healthy City Shop that is a powerhouse of community action. Financing of the shop is to a large degree independent of (and yet intertwined with) municipal resource allocation.

In Vienna, institutionalization of the entrepreneurial role has taken place within the urban bureaucracy. The development of the Vienna Project was guided by a number of strategic considerations. Recognizing that policy change and the establishment of intersectoral collaboration is essentially a power game in which resources of stakeholders are limited, the Project decided to formulate a pragmatic and yet strategic approach. Action (and intersectoral) projects were sought in areas with limited numbers of stakeholders, or domains in which stakeholders could avail of limited resources. There should also be some kind of indication that such projects would yield quick and visible results. The consequence of the approach could be termed dramatic: rapid and successful intersectoral projects were established, albeit not always in areas with the highest political, social or health priority. However, the obvious success of such projects would lead to increased interest by stakeholders from other sectors, and thereby the chances for intersectoral collaboration in domains which would earlier be labelled ‘difficult’ were enhanced. The consequence of these choices was that visible and invisible partners in the policy, problem and politics streams would almost naturally turn to the Healthy City Project when they found they could not cope with challenges in their domains alone.

The Vienna case also made us aware of a poignant problem in social entrepreneurship. Once a social entrepreneur is seen to be effective, her value on the job market will increase. Retrospectively, we could see this mechanism in other Healthy Cities as well. This means that by the time social entrepreneurs are starting to become truly effective (i.e. they master their skills and become more proficient in alternative specification), they could improve their professional position by leaving the project. This observation makes our institutionalization point even more relevant: in order to sustain social change, entrepreneurship must not and cannot be dependent on individuals. We would therefore add to the list of characteristics, skills and capacities of the social entrepreneur the ability to sustain entrepreneurship through a process of institutionalization and training.

What would this process entail? Selsky and Smith (1994) determine as an important characteristic of community entrepreneurs their ability to create systems of events. Using the ‘structure follows action’ adagium proposed among others
by chaos theoreticians, this would mean that strategic organizational development would have to take place alongside the creation of such systems (Grossman and Scala, 1993). The Vienna case differs considerably from the situation in Horsens, and yet they achieve the same kind of entrepreneurship institutionalization. The common denominator between the two is that the creation of systems of events and institutionalization has been incremental, i.e. a step-by-step process of strategic evolution in which remedial learning has played a crucial role. The identification of niches of potential success for small-scale success has to go hand in hand with subsequent incorporation of responsibilities and commitments into sound and sustainable structures. In Horsens, that structure has taken the shape of a community-oriented Healthy City Shop that acts as a think-tank for municipal bureaucrats. In Vienna, the structure is located within a bureaucratic apparatus that has provided resources and capacities which potentially can transcend formal accountabilities through valued linkages with other units inside as well as outside that apparatus.

CONCLUSIONS

Policy change is dependent on the presence and actions of social entrepreneurs. We have found in a sample of 10 cities that six of them recognized components of an empirically validated policy change model (Kingdon, 1995), and that indeed they effected increased policy modifications towards the Healthy City vision. However, the two cities most effective also had institutionalized their entrepreneurial activities. Strategic organizational development must incrementally go hand in hand with the identification of niches of potential success. This, then, must be the next challenge in health promotion: the move towards strategic incorporation of innovation in (local) practice.

The WHO Healthy Cities Project is piloting innovative approaches in urban health development. Throughout the larger study upon which this article is based (de Leeuw et al., 1998), we have found that cities part of this movement are indeed more innovative than others. This finding is substantiated by an inventory of local competencies in the health domain in all member states of WHO in the European Region (Green, 1998). The guidance offered by WHO to designated Healthy Cities is also supposed to be of benefit to other municipal administrations. However, social entrepreneurship as a determining factor of the innovation has not been dealt with rigorously so far. It may be recommended that WHO, national networks of Healthy Cities, and the group of designated Healthy Cities in Europe take a lead in the development of training materials and mutual consultancies (e.g. through twinning arrangements or through so-called Multi-City Action Plans) in order to bring social entrepreneurship to the fore.

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