Intersectoral Planning for City Health Development

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ABSTRACT *The article reviews the evolution and process of City Health Development Planning (CHDP) in municipalities participating in the European Network of Healthy Cities organized by the European Region of the World Health Organization. The concept of CHDP combines elements from three theoretical domains: (a) health development, (b) city governance, and (c) urban planning. The setting was the 77 cities which participated in Phase IV (2003–2008) of the network. Evidence was gathered principally from a General Evaluation Questionnaire sent to all Network Cities. CHDPs are strategic documents giving direction to municipalities and partner agencies. Analysis revealed a trend away from “classic” CHDPs with a primary focus on health development towards ensuring a health dimension to other sector plans, and into the overarching strategies of city governments. Linked to the Phase IV priority themes of Healthy Aging and Healthy Urban Planning, cities further developed the concept and application of human-centered sustainability. More work is required to utilize cost–benefit analysis and health impact assessment to unmask the synergies between health and economic prosperity.*

KEYWORDS *Healthy cities, Urban governance, Strategic planning*

INTRODUCTION

The European context and evolution of strategic health development planning is reviewed in a companion article.¹ The health for all policy of the European Region of the World Health Organization (WHO) which focused on wider societal influences is given renewed impetus by *Closing the Gap in a Generation*, the global report of the WHO Commission on Social Determinants of Health (CSDH)². Local governments are center stage in the European Healthy Cities Network organized by the WHO European Regional Office (WHO-EHCN), and city health development planning was the centerpiece of Phase III (1998–2002). This article summarizes the more sophisticated City Health Development Plans (CHDPs) which carried through into Phase IV (2003–2008) of the network.

CHDPs are a unique combination of three elements: (a) health development, (b) city governance, and (c) strategic planning. They draw on theoretical developments in each of these policy domains. Consider each in turn; first (a) *development*. Amartya Sen’s seminal work *Development as Freedom*³ summarizes the intellectual and moral foundations of the Human Development Index utilized by the United Nations Development Agency to measure societal progress in member states.⁴

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Developed to counter a traditional focus on economic growth as the single measure of performance, this holistic concept underpins a “new approach to development” championed by the CSDH which gathered evidence throughout Phase IV and reported at its close in 2008.

Two key CSDH propositions help guide the process and production of CHDPs; first is the wider socioeconomic determinants of health and the reciprocal influence of health on socioeconomic development. The CSDH maintains “Just as economic growth, and its distribution, is vitally important to health, investment in health and its determinants is an important strategy for boosting economic development.”^{2(p39)} The European Union’s strategic approach⁵ to health development also highlights the reciprocal “links between health and economic prosperity.”^{5(p1)} A second proposition reflects limitations on the role of the health service sector highlighted earlier by the WHO Alma Declaration and the Health for All Strategy. The CSDH maintains that “Health systems have an important part to play ... but beyond the health sector, action on the social determinants of health must involve the whole of civil society and local communities, business, global and international agencies”, (page 27).

The *second* (b) prerequisite of effective CHDPs is *city governance* which balances economic prosperity with social development. Social polarization has remained an enduring challenge for “growth coalitions” in European cities—including many recruited to Phase I (1987–1992) of the WHO-EHCN—which sought to counter rapid de-industrialization and population decline by restructuring their local economy with grand regeneration projects.⁶ From its inception, the WHO-EHCN embraced both “growth” and “equity” coalitions of partners. Economic sectors are represented by three of seven pillars of a Parthenon symbolizing early WHO guidance on City Health Planning.⁷ Health, transport, environment, and education are the other more social sectors. Intersectoral committees—required for membership of the network—are a pioneering form of local governance, acknowledging health development is the business of every sector and city mayors have a key role in orchestrating the contribution of many actors. Of course all the elements of good local governance⁸ are often difficult to accomplish in the contested arena of city realpolitik, but some form of partnership is now acknowledged globally as a prerequisite of city health development.⁹

Third (c), it is necessary to distinguish the strategic element of CHDPs from operational or project planning. Aware of the shortcomings of “projectitis”¹⁰ in the first demonstration phase, the WHO-EHCN developed the complementary concept of City Health Plans in Phase II (1993–1997) to guide “strategic policy within city government.”¹¹ These were transformed into City Health *Development* Plans (CHDPs) in Phase III (1998–2002) partly to distinguish health development from the New Public Management which had evolved to rationalize the quasi market of many providers of health and social services in European cities.^{12,13}

CHDPs reflect many characteristics of an older “modernist” planning approach, labeled “Type 1” in our companion article, namely an instrumental rationality that evaluates options; a comprehensive, multisectoral approach; a grounding in science; an assumption that the state is progressive; that planners are neutral, technocratic, and operate in the public interest.¹⁴ In practice, CHDPs may successfully combine both “modernist” and postmodernist planning paradigms, especially “collaborative planning” defined by Healey as an interactive and interpretive process, respectful and inclusive of different partners and their differing discourses.¹⁵ In many network cities, there was a discernible shift towards a “Type II” planning process in Phases III

and IV, when partner agencies adopted health development as an integral component of their own policies, signaling the overarching theme of Phase V 2009–2013 “Health and health equity in all local policies.”¹⁶

METHODS

This article, part of a wider evaluation of Phase IV of the WHO-EHCN, builds on an earlier evaluation of Phase III. For both evaluations, the principal research instrument was a *General Evaluation Questionnaire* (GEQ) sent to member cities of the network—71 in Phase III and 77 in Phase IV. For this analysis, data was extracted from responses by 59 (77%) cities in 23 countries near the end of Phase IV in 2008. Coordinators were asked to complete the questionnaire on behalf of the partnership and the responses were ratified by a political representative of the Healthy Cities steering group. Responses to the GEQ were triangulated with the 62 city responses to the 2007/8 version of the Annual Reporting Template (ART) and an appraisal of 38 city applications for Phase IV undertaken in 2005.

Of the six questions in the GEQ relate directly to CHDPs, three ask about the city health profile as the baseline for strategic intervention (Figure 1) and assessment of outcome. These are matched by a later question asking for “the impact of the Healthy Cities Project on the health of the population of your city.” A fourth direct question asks cities if they had either updated or (in the case of new entrants to Phase IV) produced new CHDPs or their equivalent during Phase IV. “Equivalence” was introduced to acknowledge the value of “health in all local policies,” either Type II CHDPs where the policies of partner agencies include a health dimension (referred to in the introduction), or Type III where health development is a prominent component of the overarching municipal or community plan for the city. A related ART question gives more precision to timelines. However, because neither of these ART or GEQ questions asks about CHDP content, it is not possible to evaluate the quality of CHDPs and the degree to which all types contain the essential components of “vision, values and strategy to achieve this vision,” identified in the Phase IV requirements for an effective CHDP.¹⁷ The degree to which CHDPs “focus on fundamental determinants,” also a requirement, may be elicited by triangulating responses to questions on equity, healthy urban planning, and health impact assessment, the core themes of Phase IV.

FIGURE 1. City health development planning.

Originally questioning the degree of harmony between the CHDP and AGENDA 21 planning processes in Phase III, the GEQ broadens the question to assess the relation of CHDPs to sustainability. Short binary responses on an ordinal scale are elaborated in narrative responses to other parts of the GEQ, signaling a shift to human (rather than environmentally)-centered sustainability developed in Phase IV by a thematic focus both on “Healthy Ageing”¹⁸ and “Healthy Urban Planning.”¹⁹ Finally, by asking about the benefits of City Health Development Planning, the GEQ invites cities to elaborate on the planning process, regarded by many Phase III cities “as important as the plan itself.” Their narrative may include also the efficacy of such plans and the realpolitik of competing plans and budgets. Four of the network cities collaborated in DECIPHER, an EU project designed to bring greater transparency to the cross-sector benefits of investing in health and other domains of city life (Figure 2).²⁰ Though such a forensic assessment is precluded here by the softer focus of the GEQ, cities are given an opportunity to reflect on budgets and investment plans.

FINDINGS

City Health Profiles

Responses to the GEQ provided a general overview of developments in Phase IV rather than repeating the forensic content analysis of Phase III covered in the companion articles on City Health Profiles by Webster and Lipp²¹ and CHDPs. The three questions on City Health Profiles asked were (1) “how cities assess the health status of the city population for developing programs and plans?”; (2) whether they “produce a city health profile” and “is there a regular cycle of production?”; and (3) how their city “measures and monitors inequalities in health?” Guidance on the rationale for CHPs as a planning tool encouraged cities to make the link with City Health Development Planning. Responses to the ART indicate an average 3-year cycle for updating CHPs and a 4-year cycle for updating CHDPs. In many cities, this follows a rationale sequence of “baseline CHP>CHDP>outcome CHP” (Figure 1) though others link CHP updates to the political cycle of the municipality, providing a baseline for strategic development by an incoming administration.

Guidance on the rationale and content of CHPs provided by WHO reports asks cities to “identify in writing and graphs, health problems, and their potential solutions in a specific city.”²² The accounting unit is the city rather than regions, provinces, or counties, which are often the providers of health services and repositories of data on illness and death. The WHO-EHCN adopts a social model of health which encourages network cities to include evidence on the wider determinants of health in their HCP. Responses “unmask” a range of lifestyle, socioeconomic, and infrastructure determinants covered in the 2005 content review by Webster and Lipp. Brno for example, reports on “The conditions of living and their influence on Brno inhabitant’s health” and Cankaya includes a “livable urban context.” Because health is more than the absence of illness, some cities supplement official statistics with special resident surveys of well-being and lifestyles. For example, Liverpool has developed a “Mental Well-Being Impact Assessment Toolkit” and a “Well-Being Survey” methodology. These primary surveys can be expensive and respondents also highlight the methodological challenges of synthesizing data from different sources. This is facilitated by coterminous boundaries between health authorities and municipalities, as in the UK where an annual report by the Health Authority’s Director of Public Health is effectively the HCP.

FIGURE 2. Sector investment for health.

The *Hidden Cities* report (WHO/HABITAT) recommends “unmasking” evidence as a prerequisite for “overcoming health inequalities.”²³ Most network cities met this requirement in their CHP by collecting evidence on the “health gradient” (WHO Commission on Social Determinants of Health), distinguishing city neighborhoods or comparing demographic groups. About a third of responses refer to demographic profiles linked to sector or departmental policies and best serve Type II CHDPs. They include for example environmental indicators linked to sustainable

energy use (Milan) and monitoring sickness in schools as a prelude to educational planning (Ishevsk). Circa 20 cities produced “Healthy Ageing Profiles” following a template developed by the subgroup developing this core theme of Phase IV and consolidated into WHO guidance.²⁴ A companion article evaluates this process in more depth. Only a third of responding cities, though all in the UK, are able to produce and compare the health profiles of constituent districts or neighborhoods. Sophisticated Geographic Information Systems have been used in a few cities to combine demographic and spatial data. Udine’s “city health map” (Figure 3) is a good example linking the distribution of older residents to the location of facilities such as pharmacies, bus stops, and parks.

City Health Development Plans

Asked for evidence “that health has become more central in the vision, strategies and policies of your city” respondents cited (1) political commitment, (2) institutional positioning to enhance the leverage of the healthy cities team, and (3) its influence on the policy agenda. “Classic” CHDPs, the dominant Type (I) in Phase III, remained a significant tool for strategic development in Phase IV, especially in the new entrant Russian cities. Moving beyond the medical model which characterized the traditional soviet approach, the city assembly of Cheboksary formally approved in 2005 a strategy for “Health and sustainable development in the city of Cheboksary. 2005–2010.” During 2007 the mayor of Novocheboksarsk approved by formal decree “The Strategic plan for protection and improvement in health of the population of Novocheboksarsk 2007–2010.” A minority of cities (circa 15%) referred to their influence on inserting health into sector plans (Type II) especially for “Healthy Ageing” which was a key theme of Phase IV. There was an increase from a quarter in Phase III to nearly half of Phase IV of cities citing the prominence of a health dimension to their overarching generic city development plan as their “equivalent” (Type III) CHDP. The UK cities of Liverpool and Sheffield pioneered classic City Health Plans in Phase II and Stoke on Trent produced one of the most accomplished classic CHDPs in Phase III. However, by Phase IV, all UK cities referred to overarching city strategies (Type III) which typically incorporate health as one of six or seven dimensions.

During Phase IV, the majority of network cities developed a strong relationship between City Health Development Planning and sustainable development; 33% (18 of 54 respondents) reported “strategic and long term cooperation to achieve similar goals” and 44% reported “regular contacts and ongoing cooperation in a number of areas.” Whereas Phase III was characterized by closer working relationships between the local agencies responsible for CHDPs (focused on health) and those responsible for Agenda 21²⁵ (tending to focus on the environment), Phase IV was characterized by efforts to synthesize local development frameworks around anthropocentric or human centered sustainability. The conceptual origins are in the *Brunntland Report* which defines sustainable development as “development that meets the needs of the present generation without compromising the ability of future generations to meet their own needs”.²⁶ Conceptual development at a city level was encouraged by the “human ecology model of settlement” developed by Barton and Grant to support the thematic priority of Healthy Urban Planning.²⁷

A political context for cities in the European Union (71% of respondents) is the 2006 *Renewed Strategy for Sustainable Development*²⁸ which emphasizes balanced and responsible progress in “social, economic and environmental spheres.” In the

FIGURE 3. Udine’s “city health map”.

following years, most European states produced national strategies which referred not only to environmental constraints on development but, as in Sweden, to “long term management and investment in human, social and material resources.”²⁹ Cities are encouraged, and in the UK “required,” to develop overarching sustainable development strategies, the “plan of plans” reported by Liverpool. Conceptual development is illustrated by the GEQ response from Ljubljana: “Room for possible vision is emerging. In the broader social environment, we wish to utilize a contemporary and broad comprehension of health and social security, which are closely connected with the social dimensions of sustainability in Slovenia.” The *Plan for Sustainable Development in Helsingborg* (updated annually) exemplifies the most developed conceptual framework and action plan, illustrated by a jigsaw of interlocking domains (Figure 4).³⁰

Responding to the final question on the benefits of City Health Development Planning, cities gave less attention in Phase IV, compared with Phase III, to highlighting determinants of health (five of 56 responses) and raising health on the political agenda (10 of 56). Determinants were previously covered by responses to the questions on city health profiles and health had already become an established agenda priority item for many cities during earlier phases. As in Phase III, partnerships were enhanced (15 of 56 responses) in Phase IV by working together on CHDPs “under the same umbrella.” In addition to intersectoral partnerships, some cities emphasized the relationship between policy makers and experts. In Ishevsk “the process of preparing the city public health development plan is a perfect, excellent school for specialists, heads of different sectors, the decision-makers and experts.” In Cherepovets, CHDP working groups established by the

FIGURE 4. The Plan for Sustainable Development in Helsingborg.

mayor “promoted closer communications between experts and heads of city spheres that has favorably affected planning and realization of the project.”

Over a third of all city respondents (20 of 56) highlighted the strategic value of their CHDPs. “Vision,” “goals,” and “mechanisms for change,” all components of a classic (Type I) CHDP, were given less attention than their value as a strategic framework for operational plans, such as “the concrete and regular actions necessary for health improvement of the population of Novocheboksarsk.” Cities referred to the better “organization of actions,” clarifying “priorities,” ordering the “city budget”, and avoiding the “overconsumption” of scarce resources. The trend away from classic (Type I) CHDPs was accompanied by a greater emphasis (also 20 of 56 responses) on the integration and harmonization of their CHDPs with either sector plans (Type II) or the city’s overarching (Type III) “plan of plans.” Typically, Stavropol reported its classic (Type I) CHDP “helped to determine priorities, to develop (Type II) joint plans and goals for all sectors concerned.” For Manchester, with an overarching (Type III) city strategy, “the process has helped to integrate thinking across all key policy areas and has ensured that improving health and tackling health inequalities are integral to the way the city works.”

CONCLUSION

Tracing the development of CHDPs over Phases II, III, and IV, a span of 15 years, evidence from successive evaluations points to six major advances. Not all cities have developed at the same pace; some have dropped out of the network others joined later phases and have either taken time to catch up or accelerated development to match or surpass the pioneers. However the trend is clear. *First*, all network cities have decisively rebalanced the demonstration projects which characterized Phase I, towards a strategic approach best exemplified in CHDPs. Projects are still valued but viewed in “magic combination” with strategy. *Second*, city health profiles are widely regarded as an evidential base for CHDPs, providing both a baseline and assessment of outcome. *Third*, the focus of almost all network cities is population health development and its wider socio-economic and environmental determinants rather than the management of health services. *Fourth* is a modernist assumption that even in an uncertain world dominated by global forces, there is value in rational planning at a city level. *Fifth*, network cities and the network itself, have reconciled health to sustainability by developing further the concept and local application of human-centered sustainability. *Finally*, the realpolitik of competing local plans and limited resources has reinforced a trend towards inserting health into all local policies (Type II and Type III CHDPs) rather than producing classic (Type I) CHDPs with health as the primary focus.

However, the CSDH report, *Closing the Gap in a Generation*, provides a significant opportunity to overcome two weaknesses first identified in the evaluation of Phase III and enduring into Phase IV. They are about evidence and synergies. The Commission’s report is evidence driven, with a very significant political and technical impact globally, nationally and at a city level. The quality of the evidence it deploys in making the case for health equity has reinvigorated network cities and city administrations beyond. The mechanisms for improving health and reducing health inequalities are now better understood and the Phase IV thematic priority of health impact assessment could be utilized more centrally in CHDPs. The synergies referred to in the introduction to this article, especially the reciprocal relationship between health and prosperity, are on the radar of many cities because difficult

choices are required in a period of economic austerity for European governments. An economic calculus could be developed technically with expert economists to move beyond cost constraints and summarize costs and benefits, the synergies of investment in the local policy domains of education, economy, environment, social life, security, and housing. These are key domains for strategic intervention if network cities are to achieve the overarching objective of Phase V, “Health and health equity in all local policies.”

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