Partnership structures in the WHO European Healthy Cities project

GEOFF GREEN1*, CHARLES PRICE1, ALISTAIR LIPP2 and RICHARD PRIESTLEY3

1Sheffield Hallam University, Sheffield, United Kingdom, 2NHS Great Yarmouth and Waveney, United Kingdom and 3RHC Health Consulting Ltd, United Kingdom
*Corresponding author. E-mail: g.green@shu.ac.uk

SUMMARY

The development of new partnership structures for public health is an important goal of the World Health Organization’s Healthy Cities project which covers a network of European municipalities. A review was carried out of the partnership structures and key changes arising from the project, based on the responses of 44 cities to a structured questionnaire, interviews with 24 city representatives and publications from the project from 1988 to 2003. Cities reported elaborate partnership mechanisms usually combining formal and informal working methods. Differences between cities could partly be related to differences in the way that local government is organized within countries and partly differences in local choices and circumstances. A relationship between the effectiveness of partnership arrangements and delivery of key elements of the project was discernable. Most cities reported having changed their processes for decision-making and planning for health as a result of membership of the WHO European Healthy Cities Network. One of the most potent stimuli for these changes was the action to which a city had committed as part of its membership of the Network.

Key words: Healthy Cities; health partnerships; intersectoral partnerships

INTRODUCTION

One of the first guidance documents (WHO Regional Office for Europe, 1997a, first published in 1992) for members of the European Healthy Cities Network (WHO-EHCN) projects an image of partners sitting around a table deliberating how to improve the health of their citizens. This image symbolized a logical development from the first European health policy adopted in 1984 by the governing body of the European Region of the World Health Organization (WHO Regional Office for Europe, 1985). Member States agreed a program with targets for health as one of the outcomes of overall social and economic development. Acknowledging these wider determinants led naturally to cooperation with agencies beyond the formal health service sector. The prerequisites for health enshrined in this policy—peace, education, a socially useful role, a supportive physical environment, housing and human rights—made health everybody’s business. The keywords of WHO became intersectoral action and community participation.

In response, the WHO Regional Office for Europe proposed a range of collaborative programs at both a national and local level of governance. Partnerships for health at the local level were important for three reasons. First, people from a range of sectors could genuinely share a common interest in the well-being of people in their town or city. Second,
more opportunities for meeting and collaborative working compared with the national level. Third, the 19th century public health movement set a historical precedent for this kind of working. Living and working conditions in European towns and cities were transformed by introducing sanitary engineering, providing social welfare services and campaigning for the rights of children, workers and marginalized groups. When the first Healthy Cities meeting took place in Lisbon in 1986, partnership for health and the role of cities in creating such partnerships were firmly on the agenda.

Municipal governments were identified by the WHO Regional Office for Europe as lead partners in the launch of its WHO-EHCN in 1987. Though responsible for providing health services in only a few European states, municipalities generally exercised a formal competence (Green, 1998) for many of the living and working conditions identified by Dahlgren and Whitehead (Dahlgren and Whitehead, 1992) as key determinants of health. However, during this period, there was a trend for European municipalities to retain oversight but cede formal provision of (health promoting) services such as housing, transport and utilities to the private sector or ‘arms-length, quasi public authorities’. In many European states, similar market regimes were also introduced into national health services, characteristically splitting ‘purchaser’ from ‘provider’ and ‘outsourcing’ some services. Over time, as the various failures of extreme market-led experiments became apparent, partnerships evolved as integrating structures (Geddes, 2000) and the New Public Management (NPM) evolved as an integrating process (Hood, 1991; Gamm, 1998; Dunleavy and Margetts, 2006). Glasby and Dickinson (Glasby and Dickinson, 2008) characterize this as a cyclical shift from hierarchies to markets to networks. Their focus is on health service management though many analysts (Taket and White, 2000) with a wider remit for ‘decision-making in a multi-agency setting’ produce typographies within the general framework of NPM.

The key sectors identified by WHO for intersectoral collaboration extend well beyond those typically covered by NPM. Represented as pillars of a Parthenon (WHO Regional Office for Europe, 1996), they include, besides health and social services, business, transport, environment, industry, education and the economic sector. They also relate to different tiers of government. Consequently, Healthy Cities partnerships (HCPs) are better located by the literature on urban governance. With legitimacy from WHO and a more strategic remit and institutional locus than typical health promotion programs and projects, HCPs accord with Stoker’s five theoretical propositions of governance (Stoker, 1998). These are:

1. Governance refers to a set of institutions and actors that are drawn from but also beyond government
2. Governance identifies the blurring of boundaries and responsibilities for tackling social and economic issues
3. Governance identifies the power dependence involved in relationships between institutions involved in collective action
4. Governance is about autonomous self-governing networks of actors
5. Governance recognizes the capacity to get things done which does not rest on the power of government to command or use authority. It sees government as able to use new tools and techniques to steer and guide

Stoker: Governance as theory: five propositions p18

Many European municipalities have a general competence for ensuring the health and well-being of their citizens. Partnership arrangements are embedded within established local governance structures. Because the normal process of engagement in these municipalities is implicit and unremarkable, our evaluation draws on key issues made explicit and remarkable by catch-up innovations in England. A general competence was granted to municipalities by the 2000 Local Government Act, and Local Strategic Partnerships (LSPs) were encouraged as the primary form of local governance. The United Kingdom Health Development Agency (responsible for health promotion) considered how health objectives could be integrated into these new arrangements ‘to improve the well-being and health of local populations’ (Health Development Agency, 2003). Analysis revealed a ‘considerable degree of consensus about the key issues’ listed as:

1. Working across boundaries
2. Partnership arrangements and accountability structures
(3) Planning arrangements (strategies)
(4) Community involvement
(5) Member (political) involvement
(6) Joint priorities, indicators and targets
(7) Reducing inequalities and tackling deprivation
(8) Using flexibilities - pooled budgets, joint
posts and integrated services

Planning Across the Local Strategic Partnership: Health Development Agency: Executive Summary

METHODOLOGY

Our approach to evaluation was shaped by theories of local governance and by the key issues for LSPs highlighted by the English Health Development Agency. We gave lesser weight to NPM approaches which characterize much partnership literature on health promotion, reviewed, for example, by Hope Corbin and Mittelmark (Hope Corbin and Mittelmark, 2008). Our first objective is to analyze the local governance structures for health development induced or altered by membership of the WHO-EHCN. Capacity and inclusiveness are important considerations, both synergies and limitations (Geddes, 2000). A typology was not attempted since Stoker (Stoker, 1998) argues governance is ‘date and place specific’. Our second objective was to describe impact, essentially the institutional processes of partnership development and maintenance which are prerequisites for healthy public policies (Draper et al., 1993) at a city level and eventually lead to better population health outcomes (de Leeuw, 2009, p. i21).

Two methods were deployed. Analysis of partnerships in the first three phases of the WHO Healthy Cities Project (1987–2002) was based on a review of reports from WHO and EHCN cities, including organigrams supplied as part of the application process and updated by an annual reporting template. The main instrument for reviewing the third phase (1998–2002) was a questionnaire completed by project coordinators from 44 of the 56 members of the WHO-EHCN. The questionnaire asked each city to describe its partnership working arrangements and the way the project linked to the city administration. It also asked a range of questions relating to outputs from the project and impact on city partnerships. Information from the questionnaire was supplemented by interviews with representatives of 24 of these cities and examination of written material, including WHO reports and products from project cities.

These methods may produce overly optimistic partnership scenarios for two reasons. First, the 44 cities responding to the questionnaire were probably more engaged in the WHO-EHCN and their partnerships more successful than in the 12 who declined to take part. Second, coordinators may be inclined to highlight the success of partnership because it reflects well on their personal performance. However, these difficulties are inherent (Sullivan and Skelcher, 2003; Dowling et al., 2004) in evaluating health promotion partnerships. We endeavored to mitigate if not overcome bias by requiring coordinators to formally clear their responses with partners and by a deeper enquiry into relations with parallel Agenda 21 partnerships established in most WHO-EHCN cities.

RESULTS

Partnership structures

From the outset in 1987, cities applying for membership of the WHO-EHCN were required to establish an intersectoral committee for health. Twenty steps (first published in 1992; 3rd edition WHO Regional Office for Europe, 1997a) provided practical guidance. Two main mechanisms were envisaged by which cities would build these mandatory intersectoral partnerships for health. The first was by establishing an intersectoral steering committee for the project and developing public policy and action involving several sectors. A second method was developing partnerships between the Healthy Cities project office and other relevant organizations, especially to support community participation. Problems and issues relating to how best to develop and organize partnership working were a frequent topic for discussion at the twice yearly business meetings of the WHO-EHCN.

All 37 members of Phase II of the network established an intersectoral steering committee, characterized by:

(a) widely representing different sectors in decision-making;
(b) involving partners in defining the problems to be addressed and agreeing on priorities and action;
(c) involving partners in strategic planning; and
(d) taking opportunities for local joint action between sectors at the neighborhood level.

However, some cities struggled in the early years to establish functioning partnership working. Some reported that partners had an uncertain commitment to Healthy Cities; others mentioned a perceived decline in interest by the committee members while there were also difficulties relating to intersectoral committees and the project staff (Draper et al., 1993).

These structural problems arose in part from the complexity of formal competences for health in European states, both within cities and between different tiers of government. Also many national and city governments were not fully sensitized to the distinction between health development and health service provision made by the Declaration of Alma Ata (WHO, 1978) and Ottawa Charter (WHO, 1986). A key assumption of the WHO-EHCN is that the municipality takes lead responsibility for health development in its widest sense. In most cities, this approach is not matched by established arrangements for health service provision, typically the formal responsibility of national, regional or county governments (Green, 1998). Adding to these multi-level complexities are varying arrangements at city level for sectors identified in the ‘Parthenon’ as influencing health. The Healthy Cities approach aimed to reduce the debate about which organization should lead responsibility for health development by placing it firmly on the shoulders of the municipality. Creating new structures for health that enabled several sectors and levels of government to work together was one of the most important outputs of this period.

Within the parameters set by WHO guidance, cities differed as to where the project was located within city structures, the organizations with which it formed partnerships and how these partnerships functioned. Most cities based their Healthy Cities team in the health department, but some put them in other departments (Györ, Kosice and Padua) or with the office of the chief executive (Glasgow, Jerusalem, Liverpool and Sandnes). A significant minority chose to locate outside the city administration. Amadora, Horsens, Kaunas and Pécs set up semi-autonomous foundations, whereas Camden and Dublin established organizations with joint agency control.

The arrangements in Horsens and Glasgow represent this diversity. Figure 1 shows the partnership arrangements of Horsens from 1994. It had a Joint Health Committee on which the municipality, County health service, voluntary organizations, employers and trade unions are represented. The project office itself was established as an independent foundation with its own board accountable to the Joint Health Committee.

Figure 2 shows alternative arrangements for Glasgow in 1994. The project there was located in the chief executive's office of the municipality but was supported directly by the Greater Glasgow Health Board, a local arm of the National Health Service, ultimately accountable to Central Government. Links to the regional level are on the right of the diagram and links
to a range of community organizations on the left. The universities were also key partners.

The most common arrangement for partnership working in Phase III was a formal structure for creating and managing the Healthy Cities project together with informal working relationships with a much larger range of partners, often described as a ‘loose confederation’. Of the 44 cities reviewed, 39 (89%, Figure 3) reported a formal structure, generally a steering group linked to the formal decision-making structure of the city. Typically, this formal body took responsibility for a project office or other executive arm charged with developing and managing the informal partnerships reported by 27 (60%) of cities. Two direct quotations from the questionnaire responses illustrate this institutional arrangement of formal and informal partnerships.

The healthy city partnership is a fairly loose coalition of many different agencies overall, but in terms of its principal partners (the Council and the Health Board) it often works in a tighter and more formal manner. (City 1)

It is strategic and operational and formal for the politicians and the departments of the Municipality. Also, it is strategic and formal for some of the citizens’ associations. It is informal but with clear lines of accountability for some others. (City 2)

Some partnerships were clearly a formal mechanism for strategic cooperation and coordination with no direct operational activity. No city partnerships were solely operational. Most combined the two (Figure 3). Many partnerships described shifting informal arrangements with a wide variety of organizations, especially in relationship with specific operational projects—in contrast to stable formal membership of the steering group with a more strategic focus.

### Partnership impact

One in five cities (9) self-assessed the success of their partnership as ‘average’ and two-thirds (30) as ‘above average’. As reviewed in the methodology section, a key measure of success is the development and maintenance of an intersectoral partnership for health in its widest sense. Four in five cities (36) were ‘confident’ and another three ‘probably confident’ that the health partnerships created or facilitated by the Healthy Cities project would continue in one form or another without continuing membership of the WHO-EHCN. City responses were overwhelming positive about the WHO connection, generally avoiding potential drawbacks of ‘mandatory’ partnerships summarized by Dowling et al. (Dowling et al., 2004). Sustained membership of the EHCN appears to have produced fundamental changes in the decision-making process in many municipalities. Typically:

Our conviction is that this Project has already created roots in our Municipality and has allowed the partnership members a new way of regarding and thinking of the development of health in a city. (City 3)

The principles of partnership working and the shared understanding of the health agenda are now embedded in [our city]. (City 3)

Maybe the name of the project would change but the way of performing it would proceed because this is now the accepted and successful way of how to organize a good city health-promoting long-term programme. (City 5)

The healthy city approach...is an integral part of city policy and strategic decision-making structures. (City 6)

Cities were also generally positive about their current membership of the EHCN.

...Involvement in the WHO Healthy Cities project is highly significant to success locally and is an opportunity to sustain enthusiasm for the work and links to the wider community that would be difficult if the partnership were not a member. (City 3)

We consider participation in the WHO Network is very important for promoting activity for health at
the top level of legislative and executive authority, for getting progressive experience from other cities and for mutual collaboration with other cities on solving similar problems. (City 7)

Cities described a tension between using the WHO Healthy Cities identity as a badge of quality to encourage participation and high standards, and the need to use the WHO Healthy Cities identity discreetly to give other partners visibility—or to allow local branding to flourish. About one-third of the cities keenly supported using the WHO identity at the local level, about one-third favored using the identity discreetly and the rest were non-committal. Favoring local use, some cities wanted to use the WHO-EHCN to ensure the survival of the local project so that it did not get swallowed up in a larger concept of sustainable development in which health issues might not be so readily recognized or be so readily acted upon.

Maintaining the healthy cities label and identity when working is the minimal requirement for any successful activity which allows the WHO Healthy Cities approach. That is also the way to grant partners healthy city strategies, methods and experience. WHO Healthy Cities is already a trademark of quality. (City 8)

There is also an issue that funders want to see work labelled as being ‘Healthy Cities’ which illustrates its importance as a brand and adds value to partnership working. (City 9).

Favoring the discreet approach, about one-third of the cities felt that it was the underlying principles of Healthy Cities that were important to follow—rather than the WHO identity. This is the realpolitik described by Green et al. (Green et al., 2009, pp. i77 & i79) which led to ‘Type II’ or ‘Type III’ city health development plans, where health development is subsumed into the plans of key partners or within comprehensive plans for the city. This group also felt that, in a partnership of equals, one logo dominating all others was sometimes inappropriate.

There have been times when media publicity for a particular health initiative has highlighted a specific agency or coalition without also mentioning the healthy city partnership’s key role, and whilst this can be a little irritating in one respect, we are equally keen to ensure that our partners are encouraged in their health work and that their sense of ownership is thereby improved. (City 10)

... Sometimes we have to give up the identity or the label in favour of some other label in order to achieve more or get more involvement. The Healthy Cities project steering group has decided upon: as long as the message is passed and understood and you are heading for the targets, that is more important than the sign itself! (City 11)

Healthy cities cannot exist as a marginalized, isolated project for the sake of retaining a separate identity. It is far better to sacrifice identity if the reward is to ensure that healthy city values and principles are sustained. (City 12)

Do not wave the healthy cities flag all the time. It does not stimulate other agencies to be fully involved. They like to have their own flag on top when they do something special in stimulating health promotion, and it is good that they do. It will make them proud and willing to go on in that field. (City 10)

While working in partnership, it is necessary to secure that all partners are visible and receive a fair share of acknowledgement for their contribution. (City 12)

In addition to the WHO connection, city respondents cited three critical factors for successful partnerships. First, a WHO requirement for membership of the WHO-EHCN, and also listed by the United Kingdom Health Development Agency, was high-level commitment by the municipality at both a political an executive level.

The main factors that determined our success were... the support of the Mayor and other local politicians (City 13)

Factors that determine success... involvement of executive decision-makers from all the key agencies in the city (City 14)

Few things have gone well in the last couple of years due to lack of political commitment and administrative back-up (City 15).

Second, another WHO requirement for EHCN membership was a project infrastructure with a ‘full time identified project coordinator or equivalent and administrative/technical support for the project’ (WHO Regional Office for Europe, 1997b). Location of the Healthy Cities office in the Mayor’s department with an overview of municipal activity, made it easier to gain the support of politicians and senior managers in specialist departments. The role of the coordinator was critical. The cross-cutting
themes which characterize the Healthy Cities approach cut across traditional professional and political boundaries. Enthusiasm and diplomacy were required to encourage potential partners to agree a common purpose.

The wide political entrusting of the coordinator and the everlasting enthusiasm of the members of the Project Office are important values to promote the Project in the best possible way and make it move forward (City 16).

Healthy city office workers, their involvement, enthusiasm (City 3) and

The coordinator’s reputation as even-handed or an ‘honest broker’ (City 17).

Third is community participation, again a WHO requirement for membership of the WHO-EHCN and also listed by the United Kingdom Health Development Agency. In their article for this supplement, Heritage and Dooris (Heritage and Dooris, 2009, p. i51) elaborate how participation and empowerment has been an enduring value in all phases of the WHO-EHCN and refer to WHO guidance (WHO Regional Office for Europe, 2002). Cities described participation in both strategic development and operational activity.

Increasing participation in city health area... Increased preparedness of the population to participate in the actions of the city health development plan. (City 18)

An overwhelming victory for WHO methods – and for the empowerment tool. From the very beginning, the healthy city staff has made a priority out of what was the most deprived area, adding our resources to the residents’ wishes for a better life. (City 19)

Over 80% of city respondents were confident of their partnerships and inclined to present a positive picture of their working arrangements. Given the resources devoted to our review, it was not possible to set an objective test of their real efficacy. As a substitute, cities were asked to report in depth on just one set of working relationships with a partner organization. Phases II and III of the WHO Healthy Cities project had focused on how cities interact with Local Agenda 21 (the United Nations program of action for sustainable development for the 21st century) which arose from United Nations Conference on Environment and Development in June 1992. In the following 10 years, many

European cities created partnerships to develop this Local Agenda (Dooris, 1999) Like the Healthy Cities ‘agenda’, these partnerships addressed the integration of economic, environmental, social, political, cultural and health factors. Thirty-seven of the 44 project cities under review had established Agenda 21, often with a focus on the natural environment.

Given the similarities between the two partnerships, city respondents were asked (i) did these partnerships complement or compete?, (ii) was one dominant or subsidiary to the other?, and (c) did they work together at a city level? Theoretically, the concepts of ‘health development’ and ‘sustainable development’ are complementary, though some Healthy Cities partnerships found it difficult to relate to the environmental focus of Agenda 21. Nevertheless, the two concepts were well integrated in one-third of cities (Figure 4) with another third having adequate working relationships. Constraining factors were the requirement to invest staff time and effort plus limited availability of resources.

CONCLUSION

Developing new governance structures for public health at the city level is one of the most important features of the WHO Healthy Cities project. The mandatory requirements (WHO Regional Office for Europe, 1997b) of WHO for membership of the WHO-EHCN induced an enduring and largely successful intersectoral partnership structure able to contribute to healthy public policy as a prerequisite for positive health outcomes. Although there is no one governance model for partnership development, the experience to date indicates that key
elements can clearly be identified that are likely to result in success. These parameters can guide and shape alternative approaches tailored to suit local needs and culture. The project has brought together diverse partners, including those formally responsible for health and a range of other organizations.

An overwhelming proportion of cities changed their processes for decision-making and planning for health as a result of membership of the WHO-EHCN. In a few countries, requirements at the national level were also important. Many of the changes were in reaction to the process of creating a city health development plan as elaborated in an article in this supplement (Green et al., 2009).

Progress in organizational development and achieving policies and strategies for health for all are linked. Cities with less evidence of organizational development have also found it difficult to produce a city health development plan. For debate is whether a Healthy Cities project exemplifies a modern public health function. Cities involved in the WHO-EHCN have linked traditional and new public health practice in several important ways, reconnecting to the economic and environmental sectors which characterized municipally led public health in the 19th and early 20th centuries. Back to the future?

FUNDING

This article is based on an evaluation commissioned by the WHO Regional Office for Europe.

REFERENCES
