City health development planning

GEOFF GREEN1*, JOHN ACRES2, CHARLES PRICE1 and AGIS TSOUROS3

1Sheffield Hallam University, Sheffield, United Kingdom, 2NHS Education South Central, United Kingdom and 3World Health Organization Regional Office for Europe, DK-2100 Copenhagen, Denmark
*Corresponding author. E-mail: g.green@shu.ac.uk

SUMMARY
The objective of this evaluation was to review the evolution and process of city health development planning (CHDP) in municipalities participating in the Healthy Cities Network 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 56 cities which participated in Phase III (1998–2002) of the Network. Evidence was gathered from documents either held in WHO archives or made available from Network cities and from interviews with city representatives. CHDPs were the centrepiece of Phase III, evolving from city health plans developed in Phase II. They are strategic documents giving direction to municipalities and partner agencies. Analysis revealed three types of CHDP, reflecting the realpolitik of each city. For many cities, the process of CHDP was as important as the plan itself.

Key words: Healthy Cities; urban governance; development planning

INTRODUCTION
City health development planning (CHDP) was the centrepiece of Phase III (1998–2002) of the European Healthy Cities Network organized by the Regional Office for Europe of the World Health Organization (WHO-EHCN). Member cities adopted a more strategic approach to health development than the projects and programmes characterizing earlier phases. This article summarizes the context and evolution of the concept, tracing its origins in the city health plans (CHPs) of Phase II (1993–1997) and earlier, to the ‘magic combination’ for successful development identified at an EHCN business meeting in 1990. More sophisticated CHDPs were carried through into Phase IV (2003–2008).

CHDPs are a unique combination of three elements: (a) health development, (b) city governance and (c) planning. They draw on theoretical developments in each of these policy domains. Consider each in turn. First, health development should be distinguished from routine planning by health care organizations, though CHDPs share with the best of these a concept of strategic planning characterized by a set of steps to accomplish a mission or vision (Swayne et al., 2006). The CHDP concept owes more to developmental models that acknowledge both the wider socio-economic determinants of health and the reciprocal influence of health on socio-economic development. The WHO Commission on Social Determinants of Health acknowledged: The Millennium Development Goals (United Nations, 2006) shape the current global development agenda. The MDGs recognize the interdependence of health and social conditions and present an opportunity to promote health policies that tackle the social roots of unfair and unavoidable human suffering (WHO, 2005).
Though the initial development paradigm focused on ‘the World’s poorest people and poorest countries’ (WHO, 2001) both WHO and the European Commission subsequently focused on investment in health in advanced European economies (Suhrcke et al., 2006). Health can be conceptualized not merely as a goal or outcome, but also as an element of human capital, contributing to social and economic development (Green et al., 2002).

Second, there is evidence of city municipalities accepting an explicit development agenda. Whereas in the late post-war period of rapid de-industrialization, city governments were characterized predominantly as organizing welfare delivery (Castells, 1977; Saunders, 1979) by the turn of the millennium, European urban elites had become deeply concerned about their economies, and eager to assume a developmental role (Parkinson et al., 2004; Turok, 2004; EUROCITIES, 2005; Healey, 2006). According to a review of English cities commissioned by the Government of the United Kingdom (Parkinson, 2006), there had been a ‘sea change’ in how European cities were regarded, transformed into ‘dynamos of national and regional economies rather than economic liabilities’. A key message promoted the integration of health in their overall development:

Urban policy should recognize the linkages between housing, education, transportation, security, health and welfare policies and not treat them separately. (p. 239).

CHDPs address these linkages, but do city governments have the power to realize such an aspirational agenda? Many political theorists argue that globalization has eroded the capability of both national and local governments to influence key developments. Gualini (2006), for example, describes how the modernist era of formal, rational, hierarchical tiers of government with settled competences has been replaced by a post-modern dispersal of authority and the emergence of ‘more complex, fluid, patchworks of innumerable, overlapping jurisdictions’. The influential theories developed by Jessop maintain that the state (including local government) ‘has no power – it is merely an institutional ensemble’ deriving power from the forces acting in and through it’ (Jessop, 1990, p. 269). Herein lies the important distinction between ‘local government’ and the concept of ‘new urban governance’ (Hohn, 2006).

The power of local government to act alone may have diminished, but these theorists accept the possibility of an influential alliance of partner agencies. Indeed, these horizontal relations between local partners, with differing roles and competences for health determinants, may more easily facilitate the production of CHDPs than traditional, hierarchical forms of local government. Primus inter pares, municipalities can be a unifying force for city health development.

Third, are theoretical perspectives which question the value of plans and planning processes. More relevant than health services planning are urban spatial planning paradigms which address the new dynamics of city governance. In one sense, CHDPs reflect many characteristics of an older and much criticized ‘modernist’ planning wisdom (Sandercock, 1998, p. 27); namely, an instrumental rationality that evaluates options; a comprehensive, multi-sectoral approach; a grounding in science; an assumption that the state is progressive; that planners are neutral, technocratic and operate in the public interest. Critics (Allmendinger, 2001) argue that such a formal conception of planning matches a formal but outmoded conception of local government. Planning practice should reflect the post-modern complexities of local governance.

In practice, CHDPs may successfully combine both ‘modernist’ and ‘post-modernist’ planning paradigms, especially ‘collaborative planning’ which Allmendinger claims became the dominant basis for planning theory in the 1990s. As defined by Healey (Healey, 1992, p. 154) collaborative planning is an interactive and interpretive process, respectful and inclusive of different communities of interest and their differing discourses, rather than characterized by a dominant rationalist theory. Of course, there is potential conflict and misunderstanding arising from the differing perspectives of each profession and the different modus operandi of each partner agency. However, the search for a common planning language reported by many EHCN Cities assumes that there can be ‘communicative rationality’ (Habermas, 1984) where everyone with a competence to speak and act is encouraged to contribute.

METHODS

Evidence was gathered in 2002 from reports, minutes, application forms and WHO guidance.
documents archived at the WHO Regional Office for Europe. Specifically, we reviewed agenda items and minutes from a series of formal meetings that structured Network business during its first three phases, and the CDPs and CHDPs produced or drafted by member cities during Phases II and III. Then, by telephone and e-mail exchange, applicant cities for Phase IV were asked to clarify the political status of their CHDP, ranging from a draft pending approval or in final form fully ratified by the municipal council. In response to a formal questionnaire, 44 cities provided a written assessment of the value of CHDPs. We interviewed representatives from 17 cities at an EHCN business meeting in September 2002 to resolve ambiguities and fill gaps in earlier responses.

From the analysis of this data, we developed typology of approaches to CHDP, which accounted for the absence of a formal CHDP document in half of the network cities. Our classification was used to further update and analyse 38 of the 56 cities joining Phase IV of the EHCN during 2004 and 2005. Evidence was drawn both from a section of the application form devoted to CHDPs and from the related section on plans to develop the physical aspects of healthy urban planning (HUP).

The genesis of city health plans

The first phase of the WHO-EHCN began in a decade when a new social model of health was developed and politicized in Europe. Referring back to the political debates within the WHO Regional Committee for Europe (the governing body of WHO in the European Region, comprising representatives of the 53 Member States the Region) in the early 1980s, the 1991 version of the Health for All Targets (WHO Regional Office for Europe, 1991) describes how a theoretical document ‘has grown into a Region-wide movement that reaches (inter alia) into parliaments, government departments, and city halls’. In reality, the small group of cities in the initial phase were obliged to expend much effort in raising the ‘new public health’ on the agendas of municipal councils and their partners. And often their approach was via demonstration projects. ‘By concentrating on concrete examples of health promotion…the Healthy Cities Project was seen as making the point at which the Health for All Strategy was taken ‘off the shelves and into the streets of European Cities’ (Ashton and Seymour, 1988). Demonstration projects characterized this proselytizing phase.

A turning point was the annual business meeting of EHCN in 1990. In a meeting in Belfast, cities agreed that demonstration projects alone were not sufficient to win hearts and minds, and certainly not sufficient to fundamentally alter the direction of city development. In their collective experience, neither the lessons from small examples nor the charisma of city mayors could sustain a coherent programme of health development. Missing, but essential, was the instrument of strategic city health planning, not as an alternative but in ‘magic combination’ with action to secure popular support. WHO signalled such a combination later that year (Tsouros, 1991). After reviewing the ‘Style of operation of healthy city projects’ and the axis of rational verses incremental planning, this WHO review concluded that ‘the Healthy Cities project seeks to combine change in strategic policy within city government and immediate action in the community’.

In 1992, WHO took a bold decision to promote city health plans when the very concept of planning was in retreat in the countries in the eastern part of the European Region and market solutions were ascendant in the west. As a condition (WHO Regional Office for Europe, 1993) of entry into the WHO-EHCN in its second phase, cities were required ‘to prepare and implement a city health plan that addresses equity, environmental, social and health issues within two years’. This requirement both reflected and reinforced early developments within WHO-EHCN. In their review of the project’s first phase, Draper et al. (Draper et al., 1993) identified embryonic city health plans in 15 cities. However, the briefest of WHO guidance on strategic planning (first published in 1992; 3rd edition WHO Regional Office for Europe, 1997a) was produced only in 1992 at the very end of Phase I. Until then there had been common understanding neither of the health planning process nor of the essential structure and content of city health plans.

The first substantial discussions on city health planning took place at the next Healthy Cities business meeting in St Petersburg in 1993. Over the next 5 years, enormous effort was expended in preparing city health plans in most WHO-EHCN cities. WHO issued technical guidance in 1994 (WHO Regional Office for
Europe, 1994) followed by definitive guidance in January 1996 (WHO Regional Office for Europe, 1996), drawing on the collective experience of cities, especially Copenhagen, Horsens, Liverpool, Poznan and Valladolid. The 1996 document shows the famous Parthenon to illustrate the essential pillars (components) of a city health plan. In a policy evaluation of 10 cities in 1998 at the end of the second phase, de Leeuw (de Leeuw, 1998) concluded that many cities invested ‘‘extensive strategic endeavour’’ and ‘‘at least eight cities (from 10) have moved health high on their political agendas through the requirement to produce a health plan’’.

The concept of CHDPs

Despite the investment in CHPs by EHCN cities, a series of business meetings towards the end of Phase II concluded that many were too limited in scope and strategic direction, often characterized by a focus on health education and disease prevention by the health sector (Tsouros, 1998). At the Jerusalem business meeting in 1997 it was therefore resolved that enhanced city health development plans would be required in the third phase. These CHDPs advance CHPs in two important respects.

First, CHDPs should go upstream to address the wider determinants of health, extending to the outer circle of general socioeconomic and environmental conditions addressed the Dahlgren and Whitehead model (Dahlgren, 1995). This is equivalent to Stage III in the evolutionary process described by Tsouros. Even 10 years earlier, it would have been a formidable challenge to provide city politicians with convincing evidence on how these upstream structures might be modified to improve health outcomes. By the third phase, evidence of the impact of these wider determinants of health was much more solid (Wilkinson and Marmot, 1998, 2003).

Second, CHDPs should relate to the development of other aspects of city life. During the planning process (‘an immense reward in itself’ for many cities (de Leeuw, 1998)), Healthy Cities coordinators and steering group representatives had made contact with representatives of other sectors and discovered that they also had their own priorities and plans. The CHDP should harmonize strategic plans at a city level, with health sometimes taking centre stage and sometimes figuring as part of another city or sector plan.

Plans may be harmonized in a trivial sense by ‘‘passive cross-referencing’’ or ‘‘cataloguing assorted contributions’’. Instead, WHO guidance on CHDPs (WHO Regional Office for Europe, 2001) recommends that ‘‘integration is an active process…taking into account the interdependence of the effects of sectoral policies and actions. It means recognizing and promoting the positive synergistic effect of actions for health with a view to achieving maximum impact’’. This is Stage V according to Tsouros, where ‘‘health and sustainable development become core values in city policies and long-term plans’’.

Agenda 21 influenced this formulation enormously. It brought the environmental sector to the fore as a key partner, but much more important was its contribution to the concept of sustainability. Discussions at the Healthy Cities business meetings in Maribor in 1996 and Gothenburg in 1997 led to the production of a key report City planning for health and sustainable development (WHO Regional Office for Europe, 1997b). Here, the linear model of health as an outcome is supplanted by the sustainable concept of health as integral to city development as a whole. The relationships between health, economy and environment are reciprocal and mutually reinforcing. An erosion of the physical environment will prejudice economic growth in the longer term, but then so will erosion in the health of a city’s population (WHO Regional Office for Europe, 2001). CHDP, as distinct from city health planning, deals in processes and synergy and not health outcomes alone.

Types of CHDP

This new formulation of city health development plans was put centre stage in the third phase of the WHO-EHCN, as a key requirement for designation (WHO Regional Office for Europe, 1997b).

Cities must produce and implement a city health development plan during the third phase, which builds on previous integrative city health planning and reflects the values, principles and objectives of health for all in the twenty-first century and Local Agenda 21; relevant national strategies; and local city-specific priorities. This plan must have clear long- and short-term aims and objectives and a system of how the city will monitor whether these objectives have been met.
EHCN cities were also required to sustain CHDP throughout Phase IV, revitalizing process and content by injecting new themes of HUP and healthy ageing (HA) and using the tool of health impact assessment (HIA).

Our analysis suggests three types of approach. First is a ‘classic’ model of city health development in WHO-EHCN cities. This (type I) is closest to the concept set out in the requirements for joining Phase III of the WHO-EHCN (WHO Regional Office for Europe, 1997c) and contains the essential elements of vision, integrative strategy and operational sector plans set out in WHO guidance on CHDP (WHO Regional Office for Europe, 2001). It is at the centre of attention for Healthy Cities projects, influenced by and in turn informing and influencing the policies and plans of other sectors and ultimately any overarching plan for the city. In this model (Fig. 1), the health status of the city as described in the initial city health profile, or the like, is improved via operational plans associated with the CHDP. The Healthy Cities project is a key catalyst in this process, and the CHDP gives strategic direction to interventions in key sectors.

‘Classic’ CHDPs were produced and endorsed by a third of the cities in Phase III and this had risen to a half during the first two years of Phase IV (Amadora, 1998; Siexal, 1998; Stoke on Trent, 1999; Vienna, 2000; Glasgow, 2001; Izhevsk, 2001; Jerusalem, 2001; Lodz, 2001; Belfast, 2002; Bursa, 2002; Copenhagen Health Department, 2000; Kuressaare, 2002; San Fernando, 2002; Zagreb, 2002; Udine, 2003). However, there are alternative approaches to this classic formulation, reflecting the realpolitik of each city—political priorities and technical capacity, timelines of competing or complementary plans.

A quarter of all cities reviewed took a sectoral (type II) approach, aiming to influence sector policies and plans rather than produce a single CHDP document. Members of the Healthy Cities project team (or steering group) negotiated bilateral agreements with competent agencies to include a health dimension in their plans. Often, the realpolitik of competing (and often compulsory) sector planning by powerful agencies limited a CHDP initiative. The Helsingborg steering group reported they had ‘decided not to begin work on the new plan, mainly due to the amount of ongoing work with other statutory plans such as the Environmental Plan, the Comprehensive Municipal Plan and the Labour Market Plan’ (Helsingborg Department of Planning, 2002). ‘Overshadowed’ by such competing plans, Gothenburg eventually decided not to apply for Phase IV of EHCN. In contrast, such was the enthusiasm of the urban planning department in Milan for a strategic health dimension to their plans and regeneration programmes, that in Phases III and IV their city planners led development of the HUP concept across the EHCN.

The remaining quarter of cities reviewed, adopted an ‘integrated’ or type III approach. This aims to embed a strong health dimension into a comprehensive city development plan. Such city development plans may be legally required or entered into voluntarily by cities. They generally include a vision for the city as a whole, a strategy for achieving it and sector

![Fig. 1: The dynamic of a ‘classic’ city health development plan.](image-url)
plans as building blocks. Here the Healthy Cities project seeks to influence the health dimension of the city plan, either via sector plans or by direct input. Such an approach may be regarded as potentially more powerful than a classic CHDP in influencing the direction of overall city development. For Sandnes politicians, the city ‘has proceeded logically in developing the city health development plan and the overarching plan in parallel, embedding the visionary and strategic element of the city health development plan into the municipal plan’. Their CHDP plan (Sandnes, 2003) is integrated into the municipal plan but also published as a stand alone document.

In Ireland and the United Kingdom, EHCN cities have gone with the flow of government policy which has encouraged strategic city partnerships (Local Strategic Partnerships in England) to produce comprehensive city development plans traditionally associated with Nordic countries. English cities tended to take a type III approach by devoting one of 5–10 chapters to health. However, the Healthy Cities vision and development approach was often subordinated to a health service perspective. For example, though the comprehensive plan for Manchester (Manchester Local Strategic Partnership, 2002) included health as one of the seven core themes, the emphasis was on health services and it failed to connect a wider conception of health with the other six themes.

Process
For many cities the process of CHDP was as important as the plan itself. The City of Stoke on Trent exemplified this position. Its CHDP was a powerful and strategic document, yet the city maintained that ‘The plan is not an end in itself but has to have a purpose . . . The process of developing the plan is more important than the actual end product’. When asked for the benefits of a CHDP approach, most (94%) cities cited the process of ‘Working together on a shared agenda for health’. Collaboration brought four specific benefits.

Highlighting determinants of health
For health to be regarded as ‘everyone’s business’, there has to be, according to Siexal, ‘awareness that health determinants concern every sector in the municipality and all sectors have their own responsibility to work with the issues in their own context’. Raising awareness is an iterative process, along a timeline from plan preparation to dissemination and action. This was expected because WHO guidance recommends that the steering group formulating the CHDP is drawn from those with responsibility for its implementation. On the preparatory phase, Horsens reported ‘The intersectoral cooperation and process leading to the plan is important in increasing a common language, understanding the broad concept of health, leading to common responsibility’ (Horsens City Council, 2001). Siexal is clear that involving the decision-makers, with leverage over the key determinants in the formulation of the plan, brings commitment to key interventions in the implementation phase. Their plan ‘is a document that gathers the consensus of the decision-makers around the main intervention areas and reflects the commitment of strategic partners towards the targets for health for all’. On the implementation phase Glasgow reported ‘The plan has begun to influence policy areas such as labour market work and housing regeneration that might not otherwise have attended so closely to their health dimension’.

Raising health on the agenda
Unlike the short-lived projects publicizing the Healthy Cities approach in Phase I, CHDPs were designed for endurance. Their rationale was placing health centre-stage in city decision-making for a 5 year planning period and beyond. On the whole, cities reported that the CHDP process was successful in first putting health higher on agendas of partner agencies or departments, and second, raising health up the corporate city agenda. Belfast said of the former ‘The key benefit of the approach we took within our city has been placing health on the agenda of sectors that would previously not have considered health as an issue within their plans’. At the corporate level, Sheffield reported success ‘in raising health up the agenda of the city’ and Maribor similarly reported ‘Through the city health development plan approach, the health and social part of the main plan was raised and gained a position that was respected in nearly all decisions during the process of elaboration’. A small proportion of cities acknowledged more effort was required to sustain the agenda through to delivery. Glasgow
reported ‘Our attempts to liaise with middle management could have been further intensified to improve the impact of the plan upon those who will principally deliver it’.

**Partnership and ownership**

The requirement to produce a CHDP in Phase III of the EHCN had a galvanizing effect on most city administrations. The decision to proceed was usually taken by municipal politicians in concert with institutional partners. Professionals from relevant sectors and disciplines then prepared supporting documents, consulted with the wider community and produced a draft plan. Partnerships formally considered the plan and endorsed a final version for ratification by the city council. Most cities reported wide ownership. Zagreb exemplified the position by claiming ‘the Plan was created by representatives of the City Council, health and social institutions, university faculties and schools, company owners, community associations and government organizations including the citizens as individuals’. Glasgow described how the process had created ‘a sense of organizational ownership from partner agencies’. This wider ownership is consistent with any formal requirement for the city council to endorse the document politically and legally. Indeed, the two aspects are mutually reinforcing. A formal council resolution of support can stagnate as a legalistic shell if it does not command wider support. On the other hand, broad support for a CHDP may fade without the resources a formal resolution can secure.

**Integration**

Type I CHDPs could be influential documents. Kuressare reported ‘The strategy is a legally binding document and influences all other plans’. However, most cities reflected on the difficulties posed by competing plans, willing to integrate their CHDP but concerned it might be unduly subordinated in both process and outcome. Evidently some could not compete and resorted to a type II approach of injecting a health dimension into these other plans, with varying degrees of success. Kuressare met the challenge of a dominant environmental agenda by embracing issues of health and sustainability in a single type I CHDP titled *Kuressare Health and Sustainable Development Strategy*. In cities adopting a type III approach of embedding the CHDP within the comprehensive plan of the city, there was more potential for influencing the strategic direction of the city, shaping the framework for operational plans and rebalancing budgets. This was a big prize, but few cities were able to grasp it fully. Izhevsk saw the potential ‘Ideally we would like to integrate the CHDP into the general plan of city development’ but struggled to deliver. Belfast exemplified the best, reporting ‘The CHDP process has been the first real attempt within Belfast to develop joined-up planning for health development. The concept of integrated planning for health development has now been embraced by the (provincial) Northern Ireland Regional Strategy, *Investing for Health*’ (Northern Ireland Executive, 2002).

**CONCLUSIONS**

A strong CHDP is based on principles of equity and a social model of health that locates the main determinants of health improvement in the socioeconomic and environmental sectors. Ideally structured to include a vision, a strategy and operational plans, it is a basic document for boosting confidence and conveying clarity of purpose in negotiations with the agencies that are already partners and those yet to be won over.

Evidence supplied for this evaluation indicates that, taken together, cities in the WHO-EHCN constitute a powerful force for health development at the level of strategic city planning, with the CHDP at the heart of development activity. Nearly every Healthy Cities project referred more positively to the concept and process than in the previous phases of the EHCN, with greater emphasis on intersectoral planning (and on intersectoral partnerships). Cities generally acknowledged that health plans must be integrated with other sector plans and, where it exists, with the comprehensive plan covering city development as a whole.

Cities often reported that development process was more important than the CHDP document itself, encouraging collaboration between municipal departments and with partner agencies around a common agenda for health. Recognition by WHO helped initiate and sustain this collaboration. The CHDP process also sharpened understanding of wider health determinants, encouraging more sector
partners to take responsibility for health improvements and giving health a higher profile on the corporate agendas of many cities. The process can be demanding of time and resources, but most cities would give it priority again, even if they were to modify their approach.

A measure of success is how lessons from Phase III informed CHDPs in Phase IV. EHCN cities addressed certain weaknesses, first with better accounting of the causal relationship between ‘upstream’ interventions and ‘downstream’ health outcomes, and second by elaborating the synergy between health and other policy domains. On the first, EHCN cities were required in Phase IV to undertake HIA. Usually undertaken in relation to a specific policy, programme or project, such cost–benefit analysis can be systematically imported into the planning process, giving more precision to one or more CHDP chapters. Ultimately, a series of HIAs could contribute to a broad-front approach that accounts more precisely for the relative prevalence and strength of various health determinants and the relative costs and benefits of various interventions.

Second, CHDPs and comprehensive city plans should properly acknowledge the synergy between sectors rather than passively cross-reference or catalogue assorted contributions, as many cities did in Phase III. In Phase IV cities systematically engaged in HUP which brought together new partners and added a powerful new spatial dimension to CHDPs. Yet, there is an assumption of a linear relationship between planning inputs and health outcomes. At their most advanced level, CHDPs should promote the reciprocal relationships between health and other domains in city development, especially the relationship between health and economy of interest to key decision-makers. As Deputy Mayor Krzysztof Panas wrote in his foreword to the Lodz city health development plan (Lodz, 2001), health is not simply an end in itself, but also ‘a resource for the community, guaranteeing its social and economic development’.

**REFERENCES**


**FUNDING**

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


Lodz Healthy City Project Office. (2001) *Directions of Actions for Health (English/Polish version)*. City of Lodz, Poland.


WHO Regional Office for Europe. (1994) *City Health Plans and City Health Planning*. WHO Regional Office for Europe, Copenhagen (ICP HCT 94 01 MT 06/7).


