

Healthy cities — WHO's New Public Health initiative

JOHN ASHTON

Senior Lecturer in Community Health, Liverpool University Medical School

PAULA GREY

Senior Registrar in Community Medicine, Liverpool Health Authority

KEITH BARNARD

Nuffield Centre for Health Service Studies, University of Leeds

SUMMARY

The World Health Organization's European Office has initiated a major new project known as "Healthy Cities". As a laboratory for the lifestyle targets agreed for Europe, the time seems right to support integrated approaches to health promotion at the city level. The city is often the lowest administrative level which can marshal the resources and has the political mandate and authority to develop and implement intersectoral approaches to health; because it is a place with which its citizens identify, there are good prospects for participation harnessed to neighbourhood or civic pride. Throughout the European Region at present there is evidence of a general renaissance of public health activity at this level and it seems appropriate for WHO to support and facilitate processes which are already under way.

The project will initially bring together ten or twelve European cities to collaborate in the implementation of intersectoral city health plans. In turn, these cities will take responsibility for supporting the development of further networks of cities which wish to participate in the project. WHO will provide technical expertise and generate a range of resource materials of value to the cities involved. In addition there will be a major collaborative European television series on the healthy city.

By concentrating on concrete examples of health promotion which include a commitment to community participation and intersectoral collaboration, it is expected that the Healthy Cities project will mark the point at which WHO philosophies and frameworks are taken off the shelves and into the streets of European cities.

That the city might be the most suitable focus upon which to build a new public health seems a reasonable proposition. In nineteenth century Europe and North America it was the cities which, when confronted by the epidemic diseases that ravaged undernourished populations living in squalid housing and environmental conditions, first responded to the challenge and created the foundations for a movement which spread throughout the world. (Chave, 1984).

That movement resulted in the establishment of municipal public health departments responsible for the implementation of public health legislation which covered a wide range of environmental issues and encompassed hygiene standards for food, water, sewage and housing.

The very successes of those involved paved the way for the ultimate near eclipse of this now traditional public health firstly by personal preventive medical services and latterly by therapeutics. It has been the growing disillusion with escalating costs and diminishing returns associated with the therapeutic era which has in part been responsible for the renewed interest in preventive medicine and health promotion.

In 1984 a conference entitled "Beyond Health Care" was held in Toronto (Beyond Health Care, 1985). The conference had its origins in a growing awareness of the need for "healthy public policy" initiatives as compared with the tendency towards victim-blaming lifestyle approaches to health promotion which had grown up in many

countries since the Lalonde report was published (Lalonde, 1974, Hancock, 1986). This conference provided the platform for the beginnings of a new synthesis bringing an ecological and holistic approach to health together with the World Health Organization Strategy of Health For All based on health promotion. According to WHO, health promotion is seen as a mediating process of enabling people through advocacy and empowerment to increase control over and to improve their health. (WHO, 1978, 1981, 1984; Kickbusch, 1985).

One implication of taking an ecological view of health is that human settlements are seen as habitats and as such provide a context for health promotion which might make sense in a very practical way. The healthy city as a context (Duhl, 1986) appears to make particular sense—by the year 2 000 the urban population of the world will exceed three billion people and almost half will live in cities with populations of over one million. The city is often the lowest administrative level which can marshal the resources and has the political mandate and authority to develop and implement multisectoral approaches to health, yet because it is a place with which its citizens identify, there are good prospects for participation harnessed to neighbourhood or civic pride. These perspectives seem to have been neglected during the 40 years in which hospital systems have become increasingly elaborated and increasingly remote from ordinary citizens.

THE HEALTHY CITY

The familiar trends of growth and decay in cities have occurred in parallel with dramatic changes in traditional social structures—the decline of the three-generation family and the changing status of marriage, redefinition of relations between the sexes and many changes in personal and social expectations. Cities as the stages upon which life is lived out have come to reflect the growing tensions among those individuals and groups that make up their populations. Traditional matters for concern—which include unemployment, housing, education, environmental and occupational health and disease—are still with us, in different and more subtle forms. Each of the traditional areas of public health needs to be re-examined with new perspectives derived from anthropology, sociology and behavioural and

political science; quality and aesthetics are now as important as quantity and function. The limitations of a mechanistic view of health which ignores these perspectives are now becoming apparent.

The nature of medical problems themselves has changed; infectious diseases have given way to heart disease, cancer and accidents as manifestations of an urban lifestyle which is increasingly seen to be out of step with those conditions under which the human species evolved. (McKeown, 1976) Underlying these lifestyle diseases are usually issues of local and national public policy.

THE HEALTHY CITIES PROJECT

The Healthy Cities project is a new European WHO initiative which is intended to lend support to city-based health promotion. The project has its origins in the World Health Organization Strategy of Health For All by the Year 2000 and is based on the 38 European targets for health for all. The European project is a collaborative one between the health promotion and environmental health sections of WHO. It has a particular emphasis on the promotion of healthy environments and lifestyles.

Each city is unique, with its own history, culture, strengths, weaknesses, resources and skills. By becoming aware of these and harnessing the positive processes to tackle the challenge of promoting good health, each city can contribute to its own region and country. By bringing together an initial network of ten or twelve European cities to collaborate in the implementation of intersectoral health promotion strategies, it is anticipated that, not only will the cities learn from each other, but that they will also play an important role in the dissemination of ideas and models which will spread out through the many other networks of collaborating cities which will become involved as the project proceeds.

By concentrating on concrete examples of health promotion which include a commitment to community participation and intersectoral collaboration it is expected that the Healthy Cities project will mark the point at which the WHO philosophies and frameworks are taken off the shelves and into the streets of European cities.

The Healthy Cities project will contain five major elements:

1. The formulation of concepts leading to the

adoption of city plans which are action-based.

2. The development of initiatives and processes as models of good practice. These will represent a variety of different entry-points into action to achieve a Healthy City.
3. The implementation and monitoring of models of good practice.
4. The dissemination of ideas and experiences between collaborating cities.
5. Mutual support, collaboration and learning between the cities of Europe.

The role of WHO in the project will be to act as a catalyst and facilitator in the process of agenda-setting, consciousness-raising and establishing models of good practice. (Ashton and Seymour, 1985)

THE FIRST STEPS: THE LISBON SYMPOSIUM ON HEALTHY CITIES, 1986

The first formal activity of the Healthy Cities project took place in Lisbon in April, 1986, when participants from 21 cities met to explore ideas about the healthy city and ways in which the project might most usefully develop. The Lisbon symposium was hosted by the three founding partners of the "Health for Lisbon" project: the municipality of Lisbon, the Lisbon Regional Health Administration and the city's social service organization, Santa Casa de Misericordia. This partnership represents an attempt to break out of rigidly defined organisational responsibilities and develop multisectoral initiatives in health promotion in the city of Lisbon.

The main theme of the symposium was to explore a new paradigm of health in the city—health as a social rather than a narrowly medical concept and to indicate those ways in which health in and of cities might be promoted and measured.

According to Hancock and Duhl, a healthy city is one that is continually creating and improving physical and social environments conducive to health and that creates and expands those community resources for health which enable people to support each other in performing all the functions of life and developing their maximum potential (Hancock and Duhl, 1986). The parameters of interest of such a city clearly range from traditional indicators of the physical environment and of mortality and morbidity into

much softer though no less important measurements which define culture, participation, intersectorality and mutual support. A provisional minimal data set of indicators for cities involved in the project is:

1. Extent of intersectoral collaboration and emphasis on healthy public policy.
2. Demography.
3. State of local economy, including unemployment levels.
4. Quality of the physical environment, including pollution; quality of the infrastructure and housing.
5. Quality of the social environment including levels of psychosocial stress and qualities of social support services and integration.
6. Traditional health indicators (mortality and morbidity).
7. New health promotion indicators e.g. participation in physical exercise, dietary habits.
8. Personal safety and social stability.
9. Aesthetics of the environment and quality of life.
10. Strength and style of cultural identity.
11. Appropriate education.
12. Extent of community power and participation; structures of governance.
13. Quality of health services.
14. Equity.

From the point of view of collaboration in data collection between cities, a common data-base will probably contain three categories of data—mandatory, recommended and optional.

As part of the process of encouraging fresh ways of looking at health in the city the Lisbon symposium began with a vision of a healthy city as a futures scenario for one of the most rapidly declining cities in Europe at the present time, Liverpool (Ashton, 1986). The contrasting visions of health in cities to be found among the symposium participants were then explored in the course of a field day spent on the streets of Lisbon before attempting the difficult process of reconciling the tension between imagination and realism which is the essence of planning. Although plans must be tempered by feasibility and resource availability, we must start by generating ideas—if we start with "realism" we will never have vision.

It is becoming clear that the WHO initiative has struck a chord with many people and has tuned into a process which is already underway. Of the cities involved in the Lisbon symposium, several had already begun to develop a practical inter-sectoral city health plan. Participants were aware of other cities which were treading the same path. What would seem to be of particular value at the present time would be a widespread sharing of plans, strategies and implementation experiences with health promotion initiatives based on the city.

Among those cities which are developing plans a great diversity of approaches is apparent; the variety of experiences which this will yield seems likely to be especially valuable in itself and cities may well wish to develop differing entry points into a healthy city strategy. Whereas it might be feasible for one city to have as an entry-point a city-wide anti-smoking programme and for another the systematic development of primary medical care and the shift to primary health care, others may have as a priority economic or community development initiatives which spill over into health programmes.

It is possible that in retrospect the Lisbon symposium will be seen to have been something of a watershed in the development of the New Public Health. The attraction of the Healthy Cities project to many of the participants was the prospect of sharing experiences and benefitting from the experience and ideas of others and of focussing on health promotion in a very concrete way.

The potential for other kinds of collaboration also became evident. There was considerable interest in building up collaboration between cities on the basis of existing twinning arrangements. The possibilities of youth exchanges in relation to job creation schemes and the twinning of schools attracted general interest. A special interest group of declining port cities declared itself during the course of the symposium.

There is a strong feeling that the crisis in cities throughout the world poses the possibility of real change at the present time. The challenge to cities which participate and become involved with the Healthy Cities project can be posed as a series of questions:

1. Can we exploit this opportunity?
 2. Can we initiate the dialogue which will help to legitimate the New Public Health, Health for All and Health Promotion?
 3. Can we shape the issues in terms which will make sense to others?
 4. Can we work with the media instead of fighting them?
 5. Can we interest health workers in talking with people and working in true partnership with them, rather than considering them beneath concern?
 6. Can we put on the public agenda the larger context of the city, its open spaces and villages and see it as the ecological context for health?
- What is concrete and practical will vary from city to city. There can be no central project prescription. Getting the balance right between vertical (selective) programmes and horizontal (integrated) ones may prove especially difficult.
- Against this backcloth, we should start to fashion the New Public Health. This will provide the tool to identify, analyse and respond to the collective needs of the healthy city and will sustain the resulting programmes. There is an urgent need to revive the historical advocacy function in public health through the re-legitimation of the principle that the health of the people must be safeguarded.
- It seems that in the new public health different styles are appropriate, compared with 100 years ago. The facilitators of the healthy city need to be catalysts and coaches rather than prescriptive bosses; politicians need to be enlisted in a commitment to this new style. There is every indication that many current politicians recognise the energy which can be released through harnessing participation and intersectoral collaboration to city pride. The seeding of concepts and models on the agendas of decision-makers will be a priority.

HEALTHY CITIES: THE NEXT STEPS

The immediate next steps of the Healthy Cities project will involve the establishment of a central group of ten to twelve committed European cities backed by local political will and funding. These cities will have fulfilled the following participation criteria:

1. Have local political commitment to the project.
2. Have produced a city health plan based on a community diagnosis which incorporates a commitment to participation and a multi-sectoral approach.

3. Have made a commitment to develop specific Healthy City entry-point strategies as concrete examples of good practice.
4. Have obtained the necessary funding to pursue the entry point strategies and implement the health plan.
5. Be willing to report back on agreed core indicators and on their experiences of implementation.
6. Have made a commitment to develop and work with a national network of other cities that wish to collaborate.

Within the first year of the project each participating city will have undertaken the following:-

1. Established an intersectoral Healthy Cities committee as a decision-taking committee of the municipality.
2. Established an intersectoral officer group to implement the city health plan.
3. Explored the possibility of appointing a health Ombudsperson to develop the health advocacy function and produced firm proposals for developing it at the city level.
4. Provided proof of some kind of public debate about the creation of a healthy city.
5. Established the agreed minimal data set.
6. Conducted a population survey of at least two population subgroups e.g. the unemployed, women, immigrants and ethnic minorities to assess their well-being and obtain true stories of their health risks.
7. Defined a clear set of research questions and integrated these with the activities of the relevant departments of local academic institutions.
8. Demonstrated dynamic working links with the local media.
9. Produced a review of public and private service health promotion activities within the city.
10. Demonstrated co-operation with the local museums, art galleries and theatres and supported the development of knowledge of public health history of the town in association with local schools and colleges.
11. Organised a forum of non-governmental organisations involved in health in the broadest sense to tackle a specific health issue.

12. Developed active working links with the other project cities hosting local meetings and encouraging technical and cultural exchange where appropriate.

In initiating action in these areas, it is expected that cities will demonstrate a commitment to making health promotion visible and credible and, through some short-term results, tangible. The structure that is envisaged for the project is rather like that of a flower with a central group of cities surrounded by an extended group of participating cities and further city networks. The whole will constitute a semi-open network with the free exchange of information and ideas to assist in the continent-wide process of developing action plans and strategies for Healthy Cities. Cities with specific expertise e.g. on drugs and young people will be regarded as a resource for the entire network of cities; sharing rather than competition will be essential.

The project will be backed up by a resource and coordinating centre at Liverpool University which will generate a range of materials of use to both collaborative and participating cities. These materials will include background papers, a resource pack, details of city health plans and model programmes, books, newsletters and reports. A central output will be a European collaborative television series on the healthy city produced in association with a major European television company.

In the immediate future there will be two workshops—one focussed on the indicators of a healthy city and the other on strategies. It is anticipated that as well as special interest workshops e.g. for politicians from collaborative cities and for the television teams involved in the film series, a variety of events will take place during the five years of the project's duration and that there will be one major conference each year.

The information and data provided by collaborating cities will provide the basis for collation and comparisons of indicators, strategies and true stories. It is through all of these activities in association with intersectoral city level action and public participation that WHO hopes to give a major thrust towards the realisation of the New Public Health.

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