Policy and practice

INTERSECTORAL ACTION, POLICY AND GOVERNANCE IN EUROPEAN HEALTHY CITIES

Evelyne de Leeuw[1,2]

[1] Centre for Health Equity Training Research & Evaluation CHETRE, University of New South Wales, Ingham Institute, Australia
[2] Glocal Health Consultants, Geelong, Australia

Corresponding author: Evelyne de Leeuw (email: evelyne@glocalhealthconsultants.com)

ABSTRACT

For the past three decades, the European Healthy Cities network has worked along principles of intersectoral action, policy and governance. This article presents an overview of the evidence, which is in turn grounded and contextualized in a brief review of intersectoral action and its relevant related concepts. The evaluations of the five five-year phases of European Healthy Cities to date show that local governments are increasingly and effectively managing intersectoral action, intersectoral policy and intersectoral governance. By reference to the insights provided by research into knowledge networks and the ways novel policies spread, i.e. "policy diffusion", the article concludes that Healthy Cities are likely to influence other local governments as well as higher levels of government to adopt effective intersectoral work.

Keywords: HEALTHY CITIES, GOVERNANCE, POLICY, INTERSECTORAL, EQUITY

BACKGROUND

The European Healthy Cities programme, led by the World Health Organization (WHO) Regional Office for Europe since 1986, is an example of policy innovation at the interface between global and local and thus is an example of true glocal health *(1)*. Since its initiation, the European Healthy Cities programme has pursued innovative policies and practices in areas such as the development of health profiles, local health plans, governance and intersectoral perspectives. Networks of Healthy Cities have been successfully established around the world with more than 10 000 local governments identifying themselves as Healthy Cities *(1)*. However, rigorous designation and accreditation protocols have been applied only in the WHO European Region.

Within Europe, the Healthy Cities programme is now in its sixth 5-year phase. Evaluations of each of the five preceding phases have looked beyond intersectoral action and also included areas such as healthy urban planning, participation and empowerment. This paper distils the evidence on effectiveness of intersectoral action, policy and governance from these evaluations.

CONTEXT

From the start of the programme, establishment of an intersectoral steering group to oversee local health development initiatives has been a requirement for designation as a European Healthy City. This stipulation reflected a wider acceptance of intersectoral perspectives as a mainstay of public health policy. Several terms to describe working together for better health have emerged over the last four decades. They include intersectoral and multisectoral action; partnerships and collaborations; Healthy Public Policy and Health in All Policies (HiAP); and various forms of governance.

The Declaration of Alma Ata on Primary Health Care, in 1978 *(2)* first formalized the urgent need for intersectoral approaches to health. Although the declaration received strong commitment and endorsement from the global public health community, this support has not necessarily led to evidence or effectiveness of intersectoral approaches in policy, governance and action. Arguably, "big words and grand ambitions" have actually impeded the simple – intersectoral – objectives of public health: to prevent disease, prolong life, promote health and reduce the health equity gap. In parallel, the scholarship around intersectorality has not yet crystallized into one coherent conceptual framework. Some see mutual engagement happening on a scale of networking–coordinating–cooperating–collaborating *(3)*, others through an isolation–encounter–communication–collaboration–integration scale *(4)*. Agencies, individuals, groups and communities may come together to act jointly on health concerns or determinants of health but this does not necessarily mean that these actions are driven by, or result in, policy.

A study commissioned by WHO for the launch of the final report of the Commission on Social Determinants of Health concluded that intersectoral action for health had generally proved to be the weakest of the strategies associated with Health for All *(5)*. Challenges had included: vertical boundaries between government sections; integrated programmes seen as a threat to sector-specific budgets, access to donors and functional autonomy; the weak position of health and environment sectors within many governments; few economic incentives to support integrated initiatives; and government priorities often defined by political expediency rather than rational analysis *(5)*. The review noted that intersectoral action for health failed in part precisely because many countries attempted to implement intersectoral action for health in isolation from interdependent and mutually reinforcing social and political factors *(5)*. An additional difficulty was that decision-makers in other sectors complained that health experts were often unable to provide quantitative evidence on the specific health impacts attributable to activities in non-health sectors such as housing, transport, education, food policy or industrial policy. Profound methodological uncertainty persisted about how to measure social conditions and processes and accurately evaluate their health effects. The problem was complicated both by the inherent complexity of such processes and by the frequent time-lag between the introduction of social policies and the observation of effects in population health *(5)*.

Some research suggests that achieving policy innovation, which is required for introducing systemic and sustainable intersectoral perspectives across society, cannot be achieved at the national level, or at that level alone. Policy diffusion researchers *(6)* argue that local governments drive policy innovation and diffusion of novel policies horizontally to other local governments and vertically to regional and national governments. For example, Healthy Public Policy formulation in the Netherlands in the 1980s failed at the national level but appeared effective at the local level *(7)*. However, global commitments, such as the Kyoto Protocol to the United Nations Framework Convention on Climate Change or the Framework Convention on Tobacco Control, can be seen as crucial benchmarks for the need to develop new policy types. Both the protocol and the framework have had very strong operational commitment from local governments but generally only rhetorical support at the national level; support at both levels is essential if the goals are to be met. Policy innovation does not happen exclusively in a bottom-up or top-down way but must be characterized as happening through a process called "mixed scanning" *(8, 9)* in which systems of incremental and reciprocal checks and balances between governance levels create opportunities for change.

APPROACH

As the European Healthy Cities programme has evolved, so too have the research methodologies employed to evaluate the phases *(10)*. Realist synthesis and evaluation were adopted for the evaluation of phase V of the European Healthy Cities programme (2009–2013) *(10, 11)*. Realist review has emerged as a strategy for synthesizing evidence and focuses on providing explanations for why interventions may or may not work, in what contexts, how and in what circumstances. The approach differs from traditional systematic reviews, which may provide evidence that certain interventions work but not under which parameters.

Realist synthesis explicitly recognizes the importance of unique local context and integrates existing

evidence on particular phenomena in the programme logic for both research and action *(10)*. The evaluation of phase V used a range of research instruments, including: a structured multiple case study approach; a comprehensive general evaluation questionnaire; data mining through existing databases; and analysis of management information generation tools used. Fig. 1 illustrates the programme logic of the phase V evaluation and outlines the stages and links between the elements of the European Healthy Cities process and how these were illuminated by the evidence generated. Critically, realist synthesis aims to describe and explain not only *that* something is present or absent (e.g. leadership for health, specific health promotion programmes or policies, actions on determinants of health or lifestyle modifications) but also *how* this presence or absence has come about. Thus the realist review of phase V explicitly interrogated the processes represented by the arrows in Fig. 1, the temporal dynamics and the programme logic. Full accounts of the analyses have been published elsewhere *(12)*; this paper summarizes the emerging evidence on intersectoral health perspectives in European Healthy Cities.

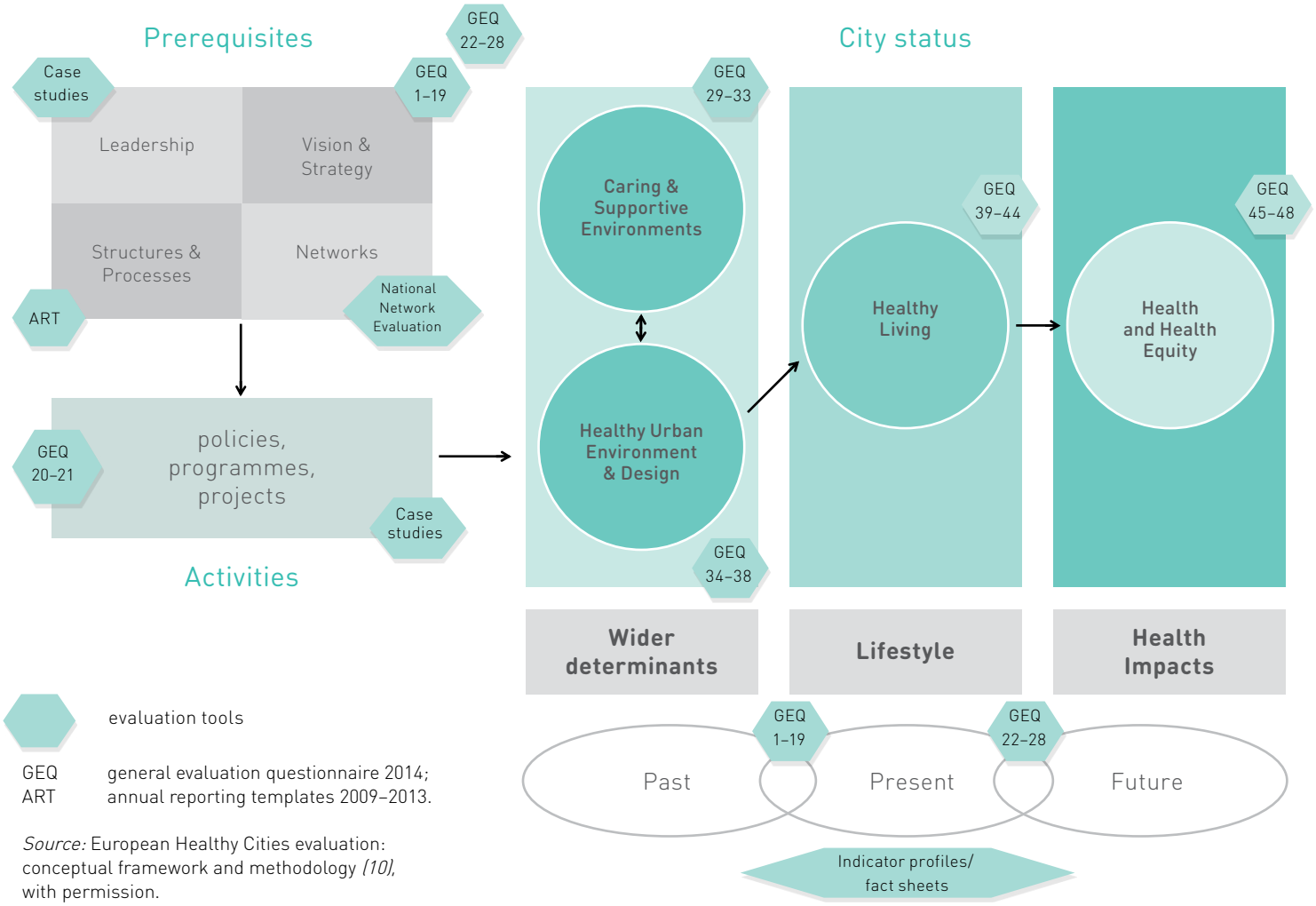
OBSERVATIONS

Three main concepts come under the generic banner of intersectorality in Healthy Cities – intersectoral governance, intersectoral action and intersectoral policy. These concepts have in part emerged from and been validated by Healthy Cities practice and continue to be pertinent to the development of Healthy Cities in Europe.

INTERSECTORALITY AND GOVERNANCE

Intersectoral governance can be defined as "the sum of the many ways individuals and institutions, public and private, manage the connections

FIG. 1. PROGRAMME LOGIC: PHASE V HEALTHY CITIES EVALUATION



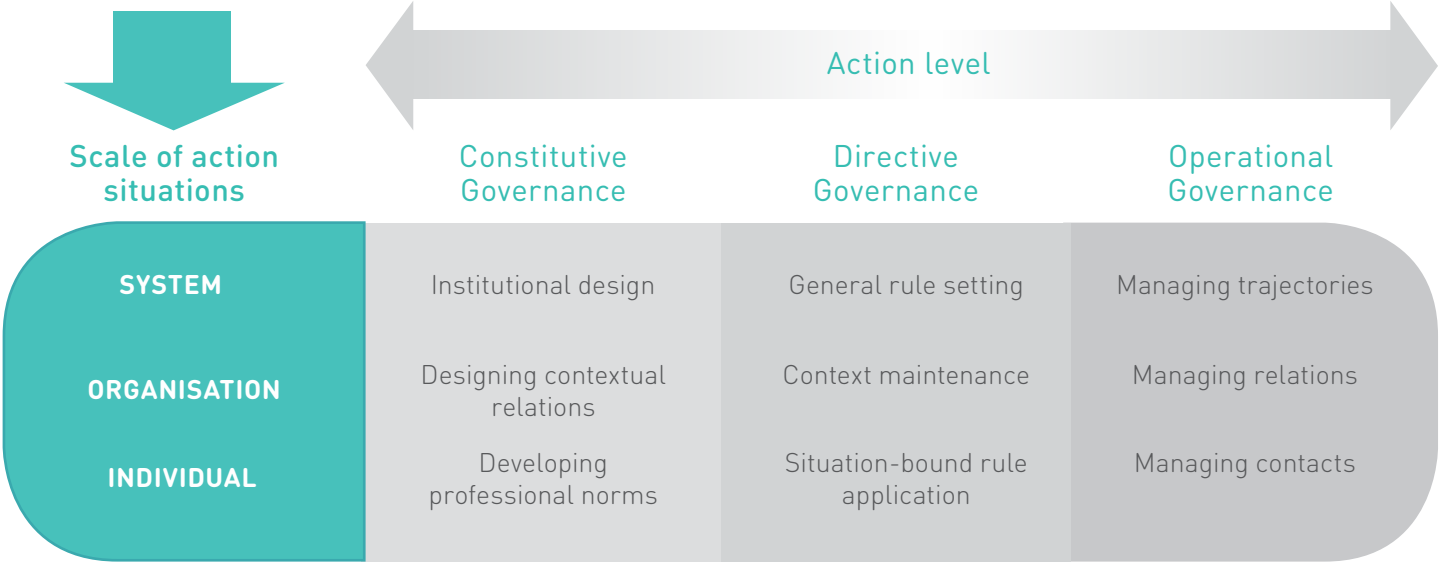
Source: European Healthy Cities evaluation: conceptual framework and methodology *(10)*, with permission.

of their common affairs. It is a continuing process through which conflicting or diverse interests may be accommodated and cooperative action may be taken. It includes formal institutions and regimes empowered to enforce compliance, as well as informal arrangements that people and institutions either have agreed to or perceive to be in their interest" *(13)*. From the early stages of the programme, a commitment to intersectoral governance has been a criterion for designation as a European Healthy City. From phase II onwards, cities needed to submit evidence that they established an intersectoral steering committee (ISC) that would oversee policy and intervention development *(14, 15)*. There are no specific requirements to the design or architecture of such ISCs, as this often is driven by unique local contexts and requirements. Whether cities lived up to the expectation beyond their formal application commitments was ascertained via annual reporting templates. Virtually all members of the network reported that they did establish an ISC, although the frequency with which this body met was variable. In some cities they met only once a year, in others more regularly, up to monthly. In cities where the ISC met annually, the role of the body was more at a systems and regulatory level, i.e. driving and approving policy development and monitoring of intersectoral deliverables, whereas ISCs that met more regularly tended to engage more directly in the operational aspects of partnership development, e.g. allocation of appropriate resources and direct supervision of working relationships.

Both the strategic and the operational aspects of intersectoral governance are important: more broadly, and applicable to all policy. In their multiple governance framework, Hill & Hupe *(16)* show these different dimensions of governance as complementary requirements for effective and transparent policy development and implementation (Fig. 2). Intersectoral governance moves between and encompasses an architecture in which implicit and explicit rules at a systems level ("institutional design" in Fig. 2) explicitly connect to the way in which individuals in collaborative processes manage their contacts (Fig. 2). Since Healthy Cities in Europe have been deliberately considered a natural laboratory of health policy innovation at the local level *(17)*, in hindsight it has been appropriate that the specific terms of reference of ISCs have never been spelt out in great detail. This flexibility has allowed the emergence of all types of governance, and an evolution of praxis in which these different levels and types of governance have been tried, tested and connected.

Regarding the actual architecture of intersectoral governance arrangements in Healthy Cities, all designated cities are required to have a coordinating office. Similar to the flexibility in terms of reference for the ISCs, WHO has not set specific expectations regarding the organizational positioning of this office. There has been an ongoing debate whether this coordinating body should be directly associated with the local government executive office i.e. a staff unit appended to the Mayor's office – (Fig. 3, model

FIG. 2. MULTIPLE GOVERNANCE FRAMEWORK



Source: Analysing policy processes as multiple governance: accountability in social policy *(17)*, with permission.

A), or a line unit at a relatively high hierarchical level able to coordinate efforts within government (Fig. 3, model B). Both models can serve a distinctive purpose, depending on the nature and maturity of the Healthy City. The evaluation of phase V revealed another type of governance architecture whereby Healthy Cities increasingly integrate and devolve the responsibility for intersectoral action for health throughout both the government and civil society *(9)*.

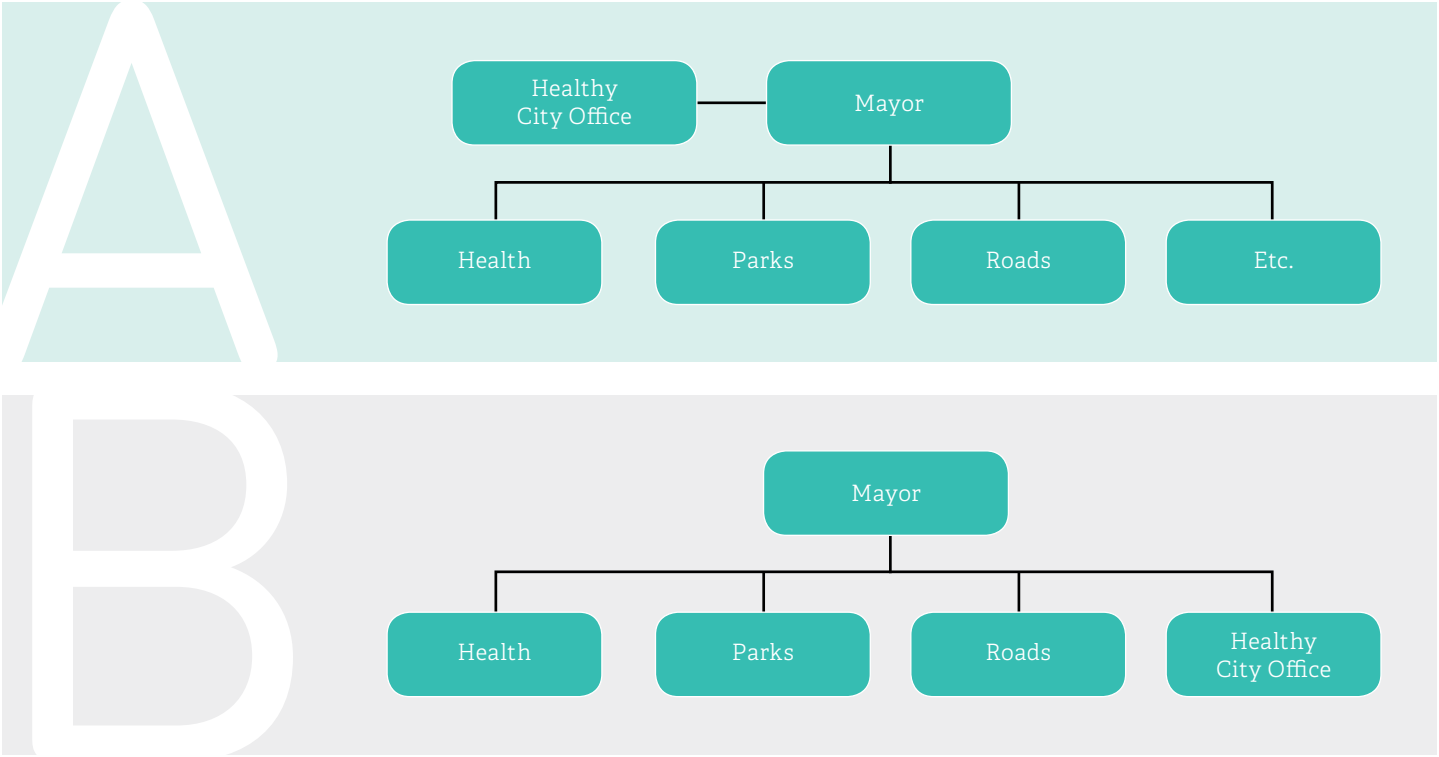
INTERSECTORALITY AND ACTION

Intersectoral action is the engagement of relevant sectors, both within and outside the public policy arena, in the implementation of activities, programmes and projects that have a multidimensional nature. Obesity, for instance, has lifestyle-choice dimensions but must also be addressed through structural interventions in the obesogenic environment *(18)*, such as in public transport, food security and community development. Ideally, this requires a policy and managerial context that embraces the values of HiAP described below and it is important that different sectoral stakeholders collaborate effectively.

Lipp, Winters and de Leeuw *(16)* show that from phase II through phase IV of the European Healthy Cities programme, intersectoral action has expanded and strengthened. For example, the 31 cities participating in both phase III and phase IV increased the extent of partnership working in all sectors studies: health services, social services, education, urban planning, voluntary, environmental protection, transport and economic development. For phase V, Farrington, Faskunger and Mackiewicz *(19)* show that Healthy Cities, in trying to address prevention of noncommunicable disease, also explicitly make concerted efforts to work intersectorally in distal determinants of health. European Healthy Cities, they find, recognize that to make healthier choices easier choices requires appropriate structuring of upstream determinants of health. For example, interventions in the built environment to make active living an easier choice included investment in city sports and exercise facilities, investment in cycling infrastructure and redesignating streets for pedestrians only.

Successive European Healthy Cities evaluations therefore show that local governments are not only embracing intersectoral work through the creation and maintenance of appropriate governance architectures, they are also increasingly deploying resources in terms of operational action to deal with complex problems in dynamic partnerships. The realist synthesis logic calls for the insertion of existing (systematic) evidence

FIG. 3. TWO MODELS FOR INTERSECTORAL GOVERNANCE IN HEALTHY CITIES



into new contextualized research. This research shows that, with the increase in upstream intersectoral governance arrangements, European local governments are addressing social determinants of health more appropriately. This in turn would arguably lead to greater effectiveness and sustainability in dealing with current health challenges.

INTERSECTORALITY AND POLICY

Thinking about intersectoral health policy has evolved over the years. The Ottawa Charter for Health Promotion identified the fact that public policies in virtually every sector may impact – positively or negatively – on health. This recognition led to the charter's call to "Build Healthy Public Policy", that is, the explicit recognition and attribution of health effects in each element of public policy, whether agriculture, transport, economy, justice, etc. The idea of Healthy Public Policy has evolved into HiAP. There are variations in definition of HiAP *(20)*, but globally there is agreement that they are, "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. It improves accountability of policy-makers for health impacts at all levels of policy-making. It includes an emphasis on the consequences of public policies on health systems, determinants of health and well-being" *(21)*.

Healthy Cities engage enthusiastically – and beyond mere rhetoric – in the development of health and health equity in all policies *(14)*. Building on a strong foundation in the various political statements on Healthy Cities over the years, most recently in the Athens Declaration *(22)*, local governments work with diverse stakeholders from the public and civil society sectors to develop such policies. In the Athens Declaration, mayors and senior political representatives of cities stated, "In an increasingly urban and interdependent world, we will step up leadership individually and collectively to make our cities healthy, safe, fair, inclusive, resilient and sustainable". The nearly three decades of Healthy City development are clearly leaving a legacy in that Healthy Cities manage the politics and logistics of interorganizational work effectively. This is clearly dependent on strong yet flexible governance arrangements and demonstrated commitments to the action component of intersectorality *(23)*.

In the evidence on intersectoral policy development and implementation compiled for European Healthy Cities *(24)*, there was an interesting mix between more traditional health approaches, such as a programme on active living in Izhevsk, Russian Federation, and initiatives where the health sector has more peripheral ownership, such as a programme on sustainability in Amaroussion, Greece. Details are provided elsewhere *(25)*. This is precisely the message for effective HiAP development – that the health sector has the capacity to share, redistribute and even disavow ownership of policy initiatives beyond its traditional remit. Healthy Cities show that such actions do not compromise but strengthen the integrity of health sector policy-making capacity.

LESSONS LEARNED

European Healthy Cities have made demonstrable progress in intersectoral action, policy and governance throughout the phases of the last decades. This progress can be attributed to strong yet flexible guidance from WHO and also from within the networks of Healthy Cities. This is a finding from earlier European Healthy City evaluations, e.g. in phase II for city networks *(25)* and for phase IV on epistemic communities *(14)*. Flexibility in the architecture and terms of reference of, for instance, ISCs and Healthy City Coordination Offices has allowed progress in highly diverse contexts across Europe. Considering the existing evidence on horizontal and vertical policy diffusion *(6)*, this innovation should spread through networks of local governments and "trickle up" to regional and national governments.

Further monitoring and research is required to track these developments and innovations still require rigorous assessment. HiAP development and implementation, locally, nationally and globally, needs to be supported by a strong conceptual foundation and appropriate methodologies *(26)*. The work to date, however, indicates that intersectoral action, policy and governance are possible and effective and affect glocal health. European Healthy Cities, and the work of the the WHO Regional Office for Europe in guiding their development, are a long-term evidence-generation programmes that continue to show that the challenges and limitations to intersectoral work can be overcome.

Acknowledgements: I stand on the shoulders of many giants in authoring this paper, notably the collaborators in phase IV and phase V evaluations who are listed as co-authors in *(11)*.
Sources of funding: Healthy Cities Evaluations have been supported financially by the WHO Regional Office for Europe and in-kind contributions from academic institutions and individuals across the world as per the affiliations in *(11)*.
Conflicts of interest: None declared.
Disclaimer: The author alone is responsible for the views expressed in this publication and they do not necessarily represent the decisions or policies of the World Health Organization.

REFERENCES

1. de Leeuw E. Global and local (glocal) health: the WHO healthy cities programme. Glob Change Hum Health. 2001;2(1):34–45. doi:http://dx.doi.org/10.1023/A:1011991014805.
2. Declaration of Alma-Ata, 1978 [website]. Copenhagen: WHO Regional Office for Europe; 2015 (http://www.euro.who.int/en/publications/policy-documents/declaration-of-alma-ata,-1978, accessed 27 July 2015).
3. The partnerships analysis tool: for partners in health promotion [website]. Melbourne: VicHealth; 2011 (https://www.vichealth.vic.gov.au/media-and-resources/publications/the-partnerships-analysis-tool, accessed 27 July 2015).
4. Hudson B, Hardy B. What is a 'successful' partnership and how can it be measured? In: Glendinning C, Powell M, Rummery K, editors. Partnerships, New Labour and the governance of welfare. Bristol: Policy Press; 2002:51–65.
5. Irwin A, Scali E. Action on the social determinants of health: learning from previous experiences. Social determinants of health discussion paper 1. Geneva: World Health Organization; 2010 (http://whqlibdoc.who.int/publications/2010/9789241500876_eng.pdf, accessed 27 July 2015).
6. Shipan CR, Volden C. The mechanisms of policy diffusion. Am J Pol Sci. 2008;52(4):840–57. doi:http://dx.doi.org/10.1111/j.1540-5907.2008.00346.x.
7. de Leeuw E, Polman L. Health policy making: the Dutch experience. Soc Sci Med. 1995;40(3):331–38. doi:http://dx.doi.org/10.1016/0277-9536(94)E0094-9.
8. Etzioni A. Mixed-scanning: a 'third' approach to decision-making. Public Adm Rev. 1967;27(5):385–92. doi:http://dx.doi.org/10.2307/973394.
9. Etzioni A. Mixed scanning revisited. Public Adm Rev. 1986;46(1):8–14. doi:http://dx.doi.org/10.2307/975437.
10. de Leeuw E, Green G, Dyakova M, Spanswick L, Palmer N. European Healthy Cities evaluation: conceptual framework and methodology. Health Promot Int. 2015;30(Supp1):i8–i17. doi:http://dx.doi.org/10.1093/heapro/dav036.
11. de Leeuw E, Green G, Tsouros A, Dyakova M, Farrington J, Faskunger J et al. Healthy Cities Phase V evaluation: further synthesizing realism. Health Promot Int. 2015;30(Supp1):i118–24. doi:http://dx.doi.org/10.1093/heapro/dav047.
12. de Leeuw, E, Tsouros A, Green G, editors. Intersectoral Governance for Health and Equity in European Cities – Healthy Cities in Europe. Health Promot Int. 2015;30(Supp1):i1–i125 (http://heapro.oxfordjournals.org/content/30/suppl_1.toc, accessed 31 July 2015).
13. Commission on Global Governance. Our global neighbourhood: the report. Oxford: Oxford University Press; 1995.
14. Heritage Z, Green G. European national healthy city networks: the impact of an elite epistemic community. J Urban Health. 2013;90(Suppl 1):154–66. doi:http://dx.doi.org/10.1007/s11524-012-9777-4.
15. Lipp A, Winters T, de Leeuw E. Evaluation of partnership working in cities in phase IV of the WHO Healthy Cities Network. J Urban Health. 2013;90(Suppl 1):37–51. doi:http://dx.doi.org/10.1007/s11524-011-9647-5.
16. Hill M, Hupe P. Analysing policy processes as multiple governance: accountability in social policy. Policy Polit. 2006;34(3):557–73. doi:http://dx.doi.org/10.1332/030557306777695280.
17. Tsouros AD. The WHO Healthy Cities Project: state of the art and future plans. Health Promot Int. 1995;10(2):133–41.
18. Kirk SF, Penney TL, McHugh TL. Characterizing the obesogenic environment: the state of the evidence with directions for future research. Obes Rev. 2010;11(2):109–17. doi:http://dx.doi.org/10.1111/j.1467-789X.2009.00611.x.
19. Farrington J, Faskunger J, Mackiewicz K. Evaluation of risk factor reduction in a European City Network. Health Promot Int. 2015;30(Supp1):i86–i98. doi:http://dx.doi.org/10.1093/heapro/dav038.
20. de Leeuw E. Health in All Policies: from the global to the local. Washington (DC): Pan American Health Organization; in press.
21. Tang KC, Ståhl T, Bettcher D, De Leeuw E. The Eighth Global Conference on Health Promotion: Health in all policies: from rhetoric to action. Health Promot Int.

2014; 29(Suppl 1):i1–i8. doi:http://dx.doi.org/10.1093/heapro/dau051.

22. Tsouros AD. Twenty-seven years of the WHO European Healthy Cities movement: a sustainable movement for change and innovation at the local level. Health Promot Int. 2015;30(Supp1):i3–i7. doi:http://dx.doi.org/10.1093/heapro/dav046.
23. McQueen D, Wismar M, Lin V, Jones CM. Health in All Policies, the social determinants of health and governance. In: McQueen D, Wismar M, Lin V, Jones CM, Davies M. Intersectoral governance for health in all policies: structures, actions and experiences. Copenhagen: World Health Organization Regional Office for Europe, 2012 (http://www.euro.who.int/__data/assets/pdf_file/0005/171707/Intersectoral-governance-for-health-in-all-policies.pdf, accessed 28 July 2015).
24. de Leeuw, E, Green, G, Spanswick, L, Palmer N. Policymaking in European healthy cities. Health Promot Int. 2015;30(Supp1):i18–i31. doi:http://dx.doi.org/10.1093/heapro/dav035.
25. Capello R. The city network paradigm: measuring urban network externalities. Urban Stud. 2000;37(11):1925–45. doi:http://dx.doi.org/10.1080/713707232.
26. de Leeuw E, Peters D. Nine questions to guide development and implementation of health in all policies. Health Promot Int. In press. doi:10.1093/heapro/dau034.