Policymaking in European healthy cities

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Summary

This paper assesses policy development in, with and for Healthy Cities in the European Region of the World Health Organization. Materials for the assessment were sourced through case studies, a questionnaire and statistical databases. They were compiled in a realist synthesis methodology, applying theory-based evaluation principles. Non-response analyses were applied to ascertain the degree of representatives of the high response rates for the entire network of Healthy Cities in Europe. Further measures of reliability and validity were applied, and it was found that our material was indicative of the entire network. European Healthy Cities are successful in developing local health policy across many sectors within and outside government. They were also successful in addressing ‘wicked’ problems around equity, governance and participation in themes such as Healthy Urban Planning. It appears that strong local leadership for policy change is driven by international collaboration and the stewardship of the World Health Organization. The processes enacted by WHO, structuring membership of the Healthy City Network (designation) and the guidance on particular themes, are identified as being important for the success of local policy development.

Key words: evaluation of healthy cities network, evidence-based health promotion, health politics, healthy public policy

INTRODUCTION

Throughout its existence, the European WHO network of Healthy Cities has been concerned with the development of policies for health. This perspective, certainly in the first decade of the ‘movement’, was more implicit than explicit. Strong pronouncements on the ‘qualities a Healthy Cities should strive to provide’ (Hancock and Duhl, 1986, Figure 1) suggest that these ideals cannot be attained through series of small-scale projects separated in time, space and scope. Rather, they need sustained and continuous long-term perspectives. This view was supported by the Ottawa Charter for Health Promotion call to build Healthy Public Policy and the evolving Healthy City call to ‘put health high on social and political agendas’.

The requirement, from Phase II on, to meet certain designation criteria supported by council decisions and resource allocation actually strengthened this policy scope. The strongest support for this evolutionary perspective may be found in the view that, throughout these Phases, WHO called on designated Healthy Cities to develop staged policy development processes. For instance, Phase II required the establishment of City Health Profiles, and based on these, City Health Development Plans would be developed from Phase III onwards. In Phase V, these requirements culminated in an overarching thematic perspective that cities should focus on the development of health and health equity in all policies. Such a view has been supported and sustained by a strong commitment
of WHO/EURO and its member states to develop Health in All Policies, initially driven by the Finnish Presidency of the European Union (in 2006), but ultimately integrated in the European Health 2020 strategy, and codified in the 2013 Helsinki Global Conference on Health Promotion which offered a strong statement on such policies and a framework on further action (De Leeuw et al., 2014b).

The methodological conceptualization of this study is presented in De Leeuw et al. (De Leeuw et al., 2015) in this volume. We interrogate the data collected through case studies and responses to the General Evaluation Questionnaire. Specifically, we are interested in assessing the following:

- Integration of policymaking in Healthy City practices
- Involvement and assessment of actors involved in the policy process
- Areas where policy is successfully and less successfully made
- Leadership for policy development and maintenance
- (Self-assessed) progress over time

- Determinants of policymaking and integration (e.g. city size, location, length of involvement, governance parameters, policy foci, etc.)
- Models of good practice

**CONCEPTUAL FRAMEWORK**

Elsewhere we have argued that policy evaluation, including of Healthy Cities, should not just be informed, but substantially driven by existing and validated theory (De Leeuw et al., 2014a). This position follows the assertion by Birckmayer and Weiss (Birckmayer and Weiss, 2000) that ‘Theory-Based Evaluation’ (TBE) adds value to evaluation practices and outcomes: the application of theory would move research beyond inventories of facts that things are happening towards analyses of why they are happening (Sanderson, 2002).

It seems important to delineate a few issues around the use and application of the expression ‘health policy’ in the
context of such a TBE and associated realist synthesis approach.

Policy is in itself a fuzzy concept for political science scholars, variably apprehended as ‘The actions of government and the intentions that determine those actions’ (Cochran, 1999), or rather ‘Whatever governments choose to do or choose not to do’ (McConnell, 2013). Some would simply see policy as ‘The Plan’, or ‘The Law’ (De Leeuw, 2007). Richards and Smith (Richards and Smith, 2008) say that ‘Policy’ is a general term usually used to describe a formal decision or plan of action adopted by an actor. . . to achieve a particular goal. . . ‘Public policy’ is a more specific term applied to a formal decision or a plan of action that has been taken by, or has involved, a state organisation. De Leeuw (De Leeuw, 2007) and Breton and De Leeuw (Breton and De Leeuw, 2011) follow a European tradition in political science that specifies public policy as ‘the expressed intent of government to allocate resources and capacities to resolve an expressly identified issue within a certain timeframe’. The latter clearly distinguishes between the policy issue, its resolution, and the tools or policy instruments that should be dedicated to attaining that resolution.

**Health policy** is possibly even fuzzier a term. It has been described unequivocally as ‘policy that aims to impact positively on population health’ (De Leeuw, 1989) and has been framed as equivalent to ‘healthy public policy’ (Milio, 1981). Milio (Milio, 2001) later developed a glossary in which she states that ‘Healthy public policies improve the conditions under which people live: secure, safe, adequate, and sustainable livelihoods, lifestyles and environments, including housing, education, nutrition, information exchange, child care, transportation, and necessary community and personal social and health services. Policy adequacy may be measured by its impact on population health’. More recently, healthy public policies reincarnated as Health in All Policies (Ståhl et al., 2006; Rudolph et al., 2013): ‘a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas’. Variations on this theme have been compiled by Rudolph et al. (Rudolph et al., 2013) (Table 1):

‘Health policy’, thus, is both Healthy Public Policy and Health in All Policy, and may include *public health policy* and *health care policy*. Public health policy can be conceived either as public sector (government) policy for population health (*public health policy*) or any policy (including corporate and other civil society approaches) concerned with the public’s health (*public health policy*).

In our evaluation of Phase III of the European Healthy Cities network and in similar work done in Canadian Healthy Cities and Villages (O’Neill et al., 1990) we found, in fact, that saying ‘health’ to communities and local government results in *hearing* ‘health care’, thus leading to the unwarranted involvement of (clinical) healthcare personnel in attempting to address determinants of health that transcend their professional remit. In analysing the impact and outcome of health policy, therefore, any scholar should conscientiously delineate what s/he (i) considers ‘policy’ to be and (ii) considers as the scope of ‘health’. In particular in relation to community action and participation in health, this is challenging, as Putland et al. (Putland et al., 2011) demonstrate. This has consequences for the policy and political nature of health literacy (Kickbusch et al., 2010).

**POLITICAL THEORY ON POLICY DEVELOPMENT**

Studying health policy requires an understanding of its development process. This is particularly important if we

<table>
<thead>
<tr>
<th>Table 1: HiAP definitions (Rudolph et al., 2013)</th>
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<tbody>
<tr>
<td>‘Health in All Policies is a collaborative approach that integrates and articulates health considerations into policy making across sectors, and at all levels, to improve the health of all communities and people.’—US Association of State and Territorial Health Officers (ASTHO).</td>
</tr>
<tr>
<td>‘Health in All Policies is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas.’—California Health in All Policies Task Force.</td>
</tr>
<tr>
<td>‘Health in All Policies is the policy practice of including, integrating or internalizing health in other policies that shape or influence the [Social Determinants of Health (SDoH)]. . . Health in All Policies is a policy practice adopted by leaders and policy makers to integrate consideration of health, well-being and equity during the development, implementation and evaluation of policies.’—European Observatory on Health Systems and Policies.</td>
</tr>
<tr>
<td>‘Health in All Policies is an innovative, systems change approach to the processes through which policies are created and implemented.’—National Association of County and City Health Officials (NACCHO).</td>
</tr>
<tr>
<td>‘Health in All Policies aims to improve the health of the population through increasing the positive impacts of policy initiatives across all sectors of government and at the same time contributing to the achievement of other sectors’ core goals.’—South Australia</td>
</tr>
</tbody>
</table>
want to impact on the direction of policy and its framed health objectives. The application of political theory would enable an appreciation of the range of stakeholders and determinants of policy choice. Mackenbach (Mackenbach, 2014) recently called for the further development of a ‘political epidemiology’ identifying the causal effects of political variables (structures, processes, outputs) on population health. In fact, the political sciences have developed a powerful toolbox of theories of the policy process framing these political variables (Sabatier, 2007) with recent updates by Nowlin, 2011 and Schlager and Weible, 2013.

Theories that have been tried and tested are the event-driven Multiple Streams Theory empirically developed by John Kingdon (2002); the Punctuated Equilibrium framework by Baumgartner and Jones (Baumgartner and Jones, 1993) in which long periods of policy stability are alternated by general shifts in policy perspectives and ambitions; the Advocacy Coalition Framework (Sabatier, 1988; Sabatier and Jenkins-Smith, 1993) that emphasizes the importance of coalition formation of camps of proponents and opponents to new policy directions; and the Policy Domains approach coming from different perspectives on network governance (Laumann and Knoke, 1987, Börzel, 1998). Other theoretical frameworks that seem applicable are Social Movement theory (McCarthy and Zald, 1977) arguing that disenchanted people will join social movements to mobilize resources and political opportunity to change public policy to their advantage; neo-corporatism (Olson, 1986) advocating that (semi-)political organizations in the social environment can play corporate roles to maximize competitiveness, and a host of hybrid approaches that mix these perspectives or address specific processes such as coalition structuring (Breton et al., 2008).

In the Phase V data collection efforts, we explicitly asked process and progress questions, both in case study templates as well as in GEQ questions. In both the strategic as well as thematic case study templates for which Healthy City coordinators received extensive briefings, we asked the following questions that would map relevant TBE factors:

(i) Is this case study describing a project, programme, or policy?
(ii) Describe the problem or situation before you started taking action
(iii) Describe what prompted you to start taking action: What happened? Describe the people and/or agencies that the action was targeting; provide time frame (try to list specific dates); in what locality, community or environment did the activity take place?
(iv) Who was and became involved? List people, communities, agencies that were involved and how their involvement might have changed over time:
(v) Why did you do what you did. ‘Healthy Cities’ are about the adoption of new ways of dealing with health. We would like to know what options for action you may have considered; tell us why you chose to do one thing and not another, if you could.
(vi) Did you consider any evidence in starting the activity, and did you collect evidence that your activity made a difference? Please specify.
(vii) What did you learn?
(viii) Are there any further details you wish to provide?
(ix) What could you do better next time or approach differently? Would you recommend this kind of work to other Healthy Cities?

These questions were designed to elicit responses pertinent to testing research questions stemming from Kingdon’s Multiple Streams theory and Sabatier and Jenkins-Smith’s Advocacy Coalition theory. They would identify actors in local government area health policy, problem and politics streams and actions taken by them to develop and implement policy different from ‘business-as-usual’ action. In doing so, the analyses would contribute to our understanding of local dynamics (e.g. coalition building, advocacy, policy entrepreneurship, etc.) that lead to Healthy City policy development in a context that presumably makes Healthy Cities different from other urban or local government authority areas.

DATA COLLECTION, MANAGEMENT AND ANALYSIS

Elsewhere in the supplement a full account is provided of the methodological considerations on data collection and management (De Leeuw et al., 2015). The original case-study template questions presented above were pre-tested with members of the Phase V Evaluation Team and selected Healthy City coordinators and adapted to address purpose and clarity. At the last Phase V Business Meeting in Izmir (20–22 June 2013) five compulsory workshops were organized for coordinators in which further testing, feedback and explanation were addressed, where relevant in languages other than English, the working language of the Network (notably in French and Russian). All coordinators present at the conference attended.

Response rates to the different research tools were, certainly considering the type of research undertaken, excellent (Table 2). We undertook (non-)response analyses (cf. below) to ascertain whether data were representative of the entire research population.

All data collected through Annual Reporting Templates, General Evaluation Questionnaires and case studies were coded in NVIVO (cf. Bazeley and Jackson, 2013).
Table 2: Response rates to three data collection tools (%)

<table>
<thead>
<tr>
<th>Annual reporting template</th>
<th>General evaluation questionnaire</th>
<th>Case studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>87</td>
<td>Thematic 67</td>
</tr>
<tr>
<td>2011</td>
<td>79</td>
<td>72</td>
</tr>
<tr>
<td>2012</td>
<td>67</td>
<td>Strategic 69</td>
</tr>
<tr>
<td>2013</td>
<td>72</td>
<td></td>
</tr>
</tbody>
</table>

Supplementary data were made available from the collection of ‘designation documents’ (the portfolios that applicant cities provided for assessment to the European Regional Office of WHO), but these were not systematically included in analyses.

**FINDINGS—CITY REPRESENTATIONS IN POLICY**

There is a small but substantial body of literature that emphasizes (i) the power of local government in policy innovation and (ii) the size of local government as an important variable in the capacity for policy innovation (Shipan and Volden, 2006, 2008). Especially in adoption of tobacco or health policies, local governments are often ahead of higher levels of government and governance, and bigger cities tend to adopt such policies first with smaller cities subsequently feeling enabled to imitate and adopt similar decisions.

City size and decision-making culture have also been found to be critical variables in the effective engagement of the public in policy development (Irvin and Stansbury, 2004). This makes 2 of the 11 qualities a Healthy City should strive to attain (‘A strong, mutually supportive and non-exploitative community’ and ‘A high degree of public participation in and control over the decisions affecting one’s life, health and well-being’) not merely value-based statements of principle and belief, but an evidence-based policy pronouncement. These findings could therefore be inserted into the realist synthesis causality chain.

In assessing policy case study responses, it was therefore necessary to look at the nature of the respondent cities. In Figure 2, we represent the number of policy case studies submitted by cities; in some cases, cities submitted more than one, and therefore, the numbers in Figure 3 do not equal the number of cities, but the number of policy initiatives. It does not appear that smaller or mid-size cities are better equipped to engage in policy development than others. What is remarkable, though, is the fact that cities from ‘New Europe’ and ‘New Independent States’ seem more inclined to work towards policy development than others (for further information on geopolitical classifications of Healthy Cities, refer to the methodology paper in the Supplement, cf. De Leeuw et al., 2015).

It is clear that cities larger than 100,000 population engage in policymaking more than smaller cities, which confirms the Shipan and Volden postulate and should bode well for further policy diffusion to smaller cities.

For all case study submissions, 115 came from ‘old’ cities (designated for the first time before Phase V), and 43 from ‘new’ ones (Table 3). Within these case studies, 38 policy studies came from ‘old’ cities, and 15 from ‘new’ ones. This does not seem to confirm our suspicion that ‘old’ cities would be more keen to engage in policy development as the distribution is similar. However, in the following, we will explore some of this further.

We would expect that longer involvement in the project would predict more policy orientation, considering the logic proposition that cities progress from smaller ad hoc projects to more integrated longer term programmes and ultimately systemic policy approaches. This seems to be confirmed here, in particular for cities from ‘New Europe’ and the ‘New Independent States’. In particular for NIS, we see that only cities that have been involved in the project for a longer time have submitted policy case studies.

On the other hand, we also see that smaller cities that more recently joined, both in OECD and in Mediterranean regions, seem to engage enthusiastically with the call for policy development that is part of the Healthy City Phase V requirements.

In summary, larger Healthy Cities adopt policy development perspectives more often than smaller Healthy Cities, and the longer a city is a designated member of the Network, the more policy initiatives are found. This is a strong suggestion that the Regional Office of WHO has policy impact on local practices. Of course such an assertion can only be confirmed decisively through larger comparative studies between matched sets of local authority areas, but within our realist synthesis programme logic, we are confident that the value base WHO brings to local health policy development has impact.

**ARE HEALTHY CITIES DIFFERENT?**

In reviewing the toolbox of impact and outcome evaluations, Stern et al. (Stern et al., 2012) suggest that the research endeavour needs to be more responsive to (local) policy and practice realities. Rather than letting academics run an esoteric set of methods imposed on unsuspecting subjects, they claim that asking specific questions how an intervention or activity has made a difference is more
We interrogated the policy case studies submitted and asked whether the policy action generated strategic differences and for whom (Figure 3). Responses fell into four categories, identifying differences (a) to the health status or health experience of communities; (b) for including actions on social determinants of health in policy decisions; (c) for the way in which the local government apparatus deals with health (equity) and well-being; and (d) for the engagement of stakeholders in policy development and implementation.

These four identified areas are equally distributed. Considering the explicit aims of the WHO project, especially in light of its Health 2020 strategy, it is critical to see that respondents perceive strategic differences in the Social Determinants and Stakeholder involvement categories.

We were also interested to know in what thematic areas cities report policy development (Figure 4). This happens in all four areas of thematic action driven by the designation process. Predictably, the Healthy Living area receives quite a bit of policy development as this is a ‘traditional’ area of concern for health authorities (see also Farrington et al., 2015).

As we can see from Tables 5–8, this development is particularly gratifying as most reported lifestyle policy
development aims for changes in the determinants of healthy choices, rather than using the orthodox behaviourist approach that would aim to change individual behaviour through communicative action.

**ACTORS AND THE POLICY AGENDA**

An important tenet of Healthy Cities from very early on in the movement has been to ‘... put health high on social and political agendas’ (Tsouros, 1994). Policymaking is one way of accomplishing this. We are therefore interested in mapping actors in Healthy City policy processes and evaluating who initiates that development in collaboration with which local and higher governance-level actors. In doing this, we need to acknowledge, as De Leeuw and Skovgaard (De Leeuw and Skovgaard, 2005) have done before, that it may well be possible that a large part of this policy development dynamic falls before the time scale of our evaluation: the designation process in the European Region requires cities to submit Council statements on their aspirations and pertinent resource allocations, and this means that local political agendas (and possibly social agendas, too) may already have been prompted towards shifting the status quo in many cities.

It would be a valid postulate, then, to suggest in line with Kingdon’s Multiple Streams approach (2002) that existing policies, problems and politics have in fact created a ‘designation window of opportunity’ upon which local government can build further opportunities for Healthy City policies and programmes. This seems to be confirmed by our findings in regard to the question ‘Who has initiated the policy?’ that cities are reporting on (Figure 5).

In the vast majority of cases, policy change is initiated within the formal political structure of the city (including the bureaucracy and Council). In ∼20% of cases, policy initiation comes as a result of external pressure on the political system, and only 5% is acknowledged to be stirred by organized community action.

The fact that existing formal political structure is engaged with Healthy City policy initiation does not, however, mean that further policy development is limited to the internal apparatus of government. Figure 6 shows the impressive array of stakeholder types involved in further policy development and implementation. Clearly, considerable work is done within municipal departments, but they do not drive the process single-handedly or uniquely. Whether this constitute fully fledged Health in All Policies, however, is another matter.

In interpreting the findings, we also needed to analyse whether certain types of cities were over- or under-represented in certain policy focus areas. In Table 9, we represent city policy case study responses. We have looked at the strategic area the policy endeavours cover (equity, governance, leadership, participation, partnership, and policy—the latter being the endeavour to invest in policy

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**Table 3:** Distribution of policy case study responses by city size and geopolitical grouping

<table>
<thead>
<tr>
<th>Region</th>
<th>Population</th>
<th>City active &lt; Phase V</th>
<th>City active &gt; Phase V</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;50 000</td>
<td>50 000–99 999</td>
<td>&gt;100 000</td>
</tr>
<tr>
<td>OECD</td>
<td>4</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Mediterranean</td>
<td>1</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>New Europe</td>
<td>1</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>NIS</td>
<td>5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Table 4:** Four key questions in impact evaluation based on Stern et al. (2012)

1. To what extent can a specific (net) impact be attributed to the intervention?
2. Did the intervention make a difference?
3. How has the intervention made a difference?
4. Will the intervention work elsewhere?

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Fig. 4: In what thematic designation areas is policy developed?
capacity; not actual policy making). In the table, between brackets, we list the total number of case studies, e.g. for ‘Equity’, 52 case studies were submitted, of which 16 had a policy focus. For each of these strategic area rows, we then looked at the distribution of those policy cases between the different classes of cities, by time of designation, geopolitical classification and city population size. For instance, 13 cities first designated before Phase V submitted equity policy case studies versus 3 cities only first designated in Phase V. These numbers are then related to the total number of cases, e.g. the 13 equity policy cases were part of a total of 40 cases focusing on any equity effort. We then calculated the percentage and colour coded these for surveyability reasons. No clear patterns emerge, although Central and Eastern European cities (NIS and New Europe) and mid-sized cities seem to be slightly overrepresented in policy cases.

Our interpretation of these data, again, is that the material collected and analysed for policy development in European Healthy Cities is representative of the entire cohort.

**POLICY CAPACITY**

An indication of the fact that Healthy Cities is becoming a mainstream policy concern, and is that in only roughly
one-third of the cities the Healthy City Office was considered to have involvement \((n = 21, \text{ out of } n = 58)\). This means that in two-thirds of policy initiatives the Healthy City office did not play a major policy role. In our view, this means two things:

(a) Healthy City leadership is often distributed across local government and beyond the formally identified core operating agent—which is excellent as it indicates a stronger policy focus.

(b) This might suggest that the idea that Healthy Cities always need a formal focal point may need to be rethought. Conditions for this to happen would indeed be found in strong leadership for health and permanent and sustainable governance structures for health.

However, when we look at the policy capacity of the Healthy City office alone, we cannot discern a radically different pattern in collaborators and involvement than we see overall. This means that in many cities the
Healthy City office is the expression of political leadership for health: the office and its coordinator are used specifically as the extension of the political arm of the Healthy City, directly engaging in health, equity and social change.

Perhaps within the Healthy City programme, we see the emergence of two different organizational principles, one in which a dedicated agent (the ‘Healthy City Office’) organizes and maintains momentum (in about one-third of cases—Figure 7), and one (in the remainder two-thirds) where Healthy City capacity is dispersed across the city and driven by strong local political commitment and leadership (Figure 6). Both models seem to have their advantages and downsides. Strong political drive could dissipate with electoral shifts, and the delegation of policy matters to one ‘office’ could easily lead to projectism (Goumans and Springett, 1997).

**HEALTH (EQUITY) IN ALL (LOCAL) POLICIES**

We also asked explicitly whether cities could submit case material on Health in All Policies (HiAP). Forty-eight case studies were received—again, this is an exceptionally good result for a policy type that was only relatively recently formalized. We should bear in mind, however, that many WHO member states have a considerable experience (for better or for worse) in related areas such as ‘Joined-Up Government’, ‘Whole of Government’ approaches, ‘horizontal government’, etc. The UK Health Action Zones of the past are one such well-documented initiative. It has also been suggested in the political science literature that local governments face less challenges in developing such integrated models of policy development and implementation (Shipan and Volden, 2008; Carey et al., 2014).

Health in All Policies typically address complex or ‘wicked’ problems that cannot be resolved by one sector.
### Table 9: Strategic areas in which policy action has been undertaken by city characteristic variables (designation, region and population)

<table>
<thead>
<tr>
<th>Strategic Area (total no. of case studies)</th>
<th>Designated in:</th>
<th>Region</th>
<th>City population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;Phase V</td>
<td>Phase V</td>
<td>&lt;50000</td>
</tr>
<tr>
<td>Equity (52 CS)</td>
<td>13 (40)</td>
<td>3 (12)</td>
<td>1 (1)</td>
</tr>
<tr>
<td></td>
<td>32.5%</td>
<td>25%</td>
<td>100%</td>
</tr>
<tr>
<td>Governance (66 CS)</td>
<td>23 (46)</td>
<td>8 (20)</td>
<td>2 (3)</td>
</tr>
<tr>
<td></td>
<td>50%</td>
<td>40%</td>
<td>66.6%</td>
</tr>
<tr>
<td>Leadership (55 CS)</td>
<td>24 (41)</td>
<td>1 (14)</td>
<td>3 (4)</td>
</tr>
<tr>
<td></td>
<td>58.5%</td>
<td>7.1%</td>
<td>75%</td>
</tr>
<tr>
<td>Participation (64 CS)</td>
<td>17 (46)</td>
<td>6 (18)</td>
<td>1 (2)</td>
</tr>
<tr>
<td></td>
<td>37%</td>
<td>33.3%</td>
<td>50%</td>
</tr>
<tr>
<td>Partnership (113 CS)</td>
<td>30 (82)</td>
<td>12 (31)</td>
<td>3 (5)</td>
</tr>
<tr>
<td></td>
<td>36.6%</td>
<td>38.7%</td>
<td>60%</td>
</tr>
<tr>
<td>Policy (65 CS)</td>
<td>27 (44)</td>
<td>9 (21)</td>
<td>4 (5)</td>
</tr>
<tr>
<td></td>
<td>61.4%</td>
<td>42.9%</td>
<td>80%</td>
</tr>
</tbody>
</table>

Numbers between (brackets) indicate total number of case studies for that cell, percentages-specific case studies as a percentage of the total.

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**Fig. 7:** The Healthy City office as a vehicle to involve and interface with other sectors: liaisons between the Healthy City office and others.
alone (Harris and Harris-Roxas, 2010). From the above, we have seen that many policy initiatives already aim to work with sectors other than health. In our assessment, we are looking at broad areas in which cities report the development of HiAP. 

If we look at the thematic areas dictated by the designation processes, several areas lend themselves more ‘naturally’ to HiAP development, such as healthy urban design, and environments for health. In our response rates to the HiAP question below (Figure 8), we see that indeed, these areas occupy roughly two-thirds (29 out of 48, or 60.5%) of reported efforts. Interestingly, though, the more ‘traditional health sector’ policy area of ‘Healthy Living’ sees a strong HiAP development (39.5% of reported HiAP instances) effort which suggests that cities more profoundly seek a social and political determinants approach to these issues.

CONCLUSION

European Healthy Cities claim to make a difference in making new types of policies (including policy network and Health in All Policy efforts), and our evaluation substantiates these claims. Being part of the Healthy Cities network has indeed put health high on social and political agendas. In line with the strategic health directions for the European Region of WHO (WHO/EURO, 2013), cities have adopted comprehensive, multi-sectoral approaches to local health policy development across different geopolitical groupings and city populations.

Cities also claim to make a difference in stakeholder involvement in local health policy development. We have mapped impressive arrays of diversity in policy development and implementation, but not in wide intersectoral involvement in policy initiation. This requires further investigation.

The process involved in designation as a Healthy City appears to effectively set the stage for local leadership in health policy development across a range of thematic and strategic areas, with good policy investment both in ‘old’ (lifestyle programmes; public participation in health) as well as ‘new’ (equity and governance for health) priorities.

Mid-size cities (with populations between 50,000 and 99,000) seem to be slightly more switched on in policy development than smaller and larger cities, but those cities are also clearly committed to novel forms and foci of health policy development. Further inquiry seems to be prudent into any patterns of policy diffusion, also building on earlier work in elite epistemic communities in the Healthy City arena (Heritage and Green, 2013).

We have found different patterns in how local diversity in Healthy City organization drives this policy development. In some cities, integral whole-of-government political approaches are taken with the Healthy City Office being the operational arm of intersectoral action. In other cities, the Healthy City Office is considered an important political actor for this endeavour in its own right.

Limited resources have impacted on our capacity to engage in a full Theory-Based Evaluation endeavour. One factor that quite substantially hampers our theory-based evaluation of responses is found in the enormous diversity in city qualities and starting points for policy action. Future research and evaluation efforts of (European) Healthy Cities should not only use theory-based evaluation parameters within a strong realist synthesis methodology, but should be resourced more comprehensively.

Limitations to this study may include issues of bias related to the source of responses to case studies and General Evaluation Questionnaire—these have been prepared by local Healthy City Coordinators (often under guidance from their local politicians) and they will obviously have a vested interest in highlighting good news and—possibly—obscuring bad news. In the methodology paper in this Supplement (De Leeuw et al., 2015), we describe to what extent we have attempted to control for this and other biases and confounding factors through processes of triangulation with data sources that were generated independently from local Healthy City offices. We do acknowledge, however, that further research is required that controls for any such factors.

REFERENCES


