

European Healthy Cities come to terms with health network governance

Evelyne de Leeuw^{1,*}, Ilona Kickbusch², Nicola Palmer¹, and Lucy Spanswick¹

¹La Trobe University, Melbourne, Victoria, Australia, and ²IHEID, Geneva, Switzerland

*Corresponding author. E-mail: e.deleeuw@latrobe.edu.au

Summary

A focus on good governance in the WHO European network of Healthy Cities mirrors the WHO Region's strategic emphasis—its member states in the Health 2020 strategy espouse governance for health as key. Healthy Cities adopted governance as a key value and approach to delivering specific health programmes and policies. This article reviews the extent to which they actually introduce and align governance concepts and approaches with their local government commitments. Healthy Cities show that better participation, policy-making and intersectoral action result from an emphasis on governance. This happens across the designated cities and is not limited to a certain class (in terms of population or geographical location) or the time they have been designated. The support of WHO in driving the governance agenda seems important, but no data are available to show that European Healthy Cities are different from other urban environments.

Key words: governance, health policy, healthy cities, Europe

INTRODUCTION

The European Healthy Cities Network from its very inception in 1986 embraced systems change for health. Grounded in the Ottawa Charter for Health Promotion (1986), it took on board a number of strongly value-driven parameters for health development. The local government environment was found to be the most receptive and suitable to both *actions for health* (through community and individual action and behaviour change) and *strategies for health* (through policy and organizational change). A programme logic, grounded in earlier work by scholars such as Len Duhl and Trevor Hancock, firmly connected Healthy Cities to historical patterns of urbanization and emerging challenges local governments could more adequately face (Table 1, De Leeuw, 2001).

Kickbusch [(Kickbusch, 1989), p. 77] in the early stages of the development of the network formulated that a Healthy City

... endeavours to put health high on the agenda of political decision makers, key groups in the city and the population at large. It aims to develop feasible strategies for reorienting public health endeavours at city level and to make prevention and health promotion a highly visible and community-supported enterprise.

The initial 'experimentation stage' was followed by a more strongly codified second phase in which European towns and cities were invited to sign up to the value base embodied in the WHO European Health for All strategy:

The WHO Healthy Cities project is a long-term international development project that seeks to put health on the agenda of decision-makers in the cities of Europe and to build a strong lobby for public health at the local level. Ultimately, the project seeks to enhance the physical, social and environmental well-being of the people who live and work in the cities of Europe. The project is one of

WHO's main vehicles for giving effect to the strategy for Health for All (HFA).

[(Tsouros, 1994), p. 1]

The strategic objectives for the second phase include the speeding up of the adoption and implementation of policy at city level based on the European HFA policy and its targets; strengthening national and subnational support systems; and building strategic links with other sectors and organizations that have an important influence on urban development.

[(Tsouros, 1994), pp. 11–12]

The idea that health as a value would visibly and invisibly penetrate social and political agendas in order to create better opportunities for health gain in communities closely aligns with the idea of 'governance' that received traction since the early 1990s and has become a mainstream concept in current health and development approaches. According to the [Commission on Global Governance \(1995, p. 4\)](#), governance is

. . . the sum of the many ways individuals and institutions, public and private, manage 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

Table 1: Healthy Cities programme logic (De Leeuw, 2001)

The logic of being a Healthy City:

- The geographical set-up in which most people live is the town or city
- Towns and cities have certain degrees of authority and governance to create, recreate and maintain their social and physical infrastructures
- Towns and cities are more often than not the lowest level of formal (democratically elected, and therefore accountable to communities) authority and level of governance in a country
- Thus, actions and policies of city authorities impact directly on the options people have for life choices
- These options are also known as (social, political and commercial) determinants of health, health equity and well-being
- Local authorities are thus in an ideal position to formulate and implement policies impacting on determinants, thereby potentially improving health, health equity and well-being; however, network governance parameters recognize the reciprocal importance of bottom-up and top-down engagement for sustainability of initiatives
- Full involvement of local communities in formulation, implementation and evaluation of health promotion programmes is therefore imperative
- In order to achieve equity in health and well-being

arrangements that people and institutions either have agreed to or perceive to be in their interest.

Geidne *et al.* (Geidne *et al.*, 2012) comprehensively review the emergence of the concept of governance as relevant for local health development. They explain that a focus on governance, as complementary to studies of government, derives from a more refined understanding of the scope and nature of the welfare state. This understanding has led to a convergence of ideas that 'government directed by sovereign politicians is not necessarily the most rational arrangement' [(Geidne *et al.*, 2012), p. 307] as argued by Sørensen (Sørensen, 2002). They follow Stoker (Stoker, 1998) who argues that, in spite of a lack of unequivocal definition of governance, a consensus exists that it refers to the development of governing styles that blur the boundaries between, and within, the public and private sectors. This makes governance a multi-dimensional and contextually relevant approach to local arrangements for health development, but also a phenomenon that can be construed as a messy research problem (e.g. Sinkovics and Alfoldi, 2012) and suitable for a methodological approach as applied in this evaluation exercise (De Leeuw *et al.*, 2015).

Contemporary theoretical approaches to governance converge also on the idea that, empirically, the study of governance requires mapping and management of networks (e.g. De Leeuw *et al.*, 2013). Geidne *et al.* (Geidne *et al.*, 2012) continue to argue that these governance networks consist of a plurality of independent but reciprocally interdependent governing actors. These actors do not have the potential or legitimacy to individually shape or implement policy, but all have a legitimate stake in debating, resolving or hindering progress on social issues (Raab, 2014).

There is a profound connection between governance and health (e.g. Plocgh *et al.*, 2006; Vlahov *et al.*, 2007; Marmot *et al.*, 2008). In a foundation report for the WHO European Region Health 2020 strategy, Kickbusch and Gleicher (Kickbusch and Gleicher, 2012) build on this evidence and argue that there is a difference between health governance and governance for health: (i) the governance of the health system and the strengthening of health systems is called *health governance*; and (ii) the joint action of health and non-health sectors, of the public and private sectors and of citizens for a common interest is called *governance for health*. The definition of the latter they propose is '... the attempts of governments or other actors to steer communities, countries or groups of countries in the pursuit of health as integral to well-being through both whole-of-government and whole-of-society approaches'.

Kickbusch and Gleicher continue to assert that

many of the current health challenges could be better resolved through whole-of-society approaches, which

include civil society and the private sector as well as the media. Health 2020 can support health ministries and public health agencies in reaching out to people within and outside government to find joint solutions. It can propose new programmes, networks and initiatives to engage many different stakeholders and, above all, citizens throughout Europe and explore new incentive mechanisms. Stakeholders could jointly identify and implement new means for assessing accountability and health impact, such as the contribution to a European health footprint. The WHO European Healthy Cities Network would be an excellent laboratory for such an innovation.

GOVERNANCE INDICATORS AND VARIABLES

It is clear from the above quote that the process of measuring and assessing governance parameters is still in its infancy. Part of the problem here is that governance is yet a somewhat fuzzy concept. The International Fund for Agricultural Development (IFAD, 1999) provided an

overview of a number of categories of governance dimensions (Table 2). Kickbusch and Gleicher (Kickbusch and Gleicher, 2012) build on commonalities between these parameters in a foundation document for the World Health Organization European Region’s Health 2020 strategy, which calls on member states and their institutions to explicitly consider the broad, multi-dimensional network nature of health governance (Kickbusch and Behrendt, 2013).

The World Bank Institute (World Bank Institute, 2006) continuously monitors several thousand individual quantitative measures for governance, and Knoll and Zloczynski (Knoll and Zloczynski, 2012) claim that—much like the established consensus on measurement of health (Hunt et al., 1981)—the easiest and most appropriate way to ‘measure’ governance is to explore the *perceived participatory dimension* of governance as well as the *perceived overall quality* of governance. This perspective aligns with the realist synthesis methodology applied for Phase V Health Cities evaluation (de Leeuw et al., 2015).

Table 2: Governance parameters, based on IFAD (IFAD, 1999) and health 2020 (Kickbusch and Gleicher, 2012)

Agency	World Bank Group	International Development Association	Asian Development Bank	African Development Bank	UNDP	WHO/EURO (Kickbusch & Gleicher)
Governance Dimensions						
Public-sector management	Yes	Yes	Yes	Yes	Yes	Yes
Accountability	Yes	Yes	Yes	Yes	Yes	Yes
Legal framework	Yes	Yes	Yes	Yes	Yes	Yes
Transparency & information	Yes	Yes	Yes	Yes	Yes	Yes
Participation	Yes	Yes	Yes	Yes	Yes	Yes
Predictability	Yes	Yes	Yes	Yes	Yes	Yes
Combatting corruption	Yes	Yes	Yes	Yes	Yes	Yes
Responsiveness	Yes	Yes	Yes	Yes	Yes	Yes
Consensus orientation	Yes	Yes	Yes	Yes	Yes	Yes
Equity	Yes	Yes	Yes	Yes	Yes	Yes
Effectiveness and efficiency	Yes	Yes	Yes	Yes	Yes	Yes
Strategic vision	Yes	Yes	Yes	Yes	Yes	Yes
Glocal and complex	Yes	Yes	Yes	Yes	Yes	Yes

For our analysis we have been challenged, however, with the opacity of governance measures, and the dynamic interaction between different indices. For instance, increased accountability would hypothetically contribute to better governance arrangements, and better governance would increase accountability. The same dynamic and reciprocal relationship exists for any of the other measures that have been explored in our assessment. Also, the concept of health governance emerged on European WHO member state and local government agendas while Phase V of the Healthy Cities programme was in operation, and adoption as well as appreciation of the potential of this approach may be diffuse, both in time as well as geographically. We will therefore show relations between research parameters but will consistently find that causality between variables is hard to establish.

RESPONSE

An overview of the realist synthesis methodology that has been driving and structuring this evaluation is found in De Leeuw *et al.* (De Leeuw *et al.*, 2015) and in this governance paper we will not repeat the generic considerations for the research. Within the governance realm, we were first of all interested in the distribution of the response of case studies devoted to governance by region. Cities were classified as belonging to either of four regions: those from countries that belong to the Mediterranean Region (Andorra, Bosnia and Herzegovina, Greece, Italy, Monaco, Montenegro, Portugal, Spain, San Marino, Israel, Turkey, Serbia and Former Yugoslav Republic of Macedonia, city response $N = 56$), those that are located in New Independent States (NIS—Albania, Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, The Republic of Moldova, The Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan, $N = 9$), those that are recent members of the European Union (Bulgaria, Croatia, Cyprus, The Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia and Slovenia, $N = 27$) and those that are located in remaining member nations of the Organisation for Economic Cooperation and Development OECD (Austria, Belgium, Denmark, France, Finland, Germany, Iceland, Ireland, Luxembourg, The Netherlands, Norway, Sweden, Switzerland and UK, $N = 66$).

As governance relates to issues of transparency, accountability and public participation there may be a strong correlation between perceived levels of corruption (as reliably monitored by Transparency International, see <http://cpi.transparency.org/cpi2013/results/>, Figure 1) it would be particularly interesting to see what efforts towards good governance have been made in more

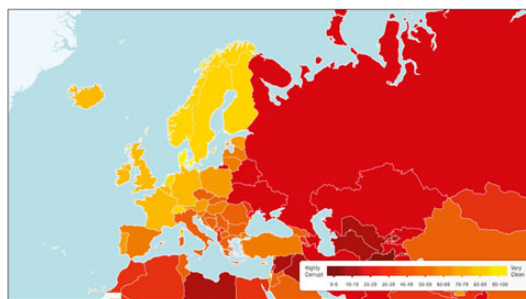


Fig. 1: Transparency International rating of corruption in Europe (reproduced by permission, Transparency International © 2014).

challenged national environments and we refer to Figure 2 in De Leeuw *et al.* (De Leeuw *et al.*, 2015) for a—admittedly almost anecdotal—comparison.

In Figure 2 we show the response generated from Healthy Cities in terms of governance case studies by regions outlined above and in De Leeuw *et al.* (De Leeuw *et al.*, 2015).

Not every member state of the European Region of WHO has had opportunities for democratic governance on the same scale or for longer time periods. ‘Democratic governance’ (UNMIT, 2015) can be described as ‘a culture (. . . that . . .) moves beyond the mere procedures of democracy and the establishment of democratic institutions. It involves promoting the sustainability of democracy which includes an enduring capacity for: the separation of powers and independence of the branches of government; the exercise of power in accordance with the rule of law; the respect for human rights and fundamental freedoms; and, the transparency and accountability of a responsible civil service, functioning at both the national and local levels’. The majority of Healthy City governance case studies (74%—Mediterranean and OECD Regions) come from cities that may have been exposed to ‘democratic’ governance for a longer time. It is, however, pleasing to see that there is a relative overrepresentation of NIS based cities in the submission of governance case studies although the number of studies ($N = 4$) may not show a decisive pattern.

From Figure 3 we see that 74% of the governance case studies were submitted by cities that had been designated pre-Phase V. This would suggest that longer involvement creates greater impetus to work on governance. However, there is no significant difference in submission rates for all case studies and only governance case studies, so we would not be able to infer that ‘governance’ has taken greater prominence over any other strategic area. Still, considering the governance area may be harder to grasp or work towards this is an altogether satisfactory response.

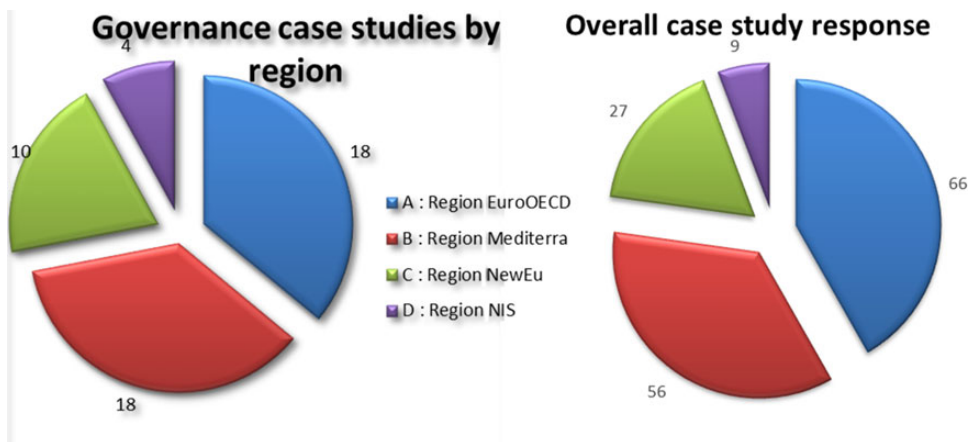


Fig. 2: Governance case studies response by region and overall.

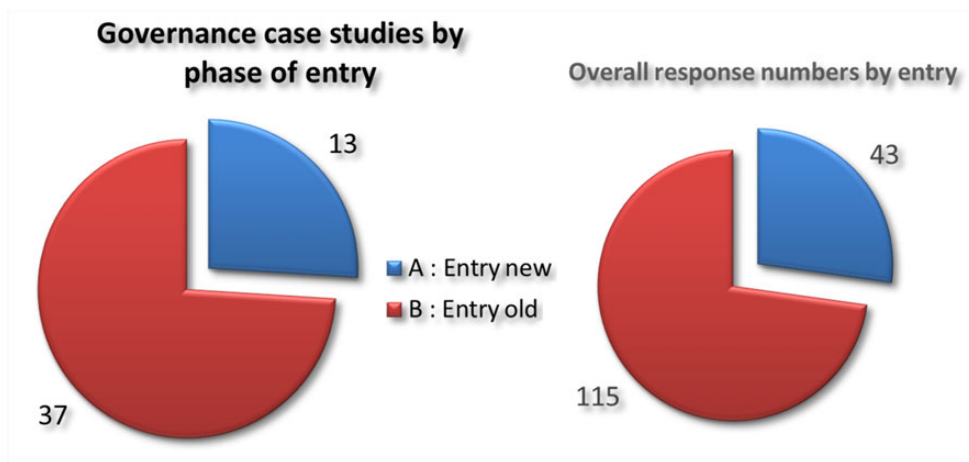


Fig. 3: Governance case study response by Phase of entry into the Healthy Cities Network.

FINDINGS

A key driver of the Healthy Cities network is that cities commit to making a difference through the designation process. Is this actually happening?

Figure 4 shows responses to the question whether action (within a case study that was labelled by cities as focusing on governance) made a strategic difference (that is, not in terms of basic projects or operations of the Healthy City, but rather on principles and vision) in four areas:

- made a difference at strategic level (63 coded case studies overall of which 33 coded under governance)
- made a difference for action with stakeholders (75 coded case studies of which 30 coded under governance)

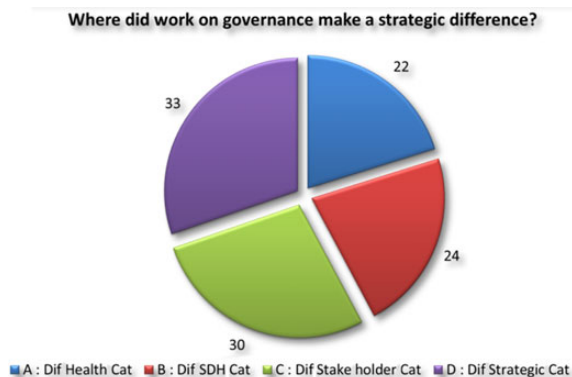


Fig. 4: Strategic difference as a result of governance actions.

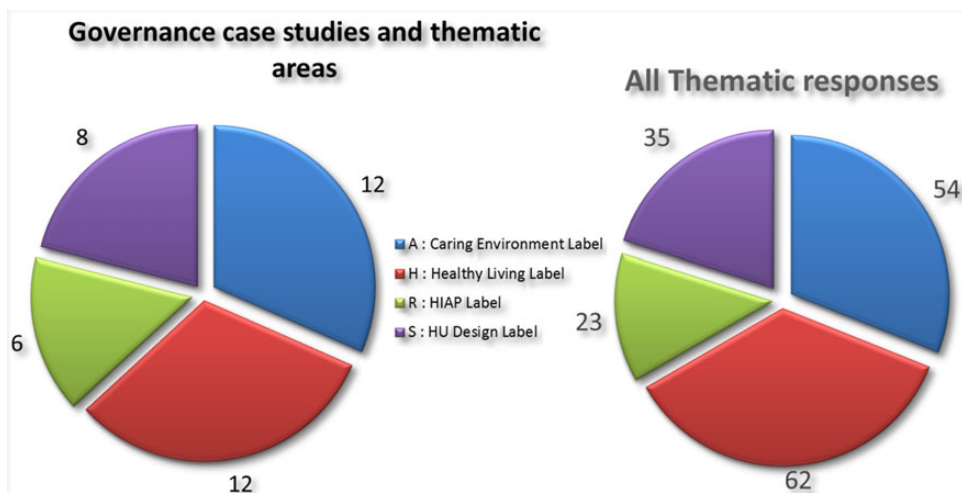


Fig. 5: Governance case studies and their spread over Phase V thematic areas.

- made a difference for health (experience) (70 coded case studies of which 22 coded under governance)
- social determinants of health category—made a difference for acting on social determinants of health (65 coded case studies of which 24 coded under governance)

As should be hypothesized, governance has more of a strategic relation generally with city vision and principles for action. It is particularly good to see that cities report strategic impact on the health experience of their communities, on action in the area of social determinants and enhanced work with stakeholders.

We interrogated these data a bit further and wanted to know whether the degree to which strategic differences reported through case studies that focused on governance parameters was different from the degree to which such differences were reported in other areas (such as equity, participation or policy-making). We did a chi-square analysis, plotting the governance differences against all differences. $\chi^2(3, N = 382) = 7.815, p < 0.05$ indicates that the governance case studies report significantly more strategic differences than all case studies.

We will come back to these in the more detailed analyses of governance actions. An interesting question to ask is whether any of the thematic areas would lend itself better/easier to governance action. One could hypothesize that the more ‘upstream’ or ‘systemic’ themes like HiAP or Urban Planning require more governance perspectives than more ‘downstream’ or ‘behaviourist’ themes (like caring environments and healthy living). Response rates (Figure 5), however, do not confirm such a presupposition.

Figure 6 shows that the vast majority of governance actions was initiated by political forces which in entirely

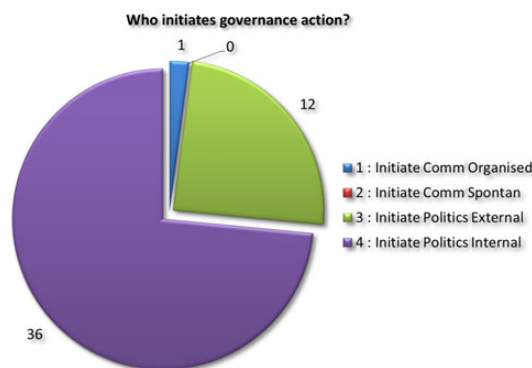


Fig. 6: Where action of governance is initiated.

predictable. In Table 3 we show how the interaction between local government area political forces and larger developments in region or nation is driving better governance for health at the local level. These case extracts show especially how local government exploits opportunities that external political forces (like the European Commission, shifts in national or regional governance arrangements, etc.) present to them. These cases are not simply ‘business as usual’ responding to change, but Healthy Cities actively engaging in those change processes.

An important aspect of the Healthy Cities vision is that designated cities commit to making a difference, or doing things differently to the ‘business-as-usual’ model that tends to be prevalent in most governments. Taking action on governance merely ‘for governance’s sake’ is therefore not what the programme intends to accomplish. We interrogated the data to see what the strategic impetus for

Table 3: Selected case studies and external initiation patterns

Case study and type	Title	Initiate politics external—quotes from case submission
Amaroussion—thematic	The bioclimatic regeneration of the historic centre of the municipality of Amaroussion	European Commission and Greek Ministry of Development
Barcelona—thematic	How Barcelona systematized intervention on inequities by linking community action with neighbourhoods regeneration projects	Government of Catalonia and Department of Health of the Generalitat de Catalunya.
Bursa—strategic	Bursa Metropolitan Municipality 1:100 000 Master Plan	'Public Finance and Inspection Law' dated 2003, 'Special Provincial Administration Law' dated 2005, 'Municipal Law No 5393' dated 2005 and the 'Metropolitan Municipalities Law No 5216' are some of the most important laws.
Copenhagen—strategic	'Smoke-free Copenhagen 2025'—a partnership for health	The overall lower life expectancy for Copenhagen citizens thus was transformed from being an issue amongst the health professionals of Copenhagen, to an issue tied to political prestige on a national level.
Derry—strategic	How Derry City has used an interagency partnership approach to build an Early Intervention City to ensure the best outcomes for children aged 0–18 and their families	NI Government commenced a planning and consultation process for the creation of a single Regeneration Strategy for Derry
Izhevsk—strategic	The Healthy Cities project in Izhevsk has made a difference in the city policy-making in health and life quality	According to the new federal legislation, the responsibility for public health care was delegated from municipal to regional level
Izmir—strategic	Izmir Kadifekale Urban Renewal Project	Boards of Ministers
Newcastle—strategic	How the city of Newcastle upon Tyne, UK, used the opportunity presented by the English Health and Social Care Act (2012) to strengthen governance for well-being and health	New Coalition Government produced a White Paper called Liberating the NHS
Østfold—strategic	Public health planning in Østfold, Norway	From 2009, two important laws that strengthened the county councils role to support municipalities in spatial planning and public health were revised or adopted
Rennes—strategic	Implementation of the local health contract for the city of Rennes	Created by law no. 2009–879 from 21 July 2009 concerning the reform of hospitals and relating to patients, health and local issues
Vienna—strategic	Vienna Network for Kindergarten Meals	Austrian Federal Health Agency funds the implementation of measures aimed at promoting healthy eating and drinking patterns
Warsaw—thematic	The Warsaw Mental Health Programme for 2011–2015	The Regulation of the Council of Ministers of December 28, 2010 regarding the establishing of The National Mental Care Programme

actions in the area of governance was. We assigned a total of 149 strategic foci within the set of governance case studies; cities may have decided that their governance actions served several strategic purposes which is understandable, considering the complex interactions between the elements that constitute governance.

In Figure 7 we see that a relatively larger proportion of strategic foci deals with partnerships in cities ($N = 35$, or 23.5% of the total 149), followed by a drive towards policy

development ($N = 31$, 20.8%), improving governance arrangements ($N = 27$, 18.1%) and developing and strengthening leadership for health ($N = 26$, 17.4%). Governance for equity and community action (total $N = 30$) has also become visible in European Healthy Cities.

In Table 4 we show some examples of innovative governance actions in these different strategic areas.

A key governance question would look at the involvement of a broad range of actors in governance



Fig. 7: What is the strategic focus of governance actions?

Table 4: Examples of governance action in different strategic areas

Strategic focus	City and case study type	Quote from case
Policy	Pécs strategic	'In December 2011 the City Council of Pécs made a resolution which says that: all strategic documents of the city (every mid and long term conception, programme, strategy, etc.) discussed by the City Council first has to be sent to the Healthy City Foundation of Pécs for assessment which is based on Healthy Cities principles and on the method of Health Impact Assessment'.
Equity	Liverpool strategic	'Healthy cities principles were applied in protest against elements that were not felt to contribute to the improvement of population health and wellbeing and the reduction of health inequalities'.
Governance	Sandnes thematic	'The courage to make forward-looking, long-term choices to ensure that future generations have good conditions at Sandnes'.
Leadership	Newcastle strategic	'Announcement of four key priorities for the Council—Working City; Decent Neighbourhoods; Tackling inequalities; Fit for purpose council—thus putting action on the social determinants of health and inequity in health centre stage'.
Participation	Barcelona Thematic	'Community prioritization of health issues. The above information is compressed into an unordered list of health problems. A Community Prioritization Day is diffused to the maximum. The neighbours and other agents vote by show of hands to prioritize problems, to a maximum of 2/3 of the total'.
Partnership	Copenhagen Strategic	'"Smoke free Copenhagen 2025" is a partnership between the municipality of Copenhagen and a number of partners from the private as well as the public sector'.

arrangements. This is not only dictated by the reality that social, commercial and political determinants of health are located in and driven by sectors outside the health system, but also because good governance is strengthened by

the real involvement of a multitude of actors; this is a position that is evidenced in the work by Burris and colleagues (Burris *et al.*, 2007) on nodal governance. We do indeed find a representation of many sectors outside health, and

even outside the local government apparatus, in Healthy City governance actions. Our research instrument development logic and subsequent coding practices suggested a

range of actors and sectors shown in Figure 8 but we found sets of actors beyond these categories shown in Figure 9. This confirms at least the strong desire of

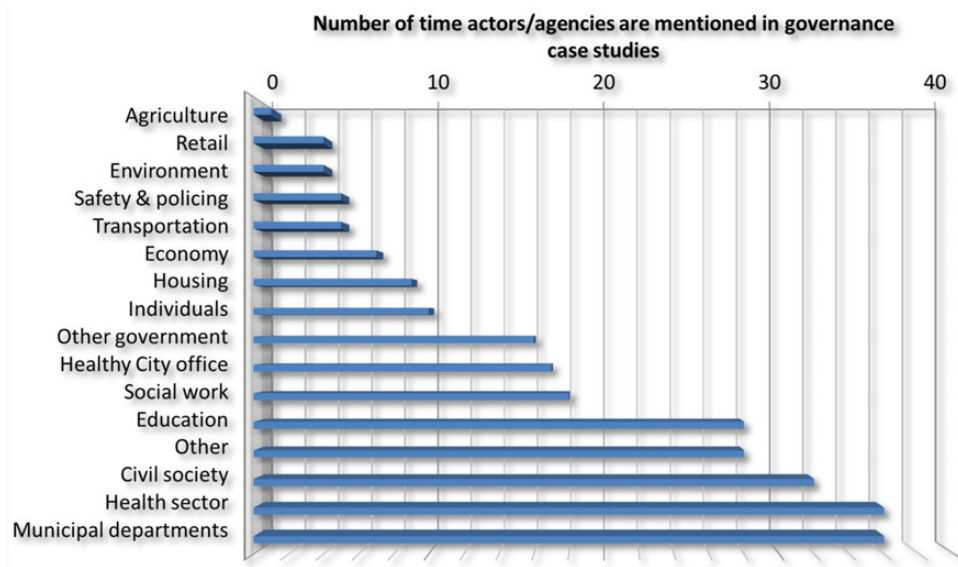


Fig. 8: Number of time actors/agencies are mentioned in governance case studies.

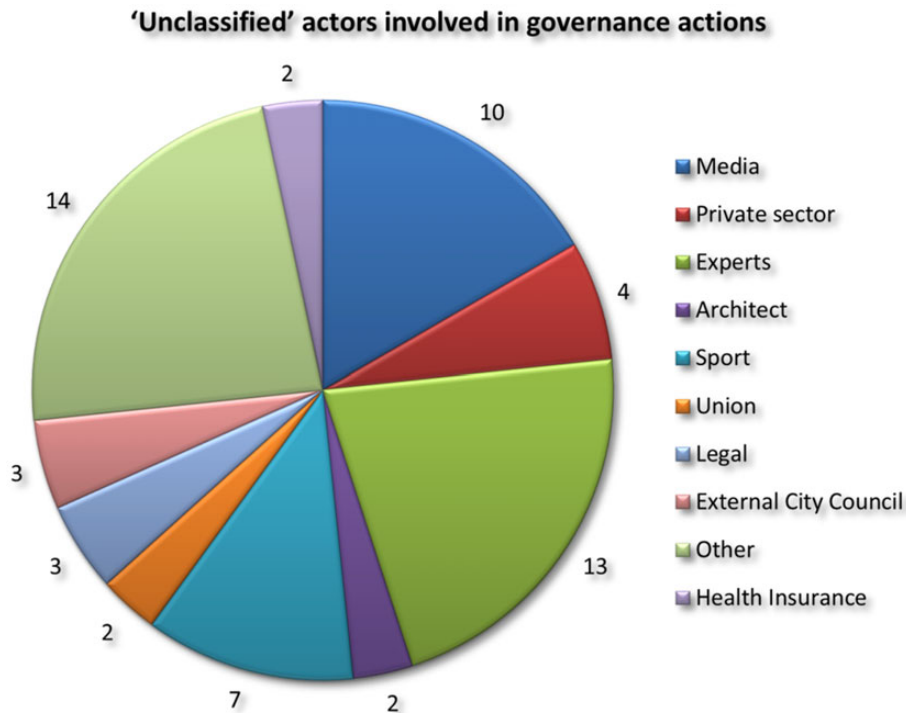


Fig. 9: Further otherwise unclassified actors involved in governance actions.

Healthy City programmes to engage far beyond ‘traditional’ health perspectives with stakeholders that also see a legitimate role in a broadly conceived perspective of health.

Critically, however, Housing, Economy, Environment, Transport and Community sectors and interests seem underrepresented in governance actions. Other articles in this Supplement touch on this relative dearth of governance on such critical infrastructural areas and further research is warranted.

IMPACTING ON CITY OPERATIONS

A key question throughout the General Evaluation Questionnaire (cf. De Leeuw *et al.*, 2015) and case studies is what the result of the action has been—has the change/action/project impacted on city operations?

Argyris and Schön (Argyris and Schön, 1974) distinguished between single-loop and double-loop learning, related to Gregory Bateson’s concepts of first- and second-order learning. In single-loop learning, individuals, groups or organizations modify their actions according to the difference between expected and obtained outcomes. In double-loop learning, the entities (individuals, groups or organization) question the values, assumptions and policies that led to the actions in the first place; if they are able to view and modify those, then second-order or double-loop learning has taken place. Double-loop learning is the learning about single-loop learning.

In Figure 10 we see that a slight majority of cities that have submitted governance case studies claim that their activities have led to second-order learning, that is, that governance actions have impacted on changes in organizational, policy or strategic contexts addressing health in local governments. This confirms the position that Hall (Hall, 1993) has taken: policy change happens through second-order learning and the practices of Healthy Cities will have become more

firmly embedded in the local government and community environments.

In Figure 11 we see the wide variety of reported learning instances, with for instance Gyor (case study 4) being coded as reporting four areas of first-order learning as well as four instances of second-order learning. At the very least, we can say that the Healthy Cities Network enables cities to innovate and learn from their innovations in substantive manners.

It has been suggested that city size may impact on the efficacy of governance operations, with medium-sized cities (with a population between 100 000 and 499 000) being more successful than others. Based on the limited data we have we tested this (Table 5).

It appears that those medium-sized cities in fact are more successful at second-order learning even without an explicit focus on governance activities, but that large cities that embrace governance activities benefit more than others from their explicit attention to governance.

Cities thus claim that they are both learning to improve their practices, as well as learning to improve and adjust their policy and organizational systems. In the General Evaluation Questionnaire we have asked cities to rate several governance parameters for 2009 (at the start of Phase V) and 2014 (for the end of the Phase). Although no significant changes have been found for all parameters (e.g. for equity or sustainability) we did find self-reported shifts in partnerships (Figure 12) and citizen participation (Figure 13).

We see in both graphs that cities reporting governance case studies had a better starting point in both areas than cities that did not report such case studies, but also that their self-reported improvements were more dramatic than those reported by ‘non-governance’ cities. This confirms the assumption that cities that were in the Healthy Cities Network longer have benefited more from the value-driven perspectives than others (although a statistical—factor-loaded—analysis at this stage is not possible), and that those who have benefited from this history do have greater potential advancing a governance agenda than others.

This is in particular confirmed when we look at self-reported engagement with the development of Health in All Policies (Figure 14), and the more generic reports of the position of health on social and political agendas (Figure 15) of the cities.

The latter graph, however, shows that we need to interpret these findings with caution. ‘Non-governance cities’ that did not report a high position of health on social and political agendas in 2009 ($N = 40$, green series) seem to have moved further to the high end of the scale than cities with governance case studies. Overall, however, both groups have improved.

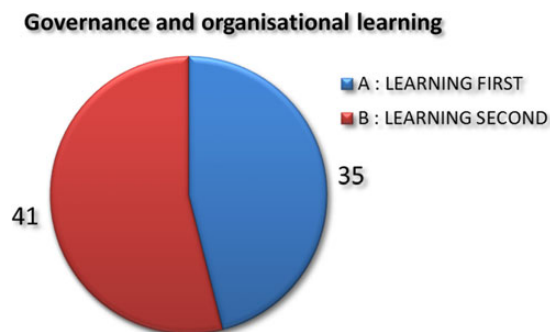


Fig. 10: Levels of learning associated with governance actions.

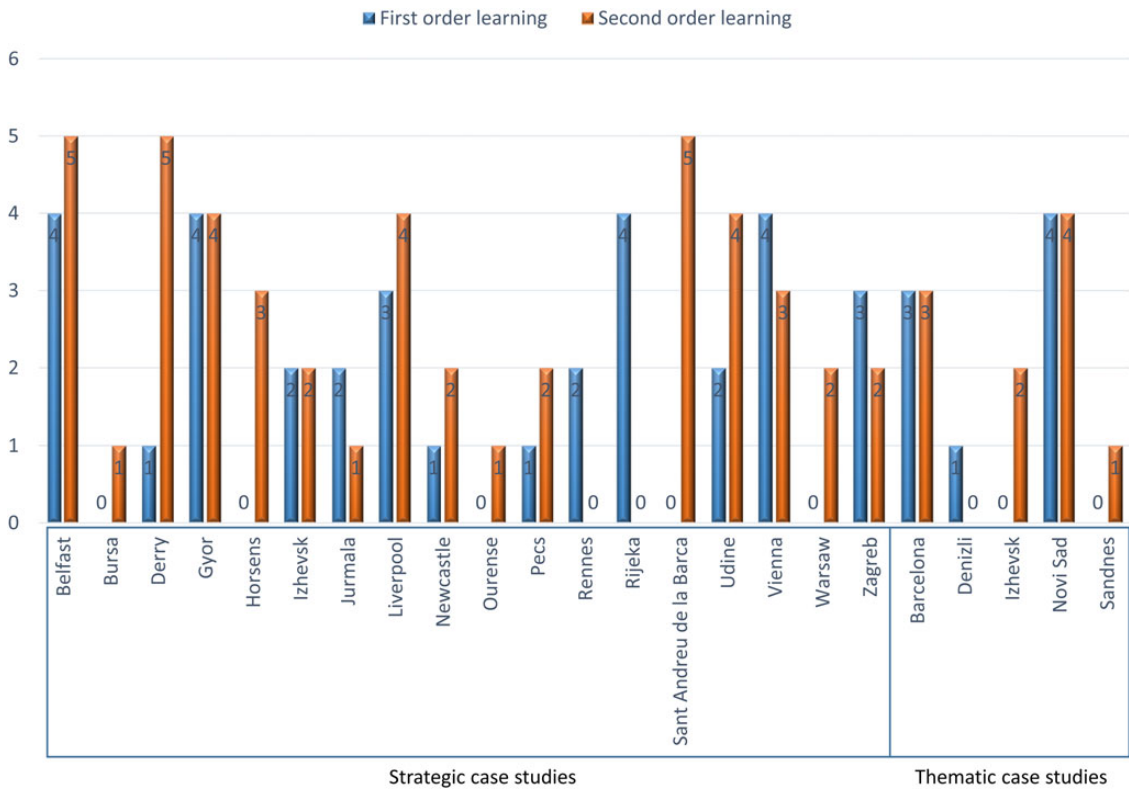


Fig. 11: Range of case studies and labels for first- and second-order learning within each case study.

Table 5: Distribution of governance labels and second-order learning

City size	City type		
	Non-Gov Cat cities with learning second	Gov Cat cities with learning second	
Cities 0–99 999	8	8	16
Cities 100 000–499 000	19	14	33
Cities 500 000 or more	7	11	18
	34	33	67

DISCUSSION

The concept of governance is extremely multi-dimensional, and in researching it, the literature suggests that it is difficult if not impossible to distinguish between dependent and independent variables: e.g. does more community participation lead to better governance, or does better governance lead to more and more effective participation?

Our analyses confirm this complexity—the dynamic, reciprocal, iterative and dynamic nature of the governance

“Our rating of the importance of partnerships for our city:”

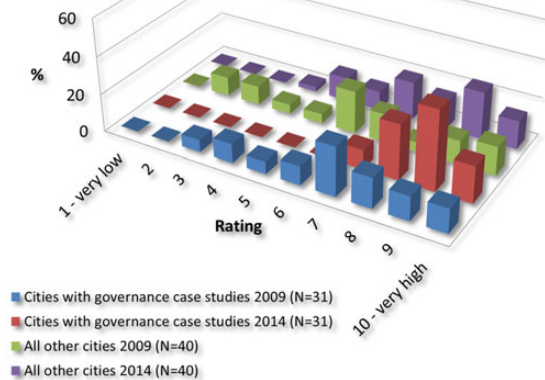


Fig. 12: Shifts in the importance of partnerships 2009–2014 between governance and non-governance city case studies (data from GEO).

concept, as well as its gradual introduction to local health (policy) development processes has as yet not fully crystallized into patterns that can be described unequivocally.

“Our rating of citizen participation in our city:”

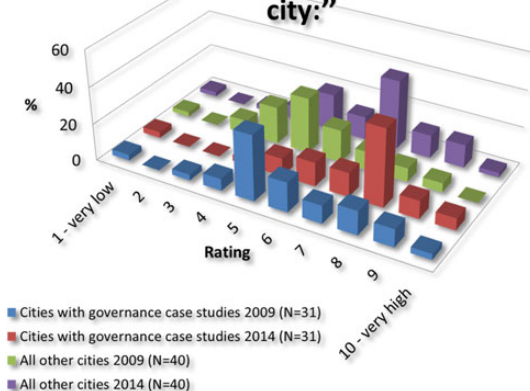


Fig. 13: Shifts in the importance of citizen participation 2009–2014 between governance and non-governance city case studies (data from GEQ).

“The position of health on the social/political agenda of the city was:”

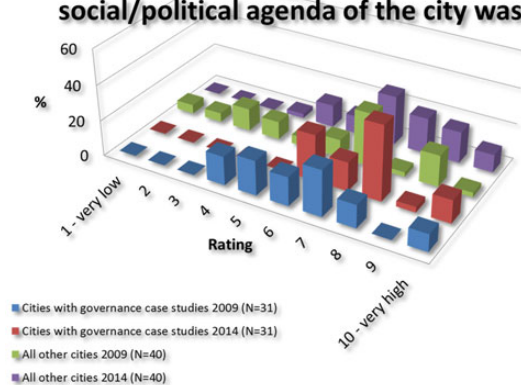


Fig. 15: Shifts in the position of health on social and political agendas 2009–2014 between governance and non-governance city case studies (data from GEQ).

“Our rating of the integration of ‘Health in All Policies’ in city vision and activities:”

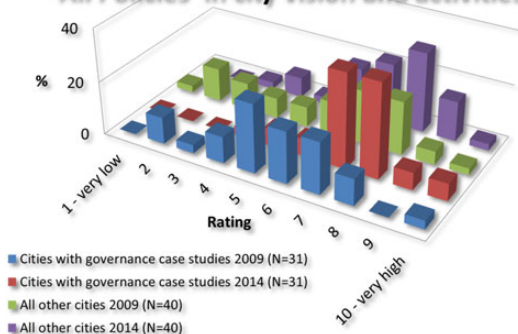


Fig. 14: Shifts in the importance of HiAP 2009–2014 between governance and non-governance city case studies (data from GEQ).

Cities with a more solid foundation in parameters that would be considered determinants of (good) governance can be shown to do better in their governance parameters over time. They distinguish themselves from cities that do not have such a stronger starting point. However, all cities in the network seem to benefit to some degree from their embracing of Healthy City values. Being a member of the network longer has a stronger impact on governance operations and shows that health does become a more integral part of social and political agendas. We can therefore confirm that the European Healthy Cities programme is achieving its main goal, although the patterns and pathways along which this happens are not limited to governance operations on their own.

ACKNOWLEDGEMENTS

The authors thank the anonymous reviewer for their frank and extremely detailed feedback on an earlier version of the article. It has improved our work in no small measure.

REFERENCES

- Argyris C., Schön D. A. (1974) *Theory in Practice: Increasing Professional Effectiveness*. Jossey-Bass, San Francisco.
- Burris S., Hancock T., Lin V., Herzog A. (2007) Emerging strategies for healthy urban governance. *Journal of Urban Health*, 84, 154–163.
- Commission on Global Governance (1995) *Our Global Neighborhood*. Oxford University Press, Oxford.
- de Leeuw E. (2001) Global and local (glocal) health: the WHO healthy cities programme. *Global Change and Human Health*, 2, 34–45.
- de Leeuw E., Keizer M., Hoeijmakers M. (2013) Health policy networks: connecting the disconnected. Chapter 8. In Clavier C., de Leeuw E. (eds), *Health Promotion and the Policy Process*. Oxford University Press, Oxford.
- De Leeuw E., Green G., Dyakova M., Spanswick L., Palmer N. (2015) European Healthy Cities Evaluation: conceptual framework and methodology. *Health promotion International* 30 (Suppl. 1), i8–i17.
- Geidne J., Fröding K., Montin S., Eriksson C. (2012) Implementation structure and participation at neighbourhood level—A multiple case study of neighbourhood development in Sweden. *Systemic Practice and Action Research*, 25, 305–322.
- Hall P. A. (1993) Policy paradigms, social learning, and the state: the case of economic policymaking in Britain. *Comparative Politics*, 25, 275–296.

- Hunt S. M., McKenna S. P., McEwen J., Williams J., Papp E. (1981) The Nottingham Health Profile: subjective health status and medical consultations. *Social Science & Medicine. Part A: Medical Psychology & Medical Sociology*, **15**, 221–229.
- IFAD (1999) *Good Governance: An Overview*. Executive Board —Sixty-Seventh Session. International Fund for Agricultural Development. Rome, 8–9 September 1999.
- Kickbusch I. (1989) Healthy cities: a working project and a growing movement. *Health Promotion International*, **4**, 77–82.
- Kickbusch I., Behrendt T. (2013) *Implementing a Health 2020 Vision: Governance for Health in the 21st Century: Making it Happen*. World Health Organization Regional Office for Europe, Copenhagen.
- Kickbusch I., Gleicher D. (2012) *Governance for Health in the 21st Century*. World Health Organization Regional Office for Europe, Copenhagen.
- Knoll M., Zloczynski P. (2012) The good governance indicators of the millennium challenge account: How many dimensions are really being measured? *World Development*, **40**, 900–915.
- Marmot M., Friel S., Bell R., Houweling T. A., Taylor S. (2008) Closing the gap in a generation: health equity through action on the social determinants of health. *The Lancet*, **372**, 1661–1669.
- Plochg T., Delnoij D. M. J., Hogervorst W. V. G., Van Dijk P., Belleman S., Klazinga N. S. (2006) Local health systems in 21st century: who cares?—an exploratory study on health system governance in Amsterdam. *The European Journal of Public Health*, **16**, 559–564.
- Raab J. (2014) Extending our knowledge on network governance. *Journal of Public Administration Research and Theory*, **24**, 531–535.
- Sinkovics R. R., Alfoldi E. A. (2012) Progressive focusing and trustworthiness in qualitative research. *Management International Review*, **52**, 817–845.
- Sørensen E. (2002) Democratic theory and network governance. *Administrative Theory & Praxis*, **24**, 693–720.
- Stoker G. (1998) Governance as theory: five propositions. *International Social Science Journal*, **50**, 17–28.
- Tsouros A. (1994) *The WHO Healthy Cities Project: State of the Art and Future Plans*. WHO/EURO/HCPO, Copenhagen.
- UNMIT (2015) *Democratic Governance. United Nations Integrated Mission in Timor-Leste*. <http://www.unmit.unmissions.org/Default.aspx?tabid=12071&language=en-US> (1 May 2015, date last accessed).
- Vlahov D., Freudenberg N., Proietti F., Ompad D., Quinn A., Nandi V., Galea S. (2007) Urban as a determinant of health. *Journal of Urban Health*, **84**, 16–26.
- World Bank Institute (2006). *Governance Data: Web-Interactive Inventory of Datasets and Empirical Tools*. Washington, DC. <http://www.worldbank.org/wbi/governance/govdatasets/index> (several thousand individual quantitative measures) (1 May 2015, date last accessed).