Building Healthy Communities

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Building Healthy Communities

II Thematic Report

Healthy Sustainable Lifestyles

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BACĂU
BAIA MARE
BARNSLEY
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LECCE
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European Union

Connecting cities
Building successes

URBACT

"The Union's aim is to promote peace, its values
and the well-being of its people"

*(Article 3 in the Treaty on the Functioning of
the European Union – The Lisbon Treaty)*

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0. Forewords. What there is in this report, and what there is not

During the Second BHC Thematic Workshop, held in Torino in March 2010, participants discussed about their Local Action Plans, the difficulties they were encountering in drafting good and effective plans, the challenges to put lots of ideas into a coherent instrument, the need to define a realistic work programme in which the greatest part was probably destined to remain as a wish because it is normally difficult to raise money, figure out in crisis time!
The LAPs, though, were there to be discussed, more or less advanced but still never disappointing. Very different, 10 peculiar action plans, and yet somehow grouped in two groups: some based on existing broader development projects or strategies in which the challenge of taking into account health and quality of life needed to be highlighted; some others developing the knowledge capacity of cities' departments or local authorities responsible for health issues through the improvement of assessment and monitoring methodologies. All the cities focusing their efforts in improving the networking among local partners, in order to work together to reach common goals. This can be considered a real added value of the URBACT experience for partner cities.
Still, the theme of the Workshop was "Healthy Sustainable Lifestyle", as if a clarification on what this is was needed. It was not. It become clear, hearing the presentations, that (first) there were at least as many healthy sustainable lifestyles as many cities in the network, and (second) what was more urgent was a better understanding of what was going to happen right after the ending of the project. This has to do with the Third – and last official – Thematic Network, on the "Use of Structural Funds in Developing Health Gains", but it has also a lot to do with a wider knowledge of the framework in which in the EU is possible to develop policies and projects dedicated to health and quality of life issues.
Be that as it may, this report is therefore not dedicated neither to describe what a healthy sustainable lifestyle is the different lifestyles in partner cities. This report is, instead, an attempt to provide a synthetic and effective guide through the wider European context of initiatives and options to which cities can be interested for carrying on their action plans well after the end of BHC.
In a draft stage it is evident, in fact, that cities will not be able to rely completely (or at all) on Structural Funds, but will need to "creatively" imagine to fund action plans with different funding sources, at EU, national and local level, public and private funds. This understanding is also a direct result of the unequal relation between the critical mass of challenges that have to be faced at local level and the practically insufficient relevant means and competences attributed to cities.
BHC does not call, anyway, neither for a major devolution of competences to cities, nor for a generic increase of available funding. The focus is instead in the improved assessment capacities to help citizens, politicians and experts to know more about their cities and to define better policies for a healthy development. Since the be-

ginning of the Building Healthy Communities project there has been a common understanding among partners: to share knowledge and practices and to know more about what was going on elsewhere when dealing with the issues of health, quality of life, wellbeing, sustainability.

Another added value of the network

Apart from the three thematic workshops, foreseen at the beginning of the project, there has been a constant request for more exchanges on specific topics that may have come out during our meetings, via email or through the newsletter. The first of these meeting, that we decided to call "Exchanges", has taken place in Belfast and was focused on Health Impact Assessment (main findings in BHC First Report). In this case a city was considered as a donor, because of its long experience in HIA, and other cities came as beneficiaries to the meeting.

A second meeting took place four months after the Torino Workshop and thanks to the discussion occurred during the works. Its theme was social marketing and the donor city – and host – has been Barnsley.

A third meeting then occurred in December in Madrid and this time its focus was on the mix of urban regeneration strategies and use of indicators of quality of life that the Spanish partners introduced in their LAP.

Both the Barnsley and the Madrid Exchanges will be briefly reported respectively in Annex 1 and 2. The need for exchanges is not over yet, though, and a fourth is foreseen in Lecce in March 2011, on urban regeneration strategies oriented towards green energies and environmental safeguard. Its results will be available in the Final Report.

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1. Health and Quality of Life in Cities

Healthy, sustainable lifestyles in European cities have a variety of possible definitions according to place's peculiarities, social conditions, cultures, climate, etc. This is true if we consider the differences between a city in Northern Europe and another one in the Southern part of the continent, but it can also be said for people with different income living in the same city and sometimes in the same neighbourhood. The European social model, well before its codification[1] and taking into account the differences among Member States, has proved that in the European Union is shared a specific attention to the balance between competitiveness and cohesion policies that results in the search for the provision of equal and fair living conditions for all its citizens, no matter where they are living.
This is witnessed at the EU level by the five Cohesion Reports that have been published, the last of which – *Investing in Europe's Future. Fifth Report on Economic, Social and Territorial Cohesion* – has been released in its draft version in November 2010[2]. In the Report there is a section that is titled "Improving well-being and reducing exclusion" (p. 73-117), in which traditional data to assess quality of life conditions in EU countries are showed (e.g. related to the access to health care, ageing, unemployment, etc.), but there is also a hint to the new trend of coupling GDP with some more relevant (and yet fuzzy) indicators of development (see box 1). The "Happiness Index", for instance, tries to measure the degree of satisfaction of their own life of EU citizens because "more economic growth does not necessarily lead to a happier population" (Fifth Cohesion Report, p. 115)[3].

Box 1. Happiness and life satisfaction

A growing number of academics[4], researchers[5] and politicians argue that wellbeing, in the form of a long and happy life, should be an important goal of public policy[6]. Research has

[1] The Commission's 1994 White Paper on social policy (COM (94) 333) described a "European social model" in terms of values that include democracy and individual rights, free collective bargaining, the market economy, equal opportunities for all, and social protection and solidarity. The model is based on the conviction that economic progress and social progress are inseparable: "Competitiveness and solidarity have both been taken into account in building a successful Europe for the future."
(http://www.eurofound.europa.eu)

[2] http://ec.europa.eu/regional_policy/sources/docoffic/official/reports/cohesion5/index_en.cfm

[3] Some Member States started to measure people's psychological and environmental wellbeing by creating their own happiness index. See for instance the cases of Italy, United Kingdom and France and the methodology set up by the New Economics Foundation (http://www.neweconomics.org/programmes/well-being). The most quoted publication on this issue is the Stiglitz, Sen and Fitoussi "Report by the Commission on the Measurement of Economic Performance and Social Progress" (2009; www.stiglitz-sen-fitoussi.fr).

[4] Layard, Richard (2006), "Happiness: Lessons from a New Science", Penguin, London.

[5] New Economics Foundation (2009), NEF, National Accounts of Well-being, nef, London.

[6] Stiglitz, J., Sen, A., Fitoussi, J. (2009), "Report by the Commission on the Measurement of Economic Performance and Social Progress".

shown[7] that although more developed countries tend to be happier than less developed ones, more economic growth does not necessarily lead to a happier population. An increase in economic activity does not always lead to more and better jobs. Nor does it automatically lead to an increase in average income. In some countries, the benefits of economic growth have largely gone to high-income groups or to companies, while median household income has barely increased or has even fallen. Economic growth can also be accompanied by longer working hours, more stress and a deterioration in the quality of life. In 2007, the three Member States with the highest scores on the happiness index were the three Nordic countries. The three with the lowest scores were Bulgaria, Latvia and Portugal. Although overall, happiness tends to be less in the less developed Member States, this is not always the case. Malta is an extreme case, ranking only 18th in terms of GDP per head, but 7th according to the happiness index, while Austria has the 4th highest GDP per head but ranks 19th on the happiness index. Life satisfaction is another frequently used subjective indicator of wellbeing. It is highly correlated with happiness. The three Nordic Member States also had the highest life satisfaction, according to a Eurobarometer survey conducted in 2009. One reason cited for the high levels of happiness in these countries is not only their high income but also the relatively equal distribution of this.
(Fifth Cohesion Report, p. 115)

It is, however, at the city level that main effects and impacts of a good balance between economic development strategies and policies promoting wellbeing can be seen. Cities have, in fact, a direct contact with citizens' life conditions – and thus direct responsibilities in providing healthy and fair living conditions – but smaller and weaker competences in terms of finances and legislation especially as far as the impact of the economic crisis is concerned. As it is stated in the recent study *URBACT Cities Facing the Crisis. Impact and Responses* (2010): "cities are clearly on the front line when it comes to the impact of the crisis and they will play a major role in both exploring and implementing many of the solutions which directly affect people's lives" (p. 10)[8]. Different answers have been designed to respond to the crisis, but apart from the common idea of the need of a sound city-level approach in dealing with the problems arising, it is clear that cities are just increasing their efforts in fields in which they were already active. The crisis didn't create new problems, it exacerbated many of them (unemployment, provision of social services, etc.). This is recognized in the last EU documents that regard European cities.

The *Toledo Declaration* is a reference document on integrated urban regeneration and its strategic potential for a smarter, more sustainable and socially inclusive urban development in Europe (thus referring to the EU2020 Strategy)[9] (see box 2). In the docu-

[7] Veenhoven, Ruut (2000), "Well-being in the welfare state: Level not higher, distribution not more equitable", Journal of Comparative Policy Analysis, vol. 2, pp 91–125.

[8] http://urbact.eu/fileadmin/general_library/Crise_urbact__16-11_web.pdf

[9] Toledo Informal Ministerial Meeting on Urban Development Declaration, Toledo, 22 June 2010.

ment the strategic importance of integrated urban regeneration to achieve a smarter, more sustainable and inclusive urban development is highlighted[10].

Box 2. The Toledo Declaration and EU cities

As has been addressed in the Europe 2020 Strategy, the European Union faces a number of major challenges in terms of economics (financial and economic recession, globalisation, etc.), social issues (unemployment, social integration, demographic structure, inequality, etc.) and the environment (climate change, preserving natural resources, etc.), maintaining that "our exit from the crisis must be the point of entry into a new economy. For our own and future generations to continue to enjoy a high quality of healthy life, underpinned by Europe's unique social models, we need to take action now. What is needed is a strategy to turn the EU into a smart, sustainable and inclusive economy delivering high levels of employment, productivity and social cohesion"(p. 8)[11]. To do so, the Europe 2020 strategy sets out three mutually reinforcing priorities: smart growth, developing an economy based on knowledge and innovation; sustainable growth, promoting a more resource efficient, greener and more competitive economy; and, inclusive growth, fostering a high-employment economy delivering social and territorial cohesion.

In this regard, cities and towns are vital for achieving the general objectives and specific headline targets of the Europe 2020 strategy. If the impact of these challenges on Europe's cities is considered and examined from the classical viewpoint of the multiple dimensions of sustainability (economic, social, environmental, cultural and governance), it comes out that urban regeneration may have a truly strategic role to play in the future of urban development in Europe, and come to represent an opportunity to help to address the challenges of European cities from this multiple perspective, and particularly to address them in the existing urban fabrics.

(from the Toledo Declaration, pp. 1-4)

The Toledo document is very important because it calls for a renewed EU effort for European cities, both in

(http://www.eukn.org/News/2010/June/Ministers_of_Housing_and_Urban_Development_approve_the_Toledo_Declaration).
For the EU2020 Strategy, see: http://ec.europa.eu/europe2020/index_en.htm

[10] There is also a Toledo Declaration on Health and the Global Crisis, which has been promoted by the International Association of Health Policy in September 2009. This declaration states that: "the economic and financial crisis which affects all countries of the world is the result of economic globalisation and of international relations made hegemonic by ideology and neoliberal forces, which have in essence steered it towards the imposition of market relations, a reduced role for the state as a guarantor of human rights, the elimination of public services (education, health and social services) and the deregulation of economic and commercial relationships at an international level. Significant global organisations have played a part in this, including the World Trade Organisation, the World Bank, the International Monetary Fund, among others. These organisations have promoted the privatisation of public services (General Agreement on Trade and Services), the reduction of social spending, the casualisation of working conditions and the elimination of constraints upon the circulation of capital, in favour of freedom to speculate". (http://privatizationhealthobservatory.eu/node/27).

[11] "Europe2020. A strategy for smart, sustainable and inclusive growth", COM(2010)2020.

terms of strategies and programmes/projects. Yet, the Toledo Declaration draws mainly from the Leipzig Charter, which, by the way, makes more direct reference to citizens' wellbeing (see § 4). What is important to stress is that the challenge of working for healthy sustainable lifestyles in EU cities is made more complicated by the crisis, but still cities act in the framework of the EU policies and directives and can exploit also the knowledge and programming capacities that the World Health Organisation is providing, especially through its "Healthy Cities" experience. In the next pages EU and WHO roles will be analyzed, updating the contents of the BHC Baseline Study that forms the basis of the network common work.

2. The EU role

On the European stage the EU, and especially the European Commission through the DG SANCO, is active in health promotion and linking issues of the environment[12] and health policies together.

> "We need to ensure that health is at the very heart of policy making at regional, national and EU level. We need to promote health through all policies. Policy measures as different as inner city development, regional transport infrastructure, applied research, air pollution, or international trade must take health into account. Health needs to be integrated into all policies, from agriculture to environment, from transport to trade, from research to humanitarian aid and development." (Byrne, 2004[13])

Improving quality of life and good health is the EU major goal, and it is achievable by approaching it from a broad perspective. While acknowledging the role of Member States in this policy area, the EU do not proposes legislation at European level, just raises awareness of the issue. Under the EU Treaty (Treaty of Amsterdam, 1997), actions must aim to improve public health, prevent human illness and diseases and identify sources of danger to human health. This has led to integrated health-related work at EU level, aiming to bring health related policy areas together. Article 152 of the Treaty is, in fact, concerned with public health when it says:

> "A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities. Community action [...] shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health".

The Lisbon Treaty recalls this attention to health and quality of life in article 3, when it highlights that "the Union's aim is to promote peace, its values and the well-being of its people". It is through the Health Strategy (adopted in October 2007) and the related Health Programme, anyway, that the EU plays its part in improving public health in Europe. The role of the EU is to support Member States in their actions of public health and to assist national decision-making. Thus, EU action focuses on strengthening cooperation and coordination, supporting the exchange of evidence-based information and knowledge. Public authorities in Member States have a responsibility to ensure that these

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[12] Although there is a Directorate General dedicated to the environmental issues: DG Environment. Its mission is to protect, preserve and improve the environment for present and future generations. It is possible to see that many projects – and possibly some funding sources – are related to the fields of action that BHC partner cities are undertaking in their LAPs. LIFE+ its the most important financial instrument for DG Environment and has entered into force with the publication of the Regulation in the Official Journal L149 of 9 June 2007. The 2011 call for proposals will be published in Mid-February 2011, with a deadline for submission for the end of Mid-July (see http://ec.europa.eu/environment/life/funding/lifeplus.htm).

[13] Byrne D. (2004), *Enabling good health for all. A reflection process for a new EU health strategy*, EC – DG Health and Consumer Protection, Bruxelles.

concerns are reflected in their policies. In addition, the European Union has a vital role to play through the obligations placed on it by the European Treaties. Community actions complement the Member States' national health policies, but at the same time bring European added value: issues such as cross-border health threats – for example influenza - or free movement of patients and medical personnel need a response at European level.

2.1 The Health Strategy and the Health Programme

"Together for Health: A Strategic Approach for the EU 2008-2013" is EU's current Health Strategy main document. This Strategy aims to provide, for the first time, an overarching strategic framework spanning core issues in health as well as health in all policies and global health issues. The Strategy aims to set clear objectives to guide future work on health at the European level, and to put in place an implementation mechanism to achieve those objectives, working in partnership with Member States. The Strategy focuses on four principles and three strategic themes for improving health in the EU.
The principles include:

- taking a value-driven approach;
- recognising the links between health and economic prosperity;
- integrating health in all policies;
- strengthening the voice of the EU in global health.

The strategic themes include:

- fostering good health in an ageing Europe;
- protecting citizens from health threats;
- dynamic health systems and new technologies.

The Health Programme is the key means to implement health objectives at European level. The "Second Programme of Community Action in the Field of Health 2008-2013" follows the first Programme of Community action in the field of public health (2003-2008), which financed over 300 projects and other actions.
The Health Programme is based on Article 152 of the Treaty establishing the European Community. It is an incentive measure designed to protect and improve human health, excluding any harmonisation of the laws and regulations of the Member States. The Health Programme 2008-2013 is intended to complement, support and add value to the policies of the Member States and contribute to increased solidarity and prosperity in the European Union by protecting and promoting human health and safety and by improving public health.
The Programme objectives are:

To improve citizens' health security:

- Developing EU and Member States' capacity to respond to health threats, for example with health emergency planning and preparedness measures;
- Actions related to patient safety, injuries and accidents, risk assessment and community legislation on blood, tissues and cells.

To promote health, including the reduction of health inequalities:

- Action on health determinants - such as nutrition, alcohol, tobacco and drug consumption,

as well as social and environmental determinants;
- Measures on the prevention of major diseases and reducing health inequalities across the EU;
- Increasing healthy life years and promoting healthy ageing.

Health information and knowledge:
- Action on health indicators and ways of disseminating information to citizens;
- Focus on Community added-value action to exchange knowledge in areas such as gender issues, children's health or rare diseases.

Aspects regarding actions or projects selection and implementation have been delegated to and Executive Agency (see box below).

Box 3. The Executive Agency for Health and Consumers

The Commission delegated to the Executive Agency for Health and Consumers the responsibility for implementing the Public Health Programme, the Consumer Programme and the Food Safety Training Measures. There are various funding possibilities under the EU Health Programme 2008-2013, although at the moment there are no calls available. Funding possibilities include (see ec.europa.eu/eahc/health/health.html):
- grants for action (projects);
- operating grants for organisations or specialised networks;
- co-financing of conferences;
- joint action by the Community and Member States as well as other (third) countries participating in the Programme;
- tendering of actions to achieve the Programme objective.

Apart from actions and policies directly promoted by DG SANCO, many other Community interventions have an impact on health and health systems across Europe. They are often developed within a different policy logic and decision makers are often not well aware of potential health effects. Important health determinants cannot be influenced by health policy on its own; there is a need for co-ordinated actions involving other policy areas such as environmental, social or economic policies.
To this purpose, it is essential to take into account the Lisbon Agenda, being the key EU policy on economic growth and productivity, and to mainstream health into the Lisbon Agenda is one of the most important achievements of mainstreaming health into other policies. The link between health and economic prosperity is more and more widely recognised, in particular in relation to the ageing population (the Healthy Life Years indicator, a measure of years lived in good health, being the only European Structural Indicators of the Lisbon Agenda that directly relates to health).

The Finnish Ministry of Health and Social Affairs has especially taken forward the up the theme of Health in All Policies as part of its 2006 Presidency of the European Union. With co-funding from the Community Public Health Programme the Presidency co-ordinated a project entitled "Europe for health and wealth", which consists of influencing determinants of health in other national and Community policies and gathering the best available knowledge on good practices to engage other sectors in

improving health and reducing health inequalities. To this purpose, also *The contribution of health to the economy in the European Union* (2005), must be taken into account, since "there is a sound theoretical and empirical basis to the argument that human capital contributes to economic growth. Since human capital matters for economic outcomes and since health is an important component of human capital, health matters for economic outcomes. At the same time, economic outcomes also matter for health" (p.9)[14]. One of the latest relevant document on this issue is *Solidarity in health: reducing health inequalities in the EU* (2009), in which the Commission shows its concern over the extent and the consequences of health inequalities both between and within Member States, suggesting an improved coordination of policies and efforts in Europe (COM(2009)567final).
According to what has been said above, the attention can be focused on three issues of the European Health Strategy – and their determinants – that can, in particular, been considered as important for an healthier Europe in which there are better quality of life conditions for all, taking into account the city/region level. These issues are: lifestyle, health inequalities and their socio-economic determinants, the environment. A brief description of these issue will be provided, while in the following pages, to reinforce the link between health and all policies and between health and a more local focused approach, the point of view of the WHO will be highlighted.

[14] http://ec.europa.eu/health/ph_overview/Documents/health_economy_en.pdf

2.2 Lifestyle

Lifestyle related health determinants are multi-dimensional. These determinants are linked to number of major health problems. Also, some health issues share same determinants such as tobacco, alcohol, and nutrition. Health problems linked to lifestyle related health determinants can be life-situation specific (e.g. in childhood or in old age) but they can also be strongly linked to cultural aspects. In addition, socio-economic factors are an important reason for variations in health. Addressing these factors is considered as important in the framework of the EU Health Strategy, and a comprehensive health promotion in various settings (e.g. schools, workplaces, families and local communities) has proven to be efficient in addressing health determinants.

2.3 Health inequalities and socio-economic determinants of health

Health inequalities lower the ability of huge numbers of EU citizens to achieve their potential. Action to reduce health inequalities aims:

- to improve everyone's level of health closer to that of the most advantaged;
- to ensure that the health needs of the most disadvantaged are fully addressed;
- to help the health of people in countries and regions with lower levels of health to improve faster.

At the EU level this involves many policy areas including:

- Economic, employment and social policy - through the Lisbon process to strengthen the European economy and at the same time ensure social protection and measures to improve social inclusion.
- Regional Policy - to support the economies and health infrastructure of countries and regions of the EU which are lagging behind or have special needs.
- Research - to identify the causes of socio-economic health inequalities and to develop and evaluate measures to combat them
- Public Health - action to reduce health inequalities is an overall aim and objective of the public health action programme 2007-2013.

2.4 Environment

The presence of natural or man-made hazards is a source of environmental diseases, which might be seen as the visible and clinical indication of inadequate environmental conditions. Key areas of action could be:

- Outdoor and indoor air pollutants quality,
- Noise
- Indoor environment and housing conditions,
- Water quality contamination,
- Electromagnetic fields and radiation,
- Chemical exposures.

The impact of these factors are felt in association with hearing problems, sleeping disorders, stress leading to hypertension and other circulatory diseases, skin and other cancers, asthma, or birth defects.

2.5 Europe at a glance: health data and the perception of quality of life

The EU has also promoted several attempts to monitor its citizens living conditions. The Eurostat offices work on collecting and harmonizing data from national statistical offices with sometimes very different collecting methodologies, and efforts have been made to collect comparable data at city level (especially through the Urban Audit). Two of the most interesting and recent studies in this field are the *Health at a glance: Europe 2010* (2010) co-production of OECD and European Commission (see box 4) and the *Perception survey on quality of life in European cities* (2010) (see box 5 and fig. 1).

Box 4. Health at a Glance: Europe 2010

OECD (2010), Health at a Glance: Europe 2010, OECD Publishing. http://dx.doi.org/10.1787/health_glance-2010-en

The first edition of "Health at a Glance: Europe 2010" presents a set of key indicators on health and health systems across 31 countries –the 27 European Union member states, three European Free Trade Association countries (Iceland, Norway and Switzerland), and Turkey. The selection of indicators is based on the European Community Health Indicators (ECHI) shortlist –a set of indicators used by the European Commission to guide the development of health information systems in Europe. In addition, the publication provides detailed information on health expenditure trends across countries, building on the OECD's established expertise in this

area.
Health at a Glance: Europe2010 presents evidence of wide variations across European countries in population health status, risk factors for health, the inputs, outputs and outcomes of health care systems, and levels of health expenditure and financing sources. It offers some explanation for these variations, providing a background to understand more fully the causes underlying such variations and to develop policy options to reduce gaps across countries. It should also be noted that while basic population breakdowns by sex and age are presented, this publication does not generally provide detail by sub-national regions, by socio-economic groups or by ethnic/racial groups. For many indicators, readers should keep in mind that there may be as much variation within a country as there is across countries.

Box 5. Perception survey on quality of life in European cities

http://ec.europa.eu/regional_policy/sources/docgener/studies/pdf/urban/survey2009_en.pdf

The survey was conducted in November 2009 to measure local perceptions in 75 cities in the EU, Croatia and Turkey (see fig. 1, below). Its main findings are related to 9 topics:

Health care, jobs and housing

· Of the 75 cities surveyed, residents of North-Western European cities were most satisfied with health care services: at least 80% of respondents in those cities said they were content. The levels of satisfaction were considerably lower in many southern and eastern European cities.

· The picture in regard to job opportunities was rather bleak: there were only six cities where more than half of respondents agreed that it was easy to find a good job.

· Apart from 10 cities, respondents held a pessimistic view about the availability of reasonably priced housing; many cities where respondents held such a view were capitals and/or large cities.

Poverty / economic situation

· Except for nine cities, respondents who thought that poverty was a problem in their city outnumbered those who believed it was not an issue.

· Despite those prevailing views about poverty, it was rare for more than half of respondents in any of the cities to admit that they have financial difficulties themselves.

Immigration / presence of foreigners

· Opinions about the presence of foreigners in the surveyed cities were generally positive: in 68 cities, a slim majority of interviewees, at least, agreed that their presence was beneficial.

· However, in almost all cities, the proportion who agreed that foreigners in their city were well integrated was lower than the proportion who agreed that their presence was good for the city.

Safety and trust

· As to whether people could be trusted, the picture across cities was mixed. In about one-third, less than half agreed that most of their fellow citizens were trustworthy. Several eastern European capitals were at the lower end of the scale.

· In most Nordic cities, about two-thirds of respondents always felt safe in their city. There was a strong correlation between the proportion of respondents who agreed that most of

their fellow citizens could be trusted and the proportion who always felt safe in their city.

· Respondents across all surveyed cities were more likely to say they always felt safe in their neighbourhood than they were to say that they always felt safe in their city.

Main issues facing city dwellers

· When asked to list the three main issues facing their city, respondents typically opted for "job creation/reducing unemployment", "availability/quality of health services" and "educational facilities".

· Job creation and reducing unemployment appeared among the three most significant problems that respondents' cities faced in 64 of the 75 surveyed cities.

· The need to improve the quality/availability of health services appeared among the top three problems in 54 cities.

Pollution / climate change

· There appears to have been an improvement in the situation regarding air and noise pollution in European cities.

· In all Italian cities in this study, a large majority of respondents agreed that air pollution was a major problem. A large number of cities in that same situation were capitals and/or large cities (with at least 500,000 inhabitants).

· In most cities, more than half of respondents agreed that noise was a major problem in their city – this proportion ranged from 51% in Rotterdam and Strasbourg to 95% in Athens.

· As with the results for air and noise pollution, a majority of cities seemed to have made progress in terms of cleanliness in the past few years.

· There was a strong correlation between the perceived levels of air pollution and perceptions about whether a city was healthy to live in or not - the same cities appeared at the higher and lower ends of the rankings.

· Cities where respondents were more likely to agree that there was a commitment to fight climate change were also the ones where respondents were somewhat more likely to agree that their city was a healthy place to live.

Administrative services

· In roughly one in three of the surveyed cities, a slim majority of respondents – at least – thought that their city spent its resources in a responsible way.

· All surveyed German cities (except Munich) were at the bottom of the ranking relating to administrative services – the proportion of respondents who disagreed that resources were spent responsibly in their city ranged from 52% in Leipzig to 73% in Dortmund.

· There was a strong correlation between the proportion of respondents who agreed that resources were spent in a responsible way and those who felt that administrative services helped citizens efficiently.

City infrastructure

· In a majority of cities (54 of 75), at least three-quarters of respondents were satisfied with their own city's cultural facilities, such as concert halls, museums and libraries.

· In 69 cities, a majority of respondents said they were satisfied with public spaces, such as markets and pedestrian areas. Many cities at the higher end of the ranking (where most respondents were satisfied with their city's markets and pedestrian areas) were situated in northern and western

European countries.

· In 25 cities, at least three-quarters of interviewees were satisfied with the beauty of streets and buildings in their neighbourhood, and in another 40 cities, between half and three-quarters of respondents expressed satisfaction.

· Nonetheless, in almost all cities, respondents were more likely to be satisfied with their city's markets and pedestrian areas than they were to be satisfied with the outlook of the streets and buildings in their neighbourhood.

· A majority of citizens were satisfied with parks and gardens in their cities except in 7 of the 75 listed cities. Similarly, a majority of citizens were satisfied with outdoor recreational facilities in all cities except for 9 of the 75.

· Many citizens found it difficult to estimate their satisfaction with their city's sports facilities – the proportion of "don't know" responses reached 44% in Liege and Riga.

· Overall, a positive picture emerged in terms of satisfaction with the types of facilities provided. In a majority of surveyed cities, at least three-quarters of respondents were satisfied with at least four of the six items listed in the survey, while this proportion dropped below 50% in just 11 cities.

Public transport

· In about half of the surveyed cities roughly two-thirds of respondents said they were very or rather satisfied with their city's public transport.

· The largest proportions of "frequent public transport users" were found in Paris, London, Prague, Stockholm and Budapest – there, at least three-quarters of respondents took a bus, metro or another means of public transport in their city at least once a week.

· Europe's capitals were among the cities with the highest proportions of respondents who used public transport to commute – for example, 90% in London, 56% in Bratislava and 52% in Sofia.

· Commuting times were the longest in Europe's capitals and large cities (i.e. those with more than 500,000 inhabitants).

· In eight cities, a relative majority of respondents – at least – said they usually walked or cycled to work or college.

The OECD study and the EU survey shows an improved capacity of the EU to know more about health and quality of life related issues, and this has to be paired with the direct and indirect actions that DG SANCO and other DGs (REGIO, ENVIRONMENT, EMPLOYMENT) have promoted. But from the point of view of the possibilities to exchange practices and to create thematic networks of cities the WHO role is quite important at European level.

Fig. 1 – Urban Audit Perception Survey Participating Cities

Source: European Commission, DG REGIO

3. The WHO role

WHO action in public health policies – especially referring to the WHO European Regional Office – goes hand in hand with EU policy developments. Since health habits and outcomes of health behaviour are highly affected by other social-economic circumstances, in 2005 the Director General of the WHO set up a global commission on the "Social Determinants of Health". The objective of the commission was to achieve policy change by learning from existing knowledge about the social determinants of health and turning that learning into global and national political and economic action[15].

According to the definition given by WHO:

> "[h]ealth is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief or economic and social condition" [16].

Not only does this statement define health, it is evidence of the public health pendulum swinging away from a medical model and back towards a social model – the new public health paradigm. The medical model focuses on the individual and on interventions that are used to treat disease. By contrast, a social model considers health as an outcome of the effects of socio-economic status, culture, environmental conditions, housing, employment and community influences.

This perspective conveys the breadth of public health and the need for health, in the broadest sense, to be considered in development processes and in policy-making. Its tenets are as follows:

1. health is not merely the absence of disease or disability;
2. health problems are defined at the policy level;
3. health is a social issue;
4. improving health status requires a long-term focus on policy development;
5. improving health status requires a primary focus on changing basic conditions;
6. improving health status requires involving natural leaders in the process of change.

Good health is, in fact, something that everyone wants – for themselves, their children and for the wider economic and social benefits it brings to our society. It plays a major role in long-term economic growth and sustainable development. This is especially true in urban areas, where the environmental, economic and social dimensions meet most strongly. Cities are where many environmental, economic and social problems are concentrated, but they are also the national economic drivers, the places where business is done and investments are made. Four out of five Euro-

15 http://www.who.int/social_determinants/en/.

16 Preamble to the Constitution of the World Health Organization, as adopted by the International Health Conference, New York, 19 June - 22 July 1946. Signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948.

European citizens live in urban areas, and their quality of life, wellbeing and health is directly influenced by the state of the urban environment, economic and social factors. The attractiveness of European cities will enhance their potential for growth and job creation, and cities are therefore of key importance to the implementation of the Lisbon Agenda[17].

At the United Nations World Summit on Sustainable Development in Johannesburg (South Africa, 2002) WHO identified urbanization as a key challenge for health and sustainable development, along with poverty, global environmental change, globalisation and disasters. Air pollution, noise, overcrowded housing, and inadequate water and sanitation – considered as characteristics of urban areas – continue to be major contributors to bad health in Europe, particularly among migrants, children, women and elderly people.

Differences in health condition, then, arise from differences in the factors that influence health. These factors, that refers to many different conditions, can be summarised as:

- age, sex and hereditary factors;
- individual lifestyle factors;
- social and community influences;
- living and working conditions;
- general socio-economic, cultural and environmental conditions.

Some of these factors cause differences that cannot be avoided. Differences in gender and/or in age can result, for example, in differences in health conditions, but sometimes improvements arise if specific measures are adopted.

WHO uses equity and inequity to refer to "differences in health that are not only unnecessary and avoidable but, in addition, are considered unfair and unjust". "Equity is [...] concerned with creating equal opportunities for health and with bringing health differentials down to the lowest possible"[18].

Approaches that are used to reduce inequity in health can be broadly divided into four different measures that:

a) strengthen individuals;
b) strengthen communities;
c) improve access to essential facilities and services;
d) encourage macroeconomic and cultural change.

A programme to address inequity in health and in quality of life conditions will require initiatives at all four levels.

3.1 Health as a resource

As per the "Ottawa Charter for Health Promotion" (17-21 Nov. 1986), health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical mental and social wellbeing, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as

[17] European Commission (2006), *Cities and the Lisbon Agenda: Assessing the performance of cities*, EC – DG Regional Policy, Bruxelles (http://www.eukn.org/binaries/eukn/eukn/research/2006/2/cities-and-the-lisbon-agenda.pdf; visited on the 15th of October 2007).

18 WHO Glossary created by Ruth Barnes and the Health Development Agency (http://www.who.int/hia/about/glos/en/index.html) (web site consulted on the 15th of October 2007).

a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing.

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system that contributes to the pursuit of health.

The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate that is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.

4. The importance of the urban dimension

Given the general context provided by the WHO, the EU and other national and international agencies, specific attention should be paid to the urban level and to quality of life in the cities. This has also been highlighted in the Leipzig Charter, in which it is stated that:

> "all dimensions of sustainable development should be taken into account at the same time and with the same weight. These include economic prosperity, social balance and a healthy environment. At the same time attention should be paid to cultural and health aspects. [...] Our cities possess unique cultural and architectural qualities, strong forces of social inclusion and exceptional possibilities for economic development. They are centres of knowledge and sources of growth and innovation. At the same time, however, they suffer from demographic problems, social inequality, social exclusion of specific population groups, a lack of affordable and suitable housing and environmental problems" (p. 1)[19].

The Charter also recommends to make greater use of integrated urban development policy approaches by:

- creating and ensuring high-quality public spaces;
- modernize infrastructure networks and improving energy efficiency;
- proactive innovation and educational policies.

In this framework specific attention has to be paid to deprived neighbourhoods within the context of the city as a whole, especially by:

- pursuing strategies for upgrading the physical environment;
- strengthening the local economy and the local labour market policy;
- proactive education and training policies for children and young people;
- promotion of efficient and affordable urban transport.

All these suggestions directly, or indirectly, refer to health and quality of life and, thus, need to be tackled. It is also clear, though, that these suggestions call for a greater effort than those that can be done by cities alone, thus stressing the importance of a coordinated action among the EU, the national, the regional and the local level in the field of health and health related policies. Conditions in cities, sometimes compounded by urban planning practices, can be in fact detrimental to health. Healthy urban planning focuses on the positive impact that urban planning can have on human health, well-being and quality of life, and reflects WHO's broad definition of health.
The health and wellbeing of any population requires a holistic approach that includes the involvement of many agencies and gives ownership to the communities involved.
The traditional notion of top-down delivery of health care is no longer acceptable to central governments, who are seeking greater value for money, or – from another point of view – who are continuously reducing

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19 www.eu2007.de/en/News/download_docs/Mai/0524-AN/075DokumentLeipzigCharta.pdf

the amount of budget for local authorities. In the same time, the increasing return to the principles of public health signifies that a purely medical approach to health cannot by itself resolve the many health problems in increasingly complex cities.

Government health strategy documents increasingly recognize the importance of the views of the people receiving services in needs-based service delivery and espouse the involvement of individuals and communities as a key objective in the future delivery of health services. To give people an effective voice in the shaping of the health services there needs to be a move away from one-off consultation towards ongoing involvement of local people.

Healthy urban planning, in the simplest terms, should mean planning that (a) is not unhealthy and (b) promotes health. Factors affecting urban planning and health include:

- high priority of urban planning and health in the political agenda;
- monitor pollution level (air, water, outside and inside air pollution, etc.) and maintaining pollution under control;
- plan, design and build urban areas focusing on people's health (green areas, housing, availability and accessibility of health and social services, etc.).

Planners must fully recognize the importance of housing environments, but an appreciation of the social and ecological consequences for the whole community is fundamental. For example, the spacious single-family home on a large lot may meet the needs of a single family, but such a solution is not feasible on a global level. When considering healthy housing design, it is necessary to strike a balance between the needs of the individual, of the family and of the larger community.

Learning from mistakes, made in previous efforts to provide quality housing, is another vital component of healthy planning. Urban renewal was intensely popular in the 1960s and 1970s in North America and Europe. Between 1964 and 1974, the London County Council built 384 high towers with the intention of providing quality housing and less oppressive conditions for the economically disadvantaged. This practice is also known as "slum clearance." The results have been a failure: in fact, some communities were found to be stronger, more vibrant and more hopeful prior to their dislocation. Dwelling types have also been linked to feelings of loneliness and isolation, particularly among the elderly and women. Such feelings of isolation are at their extreme among those living in high rises that are social housing projects, for these people have no other choice but to live in a place that isolates residents from one another and from the outside world based on their socio-economic status. To save costs, the design of each dwelling unit has often been repetitive, not taking into account the specific needs of a diversity of individuals, families and social activities. Isolation is intensified by the fact that social housing projects often look very similar and are easily identifiable, thus heightening the social stigma along with the increased feelings of loneliness among residents. Forcing people to live where they do not want to be and where they have not been given the opportunity to contribute to the process is essentially a recipe for social chaos in several EU cities. "Pub-

lic spaces become barren zones where gangs wage war."[20]

If a community does not have adequate health services, schools, libraries, recreational facilities or access to food and parks, the community loses a major buffer against violence. Without these critical institutions, not only is a buffer missing, but there is no community infrastructure and thus minimal opportunity for community cohesion, resulting in intensified fragmentation. This places urban planners in a position of great importance. It stresses the need for creating neighbourhoods that foster pride, respect and friendliness and ensure accessibility of services. It provides evidence of the importance of "liveable urban spaces located at the heart of the city or neighbourhood … [That] exemplify the essence of the community"[21].

There are, of course, many different opinions as to what constitutes a healthy city, depending upon one's discipline, values and point of view. Nevertheless, general principles, theories and common parameters can be applied in working towards healthy urban planning.

An healthy city should then focus on:

- equity. All people must have the right and the opportunity to realize their full potential in health;
- health promotion. A city health plan should aim to promote health by using the principles outlined in the "Ottawa Charter for Health Promotion" (17-21 Nov. 1986): build healthy public policy; create supportive environments; strengthen community action and develop personal skills; reorient health services;
- inter-sectoral action. Health is created in the setting of everyday life and is influenced by the actions and decisions of most sectors of a community;
- community participation. Informed, motivated and actively participating communities are key elements for setting priorities and making and implementing decisions;
- supportive environments. A city health plan should address the creation of supportive physical and social environments. This includes issues of ecology and sustainability as well as social networks, transportation, housing and other environmental concerns.

The tools and techniques used to initiate an alternative, healthy urban planning process will undoubtedly vary from city to city, neighbourhood to neighbourhood and group to group. Whatever the overall process, it must take into account the various cultures, religions and lifestyles in the community. Healthy urban planning does not view multiculturalism and diversity as problems to be overcome but rather as rich opportunities waiting to be seized. Urban planning must be sustained by dynamic leadership styles and open to various configurations. For example, it should be open to collaborative and bottom-up actions. Healthy urban planning thus makes room for citizens as leaders

20 Duhl L. J. and Sanchez A. K. (1999), "Healthy cities and the city planning process", WHO Regional Office for Europe, Copenhagen.

21 Cohen L. (1993), "A public health approach to the violence epidemic in the United States", Environment and urbanization, 5, pp. 50–66.

and requires catalytic leadership from planners.

Disadvantaged and marginalized groups are particularly at risk in urban areas. In order to ensure health for all, the standards of health must consider the most vulnerable populations. This approach is often used in the setting of environmental health standards. For example, the standard for the maximum allowable levels of lead exposure is set for the most susceptible population, in this case children. This concept relates to urban planners: "To create a liveable city for all the community, one must design for its weakest members, children, disabled and the elderly. A city that is hospitable to these groups will foster a sense of well-being among all its citizens."[22]

4.1 Cooperation between the public, private and voluntary sectors

Broader inter-sectoral cooperation in the city is vital to ensure a coordinated intervention, without one agency undermining others. This applies, for example to education authorities, health and social services in relation to equitable access, to transport authorities working with land-use authorities, to major investors in the private and voluntary sectors recognizing their social and environmental responsibilities.

In a pluralist society, achieving healthy and socially inclusive cities is difficult unless businesses and public sector investors accept some shared responsibility with planning and health agencies. On the other hand, success relies on the central authorities acting transparently, being willing to pool responsibility and coordinate action.

Political backing from the top tier of the city government is, therefore, an essential prerequisite for the development of long-term programmes and for effective liaison between departments in a situation in which each department tends to have its own specific remit and professional perspective.

Given this co-operative framework, the critical factor that will help to ensure that planning policy is aimed towards health is absorbing health into the mainstream of plan making and plan implementation activities. Merely tagging on a health objective or retrospectively assessing health impact is not enough.

4.2 What is special about urban health

> "Where people live affects their health and chances of leading flourishing lives. Communities and neighbourhoods that ensure access to basic goods, that are socially cohesive, that are designed to promote good physical and psychological wellbeing, and that are protective of the natural environment are essential for health equity."
> *Closing the gap in a generation, WHO headquarters, 2008*

Two thirds of the population in Europe live in towns and cities. Urban areas are complex living environment and often unhealthy places to live, char-

22 Crowhurst-Lennard S.H. and Lennard H.L. (1987), "Liveable cities", Gondolier Press, Southampton, NY.

acterized by traffic, pollution, noise, violence and social isolation for elderly people and young citizens.
Urban health is therefore complex because the solutions to health challenges in towns and cities do not lie with the health sector alone but with decisions made by others: in local government, education, urban planners, engineers and those who determine physical infrastructure and access to social and health services. These professionals have to face the challenges of overloaded water and sanitation systems, polluting traffic and factories, lack of space to walk or cycle, inadequate waste disposal, crime and injury.
Nevertheless, as we all can witness, solutions exist to tackle the root causes of urban health challenges. Urban planning can promote healthy behaviour and safety through investment in transport or in designing areas to promote physical activity. Improving urban living conditions in the areas of housing, water and sanitation will go a long way to mitigating health risks, together with building green, inclusive cities that are accessible and age-friendly, to the benefit all urban residents and their health.
One of the most interesting experiences in recent years is the WHO "Healthy Cities" programme.

4.3 Healthy Cities

The WHO European Healthy Cities Network consists of cities around the WHO European Region that are committed to health and sustainable development: more than 90 cities and towns from 30 countries. They are also linked through national, regional, metropolitan and thematic Healthy Cities' networks.
The WHO European Healthy Cities Network has six main strategic goals:

- to promote policies and action for health and sustainable development at the local level and across the WHO European Region, with an emphasis on the determinants of health, people living in poverty and the needs of vulnerable groups;
- to strengthen the national standing of Healthy Cities in the context of policies for health development, public health and urban regeneration with emphasis on national–local cooperation;
- to generate policy and practice expertise, good evidence, knowledge and methods that can be used to promote health in all cities in the Region;
- to promote solidarity, cooperation and working links between European cities and networks and with cities and networks participating in the Healthy Cities movement;
- to play an active role in advocating for health at the European and global levels through partnerships with other agencies concerned with urban issues and networks of local authorities; and
- to increase the accessibility of the WHO European Network to all Member States in the European Region.

A city joins the WHO European Healthy Cities Network based on criteria that are renewed every five years[23]. Each five-year phase focuses on core priority themes and is launched with a political declaration and a set of strategic goals. The overarching goal of the current Phase V (2009–2013) is health and health equity in all local

[23] http://www.euro.who.int/en/what-we-do/health-topics/environmental-health/urban-health/activities/healthy-cities/who-european-healthy-cities-network

policies. The three core themes are:
- caring and supportive environments;
- healthy living;
- healthy urban design[24].

Phase V is supported by the Zagreb Declaration for Healthy Cities.
The WHO Healthy Cities project engages local governments in health development through a process of political commitment, institutional change, capacity building, partnership-based planning and innovative projects. The primary goal of the WHO European Healthy Cities Network is to put health high on the social, economic and political agenda of city governments. Health is the business of all sectors, and local governments are in a unique leadership position, with power to protect and promote their citizens' health and wellbeing.
The Healthy Cities movement promotes comprehensive and systematic policy and planning for health and emphasizes:
- the need to address inequality in health and urban poverty;
- the needs of vulnerable groups;
- participatory governance;
- the social, economic and environmental determinants of health.

This is not about the health sector only. It includes health considerations in economic, regeneration and urban development efforts.
A process, not an outcome, defines a healthy city:
- A healthy city is not one that has achieved a particular health status;
- It is conscious of health and striving to improve it. Thus any city can be a healthy city, regardless of its current health status;
- Requirements are a commitment to health and a process and structure to achieve it;
  A healthy city is one that continually creates and improves its physical and social environments and expands the community resources that enable people to mutually support each other in performing all the functions of life and developing to their maximum potential.

The Healthy Cities approach recognizes the determinants of health and the need to work in collaboration across public, private, voluntary and community sector organizations. This way of working and thinking includes involving local people in decision-making, requires political commitment and organizational and community development, and recognizes the process to be as important as the outcomes.
The concept of Healthy Cities was inspired and supported by the European WHO "Health for All strategy" and the "Health21" targets.
Some BHC partner cities are members of the Healthy Cities network (among them Lodz, Amaroussion, Torino), thus profiting from the available knowledge and linking future strategies, possibly inspiring other BHC members to foresee future collaborations.

[24] Urban health was also the theme of the World Health Day organised by WHO in 2010.

Annex 1. The Barnsley Exchange on Social Marketing

A brief report on the Exchange

Representatives from the cities of Lidingö (SE) and Torino (IT), plus Marco Santangelo, BHC Lead Expert, and Antonella Cardone, BHC Thematic Expert, gathered in Barnsley (UK) on 8-10 July 2010 to learn more about a new methodology that applies marketing techniques to social issues.
NHS Barnsley (the National Health Service agency for Barnsley) hosted the two day workshop and its results will be shared across the BHC network during the third thematic workshop in Bacau. During the first day Steve Turnbull, Assistant Director Public Health for NHS Barnsley and Barnsley Metropolitan Borough Council (and the city representative in BHC Steering Group) welcomed the BHC delegation. Kirsty Waknell, Marketing and Communication Manager for NHS Barnsley gave an overview of social marketing and how it is used in Barnsley.
Two projects were then presented to demonstrate how social marketing has been used in social policies. Alison Millbourn, Physical Activity Lead for NHS Barnsley, presented a project on 'increasing physical activity in men over 40', while Ian Morley, Arts Development Officer at Barnsley Metropolitan Borough Council, presented a project for promoting positive lifestyles.
The morning of day two was dedicated to the principles of social marketing. Kirsty Waknell presented the eight benchmark criteria which NHS Barnsley use for this approach. In the afternoon examples of actions implemented in Lidingö were tested and discussed taking into account social marketing principles. The participants agreed that the interesting results of this exchange could usefully become part of the final BHC thematic workshop. The rest of the day was dedicated to site visits led by Alan West from Barnsley Metropolitan Borough Council and Councillor Jenny Platts, Cabinet Spokesperson for Adult Social Services and Health.
The delegation visited the Athersley area in which two projects are implemented: the "Roundhouse Motorskills Project – Motormouth", especially for young people, and the "Romero Project", developed for the benefit of the local community.

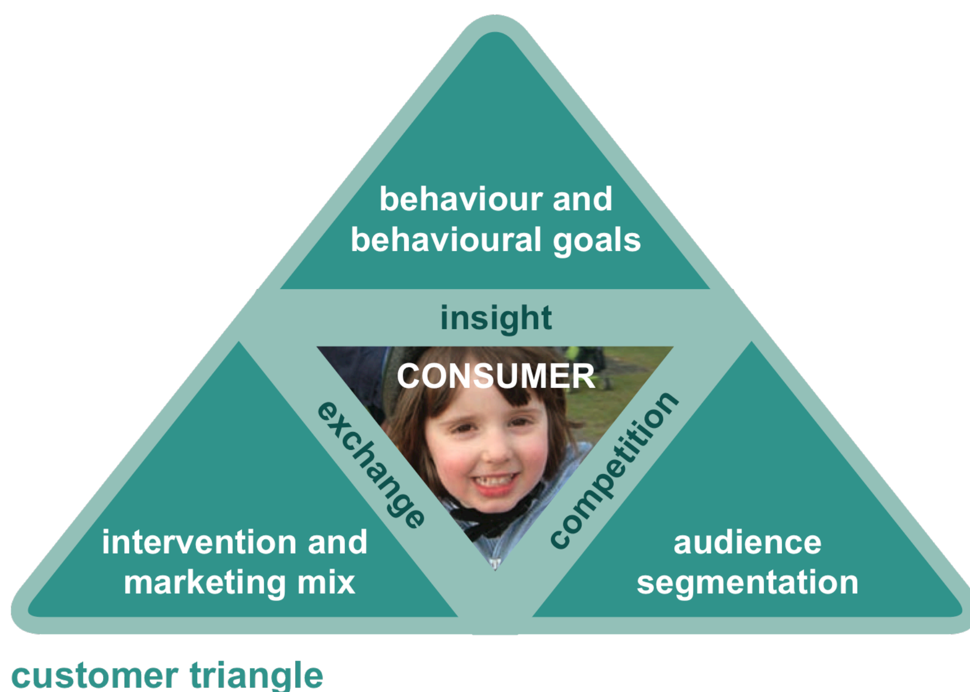
What is social marketing?

Social marketing regards the "systematic application of marketing and other concepts and techniques to achieve specific behavioural goals, for a social or public good" (French, Blair-Stevens, 2006, available in www.thensmc.com). It is an approach that is increasingly being used to achieve positive impacts on the behaviour of individuals and groups, and to help sustain these over time. Since the 1970s, when the term was first used, a range of descriptions and definitions has been developed[25]. Originally, in the 1960s and 1970s social marketing was described as the

[25] Based upon a review of these, this paragraph builds on the latest thinking and approaches to social marketing and is based on the publication *Social Marketing Works! A powerful and adapt-*

use of commercial marketing in the public sector. However, in the last decades it has become a much more integrated and mature approach that harnesses the best of marketing alongside the extensive learning and experience from social sciences and social policy. This means that rather than competing with best practices in public health and health promotion it increasingly integrates with them. Social marketing is based on a number of core concepts and principles, and it mainly differs from traditional health promotion techniques because those tends to communicate some "healthy" messages (e.g. smoking will kill you) hoping that the customer will choose to act correctly. In social marketing, instead, the intervention is focused on the customer needs and behaviours, thus promoting a more interactive strategy in which conversation (i.e. not simply delivering a message and then hoping, but collaborating to achieve positive results) and measurement (i.e. a constant monitoring of the situation) are equally important. Traditionally marketing is around what people (should) want, but not around how people (could) live, and there comes the contribution of marketing techniques paired with social issues. The social marketing *customer triangle* is a simple device to help highlight some of the principles that form part of a social marketing intervention, with the customer or consumer placed at the centre (see fig. 2).

Fig. 2 – The customer triangle in social marketing



Source: www.thensmc.com

Social marketing interventions, however, usually follow a procedure that includes eight steps and their relative benchmark criteria (as in fig. 3). Each step helps to build a correct procedure whose effects should be positively accepted by the citizens. In the first step for instance, "Customer orientation", there is on one side a research with ethnographic methodologies (e.g. vox pops, diaries, focus groups,

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able approach for achieving and sustaining positive behaviour (http://www.thensmc.com), and on other documents of the National Social Marketing Centre.

alongside the more traditional consultation of existing researches and publications), but to this there is a verification phase that can be obtained only by living and talking with the target people. Another step, the one that regards segmentation variables, is more directly linked to the collection of data for a good intervention. Beside traditional data collection, especially in the field of demography (age, gender, income, religion, etc.), more data are collected on geography (to map where people live), on behaviour (what people do, when, how much, etc., of course in relation with the goal of the intervention), on psychographic issues (social class, motivations, aspirations, lifestyle, values, etc.). These are not data that are usually taken into account when designing a policy or an intervention, but their collection certainly could enrich the quality of the action.
The aim of the eight criteria is then to help bring rigour and consistency to the way in which social marketing is approached in order to increase its chances of delivering successful outcomes. These criteria can be used in a range of ways including:

1. Commissioning. Commissioners can use the benchmark criteria with organisations or individuals tendering for social marketing related work, so that their proposals are considered in terms of consistency with the criteria.
2. Development of interventions. The criteria provide a checklist on which to reflect and therefore assist the development process. They identify the issues that will need to be addressed and during the work they act as a guide to keeping work and processes on track with the key elements of social marketing.
3. Review and evaluation. The criteria also provide a checklist of key issues to include and consider in any review and evaluation process. For example, the extent to which work was based on deeper understanding and insight of the customer had a clear behavioural focus and specific measurable behavioural goals.

Social marketing can be used to inform and assist policy formulation, strategy development and related implementation and delivery, including service development and design. To know more and to see more about good practices see the National Social Marketing Centre website (www.thensmc.com).

Social Marketing in Barnsley*

The social marketing approach has been adopted in Barnsley since 2003, for the set up of the *Fit for the Future* programme. The need for a change in the approach came from the recognition that in order to tackle inequalities a different way of working was to be found. There was, in fact, a growing understanding of what people's health was like (through health assessments or the use of performance indicators), but it was less clear why people got to that point. Being social marketing approach known at the UK level, NHS Barnsley decided to employ a marketing communication agency and then a full time practitioner to introduce social marketing principles and methodologies in everyday work. Since then many pro-

* This paragraph is based on the presentation that Kirsty Waknell, from NHS Barnsley, gave during the Exchange.

grammes have been developed according to social marketing techniques – on alcohol consumption and on physical activity of sedentary adults, to name few of them – and this has led to future goals, including the development of programmes which aren't related to a single issue, and the promotion of wider partnerships in the implementation of the different interventions.
For more information on cases and practices of social marketing see: http://www.thensmc.com/
resources/showcase/case-studies-home.html
This website is rich with case studies, but in other countries it is possible to find resources available in local language, as social marketing techniques are spreading. See for example in Italy and Spain respectively a website and an article:

- http://www.marketingsociale.net/
- Leal Jiménez A. (2004), "El marketing social en España: situación actual y estrategias para su desarrollo", *Revista Internacional de Marketing público y no lucrativo*, vol. 1, n. 1, pp. 35-52.

Fig. 3 – The social marketing benchmark criteria

Social marketing
National Benchmark Criteria

National
Social Marketing
Centre

Benchmark	What to look for
1. CUSTOMER ORIENTATION ***'Customer in the round'*** **Develops a robust understanding of the audience, based on good market and consumer research, combining data from different sources**	• A broad and robust understanding of the customer is developed, which focuses on understanding their lives in the round, avoiding potential to only focus on a single aspect or features • Formative consumer / market research used to identify audience characteristics and needs, incorporating key stakeholder understanding • Range of different research analysis, combining data (using synthesis and fusion approaches) and where possible drawing from public and commercial sector sources, to inform understanding of people's everyday lives
2. BEHAVIOUR **Has a clear focus on behaviour, based on a strong behavioural analysis, with specific behaviour goals**	• A broad and robust behavioural analysis undertaken to gather a rounded picture of current behavioural patterns and trends, including for both *– the 'problem' behaviour* *– the 'desired' behaviour* • Intervention clearly focused on specific behaviours *ie not just focused on information, knowledge, attitudes and beliefs* • Specific actionable and measurable behavioural goals and key indicators have been established in relation to a specific 'social good' • Intervention seeks to consider and address four key behavioural domains: *1: formation and establishment of behaviour; 2: maintenance and reinforcement of behaviour;* *3: behaviour change; 4: behavioural controls (based on ethical principles)*
3. THEORY **Is behavioural theory-based and informed. Drawing from an integrated theory framework**	• Theory is used transparently to inform and guide development, and theoretical assumptions tested as part of the process • An open integrated theory framework is used that avoids tendency to simply apply the same preferred theory to every given situation • Takes into account behavioural theory across four primary domains: *1: bio-physical; 2: psychological;* *3: social; 4: environmental / ecological*
4. INSIGHT **Based on developing a deeper 'insight' approach – focusing on what 'moves and motivates'**	• Focus is clearly on gaining a deep understanding and insight into what moves and motivates the customer • Drills down from a wider understanding of the customer to focus on identifying key factors and issues relevant to positively influencing particular behaviour • Approach based on identifying and developing *'actionable insights'* using considered judgement, rather than just generating data and intelligence
5. EXCHANGE **Incorporates an 'exchange' analysis. Understanding what the person has to give to get the benefits proposed**	• Clear analysis of the full cost to the consumer in achieving the proposed benefit (financial, physical, social, time spent, etc.) • Analysis of the perceived / actual costs versus perceived / actual benefits • Incentives, recognition, reward, and disincentives are considered and tailored according to specific audiences, based on what they value
6. COMPETITION **Incorporates a 'competition' analysis to understand what competes for the time and attention of the audience**	• Both internal & external competition considered and addressed – *Internal* eg psychological factors, pleasure, desire, risk taking, addiction etc – *External* eg wider influences / influencers competing for audience's attention and time, promoting or reinforcing alternative or counter behaviours • Strategies aim to minimise potential impact of competition by considering positive and problematic external influences & influencers • Factors competing for the time and attention of a given audience considered
7. SEGMENTATION **Uses a developed segmentation approach (not just targeting). Avoiding blanket approaches**	• Traditional demographic or epidemiological targeting used, but not relied on exclusively • Deeper segmented approaches that focus on what *'moves and motivates'* the relevant audience, drawing on greater use of psycho-graphic data • Interventions directly tailored to specific audience segments rather than reliance on 'blanket' approaches • Future lifestyle trends considered and addressed
8. METHODS MIX **Identifies an appropriate 'mix of methods'** 'Intervention mix' = Strategic SM 'Marketing mix' = Operational SM	• Range of methods used to establish an appropriate mix of methods • Avoids reliance on single methods or approaches used in isolation • Methods and approaches developed, taking full account of any other interventions in order to achieve synergy and enhance the overall impact • Four primary intervention domains considered: *1: informing / encouraging; 2: servicing / supporting;* *3: designing / adjusting environment; 4: controlling / regulating*

French, Blair-Stevens (2006) adapted from original benchmark criteria developed by Andreasen (2002)

Source: www.thensmc.com

Annex 2. The Madrid Exchange on Urban Regeneration and Use of Quality of Life Indicators

A brief report on the Exchange

Representatives from the cities of Bacau (RO), Baia Mare (RO), Lecce (IT) and Torino (IT), plus Marco Santangelo, BHC Lead Expert, Antonella Cardone, BHC Thematic Expert, and Delia Giorgianni, BHC Communication Assistant, met in Madrid (ES) on 16-18 December 2010 to learn more about the Local Action Plan and the use of quality of life indicators to improve urban regeneration processes occurring in the central city. The Oficina del Centro, part of Madrid Municipality, hosted the workshop and a site two site visit were organised, to see the areas of the city in which regeneration is taking place and where BHC focus is.
The Madrid Local Action Plan was presented as it is in this finalization phase, just before the end of BHC. The LAP is focused on a renewed use of some parts of the historic city, the Embajadores area, to achieve at least three main goals: to rediscover new ways of living the city, to facilitate the communication between two large green areas of the city, to promote a healthier lifestyle through improved walking facilities. The project has been developed taking into account several indicators that could help in monitoring the quality – from the health point of view – of the whole operation. This approach is new to Madrid, or at least is new in such an extensive way: to define a working methodology efforts have been made to create a common language and, thus, a common understanding; a list of indicators have been defined and for each one a specific table has been created so to allow constant monitoring; a risk checklist has been created to better define and reshape the LAP. A walking site visit to the Embajadores areas allowed all the participants to experience the challenges and potentials linked to this regeneration project.
A second project was then presented, the Madrid Rio. This is a major project in the city of Madrid and regards the creation of a park alongside the Manzanares river, in which both the goals of linking together the historic city with its first belt and the regeneration of large areas are achieved. A visit to the area was also scheduled and various art installations created for the regeneration process were visited.
Part of the workshop was also dedicated to meet members of the Local Support Group, among which members of the Complutense University and members of different departments of the Municipality. Their main message being that a significant result of their involvement in BHC is the opportunity to work together, to share ideas and to create solid networks.

The Madrid Local Action Plan

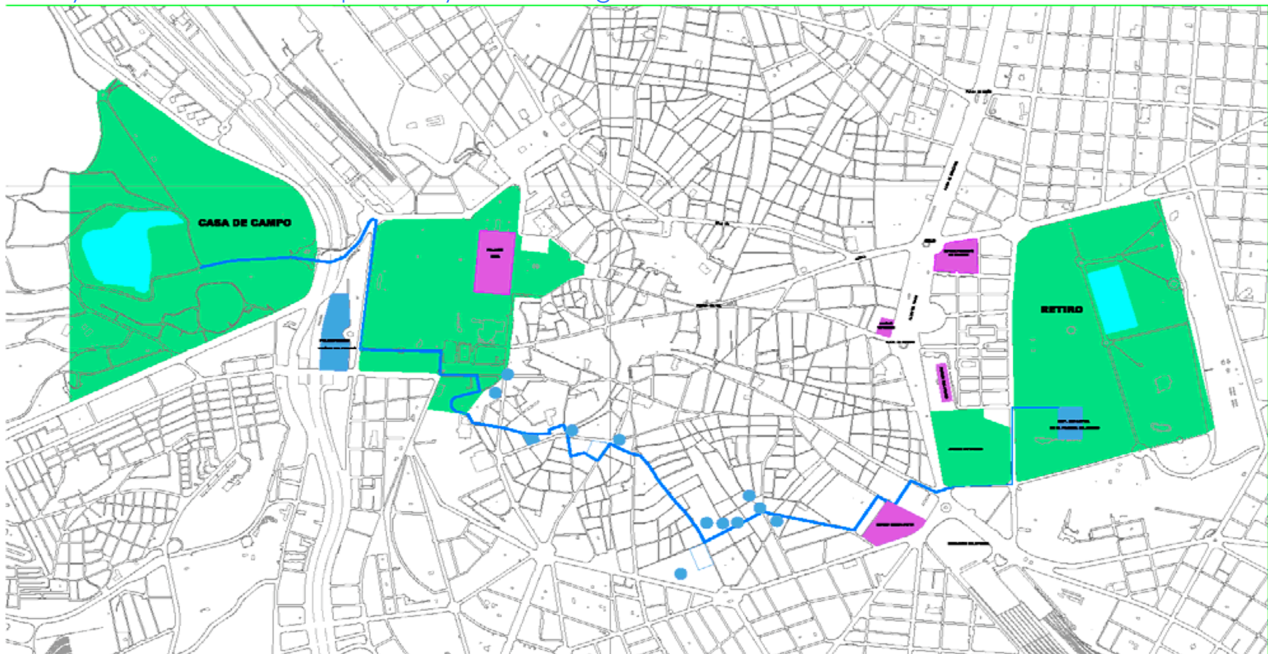
As said above, Madrid LAP is focused on the regeneration of one of the inner city areas, Embajadores, through the creation of a walking path to promote a sport attitude among citizens (see fig. 4). This is the final and concrete objective, but from

the methodological point of view a much wider set of objectives has been foreseen:

- to promote a comprehensive and innovative working methodology that brings together the different aspects of reality and fosters global actions, with the objective of creating a healthy community;
- to establish this methodology as a working practice for the different areas of government, providing a support tool for work groups;
- to create a work tool to support the prior methodology;
- to capitalise on the knowledge derived from this work, in order to monitor and evaluate the process;
- to disseminate knowledge, acknowledging and reinforcing good practices, and promoting transfer and exchanges.

There is also another important objective, which is less methodological but as much as important: to present the selected action to the relevant Structural Fund programmes for financing.

Fig. 4 – The *Itinerario deportivo* between the Casa de Campo (W) and Retiro (E) parks, right below the city historic centre. The pathway is 8 km long.



Source: Madrid LSG

The Local Action Plan of the city of Madrid is structured around three development phases:

- Designing of the work methodology and support tool;
- Application to the Embajadores area as a practical validation of the document;
- Selection and preparation of the pilot action development proposal.

As said above, one of the main objectives of the LAP of the city of Madrid include the design of a work methodology that will ultimately allow identifying areas of intervention on the basis of specific risk levels that will help to:

- distinguish among the causes of urban deterioration linked to the physical

and environmental specificity of the area, those linked to the actions of the public administration and those related to the mutual interaction between the two;
- analyse the effects and impacts of public interventions, in light of the preceding point;
- design interventions to prevent, treat and reduce risk, coordinating actions between the administration and other public officials (e.g. members of the local social services), applying and developing these actions and measuring their impact, allowing comparisons with other relevant experiences so that effective intervention methodologies may be transferred from one geographical area to another;
- reflect on the concept of vulnerability from a holistic perspective, as a multidimensional concept;
- perform this task taking into account control and monitoring mechanisms in which the Community is directly involved.

How to define a healthy city as an operative concept?

The definition of a "good" level of quality of life in a certain area is difficult, as it is based on an ideal level that must be agreed, even from a political point of view, and it certainly depend on local features and expectations as much as on a neutrally defined level according to a healthy urban environment. The definition of a healthy level of quality of life thus started by paying attention to issues that are common to any city.
To this extent, at an early phase of the LAP development, a desk research was carried on different documents (regarding urban planning, construction, social issues, economic ones, etc.). Working groups formed by mixing the different LSG members, in order to facilitate the debate, carried on this research. Each group then gave a discussion result guide. Aspects included in this document were:
- Aspects of a "healthy city";
- Strategic definition lines and related aspects;
- Quantification;
- Relationship with health-related aspects.

The final objective of this work was to define key fields for a healthier intervention in the city. The initial proposal included urban planning, construction, environment, economy and bio-psycho-social aspects. The development of this task has required several meetings, finally reaching a "consensus" in the form of a document that envisages urban planning, residential, environmental, economic, bio-psycho-social and institutional aspects. Each theme contains basic strategic lines and parameters that define them. After mapping the "attractive city" as the ideal city, an indicator system has been developed, paired with a risk checklist, where risks come from the non-fulfilment of the goal defined and considered correct by the indicator.
The application of the key indicators allows accessing the necessary information on the status of any city area we wish to study and intervene in. Although the "responsible person" for defining new plans and actions belongs to a specific sphere

of competence, he/she will also be able to access a minimum of holistic information that will alert him/her on other aspects to which attention must be paid, in order to neutralise their potential sabotaging effect or, on the contrary, enhance their capacities, providing the necessary tools to establish the required coordination mechanisms.

The next months

In the next phases of the LAP development more focus on the Embajadores neighbourhood is expected, both from the analytical and operative point of view. A special effort will be made for coordinating actions foreseen in the LAP to already existing or planned interventions in the area (as in the case of the possible relocation of the alternative cultural centre that is already established in this area). This process will also allow to further selecting indicators for future monitoring, to identify main problems to tackle and to promote a visioning process for future developments.