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Social Science & Medicine 61 (2005) 1331–1341

SOCIAL SCIENCE & MEDICINE

www.elsevier.com/locate/socscimed

Utility-driven evidence for healthy cities: Problems with evidence generation and application

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Available online 27 March 2005

Abstract

The question whether the WHO Healthy Cities project 'works' has been asked ever since a number of novel ideas and actions related to community health, health promotion and healthy public policy in the mid 1980s came together in the Healthy Cities Movement initiated by the World Health Organization. The question, however, has become more urgent since we have entered an era in which the drive for 'evidence' seems all-pervasive.

The article explores the nature of evidence, review available evidence on Healthy Cities accomplishments, and discusses whether enough evidence has been accumulated on different performances within the realm of Healthy Cities. A main point of reference is the European Healthy Cities Project (E-HCP).

Building on the information gathered through documentary research on the topic, it is concluded that there is fair evidence that Healthy Cities works. However, the future holds great challenges for further development and evidence-oriented evaluations of Healthy Cities. There are problems with (1) the communication of evidence, (2) the tension between the original intention of the Healthy Cities Movement and its current operations, and (3) the complex nature of Healthy Cities and the methodological tools currently available.

Keywords: Healthy cities; Health policy; Community health; Health promotion; Utility-driven evidence; WHO

Introduction

The relation between human health and settlement is unmistakable. In fact, the origins of modern public health can be traced back to rapid urbanization processes in the industrial revolution (Cohen, 1989).

Public health programs that address the broad range of relations between health and settlement are, however, not abundant. One of the reasons for this phenomenon may be the complexity of such programs, operating at many levels (individual and community behavior, organizational and policy development) taking into account the population diversities inherent to modern life—not least in its urban form.

One such program, the Healthy Cities Project (HCP) initiated by the World Health Organization, since its inception in the mid 1980s has been challenged to deliver the evidence that it, in substantial ways, makes a difference when dealing with urban health.

Remarkably, in the twenty years that HCP has operated, very little evidence has been accumulated and/or published in the public domain, in spite of a continuous involvement of the academic community.

It has been argued that the 'evidence debate', at least within public health science, has come to a grinding halt

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doi:10.1016/j.socscimed.2005.01.028

with essentially two positions: those who stick with experimental or quasi-experimental methodological designs for the generation of evidence, and those who take a broader position, arguing that there are many other possible sources and pathways to produce evidence. Either way, Healthy Cities do not yet seem to have lived up to expectations.

In this article, we will explore the nature of evidence; review available evidence on Healthy Cities accomplishments; and discuss the question whether appropriate evidence has been accumulated on different performances within the realm of Healthy Cities.

A particular point of reference will be the European Healthy Cities Project (E-HCP), which from the latter part of the 1980s explicitly has worked—in an increasingly formalized way—to put health high on the local policy agenda and stimulate ways to improve public health by modifying the physical environment and the social and economic determinants of health.

Utility-driven evidence

What should be understood by evidence?
McQueen and Anderson (2001) quote Butcher:

> A piece of evidence is a fact or datum that is used, or could be used, in making a decision or judgement or in solving a problem. The evidence, when used with the canons of good reasoning and principles of valuation, answers the question why, when asked of a judgement, decision, or action.

There are some unresolved issues in using such a perspective. Particularly researchers equating science with the use of experimental methodological designs would criticize this position as an invitation to use almost any data or opinion as evidence. We will explore precisely this methodological tension.

In a recent position paper by the European Advisory Committee on Health Research (Banta, 2004) the relations between public health, decision making, research, knowledge generation and evidence are presented. The Committee acknowledges the many facets of evidence for public health and singles out Healthy Cities as a prime challenge in the amalgamation of evidence:

> (…) a legitimate concern is that research in many areas of "the new public health" aims at actions that are difficult to evaluate, such as those in health promotion. For example, what is a "healthy city" and what are the general and specific outcomes sought? Because of these difficulties, decisions that are mainly determined by good evidence of effectiveness would favor interventions with a medical rather than a social focus, those that target individuals rather than communities and populations, and those that focus on the influence of proximal rather than distal determinants of health. This would clearly be unsatisfactory for population health activities.

Eriksson (2000) has further mapped these problems. He proposes a distinction between four generations of 'prevention projects' (I. clinical; II. bioepidemiological; III. socioepidemiological; and IV. environment & policy-oriented), based on different theoretical propositions, each of which need increasingly complex evaluation approaches as well as outcome parameters. Generally speaking, Eriksson, with his differentiations, cites an important development within public health research, stretched out over decades, resulting in an increased recognition that much can be gained, especially in terms of reaching many people by changing program delivery or policy, by supplementing the efforts to identify individual determinants of health and health behavior with a focus on social and environmental factors. Recognitions such as these have subsequently provoked efforts to measure, for instance, the impact of manipulating broader determinants of health and discussions on how to expand intervention goals beyond the individual to various community levels.

Birckmayer and Weiss (2000) have demonstrated that application of theory-based evaluation (TBE) yields better research information on various elements of success and failure of health promotion programs. TBE expects researchers and program directors to spell out assumptions to a micro-theoretical level, so that outcomes are not only made *evident*, but also can be *explained*. This perspective offers opportunities to integrate intra-generational 'prevention projects' such as Healthy Cities, drawing heavily on the approaches that Eriksson calls socioepidemiological and environment & policy oriented, and thus unravel and analyze its various components.

These perspectives give, however, indications of *how* evidence is to be produced, but not *for what purpose*.

Ultimately the generation of evidence seems to serve two purposes:

- To assist in decision-making, and thus implementation. In this way evidence is used instrumentally in concrete processes of *problem solving*.
- To contribute to the growth of a more general, contextual oriented body of knowledge into a given domain—in this case urban health, public policy and comprehensive health programs. The qualities of this latter perspective should not be viewed in the short time frame of instrumental utility. Its value is rather in a more non-linear sequence through which relevant stakeholders, often in complex ways, are influenced by, and themselves influence the interpretations of, a broad body of research into a certain domain which subsequently contributes to certain policy directions.