Perspectives on Urban Health

Health and the Community Series No. 2

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edited by Brijesh Mathur
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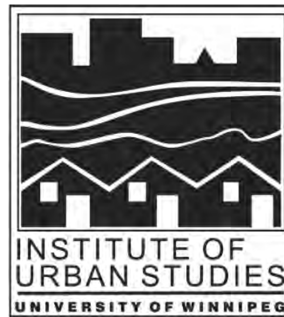

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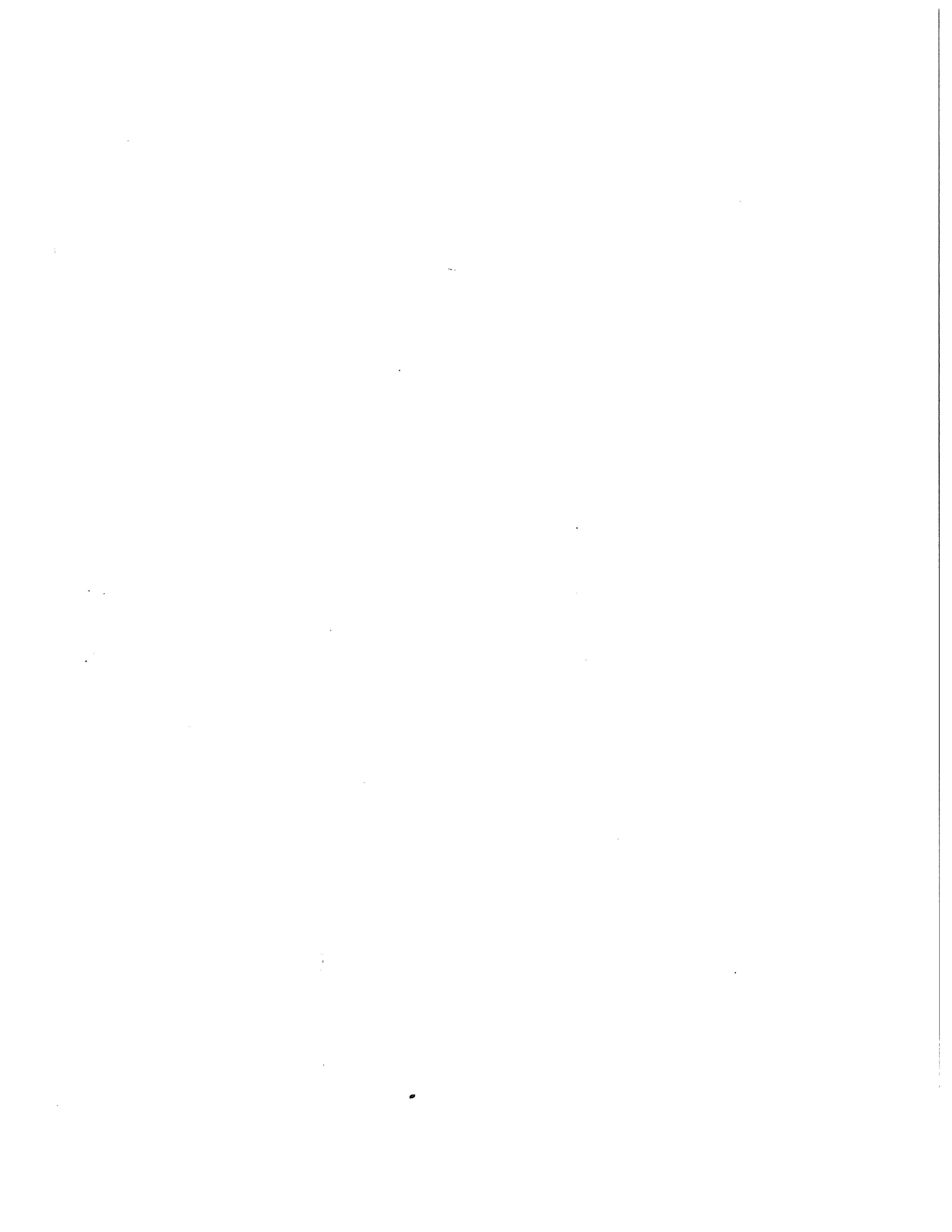

INTRODUCTION

In February 1988, the Institute of Urban Studies hosted the Canadian Urban and Housing Studies Conference. Among the various sessions at the Conference, two were devoted to "Healthy Cities." At that time, the Healthy Cities Project of the World Health Organization (WHO) was in the second year of its operation in Europe, and efforts were afoot to initiate a comparable project in Canada. To that end, the Canadian Institute of Planners, the Canadian Public Health Association and the Federation of Canadian Municipalities were jointly exploring the possibility of launching a Canadian project. As it turned out, the Canadian Healthy Communities Project (CHCP) was launched later that year as a three-year project to promote municipal involvement in creating healthy communities. In 1991, CHCP will complete three years of its operation, and funding has been extended for a further three-year period.

Looking back at the papers presented in 1988, I am struck by the fact that the content is as relevant today as it was in early 1988 to understanding the theoretical motivations of CHCP, as well as the implications it has for health promotion, public health practices and urban planning. In a way, the papers included in this volume present the challenge, as well as the potential, for improving urban health in contemporary times.

In her paper, "Health and Wellness in the City," Barbara Lane provides an overview of developments in theoretical perspectives on health. From the view of health as the absence of disease, we have now moved to the idea of heath as wellness, "entailing a total capacity or response of the system (individual, group or community) in acting out a role within physical and social environments." Given the new view of health, Lane makes a distinction between the concept of disease prevention, which stems from the older view of health, and the concept of health promotion, which follows from the newer view of health as wellness. The new view of health has implications for the delivery of health services, and has expanded the realm of possible health-related interventions to include physical and social environments. CHCP, which is geared to the improvement of physical and social environments of municipalities, is an example of initiatives that have emerged in response to the new view of health. Lane cautions the reader that the success of initiatives to improve urban health depend upon finding better tools for the measurement of health relative to social and physical environments and to the new view of health. The present indicators used to measure health (morbidity and mortality for example), are really not measures of health, but of death and disease.

Dexter Harvey's paper, "Health Promotion Approaches," explores the concept of health promotion, which he defines as the "process of enabling people to increase control over, and to improve health." He sets out three main approaches to health promotion. These are characterized respectively as the Scatter

Approach, the Managerial Approach and the Collaborative Approach. Harvey concludes that irrespective of the approach taken, health promotion must: involve the public in the context of everyday life; be directed towards action on the determinants or causes of health; combine diverse, but complementary methods; and aim particularly at effective and concrete public participation. Within the context of CHCP, Harvey's prescription would presumably require a strong component of public participation to address those factors in the urban physical and social environment which have a bearing upon health.

Chris Greensmith, in his paper "Issues and Problems in Urban Health," discusses the health issues and problems associated with living in an urban environment. Confirming the caution sounded by Lane, he points out the need for positive indicators of health which measure health by its presence, rather than its absence. Greensmith identifies cardiovascular disease as the single largest cause of death, and suggests that, although certain segments of the population are aware of health promotion behaviours that would reduce the disease, certain disadvantaged segments of the population are not so aware. Health promotion programs are required in workplaces to promote health-enhancing behaviour. Morbidity and mortality rates are higher among lower-income groups, particularly urban Aboriginals. Special emphasis on these groups is required in urban health promotion programs. Greensmith also discusses aspects of the urban social environment as these relate to health, and calls for architectural and planning policy to promote interpersonal relationships and support networks. Moreover, he suggests that housing conditions and residential environments have an effect upon health, and that lower-income households tend to find themselves in homes they do not desire and in environments which promote distress. Housing conditions and residential environments need to be more responsive to human needs. Finally, the author cites clean air, water and land as important factors in human health, and calls for greater attention to these factors.

In her paper "The Concept of Healthy Cities," Suzanne Jackson presents a review of the concept of Healthy Cities with a focus on the WHO Europe's Healthy Cities Project. Jackson links the Healthy Cities concept to the new view of health and to health promotion, and discusses the process and requirements for a Healthy City. As well, Jackson provides a list of indicators proposed for measuring Healthy Cities.

In the final paper of the volume, I assess the implications of the Healthy Cities Project for urban planning in Canada. Within the context of the project, I set out goals for the profession, and assess how these goals would affect the content and process of urban planning. It is concluded that the scope of urban planning practice would have to be expanded to incorporate ideas and themes in planning literature which have so far remained unintegrated. Moreover, new analytical tools would be required, and the planning process would need to be made more participatory. Such changes would fundamentally

change the orientation of present-day Canadian urban planning by bringing it closer to its roots in public health and welfare, "a return to reaffirm a social agenda by giving new interpretations and meanings to old truths and values . . . to regain a sense of purpose."

It is hoped that this volume will be a useful addition to the steadily growing stream of literature on the topic of urban health in general, and the Canadian Healthy Communities Project in particular.[1]

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NOTES

1. See, for example, *Plan Canada* 29:4 (July 1989), Special Issue on Urban Health; see also Barbara J. Lane, *The Canadian Healthy Communities Project: A Conceptual Model for Winnipeg* (Winnipeg: Institute of Urban Studies, 1989); and idem, *A Selective Bibliography on Healthy Communities* (Winnipeg: Institute of Urban Studies, 1989). See also three recent Healthy Cities Papers published for the Healthy Cities Project: *Promoting Health in the Urban Context*, *Five Year Planning Framework*; and *A Guide to Assessing Healthy Cities* (Copenhagen: FADL, 1986).

HEALTH AND WELLNESS IN THE CITY

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Traditionally, health has been viewed negatively, as the absence of disease or impairment, and as a physical good, a commodity possessed more by some than by others. Evolution beyond these limited perspectives has been largely a twentieth-century development.

Sigerist led the change when, in 1941, he described the healthy individual as one ". . . who is well balanced bodily and mentally, well adjusted to his [her] physical and social environment . . . Health is, therefore, not simply the absence of disease, but something positive, a joyful attitude toward life . . ." (p. 100).[1] Five years later, the constitution of the World Health Organization (WHO) defined health as ". . . a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" (p. 1).[2] While a lay, intuitive perception has persisted of health as physical well-being, including such elements as comfort and energy, most health professionals in North American have come to consider the physical component to be only part of an individual's total capacity to cope with physical and social environments.

In recent decades, several paradigms have emerged which have enlarged the concept of health. For example, Payne has related the idea that illness has multiple, and not just physical, causes to the "ecological school" of the 1960s.[3] Accordingly, individuals came to be seen as active beings, relating in and to an environment, and possessing various capacities to resist disease.[4] With the rise of the human relations school of psychology, psychosocial models emerged which highlighted the interaction of mind, body and society, and which viewed health from the standpoint of the pursuit of self-realization.[5] At about the same time, the idea of health as the norm and illness as deviance arose,[6] accompanied by another contribution of sociology, Parsons' analysis of the rights and obligations inherent in the "sick role."[7] The importance of learned behaviours and attitudes was highlighted as researchers studied the effects of socio-economic and ethnic status on whether one assumes the sick role, and on the general expectations related to health. As Fuchs has pointed out, standards of what is healthy vary according to the demands of society, so that some impairments present barriers to certain occupational roles, but matter not at all in others.[8]

Also in the 1960s, Dunn introduced the idea of "wellness" which he defined as ". . . an integrated method of functioning, oriented toward maximizing the potential of which an individual is capable . . . It requires that the individual maintain a continuum of balance and purposeful direction within the environment in which [s]he is functioning."[9] Baranowski has also preferred the term wellness. Differentiated from health (the biological well-functioning that provides the body with physical capacities), wellness, for Baranowski, comprised the *total* capacity of the person to fulfil personal goals and perform

socially defined role tasks. Consistently, Baranowski also distinguished disease (biological ill-functioning and physical incapacity) from illness (the total incapacity of the person to fulfil personal goals and perform socially defined role tasks).[10]

Other authors have also preferred the term wellness.[11] Many more, however, merely imply the idea of social role performance in their use of the concept of health.[12,13]

The trend away from the narrow interpretation of health as absence of disease has been supported by a world-wide reduction in infectious disease as a cause of death, and a consequent increasing focus on the effects of chronic disease and economics on the quality of life. In 1984, in a background paper for a conference on health promotion, WHO enlarged its previous description of health to be "the extent to which an individual or group is able . . . to realize aspirations and satisfy needs . . . It is a positive concept emphasizing social and personal resources as well as physical capacities."[14]

An interpretation of health which highlights the capacity to carry out roles may be applied beyond the individual level to families, organizations or communities. That cities can be studied for the extent to which their structures and interactions allow them to promote role fulfilment of the populations who live in them is one of the assumptions of the Healthy Cities Project of WHO Europe.

In this paper, consistent with the recent literature, "health" and "wellness" are considered synonymous, entailing a total capacity or response of the system (individual, group or community) in acting out a role within physical and social environments.

Defining health broadly has had implications for the delivery of health services. It provided the impetus for the 1978 Alma Ata Conference on Primary Health Care, a WHO gathering whose declaration specified health as an integral part of development, and, therefore, as the responsibility of the health sector, of other sectors and of the community at large. The report of that conference, with its adoption at the 34th session of UN general assembly, would increase the conviction that health for all could be attained by improving primary health care. According to Law and Larivière, the Alma Ata declaration led to the refining of concepts of community health in developed, as well as developing, countries.[15]

In Canada, as elsewhere in the Western world, the traditional physical well-being approach to health has been accompanied by a cure-oriented "sick care" system in which physical structures stood as monuments to technological advances in caring for the sick. That the system has been at best only partially successful can be inferred from variations in Canada's life expectancy, disability, and chronic and communicable disease across economic groups. In 1986, for example, Canadian health figures, revealed that men in upper-income groups lived, on average, six years longer than those with low incomes.[16]

An exciting development stemming from a recognition of the weaknesses of the traditional approach was the 1974 Canadian government publication *A New Perspective for the Health of*

Canadians.[17] The model of health in that document included the environment, individual lifestyle and the health care system, along with human biology. By these inclusions, the new perspective promoted a re-examination of health policies in Canada and beyond. It was accompanied by a realization that, historically, the most far-reaching advances in health have been outside the medical domain, arising from improvements in water treatment, waste disposal and so on. That a vision of health must move beyond individual biology to include elements like health care programs, social and economic factors, and the natural and human-made environments had become clear.

Consistent with the traditional interpretation of health was the notion that disease prevention and health promotion are interchangeable terms. Development of the definition of health as more than the absence of disease, however, has called for a broad, dynamic model of health promotion, one which makes explicit the various elements in the physical and social environments fundamental to health, and which highlights the roles of individuals, groups and governments in the process. That perceived need, and the basis provided by *A New Perspective on the Health of Canadians,* led to the 1986 Government of Canada publication *Achieving Health for All: A Framework for Health Promotion.*[18] The document acknowledged the insufficient attention paid by the current system to areas such as life expectancy, level of health and prevalence of disability within disadvantaged groups; to preventable diseases and injuries; and to chronic conditions and the availability of community supports.[19] Toward the stated goal of "achieving health for all," three health challenges were identified: reducing inequities, increasing prevention and enhancing coping. Implementation strategies were also listed—fostering public participation, strengthening community health services, co-ordinating healthy public policy—as were three health promotion mechanisms: self care, mutual aid and healthy environments.[20] The authors called for a holistic approach which includes the social and physical environments; successful implementation of the framework, they contended, requires the involvement of sectors other than health, such as employment, social services and housing.

Achieving Health for All: A Framework for Health Promotion opened the door for community-based programs to address the problems of health care in Canada. The Canadian Healthy Communities Project is one such initiative. Sponsored by the Canadian Public Health Association, the Canadian Institute of Planners and (more recently) the Federation of Canadian Municipalities, the undertaking is designed to support Canadian cities and towns in developing and implementing plans that apply the concepts of health promotion in order to achieve health for all.[21]

Given that approximately three quarters of Canadians reside in urban centres, and that population concentration may continue, the relationship between the characteristics of city life and the health of its people is important to explore. The focus in the remainder of this paper is on those implications of the

new conception of health which can guide planners and other decision-makers whose activities have an impact on the health of urban dwellers. The four elements of Lalonde's *A New Perspective on the Health of Canadians* (Environment, Human Biology, Lifestyle and Health Care System) will provide a guide. As will become evident, these are not discrete, but are closely related.

With the linking of health to the playing out of roles in a society, the concept of setting as physical and social environments assumes importance. The centrality of environment has traditionally been recognized in urban planning; initially, physical environmental aspects were highlighted in urban planning because of the field's roots in architecture and the physical sciences, areas in which city planners are still likely to have the greatest influence. Interest in social phenomena followed, as planners have become increasingly "people-oriented" over the years.

An interest in health has been evident in the assumptions of urban planners as they have sought to define the optimal environment. According to Lynch, for example, an urban environment can be considered good to the extent that it supports the health of the individual and the survival of the species.[22] This viewpoint fits with a perception of health, or wellness, as a level of personal functioning that can be promoted (or not) by the urban environment.

An area related to both the physical and social aspects of the environment, and a focus for planners, has been housing. In particular, physical deterioration, shortage of living units and urban overcrowding have been a concern, particularly in the core areas. Attention to housing arose at the turn of the century, when the health-threatening conditions of Britain's industrial area prompted Ebenezer Howard to advocate a retreat from the city to smaller green spaces, self-sufficient "garden cities."[23]

Even now, housing is the aspect of the environment most frequently cited in discussions of health. Inadequate living conditions have been identified as a prime contributor to injuries from crime, to high infant mortality rates and to personal illnesses such as tuberculosis, typhoid and emotional problems.[24] Not only individual but also family and community well-functioning are at risk to the extent that high tenancy rates, poor and crowded housing, etc., lead to social integration.

An alternative hypothesis contends not that densely populated urban areas are themselves illness-producing, but that more illness is found in those areas because the persons who are more likely to develop social and health problems congregate there. In any case, the extreme diversity and mobility of core area populations may militate against the development of community responsibility, so that heavy reliance must be placed on formal institutions and service agencies.[25]

The adequacy of air, water and waste management is a further environment-related question raised about cities by health-conscious critics. Its importance stems from a direct relation to the biological status of urban dwellers. As suggested earlier, reform in sanitation was a milestone in improving the

health potential of those in urban areas. However, in many cities, smoke, industrial waste and the dumping of untreated sewage remain major hazards. Not only do they pose direct threats to the biological status of individuals, they also have an indirect influence on health—on lifestyle, for example—as they affect the recreation capacity of the urban environment.

The "lifestyle" element of the urbanite's health is also related to the particular configuration of facilities and services offered in the city and how accessible they are to inhabitants. Among the challenges of space planning in cities, the location of recreational and cultural facilities has been particularly problematic, because filling the need requires space, and the cost of land in some areas may be prohibitively high. As a result, access to such health promoting, re-creating places as sports facilities or parks is conferred unequally, according to location and income. Art and cultural facilities, which could provide a sense of rootedness and stability, may be denied to those neighbourhoods for whom the need is greatest.

Lalonde's consideration of the health care delivery system as a contributor to health drew attention to the problem of differential access to health care resources in the city. Compared with rural areas, the strength of cities has been that they have been better able to supply residents with all kinds of services. It is generally agreed that the larger the city in Canada, the more likely it is to be equipped with complex medical services, with hospitals, physicians, nurses, dentists, and so on. However, within the city, the advantage is not universal. As Axworthy and Gillies pointed out in 1973, "The natural outcome of the urbanization process is that while progress has provided enormous economic improvement for most urbanities, it has locked a minority into a situation of relative hard core poverty . . ."[26] As a consequence, access to the resources in the city is effectively denied to some, particularly those in the urban core. As mentioned earlier, the physical conditions in which low-income urban dwellers are forced to live are counterproductive to health, through predisposing individuals and through the spread of disease-bearing agencies.[27] Another difference is noted: as predicted by Palen and Johnson, in larger cities in North America a tendency is developing for an out-migration of medical and other professionals away from the urban core and into the suburbs.[28] To the extent that the trend continues, it will pose a further threat to the well-being of low-income city residents.

In areas related to education, cities are favoured compared with rural settlements. Greater financial resources in the city, and the highly developed division of labour made possible by large numbers, contribute to innovations in educational curricula. They promote specialties such as vocational and professional schools, adult education and teaching of the handicapped. Regarding health education of the public, there are also advantages. In the city, general health promotion, or specific campaigns

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aimed at informing "at-risk" individuals about lifestyle or the availability of resources, will reach more targets per dollar spent.

The context of present-day health promotion programs is likely to be broader in scope than in past years, emphasizing lifestyle, or social or physical environments. Disease prevention, although still an important component of health promotion, has been joined by a general thrust reflecting the new perspective on health.

Health promotion programs and related initiatives like Canada's Healthy Communities Project may encounter challenges related to the concept of "role": the perception of health of a person (or community) is likely to vary from other, even similar, systems, and health promotion programs must take these unique interpretations into account. While individuals and cities can learn from the experience of others, programs must acknowledge individual differences. Reflecting the increased individual autonomy in health decisions which must accompany unique interpretations of health, equity of access to collaborate on health care resources becomes a key component of health care, as acknowledged by its primacy in *Achieving Health for All: A Framework for Health Promotion.*[29]

A final implication deserves mention. In the end, knowing how successful we are in improving urban environments and enhancing their potential for health calls for the development of better tools for measurement. The traditional approach to defining health had methodological advantages. Since health was defined as the absence of disease, the assessment of health, or at least the lack of it, became relatively easy: interpreting health on the curative model allowed comparisons to be made among communities on the basis of mortality or morbidity rates, or numbers of physicians or hospital beds per thousand population. However, in a system where health promotion is recognized, the measures do not fit.

Indicators are required which are not based on methodological convenience, but which reflect individual ability to function in a physical, social and cultural setting. As Greer has contended, it is probable that a composite of measures will be required, reflecting the variety of social roles assumed according to life stages.[30] Because the concept of role implies individual perception of what that role entails, *subjective* indicators of health status may be more important than objective ones when determining health status. Identifying indicators for cities has been the first major task of WHO Europe's Healthy Cities Project, and this was the focus of the Barcelona Conference on Indicators in March 1987. With valid, more fruitful ways to evaluate health, using a realistic definition, we can devise effective ways to monitor the relationship between life in the city and the well-being of its people, and establish a basis for effective planning.

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HEALTH PROMOTION APPROACHES

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"Health Promotion is the process of enabling people to increase control over, and to improve health" (WHO, 1984). This is done most effectively by involving people in the process of problem defining and decision making, both individually and collectively, within the context of their everyday lives.

Participation is a key factor in achieving health (Health and Welfare Canada, 1986; WHO, 1984, 1986; International Conference on Health Promotion, 1986). The benefits of participation will be greatest when it occurs within a collaborative environment, involving the widest range of expertise—intra- and intergovernmental and nongovernmental organizations, the private sector, and the population at large—working together in a spirit of partnership. This spirit of partnership, within a collaborative environment, can lead to an holistic approach to achieving health.

My review of numerous articles which fall under the rubric of "Health Promotion" led me to conclude that three major Health Promotion Approaches are emerging. I have labelled them the Scatter Approach, the Managerial Approach and the Collaborative Approach. In the ensuing discussion, I differentiate the approaches on the basis of collective locus of control, which is concordant with the prevailing concept of participation implied in health promotion (Health and Welfare Canada, 1986; WHO, 1984; International Conference on Health Promotion, 1986). Each of the three approaches will be delineated in terms of four characteristics: Locus of Administration; Source of Goals; Role of the Public; and Interrelationships Between Programs.

The term "Approach" as used in this paper refers to the administrative framework uniting a number of related programs and activities in health promotion.

SCATTER APPROACH

The Scatter Approach is best described as a potpourri of activities with no overall co-ordination or plan of action. Common to this approach is a laissez-faire position, which, in operational terms, means that various bodies (agencies, governments, groups) each go their separate ways to achieve their respective purposes. From a community perspective, there is no collective locus of control with respect to health promotion programming. The following are the characteristics of the Scatter Approach:

- **Locus of Administration.** There is no community-wide locus of administration. Each body, on its own, pursues its purposes and determines its strategies and programs.
- **Source of Goals.** Each body determines its goals for health promotion. These goals generally reflect a particular body's reason for being rather than the most salient health promotion needs at a given time.

- **Role of the Public.** People are seen as recipients or consumers of programs. Generally, people assume a passive role.
- **Interrelationships Between Programs.** Since there is no overall community-wide master plan for health promotion or its co-ordination, each body engaged in health promotion activities is on its own, with few or no inter-body or inter-program linkages.

The major advantages of the Scatter Approach are: independent bodies can respond to need in a short time frame; a lack of co-ordination is perceived to be low-cost by independent bodies, since they may opt in and out as they see fit; and the freedom is valued by independent bodies.

The major disadvantages of the Scatter Approach are: limited resources often result in programs that do not get beyond the information campaign (one facet of health promotion strategies); and salient needs are often not pursued, since they do not fall within the interests of independent bodies.

- **Professional Involvement.** Professional organizations, as a rule, do not become active in the Scatter Approach. If they do become active, they assume an advocacy position on some health promotion issue. Individual professionals become involved mainly insofar as they are part of an independent body involved in health promotion. In all fairness to the professional groups (particularly those outside of the medical system), the Scatter Approach does not make health promotion a highly visible undertaking.

MANAGERIAL APPROACH

The Managerial Approach has a clearly defined locus of control based in a single co-ordinating body which is often a level of government (Farquhar et al., 1984; Lefebvre et al., 1986; Mittelmark et al., 1986; Puska et al., 1985). In other words, there is a locus of control in a managing body which does not consist of representatives from collaborating bodies. This approach is led by decision-makers who hold strategic positions. One body (government) is seen to be in charge, with other bodies, by invitation, encouraged to become involved. Program co-ordination is extensive, and is based on an overall health promotion master plan. The characteristics of the Managerial Approach are:

- **Locus of Administration.** The locus of administration is within one power body, generally a level of government. This body assumes total responsibility for all facets of health promotion. Other bodies may be invited to participate in various ventures.
- **Source of Goals.** The power body assumes the responsibility for determining health promotion goals. These goals generally reflect the prevailing causes of morbidity and mortality in the particular community.

- **Role of the Public.** People are seen as recipients or consumers of health promotion programs. Specific at-risk groups as well as the population at large are targets for programming. The public's role is passive.
- **Interrelationship Between Programs.** The Managerial Approach provides a high degree of interprogram co-ordination and communication. All program efforts relate to an overall master plan. An important aim of this approach is for intersectoral co-operation at the decision-making level.

The Managerial Approach has the following advantages: the goals of the programs reflect community-wide issues; the Managerial Approach brings a large number of resources together to focus on community issues; and it increases chances to influence health-enhancing policy.

The disadvantages of the Managerial Approach are: the nature of the facets of health promotion that are operationalized are limited by the institution of government (e.g., government will not lobby, advocate or initiate policy changes on its own for the sake of health); the Managerial Approach is slow in responding to changes; and government-led programs generally have difficulty in getting the support of non-governmental agencies.

- **Professional Involvement.** The Managerial Approach offers the greatest opportunity for individual professional and professional association involvement. Generally, professional organizations assume an active lobby role (advocacy role) in the Managerial Approach. This role involves encouraging the power body and respective participants to focus on specific health promotion issues. Within the power body, there are numerous opportunities for professionals to increase intersectoral involvement in health.

COLLABORATIVE APPROACH

With respect to collective locus of control, the Collaborative Approach is between the Scatter and the Managerial Approaches. However, there are two major differences between the Collaborative Approach, and the Scatter and Managerial Approaches. First, in the Collaborative Approach, the collective locus of control rests with a number of bodies collaboratively assuming the responsibility for the community at large, and, second, in the collaborative approach, the population at large assumes a lead role as a partner in the locus of control. Public participation is the central focus of the Collaborative Approach (Labonté, 1987; Raeburn, 1987, 1979). The Collaborative Approach works from a master plan and co-ordinates health promotion activities. The characteristics of the Collaborative Approach are:

- **Locus of Administration.** The locus of administration is seen as a partnership among the community at large, agencies, organizations, governments and professional groups. Where possible, the leadership for this partnership is provided by the people in the community. The general public, along with the respective bodies, are responsible for determining a master plan and program co-ordination. Program ownership and commitment rest with the people at large. Keep in mind that in a large city, with this approach it might be possible to see 20-30 smaller communities, each working for their unique needs and maintaining their respective community loci of administration (Raeburn, 1987, 1979). Programming is based on a master plan, with extensive co-operation and co-ordination.
- **Source of Goals.** The health promotion goals are determined by the partner in the respective communities. Public participation leads to the identification of perceived health needs in addition to those implied by disease data.
- **Role of the Public.** While people are still seen as recipients or consumers of programs, it is their own programs that they are using. The people are seen as active players leading to program ownership.
- **Interrelationship Between Programs.** Collaboration involves a high degree of interprogram co-ordination and communication. Since the master plan is a co-operative venture, the potential for operationalizing all facets of health promotion strategy is high.

The advantages of the Collaborative Approach are: public participation and ownership increase the commitment of people to the attainment of self-determined goals; publicly perceived needs receive attention; and pooling of resources increases the potential for health promotion.

The disadvantages of the Collaborative Approach are: often, it is a very slow-moving process; and agency and government visibility may be reduced.

- **Professional Participation.** Professional associations, as well as individual professionals, can become very active in the collaborative approach to health promotion. Roles can range from advocacy and lobbying to actual intersectoral planning in government, as well as participation as a community member.

In the community, generally, a composite of the Scatter, Managerial and Collaborative Approaches is found. However, the Scatter and Managerial Approaches are most visible.

In conclusion, it is imperative to note that if we hope to achieve "Health For All," our approaches must be based on the following WHO Principles of Health Promotion (World Health Organization, 1984):

Health Promotion:

- involves the population as a whole in the context of their everyday life;

- is directed towards action on the determinants or causes of health;
- combines diverse but complementary methods or approaches;
- aims particularly at effective and concrete public participation.

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ISSUES AND PROBLEMS IN URBAN HEALTH

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My task in this paper is to discuss the health issues and problems associated with living in an urban environment. This task is large and could range from Aging to Air Pollution, from Reproductive Health to Palliative Care, so I will focus my comments by explaining what we, as public health professionals, are trying to do in health promotion programming. I will then go on to say a few words about the urban environment both social and physical, the need to facilitate interpersonal relationships, and the effects of housing on health. I will try to explain the effect of being socially and economically disadvantaged in this setting.

As an epidemiologist, I seek ways of evaluating the health status of the community I serve. The indicators we tend to use in health care planning often measure health by its impairment or, classically, by its total absence, as in death rates. When time and money permit, we conduct surveys and actually ask people what they think of their health. This can be upsetting, because the community may not perceive issues from the same perspective as the experts trying to serve them. There is a need for indicators that can assess health by its presence.

Ischemic Heart Disease is the largest single cause of death in this province and is also the largest single cause of hospitalization. A hundred years ago, the picture was very different, with communicable diseases being the major causes of morbidity and mortality.

Paradoxically, it is now our sophisticated urban lifestyle and the kinds of foods that we eat which contribute significantly to the high incidence of the chronic diseases, particularly premature cardiovascular disease, that beset us today.

The message that the public health movement is now trying to get across to the people is that if they stop smoking, eat less fat, exercise regularly, maintain a healthy weight and keep their blood pressure under control,[1] then they can significantly reduce their risks of coronary artery disease, stroke, lung cancer and some other diseases.

The Canadian Health Promotion Survey showed that at least half the population is aware of these messages, and that many try to incorporate them into their daily activities.[2] The problem now is to provide people who are aware of the messages, but who have not changed their behaviours, with the skills to do so; to provide supportive environments that prevent the acquisition of hazardous lifestyle habits such as smoking, and that support those who have changed and preclude relapses. I see the Canadian Heart Foundation's Heart Smart Project in this supportive category.[3] Here, participating restaurants label menu items that are less hazardous to your coronary arteries. Obviously city planning plays a very important role in providing a supportive environment. A city needs places where people can walk, relax or ride their bicycles. Municipal bylaws can reduce exposure to hazardous chemicals such as second-hand smoke.

TABLE 1 STANDARD MORTALITY RATES CORE AREA RESIDENTS		
	Male	Female
All Causes	1.89	1.94
Cancer	1.636	1.767
Cardiovascular	1.98	2.10
Accidents	2.34	1.92

Several well-researched health promotion intervention studies have been reported in the literature (see endnotes 1 to 8). They take different approaches to the problem of cardiovascular disease. We know that change is more likely when it is demanded from the bottom up and not imposed on a population from the top down. Therefore, specific programs must be community-based, and preferably be community-controlled. The healthy community movement can play an important role in bringing the concerns of communities to a focus and to the attention of community decision-makers. If participating groups are well enough organized, they can seek out sources of funding for their projects which may not be available to municipal and provincial government agencies, and thereby make a proactive contribution to the health of their community.

Although I have said that at least half the population is aware of the standard health-promoting behaviours, this is not necessarily true of blue-collar workers, and it is definitely not the case for the socially and economically disadvantaged among us, who are preoccupied with the basic struggle to survive. Health promotion programs in the workplace can influence workers and should be encouraged whenever possible. However, active social, health and planning policies are required to support those who cannot help themselves, and to encourage those who can.

I now want to spend some time on the disadvantaged to bring home the fact that they suffer an inequitable proportion of adverse health outcomes. You are more likely to be disadvantaged in Canada if you are from a single-parent, female-led family, old, unemployed or Native.

People in the lowest socio-economic strata of society exhibit the highest rates of morbidity and mortality.[9] These observations have been made throughout the world, and apply to both infectious and non-infectious diseases. Those in the lower socio-economic groups have higher death rates for every cause of death listed, except cancer of the breast and motor vehicle accidents. Higher rates of morbidity include virtually every disease, including mental illness.

These findings have been confirmed in Winnipeg. In 1982, I participated in a study of the health status of Winnipeg's Core Area.[10] We compared mortality and morbidity rates of the Core with a more prosperous area of suburban Winnipeg. Standardized mortality rates of Core Area residents for cancer, cardiovascular disease and accidents were found to be significantly elevated (Table 1).

Some sixty sentinel conditions were examined to determine differences in morbidity. Virtually all were elevated. This was particularly true for children under five years of age and the elderly. Interestingly, utilization rates for non-acute health services such as inguinal hernia repair were significantly lower than expected for Core Area residents, indicating that although services may well be physically available, they are not necessarily accessible to or utilized by those who need them. Simply providing hospital and

medical services in these environments is not enough. We need culturally appropriate initiatives that reach out to the community and which support it in improving health.

Low social status has other implications. Those low on the social scale have less opportunity to participate in the planning and implementation of activities that affect them. Their opinions are sought less frequently and they are less able to prevent the untoward from happening to them. They have fewer options regarding occupation. Their work is more likely to be hazardous, and unrewarding emotionally and intellectually.

No discussion of those low on the scale would be complete without mentioning Canada's Native population. Canadian Indians living on reserves have high mortality and morbidity rates. Their life expectancy is ten years less than the national average. The infant mortality rate is 60 percent higher, and postnatal mortality rate 100 percent higher, than the national figures. The incidence of suicide is much higher in Native youth than in any comparable group. Mental health disorders, and problems resulting from drug and alcohol abuse, are prevalent. The proportion of disabled and handicapped Native people is higher than in any other segment of the Canadian population.

Information on the health problems, medical needs and barriers to care among Native Canadians living in cities is not nearly as extensive as that for Natives living on reserves; nevertheless, there is good evidence that these people have many unmet health care needs.[11] Indians who migrate to cities continue to have many of the health problems seen on reserves, but these are augmented by the stress of adaptation to urban living, unfamiliarity with urban health care systems, which often differ dramatically from the community-based health care systems on reserves, and Native/non-Native communication problems.

Demographically, single Native persons between 25 and 44 years of age have educational levels far below those of the average Canadian. This group also has a high rate of unemployment, a low average income and a high level of welfare dependency, which, along with discrimination, result in substandard or inadequate housing. Many are transients, staying in cities for only short periods, and returning frequently to their rural communities.

The exact number of Indians in Canadian cities is uncertain because of the migration flows of this population, transiency within the cities and problems in survey methods. We have about 16 thousand Natives in Winnipeg, approximately 3 percent of the city's population.

A recent survey of medical officers of health in major urban centres found that although several respondents expressed concern about the health care needs of Native people, most city governments have not identified their needs or investigated means of meeting them.

It is evident that the health care problems of Native Canadians in urban centres require further definition and dialogue. Jurisdictional issues between federal and provincial governments must be

overcome. Non-Status Indians and Métis are a provincial responsibility. The migration of Status Natives to urban centres results in a shift of this responsibility that is not clearly understood. Most city health departments have little empirical information on the barriers to health care and health problems of Native people. Epidemiologic studies of the health problems, needs and barriers to care among Indians in cities are needed, and it is important that such research be done in collaboration with local Native organizations.

SOCIAL ENVIRONMENT

I now want to change tack a little and discuss the social environment and health. The significance of supportive social relationships in maintaining health was established in 1987 by Durkheim's study of suicide.[12] He showed that those who were part of groups with weak social ties had higher rates of suicides than those living in groups with stronger ties. In a study done in Alameda County, California, an increased mortality rate was observed among a large group of persons identified as having few friends and social relationships.[13] Those with few social ties had mortality rates two to five times higher than those with more ties. Similar statistics have been observed repeatedly in studies of bereaved persons. When widowers, aged 55 years or older, were tracked after the death of their wives, the mortality rate during the first six months of bereavement was 40 percent higher than would have been expected for married men of the same age.[14] Urbanization and industrialization have decreased the likelihood of supportive social relationships, even though they have created the conditions for a higher standard of living as regards material goods and sanitation. The massive migration of people into cities caused profound changes in interpersonal relationships. Rural communities are characterized by primary group relationships involving intimate face-to-face contacts between people who know each other. In contrast, urban contacts tend to be secondary rather than primary, utilitarian rather than personal and emotional. Relationships tend to be between buyer and seller, doctor and patient, teacher and student, worker and boss.[15] As a result of the secondary nature of such relationships, the city dweller often feels anonymous and isolated.

Industrialization requires a mobile labour force. The need constantly to follow the job market disrupts relationships. Historically, this constant movement has separated families, and, in many cases, has ruptured ties between the nuclear and extended family.

Architectural and planning policy must provide an environment that promotes the development of interpersonal relationships and support networks. Industrial and economic development must be equitable and evenly spread to preclude mass migrations of workers.

HOUSING AND HEALTH

The relationship between housing conditions and health has been known at least since Hippocrates' time. John Graunt (1662) showed how death rates varied between urban and rural areas. William Farr drew attention to the striking difference in infant and mortality rates between the healthy and unhealthy districts of Victorian England. Osler, in the first edition of his textbook on medicine (1892), noted the association between overcrowding and common serious diseases like tuberculosis and rheumatic fever.

The second industrial revolution midway through the twentieth century led to the decay of old industries and the birth of new ones, often in different parts of the country. New Towns were built to house the people who came to work in these new industries, and the trend was encouraged by population growth and economic boom. Sometimes, these New Towns were well planned, sometimes not. The health problems encountered have been documented in New Towns in England. There seem to be no life-threatening problems, but a syndrome known as suburban neurosis is a common affliction of young married women with preschool children who are house-bound all day while their husbands are away at work. Unless there is a car or other convenient means of transport for the housewife to use, she can become isolated. Therefore, public transportation systems play an important role in reducing urban isolation. The configuration of houses in new suburban areas can contribute to or relieve this problem; if the houses are arranged to face each other in semicircles so that neighbours can look at one another, the problem is said to be less severe than if the houses face away from one another.[16]

Feelings of isolation, particularly among women and the elderly who stay at home, are increased by type of dwelling, by the separation of living from working, and by the segregation of generations. Some social critics have claimed that high-rise apartment living is "unnatural" and "unhealthy," but the evidence is slender. Among the least satisfied people living in high rise buildings are mothers with children under five years of age. These mothers are afraid to let their children go out by themselves if they live too high up to supervise them adequately. As a result, children are kept indoors, get less fresh air, and play less with other children.[17] Fanning found that children and their mothers in apartment flats have significantly higher rates of consultation psychoneurotic complaints, compared with families living at ground level.[18] Cramped quarters and isolation were suggested causal factors. Obviously, not everyone dislikes high-rise living. Young adults and some older singles and couples find high-rise living compatible with their needs and enjoy the light, air, view and feeling of relative security.

The lower the family income, the more likely people will be to live where they must, rather than where they would like, and the more likely their housing will be the least desirable. Higher rates of

domestic and street accidents have repeatedly been observed in substandard housing. Rates are higher for street accidents because children have no other place to play. Within the home, poor construction and poor maintenance, unsafe, ill-lit stairs, loose floor coverings and faulty electric wiring may be to blame. Burns, scalds and domestic poisonings are all more common in inner-city slum districts than in prosperous suburbs, because overcrowding, inadequate storage, and less safe stoves and fireplaces are a greater hazard. In addition, those in run-down neighbourhoods are subject to increased incidence of violence to themselves and to their possessions: rape, assault and theft. This housing often is more heavily exposed to air pollution, excessive noise, and other environmental pollution. High environmental noise levels may be hazardous to health. People who live under the flight path of a major airport have higher than expected admission rates to psychiatric hospitals.

The home should provide more than shelter and a safe place to raise children. It should be a place where the family lives and grows together, where bonds of affection and mutual trust are strengthened, where socialization into the prevailing culture and intellectual stimulation are occurring, and where there is privacy when it is wanted and needed. Improving and enhancing these intangibles lies at the core of the Healthy Communities movement. I cannot, as a physician, write a prescription for any of them. They underlie the need for an intersectoral and multi-disciplinary approach to a healthy community.

THE PHYSICAL ENVIRONMENT

The classic concerns of public health have, since John Snow, been to ensure the supply of safe drinking water and the sanitary disposal of sewage and waste. As cities become larger and new industrial processes are developed, these problems multiply. I cannot do justice to such enormous problems in this short paper. You must realize, however, that despite having the largest reserves of fresh water in the world, the supply of safe potable water in Canada is constantly threatened and the natural environment continuously polluted.

In keeping with the theme of this conference, I do, however, want to say a few words about the artificial environments created for us in our homes and workplaces. It is now recognized that non-industrial indoor environments can contribute significantly to human exposure to airborne pollutants.[19] This is particularly true in countries such as Canada where long cold winters and hot summers result in considerable periods of time spent indoors—as high as 70 percent for the average Canadian, and higher for the very young, the elderly and the infirm. Also, within the past few years, incentives have been undertaken to reduce the consumption of energy, particularly oil, in buildings, by reducing the rate of air

exchange, installing additional insulation and using alternative sources of energy. Such measures can raise the concentrations of some contaminants in indoor air above those found in outdoor air, and so have aroused the concerns of public health authorities, those concerned with building standards and home construction, and the general public.

A prescription for ventilation requirements is only one of several strategies that might be adopted to control the presence of airborne contaminants in the home. Other possibilities include specifications for building design and materials and consumer products. In many instances, measures to minimize exposure to chemical contaminants can be taken by the occupants. Public education is an important strategy for attaining an acceptable quality of indoor air.

Most people also spend their working hours in artificially ventilated buildings. Control of temperature and humidity is important in some industrial processes (e.g., the production of textiles and paper), improves the performance of computers, and, with stringent filtration of theatre air, provides a safe environment for patients undergoing major surgery. But with exceptions like these, the main aim is a comfortable working environment. Unfortunately, like other technological advances, mechanical ventilation has created new health problems.[20]

The adverse effects were lately reviewed by Finnegan and Pickering.[21] Health problems are related to the source of external air, to particles in recirculated air, and to contaminated humidifiers. Infectious disease, extrinsic allergic alveloitis, humidifier fever, asthma, and "sick building syndrome" have been reported.

Hippocrates, 24 centuries ago, believed that the air and water around us might affect health. It seems strange that, with modern technological skills, buildings are constructed with microclimates that vindicate his views. Design and engineering faults are a recurring theme in reports of ventilation illness. Systems are inaccessible and difficult to clean, air intakes are regularly sited close to outlet ducting, mechanical failures go undetected for long periods, maintenance is irregular and inadequate, and contaminated humidifiers are treated with biocides whose toxicology has not been studied in detail. Architects and engineers must consider the potential adverse effects of their systems at the design stage.

CONCLUSION

In closing my remarks, I want to touch on the subject of funding. The health care dollar in this country is already severely stretched. Given that reality, we cannot expect massive injections of money to add on health promotion programs. If we are to succeed in making our communities healthier, we must embrace a broader definition of the determinants of health in a process of planning and consultation.

Public input and acceptance of any plan is essential. We must also start to reorient our health care services to a properly evaluated preventative approach. The Healthy Community concept provides an opportunity for an inexpensive, community-based approach to health promotion which perhaps can be paraphrased as "health promotion for the people by the people."

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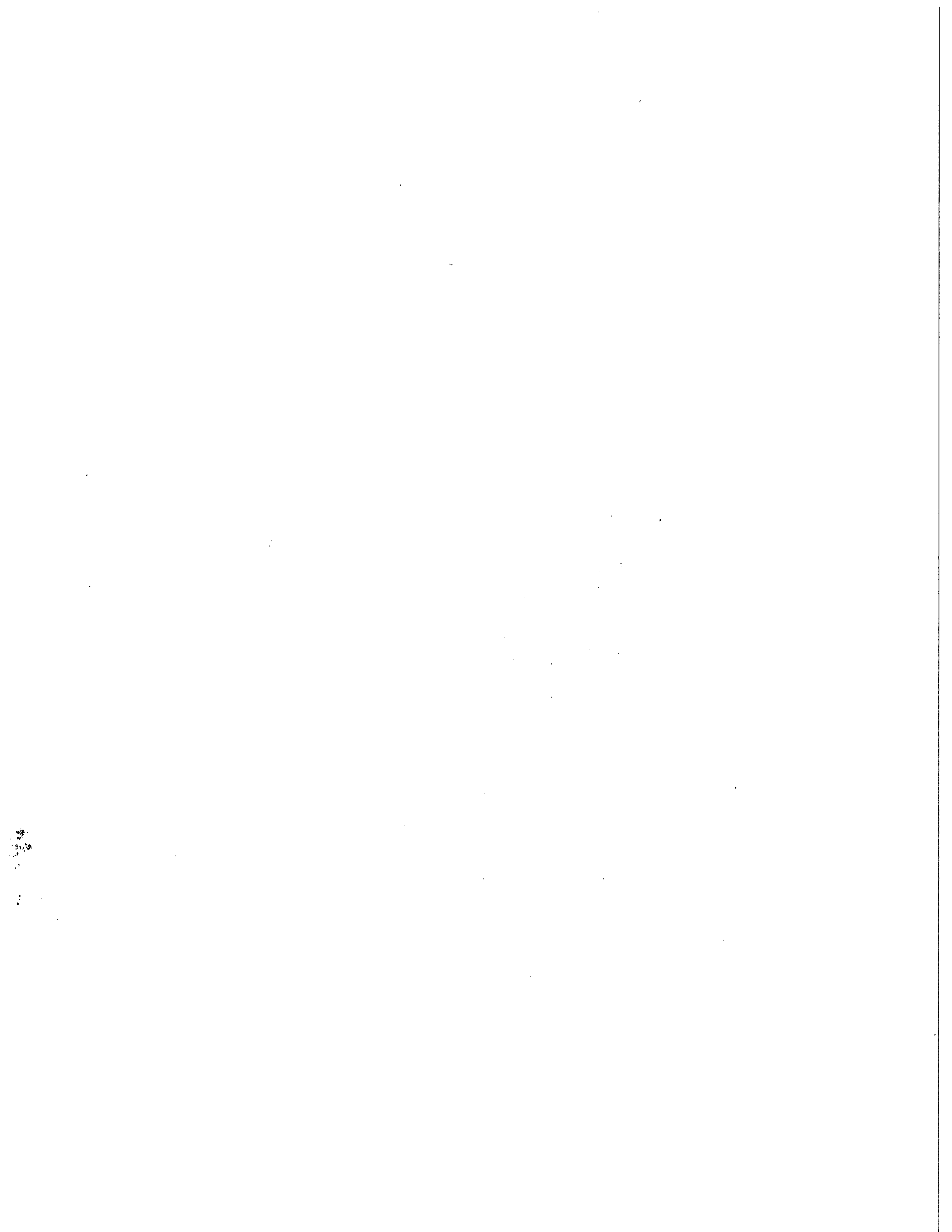

THE CONCEPT OF HEALTHY CITIES

Suzanne F. Jackson, Ph.D.

In this paper, I will be presenting a review of the concept of Healthy Cities with a focus on the evolution of the WHO Europe Healthy Cities Project and on the role of Canadians in public health. The development of the concept of healthy cities closely follows the evolution of the concept of health. As key proponents of health promotion, leaders in the public health field in Canada have played a role in initiating and stimulating the idea of Healthy Cities.

Faced with the problem of growth from a village to a city of 50,000, the pooling of efforts between public health and urban planning in the early twentieth century contributed to the eradication of communicable disease. Now, the problem is growth from cities of 50,000 to those of up to 2 million or more. Thus, the issue we face in the late twentieth century is the elimination of human-made disease or the pathology of the environment, the solution to which suggests that urban planning and public health need to join forces again (Oberlander, 1984). The common historical origins of both public health and urban planning, and the nature of their renewed relationship through the Healthy Cities movement, are aptly described by Mathur (1988).

This paper will touch on a few of the points discussed in both Mathur's and Lane's papers (published in this volume). However, the aim will be to present a coherent picture of the nature of the concepts which drive the Healthy Cities movement, both in Europe and here in Canada.

CHANGES IN THE CONCEPT OF HEALTH

In the late 1800s and early 1900s, public health (in the persons of medical officers of health) recognized the links between environments and disease, and advocated inspections of foodstuffs, cleaning drains and privies, chlorination of water, pasteurization of milk and vaccination. They recognized the connections between workers' health and working conditions, and the vulnerability of children's health in the urban environment.

As curative medicine became the dominant force in the health field, the broad perspective of municipal public health narrowed, and focused on the prevention of communicable disease. Health was generally considered in terms of medical doctors and the sick care system, and equated with the absence of disease.

The renaissance of the broader concepts of health and disease which characterized the public health field at the turn of the century did not occur until the 1970s (Lane, 1988). With the emergence of new concepts of health came changes in the concepts of health promotion and disease prevention, and changes in the roles of public health, public policy and the municipality in creating the conditions for health.

Canada and Canadians have played a significant role conceptually in broadening the discussions of health and health promotion and in talking about the implementation of these ideas via Healthy Cities and healthy public policy as illustrated in Figure 1.*

It was at a conference in Toronto in 1984 that the ideas of healthy public policy and Healthy Cities were first discussed. Shortly thereafter, in 1985, WHO Europe initiated its Healthy Cities project. Through a series of symposia, workshops and conferences in Europe, the Healthy Cities idea gained currency there and elsewhere in the world.

The same time frame (1984-present) also encompasses key conceptual developments in health promotion with the Ottawa conference on health promotion in 1986 and the Adelaide conference on healthy public policy in 1988. Community development and community participation are themes which have gained strength and credibility as an essential part of health promotion.

Thus, as health becomes more than the absence of disease and health promotion becomes "a process of enabling people to increase control over, and to improve their health,"[1] solutions to health problems move beyond the traditional health care sector to include healthy public policies in many sectors, including urban planning:

> As long as health was considered to be a matter for doctors and hospitals on the one hand, or personal responsibility on the other, the city had only a small role to play. If, however, health results chiefly from the influence of the physical and social environments (either directly or mediated through personal behaviour), the role of the city in creating health may be very important (Hancock and Duhl, 1986, p. 14).

In recognition of such a statement, the role of the city in promoting health is a key part of the WHO strategy to achieve "Health for All by the Year 2000" in Europe. Hence, the Healthy Cities project in Europe and the concept of Healthy Cities itself are associated closely with health promotion and its principles. Health promotion addresses the population as a whole in the context of everyday life; it is directed towards action on the determinants or causes of health, it combines diverse, but complementary, methods or approaches, and it aims particularly at effective and concrete public participation (WHO Europe, 1984). It is this concept of health promotion, with an emphasis on process, that is the backbone of the concept of Healthy Cities.

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*See Appendix for Figures 1, 2 and 3.

THE CONCEPT OF HEALTHY CITIES

Looking at the definition of a healthy city is like looking through a kaleidoscope—there are so many versions of what it is and could be:

> . . . the concept of a healthy city is a very broad one, incorporating ideas from sociology, urban geography, city planning, ecology, politics, economics, philosophy and a host of other disciplines in addition to public health. And, of course, the concept will mean different things to different people from different cultures, from different cities, even from within the same city (Hancock and Duhl, 1986, p. 20).

For example, there are many definitions of a city:

- area described by hard infrastructure;
- where permanent residents live at high density;
- where local inhabitants satisfy an economically substantial part of their life locally;
- where cultural ingredients exist such as fine arts, writing, and science;
- area described by existence of soft infrastructure;
- a legally and politically defined entity;
- an organic living system, partly organism, partly ecosystem (Hancock and Duhl, 1986).

Any or all of these "definitions" of a city exist among any group of city dwellers. The concept is value-laden and therefore depends on who you are. Similarly, the concept of a *healthy* city is also value-laden. Based on a scan of the literature in all of the fields listed above, Hancock and Duhl (1986, p. 35-36) describe some general parameters that appear to contribute to the process of making a city healthy.

- a clean, safe, high-quality physical environment (including housing quality);
- an ecosystem which is stable now and in the long term;
- a strong, mutually-supportive and non-exploitive community;
- a high degree of public participation in and control over the decisions affecting one's life, health and well-being;
- the meeting of basic needs (food, water, shelter, income, safety, work) for all the city's people;
- access to a wide variety of experiences and resources with the possibility of multiple contacts, interaction and communication;
- a diverse, vital and innovative city economy;
- encouragement of connectedness with the past, with the cultural and biological heritage and with other groups and individuals;
- a city form that is compatible with and enhances the above parameters and behaviours;
- an optimum level of appropriate public health and sick care services accessible to all;
- high health status (both high positive health status and low disease status).

Most of these parameters are familiar to public health workers and to urban and community planners. Thus, for both groups, Hancock and Duhl's definition of a healthy city is probably reasonable: "a healthy city is one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to support each other in performing all functions of life and in developing themselves to their maximum potential." This is a process definition which closely parallels the definition of health promotion cited earlier.

THE PROCESS OF BECOMING A HEALTHY CITY

The process of creating a healthy city project requires the commitment of the municipal government; the key figures within the city's power structure must be willing to ask, "What is our vision of a Healthy City, and how do we become one?" It also requires the involvement of a broadly-based coalition of agencies, organizations and groups from all segments of the city and its communities, and it requires participation by citizens. This widespread consultation establishes the city's values and goals, develops a vision of a desired future and develops the tactics and strategies required to reach the vision.

John Ashton, of the Liverpool Healthy Cities project (1987, p. 24), describes the following steps for creating a Healthy City:

- The production of a corporate health plan for the city which is based on a community diagnosis and represents collaboration between the relevant governmental and non-governmental bodies within the city. This plan should incorporate a commitment to participation, a multisectoral approach, and to the identification of city health goals based on action strategies in line with WHO philosophy.
- The establishment of an intersectoral Healthy Cities Committee as a decision-making committee of the city council.
- The establishment of an interdepartmental officer group to implement the health plan, and to advise on the health aspects of city policies through the production of health impact statements.
- Exploring ways in which the Health Advocacy function can be established within the city.
- The generation of a broad-based public debate about the creation of a Healthy City.

These steps are consistent with both participative planning processes and with the principles of health promotion. One of the key challenges to planners in implementing the participation principles of the Healthy Cities movement is to develop better techniques for enabling participation on a large scale. Community involvement and multisectoral participation in the entire planning process are important to the success of the whole endeavour, including involvement in the selection and interpretation of Healthy City indicators. Thus, another challenge for the planner is to develop participative ways of monitoring and assessing progress towards becoming a Healthy City.

HEALTHY CITY INDICATORS

In a manual created by Duhl and Hancock (1988) for those hired by WHO Europe to assess their Healthy City projects, there are guidelines for creating the information system required to assess and monitor a city's health. This is a particularly important aspect, because we must find ways to assess the "soft" or qualitative aspects of a city as well as the aspects which are easily quantified. As Hancock states in his Vienna paper (May 1988), a Healthy City needs information to stimulate, monitor and assess the impact of change.

To stimulate change, information needs to include data and stories which point out the differences or inequalities in health within and between cities and which are sensitive to short-term change. Monitoring the process depends on stories and observations about the formal and informal processes of developing Healthy Cities and Communities, rather than hard data. To assess the impact of change, information on individual and community health status at the neighbourhood level is required (such as objective and subjective assessments of physical, mental and social well-being).

A fundamental principle underlying the Healthy Cities movement is that communities need information in order to assess their own situations and take action. Hence, although there is a tendency to describe information in technical terms, Healthy Cities information needs to be user-friendly in its presentation to communities, politicians and community agencies, as well as to health professionals and planners. In other words, community empowerment is only possible if the community itself defines what a healthy community is and how it would measure and assess progress.

Total community involvement is the ideal. The challenge is to develop the means to enable this to happen, especially in larger communities or cities. A city the size of Toronto, for example, is made up of many cultural and geographic communities. Fifteen visioning workshops were held on a somewhat localized basis involving community members, organizations and politicians. This only approximated the process of having the community define a Healthy City, because most community members spoke to their individual and localized experience of the city, and the information was not "owned" by the neighbourhoods concerned. The results of all the visioning workshops held in Toronto were synthesized into an overall vision statement for the city as a whole. Then, Healthy City indicators were developed, using the vision as a guide, by members of the Department of Public Health, not by community participants. This kind of situation, which falls short of the ideal, is one most cities face as they try to develop Healthy City indicators.

The HOUDA/Reporting framework for WHO Europe's Healthy Cities Project (Duhl and Hancock, 1988) gives some details about what kind of information is required to stimulate, monitor and assess

change (see Figure 2). Each community/city is required to develop a list of indicators as part the project. Some assistance and guidance have been provided by the development of a core list of 27 indicators in Barcelona in March 1987. The Barcelona indicators are considered to be *preliminary*, and are meant to be adjusted as cities work with them over the next few years.

The Barcelona group chose enough indicators to reflect the richness and diversity of cities, but not so many as to be incomprehensible and overwhelming. They are meant to include both subjective and objective assessments, qualitative and quantitative information, and aggregate and distributive characteristics. The criteria for choosing this particular list of indicators were: to stimulate action, have social and political punch, and be sensitive to short-term change; to be reasonably simple to collect, use and understand; to be available now, at reasonable cost; and able to be shown to be related to health.

The list is long, and makes better reading if it is grouped. The general parameters of a Healthy City described earlier were used to create the following clusters for the Barcelona indicators (listed in Figure 3): a clean, safe, high-quality physical environment; a stable, sustainable ecosystem; a mutually supportive and non-exploitative community; public participation and control over decisions; the meeting of basic needs (food, water, shelter, income and work); optimum public health and sick care services; and high health status. These are all factors influencing the health of individuals in any setting.

The whole area of Healthy City indicators is under development worldwide. Some indicators are readily available, others are not, and each community/city has a unique experience to report as it tries to come to grips with the issues it faces. For those who enjoy information and data issues, this is an exciting area of involvement.

CURRENT STATUS OF THE HEALTHY CITIES MOVEMENT

NATIONAL PROJECT IN CANADA

In Canada, the project is called The Canadian Healthy Communities Project and it is co-sponsored by the Canadian Institute of Planners (CIP), the Canadian Public Health Association and the Federation of Canadian Municipalities. A national office with a project co-ordinator was established as of September 1988 out of the national CIP office and funded by Health and Welfare Canada. By mid-1988, a number of Canadian city councils had passed resolutions endorsing the Healthy City concept: Dartmouth, Sherbrooke, Rouyn-Noranda, Regina, Edmonton, Victoria and Calgary. Vision sessions have been held in Toronto, Victoria, Calgary, Edmonton, Winnipeg, North York and Rouyn-Noranda.

INTERNATIONAL ACTIVITIES

In the WHO Europe project, 20 cities have been designated, and 30-40 cities are interested. In Australia, with encouragement of the Australian Community Health Association, three cities are participating, and three more will soon join them. In the United States, a few cities are beginning to be interested, and it is hoped that a Pan-American project involving the Canadian International Development Association, the Pan-American Health Organization and other national organizations will be underway in the near future.

PROVINCIAL PROJECTS: ONTARIO

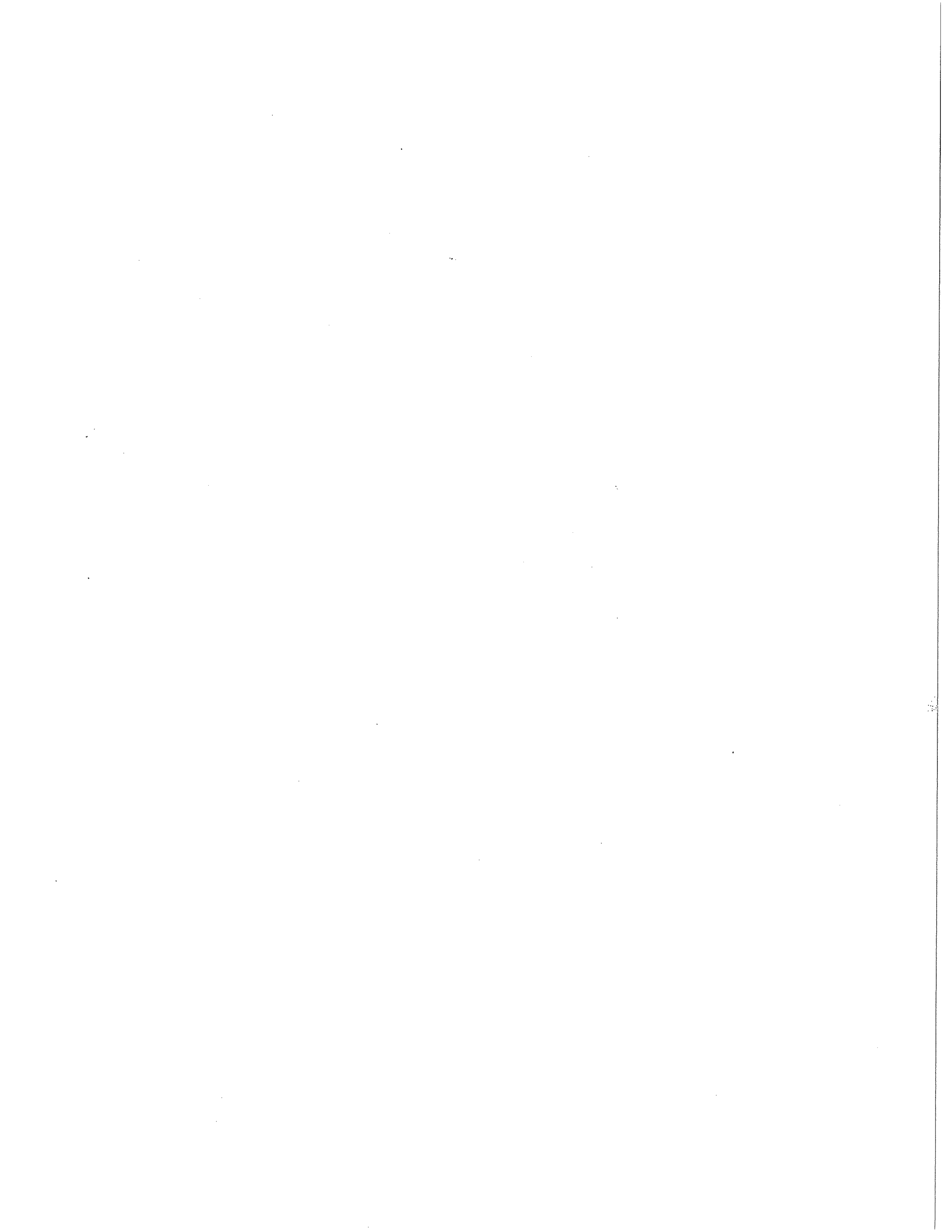
In Ontario, the Association of Municipalities of Ontario, Ontario Public Health Association, Ontario Professional Planners Institute, Ontario Association of Landscape Architects, the Conservation Council of Ontario and the Ministry of Municipal Affairs are involved in setting up a project related to Healthy Cities called "Urban Design for Health and Sustainability."

PROVINCIAL PROJECTS: QUEBEC

Quebec has an active provincial organization *Villes et villages en santé*, sponsored by the Quebec Public Health Association and the DSC de l'Hôpital du Saint-Sacrement in Quebec City. Projects have been started in the following municipalities: Rouyn-Noranda, Sherbrooke, Québec, Montréal, Montmagny, Saint-Fabien, Pointe-Claire, Rigaud, Pintendre and Saint-Pacôme. Several of these projects have already been officially sanctioned by their municipal councils.

SUMMARY

In conclusion, I would like to make several points. First, the Healthy Cities concept derives much of its impetus from the definition of health promotion and the global drive to achieve "Health For All By The Year 2000." Although each participating city has to develop the commitment to a vision and a process which reflects its own unique characteristics, all are part of a global movement which provides some general guidelines and opportunities to exchange experiences. The *process* of becoming a Healthy City is most important. Community involvement and multi-sectoral participation in the entire planning process are keys to the success of the whole endeavour. Healthy City indicators aim to stimulate, monitor and assess the impact of change. These factors will stimulate our creativity and ingenuity to improve and invent the appropriate planning techniques. These are exciting challenges for both urban and health planners, and it is my hope that they will work together through the Healthy Cities projects.



APPENDIX

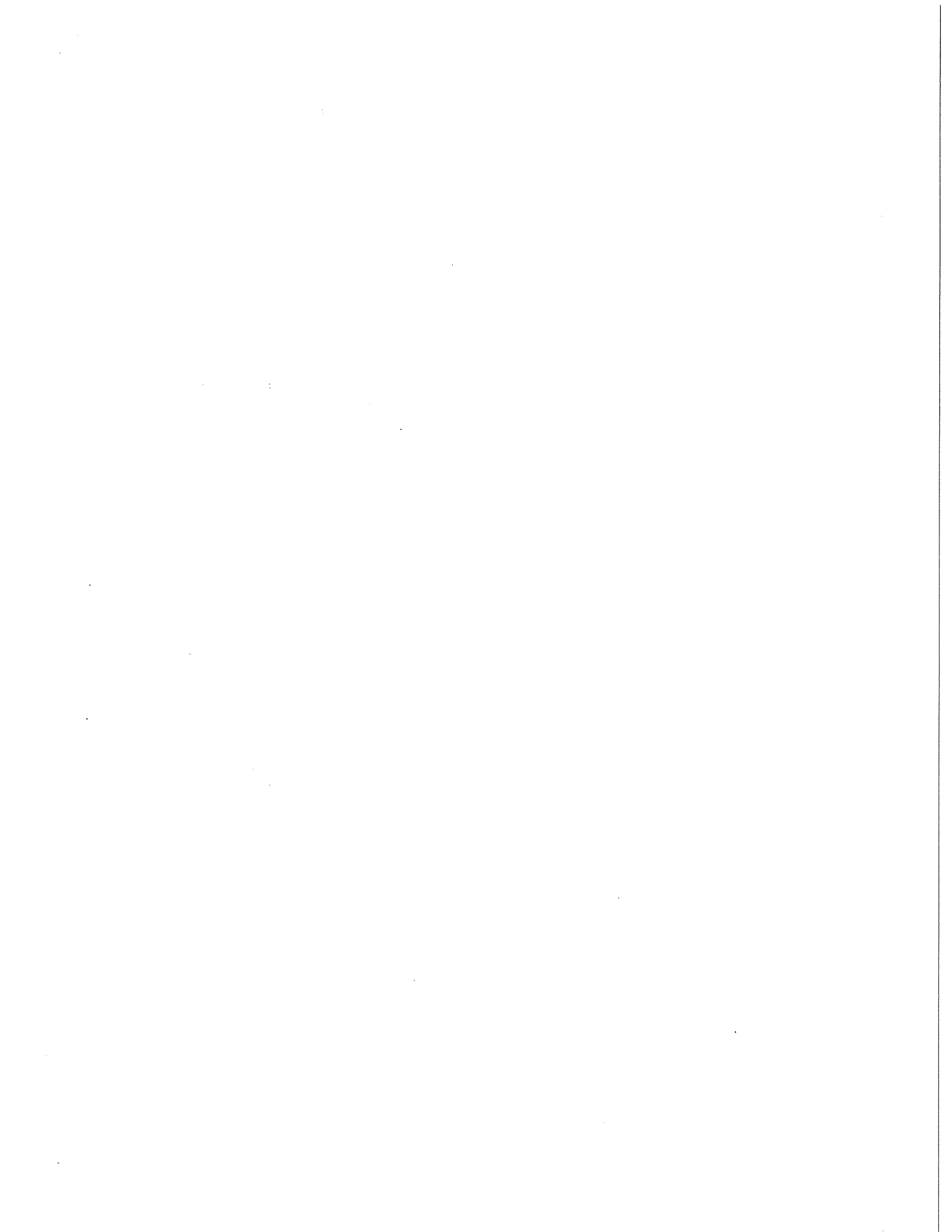


Figure 1. CANADIAN CONTRIBUTIONS TO CHANGING THE CONCEPT OF HEALTH

Year	Place	Who & What
1974	Ottawa	**Lalonde Report:** Health and Welfare Canada document broadening the concept of health to include four determinants of health—human biology, lifestyle, environment and the health care system.
1984	Toronto	**Beyond Health Care Conference:** Canadian Public Health Association—first conference exploring concept of healthy public policy.
1984	Toronto	**Healthy Toronto 2000 Workshop:** Department of Public Health, Toronto—beginnings of Healthy Cities concept.
1985	Toronto	**Mandala of Health:** Department of Public Health in Toronto developed this broad framework of the factors influencing individual health with an emphasis on various environments.
1986	Ottawa	**Ottawa Charter for Health Promotion:** WHO international agreement on enabling definition of health promotion and setting an agenda for global action on health promotion.
1986	Ottawa	**Epp Framework "Achieving Health for All":** Health and Welfare Canada—most recent official Canadian government stand on health promotion consistent with emerging concepts.
1987	Toronto	**Health for All Ontario:** Report of Spasoff Panel on Health Goals for Ontario—recognition of the importance of equity, socio-economic environments and healthy public policy for achieving health.

Figure 2. THE HOUDA/REPORTING FRAMEWORK FOR WHO EUROPE'S HEALTHY CITIES PROJECT

SECTION A. CITY PORTRAIT

An outline of the history, character and physical form of the city. (To be done in full once only and updated as required). *Specifications included.*

SECTION B. CITY CONTEXT

A schedule of general characteristics of the city to complement the material in A and provide the background to the HCP. (To be done once only and updated as required). *Specifications included.*

SECTION C. CITY PROFILE

The main set of indicators to be used in routine reporting to WHO to trace developments and changes in the city. (To be done annually or otherwise as agreed). *Specifications not included.*

SECTION D. PROGRESS OF HCP

The current status of the common intermediate objectives forming part of the city's agreement with WHO; and of innovations under the HCP planned or completed. (To be done annually or otherwise as agreed). *No specifications.*

SECTION E. CASE STUDIES

An optional section giving the chance to describe in more detail problems and opportunities arising during the project. (To be done annually or as otherwise decided by the city). *No specifications.*

SECTION F. GLOSSARY OF TERMS

A schedule of terms used in the reporting framework. (Please identify where any terms are not defined or are inadequately defined).

Figure 3. **BARCELONA HEALTHY CITY INDICATORS GROUPED ACCORDING TO THE GENERAL PARAMETERS OF A HEALTHY CITY**

Clean, Safe, High-Quality Physical Environment

1. Number of days per year with average acid pollution (NOx, S02) above WHO guidelines

2. Perceived Annoyance Index. Composite index of noise, smell, and dirtiness (the sum of 1-5 scores given to each of the 3 items)—to be developed

3. Percentage of substandard dwellings (defined according to the standards in each city)

4. Rate of reported violent crime (as defined by police)

5. Percentage of people reporting that they feel safe walking at night in the neighbourhood

A Stable, Sustainable Ecosystem

6. Percentage of domestic waste recycled

Mutually Supportive, Non-exploitative Community

7. Perceived accessibility to local shops

8. Self-perceived loneliness—percentage reporting loneliness often or always

9. Percentage of people reporting the city as a good or very good place to live

Public Participation and Control over Decisions

10. Percentage of people reporting involvement in a health, social, peace or environmental group

Meeting Basic Needs (food, water, shelter, income, work)

11. Work satisfaction (to be developed)

12. Percentage of families without independent dwelling (as nationally defined)

13. Percentage of unemployment (as nationally defined) or percentage of population receiving welfare/social assistance or percentage of population receiving less than 50 percent of the average wage (national if no city average available)

14. Incidence rate of salmonellosis (per 1,000 population per year)

Optimum Public Health and Sick Care Services

15. Percentage of city budget devoted to public health (or number of new health promotion activities to which resources are allocated)

High Health Status

16. Proportion of daily smokers in the population
17. Percentage of people reporting they have restrictions on smoking in their workplace (covers only the working population—to be developed)
18. Percentage of reported motor vehicle accidents involving alcohol
19. Incidence of motor vehicle accidents (per population over 18)
20. Percentage of people reporting daily use of tranquillizers sold per adult population)
21. Self-esteem (to be developed)
22. Percentage of people reporting good or excellent health
23. Average days of reported restricted activity per year
24. Perinatal health—rate of babies born below 2500 g
25. Potential years of life lost due to cardiovascular disease under the age of 70
26. Standardized death rate due to AIDS or HIV positive tests per total number of tests performed

NOTES

1. This perspective is derived from a conception of "health" as the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs, and, on the other hand, to change or cope with the environment. Health, therefore, is seen as a resource for everyday life, not the objective of living; it is a positive concept emphasizing social and personal resources, as well as physical capacities (Ottawa Charter, 1986).

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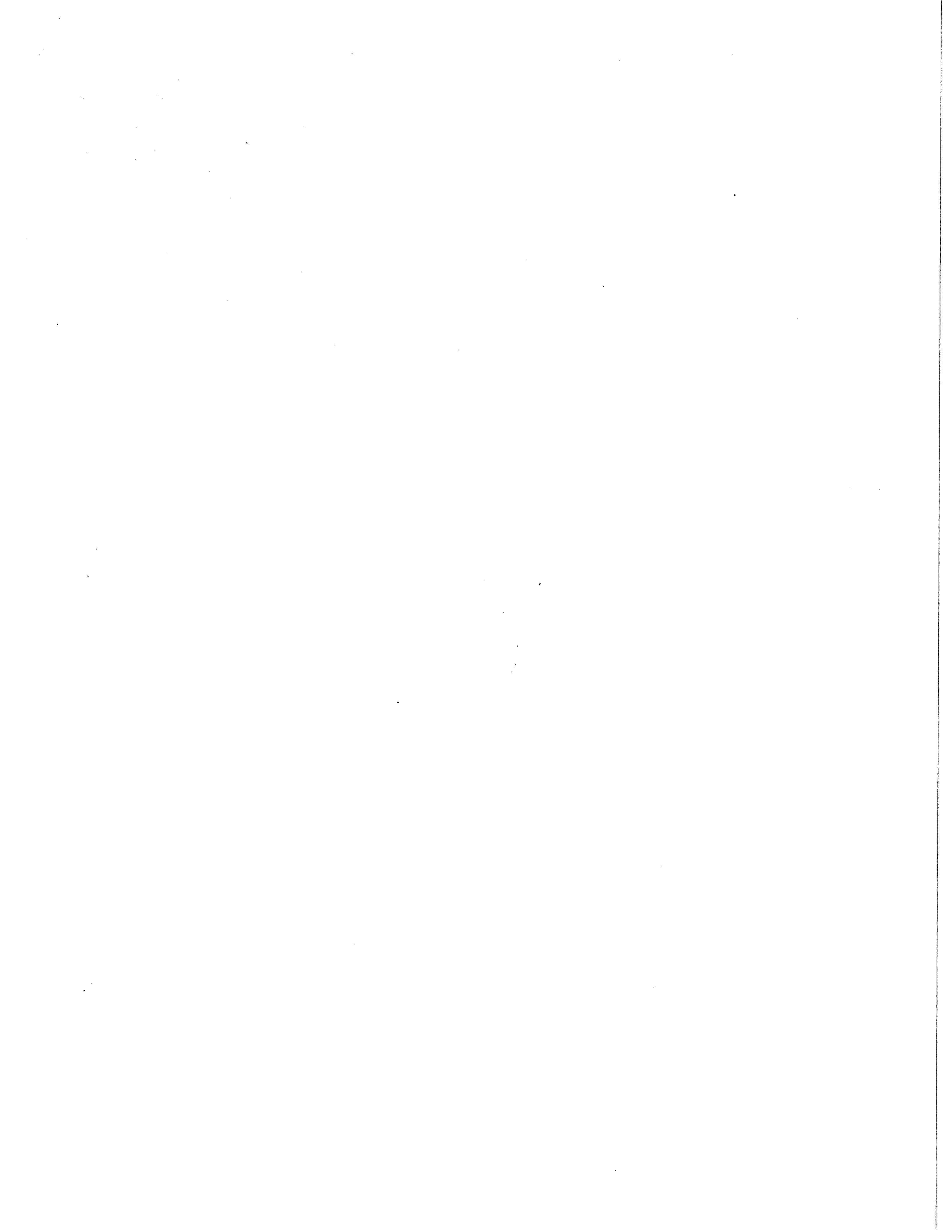

HEALTHY CITIES: IMPLICATIONS FOR URBAN PLANNING

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INTRODUCTION

In their presentations at the two sessions on Healthy Cities at this conference, speakers have outlined some of the recent developments in the ideas about health, how these ideas have been set out in the federal government's framework for health promotion,[1] and how this framework has influenced the formulation of the Canadian Healthy Cities Project. In my presentation, I will attempt to outline what I see as some of the important implications of the Healthy Cities Project for urban planning,as well as for urban planners in Canada.

THE CANADIAN HEALTHY CITIES PROJECT AND URBAN PLANNING

Although the Canadian Healthy Cities Project is still in the process of being developed, a review of program-related literature indicates that in essence, the project's goals will mirror those in the Canadian federal government's framework for health promotion both in scope and orientation.[2] Implementation models for Canadian project will likely adapt the experience of the European cities (where the first Healthy Cities projects were implemented) to suit Canadian goals and settings. Already, program-related literature being circulated to promote the project in Canada contains descriptions of European projects.[3]

The federal framework identifies three health challenges—reducing inequities, increasing prevention and enhancing coping—and proposes to meet these challenges through the mechanisms of self care, mutual aid and healthy environments, which are to be achieved through the fostering of public participation, strengthening community health services and co-ordinating healthy public policy.[4] From this framework are emerging the goals of the Healthy Cities Project, which are to be achieved through a multi-sectoral approach involving "local action in areas such as education, housing, urban planning, economic development, environmental hygiene, public health, social services and much else."[5]

Within the broad framework of goals for the Healthy Cities Project, goals for the urban planning sector have to be derived on the basis of the scope of urban planning activity in Canadian cities. For the purpose of this paper, I have interpreted these goals, perhaps ambitiously, as follows:

> the creation of healthy physical environments through the fostering of public participation to meet the challenges of reducing inequities, increasing the prevention of disease and enhancing coping with urban living.

FOCUS OF THIS PAPER

Already, urban planners who have participated in Healthy City workshops have started to turn their attention to how Healthy City projects can be designed and implemented within their respective institutional and organizational settings.[6] The Institute of Urban Studies at the University of Winnipeg will also undertake such an exercise for Winnipeg during 1988-1989.[7]

As we proceed to build models of implementation, three questions arise:

- How do the goals of the Healthy Cities Project fit into Canadian urban planning?
- How will the Healthy Cities Project affect the urban planning process?
- How will the Healthy Cities Project affect public participation in urban planning?

These questions require closer examination.

In addressing the question of "fit," this paper will review the urban planning experience in pursuit of healthy environments and assess the extent to which the goals of reducing inequities, increasing the prevention of disease and enhancing coping with urban living have influenced urban planning thought and practice. From this review, the paper will identify the implications of the Healthy Cities Project for urban planning and planners.

In addressing the question of planning process, the paper will attempt to identify the implications of incorporating Healthy Cities concerns into certain steps in the urban planning process, i.e., problem description and analysis, formulation of options, and evaluation of costs and benefits.

In addressing the question of public participation in urban planning, the paper will provide a brief overview of the history of public participation in Canadian urban planning, and identify the implications of the Healthy Cities Project for public participation in the future.

URBAN PLANNING AND THE GOALS OF THE HEALTHY CITIES PROJECT

Urban planning emerged as a response to the unhealthy conditions of nineteenth-century cities in Europe and North America, which faced problems of communicable disease, potable water, sanitation, slums and fire. Several proposals for new urban forms were formulated in the 1800s to improve the health and living conditions in cities.[8]

Dubos has cited a work by Benjamin Ward Richardson called "Hygeia: A City of Health."[9] According to Weinstein, Hygeia (which was never realized) was devoted completely to the prevention of disease and the promotion of health through environmental sanitation.[10] Other formulations on the theme of creating healthy environments include the Garden City planners who dominated urban planning during

the early part of the twentieth century, and who emphasized health and housing as the main concerns for urban planning.[11]

Canada experienced a surge of urban growth between 1881 and 1921. During this period, Montreal and Vancouver more than quadrupled in population. The population of Toronto increased six times and Winnipeg's, three times. Such growth brought with it slums, squalor, disease and environmental degradation caused by industrial expansion. As urban conditions grew worse, public movements emerged around four issues of concern: public health, housing conditions of the poor, conservation of resources, and the capabilities of the local government to address the issues of the times. These movements have come to be known as the urban reform movements.

Canadian urban planning emerged in the first decade of the twentieth century out of the urban reform movements. As a result, it drew its social objectives from the values of the reform movements.

From the public health movement emerged the objectives of better water and sewage systems, the eradication of slums and the adoption of better standards for buildings and for sanitation. In addition, better systems for recording vital statistics were put in place to provide a data base to substantiate needs in public health. From the housing reform movement came the objectives of better planned housing and the integration of amenities such as playgrounds and open spaces into housing projects.[12]

The conservation movement in Canada found common cause with the United States in concerns related to the environmental effects of increasing industrialization. Following the lead provided by the U.S. Government, the Government of Canada established the Commission for the Conservation of Natural Resources in 1909. The Commission concerned itself with a broad range of natural resources and human issues including public health. It appointed Dr. Charles Hodgetts, a former Medical Health Officer of Ontario, as its Advisor on Public Health, and constituted a Committee on Public Health. Hodgetts and the Committee established a strong commitment to public health, and later, with the recruitment as Town Planning Advisor of Thomas Adams, a former associate of Patrick Geddes and the British Garden Cities movement, they pioneered urban planning in Canada. The goals of public health and conservation thus were implanted in Canadian urban planning of the early twentieth century.[13]

The Commission drafted model planning legislation, drawing heavily on the British experience. During the tenure of the Commission, eight provinces enacted planning legislation to permit municipalities to prepare urban plans. By the early 1920s, Canadian cities had overcome the worst of their urban sanitation problems; urban planning contributed significantly in this regard.

The Commission of Conservation was dismantled in 1921 by Prime Minister Meighen, and with it ended the most important Canadian era in quest of healthy urban environments. Between 1921 and the mid-'40s there was little urban planning activity in Canada.

FIGURE 1

THE STATUS OF HEALTHY CITIES GOALS IN THE TWO MAIN PHASES OF URBAN PLANNING IN CANADA

Healthy City Goal	Phase 1 (Pre World War II)		Phase 2 (Post World War II)	
	Planning Literature	Planning Practice	Planning Literature	Planning Practice
Reducing Inequities	strong	weak	strong	weak
Increasing Prevention	strong	strong	absent	absent
Enhancing Coping	absent	absent	weak	weak

Urban planning was revived in the wake of the reconstruction activity which followed the Second World War. However, two decades of inactivity had caused a complete break with the values of the reform movement. Considerations of public health and conservation did not figure prominently, and this trend has continued to the present time.

Figure 1 shows that the three goals of the Health Cities Project—reducing inequities, increasing prevention and enhancing coping—have received mixed attention in urban planning literature and practice during the two phases.

The goal of reducing inequities figures strongly in urban planning thought in both phases, but has been weak in practice. For example, Clifford Sifton, the head of the Conservation Commission stated:

> It seems a terrible indictment of modern civilization, but it is undoubtedly a true one that the growth of unsanitary, unhealthful conditions, the growth of slums and slum populations are in direct reaction to what we call progress. The immense growth of the city is invariably accompanied by these undesirable conditions . . . The growth of poverty, misery and crime accompany industrial and commercial expansion on a large scale . . . Why is it that, as countries grow richer, the rich become richer and the poor become poorer?[14]

Spragge cites a 1922 article from the *Journal of the Town Planning Institute of Canada* entitled "Town Planning: A Peoples' Movement," in which the author claimed that the intention of town planning was not decorative luxury, but "to give to the average man [*sic*] a larger share of the benefits of civic life."[15] Gerecke observes that although Canadian planners were serious about reform, Canadian planning did not go beyond dealing with symptoms to dealing with the basic changes in social structure. On the contrary, a belief in philanthropy, social engineering and the salvation of science was urban planning's greatest weakness.[16]

During the second phase of urban planning, urban planners have been preoccupied with the goal of facilitating growth through land allocation decisions. From the writings of Lorimer, Gerecke, Kiernan and Clark, it would appear that although their land allocation activity results in redistribution, urban planners have not interpreted this function from a social justice perspective and have largely either ignored the question of reducing inequities or aligned themselves with developers.[17] At the same time, urban planning literature has not been deficient in raising concerns of distributional equity. This is to be attested by the spate of articles on this topic in popular planning periodicals such as *City Magazine*, and reports prepared by social planning agencies operating in Canadian cities.[18]

It must be mentioned here that a small group of planners who believe in the goals of social justice have played an important role in advocacy planning over the past two decades, but they have operated, for the most part, outside of official urban planning, have had only limited success, and that success has been in preventing official planning outcomes rather than promoting equity. In order for distributional

equity to be incorporated into urban planning, it will have to be adopted into mainstream planning as a specific goal. In this respect, we can take heart from the recent experience with the Core Area Initiative in Winnipeg, where a concerted effort is being made to reduce inequities in the inner city. Only time will tell whether this experiment will succeed in meeting its goals.

The goal of increasing prevention of disease was, as we have seen in the earlier part of this section, one of the important goals in urban planning literature and practice during the first phase. In the second phase of urban planning, this goal has been absent. Weinstein has pointed out that urban diseases of concern in contemporary times are chronic diseases, in contrast to the turn of the century, when concern was with communicable diseases. While the prevention of communicable diseases required a largely environmental sanitation approach, the prevention of chronic diseases requires a holistic, ecological approach to public health problems such as pollution of land, air and water, noise pollution, radiation, toxic chemicals and psycho-social environmental conditions such as stress, crowding and lifestyle.[19] This concept has yet to be recognized in urban planning.

The goal of enhancing coping with urban living was largely absent during the first phase of urban planning in Canada. It has surfaced in recent times in urban planning literature—mostly in the writings of environmental planners such as Hough, who have advanced the argument that the presence of ecological diversity in the urban environment is an important factor in increasing our capacity to cope with stress.[20] In the late 1960s, several authors also made a link between the physical environment and behaviour.[21] With the exception of noise containment measures, there has been very little effort in urban planning practice to incorporate measures to increase coping in the urban physical environment.

The foregoing review of Canadian urban planning indicates that, at the present time, the three goals of the Healthy Cities Project are at lest marginally incorporated into urban planning, and that a major effort will be required to develop them conceptually and to adopt them in practice to create the Healthy City.

URBAN PLANNING PROCESS AND THE HEALTHY CITIES PROJECT

Urban planning in Canada is a function of municipal government. The local governing body, i.e., the elected city council, is responsible for making the final decisions regarding urban planning matters. It follows, then, that decisions about urban planning matters are made in a political environment.

However, council's decision on an urban planning matter is really the *final* step in the urban planning process. In most Canadian cities, professional planners employed by the municipality conduct analyses and make recommendations on each urban planning matter which is presented to council for

a decision. Recommendations of urban planners are often channelled to council through a standing planning committee. Thus, the normative urban planning process is comprised of several cycles. Urban planners play a prominent role in the first cycle by undertaking analyses and interjecting urban planning values into their recommendations. The planning committee of council plays a buffer role in which the values of urban planning, embodied in the recommendations of the planners, are balanced with other public and private values and issues. Council's decisions are based upon the advice of its planning committee, representations and lobbying from various interest groups, and its own collective value orientation, which rarely reflect concerns for reducing inequities or improving the quality of the environment.[22]

It is not the intention of this paper to assess the implications of the Healthy Cities Project for all of the cycles in the normative urban planning process. Rather, this paper will focus upon the first cycle, i.e., the process by which planners arrive at their recommendations.[23] This process is often characterized as the "rational comprehensive process" because of the studies and analyses which are conducted by planners to provide information on all relevant facts for those involved in decision making—the planning committee, city council, interest groups and the public. The process has three main components: description and analysis of the problem; formulation of options for intervention; and evaluation of options in terms of costs and benefits. Each of these components will be reviewed in the context of the goals of the Healthy Cities Project.

In *describing and analyzing* an urban planning problem, urban planners employ descriptive statistics and social indicators, as well as survey research related to population, physical environments and socio-economic conditions. At the present time, these descriptions and analyses do not provide the kind of information which would be required to address the three goals of the Healthy Cities Project. To provide the necessary information, planners will require additional data and analytical tools. For example, in Oxford, England, the planning department has devised an "index of deprivation" for its neighbourhoods, using class indicators such as housing and employment. This ranking led to the recognition of a social geography of ill health in the city, and to the subsequent formation of a neighbourhood health audit group.[24]

To develop a data base for Healthy Cities, new indicators will have to be devised to assess the degree to which a city is oriented toward the prevention of disease and the enhancing of coping. To this end, some preliminary indicators were proposed at the Healthy Cities Project Workshop in Barcelona, Spain.[25]

In *formulating options for intervention*, planners employ the systems approach. Here, the problem to be addressed in the analysis is viewed as a set of linked problems forming a functioning whole or system,[26] as revealed in the following analysis:

> This (housing) problem leads to and compounds other serious problems facing native people. Poor housing inevitably results in continuous health problems and social and educational dislocations caused by frequent moves in search of better living conditions. Agencies which deal with the housing problems of native people confirm that housing units in poor condition are over four times as likely to have severe crowding as units in good condition. Over 6,200 (of 14,000) of Winnipeg's poor quality units were estimated to be overcrowded.[27]

Although the formulation of urban planning options is predicated on a systems approach, it is rare to find options formulated to address the interrelated problems of urban inequities. To address the goals of the Healthy Cities Project, urban planners will need to expand the scope of their intervention formulations to address problems which relate to inequities in the urban environment.

In *evaluating options for intervention*, urban planners evaluate the relative merits of possible intervention options. In conducting their evaluation, planners attempt to assess two things—how well the option attains the goals, and the impacts and costs—that will be involved in going ahead with the option.[28] To conduct their evaluations, urban planners use such methods as goals achievement evaluation, environmental impact assessment and social impact assessment. These tools have been criticized for their value-neutral stance, which seeks to aggregate impacts in a manner that minimizes the differential impact on disadvantaged groups.[29] As such, these tools are not appropriate in assessing the merits of urban planning options from the perspective of distributional justice.

In order to address the goals of the Healthy Cities Project, urban planners will need to use evaluation methods which identify the differential costs and benefits of urban planning interventions.

From this review of the urban planning process in the light of the goals of the Healthy Cities Project, it may be concluded that, in order to address the goals of the Healthy Cities Project, new data bases and indicators will be required, the systems approach to option formulation will have to be expanded, and new evaluation methods will have to be adopted to assess the differential impacts of urban planning interventions.

PUBLIC PARTICIPATION IN URBAN PLANNING AND THE HEALTHY CITIES PROJECT

Public participation in urban planning occurs, in various degrees, as represented in the "ladder of citizen participation" proposed by Arnstein.[30] This ladder has eight rungs. The two bottom rungs represent "contrived participation" through manipulation or the use of participation as a therapy. The three

middle rungs represent a degree of "token power sharing" through information, consultation and placation. The three top rungs represent "degrees of citizen power," sharing through partnership in decision-making, through the delegation of power, and, finally, through citizen control.

The degree of public participation embodied in the goals of the Healthy Cities Project parallels the top three rungs in Arnstein's ladder, i.e., the project aspires toward degrees of citizen power-sharing in creating healthy environments.

During the first phase of urban planning in Canada (pre-1945), public participation was limited to appointing influential members of the business community to planning advisory committees in order to obtain support for urban planning schemes. This "participation by invitation"[31] can be likened to Arnstein's "contrived participation."

During the second phase of urban planning (post-1945), public dissatisfaction with specific urban projects resulted in protracted confrontation between interest groups and proponents of the projects. As these confrontations became more widespread, changes were made to the manner in which urban planning was conducted by legislating provisions for public consultation and comment in urban plan making. Planning processes became more open, and the public was recognized as a legitimate participant in urban planning. At present, the urban planning process in Canadian cities provides for formal public consultation in urban planning, although decision-making power is rarely shared with the public. On Arnstein's ladder, public participation has moved from the level of "contrived participation" to various degrees of "token power sharing."[32]

In recent years, public interest in planning issues has dwindled. Fewer people show up at public meetings to discuss planning proposals. Moreover, those who do participate, do not always represent the disadvantaged segments of the public. Often, the lack of attendance at public meetings has been interpreted by planners as a sign of public apathy to planning issues. However, Grant has pointed out that the lack of response may reflect the inadequacy of participation techniques used by planners to involve the public.[33] Glass has suggested that a diverse participation program with a variety of opportunities, including both formal and informal techniques, produces the broadest cross-section of community input.[34]

Other methods of participation involve "action research" where planners and the community participate not only in collecting information but also co-operate to "help in altering certain conditions experienced by the community to be unsatisfactory."[35] Action research is a method to involve the community in the earliest stages of the planning process, i.e., in data collection and analysis. Such involvement leads to a level of participation to which the Healthy Cities Project aspires. The technique

has been successfully employed in Canada, and is now being employed by the planners in Oxford, England in implementing their Healthy Cities Project.[36]

From the above discussion, it is evident that in order to address the objectives of the Healthy Cities Project, public participation in Canadian urban planning would have to move from the current level of token power-sharing to higher degrees of citizen power-sharing.

HEALTHY CITIES PROJECT—IMPLICATIONS FOR URBAN PLANNING

This paper set out to address the implications of the Healthy Cities Project for urban planning. The paper examined the goals of the Healthy Cities Project in relation to urban planning thought and practice, the urban planning process and public participation in urban planning.

From the analysis contained in this paper, it can be concluded that the Healthy Cities Project will require the reincorporation into urban planning of goals of public health, social justice and environmental conservation which occupied a central place during the first phase of planning in Canada. Moreover, new data bases and indicators to reflect these goals will have to be developed, the systems view of option formulation will have to be expanded and new methods of option evaluation will have to be adopted to address concerns related to differential distribution of costs and benefits. In addition, more diverse methods of public participation will have to be employed to obtain participation from a wider cross-section of the society.

Although these measures would amount to a fundamental change in the orientation of present-day planning in Canadian cities, in a way, it will be like going back to the roots which urban planning has in public health and welfare—a return to a social agenda, giving new interpretations and meanings to old truths and values. At a time when there are growing doubts about the purpose of planning and the role of planners in Canadian society, the Healthy Cities project offers an opportunity to regain a sense of purpose.

NOTES

1. Ministry of National Health and Welfare, *Achieving Health for All: A Framework for Health Promotion* (Minister of Supply and Services, Canada, 1986).

2. See, for example, the draft document, "Healthy Communities: A Project Proposal," November 1987, prepared by the Canadian Institute of Planners and the Canadian Public Health Association, Canadian Institute of Planners, Ottawa.

3. See, for example, Phil Fryer's article, "Oxford's Aim of Health for All," in *The Health Service Journal*, March 1987, circulated by the Canadian Institute of Planners in its information kit on the Canadian Healthy Communities Project in December 1987. See also, "Practical Ideas" (memo) in the same kit.

4. *Achieving Health for All.*

5. "Healthy Communities: Proposal," p. 2.

6. Sandra Smith, "Healthy Communities: Visions and Strategies Workshop," in *PIBC News* (Sept./Oct. 1987).

7. Brij Mathur, "The Winnipeg Healthy City Study," *IUS Newsletter*, 23 (1988).

8. Gerald Hodge, *Planning Canadian Communities* (Methuen, 1986), p. 87.

9. Rene Dubos, "The Biological Basis of Urban Design," in *Anthropolis: City for Human Development*, edited by C.A. Doxiadis (New York: Norton Publishing Company, 1975).

10. Malcolm S.Weinstein, *Health in the City* (Pergamon Press, 1980), p. 69.

11. Alan F.J. Artibise and Gilbert Stelter, "Conservation Planning and Urban Planning: The Canadian Commission of Conservation in Historical Perspective," in *Planning for Conservation*, edited by Roger Kain (London: Mansell, 1981).

12. For an excellent overview of the contribution of the reform movement to urban planning, see Hodge, *Planning Canadian Communities*.

13. For a comprehensive review of the relationship between conservation planning and urban planning in the work of the Canadian Commission of Conservation, see Artibise and Stelter, "Conservation Planning."

14. Thomas Adams, *Rural Planning and Development in Canada* (Ottawa: Commission of Conservation, 1917), p. 12.

15. Godfrey Spragge, "Canadian Planners' Goals: Deep Roots and Fuzzy Thinking," *Canadian Public Administration*, 18,2 (1975): 217.

16. Kent Gerecke, "The History of Canadian City Planning," *City Magazine* 2,3 (Summer 1976): 12-23.

17. See, for example, James Lorimer, *A Citizen's Guide to City Politics* (Toronto: James Lewis and Samuel, 1972); Gerecke, "History of Canadian City Planning;" Matthew Kiernan, "Ideology and the Precarious Future of the Canadian Planning Profession," *Plan Canada*, 22,1: 15-24; Ken Clark, "The Crisis in Canadian City Planning," *City Magazine*, 1,8 (January-February 1976).

18. See, for example, Social Planning Council of Winnipeg, *An Analysis of Social Problems, Needs and Trends for Winnipeg* (Winnipeg: The Council, 1980), and *Housing Conditions in Winnipeg* (Report No. 1, 1979).

19. Weinstein, *Health in the City.*

20. Michael Hough, *City Form and Natural Process: Towards a New Urban Vernacular* (Van Nostrand Reinhold, 1984).

21. See also Harold M.Proshandsky, William H. Ittleson and Leanne G. Rivilin, eds., *Environmental Psychology: Man and his Physical Setting* (New York: Holt, Reinhart and Winston, 1970).

22. See, for example, Herbert J. Gans, "Planning and City Planning for Medieval Health" in *Taming Metropolis*, vol. 2, edited by Eldridge Wentworth (Garden City, NY: Anchorage Books, 1967).

23. See, for example, Lorimer, *A Citizen's Guide to City Politics*, and *City Politics in Canada*, edited by Warren Magnussen and Andrew Sancton (Toronto: University of Toronto Press, 1983).

24. Discussion of the planning process adopted by planners is based upon the description of this process in Hodge, *Planning Canadian Communities.*

25. Fryer, "Oxford's Aim," p. 3.

26. *Proceedings*, Healthy Cities Project Workshop on Indicators, Barcelona, Spain, March 8-12, 1987.

27. Hodge, *Planning Canadian Communities.*

28. Taken from Harvey Bostrom, "Government Policies and Programs Relating to People of Indian Ancestry in Manitoba," in *The Dynamics of Government Programs for Urban Indians in the Prairie Provinces*, edited by Raymond Breton and Gail Grant (Montreal: Institute for Research on Public Policy, 1984), p. 45.

29. Hodge, *Planning Canadian Communities.*

30. See for example, Kiernan, "Ideology."

31. Sherry R. Arnstein, "A Ladder of Citizen Participation," *Journal of the American Institute of Planners* (July 1969): 216-224.

32. Hodge, *Planning Canadian Communities*, p. 350.

33. See for example, Clark, "Crisis"; Lorimer, *Citizen's Guide*. For a review of public participation requirements in Nova Scotia, see Jill Grant, "They Say 'You Can't Legislate Public Participation': The Nova Scotia Experience," in *Plan Canada*, 27,10 (January 1988).

34. Grant, "Public Participation."

35. James J. Glass, "Citizen Participation in Planning: The Relationship Between Objectives and Techniques," *American Planner's Association Journal* (April 1979): 180-188.

36. David Vincent, "Research Perspectives in Participation and Planning," in *The Citizen and Neighbourhood Renewal*, edited by Lloyd Axworthy (Winnipeg: Institute of Urban Studies, 1972), pp. 161-176.

37. For a Canadian example, see Institute of Urban Studies, *Developing Approaches to Health and Social Service Planning in the Inner City*, Report 25 (1973). The Oxford example is cited from Fryer, "Oxford's Aim."