Healthy Cities and Communities: Past, Present, and Future

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The concept of a healthy city or community has grown from a small European project to a worldwide movement in the past ten years, but it did not emerge in a vacuum. There is a long tradition of attempts to improve the health of cities and their citizens, dating back to at least the time of Hippocrates, the Greek "father of medicine." Even boards of health are an older invention than most of us realize. They existed in the city-states of Renaissance Italy in the fourteenth century.[1] In this article, I review some of the high points of the more recent aspects of that history—going back just over 150 years—and the evolution of the modern healthy cities or communities movement since its inception in 1986. This history provides an important context for understanding the healthy cities approach, its aims, and its methods.

Nearly a Century of Healthy Cities, 1843-1938

It is not my intent to provide an exhaustive and detailed history of the healthy cities movement. Rather, I focus on those aspects that I have found particularly significant in the development of my own ideas.

Health in Towns, 1843. Modern-day public health traces its roots most directly to Edwin Chadwick, secretary to the Health in Towns Commission. (I am grateful to John Aston, a lecturer in community health at the University of Liverpool and one of the pioneers of the healthy cities movement, for drawing my attention to this part of British history.) This commission was established by the British government in 1843 to examine the health of the working poor who had flocked (or had been driven) to the slums of the rapidly urbanizing and industrializing cities in the early part of the nineteenth century. To gain some understanding of the conditions in which they lived and worked, we can turn to Frederick Engels, who described Manchester's River in 1845 as "a narrow, coal-black, foul-smelling stream . . . in dry weather, a long string of the most disgusting, blackish-green slime pools are left standing . . . from the depths of which bubbles of miasmatic gas constantly arise and give forth a stench unendurable even on the bridge forty or fifty feet above the surface of the stream."[2] Hippolyte Taime wrote of his visit to Manchester in 1859, "Earth and air seem impregnated with fog and soot. The factories extend their flanks of fouler brick one after another, bare, with shutterless windows, like economical and colossal prisons . . . Through half-open windows we could see wretched rooms at ground level, or often below the damp earth's surface. Masses of livid children, dirty and flabby of flesh, crowd each threshold and breathe the vile air of the street, less vile than that within."[3]

Edwin Chadwick was a gifted public servant concerned with social reform on both philosophical grounds (he was the private secretary to the utilitarian philosopher Jeremy Bentham at the time of Bentham's death) and pragmatic grounds, as he recognized the

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potential for instability and revolution spawned by the horrors of the slums, a revolution that was to partially break out in Europe in 1848.

The work of the Health and Towns Commission led directly to the "sanitary idea" and to the establishment of public health measures such as housing standards, sewer systems, hygiene regulations, and proper public water supplies. Thus, from the outset, public health concerns involved issues of town planning. The Health of Towns Association was established in 1844, and branches quickly sprang up in other cities throughout Britain. As John Aston[4] noted, "The work of the Health of Towns Association in pressing for the application of the sanitary idea and its insertion into policy making had a dramatic effect on public health in Britain in a comparatively short space of time."

Hygeia, a City of Health, 1875. The vision of an ideally healthy city sketched by Sir Benjamin Ward Richardson, a self-proclaimed disciple of Chadwick, and his biographer, has been a inspiration to me since I first came across it some twenty years ago. It certainly helped to stimulate and crystallize my own thinking about how to make a city healthy, and it is now the name of one of my business partnerships, which focuses on how to design healthy communities.

Richardson was a physician and sanitarian, founder and editor of the *Journal of Public Health and Sanitary Review*, a former president of the Medical Society of London, and an energetic and tireless reformer. In 1875, to mark the passage of the Great Public Health Act of that year, he traveled to Brighton to preside over and to address the Health Department of the Social Science Congress. His presentation, titled "Hygeia," was a comprehensive and detailed vision of a city of health: "A community so circumstanced and so maintained by the exercise of its own free will, guided by scientific knowledge, that in it the perfection of sanitary results will be approached, if not fully realized, in the coexistence of the lowest possible general mortality with the highest possible individual longevity."[5]

Richardson's Hygeia contains many features that we would recognize and support today, including many we have yet to achieve. He foresaw a city of one hundred thousand people at a density of five houses per acre, with no buildings rising above sixty feet. In Hygeia, railways run beneath the major highways and there is a subway system. Side roads are lined with trees, there are parks and gardens everywhere, and street drainage is via sewers. The houses are light and airy, brick-built, and smoke-free, and they have roof gardens, running hot and cold water, garbage chutes, and main drains and sewers.

Nobody smokes or drinks in Hygeia, but for those who fall ill, there are small general hospitals, more like what we today would call health centers. Orphans, the insane, the helpless, and the aged are housed in small community homes similar to other homes in the community, what we call group homes.

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Richardson was a very modern man! His vision of Hygeia was very influential in both Britain and the United States and echoes of it can perhaps be seen in Ebenezer Howard's Garden City.[6]

City Healthy, Canada, 1909-1921. "It is not so much the city beautiful as the city healthy that we want for Canada."[7] The story of Thomas Adams and the Commission on Conservation was first drawn to my attention by Peter Oberlander in 1984, when he was the theme speaker on healthy communities at the "Beyond Health Care" conference, which was the genesis of the healthy cities project.[8] Oberlander was at that time director of the Centre for Human Settlements at the University of British Columbia in Vancouver, which had been established following the first U.N. conference on human settlements (Habitat) in Vancouver in 1976.

The Commission on Conservation was established by the Canadian government in 1909. It was modeled on a commission established in the United States by President Roosevelt (who was also one of the founders of the National Civic League). The commission, like its American counterpart, grew out of a growing recognition at the end of the nineteenth century that the North American continent was not limitless, that there was no longer a frontier, and that European settlement had for all intents and purposes expanded to fill the entire continent.

The Commission on Conservation had a broader concept of conservation than we do today, expanding the purpose from conservation of the natural environment and resources to include conservation of the social environment and human resources. Charles Hodgetts, the commission's adviser on public health, put it this way: "There are two important factors in the question of national conservation: the physical and the vital. The former relates to the protecting of our land, our forests, our minerals, our waters, our sunlight, our fresh air; the latter to the prevention of diseases, to health, and to the prolongation of life."[9]

The commission's Public Health Committee addressed the issue of town planning because "in housing and town planning we are dealing with most of the former [conservation of natural resources] and all of the latter [conservation of vital resources]." Due to its interest in health in towns, the Public Health Committee recommended in 1913 that a national conference on housing and town planning be held and that Thomas Adams be invited. Thomas Adams had been the secretary to the first Garden City Company at Letchworth and was a renowned advocate and practitioner of town planning. In 1914, the Commission on Conservation secured his service from the British government. In the five years that he spent in Canada as the commission's town planning adviser, from 1914 to 1919, Adams revised the commission's model town planning bill and had a hand in preparing town planning bills in most of the provinces, prepared a pioneer document on rural planning and development, consulted with nearly forty local councils, wrote "most of the material for a quarterly bulletin called *Conservation of Life* put out by the Commission,"[10] helped to organize the Civic Improvement League, and in 1919 was elected as the first president of the Town

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Planning Institute of Canada. Thus, town planning in Canada can trace its roots to public health and to the desire to conserve both natural and vital resources.

Healthiest of Large Cities, Toronto, 1915. From 1980 to 1988, I worked for the Toronto Department of Public Health. We held the first healthy city workshop (Healthy Toronto 2000) in 1984, which led to the establishment of the World Health Organization (WHO) Europe Healthy Cities Project. Toronto's rich history made it a natural and very supportive place for this work.

In July 1919, *MacLean's* magazine in Toronto published the article "Saving Lives on the Wholesale Plan: How Toronto Has Been made the Healthiest of Large Cities"—large cities being those with more than 350,000 population. The article compared the health status of Toronto with that of similar large cities in Great Britain and the United States and declared that in terms of mortality rate, Toronto came first, followed by Milwaukee, New York, Chicago, and then the large British cities. This preeminence in health, *MacLean's* stated, was due to "an awakening, a man and several years of varied and strenuous activity." The awakening "was in the municipal air all over the continent of North America. New light had broken on the subject of keeping people well by the cityfull or the townfull. New machinery to prevent people from becoming ill was coming into being from the Pacific to the Atlantic. A new idea of health and health work had taken shape, a more economic and democratic and twentieth century idea."

This new idea consisted of "conserving of the human asset," an idea encapsulated in the legend at the masthead of the Toronto Department of Public Health's monthly newsletter: "With a well organised Department of Public Health, a municipality may have as much health as it is willing to pay for."

The "man" referred to in the *MacLean's* article was Dr. Charles Hastings, appointed the city's medical officer of health in 1910, a post he held until 1929. Hastings was a well-respected member of the medical fraternity in Toronto who became attracted to public health somewhat late in his life, in response to the death of one of his daughters, who contracted tuberculosis from drinking infected milk. It is not surprising that one of Hastings's first initiatives was to ensure pasteurization of the city's entire milk supply. In addition, Toronto began chlorinating its drinking water in 1910, one of the first cities in the world to do so, and by 1915 was also chlorinating its sewage and filtering its water.

Under Hastings's leadership, the city's Public Health Department became one of the most respected in the world. The work of the department expanded to include industrial hygiene, social welfare, housing, school health, and municipal housekeeping, which taught women the principles of hygiene and sanitation, diet and nutrition, child rearing, and care for the sick. The department grew in size tenfold under his leadership, with the nursing staff increasing dramatically from 2, when Hastings became medical officer of health in 1910, to 110 when he retired nineteen years later.

The results were impressive: the mortality rate from typhoid fever dropped 90 percent between 1910 and 1915, the last case of smallpox was recorded in 1932, and

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the last diphtheria death was in 1934. Through the leadership of one person, the political commitment of the city council, and the support of the community, Toronto had indeed reached a high level of public health.[11]

Healthiest American City, Milwaukee, 1929-1938. The city of Milwaukee can justly lay claim to having been the healthiest American city not only in 1915, as the *MacLean's* article made clear, but throughout the 1930s. It came in first in the large city category (over five hundred thousand population) of the U.S. Chamber of Commerce's Inter-Chamber Conservation Contest in the first year of the contest in 1929, and was either first or second six more times in the 1930s.

The Inter-Chamber Health Conservation Contest was established by the U.S. Chamber of Commerce in partnership with the American Public Health Association, the National Association of Life Underwriters, and the U.S. Public Health Service. The contest ranked cities on the basis of sanitary measures, disease prevention, health promotion, financial support for health work, and death rates. The contest was rooted in very pragmatic ground, as indicated in the speech of the president of the chamber at the first award ceremony in 1930: "Rough calculations . . . indicate a direct monetary expense of something like 2 billion dollars a year for sickness . . . . In addition to this enormous loss, the total capital value of lives prematurely lost has been estimated as aggregating over 6 billion dollars annually . . . . Much of the tremendous economic losses resulting from injuries, sickness, and death is preventable."[12]

In her study of Milwaukee and the politics of health reform, Judith W. Leavitt pointed to the long tradition of public health in the city that laid the foundation for success in the 1930s.[13] She identified a number of factors underlying the process, including the nature of the issue, medical theory and abilities, economic interests, political pressures, individual actions, and social and cultural diversities. The combination of many of those interests is apparent in the sponsors of the Health Conservation Contest. But it is intriguing that many of those factors are again prominent today. So it is on these broad historical shoulders that we create our modern-day healthy city movement.

Healthy City and Community Movement, 1986-1996

In January 1986, a small group of health promoters gathered at the WHO Regional Office for Europe in Copenhagen to plan a WHO Europe healthy cities project. The group was convened by Dr. Ilona Kickbusch, at that time regional officer for health promotion. Her interests in the concept of healthy cities had been sparked by a one-day workshop—Healthy Toronto 2000—organized in conjunction with a 1984 conference on healthy public policy and by Len Duhl's workshop speech on healthy cities. She saw in the healthy city concept the potential to take the concept of health promotion then under development at WHO Europe off the shelf and onto the streets of the cities of Europe, to take global concepts and apply them locally and concretely. The planning group anticipated that their project might attract the interest of six to eight cities.

The WHO Europe Healthy Cities Project began with a Healthy Cities symposium in Lisbon in April 1986, attended by fifty-six participants from twenty-one cities and

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seventeen countries. Within three months of the start of the project, it was clear that the initial expectation for six to eight city projects was far too modest. Eleven cities were selected for the WHO project in 1986, but the popularity of the project translated to the selection of another fourteen cities in 1988, growing to thirty-five cities by 1991. In 1988 there was a national network meeting in Helsinki, attended by ten national networks, including two—Canada and Australia—from outside Europe. The project also got a boost that year because a number of case studies on local-level healthy public policy were presented at the Second International Conference on Health Promotion (Adelaide, South Australia), which were subsequently published.[14]

The project received a further boost when it was one of four subthemes at the 1991 World Health Assembly Technical Discussions. This conference provided an important opportunity to discuss the potential of the healthy cities concept with delegates from the developing nations of Latin America, Asia, and Africa, as did the Third International Health Promotion Conference in Sundsvall, Sweden, held a month later. As a result, there has been a growing interest in the healthy cities project in these countries, although advocates more often refer to the project as healthy communities.

In June 1992, the Seventh Annual European Healthy City Symposium was held in Copenhagen, hosted jointly by WHO Europe, the city of Copenhagen, and the Danish Ministry of Health. The symposium was attended by 465 delegates from ninety-two cities in thirty countries. It marked the end of the first five-year phase of the WHO Europe Healthy Cities Project, which by then encompassed thirty-five project cities in Europe; eighteen national networks in Europe and elsewhere; nearly four hundred cities and towns in Europe, several hundred more cities, towns, and villages in North America and Australia; and a growing interest from cities and towns in the developing nations. As indicated in Tsouros,[15] if this had been a private company, it would have been one of the success stories of the 1980s.

The First International Conference on Healthy Cities and Communities, organized by Len Duhl and held in San Francisco in 1993, attracted nearly fourteen hundred participants from dozens of countries and helped to stimulate wider international activity, as well as more activity in the United States. By then, national networks had also developed in countries such as Iran, Saudi Arabia, Egypt, Yemen, Tunisia, and Morocco, and regional networks were developing in Africa, Southeast Asia, and the Western Pacific.

In April 1996, WHO chose "healthy cities" as the theme for World Health Day. The information package noted that by then around one thousand cities, towns, and villages in nearly fifty countries were involved (undoubtedly an underestimate), and that the program was encouraged in all of WHO's regional offices.

National networks now exist in countries as diverse as Iran, Malaysia, New Zealand, Mexico, Morocco, and a number of West African countries. A French-speaking network links France, Belgium, Quebec province, Martinique, Guadeloupe, and several West African nations. In Latin America, there are strong national networks in Mexico (roughly

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one hundred communities), Brazil, and Peru, and smaller programs in several other countries. City links (twinning) have been established between cities as diverse as Glasgow, Scotland, and Chittagong, Bangladesh, or Sao Paulo and Toronto.

In Canada, while the national network is now defunct, there are provincially supported networks in Quebec, British Columbia, and Ontario. They involve nearly one hundred communities in each province, together with a smaller network in Manitoba and individual cities and towns in a number of other provinces. In the United States, the emerging National Healthy Communities Coalition includes state-level projects in a number of states. Moreover, the healthy cities movement is slowly forging links with other, complementary movements, including the sustainable cities and safe cities movements.

Prospects for the Future

One of the things we need to learn from our history is that the concept of the healthy city—and the tradition of public health and health promotion in which it is imbedded—will be adapted to different times. How we go about creating healthier cities and communities in the years to come will be very different from how it was done in the industrializing cities of nineteenth-century England or in the reform-oriented cities of early twentieth-century Canada and the United States. Having been centrally involved in this modern day movement for the last ten years, I offer the following list of future key issues and challenges:

Intersectoral partnerships: One of the fundamental precepts on which the healthy cities approach is based is that the major determinants of health are to be found in environmental, social, economic, political, and cultural conditions—and the behaviors they shape—rather than in the provision of health care. Accordingly, most of the people and organizations who will have the biggest impact on health in the community are to be found beyond the health care sector. It follows that if the health of a community or city is to be improved, a coalition of partners from many different sectors must be forged. Although the health care sector might be instrumental in initiating this process, there will only be success when the health care sector is but one partner among equals, rather than being dominant. The creation of healthy community coalitions remains a fundamental objective of the healthy city and community approach.

Local government involvement: Jessie Parfitt said it best in her review of the history of health in Oxford, England, between 1770 and 1974: "Many would be surprised to learn that the greatest contribution to the health of the nation over the past 150 years was made not by doctors or hospitals but by local government. Our lack of appreciation of the role of our cities in establishing the health of the nation is largely due to the fact that so little has been written about it."[16] Local government, even in America, has significant power. Policies relating to urban planning, transportation, housing, community and social services, parks and recreation, education, policing, public works, and other areas can play a significant role in shaping the health and well-being of the

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residents of the community. Those who fail to engage local government in the process of creating a healthier community are missing an important and powerful partner.

Community involvement: The healthy cities and communities approach is rooted in health promotion, which can be defined as the process of enabling people to increase control over and improve their health. In other words, health promotion and the creation of healthier cities and communities require the empowerment of individuals and communities to exert more control over all of the factors that contribute to their health and well-being. This means that people, as individuals and as members of community and neighborhood organizations, have to be centrally involved in the process of creating a healthier community. They or their representatives need to be at the table as active participants in the citywide coalition. Identifying and mobilizing the community's capacity and ability to take action in the interests of its health are key aspects of a healthy city or community project.

Healthy and sustainable communities: One of the key attributes of any healthy city is regard for the environment and the health of the ecosystems of which it is a part, that is, environmental sustainability in current and future generations. One of the most promising developments is the growing linkage between the healthy communities movement and the sustainable communities movement. The International Council for Local Environmental Initiatives, headquartered in Toronto, was established in the late 1980s and has been instrumental in developing a global network of cities that focus on how to be more environmentally sustainable. In 1994, a joint meeting of the healthy cities and sustainable cities networks was held in Madrid, highlighting the parallels between and the complementary nature of these approaches, and thus the need for future collaboration.

Sustainable, safe, livable, green, whole communities: Health is a very broad concept, and the determinants of health cover everything from DNA to global climate change. Thus, the concept of a healthy city or community can readily incorporate concepts of safety, environmental sustainability, livability, and other aspects of city and community life. However, it would be a mistake for those concerned with making cities more healthy to claim to cover all of these other approaches. For some people and for some communities, the concept of safety or livability or sustainability may be a more appropriate and useful construct around which to mobilize people's energy and commitment. But if any of these issues is pursued in depth and holistically, we are likely to find the overlap—the similarity and complementarity of these different approaches. What is important is to find the approach that works best in any given community and to bring to it the other concepts that will result in a holistic approach to improving the health, well-being, and quality of life of the community and its members. After all, the word *health* shares the same language root as the words whole, hale, and holy—the Old English work *hael*.

From economic to human development: There has been a promising shift in the debate around the meaning of the word *development*. Typically, this term is used to refer only to economic development. However, the work of the U.N. Development

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Program in developing and publicizing the Human Development Index has helped to shift the debate to a focus on what should be our real concern—human development.[17] Even the World Bank has gotten in on the act, not only by reporting on health but also in working to develop a broader measurement of national wealth that includes human, social, and ecological (or natural) capital as well as simply economic capital and gross national product.[18] The healthy communities approach is a local expression of this same theme. We are beginning to realize that our objective is not simply health, even broadly defined, but rather human development and the building of human capital. (This point is in fact central to the definition of a healthy city first promulgated by Len Duhl and myself for WHO Europe in 1986: The definition ends with the statement that our aim is to enable people to realize their full potential.) Optimizing human, social, ecological, and natural capital at the local level is ultimately what the healthy communities movement is all about.

In ten short years, but building on hundreds of years of experience, the healthy cities movement has grown from a small European project to a world-wide phenomenon. It is truly an expression of Rene Dubos's famous dictum that we need to think globally and act locally. It is now forging links with other movements that are involved in the business of building human, social, and ecological capital. The healthy communities approach promises to be one of the key strategies for achieving human development in the twenty-first century.

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