

HEALTHY URBAN PLANNING

Setting the Scene



Figure 1 - Is this the angel of Town Planning arriving to rescue the desperate residents of 19C Manchester from cholera, typhoid and scrofula?

Town planning and public health are long term bed-fellows. Modern planning and urban design originated in reaction to the unsanitary, overcrowded and inhumane conditions of nineteenth century industrial cities – Blake’s “dark satanic mills” and the mean streets around them. It was recognised then, and it is recognised now, that there is an umbilical link between environmental conditions and human health. This link is not only a matter of the direct physical impacts on health – for example of foul air or contaminated water – but also of indirect social and behavioural effects, on the exercise we take, the people we meet, the degree of inequality in access to housing, employment opportunities, health services and other facilities. According to VicHealth (the Victorian Health Promotion Foundation in Australia) there are four key reasons why planning health into the environment is positive for population health. Good planning can:-

- reduce the inequalities that exist in access to transport for different socioeconomic groups and vulnerable groups in the population, such as the elderly or children;
- increase the amount of incidental physical activity necessary to reduce the burden of disease, disability and mortality due to sedentary life styles by improving access and providing walkable, mixed use communities
- contribute to the improved health of the population by the reduction of air and water pollution and greenhouse emissions, combating the threat of climate change
- contribute to a changed social environment by improving the liveability of streets, making them safer and improving communication between people and therefore improving community cohesion. (Butterworth 2000).

All this reflects a broad view of health as a positive experience of well-being and not merely the absence of disease - a view which the World Health Organization has been preaching for half a century.

Yet despite the symbiotic relationship between planning and health, the connections in practice have until very recently been severed. Health authorities have been charged with providing services for those who are ill. In-as-much as prevention is pursued, public health programmes focus on infectious diseases and addiction (tobacco, alcohol, drugs) rather than healthy environments. Planning authorities are equally blinkered. Local councils, encouraged by government until recently, consider the purposes of town planning are economic development and environmental protection rather than health promotion. Health and safety and environmental health agencies have taken a narrow functional view of their remit. Each sphere of public policy has been pursued independently, with agencies adopting specific targets in order to deliver on their unique mission, failing to grasp the integrated nature of real life.

Partly as a result we are, in some respects, quite literally building unhealthy conditions into the fabric of our cities, towns and villages. All levels and types of planning are implicated. For example at the strategic level in the UK, decisions on housing allocations, criticised by the Barker review on economic grounds, also have profound implications for health. If supply is constrained and prices rise then social exclusion in the housing market increases and health inequalities are exacerbated.

At the city level the market and political fashion for low density, edge-of-city commercial development, in the form of business parks, retail parks and leisure parks, is forcing a pattern of car-dependent travel which reduces the likelihood of regular healthy exercise, increases pollution and compounds inequalities of access. At the local level the dominant layout characteristics of the 1990s were cul-de-sac access, hierarchical road systems and segregated land use patterns, militating against pedestrian street life and the development of the social networks that are so crucial to the mental well-being for those whose lives are locally based.

We are discovering that diseases of “advanced” civilisations – such as cardiovascular disease, diabetes, asthma and chronic depression – are associated with particular social and environmental conditions. The overriding impression from recent research is that environmental factors are ignored at our peril: for example the malign effect of urban sprawl on physical activity, obesity and chronic disease (McCann and Ewing 2003); the significance of land use and housing spatial patterns for mental well-being (Halpern 1995); the critical importance of social inclusion for health, and the key role that accessibility, inclusive transport, affordable housing and safe neighbourhoods play in shaping social inclusion (Marmot 2004).

Attitudes are changing fast. There is now widespread recognition amongst professional planners that the health-environment link is important, and that some current development trends compromise health. A survey for the Australian Planning Institute found that 88% of planners recognised the link and considered planners had a health role (Market Solutions Pty 2002). A survey of European chief planners found they were not at all sanguine about the healthiness of current policy: with commendable frankness the planners considered that far from assisting with the creation of a healthy city, planning was often counter-productive. They identified problems of traffic generation, pollution, rigid zoning, increased social polarisation, the loss of open space and the focus on short-term profits at the expense of environmental quality (Barton and Tsourou 2000).

However, things are on the move. The gradual and progressive political recognition of sustainability and *sustainable development* over the past two decades has been tremendously influential. Where initially the issue was seen as about *environmental* sustainability (and governments have always been concerned about *economic* sustainability) it has now broadened to encompass the social agenda as well. This is well illustrated by the changing UK requirements for plan appraisal: in 1992 Planning

Policy Guidance Note 12 introduced the idea of the environmental appraisal of development plans; now, in 2004, the ODPM has changed the obligation to *sustainability appraisal*, expressly including questions of social inclusion and cohesion, and requiring the logical evidence-based approach of SEA to be incorporated (ODPM 2004).

The recognition of sustainable development in its broader sense has been paralleled, perhaps rather more slowly, by changing perceptions of *health*. There is in process a significant shift in the meaning and ownership of the term health, away from the absence of disease and towards a more holistic definition. Ironically this broader view was articulated with idealistic fervour in the Charter of the World Health Organisation immediately after the war:-

‘Health is not only the absence of disease but a state of physical, mental and social well-being. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political belief or economic or social condition’ (WHO 1946).

The Agenda 21 agreement at the Rio Earth Summit in 1992 restated this broad view of human health. The targets set out in the agreement extend well beyond primary health care, and it is made clear that the responsibility is multi-agency, as “health ultimately depends on the ability to manage successfully the interaction between the physical spiritual, biological and economic/social environment.” (UNEP 1992 – Chapter 5, para 6.3). This challenging vision is not likely to be realised unless health, planning, transport and housing agencies work together.

In this general context WHO Europe decided to initiate a campaign for “healthy urban planning” which would attempt to bridge the gulf between planning and health and give greater momentum towards healthy, sustainable cities. This campaign has gathered momentum over the past five years and is now being ‘mainstreamed’ within the Healthy Cities movement. It is not the only project of its kind, but it does provide a useful model which could provide a more general inspiration. The next section explains the healthy urban planning initiative.

The WHO Healthy Urban Planning initiative

The Healthy Cities movement was started by WHO in the late 1980s. Its focus is health promotion, and it has been ahead of the game in espousing joined up thinking,

inter-agency collaboration and sustainable development. It is distinctive in demanding from participating cities both top-level political support, giving profile and kudos, and grass-roots community action. The European Healthy Cities club stretches from Russia to Portugal, Norway to Greece, with 40 front-line cities and 800 linked by national city networks. The campaign in Europe has covered themes such as smoking, drugs, exercise and children's health, but it is moving on to include "healthy urban planning" and health impact assessment (HIA). Cities across Europe are invited – if they wish to join the movement – to produce strategies for developing both these themes. In their applications they must show:

- how health, planning, transport and regeneration agencies in the area are intending to work together with citizens to improve quality of life
- how health objectives are going to be integrated into plan-making
- how health criteria are going to be systematically used to assess development projects

This new requirement of the HC network has emerged as a result of a long-standing concern and a cluster of pilot projects. The initiative is based on the conviction that urban spatial and transport planning significantly influences the determinants of health (Duhl and Sanchez 1999); together with a recognition that attempts to change personal behaviour without also changing basic social, economic and environmental conditions, are likely to have little success (Lawler et al 2003; McCarthy 1999). This recognition, while scarcely revolutionary, can present quite a challenge to the health promotion industry. For example, the normal approach to promoting exercise in children is by small-scale advocacy and education projects, such as 'walking buses' to school. It is exactly such projects that have been found to have only short-term and local effects.

A report published in 2003 by WHO, edited by Barton, Mitcham and Tsourou, tells the story of the development of the healthy urban planning idea. A set of 12 health objectives for planning were negotiated between city practitioners, academics and WHO in a series of pan-European seminars. These were presented in the *Healthy Urban Planning* book (Barton and Tsourou 2000), which also set out guidelines for intersectoral co-operation in development projects, neighbourhood and strategic planning. A group of pioneer municipalities, including Milan, Gothenburg and Belfast, built organisational bridges between health, planning and other relevant agencies. They pursued the goal of health-integrated design and planning. The experience of

these cities over the past four years makes illuminating reading. For some cities, particularly in Scandinavia, the new emphasis merely reinforced a direction they were already headed. For others it meant a radical new departure. Seixal, in Portugal, for example, found that building consensus around health objectives broke down long-standing institutional barriers, and unlocked a new ability to plan for people and a sustainable environment. In Belfast, the project is triggering a new engagement between local and national agencies that before jealously guarded their autonomy.

The twelve WHO healthy urban planning objectives range across the main social and environmental determinants of health, and are summarised here under four headings: *individual lifestyles*, particularly the propensity to take exercise, are affected by land-use transport planning and urban design. *Supportive social networks* at the local level, important for mental well-being, are influenced by the availability of local activities and safe communal spaces. *Living conditions* - in terms of equitable access to good housing, services, food and work, are a core concern of planners. The *quality environmental stock*, including air and water, and the stability of the global climate, are influenced by energy, transport and industrial planning.

The striking feature of the WHO list, like the Australian equivalent earlier, is its breadth of vision. The health/planning relationship is not seen as being only about specific, discreet aspects – like for example air quality or road accidents – but about the whole nature of human settlements. Within the global ecosystem towns and cities are seen as providing the essential human habitat. The health of the habitat is the responsibility of a wide range of agencies and professions. But the planners and urban designers have a specific remit to co-ordinate the process of physical habitat change, which in turn affect healthy and well-being. In some ways it is difficult to distinguish this broad WHO perspective on health from the anthropocentric view of sustainable development represented by the Brundtland definition. At the very least health can be seen as providing a version of *social* sustainability. At most (as argued by Barton et al 2003) health could be considered as a proxy for sustainable development as a whole. It would appear (at least from the evidence of the 2005 UK general election) that health has a much more direct public and political appeal than the abstruse concept of sustainable development. Health is also linked to a clear and specific base of scientific research, and perhaps is less open to false rhetoric than sustainable development. So it could be timely to drop the s.d. concept and supplant it with the broad WHO version of health.

The need for evidence and will

This brings us to a fundamental difficulty in applying the principles of healthy urban planning to the design of cities: while we know much about health determinants we know remarkably little about how planning affects those determinants. Where the surgeon and the anaesthetists can consult copious research reports before operating on a *person*, urban planning, designers and developers typically have inadequate scientific evidence to back decisions when they operate on a *town*. Instead there is reliance on past practice, political pressure and professional hunch. What evidence there is, is often ignored, or never uncovered. In Britain one can point to a host of policies where the long-term health impacts are not properly examined: green belts, park and ride schemes, business parks, housing mix, rural diversification, traffic and pedestrian management – yet in each case worrying theoretical arguments can be constructed which could give pause for thought.

A brief review of certain assumed connections between health and urban design will illustrate the point. The *new urbanist* design agenda is being powerfully promoted by official agencies and the design profession (e.g. Urban Task Force 1999, Rudlin and Falk 1999, DETR and CABE 2000, Western Australia 2004). In this new consensus it is axiomatic that by creating a higher density, mixed use, pedestrian-friendly environment with accessible local facilities and social diversity, people will be healthier and global emissions reduced. But looking at the very patchy research in this field it is equivocal to say the least. One British study of suburban estates found that the availability of local facilities did not generally lead to less car use (Winter and Farthing 1997); another found that a permeable pedestrian environment did not apparently perform better than a cul-de-sac layout in an otherwise similar area (Perry 2003); a review of mental well-being and the built environment concluded that in some situations social mix correlated with mental illness, not well-being (Halpern 1995).

There is, in other words, a tremendous danger of wishful thinking. There is often an assumption of direct, simple cause and effect. If there is a problem of unemployment in villages (with attendant health effects) then allow new businesses in the village; if there is a problem of commuters congesting the city and causing extra emissions, cut off their route with a park and ride. But reality is often more complex sometimes counter-intuitive. The new village and farm businesses are not (in most cases) aimed at local pockets of employment, but draw in traffic from elsewhere and exacerbate

general problems of car dependence and emissions (Barton et al 1995); the park and ride scheme may reduce traffic in the inner city but increase it in the outer city and undermine the viability of outer bus services.

There is a real need for an improved evidence base for planning. With the revival of urban design we are in the process of rediscovering the art of town planning, but let us not ignore the science. This health edition of Built Environment is a contribution to the science. There are four articles dealing with different facets of the health / planning agenda: food, transport, housing and nature; and one which seeks to provide a new integrated conceptual framework.

- The paper by *Findley et al* looks at the issue of food deserts. Reporting on a recent empirical study, it investigates how far the creation of a new food outlet affects the food choices and dietary habits of residents, concluding that from the viewpoint of promoting healthy eating, retail provision of itself is not enough. However from the viewpoint of encouraging walking and increasing work opportunities, local provision has considerable value.
- *Racioppi, Dora and Rutter*, in a wide ranging review, examine the link between health, physical activity and provision for cycling and walking. They conclude that the choice to walk and cycle is strongly influenced by urban settings and transport policy, and that planners have a crucial role in determining whether cycling and walking are obvious and realistic options for urban dwellers.
- *Lawrence's* article looks at health and housing. It presents an interdisciplinary interpretation of issues, showing the complexity of the interrelationships between and behavioural, biological, cultural, economic, social, physical and political factors, advocating an ecological approach to understanding that complexity.
- *Brown and Grant* examine an area where intuitively people feel a link between health and environment but it is difficult to pin down - that is in relation to nature, or the green environment. They explore the varied literature on the subject and demonstrate that there are clear, well-documented links between human health and nature. The results suggest that planners and built environment professionals could have a profound impact on community well-being by promoting urban biodiversity and green settings in all new development.

- The final paper by *Barton* looks at the theories of settlements that are available to planners and finds them wanting in relation to health. It seeks then to draw all the strands from earlier papers together using a new conceptual model of settlements that incorporates the social, economic and environmental perspectives in a systematic way. The model integrates an eco-system approach with an analysis of the determinants of health, and can be applied to a wide range of practical situations.

These articles illustrate the kind of theories and evidence that could contribute to a rational debate on the impact of planning policy on health. The hope is that the growing insistence of the EU, the UK government and the WHO on careful sustainability and health appraisal of policies, plans and projects will make an impact on practice. In particular the introduction of Strategic Environmental Assessment (SEA) across Europe could help drive a more systematic, informed approach to policy-making. In addition the inclusive stakeholder approach of Health Impact Analysis, if combined with SEA and EIA, could increase mutual understanding between health, planning and other interests, and assist with achieving multi agency commitment to common goals.

Even more fundamental than science, however, is *will*. Jonathan Porritt made the point powerfully at a recent public health conference. The health logic for many planning and public health interventions is “blindingly obvious”, he said, and should not wait for scientific evidence (Public Health News 6 April 2005). Creating a convenient, safe, walkable, living environment is one such intervention. There may be uncertainties about the degree to which the retrofit of such a walkable environment to existing areas leads of itself to a change in residents behaviour, but there is no uncertainty that a pedestrian-*unfriendly* environment deters walking, with consequent health penalties.

The WHO Healthy Urban Planning initiative in Europe shows one way that political and professional will to act can be galvanised. The key is integrated programmes, across departmental and agency responsibilities, with commitment from key decision-makers and awareness-raising at grass-roots level. If public health and planning departments could form a real alliance beneath the banner of human well-being and quality of life, it would powerful force for good.

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