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Health at the Heart of Spatial Planning Strengthening the Roots of Planning
Health and the Urban Planner
Health Inequalities and Place
Planning for the Health of People and Planet: An Australian Perspective

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The professions of urban planning and public health spring directly from the same source: a response to overcrowding and lack of adequate sewerage and water infrastructure in rapidly industrialising cities during the nineteenth century. Now, in the twenty-first century, a comparable movement is occurring in industrialising nations, as spatial planning is linked to the achievement of development goals (UN Habitat, 2009). Despite this, close working relationships between urban planners and public health practitioners are remarkably scarce, and several recent injunctions (Government Office for Science, 2007; Nuffield Council on Bioethics, 2007, Royal Commission on Environmental Pollution, 2007) highlight that divisions between them need to be overcome. There are particularly deep concerns about the impact of urban environments on health outcomes and the lack of a shared vision of how to support healthy lifestyles.

This Interface explores the nature of the links between spatial planning and health by eliciting views from a number of practical perspectives. The authors are closely involved in this crossover field: delivering projects, training and educating others, and testing the boundaries between health and urban planning. Their contributions aim to reflect on the extent to which planning and public health practitioners work to a shared agenda, and raise questions about the ways in which they cooperate. Can there be a shared focus on outcomes? What evidence is there of intersectoral working? Where is collaboration generating new approaches and ways of working? What are the barriers to further collaboration and development? Where are there conflicts? Which techniques are being shared (e.g. Health Impact Assessments (HIA) as part of Strategic Environmental Assessment)? What are the implications of cooperation for theory, training and institutional structures? Which aspects of the dynamics between the two fields are poorly researched and understood?

In addition to highlighting the issues of institutional integration, as explored by Kidd (2007), the contributors provide additional insights into emerging relationships between the spatial planning and public health professions and emphasise related shifts in professional paradigms. There are both economic and social drivers for these shifts. The fact that, for instance, people in the most deprived districts of an urban area may have a life expectancy that is twelve years shorter than that of those living in its most affluent areas is of direct concern to health and development planning policy alike (Marmot & Wilkinson, 2006). Understanding the importance of environmental factors on health also allows strong connections to be made between health outcomes and subjective measures of “quality of life”, a tool increasingly used by local authorities and planners to measure the success of their place making (Carmona & Sieh, 2006; Wong et al. 2008).

The relationship between health and the built environment goes far beyond obviously physical factors. According to the World Health Organization, mental illness accounts for 15.4% of lost disability-adjusted life years (DALYS), second only to cardiovascular disease in the US. Major depression alone accounts for 6.8% of lost DALYS in developed countries, more
than any other single disease except ischemic heart disease. Frumkin et al. (2004) argue that urban design and planning must recognise more fully the impact of the built environment on human emotional and stress responses. In its report on public health, the Nuffield Council on Bioethics (2007, p. 5) concluded that any government that seriously aims to promote and implement public health policies has to adopt a “stewardship model” which recognises that the state has a responsibility “to provide the conditions under which people can lead healthy lives if they wish”. This includes a particular responsibility for protecting the health of vulnerable groups, such as children, and embraces a commitment to addressing disparities in health outcomes. As more research in these areas emerges, and as scientific understanding of the environmental factors affecting health becomes increasingly sophisticated, the indications are that this is a rapidly growing area of professional and academic practice.

The Royal Town Planning Institute has recognised this agenda through the work of a Healthy Communities Task Group which brings together planners with public health practitioners to develop closer professional working. Their publication Delivering Healthy Communities (RTPI, 2009) identifies the planning contribution to health outcomes through its influence on environmental quality, social cohesion and social capital (e.g. through inclusion, mixed use, community infrastructure and design factors) and economic activity (e.g. relationships between commercial land use and transport infrastructure). Its recommendations are all-encompassing, ranging from the siting of local facilities and the provision of public transport to contaminated land assessment. It demonstrates that any attempt to reduce the relationship between planning and health outcomes to a few shared indicators will fail. The challenge is to understand the unique relationship between development options and the alternative health futures for particular populations in particular places. Tools such as the healthy communities checklists, and models developed by the NHS London Healthy Urban Development Unit (www.healthyurbandevelopment.nhs.uk) are transferable because they are clear about the importance of locational context and scope.

It is also important, however, to recognise that coordination and communication around the public health agenda is not only split between the planning and public health disciplines but is fragmented further between medical practice, social services, housing and regeneration. This was highlighted by experience from a joint project by the RTPI and the English Department of Health’s Housing and Learning Information Network. Financed by the Department of Health’s Extra Care housing fund, it aimed to give guidance on development planning and management for housing specifically designed to support the health needs of older people. This revealed the challenges of communication between social care providers, health policy makers, housing experts and planning professionals, challenges that remain entrenched despite widespread recognition of the health and social care expenditure pressures created by a rapidly ageing population. Social care expenditure alone is set to increase by over 300% by 2041. The policy response has been to insist that housing, health and care will be increasingly interdependent (Communities and Local Government, 2008).

Extra Care Housing describes a type of specialised housing that aims to provide household independence to adults with varying care needs. It is fundamentally different from residential care in its insistence on supporting the independence of household units. These are clustered in groups of varying sizes and designs around support services, which may be part of wider community amenities. In this model, independent housing is treated as an integral support mechanism for an individual’s health. £80 million will be made available by the Department of Health to local authorities and their housing partners between 2008 and 2010 to provide new Extra Care Housing units. The intention is that it should provide
a stimulus to provision, but it is a very small lever trying to address a very large problem of housing for those coping with disabilities or the health challenges of ageing.

The Department of Health has taken a very proactive approach to promoting this agenda through its Housing Learning and Improvement Network in the last three years. It has sought to improve dialogue between social services, primary care trusts, housing providers and private developers. With the development planning and management processes perceived as both a frequent barrier and an important opportunity, the Department approached the RTPI to collaborate on producing guidance for planners to include such housing provision in their housing needs assessments (RTPI, 2007). In scoping and developing the guidance, we encountered a very broad range of experiences of collaboration but very little evidence of the type of integration that would be necessary to support large-scale investment in lifetime neighbourhoods, incorporating the required range of housing and environmental support for health over the long term.

The UK research councils recently announced a major new focus on interdisciplinary research on the implications of an ageing society. An important theme should be the intersectoral and institutional processes of policy making and delivery of health outcomes. But a major challenge remains in the form of our limited cultural understanding of what health actually means and the small value placed upon it in the development of the built environment. The latter needs to be recognised as the source of major, complex health drivers which must be better understood, communicated and acted upon.

From a development planning perspective, a renewed focus on the health outcomes of spatial planning will change how we approach the assessment and delivery of housing needs and the evaluation of all types of infrastructure, including social infrastructure. There are market opportunities inherent in delivering healthier living environments (Suhrcke et al., 2005) that must be tapped as part of the delivery of services and economic stimuli in the face of major demographic and fiscal pressures. At the same time issues of equity and social cohesion will underpin the planner’s dialogue, with developers required to deliver healthy places.

In the following papers, Hugh Barton offers his reflections on long experience of working as a planning academic and researcher with the World Health Organization’s (WHO) Healthy Cities programme. The WHO has driven a global agenda for health that is as strongly relevant to post-industrial economies as it is to more recently urbanising territories. It takes a systemic approach to health, emphasising the interactions between natural ecosystems, the built environment and socio-economic factors, as well as medical services and infrastructure. In this context, Barton argues that the outcomes sought by planning and public health practitioners are so intertwined that they should be recognised as indivisible: the basis of shared frameworks of urban analysis and policy. As such, he believes that health offers a focus and a language that breaks down the entrenched economy–environment dichotomy of development practice in a more potentially effective way than the concept of sustainability. His paper is a call-to-arms for planning and public health practitioners to revisit current professional parameters, joint tools of mainstream health and spatial analysis, and forge policy frameworks for urban development that meet their shared objectives. Barton uses the example of UK transport policy to demonstrate the urgency of the integration of health and environmental outcomes in order to reverse overwhelming trends in the consumption of energy and sedentary lifestyles.

Tim Chapman has been at the forefront of joint working initiatives in England in recent years. His paper gives a personal perspective on his professional journey as an urban planner engaging with “health sector” agendas. His approach is dynamically pragmatic, committed to demonstrating the role of spatial planning in increasing the economic
effectiveness of sectoral policy. This approach has given rise to new ways of place-focused working. At the same time, Chapman also suggests that health can reframe professional planning practice, strengthening emphasis on quality indicators as opposed to short-term targets and driving a re-engagement of planning with issues of inequality. The theme of professional relationships is taken up in Martin Higgins’ reflections on current joint working between planners and public health professionals in Scotland. As a public health official facing one of the most challenging health profiles in Europe, he welcomes increasing moves to overcoming sectoral divisions. In this context, Higgins cautions that recent reforms to the Scottish planning system aimed at “streamlining” its processes could be counterproductive. This raises the overall issue of the institutional capacity for greater integration and joint working and the way in which changes to planning systems can enhance or constrict this capacity. As the WHO (2008, p. 74) argues, a “whole-of-government” approach to healthcare “has the potential to change radically the type and quality of policy dialogue.”

Tony Capon and Susan Thompson bring together public health and spatial planning voices in their paper on Australian policy responses to this agenda. While Kidd (2007) emphasised the political and educational dimensions of integration and suggested that an emphasis on interprofessional networking is critically important to progressing spatial planning activity, Capon and Thompson propose “a transcendence of disciplines” through professional or disciplinary integration. The implications of a refocusing on health outcomes for the disciplines and professions of planning and public health are profound. It casts a spotlight on the role of, and capacity for change of, professional demarcations in both spatial analysis and policy making. In doing so it promises new territory and new methodological challenges for planning research and knowledge transfer.

References


Strengthening the Roots of Planning

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It has struck me with some force over the past year that a significant shift is occurring in the philosophy of planning. Recognition of this fact has not yet reached the general practice of planning, nor has it been reflected in the policy of government to any great extent. However, its development from a standing start only a decade ago has been phenomenal, and the momentum is, I believe, unstoppable. In time it may be seen as a more important change in our societal understanding of the purposes of planning than the principle of sustainable development. It is the recognition that the overarching goal of what is now called spatial planning is human health and well-being, a realisation that goes back to the roots of modern town planning, re-invigorating them.

Synergy and Division

Health and planning are historically linked. Modern planning originated in the nineteenth century expressly in order to combat the unsanitary, overcrowded and inhumane conditions of the burgeoning industrial cities. It was recognised then, and it is recognised now, that there is an umbilical link between environmental conditions and human health. This link has been continually articulated in the modern era, with the environment seen as one of the key determinants of health alongside inherited characteristics, lifestyles, and social and economic variables (Lalonde, 1974, Whitehead & Dahlgren, 1991, Barton & Tsourou, 2000). Increasing amounts of attention have been directed not only towards the direct physical impact of the environment on health—for example of foul air or contaminated water—but also towards indirect social and behavioural causes of health and disease, such as the exercise we take, the people we meet, and the degree of inequality we experience in accessing housing, employment opportunities, health services and other facilities. 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 we ignore environmental factors at our peril.

According to VicHealth (the Victorian Health Promotion Foundation in Australia) there are four key reasons why factoring health into planning has a positive impact on population health. Good planning can:

- reduce the inequality between different socio-economic groups when it comes to accessing housing, facilities and transport, protecting vulnerable sectors of the population, such as the elderly and children
- increase the amount of incidental physical activity taken by improving access and providing walkable, mixed-use communities, thereby reducing the burden of disease, disability and mortality due to sedentary lifestyles
- contribute to the improved health of the population by reducing air and water pollution and greenhouse emissions, thus combating the threat of climate change

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• contribute to a changed social environment by improving the liveability of streets, making them safer and improving communication between people, thereby improving community cohesion (Butterworth, 2000)

All this reflects the broad view of health adopted by the WHO in 1946, in which the concept is defined as a positive experience of well-being and not merely as the absence of disease. Yet despite the symbiotic relationship between spatial planning of the human habitat and health, in practice the connections between well-being and urban space have been neglected. This is in part because of departmental silos: health authorities have been charged with providing services for those who are ill, while public health programmes have concentrated on infectious diseases and addiction (tobacco, alcohol, drugs) rather than healthy environments. Health and safety departments and environmental protection agencies have been given narrow, functional remits. Planning authorities have often been equally blinkered. Local councils, guided by national governments and local politics, have taken the view that the purposes of town planning are economic development and environmental protection, not the promotion of health. Each sphere of public policy has been pursued independently, with agencies adopting specific targets in order to deliver on their mission, and failing to grasp, or at least failing to deal with, the interdependence of the issues at stake.

Partly as a result of this, we have been quite literally building unhealthy conditions into the fabric of our cities, towns and villages. This is particularly true in relation to levels of physical activity, a huge concern for those dealing with the obesity “epidemic”. All levels and types of planning are implicated, as the report Building Health (National Heart Forum, Living Streets and CABE, 2007) indicates. This document shows how broad strategy, urban and transport policies, urban design and green space management are all important in achieving satisfactory levels of activity, and illustrates the ways in which current planning conventions are sometimes counterproductive in producing these healthy conditions.

Integrating Health and Planning

Attitudes are changing fast, partly as a result of WHO policy. The WHO Healthy Cities Programme has been acting as a catalyst for “healthy urban planning” in municipalities across Europe since 1998 (Barton, forthcoming). There is now growing recognition amongst professional planners that the health–environment link is important, and that some current development trends compromise health (see RTPI, 2009). But while many planners do recognise that urban planning influences health, they do not normally perceive that it is their job to worry about it or to study it. Their priorities are elsewhere.

At the same time public health professionals are beginning to take a real interest in spatial planning. They have become conscious that advocacy and specific population programmes are not enough to change behaviour (e.g. to persuade people to take more exercise) when structural limits, the very forms of towns and cities, are working against them. In 2008, and even more in 2009, there has been an explosion of demands from public health authorities for knowledge exchange and effective contact between the health and planning sectors. In part this may reflect the fact that the National Institute for Health and Clinical Excellence, a body normally associated with evaluating medical treatments, has issued guidelines on physical activity and the environment (NICE, 2008), and is now commissioning systematic evidence reviews that it hopes will build towards the formulation of explicit requirements for a healthy human environment.

It is all too easy for beleaguered planners under pressure from all kinds of legitimate interests to see new objectives of “mental health” or “combating obesity”, as yet more rods for their backs. Understandably, professional planners can take a jaundiced view of the
exponential growth of expectations placed on them by a society desperate to find solutions to intractable problems in the built environment, and can feel beleaguered by conflicting demands, which seem to pull in different directions (including the responsibility to mitigate or to adapt to climate change). But I have a different view: I believe health provides an underlying philosophy which can give a coherent rationale to spatial planning and design.

Consider the apparently very different agendas of climate change, obesity, economic development and accessible environments—all things the government expects to be addressed by planning. The problem is that guidance appears for each of these concerns in a segmented way—with specific criteria or targets attached. The principle of planning for human health and well-being (or quality of life) offers a means of orientating our thinking about them, so that integrated policies can emerge. The connection between climate change, obesity and access is perhaps self-evident. Climate change is the biggest health threat on the planet, vast in terms of its potential impact and increasingly viewed as inevitable. Part of the cause is the continued growth of emissions from fossil-fuel-based vehicles. But our growing dependence on cars is also centrally implicated in the decline in our daily physical activity, particularly “active travel” on foot and bike. At the same time, it is not only people who are frail or disabled who may experience exclusion because of the inconvenience and perceived dangers of the environment, it is everyone who cannot drive, or does not want to use a car. So the policies to tackle all three issues can be mutually reinforcing. And we begin to perceive, perhaps through a glass darkly, that the health of individuals, the health of towns, and the health of the planet are indissolubly linked.

The approach to economic development is not so simple. Conventionally in political discourse, economic growth is opposed to environmental concerns. Battle lines are drawn between councillors who believe that economic concerns are vital to promoting new jobs and environmental activists who argue that growth is exacerbating climate change, as well as destroying valued local environments. Introducing health into the debate can build bridges. Employment (and the income that goes with it) is a key determinant of health and well-being. Put another way, unemployment is bad for your health. So is climate change. The solution, therefore, cannot be a question of either/or; it has to be both/and. The healthy resolution must involve a fundamental review of the nature of economic development, and from the spatial planning perspective, a determination to locate new economic initiatives in places which are accessible by bus, foot and pedal, as well as a commitment to reinforcing the viability of existing businesses. Some cities—one is described later in this paper—are already pursuing this integrated vision.

Health and well-being can be seen as the human face of “sustainable development”. There is no dichotomy between these two goals; rather, health provides a core value which everyone intuitively understands and supports—much more so than the abstruse concept of sustainable development. The “settlement health map” below offers a way of linking the two. It combines an ecosystem approach to settlements—seeing the town or city as part of, and dependent on, the wider natural environment—with the social and environmental determinants of health: all the sectors of the map have an impact on health, and on each other. Spatial planning directly affects the “built environment”, but also influences to a greater or lesser degree what is possible in all the other spheres. The map has been widely welcomed in public health circles as helping to articulate the relationship between individual, social, economic and environmental variables.
Cautionary Voices

You might legitimately take the view that the perspective given above is all very well, but that it smacks of idealism not realism. Planners and researchers are rightly wary about claims that changes to the physical environment can alter deeply ingrained unhealthy habits. There are too many cautionary tales from the past to take a sanguine view—take, for instance, the naïve belief in physical determinism adopted by the slum redevelopment programmes in the 1950s and 60s, where the false hope was that by transforming the physical conditions in which people lived, their family and social problems would somehow evaporate. Indeed, for a while there was scepticism about whether space was at all influential in social and economic terms, with some academics arguing that key spatial planning policies, such as neighbourhoods, were irrelevancies in the brave new world of the “non place urban realm” (Dennis, 1968; Giddens, 1990; Webber, 1964). If we look at the more recent research into active travel—inspired by the concerns over obesity—we find some support for this stance. In 2005, for example, Handy—one of the leaders in the field—still found the research equivocal, concluding that the many studies reviewed showed no clear relationship between either density or mixed use and the level of active travel occurring within a particular area.

Malign Trends, False Perceptions

This is not an isolated case. A recently completed major research programme into future urban form and transport throws uncomfortable light on the UK government’s plans...
in relation to climate change (Hoswell et al., 2009). Their programme of action, unveiled in July 2009, claims that transport carbon emissions will be reduced by 15% by 2020 as part of an overall plan to cut UK carbon by 80% by 2050. However, the EPSRC-funded research, involving a consortium of universities (Leeds, West of England, Newcastle, UCL) led by Cambridge, shows this to be highly unlikely, and therefore misleading. The five-year project involved two linked areas of work at strategic and local levels. The strategic research was very ambitious and involved modelling land use and transport futures up to 2031 in two contrasting regions: London (and the wider south-east) and Tyne and Wear. The results were salutary. Far from cutting transport carbon emissions, current policies, based around urban containment, brown-field intensification and a rough balance of road/public transport investment, will lead almost inevitably to a significant increase. Total emissions would rise by 34% in the south-east and 10% in Tyne and Wear. The alarming thing is that even if we change the strategic land-use transport policies significantly (towards a much more compact or dispersed pattern of new development than is at present planned) and introduce road user charging in the cities, the result is broadly the same. The essential reasons are simple: the momentum of social and economic change is such that it overwhelms any benefits that might accrue, for example from extra investment in public transport or a better balance between employment and housing.

This research does not suggest that the physical environment is unimportant in determining travel behaviour. On the contrary, the established pattern of development is a huge factor. Rather, it shows that the timescale over which significant change can be achieved through strategic planning is much longer than the 11 years of the official target or even the 21 years of the model run. The local level research reinforced these conclusions. It involved empirical analysis of both local facilities and household travel in twelve suburban neighbourhoods of varying kinds, followed up by an evaluation of alternative local development trajectories. The findings were, at one level, inauspicious. The most recent developments, far from being an improvement on older localities, showed the most carbon intensive behaviour and the lowest level of active travel. The car dependence for “local” trips was 80% in some neighbourhoods, yet in others that were not too dissimilar socially, it was only 40%. Also, the pattern of intensification in suburbs was somewhat indiscriminate: high density brown-field housing development was shown to be occurring not only close to local centres and good public transport but also in less accessible locations, deterring pedestrian trips and forcing higher car use. It is clear that the well-intended signals given by government to local authorities and builders are often resulting in unsustainable and unhealthy development.

Grounds for Hope

But there is a basis for hope in the research, and also a rebuff to the pessimists who say that urban form has only marginal significance. It might well be that the variables of density and mixed use, relied upon in the studies examined by Handy, are not the most important variables to consider. This study suggests that the two key spatial variables in determining whether people walk/cycle are the locational pattern of facility provision and the actual distance from home to facility. On the social front, car ownership levels are important, but age, income and gender much less so. This confirms the findings of another recent study in a very different setting (Lee & Moudon, 2008). Essentially, if the neighbourhood functions in such a way that facilities (public and private) are viable and well located, and dwellings are within certain threshold distances along tolerable routes, then active travel will be the norm.
The study of alternative design trajectories, in areas of change, went one stage further. It was clear that current proposals often represented unfortunate compromises between what the planners might ideally like and what the market and the politicians would tolerate. In some situations, alternative structures—often based on local high streets and graded densities—could achieve much better levels of accessibility for most households within key threshold distances, a situation likely to lead to high levels of active travel. There remains, however, the question of timescale. How fast can places change? The overall conclusions of the solutions project was that carbon emissions can only be reduced—and lifestyle choices about physical activity changed—if dynamic action is to be taken urgently on every front possible. Alterations in land use and transport have to happen, and a technological revolution in the latter is also necessary. But there is also a necessity for firmer fiscal signals to businesses and households, and for a huge shift in both public and political values and corporate decision making to reinforce healthy, low carbon lifestyles.

**Inspiration and Action**

Some places are getting it right. Since the beginning of the decade a growing number of British planners have been making a pilgrimage to European cities where a remarkable transformation towards healthy lifestyles has been occurring for decades while British and American cities have been treading the primrose path to the global warming bonfire. An important report from PRP, Urbed and Design for Homes (2008) draws some trenchant lessons from these places. I have recently led a study tour to one of their examples—Freiburg. All who went experienced the city as humane, inclusive, healthy, economically dynamic, and environmentally forward acting. In short, it provided an enviable quality of life. In one new suburb, designed around the principle of low car use, car ownership has fallen to 30% (by another calculation, it stood at a mere 10%). Despite experiencing quite high densities, the place is ideal for children and they freely colonise the public spaces.

The reasons for Freiburg’s relative success are complex, but for me four stood out: superb political and technical leadership, with the chief planner and other planning staff knowing the place and the population from the inside; a consistent, wise approach to planning, so that strategic and local decisions (with active participation from local people) reinforce each other; substantial autonomy for the local authority to raise money, invest, and make policy; and the willingness of the city to buy up development land and act as key managers of the process of development, which sells at a price that makes the whole process viable for the community once infrastructure has been constructed (trams are provided in advance of development).

Ironically the prime drivers of policy in Freiburg are not “health and well-being” per se, but quality of life and environmental sustainability. In practice, however, this does not seem to matter. The key is the seriousness and commitment with which the city is planning its future for the good of all. The timescale for its transformation—still continuing of course—was over thirty years. There is a desperate need for UK cities and their regions to follow suit. We need to create an urban infrastructure that encourages healthy, active living and is capable of coping with the exigencies of climate change. I do not see this happening without a sea-change in government thinking, giving local authorities the muscle and the obligation to plan in a forward-looking way, and reinforcing this through fiscal and financial policy. Health, in its broadest sense, could be the motivator for such a sea-change.

But truthfully, the time for rhetoric has passed. I am reminded of the old adage: if we fail to plan, we plan to fail.
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Health and the Urban Planner

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As a former local authority planner, I first became aware of health issues in a meaningful way when I became deputy head of the newly created London National Health Service Healthy Urban Development Unit (HUDU). I went through each policy of a previous Unitary Development Plan I had worked on in the London Borough of Southwark, trying to imagine how that policy might influence health by using the World Health Organization’s healthy planning framework. Most of the relationships between place and health seemed straightforward and obvious: the relationship between the provision of open space, exercise and health, for example; or the need for accessible health facilities. Some needed a bit more thought, however, such as the fact that employed people have generally better health than those who are unemployed; or that noise, social isolation and crime affect health. And some required deep consideration, for instance the potential relationship between mental health

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and policies protecting buildings in conservation areas which can conceivably affect people’s feelings of connection with place and local social capital.

However, trying to get professional health and planning colleagues to engage with these topics took time. HUDU was formed in 2003 as a response to recognition within the London National Health Service that Primary Care Trusts (PCTs) in London needed to relate more closely to town planning departments in order to improve health outcomes. The unit, which started with three experienced town planners, encourages the NHS to take account of the increased need for healthcare created by new housing schemes in London, for example, by engaging in planning obligations negotiations, or by seeking to influence local planning policy. It also promotes the consideration of wider public health matters in planning decisions, including the importance of employment, environmental factors, transport and access to public services.

Much of HUDU’s work involves relating the health and planning sectors to one another and providing tools and processes to help both sides work together more effectively. HUDU can be seen as a practical response to, on the one side, health policy developments such as the Acheson (1998) and Wanless (2002) reports and, on the other, the emergence of a wider challenge for planning to co-ordinate and deliver growth, otherwise known as spatial planning. In order to define the likely impact of new housing on demand for NHS services, and subsequent costs, HUDU defined and commissioned a numeric tool known as the HUDU Model. This tool has been widely used in London and has generated over £10 million for London PCTs to develop services. In recognition of its partnership work, HUDU received the RTPI Award for Planning Process 2008 for its Health and Urban Planning Toolkit publication.

My role in HUDU was to work with both local planning authorities and local Primary Care Trusts responsible for delivering healthcare facilities, often acting as a conventional planning consultant advising the latter. My previous role as Planning Policy Officer for the Association for London Government, representing planners in London’s 33 boroughs, gave me a excellent network and understanding of relevant concerns. I found that it was often harder to engage the local PCT in the agenda than the Local Planning Authority, despite HUDU being a sister organisation within the National Health Service (NHS). The often departmentalist approach of the PCTs did not help. Planners were usually open to explore the impacts of their work on health: many had already been starting to think about health but needed some structure to assist. PCT officers, however, would typically remain focused on their core job, such as estates or service development. Only the public health team would typically understand the potential benefits of engagement with town planning. But most public health teams are not particularly powerful within the PCT’s hierarchy.

How did this change? In a word, money. By showing the likely financial impact of new housing upon the local NHS, by providing the ability to fund increased health needs via planning—and by clarifying what the costs of non-engagement might be—HUDU was able to persuade PCTs to get involved. Once a bridge had been established (the typical catalyst being a large housing proposal) then the PCT would engage with planners on wider issues, including planning policy development and the public health agenda.

As a consequence of NHS reorganisation in London I left HUDU in early 2007, joining the Advisory Team for Large Applications (ATLAS) to advise on how to best provide social and community infrastructure for large housing developments. ATLAS is a government funded unit, now part of the Homes and Communities Agency, charged with providing free and independent advice to local authorities across England. Having
previously worked entirely in London, I found my horizons literally broadened. My work for HUDU, in particular project managing the London Thames Gateway Social Infrastructure Framework for Communities and Local Government (CLG), gave me a wider perspective than health services alone, and I was keen to apply what I had learned outside the capital. Soon after joining ATLAS I met Caroline Davis, Head of Partnerships at Kent Coastal PCT. Caroline told me: “The most important single thing a person can do to improve their health is to give up smoking. The second most important thing is to get a job.” This phrase, at least for me, helps to encapsulate the multifaceted factors that affect our health, and the complexity of the policy environment that town planning is attempting to understand and, ultimately, improve.

My work for ATLAS has focused on the negotiation of collaborative solutions which have been acceptable to all parties, including developers, planners and service providers. The use of objective evidence is important in the process, but not to the exclusion of fundamental understanding of the needs and aspirations of partners. Pragmatic problem solving and acknowledgement of the real-world concerns of others are important too. For example, my involvement in health impact assessments in respect of Brighton Marina and the new town of Northstowe in Cambridgeshire has brought home the opportunities and limitations of this tool. Promoting shared facilities, such as the development of a shared health centre and library in north-west Cambridge, is another key area. As a consequence of this work, ATLAS has created a Social Infrastructure Matrix1 to assist in systematically capturing the requirements and issues of all the social and community infrastructure likely to be required by large housing schemes.

The Outputs/Outcomes Dichotomy

These days measurement is the name of the game for planning practice: “robust evidence bases”, “target setting”, “justification for Section 106 requirements”, “viability assessments”, etc. all require objective, predominately quantitative evidence in order to be acceptable. But what is all this measurement really delivering, apart from a focus on the numbers themselves? By measuring outputs (e.g. numbers of houses built) you have a clear measure of whether you have achieved your targets or not. What is less clear, however, is the relationship between those outputs and the outcome you desire. To put it another way, by focusing on an outcome, such as reduction in primary school obesity, your overall aim is clearly in mind. However, important factors, such as how you achieve it, what impact your intervention might have had (as distinct from external factors) and how long your actions took to be effective, are ignored. In other words, the focus on evidence and the need to distinguish between outputs and outcomes is important, but just because you can’t provide a direct and explicit causal link between an action and an outcome does not mean that intuitive assessments about their relationship should be ignored. One way to attempt to square this circle is to gather qualitative evidence that takes account of people’s perceptions of the drivers and impacts of change.

Not surprisingly, the outcomes of healthcare are a major concern to the NHS. One main measurement of this is quality-adjusted life years (QALYs), which is a comparative tool used to judge the likely impact of a health intervention (such as a course of treatment) in terms both of how much longer the recipient will live but also how good their quality of life will probably be. This information is assessed in relation to the financial cost of the intervention. The Wanless report (2002), which shows the likely impact of increases in obesity and other public health trends on health spending, concluded that without a change in focus towards preventing people getting ill in the
first place (i.e. prevention rather than cure) health spending will outstrip our ability to
fund it in the foreseeable future. It also emphasised that planners have an important role
in ensuring that the design of places maximises good health as part of Wanless’s “fully
engaged scenario”.

Reassessing the Health and Planning Relationship

The central role of spatial planning as the “ringmaster” in assisting other services to
coordinate and deliver their agendas was reinforced by the creation of the 2004 spatial
planning system in England and Wales. So, five years on, how well have we done?
Certainly, planners are generally taking much more account of health these days. Planning
obligations now regularly require health facilities to be provided as part of the deal. PCTs
are consulted on major planning applications as well as planning policy development.
Health impact assessments are increasingly required, albeit without a statutory context.
Statutory Strategic Environmental Assessments, Environmental Impact Assessments and
Sustainability Appraisals now sometimes cover the impact of a development proposal on
human health, alongside their more usual focus on newts, badgers and bats. Public health
and planning are rediscovering their shared Victorian roots.

Government’s focus on sustainable communities has provided helpful mood music for
these developments. The establishment and strengthening of local strategic partnerships
and the agreement of local targets via local area agreement mechanisms all point towards
a more joined-up approach where planning can take on a greater coordinating role.
Establishing a focus on children and older people in local service provision is also a
positive cross-cutting development. But fundamentally, a failure to move away from silo
approaches, as embodied by government departments and funding mechanisms, means
motivation for change at a local level has been limited. The focus remains on quantitative
and short-term output measures such as the amount of housing produced and funding
spent. A more comprehensive approach, where the impact on health is held central to
design and decision making, is still some way off.

Something else is missing too. It is the understanding of what works: a systematic
assessment of the effect of recent planning decisions on human health. It’s only by
analysing this impact, by isolating the contribution made by planning, that the success of
the spatial planning system can be judged. Inevitably, bucket-loads of professional
intuition, judgement and consensus will be needed to fill in the gaps. But starting with
clear quantitative and qualitative assessments of impact and cost is a prerequisite. This is
what I hope the proposed spatial planning and health research being undertaken by the
United Kingdom’s National Institute for Health and Clinical Excellence (NICE) will
do. In addition to assessing current practice it will ask the following fundamental
questions:

- How effective and cost effective are the following approaches in terms of influencing
  planning decisions (including spatial planning decisions) to secure improvements in
  health and address health inequalities:
  - strategic environmental assessment
  - sustainability appraisal
  - environmental impact assessment
  - health impact assessment?

- What lessons can be learnt from other countries about how to ensure health issues are
  fully incorporated within the planning decision-making process (including the spatial
  planning process)? To what extent can these lessons be applied in England?
What approaches or techniques should be used to assess ways of promoting health and reducing health inequalities when making spatial planning decisions? How and when should these approaches or techniques be used to ensure health considerations shape spatial plans and projects and thereby improve health and reduce health inequalities?

How can local authority planners and PCTs collaborate more effectively to ensure health considerations (including health inequalities) are assessed and integrated within the spatial planning process?

How can evidence be used to ensure health is appropriately considered in the spatial planning decision-making process?

What are the limitations and gaps in the evidence that prevent health issues (including the need to reduce health inequalities) from being effectively and cost-effectively incorporated within planning decisions (including spatial planning decisions)? How can these limitations be overcome?

How can the differential health impact on different groups be assessed and considered within the spatial planning process?

Would a national planning policy statement on health improve the way health issues are considered when making planning decisions?

The impact that planning can make on health is clearly not limited to tweaks and improvements to existing processes and proposals. Establishing a clear link between planning decisions and health could provide a funding stream to help deliver better solutions. If the evidence is there, the argument can be made that health services should help fund the provision of a local park/improved local transport/employment training in order to improve people’s health outcomes. Since April 2008, health and local authorities in England have had a statutory duty to produce joint strategic needs assessments (JSNA) to assess the social needs of the local populations and provide the basis for decisions about commissioning and investment. The JSNA will inform and in some cases build on the considerable current focus nationally and locally on strategy and planning. Public health’s increasing awareness of health inequalities focuses attention on the polarised nature of society and the increasing social dislocation which can exist within small geographic areas. Households who experience material disadvantage, poor housing, lower educational attainment, insecure employment or homelessness suffer higher levels of deprivation and poorer health outcomes (Brent Borough Council, 2008). This is likely to become an increasingly important shared area of spatial analysis for planning and public health policy.

Note
1. The Social Infrastructure Matrix is part of the website ATLAS Guide: Planning for Large Scale Development

References
Health Inequalities and Place

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Why do people living in less affluent areas suffer more illness and disease? Why do they live for a shorter time than people living in more affluent areas? Planners and public health specialists have attempted to address these health inequalities, most notably in regeneration activity. But 30 years of regeneration shows limited, if any, success in health terms (Fyfe, 2009). Lessons may have been learned about what does not work, but in terms of reducing the basic statistical inequities there is limited evidence that regeneration programmes are effective (Thomson, 2008). The creation of car-dependent suburbs, the loss of green space and the construction of out-of-town shopping centres are now recognised as raising new challenges, particularly in relation to the rise in obesity-related illness (Cross-Government Obesity Unit, 2008; Government Office for Science, 2007). At the same time, anti-social behaviour, such as vandalism, may not directly be a planning or health problem, but impacts heavily on the success of regeneration investments.

What makes successful regeneration? What is the most beneficial balance of housing tenures and types? What type of neighbourhood layout best encourages physical activity? What are the key environmental determinants of child health? Research in these areas is being pursued by the Medical Research Council’s Social and Public Health Sciences Unit in Glasgow, the Scottish Collaboration for Public Health Research and Policy in Edinburgh and the Scottish Government-funded Environmental Determinants of Public Health in Scotland. Key areas include the impact of new technologies and changes to the built environment on physical activity as part of daily life. Urban development that reduces possibilities to walk, cycle or use public transport results in steep rises in car use and falls in more active forms of travel (Scottish Executive, 2006). Neighbourhood design can either encourage or discourage walking and cycling. Areas that are most “walkable” are aesthetically attractive, with varied, higher density land use mix including local shops and services, good connectivity and safety (Frank et al., 2005; McCormack et al., 2004; Owen et al., 2004; Physical Activity Task Force, 2003). The Scottish Household Survey (2009) suggests that people from the most deprived communities have a poorer perception of their neighbourhood, are less physically active and more likely to be overweight or obese. Access to high quality green space can encourage physical activity, with large, multi-functional, attractive green space, which is close to people’s homes, accessible, and provides connections to residential and commercial areas, most likely to be used (Greenspace Scotland/Health Scotland, 2008).

Indoor and outdoor air pollution and climate are also key environmental factors that are directly affected by planning policy. Air pollution increases premature deaths from cardiorespiratory disease, hospital admissions, exacerbation of asthma and other respiratory symptoms. The main cause is exposure to fine particles, known as PM$_{2.5}$. About 30% of emissions of PM$_{2.5}$ are from road transport. It is estimated that there is a 6% change in mortality per 10 $\mu$g.m$^{-3}$ change in average annual PM$_{2.5}$. In Scotland in 2007/08 there were over 2000 “additional” deaths in winter (GRO Scotland, 2008) Excess winter mortality is

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associated with poor housing insulation, and there is good evidence that housing improvements that enhance insulation can improve health (Howden-Chapman et al., 2007, 2008). The design of houses and neighbourhoods are also critical factors for the prevention of accidental injuries (Douglas et al. 2007). Efforts to apply this research to the creation of policy are critical to the development of integrated practice.

Equally Well

In 2007 the Scottish Government published Equally Well, its policy statement on health inequalities. A series of work-streams were identified that have direct relevance to both health and planning. The government also invited proposals for pilot schemes—called test sites—that could help tackle the problems of health as they related to planning. In Glasgow, the city council’s development and regeneration services team and the Glasgow Centre for Population Health teamed up to develop a bid to investigate healthy place-making.

The pilot investigates the potential of the Healthy Sustainable Neighbourhoods Model, which has been developed in the planning department at Glasgow as part of the Health Impact Assessment of the city’s East End Local Development Strategy. As demonstrated in Figure 1, the Healthy Sustainable Neighbourhoods Model is based around nine sections: Employment and Training; Health and Well-Being; Climate; Lifelong Learning; People; Transport; Green Engineering; Leisure and Recreation; and Housing Diversity. It has been used to structure community consultations as well as more systematic considerations of health issues within the planning process.
A major aim of the Glasgow Equally Well test site is to reduce people’s exposure to factors in the physical and social environment that cause stress, are damaging to health and well-being, and lead to health inequalities. The basis for the project is the realisation that people and places have to be considered together if healthy lifestyles are to be promoted. There are a number of projects related to the test site. One is to gather evidence of healthy place-making—qualitative evidence in particular—from around Scotland, with a view to producing place-making design guides. There are also plans to use the Healthy Sustainable Neighbourhoods Model to inform planning developments throughout Glasgow. A set of Quality of Place Indicators is envisaged, alongside further refinement of the model. The Glasgow planning team has also helped to produce a film about social determinants of health, with an emphasis on planning issues.

Professional Boundaries

One of the more challenging aspects of this work for planners and public health specialists is the need to cross professional boundaries and norms. It is not uncommon for planners to observe that the planning system can or should only be expected to address planning issues—a not unreasonable position, given current legislation and guidance. Conversely, public health specialists consistently maintain that population-level inequalities can only be improved by addressing all the so-called determinants of health, which includes an overwhelming proportion of non-NHS factors (sometimes public health specialists tend to outline problems rather than producing solutions, although the evidence base for positive interventions is improving rapidly). Creating organisational structures and processes that allow both planning and public health priorities to be addressed seems to be a key objective, albeit one that is perhaps easier said than done. Many public health specialists have long wished for specific health guidance within the planning system, either as an advice note or as part of planning policy. However, the recently condensed Scottish national planning policies have removed that possibility for the time being. The impact of the reformed, “streamlined” planning system on the prospects for integrating health and planning and addressing inequalities should be an important focus for further research.

References


Planning for the Health of People and Planet: An Australian Perspective

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As cities are now the dominant human habitat, it is essential that they are planned, developed and managed as healthy human places. To achieve this end, it is necessary to think about the health of both people and the planet in an integrated way. Increasingly in Australia there is acknowledgment that effective responses will require:

- Acceptance of diverse ways of understanding health
- Transcendence of disciplines in research, education and action
- Adaptive management approaches in urban governance

The purpose of this paper is to discuss some recent Australian developments in healthy planning and their wider implications.

**Ways of Understanding Health**

Epidemiology is the classical method for understanding the distribution of health and disease in populations. It has enabled the identification of major risks to health, such as the knowledge that tobacco smoking causes lung cancer. Classical epidemiology is less useful for understanding the complex interplay between multiple biophysical, social and economic factors and the health of people in urban environments. Consequently, it has been argued that epidemiology needs to adopt and develop methods to understand such complexities by drawing insights from ecology (March & Susser, 2006).

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Boyden (2004) proposes biohistory, founded in human ecology, as an approach to understanding complex human situations. Biohistory takes knowledge of the processes of life as its starting point, and recognises the enormous significance to the history of life on Earth of the relatively recent emergence of humankind’s most distinctive biological attribute—a capacity for culture (language, ideas, knowledge, assumptions, priorities, beliefs, values). The biohistorical approach is based on understanding humanity’s place in nature. Its evolutionary health principle enables an understanding of contemporary human health problems (such as the obesity and depression epidemics) as consequences of maladaptation to our contemporary habitat.

The first ecological study of a human settlement was conducted in Hong Kong in the 1970s (Box 1). From this, and subsequent work, Boyden developed a listing of universal health needs of the human species (Table 1) which provides solid foundations for the specification of healthy urban planning objectives. The task of urban governance, then, is to plan, develop and manage urban environments to ensure that these universal needs are met for those inhabiting a given urban environment. This understanding has informed decision-support tools for public health workers and planners (Capon & Blakely, 2007).

Box 1. The ecology and a city and its people: The case of Hong Kong
The Hong Kong HumanEcology Program was the first attempt to describe the ecology of a city and its human population in a holistic and integrative way (Boyden et al, 1981). It was concerned with the “system as a whole”—changing patterns of flow and use of energy, of nutrients and of water, and changes in housing and transport. It was also concerned with individual people—their actual conditions of life and their physical and mental health. It described the mechanism by which people adapt to potentially stressful conditions as well as the limits of human adaptability. The book discussed important principles of human ecology founded on interrelationships between society, environment and human well-being.

The project was carried out by researchers from the Australian National University in collaboration with specialist groups from Hong Kong and Australia, and with support from The Nuffield Foundation, UNESCO and UNEP. The resulting book outlines constructive ideas on the way in which society should develop if humankind is to derive the greatest benefits from advanced technology without serious damage to the ecosystem as a whole.

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<th>Physical</th>
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<td>Clean air</td>
<td>An emotional support network</td>
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<td>Clean water</td>
<td>The experience of conviviality</td>
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<td>A natural diet</td>
<td>Opportunities for co-operation</td>
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<td>Absence of harmful levels of radiation</td>
<td>A natural level of sensory stimulation</td>
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<td>Minimal contact with pathogens</td>
<td>An interesting environment</td>
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<td>Protection from extremes of climate</td>
<td>An aesthetically pleasing environment</td>
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<td>A natural amount of physical activity</td>
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<td>Sleep</td>
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<td>Variety in daily experience</td>
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<td>A sense of belonging, purpose and love</td>
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<td>Absence of alienation and deprivation</td>
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*Adapted from Boyden, 2004.
Transcendence of Disciplines

Lawrence (2004) argues cogently for integrative and interdisciplinary approaches in responding to links between the built environment and health. An effective interdisciplinary approach acknowledges disciplinary expertise, but brings it together with expertise in other disciplines to create new knowledge. There is value in augmenting such efforts with systems-orientated investigations that not only bridge divides among the natural science, social science, and engineering disciplines, but also integrate “formal” research and development efforts with “informal” grassroots knowledge and innovation (ICSU, 2005). This has been characterised as a transdisciplinary approach (Box 2).

Health professionals and organisations have spearheaded much of the early work in healthy cities in Australia. Healthy by Design (National Health Foundation of Australia, 2004) is one example (interestingly, it gained an Excellence Award from the Planning Institute of Australia). It provides a resource to support professionals who have responsibility for the design, development and maintenance of the public realm. It can be used as a tool for preparing plans, designing and assessing proposed developments, and influencing strategic directions.

The New South Wales (NSW) Premier’s Council for Active Living, established in 2004, aims to build and strengthen the physical and social environments in which communities engage in active living. It comprises senior representatives from across government, industry and the community sector. The Council has played a leading role in workforce development and policy integration for active living.

The Planning Institute of Australia (2009) recently launched Healthy Spaces and Places—a national healthy planning initiative developed in partnership with the Australian Local Government Association and the National Heart Foundation of Australia. The web-based resources include practical tools, case studies and guidelines for planning and developing sustainable communities to encourage healthy ways of living.

The Australian Academy of Science’s 2006 Fenner Conference on the Environment, entitled Urbanism, Environment and Health held in Canberra, brought together researchers, policy makers, industry and community across a range of disciplines and sectors. The purpose of the conference was to explore the implications of the current pattern of urban development in Australia for the health of people and ecosystems. This interdisciplinary conference contributed to the reframing of urban health policy in Australia as an integrative response to health and environmental challenges.

Box 2. Terms*

Interdisciplinary refers to research involving two or more disciplines where there is modification, or mixing together, of disciplines to develop new ways of understanding complex problems.

Transdisciplinary refers to a fusion of disciplinary knowledge with the know-how of practitioners and lay people to create a new hybrid which is different from any specific component part. It requires an ingredient referred to as “transcendence”. This implies the giving up of sovereignty over knowledge, the generation of new insight by collaboration and the capacity to consider the know-how of practitioners and lay people.

*Adapted from Lawrence, 2004
The success of these approaches can be attributed, at least in part, to the willingness of health professionals to share “sovereignty” of knowledge about health with other disciplines. This opens up discussions about differences in research traditions in the sciences and social sciences and the need for better understanding of their complementary roles, such as the value of qualitative research for enabling deeper understanding of a problem.

There is a critical role for interdisciplinary learning in undergraduate and postgraduate courses and in continuing professional development. The Healthy Planning course at the University of New South Wales is an example of a practice-based course using an interdisciplinary approach to understand and address the lifestyle-related health problems that are increasingly common in contemporary urban populations. Through interdisciplinary research, fieldwork and educational models, the relationships between urban planning, city form and human health are examined. Students from a range of built environment and health/medical disciplines work in interdisciplinary teams to explore these issues. Field work includes a detailed neighbourhood audit where the students observe and survey selected urban areas to determine the level of support for healthy behaviour. Learning outcomes are focused on interdisciplinary knowledge and potential application for professional practice.

**Adaptive Management in Urban Governance**

There is no argument for a single healthy urban planning model because there can be many options for a healthy urban environment. Cities are complex and dynamic (Batty, 2008) and responses should reflect local histories, geographies, cultures, values and economic circumstances. In responding to links between health and the built environment, planners should acknowledge this, but must not be overwhelmed by it. A systems understanding can help navigate a path through the complexity.

Adaptive management is an ecological concept defining a way of optimising decision making in the face of uncertainty (Walters & Holling, 1990). The principles of adaptive management are potentially relevant to urban planning, development and health. With any urban development there may be unintended consequences for health, so urban managers should be watchful and make adjustments as appropriate (Capon, 2007). However, governance is more than government, and whilst governments should lead on the governance of towns and cities, they should do so in partnerships with industry and the wider community.

**Moving Forward**

Climate change and sustainability are now firmly on the planners’ agenda, but human health isn’t quite there yet. However, achieving goals for the health of the planet can also achieve goals for the health of people (Capon et al., 2009). Understanding these synergies should encourage planning policies and actions in this area. Paying attention to health does not need to mean more work for planners; rather, it will require re-orientation of existing work and recognition of its broader benefits.

The Australian Government recently undertook a suite of national reviews of health promotion and the health system more generally. During these reviews, there was openness to hearing from urban planners and designers and, consequently, planning responses were embraced in key recommendations. Strategies proposed include the establishment of a prime ministerial council for active living to “develop and implement a national framework for active living encompassing local government, urban planning,
building industry and developers, designers, health, transport, sport and active recreation.”

At the state level, the NSW Health Department has recently funded a research and workforce development programme aimed at creating a healthy built environment, which will be established within the Faculty of the Built Environment at the University of NSW. This initiative is interdisciplinary and brings together a group of health and built-environment professionals, crossing the public and private sectors to advance research and education into planning and health, as well as to advocate and show leadership for healthy cities.

So for us in Australia, the key challenge in moving forward is to harness this heightened policy and professional interest and to translate it into action that both urban planners and those working in health can embrace. Unless there are changes to the current pattern of urban development, and the ways in which planners and health professionals collaborate, healthy planning will not deliver healthy places.

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