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Health-integrated planning at the local level in England: Impediments and opportunities

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ABSTRACT

The project commissioned by the National Institute of Health and Clinical Excellence (NICE) aimed to examine the degree to which UK, mainly English local planning authorities, incorporate health in their land use plans and development decisions. The project involved systematic reviews of evidence together with case studies. The range of performance in relation to health identified in the project shows that best practice in England depends not so much on the planning system per se, as on the leadership, commitment and knowledge of politicians and practitioners involved. The barriers to health integration are organisational and professional silos, ignorance, resources, and reactive planning regime. Clear lessons for research and practice are emerging: first, well attested research evidence is quite scarce, for example in relation to sustainability appraisal and health; second, planning agencies need to forge good partnerships with public health, transport, housing and economic development decision-makers, and develop proactive, healthy plans; the new planning regime and move of the public health function into local authorities in 2013 in England will give policy opportunities for the consideration of health outcomes in planning decisions, and research should in time evaluate if results have been achieved on the ground.

Introduction

The significance of the built environment for human health and well-being is now well established in academic circles (Barton, 2009, for a systematic review of evidence on this topic see WHO, 2010a,b). There are advice and guidance documents reflecting this growing consensus from national and international bodies (Barton and Tsourou, 2000). The most recent national policy guidance in England, the National Planning Policy Framework (CLG, 2012) itself highlights "health and well-being" as a key facet of sustainable development, to be properly addressed through plans and development projects. But there remains a strong suspicion, supported by extensive non-systematic evidence, that local plans and related policy documents are not taking health on board.

This article reports on a research project that sought to test the validity of this suspicion and point the way to good practice. It reports on a series of connected studies commissioned by the National Institute of Health and Clinical Excellence (NICE) which involved systematic reviews of evidence together with case studies. This aimed to examine the degree to which UK, mainly English, local planning authorities incorporate health in their land use plans and development decisions. The research was carried out in 2010–2011 prior to a series of political and planning policy changes. In November 2011 the Localism Act gained Royal Assent. This decentralises many functions from national to local government, not least spatial planning. However not all the provisions of the Act apply to Scotland and Wales. March 2012 saw publication of the National Planning Policy Framework (NPPF) (CLG, 2012). Applying only to England this streamline national planning policy guidance into a consolidated set of priorities on which to base local plans and decision-making development proposals. We will discuss the extent to which the findings from these interlinked studies are relevant and applicable in the new policy context. However, it is too early to draw any conclusion on a new policy regime.

We will first summarise the theoretical approach and methods used to address the research questions. Second, we will report some key findings. Thirdly, we will highlight examples of good practice as well as key barriers to such integration, and opportunities for improvement, drawing the lessons for England.

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Theory: built environment, planning and health

The built environment as a broad determinant of health

This research focussed on the degree to which, and the ways in which, the planning system and plans or development decisions by key regulatory actors impact on health and well-being, not on whether or how the built environment impacts on health. However, an understanding of links between health and the built environment is vital, since planning will influence health through changes in the built environment. In this context, health is understood as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (World Health Organization (WHO), 1946). The body of research evidence demonstrating that the physical environment has a direct impact on health and well-being is growing (Barton, 2009; Braubach and Grant, 2010; Dannenberg et al., 2011). In addition, the Marmot review on health inequalities in the UK identifies a strong link between built environment and health inequalities (Marmot, 2010) and recommends the creation and development of 'healthy and sustainable places and communities'. More specifically, Rao et al. (2011), for instance, emphasises the impact of urban planning on non-communicable diseases in urbanised societies, while it has been demonstrated that housing and public space can impact on behaviour and the sense of community (Barton et al., 2010), and evidence shows that quality green spaces can encourage social interaction and greater physical activity (Croucher et al., 2007) and reduce health inequalities (Mitchell and Popham, 2008). In terms of policy development, key stakeholders have also started to identify the risks that poor urban development, transport, and living and working environments pose to human health (WHO, 2010a,b; Greenspace Scotland, 2008). The UK government now recognises that the built environment's effect on health risk is an important problem (Wanless, 2002; Royal Commission, 2007). The government is in particular conscious of the contribution of the built environment on obesity and health inequalities (Butland et al., 2007; Marmot, 2010) and the need to take action (DoH, 2008a,b). Our project is therefore founded on the premise that the built environment is a determinant of human health and well-being just as a person's characteristics and hereditary, their lifestyle, the community, local economy and natural environments in which they live, their activities and the global ecosystem influence their health and wellbeing (Barton and Grant, 2006).

Development and planning processes

Improvement of the health and well-being of citizens was one of the key factors leading to the development of the planning system before the first World War, but that perspective has often been overlooked over the last century and other priorities given precedence. Some countries are seeking to ensure that health becomes central again. In England, planning policies and processes are tools of the public sector to regulate and guide development towards a vision for places (RTPI, 2007). This means that local authorities can, in theory, contribute healthy changes to the built environment through policy interventions, their local plans and planning decisions. As part of this, appraisal processes, whether compulsory or voluntary, are key tools to support the assessment of plans or projects for their potential positive and negative impacts on the environment and health. As such they can also be used by local authorities to guide healthy planning outcomes.

However, plans themselves, in the UK context, can guide but not dictate, and have to operate within what the market, in the broadest sense, can deliver. The ability of local authorities to deliver healthy built environments and communities is therefore limited since planning is only one key driver of built environment change (see Fig. 1). The statutory processes intervene in the on-going market process of land development. This means that regulatory authorities may often have much less influence than the land owners, developers, investors, operators, designers, builders and users who are the other players in the development process, who can generate actual change to the human environment and can influence health and well being.

The contribution of local planning policies and processes to health must therefore be examined within that limited scope for intervention, including:

How far is health integrated into local plans and land use strategies?
How far is health integrated into plan and project appraisals?
Is this integration realised on the ground?
What are the barriers and facilitators for such integration?

Materials and methods

The initial research questions were developed by the Programme Development Group (PDG) on spatial planning for health set up by NICE as steering committee for the reviews. The PDG

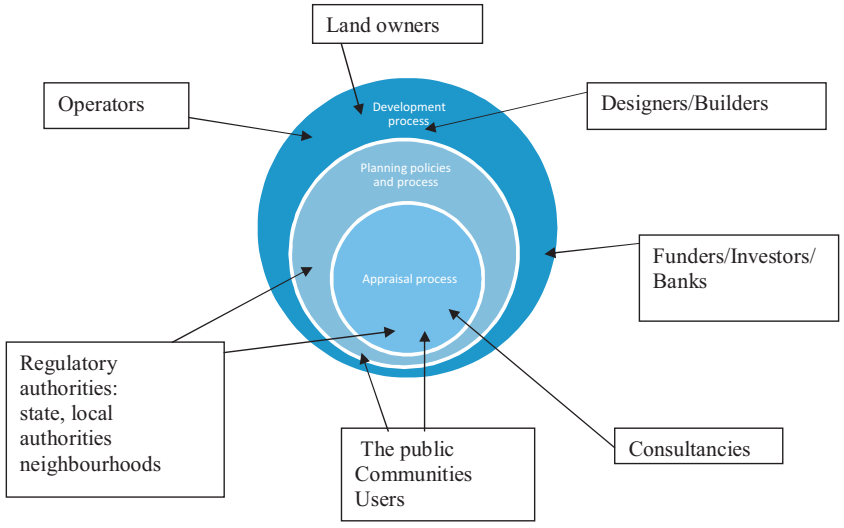

Fig. 1. The planning system as part of the development process and their key stakeholders.