Leveraging Health: The Urban Planner's Dilemma

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Abstract

In recent decades, a trend has emerged advancing the view that urban planning is a critical instrument for public health action. A popular concept now used to articulate this position is "healthy urban planning" (HUP). The concept of HUP adopts a human-centric philosophical perspective towards urban planning, one which emphasises human health and wellbeing. By positioning HUP and the urban planning-health interface as the point of departure, this thesis investigated the conceptual, epistemic and technical factors affecting the construction and mobilisation of the HUP concept, and the wider integration of health into urban planning. The study employed a qualitative, case study methodology with a social constructivist, postmodernist philosophy, acknowledging the multidimensional nature of knowledge and practice of urban planning within real socio-political contexts.

The findings of the study reveal a funnel of contestation as one moves from the normative and policy spheres of HUP, within which its merits are not disputed, through to its theoretical and practical spheres, where conflict in meaning and understanding is both observable and arguably a natural response to the complex nature of the concept and its definition. The aim of HUP may appear straightforward and determined: to promote and not harm human health. However, such abstraction creates a binary that veils a complex relational web in which multiple structural, institutional and agential factors interact to construct novel interpretations of HUP and shape the relationship between health and urban planning.

This research proposes that the concept of HUP does not have a discrete, universally accepted meaning. Instead, this same basic concept attracts multiple meanings. These meanings, moreover, do not simply vanish when contradicted by fact, authority, or competing theory, but often become more entrenched and their dismissal more vehemently resisted. There is, therefore, a need to view HUP as a "contested concept", which far from lacking theoretical or policy-making purchase is valuable in promoting healthier forms of urban planning. In light of this, this thesis recommends that to secure the benefits of HUP in the long term there is a need to further clarify the concept's definition, its use in urban planning practice, and to address the implications of both these aspects for research and theory development.

Acknowledgements

The idiom 'double-edged sword' refers to something that is simultaneously positive and negative, or something that is beneficial but probably disliked. If there was ever a better example of a 'double-edged sword', then I have no doubt it would be a PhD. Completing a PhD can be a complicated and solitary pursuit, and at times isolating and overwhelming. Yet pursuing a PhD offers an exciting opportunity to learn and to challenge yourself, and to explore a subject for which you are passionate both in great detail and in your own way.

By my own admission, the completion of this PhD took longer than expected. It involved countless hours and late nights spent crouched over my laptop keyboard, mountains of scribbled notes and doodles, and copious amounts of coffee. However, it is important to recognise that this work would not have been possible without the guidance and support of a wide range of people and organisations. I wish to thank some of these here.

To start with, I would like to thank my supervisors: Dr John Sturzaker and Professor Thomas Fischer (University of Liverpool). It is hard for me to articulate how much I have valued, and continue to value, their tireless generosity, encouragement, and friendship.

I must say thanks to the Economic Social Research Council and North West Doctoral Training Centre who provided the funding for this research. I am also grateful to those practitioners who responded to my call for interviewees and survey respondents. Without this generosity of spirit, the research would not have been able to draw upon the mounds of rich data that they provided.

I would also like to thank all the staff at the University of Liverpool's Department of Geography and Planning – Dr Olivier Sykes, Dr Richard Dunning, Dr Urmila Jha-Thakur, Professor David Shaw, Dr Lynne McGowan, to name but a few. Many thanks also go to my fellow PhD students (including a certain Dr Bertie Dockerill) for providing me with invaluable advice and friendship over the last four years. To John Farrell, thanks for sharing an office with me and providing the musical soundtrack to the working week.

'Upon the broad minds and vision of our Local Authorities the future health of our population depends'

Dr George M'Gonigle
'The Housewives Champion'
Chief Medical Officer 1924-39
Stockton-on-Tees

Part I
Introduction and background

1. Human health: a "new" agenda for urban planning

This first chapter of thesis provides an introduction and background to the thesis. It sets out the genesis of the work, the main research problem explored, and the structure of the thesis. As an introductory thesis chapter, it is perhaps longer than most. This is because it includes an overview of the history pertaining to the advent of urban planning, the role played by public health in this, and the modern context within which the intersection between urban planning and public health should be understood.

1.1 Introduction

Over the past century, the world's human population has experienced an increase in size three times higher than during its entire prior history. In 1900 the total human population was around 1.65 billion. By 2017, it had increased to over 7.5 billion (United Nations 2017: 1). The same period experienced an unprecedented demographic transition from rural to urban living. In 1900, just over 13% of all people lived in urban areas. Today, statistics indicate that over 50% of humans live in urban settlements (United Nations 2006: 1). By 2050, it is anticipated that than 72% of all people will be urban residents (United Nations 2008: 3-4).

The growth in urban living has undoubtedly increased the living standards and quality of life for great swathes of people. Cities are crucibles of social, cultural, economic, and technological innovation. They provide physical settings for people to live, work, and play, housing processes and structures for societal functioning, development, and healthy living (Bettencourt et al. 2007; Dye 2008; Johnson 2008). But for some, including Patel and Burke (2009: 741), the "urbanisation transition" is 'happening chaotically, resulting in a disorganized landscape'. It is also occurring in many places at the expense of ecological sustainability (Ehrlich et al. 2017) and social wellbeing (Barton

2017). In recent years, the terms "urban penalty" and "urban disadvantage" have begun to gain increasing traction in the modern vernacular of cities (Roth 2017).

Worryingly, from a public health perspective, there is now mounting concern about a growing threat to urban health. This threat consists of both "persistent issues" – e.g., increasing concentration of urban poverty in certain regions, and changing family structures – and "emerging issues", such as climate change, rising inequality, and evolving trends in urban governance and management (WHO 2011). Over the past several decades, urban governance structures in many places have overseen the "building in" of unhealthy conditions into the fabric of towns, cities, and other settlements (Larkin 2003; Frumkin 2003; Barton 2009, 2017; Allen et al. 2010; World Health Organization & UN-Habitat 2010). This has resulted in, among other things, a negative overall impact on people's physical and mental health, alongside the creation of living environments in which opportunities for human health (health) are frustrated (Knox 2003).

Although health is determined by a multitude of factors (Wilkinson & Marmot 2003), many pressing health problems have been linked to the design and quality of the urban environment. Issues that impact on health and that have associations with the urban environment include physical activity, diet, employment, and community cohesion (Rao et al. 2007). Again, it is important to stress that the determinants of health are many and cover physical, social, cultural, and environmental factors. However, it cannot be ignored that urbanisation and urban residency is increasingly being linked to transformations in lifestyle and behavioural patterns – including unhealthy diets and physical inactivity – that are driving up the incidence of disease. This is particularly true of "lifestyle" diseases, more accurately termed non-communicable diseases (NCDs)[1] (Larkin 2003; Rao et al. 2007). Indeed,

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[1]A non-communicable disease (NCD) is a disease that is non-infectious and non-transmissible among humans (Kim & Oh 2013). NCDs have been identified by the World Health Organization as a pressing 21st century health challenge – with the four main types being: cancer, cardiovascular disease (CVD), chronic lung disease, and diabetes (World Health Organization 2014a).

NCDs, such as obesity[2], are a pressing health concern across the world (Beaglehole et al. 2011; Hunter & Reddy 2013; Allen 2017).

Evolving attitudes to and conversations about health have emerged at a time of growing change in the way public health is thought about and reflected upon. A growing awareness that health is determined by economic, social, cultural, and environmental forces has led to the realisation that public health interventions must go beyond an exclusive focus on providing healthcare and treating disease. A successful mix of public health interventions and strategies must also include those that aim to tackle the causes of disease and sickness, including tackling the place-based or environmental causes of disease. Increased understanding of the complexity of the determinants of health has led to the recognition that public health should not only be the reserve of health professionals Instead, public health must involve all those stakeholders who can and do affect health (Sarker et al. 2014).

The ongoing challenge to the monopolisation of health promotion by health professionals has made room for other professionals and disciplines to join the crusade against current and emerging health threats (Carr et al. 2006). This includes the field of urban planning, but also other built environment disciplines such as urban design and architecture. A new zeitgeist is now capturing the academic, professional, and policy-making world, together looking to formulate novel approaches to urban governance and adopt "better" ways of planning the urban landscape to make the conditions within it more conducive to health. Today, the concept of – or at least the idea and phrase – "healthy urban planning" (HUP) is rapidly becoming part of the lexicon of 21st century planning research and practice. Though much has now been published on the HUP, and despite the general buzz from the academic

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[2]Obesity is defined by the World Health Organization as an 'abnormal or excessive fat accumulation that may impair health' (WHO 2017). Obesity is a major risk factor associated with increased morbidity and mortality from many NCDS, but it is also well recognised as a disease in itself. Lake & Townshend (2006: 262) describe obesity as 'significant health and social problem, which has reached pandemic levels'. Since 1975, the prevalence of obesity has tripled. In 2016, almost 1.9 billion adults worldwide were overweight – over 650 million of which were classified as obese (WHO 2017). In England, obesity is said to be at "epidemic levels" (AMRC 2013) and an estimated 24% of men and 27% of women are now classified as obese (Scantlebury and Moody 2015: 7).

community on how considered HUP can achieve health improvement, it is a nascent subject.

As a concept, area of study, and focus for practice, HUP is still forming and being defined. The ambiguity that surrounds the theoretical and empirical validity of HUP creates much opportunity for research, alongside room for controversy, conflict, and challenge as to the concept's meaning and value. The research documented in subsequent chapters of this thesis has sought to expand the existing knowledge of the conceptual, philosophical, and practical issues embedded in the task of "planning for health". It is the hope of the author that this thesis will stimulate further research around HUP and will form the basis for constructive dialogue between all stakeholders of the planning process on the issue of health.

The remainder of this chapter is dedicated to setting out the background for this thesis, as well as outlining the main research problem and aims of the work.

1.2 Health in the planning project

The purpose of this section of the chapter is to trace the history of modern English urban planning through a public health lens, starting from the early 19th century and working up to the modern day. The story of urban planning is long and its relationship with public health complex, and the author does not intend to provide an exhaustive history here[3]. Instead, it is the author's intention to provide an overview of and insight into the changing focus of health within urban planning.

1.2.1 The birth of modern urban planning

Throughout the 19th century, the social, economic and physical landscape of Britain experienced dramatic upheaval (Ashworth 1968; Kotkin 2005). The industrial revolution had brought with it, and was itself driven by, advances in science and technology. Innovative ways of manufacturing and transporting goods and resources emerged, fuelling a transition away from craft manufacturing to mass industrial production, and the development of new industrial forms. Considerable industrial growth occurred in existing regional towns and cities, alongside the creation of new industrial villages. New urban employment resulted in mass inward migration from surrounding rural areas, consequently leading to rapid urbanisation. At the same time, there was also considerable population growth.

Uncontrolled urban growth resulted in a sprawling mix of residential and industrial uses in many towns and cities (Kotkin 2005). The expansion of urban areas as centres of production and consumption had both positive and negative impacts on their citizens. Many urban dwellers witnessed their quality of life deteriorate (Ravetz 1986). Most urban centres were overcrowded and unsanitary, and many were heavily polluted due to industrial and human activity. They also often lacked the basic public infrastructure essential to

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[3] For a more comprehensive historical account of 'health and urban planning', see Barton (2017) or Freestone & Wheeler (2015).

liveability, such as adequate drainage and waste removal systems. Outbreaks of infectious disease were inevitably triggered and exacerbated by such "unhealthy" conditions (Ashton 1992a). For example, outbreaks of cholera, typhoid, scarlet fever and small pox had a dramatic impact on urban morbidity and mortality rates in Britain (House of Commons 1999). This bleak situation was further compounded by widespread poverty. In the 1880s, for instance, almost one-third of Londoners lived in poverty (Wohl 1983: 44).

By the mid-19th century, the industrial city was described by commentators of the day as "decaying" and in need of urgent reform. In his book on the *Condition of the working class in England* (1845), Frederick Engels, an influential German philosopher and social scientist, described in graphic detail the abysmal environmental conditions within a working-class district of Manchester:

> 'Above Ducie Bridge there are some tall tannery buildings, and further up there are dye-works, bone mills and gasworks. All the filth, both liquid and solid, discharged by these works finds it ways into the River Irk, which also receives the contents of the adjacent sewer and privies. The nature of the filth deposited by this river may well be imagined. If one looks at the heaps of garbage below Ducie Bridge one can gauge the extent to which accumulated dirt, filth and decay permeates the courts on the steep left bank of the river. The houses are packed very closely together and since the bank of the river is very steep it is possible to see a part of every house. All of them have been blackened by soot, all them are crumbling with age and all have broken window panes and window frames.'

The work of Engels and his contemporary writers challenged the status quo. Their observations and prognostications contributed to the creation of a social consciousness on the importance of a healthy population for the proper functioning of society. Also significant in this event was a report commissioned by the House of Lords: the *General Report on the Sanitary Conditions of the Labouring Classes of Great Britain* (1842). Written by Edwin Chadwick, a

revered pioneer of public health reform, the report demonstrated the link between the urban environment, sanitary conditions, overcrowding and health outcomes. The findings from this report were instrumental in the founding of the Royal Commission on the Health of Towns (1843) and the Health of Towns Association (1844).

These organisations, coupled with the efforts of other public health activists, pushed through an ambitious agenda of reform that became known as the "Sanitary Revolution". A wave of Public Health legislation was introduced through the second half of the 1800s. Public Health Acts, including the Public Health Act of 1875, created new responsibilities for local authorities towards sanitation and public health more broadly – including allowing them to control and co-ordinate the construction of sewage systems, as well as compiling and imposing new by-laws such as those relating to building codes (including those stipulating minimum housing standards, minimum separation of buildings and land-uses, natural lighting requirements, and street widths).

In parallel with municipal schemes aimed at improving the health and wellbeing of urban populations through the proper organisation of the city, there was a civic movement pushing back against the failing physical (and moral) health of the nation. This movement was led by a score of "city improvers", comprising public health and social reformists, and industrial philanthropists. These city improvers effectively reconceptualised the city as a dynamic social and public health space (Cullingworth 1976). From a planning perspective, key figures included Benjamin Richardson and Ebenezer Howard. In 1876, Richardson introduced *Hygeia, A City of Health*. Hygeia was Richardson's theoretical exposition of how a city might be designed around and function for the purpose of maximising the health of its inhabitants (Richardson 1876). Two decades later, Howard set out his vision of the Garden City. In many ways, the Garden City was a spatial manifestation of the growing social radicalism of the time.

The object of the Garden City, according to Howard, was:

> 'to raise the standard of health and comfort of all true workers of whatever grade – the means by which these objects are to be achieved being a healthy, natural and economic combination of town and country life.' (1902: 51)

Howard's notion of the "Town-Country Magnet" (figure 1) visibly illustrated the Garden City as his antithesis of the polluted, overcrowded industrial city; the Garden City being at once a compact and spacious place, economic and social, and harmoniously balancing the machine of industry and the garden of the country.

Overall, concern for public health and the creation of healthy living environments spurred the development of new laws and practices. Simultaneously, professional expertise in the areas of public health, environmental health, urban design, and municipal planning (or town planning) increased. By the end of the 19th century, all signs were beginning to point towards a nascent urban planning profession.
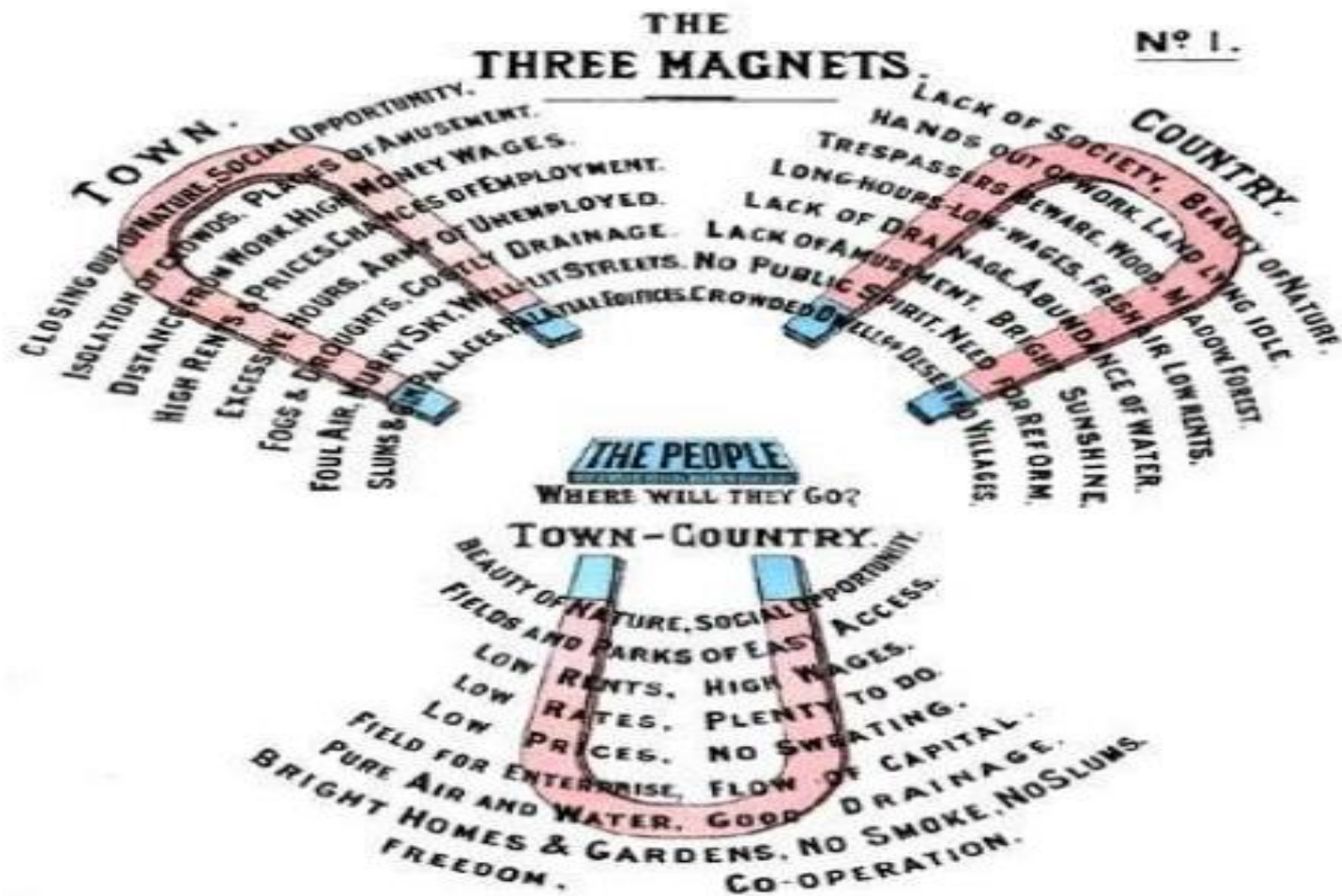
Figure 1 – The Three Magnets.
First published in *To-Morrow: A Peaceful Path to Real Reform* (1898)

1.2.2 Integration and fragmentation

The beginning of the 20th century was a defining moment in the history of modern planning. It was then that urban planning began to gain huge traction in Britain. Patrick Abercrombie, an influential British town planner, described planning as having 'suddenly made its appearance as a technique of human habit as old as humanity itself – the grouping together of human habitations' (Abercrombie 1915: 77). Planning's legislative debut came in 1909, with the introduction of the Housing, Town Planning, Etc. Act (1909 Act). The 1909 Act was the first to reference 'town planning' in its title. It sought to improve urban housing by enabling local authorities to prepare residential schemes; however, in many respects, it did not alter the preceding system of land-use control and management (which relied heavily upon building by-laws). Although the 1909 Act has been described as an inadequate response to the needs of the emerging planning profession (Cullingworth et al. 2015), it was pioneering from a public health perspective.

Planning and health were linked together by the 1909 Act through its focus on urban housing. While stronger on rhetoric than actual legislative detail, it did introduce new standards for housing development (including prohibiting the construction of 'back-to-back' forms of housing). Speaking in the run-up to its publication, the then President of the Local Government Board, John Burns, a promoter of the bill, stated:

> 'The object of this Bill is to provide a domestic condition for people in which their physical health, their morals, their character and their whole social condition can be improved… The Bill aims in broad outlines at, and hopes to secure, the home healthy, the house beautiful, the town pleasant, the city dignified and the suburb salubrious.'[4]

The notion that the purpose of planning was to create healthy environments that empower people to thrive, was further strengthened by the foreword to the practical guide that accompanied the Act. A century ago, the term 'town

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[4] J Burns quoted in Hall, *Cities of Tomorrow* (2002: 53)

planning' had only recently been coined. It was largely undefined and to the casual reader it was somewhat meaningless – even circumspect. Seeking to address this, Raymond Unwin, an influential British town planner and architect, wrote in the foreword to the guide to the 1909 Act:

> 'Town planning has a prosaic sound, but the words stand for a movement which lias [sic], perhaps, a more direct bearing on the life and happiness of great masses of people than any other single movement of our time…Town planning simply represents the attempt of the community to control development with a view to provide health.'[5]

In the decades that followed, many further pieces of planning legislation and were created. The Housing and Town Planning Act of 1919, for instance, introduced new responsibilities for local authorities to, with the help of central government subsidies, build new residential estates to meet the growing demand for housing. This Act required that all local proposals for residential development be submitted to the Department of Health for approval, prior to the start of any construction works. More notably, the Town and Country Planning Act of 1947 (1947 Act) established the legislative framework necessary for the incremental development of a "planning system". The 1947 Act introduced the concept of a flexible development plan – setting out the development proposals of a local authority – and a process of development control – which effectively democratised the use of land. This process of development control was achieved by creating a system of planning permissions (Cullingworth 1976). As Stephenson (1949:125) states, 'it put all land development rights in the hands of the state'.

As urban planning had grown out of the architectural practices of previous centuries, it traditionally focused on the design of urban spaces. It also had a concern for achieving amenity, convenience, safety and public health (Abercrombie 1959), at the same time as promoting social progress (Adams 1994). In the 1940s and 1950s, a system of strategic planning began to

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[5] R Unwin quoted in Bentley & Taylorwith, *Housing, Town Planning, etc., Act, 1909. A practical guide…*(1909: v)

develop in many Western countries (including in England) (Albrechts 2004). Yet by the 1980s, the cultural landscape of planning had radically changed, and the concept of strategic planning and development was beginning to be abandoned (Ward 2004; Thornley 2018). Planning became more disjointed and fragmented, as well as project-focused and burdened by increasingly bureaucratic regulatory processes (Davoudi & Strange 2009; Davoudi 2000; Albrechts 2004). Albrechts et al. (2004: 734) suggest that the fuel driving this retreat from strategic planning was,

> 'neoconservative disdain for planning, but also postmodernist skepticism, both of which tend to view progress as something which, if it happens, cannot be planned.'

One outcome of this process was that urban planning became less concerned with civic design and functioned more as a component of state policy. Emphasis in urban planning also shifted from environmental reform towards land-use regulation and economic growth. Health was not viewed as a leading concern for these planning goals, and thus became an increasingly marginalised interest (Nigel Taylor 1998; Tewdwr-Jones 2012; Cullingworth et al. 2015; Barton 2017). It would be wrong to assume, however, that all concern for health was abandoned. Health was still a consideration in planning; but the scope of this consideration narrowed, becoming increasingly confined to issues relating to the provision of healthcare services, minimum space standards (including internal room sizes) and sanitation, with the wider determinants of health overlooked.

Urban planning and public health had been individually carving out their own distinct disciplinary territories since the final decades of the 19th century. What had at first involved the emergence of subtle differences in understanding, eventually manifested into separate public policy processes; as well as contrasting disciplinary cultures and competing belief and knowledge systems. The separation between public health and planning (and the associated disciplines of transport, civil engineering and architecture) was partly due to planning becoming a 'victim of its own success' (Freestone & Wheeler 2015:

27). With the most immediate and pressing environmental health issues resolved, the function and purpose of planning was reassessed.

As Perdue et al. observe (2003: 1390):

> 'infectious disease had been brought under control, and as a result the layout and planning of cities came to be viewed as matters of esthetics or economics, but not health.'

A more economically-oriented planning profession emerged during the 1980s in Britain with the introduction of wide-reaching neoliberal reform (notably spearheaded by the Thatcher Administration), which championed private sector development, privatisation and the free market (Tewdwr-Jones 2012). The framework of modern planning (and public health, see below) became overlaid with a new set of operating principles, articulating a new frame of reference for the profession; one that accommodated a more neoliberal approach to land-use governance, and which focused more on "opportunities" rather than "problems". This new approach encouraged planning authorities to support economic growth and job creation, as opposed to identifying and tackling more normative issues – such as social inclusion, health and wellbeing (ibid).

The circumstances and pressures that contributed to the divorce of planning activities from those of public health came from within the public health profession, too. Since the start of the century, public health professionals had slowly begun to move away from preventative medicine towards clinical treatment. What drove this movement, was the study of germ theory – especially the contributions of Louis Pasteur (a French biologist and chemist) to the understanding of the relationship between germ and disease (Gal 2011). Medical interests, and consequently public health efforts, were refocused on the treatment of disease hosts – people – through clinical treatment and immunisation programmes (Corburn 2004). This was further enhanced by the adoption of a biomedical perspective of health (see, Chapter Three) and clinical treatment as the appropriate medical intervention to prevent and treat sickness and disease (Yadavendu 2013).

In Britain, the introduction of the National Health Service (NHS) in 1948 served to reinforce public health's preoccupation with clinical medicine. The creation of NHS services inevitably resulted in public health experts assuming greater responsibility and influence on health-related matters. Over time, planning and public health drifted apart resulting in separate, institutionalised professions. Collaboration and interdisciplinary engagement, in the main, ceased, with what joint-working there was being largely symbolic, rather than functional. The succeeding vacuum between health and planning did not go unnoticed, however. Many lamented it, with Northridge et al. (2003: 557) describing it as a lost opportunity:

> 'The loss of close collaboration between urban planning and public health professionals that characterized the post-World War II era has limited the design and implication of effective interventions and policies that might translate into improved health for urban populations.'

1.2.3 Shifting perspectives and healthy cities

From a common purpose a century ago, the connection between planners and public health professionals waned over the course of the 20th century – becoming, at times, more symbolic than functional, as health became a more marginalised concern of planning. Today, the narrative space around 'planning and health' suggests that these two disciplines are experiencing another period of close realignment. The success of the planning-health relationship is seen as critical to meeting the health needs of towns and cities (Rydin et al. 2012). It is difficult to ascertain exactly what sparked the contemporary movement towards recreating the common space between urban planning and public health. Two particular events stand out for their contribution towards strengthening the convictions to disciplinary reconciliation.

Firstly, there has been a shift in perspective among medicine (especially epidemiologists) from a biomedical to a more holistic view of health (Sarker et al. 2014). Such a view of health, notably the World Health Organization (WHO) definition of health (see, Chapter Three), has placed increased emphasis on

the importance of the environment (and its conditions) as a determinant of health. It has also contributed to the development of a new argument favouring environmentally driven health-promotion initiatives, and the development and implementation of multi-agency public health strategies and programmes.

Secondly, in the past several decades new insights have emerged on how best to approach public policy development and implementation. Such insights have focused heavily on collaborative working, drawing attention to the importance of a "joined-up" multi-agency policy-making and decision-taking (Kickbusch & Gliecher 2012). More recently, the WHO and other institutions have promoted a multidisciplinary approach and intersectoral cooperation between health and other sectors to achieve public health aims. This has been encouraged as part of the strategy of 'Health in All Policies (HiAP)' (World Health Organization 2014b). Today, HiAP has become a catchphrase for efforts to integrate health and equity into the policies of non-health sectors (Kickbusch 2013). It is an approach that recognises that major causes of illness and the major assets for health are best addressed by engaging non-health sectors and actors through policies and strategic initiatives at all levels of governance, with or without the involvement of the health sector (Kickbusch & Gliecher 2012; Rudolph et al. 2013; Becerra-Posada 2017).

Traditionally, healthcare access and provision were widely held to be the most important determinants of health. From the 1960s onwards, however, this understanding began to be increasingly challenged by a spate of new medical studies. These studies presented evidence that indicated that the effects of environmental (social and physical) factors on peoples' health are more extensive than those emanating from healthcare provision. In the late 1970s, Thomas McKeown, a British epidemiologist and medical historian, produced work concluding that improvements in British public health, since the 18th century, were primarily due to improving economic and environmental conditions including better nutrition and access to clear water supplies; rather, than the result of medical advances during the same time (McKeown 1978, 1979). The "McKeown thesis", as it became known (Colgrove 2002; Grundy 2005), argued for a redistribution of attention and resources from curative

health measures (and the treatment of disease) to environmental health measures (and the prevention of disease).

Since the 1960s, the WHO has taken an active interest in environment-related health issues (such as those linked to air and water pollution). A key concern of the WHO is urbanisation, particularly the health problems endemic to unregulated forms of urbanisation. In a 1965 report, titled *Environmental Health Aspects of Metropolitan Planning and Development*, the WHO advocated that planners and environmental health workers should work together to create healthier places – calling for public health to be given due consideration in the processes of urban planning, and for a 'greater co-operation and co-ordination on a much wider scale between planners and environmental health workers' (WHO 1965: 13). To support the development of health-planning collaboration, the WHO established an expert committee on planning and environmental health and published guidelines on the relationship between environmental health and land-use planning.

Much of the work around health and planning in past decades has been inspired by the WHO's Healthy Cities Programme. The Healthy City approach was the idea of two health physicians: Trevor Hancock and Leonard Duhl (Duhl 1986; Hancock & Duhl 1988; Hancock 1993). Launched in 1986, the Healthy Cities Programme was originally designed to contribute to the realisation of the Health For All and Local Agenda 21 principles and objectives (such as sustainable development) in the urban context (Breuer 1999). Since then, the WHO's Centre for Urban Health, Healthy Cities and Urban Governance Programme has invested significantly in supporting urban planners to design and develop healthier and safer cities. In 1997, the Director of the European Healthy Cities Programme, Agis Tsouros, launched the European Sustainable Cities & Towns Campaign (ESCTC). The involvement of the WHO European Healthy Cities Network (WHO-EHCN)[6] marked the beginning of the contemporary "healthy urban planning" initiative.

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[6] In 2016, the European Healthy Cities Network had over 1400 registered members (towns and cities). The goal of the network is to 'put health high on the social, economic and political agenda of city governments' (WHO 2017).

The HUP initiative was launched as part of a broader move to integrate the agenda for public health with that of sustainable development. Collaboration between urban planning practitioners, health professionals and academic advisors resulted in *Healthy Urban Planning: A WHO Guide to Planning for People*, which was published in 2000. After the publication of this book, the WHO Regional Office for Europe established the WHO City Action Group on Healthy Urban Planning. Members of the City Action Group, which includes planners from across Europe, have pushed forward with practical programmes aimed at implementing the principles advocated in the 2000 book. The Group has focused on two principal areas: (1) incorporating health principles and objectives into strategic planning documents and policies; and, (2) promoting specific projects that incorporate HUP principles (see, Chapter Four), for example intersectoral action and community based approaches (WHO City Action Group on HUP 2003).

Activities of the WHO-EHCN are organised into separate phases, with each phase roughly five years in length. The third phase of the Network (Phase III, 1998-2002) emphasised the need to promote health through the processes of urban planning (WHO 1997), and in Phase IV (2003-2008) health impact assessment (HIA) formed a key theme. Participation in Phase IV required cities to make commitments to health development, with particular emphasis on health equity, sustainable development, and participatory and democratic governance (World Health Organization 2003). At the time of writing, the Network has recently ended work in Phase VI (2014-2018), which placed priority on life course approaches in city policies and plans; including a focus on early child development, ageing and vulnerable populations, tackling leading public health challenges (e.g., physical inactivity, obesity and mental health issues), strengthening people-centred health systems, and fostering resilient communities (World Health Organization 2018).

1.2.4   Cities at the crossroads

The health of cities (and other urban settlements) is at a crossroads (WHO-UN Habitat 2010). With urban growth set to continue, there is a need to better consider and comprehend the future development of urban centres. This includes enhancing our understanding of the challenges and opportunities posed by current and emerging urban development; including understanding how this development will affect the environment, the economy, and members of society – including individual and collective health outcomes. Various observations have been made about the deficiences in the way that urban centres have been, and still are, planned and managed (see, e.g., UN-Habitat (2009) and Barton (2017). But not all is lost, and there are many reasons to be optimistic about future health of urban citizens. There has recently been a mass publication of agendas and strategies related to improving the health of towns and cities, and tackling the negative health (and other) effects of urbanisation and urban living.

Many such agendas and strategies have been framed around the concept of "sustainable development" (see, Chapter Four). The idea of sustainable development is now firmly entrenched in the rhetoric of international and national politics, and policy-making. On the international stage, the United Nations (UN) – of which the WHO is a specialised agency – has set the tone on the promotion and advancement of inclusive, sustainable, and healthy urban futures. In 2016, at the UN-Habitat III summit, attending nation states adopted the 'New Urban Agenda' (United Nations 2016).   This agenda establishes a normative framework for sutainable urbanisation for the coming decades (up to 2036), and calls for an "urban paradigm shift" in the way governments 'plan, finance, develop, govern and manage cities and human settlements' (ibid: 3). It, moreover, commits nation states to a 'vision of cities for all' – where all peoples are free to 'inhabit and produce just, safe, healthy, accessible, affordable, resilient and sustainable cities and humans settlement to foster property and quality of life for all' (ibid: 2).

The New Urban Agenda sets out a vision for future urban governance and management. It also serves as a means for achieving the seventeen UN Sustainable Dvelopment Goals (SDGs). These SDGs were introduced in 2015 to replace the previous Millenium Development Goals (MDGs). SDGs vary in scope and focus, and include, for example, SDG 3 and 11 which focus on 'good health and wellbeing' and 'sustainable cities and communities' respectively. According to the WHO, the "pulse" running throughout both the New Urban Agenda and the SDGs is health and wellbeing (WHO 2016). The WHO also acknowledges that the achievement of the SDGs will require a global effort. This effort needs to be built on action, collaboration, and cooperation at multi-scalar levels – from the very local through to the national and international levels.

Urban governments are being increasingly challenged by the WHO, alongside other national institutions and the wider academic and professional community, to think about how towns and cities can be transformed into spaces for health. Much of the focus of this challenge has been directed towards national and local urban planning policy and guidance, which collectively is used for development management purposes – thus helping dictate future urban development. It has been argued, for example, that the relationship between health and land-use is often absent from the urban governance equation (RCEP 2007) and that it is time for towns and cities to use the planning system as an instrument for acheving sustainable, healthy development (Newman 2004; Patel & Burke 2009).

In what has been described, by Sarker et al. (2014), as rerun of the early 20th century, the first decade of the 21st century witnessed urban planning being heralded as a powerful antitode to urban health problems. Interest in HUP in the UK has come from a variety of sources, including academics, policy-makers and professionals working within and outside the disciplines of urban planning and public health (e.g., Barton 2009, 2017; NICE 2008; RTPI 2009; Geddes et al. 2010; TCPA 2013)[7].s The House of Commons Health

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[7] The UK is not the only nation in which actors are consciously pushing for the reintegration of health into urban planning – the same is happening across continental, in the USA, Australia, and elsewhere.

Committee on Health Inequalities in 2009 stated, 'In our view, health must be a primary consideration in every planning decision that is taken' (p.111). Moreover, a raft of strategies and initiatives have been proposed across the UK aimed at arresting or even reversing the growing human and financial cost of sickness and disease. These include those focusing on specific health issues, such as obesity and diabetes, but also wider health-oriented programmes. In 2013, for example, Public Health England (PHE) launched 'Healthy People, Healthy Places: building a healthy future'. This programme encourages, inter alia, the use of development regulation and spatial-retrofitting of existing urban spaces as mechanisms for creating healthy places (PHE 2013).

The link between urban planning and health was also made in a 2010 public health White Paper in England – 'Healthy Lives, Healthy People'. This White Paper explicitly noted that 'Health considerations are an important part of planning policy' (para. 3.35). The 2010 'Strategic Review of Health Inequalities' in England, more commonly known as the Marmot Review, also drew attention to the role of urban plannng in public health. The review highlighted that planners can assist in the provision of employment opportunities through local plans, achieved by allocating land in suitable locations and enforcing policies that protect local employment spaces. It is also included recommendations with direct relevance for the planning system, including several under the heading to 'create and develop healthy and sustainable places and communities' - Policy Objective E (p. 30).

One recommendation reads (p. 134),

> 'Fully integrate the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality.'

The Marmot Review called for greater systematic concern about the impact on health and health equity from urban development in the planning process. Authors of the report argued that (p. 134-135),

'… the lack of attention paid to health and health inequalities in the planning process can lead to unintended and negative consequences. A policy planning statement on health would help incorporate health equity into planners' roles.'

Today, there is now strong indication of growing parallel interest in health among the planning community. This is evidenced by, among other things, the organisation of the 'Reuniting Planning and Health' Economic and Social Research Council (ESRC) seminar series (2015-16); the establishment of the UK 'Spatial Planning & Health Group' in 2010 (SPAHG 2011); the publication of a report by the Royal Town Planning Institute (RTPI) subtitled *Why planning is critical to a healthy urban future* (RTPI 2014); and the launch of the UK-wide 'Reuniting Health with Planning' initiative by the Town and Country Planning Association (TCPA) in 2010, which has resulted in over ten publications on the theme of 'Health and Planning' – including two special issues of the TCPA's journal on this subject, one published in 2014 and another in 2016.

The goal of integrating health back into urban planning was given additional stimulus in England by recent changes to national public health legislation and planning policy. In March 2012, the NPPF was published and immediately superseded existing national planning policy (see, Chapter Eight). The Framework contains a number of health-related provisions. These include establishing 'a social role" for planning as that of 'supporting strong, vibrant and healthy communities…' (paragraph 7), as well as encouraging collaboration and cooperation between local planning authorities (LPAs) and local public health leads (and organisations) (paragraph 171).

Many new statutory duties for public health were conferred on local authorities in England by the Health and Social Care Act 2012. This Act introduced a new duty for all upper-tier and unitary local authorities (in England) to take appropriate steps to improve the health and wellbeing of communities and individuals living in their area. It also provided new organisational arrangements for local health and social care provision, designed to ensure (inter alia) better integration between public health and other local authority policies and strategies. This and other arrangements introduced by this Act,

coupled with the relevant paragraphs of the NPPF, represent (at least in theory) an opportunity to strengthen the relationship and collaboration between public health and urban planning professionals - especially at a local level in England.

1.3 Project details

This section of the chapter lays out the genesis of the research, alongside the main research problem explored and the study aims and objectives that flowed from this.

1.3.1 Genesis of the research

The genesis of this research project rested on many things, from the observations of other researchers to the author's own experiences. It mainly lies, however, in a decision made by a Borough Council in England to allow the development of a McDonald's fast food restaurant on the edge of a recently regenerated local district centre (see, Blackburn 2013a, b and Stockton-on-Tees Borough Council 2018). The council in question is Stockton-on-Tees Borough Council and the district centre is that of Thornaby district centre[8]. Thornaby – or Thornaby-on-Tees – is a royal charter town and civil parish located in the north east of England, it is in the unitary authority of Stockton-on-Tees and is a town with deep personal connections to the author.

In many respects, the decision of a unitary authority to permit the construction of a fast food restaurant in a socio-economic setting consisting of other shops and services (including other fast food restaurants) may seem quite ordinary, even routine. Yet, from a health perspective and in the context of both this research and the actual "decision-taking context", this decision is particularly interesting. The development is located immediately adjacent existing residential development and within close proximity to three schools, two of which (a primary and secondary school) lie less than four hundred metres away. This work does not seek to pass judgement on the merits or harms of permitting this development, as undoubtedly multiple complex social,

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[8] A 'district centre' will typically comprise a group of shops and services, together with other appropriate supporting non-retail facilities and services, laid out in a coherent manner. District centres are often accessible by a means of transport and/or within walking distance of the local population.

economic and political factors were contended with as part of the decision-making process (see, Stockton-on-Tees Borough Council 2013).

But what is interesting is that this development proposal was granted planning permission at a time when concern about the links between fast food availability and obesity in the UK and elsewhere had been growing for a number of years previously (Cummins et al. 2005; Lake & Townshend 2006; Townshend & Lake 2009; Fraser & Edwards 2010; Fraser et al. 2012; Garcia et al. 2012; Wright & Aronne 2012); the high prevalence of diet-related obesity was recognised as having a negative impact on the health of the Borough (Kelly 2013); and within the literature there was increasing focus on the use of environmental interventions to control the proliferation of fast-food outlets with a view to safeguarding and improving population health (Pothukuchi & Kaufman 1999; Butland et al. 2007; Department of Health 2008; Chartered Institute of Environmental Health & London Food Board 2012;). This included increasing emphasis on the role of urban planning in creating food environments that promote the access and availability of healthy foods, thus supporting healthy diets and positive health outcomes (Morgan 2009; Sallis & Glanz 2009; Northridge & Freeman 2011; Dannenberg et al. 2011; Brinkley 2013).s

Against this background, this work initially sought to investigate the role of local planning policy in guiding the development of food environments and the consequential health effect. The original funding application for the research outlined the context and framework for a study into this subject matter, i.e., the urban planning of food environments and the related health outcomes. Early in the progress of this ("first") study it became apparent that this approach had certain limitations. This included the problem of measurement, especially in establishing a causal or even contributory connection between planning policies, diet and health. This last factor – health – would prove a major frustration in this regard, as the ambiguous, contested nature of the concept created uncertainty in respect to what it was the author was attempting to measure. To that end, the author resolved to undertake further reading on the wider subject of urban planning and health. Based on this, the study's direction and scope were revised to focus more on the concept of "healthy urban

planning" and the structural, institutional and epistemological factors that affect the practice of HUP and the integration of health and urban planning at the local level in England.

1.3.2 Problem statement

What is planning? Why do we plan? How do we plan? Questions such as these have formed the basis of many inquires in the field of urban planning. Yet, "urban planning" is a rather elusive term. It has been conceptualised in many ways through the past century, and it has also been defined along distinct lines. Urban planning has been perceived as a utilitarian means for implementing sanctioned policy, as well as a means for social change; a purely scientific endeavour, as well as an intrinsically political activity; among other perceptions (Allmendinger 2017). What binds many conceptions of urban planning together, and thus supports the identification of one distinct concept, is the general understanding that urban planning is future oriented and is a '… professional practice that specifically seeks to connect forms of knowledge with forms of action in the public domain' (Friedmann 1993: 482). Urban planning involves an idea (or vision) about the future and how to implement it.

By having an idea or objective(s) about the future, urban planning is distinctly normative in nature. It has an interest in how things "ought-to-be", with this somehow different to the current actual state – the "is-state" (Fainstein 2000). The concern for human health is a recognition of the normativity in urban planning. An approach that has been termed "healthy urban planning" is being created that acknowledges the needs of people and encourages a discourse about human health and wellbeing (Duhl & Sanchez 1999; Barton & Tsourou 2000; Barton 2017). However, how and on whose terms these needs are determined, how health and wellbeing are defined and how they are judged is still very much open to debate. It has been argued that while health and wellbeing are concepts that have become a key part of the political and policy vocabulary, they have been taken for granted from both a conceptual and practical perspective (Bond & Corner 2004).

Institutions and researchers are helping to further this concern by interpreting and relaying evidence that urban form and environment are linked to health, and through its role in shaping the components of these spaces urban planning is too linked with health (e.g., PHE 2017). Healthy urban planning encourages us to view health not as an adjunct but as the goal of urban planning (see, Chapter Four). Rather than asking what is healthy or unhealthy within the "proper" order of things, rather than making health contingent or reliant on an additional factor (e.g., a successful economic return from a development), this approach has an essential occupation with how urban planning can facilitate the delivery of development that is equitable and sustainable, and which promotes health objectives – needing what Barton (2012: 17) observes as a revision to the mainstream view of the planner, from that of "plan maker" to that of "settlement doctor" whose job is to 'diagnose the potential health-damaging effects of place shaping and prescribe remedial solution advice to politicians and policy-makers'.

Despite a growing body of opinion and research indicating an association between health and urban planning, evidence on where, how and the outcomes of HUP interventions is lacking. Moreover, the concept of HUP remains comparatively understudied compared to other concepts used in urban planning – such as sustainability and sustainable development, urban growth, space and place, among others. In the early 2000s, and based on the findings of a study into the efforts of a group of cities in the WHO-ECHN to introduce health into their municipal planning practices (see, Chapter Four), Barton et al. (2003: 56) wrote that HUP is,

> 'a multifaceted field that still needs to be explored to its full conceptual depths as well as policy and practical implications'.

This observation still holds today, with its implications a catalyst for this current research. As the literature discussed in this chapter and throughout the thesis attests, interest in HUP has significantly increased in recent times; this well evidenced by the expanding number of publications directly regarding or closely related to the subject. As with any emerging field of practice and inquiry, gaps remain in our knowledge with respect to certain aspects of it. For while there has been much discussion about the relation between health and

urban planning, an outline of the range of understandings and definitions of what constitutes HUP from the perspective of those involved in its delivery is lacking. Wright (2001) has written of the importance of meaning within an urban planning context, and the need to actively interrogate the diversity and evolving meanings attached to concepts both from a theoretical and practical angle. Through the acceptance that the meaning of some concepts is fuzzy and contested, and through the interrogation of meaning it can be possible to secure wider benefits in different theory and policy spheres as well as on the ground (ibid).

If meaning has normative implications for how the users of a concept ought or ought not to use it (Gallie 1964), then it follows that it is necessary to examine and develop a framework for HUP that is cognisant of the wide range of meanings attached to health and the theoretical and practical consequences of their use. But this need for knowledge also extends beyond the meaning of the concept of health itself. The integration of health within planning policies, what form this integration takes, and what effect this integration is having on population health remain debatable and open to further empirical investigation. Similarly, further research is needed to identify those institutional, structural and technical factors that promote or inhibit the successful the practice of HUP and the wider integration of health into local urban planning.

Work conducted over the past decade has made an important contribution to our understanding of HUP and the practice of "healthy urban planning". Taken together, this has provided valuable insight into multiple aspects of this topic, uncovering distinct features of how health is integrated within planning policy and practice, and the factors that can serve as barriers or opportunities for promoting health through urban planning. While still relevant and insightful, much of the existing research on the English urban planning context was undertaken in the context of a previous legislative and national policy framework, which pre-dates the NPPF (2012). Without taking aim at the methodology and thoroughness of extant work, it does ultimately provide only a snapshot of a much bigger and dynamic process, and, therefore, conclusions obtained from these studies are invariably limited.

To further contribute to existing knowledge and provide new insights into the concept and practice of HUP, and the wider integration of health within urban planning, there is a need to revisit the conceptual space, epistemological space, and implementation space surrounding the concept. And to explore these "spaces" within the context of new developments, thinking and an updated national policy and legislative sphere in urban planning in England.

1.3.3   Research aims and objectives

The main aims and objective of this research project are outlined below.

Aims of the research

The purpose of this research is to help inform the future development of healthy urban planning (HUP), by investigating and identifying those factors that underpin its theory and shape its practice. Consistent with this, the twin aims of this research are to develop a further theorisation of HUP as a conceptual and epistemic framework and practical enterprise for planning activity; and to generate new empirical knowledge and understanding in regard to the implementation of HUP and the integration of health and urban planning at the local level, contributing in turn to the ongoing debate on the position of health as an attribute of the planning process. These aims are intertwined, meaning that definition and theorisation is necessary to support new empirical knowledge (and vice versa).

Objectives of the research

The research underpinning this thesis has one primary research objective and three secondary research objectives. The primary research objective directly addresses the need for knowledge and theoretical development on healthy urban planning. The first two secondary research objectives are theoretical, while the third and fourth are empirical and support the necessary empirical investigation. Realising these secondary research objectives will contribute to meeting the primary research objective.

The primary research objective is:

PO - To elaborate and deconstruct the epistemic, technical and structural features that shape the conceptual and practical dimensions of healthy urban planning.

The secondary research objectives are:

SO1 – To examine the interface between urban planning and health, including reviewing relevant planning and health policy, practice guidance, and academic and non-academic literature on the topic.

SO2 – To explore how the concept and application of healthy urban planning, both as an independent concept and two separate areas (health and planning), has been described and theorised.

SO3 – To identify how health and the roles and responsibilities of planning towards it have been considered and described in national and local planning policy.

SO4 – To describe and interpret practitioners' own experiences and perspectives on the role, responsibility and challenges of healthy urban planning and the wider integration of health into the local urban planning process.

These research objectives are developed, following the literature review presented in Chapters Two to Five, into a set of research questions, which can be found at section 6.2.

1.4 Structure of the thesis

This thesis comprises ten chapters, which are divided into five parts.

Part I incorporates Chapter One which provides an introduction and background to the work, outlining the genesis and aims of the study.

Part II includes Chapters Two through Five which present the findings of a comprehensive review of literature around the subject of health and urban planning, with Chapter Two and Three focusing on 'The Concept of Health' and Chapter Four and Five looking at the concept, principles and practice of 'Healthy Urban Planning'.

Part III includes Chapter Six which details the research strategy underpinning the empirical component of this study. It includes discussion of the chosen methodology, theoretical perspective, and research design (including the selected data collection methods), as well as the data sources that were used and how collected data were analysed.

Part IV comprises Chapters Seven through Nine and presents the findings of the empirical data collection, with Chapter Eight comprising a discussion of the stakeholders approach to healthy urban planning; Chapter Eight looks at the planning system and policy landscape for health in England; finally, Chapter Nine seeks to develop an understanding of the factors that serve as barriers and opportunities to the application of HUP.

Part V includes Chapter Ten which discusses and reflects upon the principal findings of the work, including their implications for current and future practice and research, and presents the conclusions and recommendations of the work.

Part II
Healthy urban planning: theoretical and empirical perspectives

A review of the literature

In recent years, much has been written on the role and contribution of urban planning in public health efforts. With the focus of this thesis on healthy urban planning (HUP), and the wider relationship between urban planning and public health, it is important to contextualise and explore this literature. To this end, a detailed review of the literature[9] (or "literature review") was undertaken. The literature review had three main purposes:

- summarising and gaining a better understanding of the literature on and around the theme healthy urban planning;
- identifying gaps in the literature that can be filled by this research; and,
- providing a theoretical and empirical background to support the design of this research study (see Chapter Six).

Undertaking a literature review can be a lengthy, complex, and – by the author's own admission – an arduous process. Regarding this study, the main difficulty encountered when conducting the literature review was that of "scope". More specifically, how to appropriately delimit the scope of the review; in other words, how to decide what to include and what to exclude. This issue, which admittedly is common to all literature reviews, derived from the fact that "healthy urban planning" is a diverse and expansive topic of study.

While rooted in the field of urban planning, HUP is not bounded by disciplinary affiliation. HUP is a multidimensional concept; it spans across many fields of social and medical science – pathology, population and public health, politics, medicine, epidemiology, sociology, planning, philosophy, among others. In trying to account for this, the literature review process was designed to cover, in equal measures, the following dual themes: (1) the concept and determinants of health, and (2) the concepts, challenges, and the practice of healthy urban planning.

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[9] The literature review covered both peer-reviewed – such as scientific journals and books – and grey literature, including government documents, conference papers, reports, and media publications. It focused on texts published up to Summer 2017, although some later texts were retrospectively included in the review.

The literature review is presented across four chapters, which together aim to incrementally develop a comprehensive overview of the theoretical and empirical elements of HUP. These four chapters are split into two sections. Section One (Chapter Two and Three) focuses on the theme of "the concept and determinants of health". Section Two (Chapter Four and Five) focuses on the theme of the "concepts, challenges, and practice of healthy urban planning". A discussion and summary of the research issues suggested by the literature review are presented at the end of Chapter Five.

Section One
The concept and determinants of health

2. The determinants of health

This chapter explores the determinants of health and contains sections on individual categories of health determinants. It starts by examining the wider determinants of health, outlining the role that these have in shaping people's health behaviours and outcomes. The chapter then explores the spatial dimensions of health, looking at the interaction between the urban environment and health.

2.1 Introduction

Human health is affected by a host of factors, things and conditions. Together, these affectors are referred to as the "determinants of health". It is important to understand what influences people's health for many reasons, not least because it is the first stage in developing effective public health policies and strategies. Gaining this understanding requires us to look at health through a "determinant" lens (McKeown 1978). To this end, this chapter explores the determinants of health. It does so by looking at two broad categories of health determinants. Firstly, it looks at the concept of the wider determinants of health. Secondly, it looks at the spatial dimensions of health.

2.2 The wider determinants of health

The wider determinants of health, also known as social determinants, are a diverse range of economic, environmental and social factors which impact on people's health. Wider health determinants with immediate relevance to urban planning include policy-making, social context, healthcare, and health behaviours (Barton & Tsourou 2000). An overview of some of the essential elements of each of these four wider determinants is presented below.

2.2.1 Public policy-making

Over past decades, there has been a growing recognition of the impact politics and public policy-making can have on people's health. Mooney (2011), for example, touches on the important role 'political context' plays in influencing health at the population level. The act of policy-making has been described as being 'a technical and political process of articulating and matching actors' goals and means' (Howlett & Cashore 2014: 17). Policies are actions that contain predefined goals and outline the means to achieve them; as opposed to laws (or legislation) that set out legal standards, procedures and principles that must legally be adhered to. Many definitions of 'public policy' are available in literature, but one of the simplest and most succinct is offered by Dye (1972: 2): '[public policy] is anything a government chooses to do or not to do'.

Many organisations and institutions create polices which their members and actors must follow, however Dye's definition points to the national government as being the primary agent of the public policy-making process. While the decisions made by other actors, such as private businesses and charitable organisations, may play a significant role in public policy-making, national governments enjoy a special status in the policy-making process. That is, that they have the unique ability to make authoritative decisions on behalf of their populace (and the private sector) (Howlett & Cashore 2014). The establishment of public policy is said, by de Leeuw et al. (2014), to be key in planning and implementing actions for health.

Policies at the local, regional, and national level affect the health status of individuals and populations. There are growing claims that the political determinants of health have, to date, not received due consideration from researchers, policymakers and health professionals (Bambra et al. 2005; Bernier & Clavier 2011). Public policies from both within and outside the health domain are increasingly recognised to have a significant impact on population health and health inequalities (Wilkinson & Marmot 2003). The realm of public policy is vast and there are a wide range of public policy issues – some traditionally associated with health, some not – that can directly or indirectly influence population health.

Public policies affect the drivers of health in numerous ways. This may include public policy in the international arena, such as on human rights (e.g., the European Convention on Human Rights), as well as domestic regulation of healthcare and social services; education; food access and standards and those policies that create, regulate and maintain urban and built environments (ibid). In addition to being aware of suitable policy options, several authors have drawn attention to the role of the politics and the legal organisation of public policy-making process in the creation of health inequality and inequity[10] (Marmor et al. 2005; Kjellstrom 2007; Navarro 2008). Politics and regulation influence opportunities for participation in the policy-making process, alongside guiding the content and impacting the implementation of public policy.

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[10] The terms "health inequality" and "health inequity" are often used in discussions concerning public health. These terms are sometimes confused but are not interchangeable. Health inequity refers to unfair, avoidable differences that arise from poor governance, corruption or cultural exclusion. Health inequalities refers to the uneven distribution of health and/or health resources as a result of genetic or other factors, or the lack of resources.

2.2.2 Healthcare

Healthcare is defined by the WHO as all those 'services provided to individuals or communities by health service providers for the purpose of promoting, maintaining, monitoring or restoring health' (WHO 2004: 28). There are a wide variety of healthcare services available, with healthcare delivery systems (including hospitals and clinics) providing three main types of service:

- **Health promotion and disease prevention services** – those which aid people in reducing the risk of disease, maintaining optimal function, and adopting a healthy lifestyle. These services are provided in a variety of ways and settings, and include, for example, immunisation and prenatal nutrition classes offered by hospitals and local health centres, educational efforts aimed at involving patients in their own care (including increasing knowledge of and how to mediate risk factors); promoting better health through lifestyle changes such as public health education programmes on healthy eating and physical activity such as Change4life; as well as social prescribing and encouragement to join physical activity programmes designed to encourage aerobic exercise (e.g., walking groups, running clubs, swimming session at a local leisure centre); and legislation and regulation on health risks, for example, alcohol, tobacco and sugar.
- **Disease diagnosis, treatment, and prevention** – traditionally services aimed at diagnosing and treating disease have been the most used healthcare services. It was often the case that people would wait until they were "ill" before seeking medical attention; however, advances in technology and early screening and diagnostic techniques have significantly improved the capacity of healthcare delivery systems to screen for, diagnose and treat disease e.g. breast cancer screening, diagnoses and treatment.
- **Rehabilitation** – involving services aimed at restoring a person to normal, or near normal, function following physical or mental illness (or injury). Rehabilitation programmes take place in many settings, such as

people's homes, community centres, specialist hospitals and extended care facilities.

There is some evidence to suggest that access to and the quality of available healthcare can have a significant impact on individual and population health (Wilkinson & Marmot 2003; Aakvik & Holmås 2006; McGibbon et al. 2008; Gu et al. 2009; Langheim 2014). For example, a Spanish study, which used a population-based sample of elderly residents living in Barcelona, found that "unmet" health needs was associated with an increased risk of mortality – especially for senior citizens living with two or more chronic conditions (Alonso et al. 1997). Access to healthcare is a principal factor in determining the probability of an individual or community participating in preventative care or receiving necessary medical treatment. Several studies, that have examined the relationship between healthcare access and diabetes control (and prevention), have concluded that access to and the use of healthcare services is positively associated with both the control and treatment of diabetes (Zhang et al. 2008; Zhang et al. 2012), and prediabetes awareness (Campbell et al. 2016).

More recently, a number of studies have explored the role of health insurance in rates of healthcare usage and community health outcomes. Much of the research efforts on health insurance have focused on the United States, where the presence of health insurance is a key determinant of access and use of healthcare services. Evidence of the negative health consequences of "uninsurance" has strengthened over recent years. Studies have linked a lack of insurance to adverse health outcomes (including declines in health and function), preventable health problems, lower self-reported health status, lower use of physician and preventative services, and premature mortality (Goins et al. 2001; Freeman et al. 2008; Card et al. 2008; McWilliams 2009; Gaudette et al. 2017). Card et al. (2008) explains that the differential in health outcomes between those with and those without health insurance could be due to early detection and diagnosis of health problems arising from more frequent usage of healthcare services.

2.2.3 Social context

Social context tends to be encompassed within what are known as the "social determinants of health" (SDOH). Social determinants of health are specifically those non-medical factors that influence health. They include socioeconomic status, personal health-related knowledge, norms (attitudes and beliefs) and behaviours (e.g., diet, physical activity) (Bharmal et al. 2015). Although SDOH are not typically directly responsible for illness or disease, they have been described as "the causes of the causes" of illness and disease (Marmot 2005). SDOH serve to structure people's behaviours and lifestyle choices, which interact to produce positive or negative health outcomes.   Marmot (ibid) explains that SDOH may give rise to NCDs by acting through unhealthy behaviours, or even through the effects of lifestyle and work stresses. SDOH are also seen as being primarily responsible for health inequities (Wilkinson & Marmot 2003; Allen et al. 2010).

The range of SDOH is extensive, and it is reasonable to assume that no single model will capture their full extent. There have been various descriptive and interrelational models created with the aim of explaining the SDOH, alongside the relationship between human health and the total environment (biological, social, physical, and economic). One such model is eponymously named 'Dahlgren and Whitehead Model of Health'. This model, presented below at Figure 2, illustrates the links between the social dimensions of health, and describes the four levels (or strata) of influence – moving from lifestyle choices to broad environmental factors.
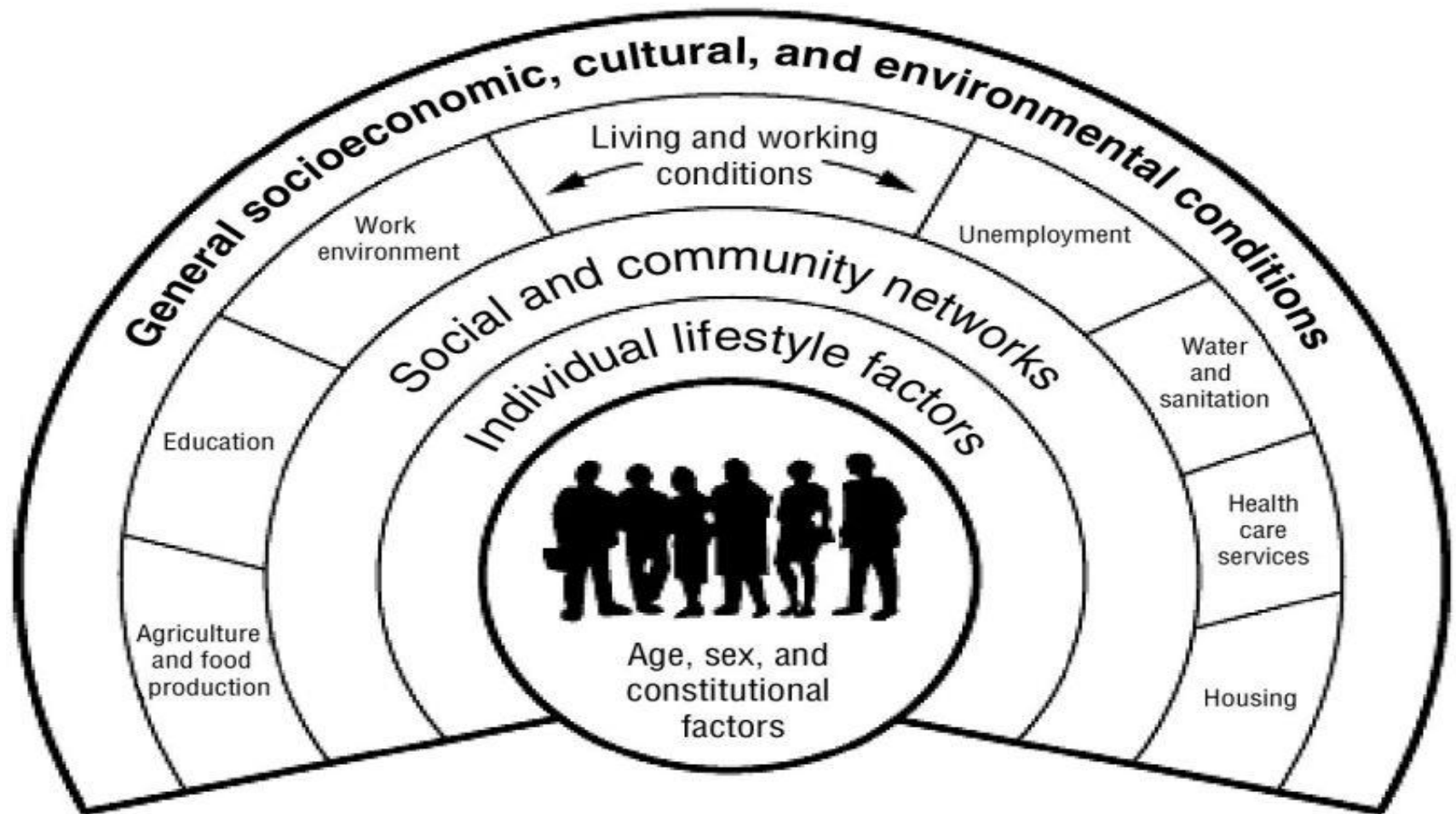
Figure 2 – The Dahlgren and Whitehead Model of Health (Whitehead & Dahlgren 1991)

The SDOH can be defined in many ways, including as follows:

> 'the socio-economic conditions that influence the health of individuals, communities and jurisdictions as a whole. These determinants also establish the extent to which a person possesses the physical, social and personal resources to identify and achieve personal aspirations, satisfy needs and cope with the environment' (Raphael 2004: n.p.)

This definition recognises that SDOH are multitudinous but are not always immediately obvious and adaptable to conventional methods of measurement. Responding to the lack of clarity related to defining SDOH, the WHO commissioned a group of researchers based at University College London (UCL) to summarise the available evidence on the SDOH. The findings of this summary were published in 2003 report, titled *Social Determinants of Health: The Solid Facts*. The report is premised on the understanding that individual and community health is influenced by, and sensitive to, the wider socio-physical environment. What is more, the extent and impact of this influence is not uniform across a community or population). Instead, the influence of SDOH strongly follows a "social gradient" – the more deprived an individual or community is the greater the effect of SDOH (Wilkinson & Marmot 2003).

The 'Solid Facts' report identified nine key SODH (ibid: 12-30):

1. stress
2. early life
3. social exclusion
4. work
5. unemployment
6. social support
7. addiction
8. food
9. transport

Social context and SDOH have a powerful influence upon people's health. At the same time, many SDOH are themselves influenced and shaped by public policy – and modifiable. For example: transport policy can enable and support the provision of sustainable transport measures designed to promote the use

of public transport and cycling, which may deliver health benefits associated with reductions in transport-related air pollution and increased physical activity. Campbell explored the role of local government in the SDOH in a 2010 article, drawing attention to the policy-making powers of local government and thus their ability to influence health and wellbeing. In the article, Campbell presents an adapted version of the Dahlgren and Whitehead Model of Health listing all the areas that local government can impact the SDOH (Figure 3).

Figure 3 – The social determinants of health and the role of local government (Campbell 2010)

2.2.4 Health behaviour

A health behaviour is broadly defined as 'any behaviour that may affect an individual's physical health or any behaviour that an individual believes may affect their physical health' (Sutton 2004: 94). This includes choices people make with respect to alcohol consumption, tobacco or other drug use, diet, etc. There has been extensive discussion of health behaviours in literature. Indeed, Sutton (2004) claims that there are simply too many theories on health behaviour. People's behaviour, according to Baum and Posluszny (1999), can influence their health in one or more of three ways:

1. through direct biological changes
2. through the conveyance of health risks or protections against them
3. through the early detection and/or treatment of disease or illness

The latter of these three ways is important because it suggests that behaviour is not only a key factor in people's health, but that it is modifiable – i.e., people have agency over the choices they make in relation to their health.

There are significant theoretical and philosophical differences that distinguish many of the existing health behaviour models from one another. Most of these models, however, present health behaviours as being the outcome of a combination of biological, psychological, and social issues (Sutton 2004). Writing on this subject matter, Conner (1998) explained that there are many forces that exert some level of influence over people's behaviour. Such forces include a person's personality; the availability and access to healthcare services, which may affect whether (and how) they use such services; and cognitive factors that help explain how other forces shapes people's health behaviour (for example, people's knowledge about health risks will inform their perceptions of and efficacy to respond to these risks and their practice of certain behaviours).

The above indicates that health behaviour (however, one defines it) is not isolated and self-subsistent, but contextually dependent. Context is therefore an important determinant of health behaviour (and wider health outcomes). While people may decide how they act in situations, circumstance (the

decision-making context) directs their decisions. Recent research in the area of human decision-making has stressed the importance of the context in which a problem is embedded (Fantino & Stolarz-Fantino 2005). For Croucher et al. (2007), for instance, health behaviours (and wider health outcomes) are not just determined by "who we are" but "where we live" (i.e., the living context).

2.3 Spatial dimensions of health

In recent times, the Western discourse on public health has undergone considerable shifts with the emergence of a body of knowledge that espouses the materiality and significance of social and physical context in shaping people's health outcomes. The socio-physical context or environment in which people live, and how they interact with this environment, can harm or benefit their health and quality of life in many ways (Sarker et al. 2014). The principle that health has a spatial dimension and this dimension is particularly important to public health is now widely acknowledged. Evidencing this is the tangible traction being gained by the use of a "health settings[11]" approach to exploring the complex relationship between people and place (Dooris et al. 2007). This section of the chapter examines the spatial dimensions of health with a focus on settlements as health settings and factors in population health.

2.3.1 The settlement as a health setting

Towns, cities and other settlements comprise physical elements such as buildings and roads. But they also encompass wider non-physical elements, including ecological, economic, and social networks. It is this combination of physical and the non-physical elements that forms the foundation of the urban environment. Urban environments have been defined as 'highly complex, interdependent, social, ecological, economic and technical systems' (RECP 2007: 149). They comprise multiple subsystems (economic, ecological, health, retail, transport, amongst others) and have emergent properties above and beyond the aggregate of their constituent parts (Moffatt & Kohler 2008).

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[11] The WHO defines a "health setting" as a 'place or social context in which people engage in daily activities in which environmental, organizations and personal factors interact to affect health and wellbeing' (WHO 1998: 19).

Smit et al. (2016), drawing on the work of Vlahov & Galea (2002), note that the urban environment can be subdivided into three main components according to their relevance for population health. These are:

- the social environment;
- the physical environment, and
- healthcare and social services.

The physical environment can be further subdivided into

a) the natural environment[12]

b) the built environment.

In recent decades, there has been a resurgence of interest in studying the relationship between urban environments and population health. The relationship between health and the urban environment, especially how land within this environment is used, is hugely complex (Barton 2009). Developing solutions to health problems requires an understanding of the system-level dynamic, with solutions designed with a system-related perspective in mind (RCEP, 2007).

Many attempts have been made to create a systemic model of the determinants of health. This includes Hancock's work on an ecosystems-based model of health (The Mandala of Health) (Hancock 1993), and the Whitehead and Dahlgren Model of Health (Whitehead & Dahlgren 1991). Building on and extending the work of Whitehead and Dahlgren, Hugh Barton and Marcus Grant developed an ecosystem model of the determinants of health and how they relate to the human settlement (Barton & Grant 2006) (Figure 4).

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[12] Smit et al. (2016) note that the natural environment can be conceptualised as providing ecosystem services, which have a significant impact on human health and wellbeing (Millennium Ecosystem Assessment 2005)
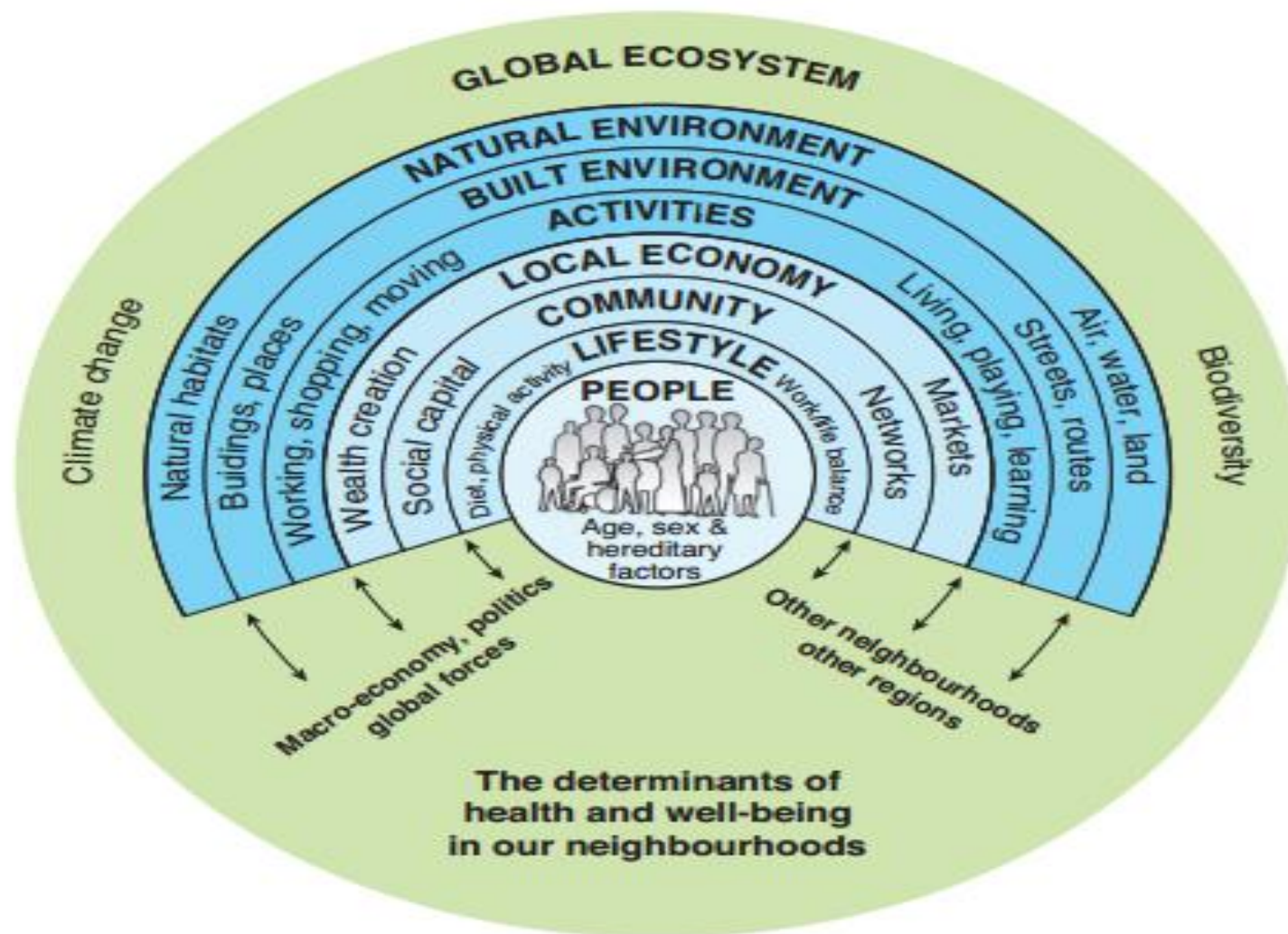
Figure 4 – The Settlement Health Map (Barton & Grant (2006: 2)

In the WHO's *Guide to Planning for People* (2000), Barton and Tsourou proposed that the model of health developed by Dahlgren and Whitehead could be redesigned and refurbished to better serve as a conceptual framework for urban planning. The outcome of their efforts was the "Settlement Health Map"*.* The Settlement Health Map articulates the human settlement as a holistic spatial ecosystem, as opposed to a space of independent, unconnected subsystems.   The design of the health map is intentionally minimal, just a sequence of spheres (or rings) moving through social, economic, ecological, and political variables.

In avoiding a duality between "people" and the "environment", the Settlement Health Map communicates people as not functioning in isolation from their environment; rather, people and the environment act and interact with one another continuously and in a cyclical and mutually constitutive fashion. Like the nodes within an ecological network, the bioregional and global ecosystem provides the necessary ecological life-support for and setting within which human-environments are played out, with the network being influenced by macroeconomic and political forces (Barton et al. 2010).

Like its antecedent, people are placed at the heart of the health map. People's lifestyles, community networks, economic opportunities, and activities (spheres 1-4) are all affected by the built environment (sphere 5). The built environment, along with people's lifestyles and activities, has an impact on the natural environment (sphere 6), and global ecosystem (including climate and biodiversity). Collectively, all the spheres of the settlement health map – social, economic, and ecological – affect people's health and wellbeing.

From an urban planning perspective, it is the 'built environment' (sphere 6) which is most significant. This is because, as Barton (2017) explains, it is within this sphere that urban planners, designers, and decision-makers can have the most direct impact.

2.3.2 The built environment and health

The built environment has been described as meaning different things to different people. For Roof & Oleru (2008: 24) it is 'the human-made space in which people live, work, and recreate on a day-to-day basis'. Whereas for Rao et al. (2007: 1111), it simply encompasses 'all buildings, spaces, and products that are created or modified by people'. The built environment has many components, including: green and open spaces, the presence and conditions of public footpaths, land use mix, population density, underground and overhead areas, internal environments, and social capital (Renalds et al. 2010). It can therefore be viewed as a human-engineered space, complete with social, physical, grey and green dimensions.

Much has been written on the impact of the built environment on health. The built environment has been described as the missing "causes of the causes" of non-communicable diseases (NCDs), and other health-related issues (Walls et al. 2016). A variety of literature has shown that there is a complex and subtle set of pathways and mechanisms through which the built environment influences physical and mental health. Understanding how the built environment affects health outcomes is widely recognised to be an urgent public health priority, as evidenced by the WHO in declaring 2010 as the Year of Urban Health.

Within urban areas, the built environment shapes both physical and social environments – indoors and outdoors – and subsequently people's health, wellbeing and quality of life (Rao et al. 2007). This includes urban design, land-use planning and transportation systems and associated policies that affect urban and non-urban areas (ibid). The health-promoting and -inhibiting dimensions of the built environment are becoming increasingly better understood[13].

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[13] In a 2014 paper on "urban planning for health and wellbeing", Kent and Thompson (2014), based on a comprehensive review of the literature, identified the major built-environment health pathways to be: (1) physical activity, (2) healthy eating, and (3) community interaction.

Much of the work in this area of study has focused on the role of built environmental variables in the incidence and prevention of NCDs (Lovasi et al. 2009; Pasala et al. 2010; Salois 2012; Smit et al. 2016; den Braver et al. 2018). For example, the creation of an "obesogenic" built environment that frustrate opportunities to pursue healthy lifestyles has been linked to the growing global incidence of obesity and type-II diabetes (Papas et al. 2007; Butland et al. 2007; The Lancet 2014).

The built environment has been denoted as being fundamental to the human experience and a key determinant of health; creating a "sense of place" (RCEP, 2007) and serving as the "foundation for health and wellness" (Renalds et al. 2010). Nevertheless, it has to date proved difficult to establish empirically founded casual relationships between the built environment and population health - including specific illnesses and diseases (Srinivasan et al. 2003). The dynamic and multidimensional nature of the built environment, coupled with its multifaceted relationship with health, frustrates attempts to determine causal links between it and health (Papas et al. 2007; Croucher et al. 2007; Feng et al. 2010; Ding & Gebel 2012; Barton 2017).

Notwithstanding this, evidence now indicates that there is a very close relationship, if not a causal connection, between the built environment and health. In *City of Well-being,* Barton (2017), provides a comprehensive summary of available scientific evidence on the relation between the urban and built environment and people. This, and other summaries of evidence, such as that by Public Health England (PHE) (2017), highlights the many pathways and mechanisms by which the built environment affects health. According to Barton (2017), his summary of available scientific evidence demonstrates that claims of "missing evidence" are no longer a valid excuse for not evaluating the health impacts of land-use plans, policies, and projects.

Rao et al. (2007) produced a useful map (figure 5) showing a range of health problems investigated for links with the built environment. The map illustrates which factors of the built environment are associated with specific aspects of physical, mental, and social health. Many health problems are also shown to have a multi-causality. For example, obesity is associated not only with

physical activity but also the appearance of the built environment; as well as other factors, such as distance, safety, and social networks. This means that built environment could contribute to the development of major comorbidities (whereby people suffer from one or more associated disease that are concomitant or concurrent with a primary disease). That many health problems associated with the built environment have multiple causalities, which function over multiple levels and scales, has led to them being labelled "wicked problems" – in that they are inextricably difficult to resolve due to their systemic and complex contexts (RCEP 2007; see, also Section 5.3).
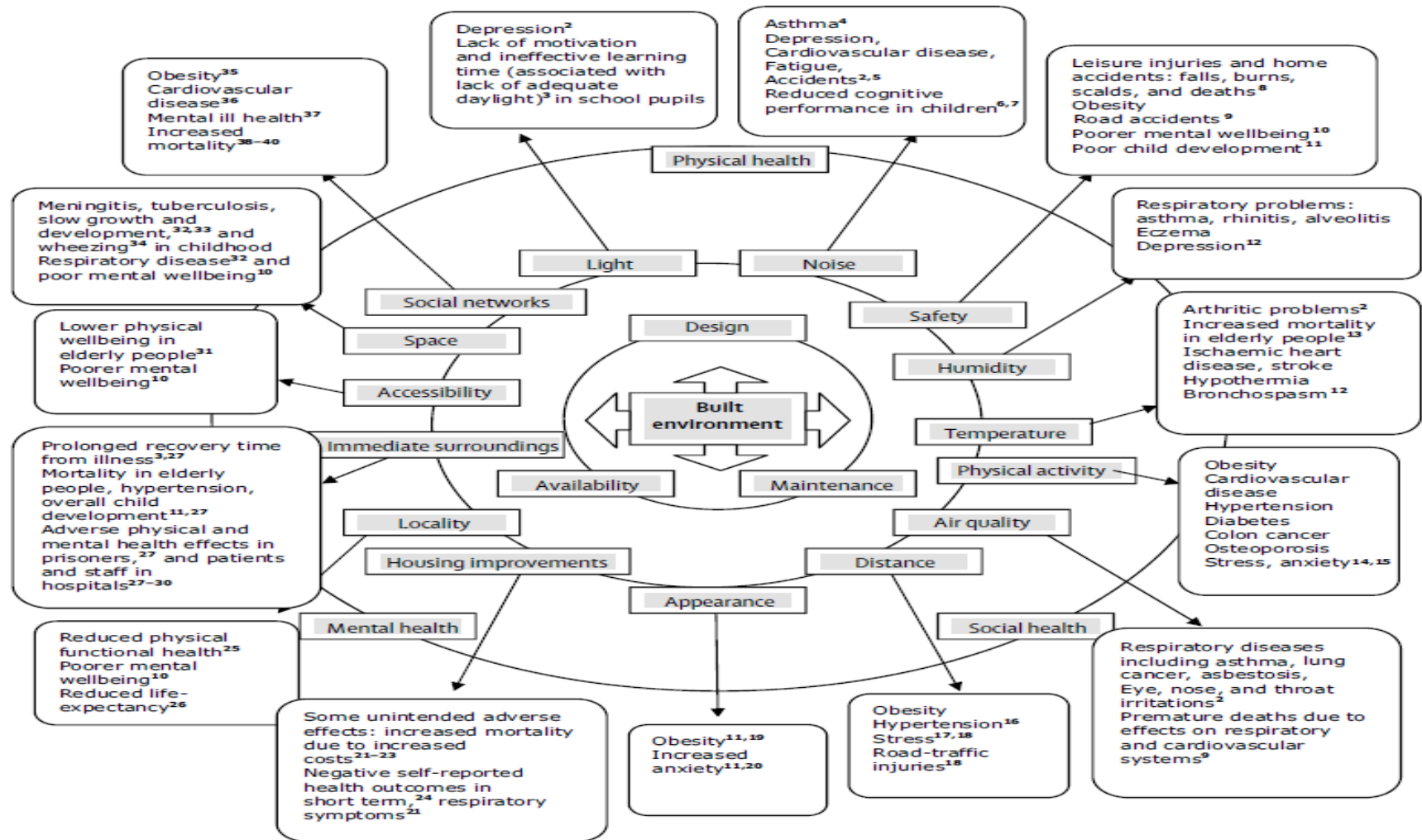
Figure 5 – Health issues linked to the built environment (Rao et al. (2007)

The map by Rao and colleagues shows that the built environment can interact with people's health through: a) health behaviours and b) health exposures. This is something which Frank et al. (2012) also identified in a summary of key research and evidence on the interaction between the built environment and health. Application of this theory in practice can be illustrated through considering the hypothetical scenario of a city centre whose structure and physical fabric inhibits physical activity and exposes people to multiple fast-food outlets (which specialise in serving food that is commonly associated with unhealthy eating). Such an environment is potentially damaging to health through its exposure to unhealthy food and its hindrance to an active lifestyle. Alternatively, the city centre might promote physical activity and encompass a high availability and accessibility to healthy food. Yet, despite these positive health attributes, people may be exposed to elevated levels of air pollution caused by vehicle traffic or industry.

A final point to note here is that the built environment is not just an important determinant of health, but also of health inequality and inequity (Allen et al. 2010). People's health is affected by the built environment – including the physical and social contexts – but this impact is moderated by personal factors such as socioeconomic status (Dahlgren & Whitehead 2007). When health variations disproportionality affect lower socioeconomic groups they can be interpreted as "social inequalities" in health (Gelormino et al. 2015a). It is well recognised that health inequalities are caused by social inequalities (Stringhini et al. 2010); with social inequalities being linked to the built environment.

People can be exposed differently to health determinants related to the built environment depending on where they live and work, and how they interact with the built environment. According to Gelormino et al. (2015), administrative and political priorities manifested through urban policies (affecting structural and social aspects) can result in the unequal distribution of neighbourhood resources, opportunities and capacities. Gelormino and colleagues, in a scoping review of evidence, identified three key pathways through which the built environment can have a health equity effect: the natural environment, social context and behaviours. These pathways, moreover, are connected

(partially or totally) to one of three components of the built environment: density (including the concentration of buildings and population in an area), availability of public spaces and facilities, and integration of different function within the same neighbourhood (ibid).

2.4 Chapter Summary

The main focus of this chapter has been on exploring the determinants of health. Literature written from both within and outside the medicine field suggests that human health is determined by an extensive range of factors – from biological and genetic inheritance, through personal lifestyle and health behaviour, social and community circumstances, to physical and social environments. Research also identifies the human settlement as being an important health setting, with urban and built environments being both in themselves determinants of health and settings within which other determinants of health operate. Finally, the literature suggests that there is a synergistic relationship between the determinants of health, and that there is a need to consider the full spectrum of determinants of health when preparing and implementing public health policy.

3. The meaning of health

This chapter presents a detailed exploration the concept of human health (health). It overviews the theory and many meanings attached to the concept of health, as well as the importance and rationale for developing a compression of this theory and these meanings. The chapter also looks at some of the definitional and ethical considerations that planners need to be aware of when defining health are outlined.

3.1 Introduction

Human health is a comprehensive and complex area of study. It is this very complexity – and the curiosity that it evokes – that makes health the subject of extensive and continued research. In Chapter Two, it was established that people's health is determined by multiple biological, social, and physical determinants. But what, exactly, is meant by the term 'health'? It is this question that for centuries scholars and philosophers have sought the answer to. In exploring this question, it is important to recognise that the *determinants* of health are a distinct (yet interconnected) consideration from that of the *definition* of health (Evans & Stoddart 1994).

When looking at any health-related activity, the definition of health employed must be distinguished from that of the determinants of (that definition of) health. Finding "the" meaning and definition of health is by no means straightforward, especially given the wide-ranging approaches to defining the concept. In recognition of this, this chapter studies how and why health has attracted multiple definitions; what some of these definitions are and the theory that underpins them; and the definitional and ethical considerations associated with definitions of health.

3.2 A conceptual and lexical quandary

The meaning of health is considered one of the most ambiguous and perplexing problems in the philosophy of medicine (Kelman 1975; Earle 2007). Even in medical practice, a business to which health provides its very definition and raison d'être, a fixed definition of the concept is missing (Engel 1977). Though present in much medical, social, and other analysis, the concept of health does not lend itself easily to conceptualisation. Not only do a host of philosophical problems exist but any attempt at coining a universal definition of health raises the additional problem that the term itself is less evident in some cultural traditions than in others (Dolfman 1973).

In many respects, conflict is a permanent feature of the concept of health. Multiple reasons are cited as to why this conflict is seemingly intractable. The literature on the origins and progression of this conflict tend to focus on construction of meaning and valuation as key motivating factors driving conflict and preventing the progression towards a unified a definition of health.

3.2.1 Lexical ambiguity

When in need of a definition, people will often turn first to a dictionary for assistance. Dictionaries provide lexical information about terms. The information given about a term is not exhaustive, and the reported definition is neither inherently right nor wrong; rather, what is presented is a description of the "common" meaning of a term[14] – in other words, a lexical definition. Dictionaries provide a *descriptive* account of how a term is used – normally within the speaking language in which it is authored – not a *prescriptive* account of the fixed meaning of a term – fixed in the sense that it will not change regardless of how the term is used in conversation, writing, or even thinking.

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[14] A relevant example here is taken from the Oxford Dictionary, which defines health as 'the state of being free from illness or injury' (Oxford Dictionary 2018a).

The definition of terms in dictionaries can be beneficial for communication purposes because they will often give a common starting point for understanding, but this inclusivity may render them too vague or uncertain for many purposes (Cabanas 2012). Health is no exception to this – if not a rule – presumption, as, despite its heavy usage in literature and elsewhere, dictionary definitions of health belie the term's complexity and heterogeneity.

The meaning of health is contentious and elusive (Simmons 1989). Health as a concept sits at the interface of medicine and philosophy; it is neither a medical abstraction, nor of a purely philosophical nature, but neither it is devoid of philosophical foundations. Notwithstanding how a dictionary might define health, the meaning of health is an emergent property that arises from three types of claims:

1. factual claims about the individual who is said to be in a state of health or non-health;
2. normative claims about what it is meant by health and non-health; and
3. epistemic claims about if it is necessary, or even possible, to make the first two claims (Adamson 2019).

In addition to its definition, health is neither a vague nor precise phenomenon. The term we use to describe this phenomenon – health – is merely an artificial label or linguistic device used to express a collection of thoughts and feelings. Essentially the concept of health is not static over time or within different contexts, rather it is variable and responsive to social and cultural developments (Dolfman 1973, 1974).

Health has been understood by people in many ways at separate times and in different sociocultural contexts. For example, health was historically perceived to be a divine outcome: health is a state bestowed upon people by supernatural forces, hence it is outside the realm of human influence (Dolfman 1973). Today, the idea of divinity has been largely replaced by the understanding that health is influenced by (qualitatively if not quantitatively) measurable health determinants.

Finally, health can be viewed and thus valued in many ways (Downie & Macnaughton 2001). For some health is "instrumentally valued" and is a

prerequisite factor in the attainment of other ends and undertakings; for others it is "intrinsically valued" and is worth pursuing on the basis of its own merits, not as part of any overall scheme or strategy; for others still it is an "elusive aspiration" which cannot be attained in a traditional sense, yet nevertheless should be pursued (Simmons 1989; Frenk & Gómez-Dantés 2014). Some believe that health is crucial to social accomplishment, others as part of, and a constitutive element in, accomplishment. Some think that a "state of health" is achievable, if the necessary conditions are met; others think that it is purely theoretical, being always relative and not an absolute value, although we should aim to deliver it as close to as can be possibly be delivered.

These three factors – claim-making, variability, and valuation – imply a multiplicity of perspective about health. They also allude to the possibility that the same basic concept can have a variety of meanings. This provides some indication as to how and why it is difficult to arrive at a unified and transferrable definition of health. There is, however, another dimension to this debate, and that other dimension is in conglomerate the effect of the lexical polysemy and the relations that hold among the multiple meanings of polysemantic terms[15]. That other dimension deals with the powerful idea of the "contested concept", and it is explored in the section below.

3.2.2 The (contested) concept of health

Health is a prime example of a concept. A concept is commonly understood to represent an abstract idea, plan or intention (Durbin 1988). Concepts are an important part of both informal (everyday) and formal (scientific) discourse. In the social sciences, authors regularly employ concepts as theoretical references when discussing abstract notions – especially those notions that cannot be directly observed, like freedom, power or sustainability. In the field of urban planning, the 'ideas and labels' embodied within concepts actively

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[15] The term 'polysemy' means "the coexistence of many possible meanings for a word or phrase". As such, a "polysemantic term" can be any term that has more than one possible meaning, e.g., book, bank, pen, etc.

shape, and are in themselves shaped by, theory and practice (Parker and Doak 2012: 1). Notwithstanding their importance, little agreement exists about the intention and nature of the concept.

The controversial concept

The "concept of the *concept"* is among the most controversial subjects in the Western philosophical tradition (Durbin 1988). To date, there is no common understanding about what concepts are, how they should be used, or how a concept should be defined (Rey 1996; Adajian 2005; Margolis & Laurence 2007; Hjørland 2009). Deleuze & Guattari (1991) argue, from a post-structuralist standpoint, that concepts are by themselves ambiguous and vague, only gaining content through reference to other concepts, including the components and elements of other concepts from which they are formed, and wider empirical considerations.

That there is a conceptual and practical confusion surrounding concepts is naturally expected, if only for the reasons set out so far in this discussion. But why is this the case? Collier and colleagues (2006) propose that conceptual confusion is the consequence of the failure to specify the relationship between "term" and "meaning". Scholars sometimes use concepts inconsistently, or they may simply fail to fully comprehend the definitions used by other theorists. Such confusion is, however, likely to be resolvable.

Let us consider a scenario in which the source of conceptual dispute is an inadvertent homonymy, i.e. partisans using different terms to describe the same phenomenon. With sufficient time and commitment among the academic community, it can be assumed that a standard usage of the concept in question would be arrived at. In not all cases, however, can consensus about the meaning and application of concepts be achieved. This brings us onto the issue of conceptual contestation (ibid).

Any use of any concept is liable to be contested. Although whereas some concepts carry with them an assumption of agreement as to their proper application that partisans can unify around, there are others – like art, democracy and social justice – whose usage generates endless dispute

(Gallie 1956: 167). Concepts can have a strong normative valence associated with them. Normative valence, combined with other relevant considerations, can motivate users to favour a certain meaning. This can create a source of intractable conflict between the users of the concept. Users may defend that the special function which the concept fulfils on *their* behalf or on *their* interpretation is representative of the concept's proper usage, whereas others will contend that their application is correct.

This phenomenon of contest in regard to concepts has been comprehensively examined by several authors, including Walter Gallie in his exposition of what he coined "essentially contested concepts" (Gallie 1956).

The essentially contested concept

Based on the discussion so far, it is not surprising that health has been conceptualised in many ways within the medical and social sciences. Indeed, we can find the following variations in definition alone. The traditional medical model of health, for instance, restricts health to the absence of disease, in which an individual gains health through possession of a disease-free state (Engel 1977). Similarly, Boorse (1975) sees the "absence of disease" as the essence of health, but he locates health within biological functioning, normality and the naturalistic perspective. Another view is provided by the WHO, who see health as being linked to wellbeing and wholeness. Others have seen health as being how individuals achieve their potential (i.e., as instrumentally valued), with Seedhouse (2001) describing health as the "foundations for achievement".

This limited selection of understandings of health challenges the assumption that there is a unified or standard use of the concept. As Blaxter (1990: 35) observes,

> 'Health is not, in the minds of most people, a unitary concept. It is multi-dimensional, and it is quite possible to have 'good' health in one respect, but 'bad' in another.'

That health can be conceived of and understood in diverse ways creates tension, primarily because with this comes a sense of ambiguity about health that in turn generates debate over what the "correct" definition of it is. Curtis (2004) argues that health is a socially constructed phenomenon, its meaning related to individual and collective ideas and beliefs about identity, and the nature and significance of the human body.

Similarly, Downie and Macnaughton (2001: II) state that health 'does not have a clear identify of its own'. Moreover, Johnson (2007: 91) posits that, 'the concept of health is a cluster of sub-concepts, which together constitute a dynamic whole'. There is a challenge, therefore, when trying to define what health is. Pridmore and Stephens (2000: 30) argue that there is no universally agreed definition of health, nor can there be a unitary conceptualisation of health because its meaning is contextually dependent and constantly evolving. For these and other reasons, health has been characterised by many scholars as a "contested concept" (Larson 1999; Gesler & Kearns 2002; Starfield 2004; Griffen & Seedhouse 2007; Weinstock 2011; Warwick-Booth et al. 2012; Heginbotham & Newbigging 2014; Marinescu & Mitu 2016).

The idea of the "contested concept" has been examined by several authors, but Walter Gallie provides the most noted prominent exploration (Gallie 1956; Gallie 1964). In a 1956 essay titled 'Essentially Contested Concepts', Gallie presented an approach for coherently and rationally analysing complex concepts. The intention of Gallie's essay being to demonstrate that, 'in the case of an important group of concepts, how acceptance of a single method of approach – of a single explanatory hypothesis calling for some fairly rigid schematisation – can give us enlightenment of a much-needed kind' (p.168).

Gallie's essay, moreover, charts his interest in a category of concepts whose usage generates a certain kind of dispute, setting them apart from other concepts and making them especially problematic. These concepts are referred to by Gallie as "essentially contested concepts"; concepts for which, 'there is no one clearly definable general use that can be set up as the standard use' (ibid: 167).

Conceptual dispute was recognised by Gallie to be expected, if not inevitable. He, moreover, considered that just because in some instances no resolution to a conceptual dispute can be found, this does not automatically render the concept under dispute redundant or irrelevant. Gallie's main thesis is that there is theoretical and pragmatic value in identifying and analysing contested concepts. On the topic of dispute, Gallie wrote,

> 'there are disputes…. which are genuine; which, although not resolvable by argument of any kind, are nevertheless sustained by perfectly respectable arguments and evidence. This is what I mean by saying that there are concepts which are essentially contested, concepts the proper use of which inevitably involves endless disputes about their proper uses on the part of their users.' (p.169)

In relation to appreciating the value of essentially contested concepts, he wrote,

> 'recognition of a given concept as essentially contested implies recognition of rival uses of it (such as oneself repudiates) as not only logically possible and humanly "likely", but as of permanent potential critical value to one's own use or interpretation of the concept in question; whereas to regard any rival use of anathema, perverse, bestial or lunatic means, in many cases, to submit oneself to the chronic human peril of underestimating the value of one's opponents' positions.' (p.193) (emphasis in original)

Alongside Gallie, other authors[16], including Clarke (1979), Waldron (2002) and Ruben (2010), have provided explanation and criteria for determining whether a concept is in fact "essentially contested". Detailed discussion of these provisions is outside the scope of this review, but two fundamental principles of relevance to the meaning of health are as follows: concern when examining

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[16] Since the publication of Gallie's 1956 essay, the idea of the essentially contested concept has received broad attention from philosophers and researchers working in dissimilar fields – including in the arts ("work of art"), law ("rule of law" or "justice"), medicine ("health" or "medicine"), politics ("democracy"), environmental science ("sustainability"), to name just a few examples.

contested concepts is pragmatically grounded (i.e., how a concept is used, not philosophically constructed), with the interest being in how partisans of a dispute can each claim, with justification, that their application of a concept is *the* authentic use – the "essential" contest is therefore not on the general agreement of the concept but its application, or realisation; and contestability emerges from some feature or property of the concept itself – and not from the contest itself – making it polysemantic, not ambiguous, and inherently conflictual[17].

Gallie famously employed the two concepts of "the champions" and "democracy" in his work to illuminate his theory, and to draw attention to the fact that contest, in this context, is about application; as opposed to philosophical construction. The essential contestedness over democracy, for instance, is argued to stem not from the merits of its existence, but from what political actions are needed to satisfy the statement 'this is an example of democracy' (1956: 183). As already mentioned, health has been described as a contested concept. Naidoo & Wills (2015: 375) contend that health 'is a contested concept that is variously defined according to place and time'. They also address the polysemantic nature of health, considering the meaning of health to be intractably contended over by those using the concept due to its normative heterogeneity; this being the result of the concept's socio-cultural and temporally specific application.

Beyond the concept of health, the idea of the contested concept, specifically Gallie's interpretation of it, has been applied in the analysis of other, some may argue more readily planning-related, concepts, including sustainable development and green infrastructure. In the book chapter 'Sustainable Development as a Contested Concept', Jacobs (1999) applies Gallie's thesis of the essentially contested concept in his examination of the concept of sustainable development. Reflecting on the wider discourse on the concept,

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[17] According to Clarke (1979), the process of determining whether a concept is "essentially contested" begins with the identification of if a true polysemy or inadvertent homonymy exists; with this done through locating the source of the dispute: for the former (polysemy) the source might be either "within the concept itself" or within "some underlying non-conceptual disagreement between the partisans", whereas for the latter (homonymy) the conceptual contest would be the outcome rather than the source of a dispute (p.123).

Jacobs positions sustainable development as a widely adopted nominal objective.

Sustainable development is not, however, without criticism. The inability to find a unitary definition of sustainable development is said, by Jacobs, to lead to authors questioning its theoretical and policy-related purchase. This query arising because in the theory of sustainability the critical question to be answered is "what is to be sustained?", and there is no fixed answer as to what the "what" is. Jacobs rejects this conclusion, instead contending that the concept of sustainable development is contested, valuable and not empty, and has multiple levels of meaning.

A similar argument is made by Wright (2011) in relation to the concept of 'Green Infrastructure' and its application in the English planning system. Wright draws attention to the battle for ownership over the concept's meaning and the importance of understanding the policy space around specific concepts to improve the potential of securing a wider range of benefits in their application in practice, achieved through the retention of broader purposes of the concept as it continues to develop and be employed by partisans with different interests.

The above discussion touches on some of, if not all, the difficulties encountered in trying to produce a satisfactory definition of health. Building on this, the next section of this chapter examines several theoretical perspectives and models of health. In doing so, it considers what these might offer in terms of our understanding of "what health is".

3.3 Locating the meaning of health

Relative to other concepts, the definition and meaning of health is a neglected subject matter in literature. Converse to the question of what *determines* health, the question of what health *is* has also attracted little discussed in planning literature. It is a question that has arisen infrequently in view of the widely accepted definition of health: that health is a "complete state of physical, mental and social wellbeing". This condensed version of the famous WHO definition of health appears to be by far the most prevalent within the planning literature[18]. For instance, it is the definition proposed in the introduction of the *Routledge Handbook of Planning for Health and Well-being* (2015), the WHO commissioned book *Healthy Urban Planning* (2000), and by other authors writing on the subject of health and urban planning (e.g., Rydin et al. (2012), Tewdwr-Jones (2011), Carmichael et al. (2013), among others).

On this basis, some may regard "the" question as a semantic one, with the inevitable debate it generates having little practical reward. Others, however, would suggest that the meaning of health has very practical importance. Not only do certain scholars view the meaning of health as a matter of theoretical interest, but they view it also to be a matter of practical importance for decision-making, policy-making and in shaping health behaviours and expectations. For example, Hughner & Kleine (2004) have argued that the way in which people conceptualise health influences their health behaviours. Some other authors, such as Smith (1981), Gunderman (1995), Barrett et al. (2003), and (Marinescu & Mitu 2016), have noted that how healthcare professionals conceive of health has profound ramifications for healthcare delivery.

How health is defined also guides thinking about the components and parameters of promoting public health, and the design, delivery, and evaluation of health-related initiatives. As Jones (1997:18) indicates,

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[18]In many regards, the WHO definition of health draws comparisons with the Brundtland Commission's anthropogenic definition of 'sustainable development'. The concept of 'sustainable development' has been defined in many ways. However, the most frequently citied definitions is from *Our Common Future*; also known as the Brundtland Report: 'Sustainable development is the development that meets the needs of the present without compromising the ability of future generations to meet their own' (World Commission on Environment and Development 1987).

'definitions of health contain within them complex ideas about what it is to be healthy, whose responsibility it is to maintain health and how illness and disease should be interpreted'. The understanding of health is, moreover, crucial to the assignment of who is and is not responsible for promoting and safeguarding public health (Smith 1981; Braveman & Gruskin 2003; Beeck et al. 2005; Earle 2007; Boddington & Räisänen 2009; Hill 2012). Based on this, the meaning (or at least usage) of health can be thought of as an important consideration for urban planning; this is a point discussed later in the chapter.

It has already been alluded to that health has multiple meanings, as opposed to a singular meaning. But this chapter has hitherto attempted to explain what these meanings are and what they involve. The number of meanings and definitions attributed to health is extensive. In fact, it would be impossible to do full justice to the detail and contribution of each of these here. Nor can the true extent of the arguments for and against specific meanings (and definitions) be fully examined. To do so in a comprehensive manner would undoubtedly require a text of encyclopaedic proportions[19].

For our current purposes, it is enough to select a few ("Western") examples, and to explain only their salient features (including associated criticisms and problems). The following discussion makes use of "paradigms" as a way of structuring the examination of health. Broom and Willis (2007: 17) defined a paradigm as 'an overarching philosophical or ideological stance…' Alternatively, Kuhn (1962), who first coined the term, characterises a paradigm as an integrated cluster of substantive concepts, variables and problems attached with corresponding methodological approaches and tools.

A paradigm is thus a basic system of beliefs, assumptions, and practices of thought that a group of people share among themselves. Through looking at the "paradigms of health", we can better aim to discover the intellectual, theoretical, and philosophical assumptions upon which meanings (and definitions) of health are based; or from which they are abstracted (ibid). To

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[19] The meaning and definition of health has been explored to various degrees by many different authors. While this chapter is based predominantly on the author's own reading of the "health" literature, it builds upon explorations made by some other authors – namely, Dolfman (1973); Simmons (1989); Boruchovitch and Mednick (2002); Earle (2007); Ereshefsky (2009); Vatsyayann (2009) and Roepke et al (2014).

this end, three major paradigms of health to have emerged in more recent times, and which have been derived here from literature, are considered:

1) the naturalist paradigm: health as the absence of disease;
2) the normative paradigm: health as wellbeing; and
3) the ecological paradigm: health as a resource.

3.3.1 Health as the absence of disease

Health as the absence of disease – this definition of health has been observed as one of, if not the most, pervasive throughout modern medicine. Known as the "biomedical" model of health, it is the most commonly used definition of health in government reports and medical documents (Earle 2007). The identifying feature of this definition is its unidimensional reference standard: the individual is either healthy or diseased. Critics complain, however, that this definition does not actually define health, but disease – it defines what health is not, rather than what it is. Moreover, it has been described as a "negative" definition of health that prevents consideration of the wider contextual and structural factors that co-construct health (Ahmed et al. 1979; Boddington & Räisänen 2009; Earle 2007).

The characterisation of health as 'the absence of disease' is grounded in the philosophical viewpoint of naturalism. Recent scholarship in the field of medical philosophy has tended to adopt a naturalist perspective, emphasising that classifying 'diseased' and 'healthy' states involves making empirical and objective judgements about human physiology (Boorse 1977, 1997; Balog 1981, 2005; Scadding 1990; Thagard 1999). Naturalist accounts of health echo elements of biological theory, holding that health is a biological state and that our focus (on health) should be directed on a single variable: biological functioning. More specfically, normal biological functioning for humans who are members of relevant references classes – defined by age, group and sex) (Earle 2007). Consequently, medicine should aim to discover and explain the biological (natural) criteria which enables various diseases to be defined (Reiss & Ankeny 2016).

One of the most influential and well-developed naturalist definitions of 'disease' and 'health' is Boorse's formulation, which is based on bio-statistical theory. Many have criticised naturalist definitions of health, and specifically Boorse's approach (cf., Engel 1977; Fulford 2001; Guerrero 2010; Hamilton 2010; Kingma 2010; Reznek 1987; Wakefield 1992). Before looking at some of these criticisms, we will first look at the Boorsian account of disease and health. In a 2014 article, Boorse described the target of his work as thus: 'scientific medicine's concept of theoretical health as normality' (p.683). "Normality" entails the 'absence of disease', with Boorse defining a disease as:

> 'a type of functional state which is either an impairment of normal functional ability, i.e. a reduction of one or more functional abilities below typical efficiency, or a limitation on functional ability caused by environmental agents.' (1997: 7-8)

In his account of disease and health, Boorse introduces the idea of a reference class. A reference class is a natural category containing organisms of uniform functional design (a specific age group or sex of a species). When a process of a part (such as an organ, e.g.,, the heart) functions in a normal way, its contribution is recognised to be statistically typical to the survival and/or reproduction of the individual organism (such as a human) within whose body that process takes place or part is contained (Boorse 1977; Boorse 2014). Boorse's definition includes an "environmental clause" to address those diseases – such as dental cavities, acne and gingivitis - that are (statistically) common to all humans and occur in most humans in a reference class.

Many have criticised Boorse's account of health, as well as the naturalistic perspective more generally (Engel 1977; Goosens 1980; Reznek 1987; Wakefield 1992; Fulford 2001; Guerrero 2010; Kingma 2010, 2017). Most of this criticism has been directed at the failure of naturalistic accounts to accurately capture how people typically use the terms 'disease' and 'health'. Naturalism does not consider the values which shape and the normative judgements that are enacted when declaring someone to be in a state of health

or non-health (see Ereshefsky (2009) and Reiss and Ankeny (2016) for a more extensive examination of this point).

A more telling criticism of naturalism is that it fails to attain its desideratum: to be naturalistic (Ereshefsky 2009). Naturalists advocate the use of biological science as the basis for generating their definitions of 'disease' and 'health'. Consequently, they rely on biological theory to illuminate the standard – biological normal – traits of humans. Scholars such as Ereshefsky (2009), Sober (1980) and Wakefield (1992), have argued that biology (and biological taxonomy or genetics) does not directly provide us with these norms, and that in "species design" there is no absolute, natural state – even though Boorse and others would dispute this point (see, Reiss and Ankeny 2016). Hence, developing an acceptable conception of "normal functioning" (and dysfunction) is seen as a major problem with Boorse's and other naturalistic accounts (Cooper 2002; Cooper 2016).

Another critique of naturalism, and Boorse's account, is that it assumes that biological "fitness" (survival and reproduction) is the goal of all humans. It, therefore, excludes the possibility that humans (and other organisms) may have other goals that are in opposition to or have no bearing on the goal of biological fitness (Smith 2008; Ereshefsky 2009; Reiss & Ankeny 2016). Finally, Kingma (2007; 2010; 2017) has objected to the naturalists' (including directly Boorse's) appeal that 'disease' and 'health', and reference classes, are objectively identifiable. Kingma argues that while 'disease' and 'health' may be medical (scientific) concepts, they are also value-laden concepts, the meaning of which cannot be discovered without recourse to normative judgements.

3.3.2 Health as wellbeing

The most recognisable definition of health comes from the Constitution of the World Health Organization (1946):

> 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

> 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, economic or social condition.'

An essential feature of this definition is that health is not just "the absence of disease" and not just a "positive state of wellbeing[20]" – but the absence of any disease or condition that detracts from a state of positive wellbeing. The positioning of disease (and illness) as commensurate with socio-psychological wellbeing has been described as a paradigm shift in the discourse and construction of health. Indeed, its introduction challenged (and continues to challenge) many assumptions about health. For one, it conceptualises health in terms that are the antithesis of naturalism: health is multidimensional not unidimensional, subjective not objective, a social not natural phenomenon. The definition embraces factors other than disease, thus encouraging the evaluation of health to extend beyond the physiological to include psychological and socio-cultural aspects. Secondly, the definition identifies health – if implicitly – to be a concern not just for medicine but for all professions and fields of study.

The WHO definition of health is synonymous with the "normativist" and "constructivist" view of health. These have the shared aim of attempting to move away from a unidimensional characterisation of health (i.e., the absence of disease) and to more accurately capture how we use the terms 'disease' and 'health'. Most proponents agree that there is a need to define the terms

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[20] The concept of 'wellbeing' has been defined in many ways, with the term being used in a variety of ways in health research and health promotion (Chavez et al. 2005). A useful definition of wellbeing is provided by the Scottish Executive (2002): 'A person's sense of positive feeling about their life situation and their personal health, both physical and mental. You can have a physical illness, injury or mental health problem or illness and still have a sense of well-being'.

'disease' and 'health', but in doing so recourse to normative principles must be taken. This is because our definition of 'disease' and 'health' are a reflection of usage function of our values (Goosens 1980; Sedgewick 1982; Engelhardt 1986; Peregrin 2016).

Defining various conditions as "diseases" involves both discovering patterns in nature and value-laden judgements, alongside the construction of terms to describe such conditions (Reiss & Ankeny 2016). Our values are more readily reflected in our usage of 'disease' and 'health' in cases where we label those physiological and psychological states that we desire as "healthy", and those we want to avoid as "diseased" (Ereshefsky 2009: 233). Engelhardt provides a representative argument supporting this claim, stating that the definition of disease (and thus health) is invariably value-driven:

> 'disease does not reflect a natural standard or norm, because nature does nothing – nature does not care for excellence, nor is it concerned with the fate of the individuals qua individuals. Disease must involve judgements as to what members of that species should be able to do – that is, must involve our esteeming of a particular type of function.' (1976: 266)

Normativists believe that their approach avoids standard counterexamples to naturalism. Consequently, they view their approach as better capturing the actual usage of the terms 'disease' and 'health' (Reiss & Ankeny 2016). Through accurate reflection of our usage of these terms, normativists claim that they can more adequately explain how specific conditions can come to be viewed and classified differently as society and social values change (even though our understanding of biological principles may not have advanced to the same degree).

Finally, normativists perceive their approach to defining disease and health as being a "positive" approach. One which accommodates social and cultural aspects of life that produce health, and which naturalism discounts (Niebroj 2006). The perspective that humans are not just physiological but psychological and sociocultural beings exposes wider notions of health,

nuancing the debate around disease and health and (again) helping to better reflect our usage of these terms.

Many objections have been launched against normativism similar to naturalism. The normativist approach aligns those states that we value with either 'disease' or 'health'. But this alignment between value and outcome opens itself to many problems. Specifically, it is questionable whether normativism can accurately capture how we use the terms 'disease' and 'health'. Normativism ties the term 'disease' to the states we consider undesirable, yet is unable to deal with cases where there is general consensus that a state is undesirable but no similar general consensus as to whether the state constitutes being classified as "diseased" (Ereshefsky 2009). Another objection is that normativism does not allow for earlier judgements about disease categories to be retrospectively reviewed, for instance in terms of their methodology and validity (Reiss & Ankeny 2016). Consequently, normativism fails to account for the fact that our usage of 'disease' and 'health' involves more than just normative considerations[21].

Referring back to the WHO definition of health, it too has faced considerable criticism (Larson 1999; Saylor 2004; Jadad & Grady 2008; Smith 2008; Lancet 2009; Frenk & Gómez-Dantés 2014). Most of this criticism concerns the inclusion of the word "complete", more specifically the absoluteness of this term in relation to wellbeing. Completeness is impossible; if for no other reason than because the boundaries of wellbeing are fluid and difficult (if not impossible) to draw firmly. A requirement for complete wellbeing would hence leave most people unhealthy most of the time (Smith 2008; Frenk & Gómez-Dantés 2014). There are two main problems associated with this. Firstly, it can lead to the unintentional medicalisation of society; an issue discussed later in this chapter. Secondly, the requirement renders the definition as non-

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[21] To overcome the problems associated with naturalism and normativism, so-called hybrid theorists use both naturalist and normativist elements in their definitions of 'disease' and 'health' (such as Reznek 1987; Caplan 1992; Wakefield 1992, for example). For more information on this approach, see, e.g., Ereshefsky 2009 and Reiss & Ankeny 2016.

operational, or impractical. Since it cannot be operationalised, it cannot be tested nor health measured against it (Huber et al. 2011).

Another objection to the WHO definition stems from its fixed generalisation of all people living with chronic diseases and disability as categorically unhealthy (Lancet 2009; Huber et al. 2011). Huber et al. (2011) argue that this is counterproductive to the modern conception of what it means to be healthy, given that advances in public health are now enabling a growing proportion of people to live with chronic diseases and/or disabilities for multiple decades (converse to the situation in the 1940s when the WHO definition was first coined). Classification of people with chronic diseases and disabilities as unhealthy may be practical in the first instance. Over the longer term, however, it is counterproductive to health and public health systems, because it fails to recognise, or even diminishes, the role of human capacity to autonomously adapt and evolve in response to changing internal and external conditions; and it neglects the possibility that health, as a dimension of existence, may be able to co-exist with the presence of a disease or disability (ibid; Sartorius 2006).

3.3.3 Health as a resource

The position of wellbeing within the concept of health was reinforced by the Ottawa Charter for Health Promotion (WHO 1986). Specifically, by the definition of 'health promotion' set out in the charter:

> 'Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical mental and social wellbeing, an individual or group must be able to identify and realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just responsibility of the health sector but goes beyond healthy lifestyles to wellbeing.'

This formulation has obvious, even intentional, links with 1946 WHO definition of health. It does, however, differ from its predecessor in two main respects. First, it positions health not as the objective of living, but as a resource for living. In other words, health is a means to securing what is valued. Second, it relates health to the ability of people to cope and adapt to their surrounding environment. The recognition of environmental health determinants accompanies the recognition of human agency, and in this sense "agency" is bound up with not only the recognition of independent, autonomous responsibility for oneself but recognition of one's capacity to care for oneself and others.

Many scholars have promoted the view that health is not a state *per se* but is something always in the process of becoming (Parsons 1958; Engel 1977; VanLeeuwen et al. 1999; Tulloch 2005; Lancet 2009). These same scholars are cognisant of the need to look from an entirely unfamiliar perspective at what health is and is not. To move towards a more coherent and humanistic understanding of health, it is argued that "perfection" must be replaced by "adaptation". In the literature on medicine, formulating a definition of health

based on one's "ability to adapt" and to "function" in the context of their surroundings has attracted growing support.

In more function-oriented perspectives on health, health is defined in two main ways. These are as follows. First, in terms of "proper functioning" that enables an individual to perform their duties and responsibilities. Second, in terms of their "quality of life" which encompasses the individual leading the life they want, the one they choose, and having the necessary means to do so (ibid). Psychological and physiological functioning was distinguished between by Parsons (1958): the former relates to a person's ability to carry out institutionalised roles, while the latter relates to the person's effectiveness in accomplishing valued tasks. Moreover, Parsons defines health as a:

> 'state of optimum *capacity* of an individual for the effective
> performance of roles and tasks for which he has been socialized.
> It is thus defined with reference to the individual's participation in
> the social system.' (1964: 274) (emphasis in original)

Williams (2005: 138-139) explains that health, according to the Parsonian thesis, is not a question of *commitment* (to any role, task, or norm) but of *capacity* which itself is relative – including qualitative ranges in the variance of capacity within and between groups. The emphasis on conceptualising health with reference to "capacity" is most visible in those ecological approaches that are more adaptation-oriented. In these cases, the health of an individual is defined in terms of their capacity to assimilate to their environment. For example, Huber et al. (2011) posited that a definition or conceptual framework of health should be constructed on the principle of "the ability to adapt and self-manage". Moreover, Dubos states that:

> '[health and disease] are expressions of the success and failure
> experienced by the organism in its effort to respond adaptively to
> environmental changes.' (1965: xvii)

Here the environment and its relationship with people are depicted as independent variables: that is, "independent" in the sense that people are not passive receptors of external environmental factors, but active participants in the production of their own health. Dunn (1959; 1973) extends the definition

of health to include the concept of "wellness" – defining it as the ability of people to function in their environment and adjust to the health stresses in this environment. Dunn captures this environment-people-health relationship in his High-Level Wellness Grid (figure 6):
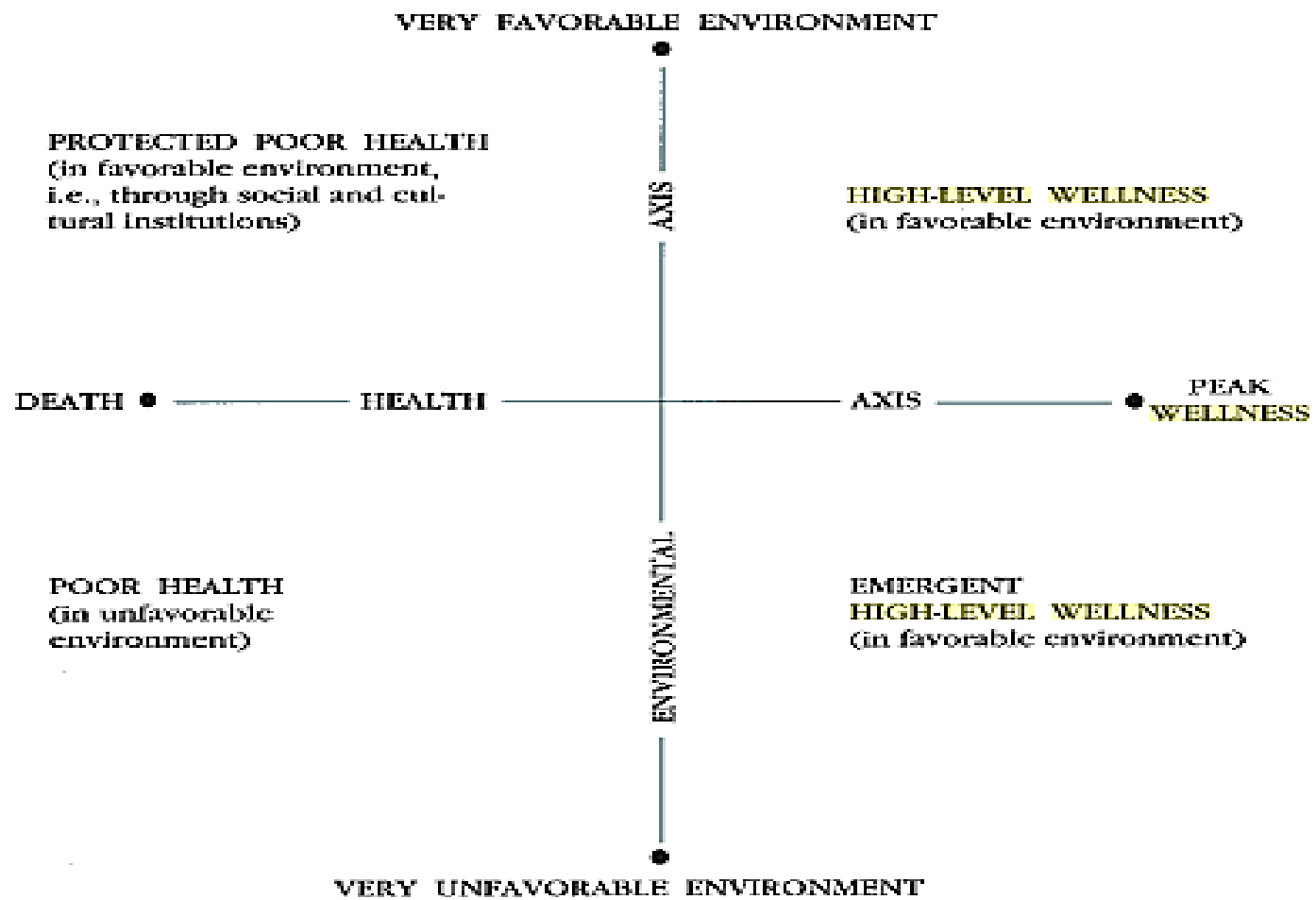
Figure 6 – The high-level wellness grid (Dunn 1973)

The "health grid" places the individual both at the centre of their own dynamic time-space setting and at the centre of their own care. Health (or wellness) of an individual is dependent environmental factors and how that individual is able to evaluate and interpret the impact of these factors on their health; and how they project this impact onto their current future choices – both directly and indirectly health-related. Achieving and maintaining a state of health or high-level wellness[22] is thus considered by Dunn to be an ongoing human challenge. Or, as he puts it, 'an open-ended and ever-expanding tomorrow with its challenge to live at full potential' (Dunn 1973: 223).

Criticism of ecological views of health appear not to have been as forthcoming as those floated against other views of health. However, the ecological view does present some difficulties. For instance: a person may think that they have satisfactorily adapted to their situation, but we (the "evaluator") have no clear criteria for determining whether this is an example of healthy or unhealthy adaptation (Lewis 1953). Moreover, a person may, as mentioned by Boruchovitch & Mednick (2002), adapt to a diseased condition and/or may be sick but still capable of carrying out social responsibilities. Yet, again, we have no clear way to distinguish this person as being healthy or unhealthy. Finally, Boruchovitch & Mednick (2002) observe the notions of "functioning" and "adaptation" to be socially constructed concepts. As these are value-judgements constructs, one could conclude that what constitutes health in one sociocultural context might not be the same as in another – hence, the meaning of health should be qualified both socially and culturally (Parsons 1958).

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[22] High-level wellness refers to ability of an individual to perform at full potential in accordance with that individual's age and makeup (Dunn 1959a: 787).

3.4 Considerations for urban planners

To this point, the chapter has illuminated the complex nature and epistemological problems associated with the concept of health. It has also provided an overview of three paradigms of health. As already noted, health is a challenging concept and its meaning is open and multiplex. The contention and elusiveness of health is important, not least for the purposes of developing, implementing, and evaluating health-related strategies and policies. In the remainder of this chapter, we will briefly examine a selection of theoretical considerations that should inform the conceptualisation and application of 'health' in the process of decision-making (or policy-making).

Two main considerations will be examined, which are as follows: 1) Definitional considerations – how can and should we aim to clarify the "correct" meaning of health; and 2) Ethical considerations – how might our understanding or definition of health inadvertently lead to the undertreatment, overtreatment, or mistreatment of society. These considerations will be looked at through an urban planning lens and are presented in a broad sense so as to be applicable irrespective of institutional context. Importantly, and as well become evident below, there are no definitive answers or solutions to the questions raised by these considerations.

3.4.1   Definitional considerations

Many scholars and philosophers have been moved to find the true definition of health, and to construct a universally valid concept of health. But, as this chapter has shown, "truth" is something of a philosophical chimera in the health debate. All conceptions of health have their proponents and opponents, resulting in competing theses regarding the question of 'what is health?'. In terms of our instant concern, this raises an important question: can and should a planning authority seek to define and clarify the correct meaning of health? Or, alternatively, should it seek an alternative approach?

There are those who advocate, and those who decry, the search for a universally valid concept of health. Joseph Balog (1978; 1981; 2005) has repeatedly insisted that it is both possible and important that we attempt to assimilate competing views of health into a single unifying concept. Balog argues that, while the evaluation of health status inherently involves normative judgements, it is possible to establish a conceptual basis for health which captures its essential criteria – with these criteria providing a legitimate focus and direction for health-related efforts.

According to Balog (ibid), health needs to be defined in terms of two critical criteria:

1) biological and individual functional objectives – which are common and general to all humans; and
2) 2) an individual's physiological and psychological functioning - which is unique to each human being.

Yet even Balog's definition has its own problems. For example, Boruchovitch & Mednick (2002) describe it as too vague, too subjective, and ultimately too multidimensional. Other scholars have argued against the search for a universally valid concept of health. Scholars generally fall into one of two perspectives on this point. Firstly, some concede that health by its nature is a normative, value-loaded concept, whose meaning is contextually bound and thus devoid of a singular, objective interpretation. Rather than representing a single entity, it is viewed as a collective term for a constellation of different

entities. Health, therefore, should be treated as a multidimensional concept, the constituting elements of which can neither be indifferently broken down nor summarised in a single explication (Parsons 1958; Dolfman 1974; Laffrey 1986).

Smith (1981)[23], whose ideas contrast markedly with Balog's (1978, 1981, 2005), proposed that the various ideas on the nature of health can be divided into four distinctive models:

(1) Eudaimonistic
(2) Adaptive
(3) Role-performance
(4) Clinical

These four models are described by Smith as occupying the same conceptual plane, with an inclusive and inverse progression existing among them. The 'eudaimonistic' model represents the most encompassing view of health (it includes and goes beyond the basic premises of the other models), whereas the 'clinical' model represents the narrowest view of health (i.e., the absence of disease). Smith observes that each of these four directive ideas of health provide four different targets for directing the practices of health (and other) professionals. Moreover, alignment with a specific health goal, derived from one of the health models, in the first instance does not preclude consecutive or even simultaneous alignment with another goal. In fact, according to Smith there is a fluidity to the way in which we move from one idea of health to another (ibid).

The second perspective sees efforts to seek a true definition of 'disease' and 'health' as a venture bound for failure. Moreover, this venture is portrayed as needlessly distracting and irrelevant to the task of making health-related decisions. Writing from a clinical health viewpoint, Hesslow states:

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[23] Smith's notion of "health as a continuum" is divisive. Some may see it as a paradigm shift in the effort to define and understand the concept of health (and its associated meanings). Others may see it as an adaptive response to the confusion and plurality of the theory of health; a response that seeks to transcend the limitations of the traditional "siloed" philosophical approach.

'the crucial role of the 'disease' concept is illusory. The health/disease distinction is irrelevant for most decisions and represents a conceptual straitjacket.' (1983: 1)

Key to Hesslow's thesis is his argument that contest over the conceptual definition of health is inconsequential for clinical and non-clinical health activities. That is not to say that meaning is not a potent force in decision-making on health issues. On the contrary, meaning encompasses issues and ideals that are integral to the decision-making process. The distinction here lies in how this meaning is generated, with Hesslow proposing that the meaning of health should be formulated by determining whether a state is desirable or undesirable to an individual (as opposed to debating whether they have a medically defined disease).

The work of Hesslow was advanced by Ereshefsky (2009) in his own alternative approach to defining the terms 'disease' and 'health'. Instead of pursuing correct definitions of disease and health, Ereshefsky claims that discussion of these concepts should be framed in terms of *state descriptions* – descriptions of physiological or psychological states which avoid the notions of naturalness, normality and claims about functionality – and *normative claims* (explicit value judgements concerning whether we value or disvalue a physiological or psychological state) (p.225). Ereshefsky contends that this approach has several benefits; particularly that it forces us to distinguish current human states from those we wish to promote or diminish. It also helps to distinguish, 'the current state of the world from how we want the world to be', capturing this critical distinction more effectively than the terms disease and health (p.227).

As this chapter has shown, there have been many efforts to construct a universally valid conceptual definition of health. However, disagreement continues to outweigh consensus on the theoretical and pragmatic value of clarifying the "correct" meaning. As Huber et al. (2011) explain, defining health is an ambitious and complex goal; many aspects need to be considered, including consultation with stakeholders, reflection of many cultures, and accounting for future scientific and technological advances. For this reason,

we might conclude that, as opposed to a definition of health, the adoption of a general concept or conceptual framework – that represents a general characterisation of the generally agreed direction to which to look, as reference – may be a more preferential approach for a planning authority. Conversely, as Huber et al. observe, operational definition is needed for practical life such as measurement purposes (ibid).

The debate on whether we (or a planning authority) need to define health is one which is not new. This debate, moreover, appears to be one that can have no end; as opposing epistemological systems and opposing sources of knowledge show no signs of being able to be reconciled with one another. But what if a planning authority chose to construct their own or adopt an existing definition of health – are there any moral or ethical dimensions to this?

3.4.2 Ethical considerations

If we assume for the moment that a hypothetical planning authority has chosen to define health, for example on the grounds of pragmatism, how might they do it? One approach might be to define health as the product of biological functioning – or 'the absence of disease'. This definition, however, could be subject to the same criticisms of naturalism elucidated previously in this chapter. Another approach might be to utilise the 1946 WHO definition of health, in turn viewing health as not just the absence of disease but as a positive state of wellbeing. Again, however, this definition has its own problems, namely that it is ambiguous and difficult to operationalise. How the planning authority defines health, whether in the first, second, or some other way, is an institutional choice – especially in instances where there is an absence of a specified definition in policy or legislation.

However, our concern here is thus not how the planning authority defines health. Our concern rather is what ramifications their definition – or conceptual understanding – of health might have for the formation and implementation of health policies and strategies. The definition of health influences how health is assigned, measured, and evaluated, including whether society regards certain

conditions as healthy or unhealthy. It also establishes the approach to eliminating or minimising illnesses and diseases, and identifies how and who is responsible for doing so (Braveman & Gruskin 2003; Beeck et al. 2005; Sartorius 2006; Boddington & Räisänen 2009; Hill 2012).

As Engelhardt (1975: 127) has observed:

> 'the concept of disease acts not only to describe and explain, but also to enjoin to action. It indicates a state of affairs as undesirable and to be overcome.'

How we define health is not just a matter of philosophical or theoretical interest, but a critical ethical consideration. The definition of health has ethical value for two main reasons. Firstly, it strikes at whether health knowledge should be used in and how certain health-related activities (such as medicine or planning) should contribute to protecting, promoting, and restoring people's health through application of this knowledge. Secondly, and as explained by Engelhardt (ibid: 127), it is ethical in that the definition of health is aesthetic; it suggests what those qualities and states we value and do not value.

Let us consider a more naturalistic definition of health, the premise of which is that the aim of medicine or any health activity is the negation of disease – hence, to restore people to a disease-free state. Under such a definition, public health and medicine should refrain from engagement in activities nor pursue procedures (e.g., cosmetic surgery) that are not designed exclusively to restore health. Boorse (1977) has argued that health delivery systems which aim for more than the treatment and negation of disease raise a profound ethical conundrum. That is, in introducing normative social and cultural expectations into our equation or health we tread the precarious line of demarcation between what is the '*biological* human' and what we consider to be the '*ideal* human'.

Boorse's view, however, has been met with much reproach by some scholars. For example, Boddington & Räisänen (2009) posit that this "tunnel focus" on disease comes at the expense of an appreciation of the richness of the causal nexus that underpins health. Ahmed et al. (1979), in direct conflict with Boorse, moreover, claims that the naturalist dichotomy between disease and health

emerges from a misconception of what health is – and how we should aim to protect and restore it. Advances in scientific understanding are said, by Ahmed et al. (ibid), to have led to the need to conceive of health beyond the biomedical model, and for health delivery systems to transcend beyond treating disease to that of "upgrading" the socio-physical conditions that can then support "whole person health" (p.8).

Yet, this latter aim could be regarded as too broad, holistic, and vague or too value-loaded and ideological to underpin a rationale, moral and productive health delivery system. More generally, holistic models of health indicate that health involves a "complete state" (e.g., the 1946 WHO definition of health) have been observed as providing a platform for encouraging far-reaching social health strategies that aim to negate *and* prevent disease and which justify – even demand – excessive resources being directed towards the attainment of health based on a signifier ("highest standard") that is not reflective of the reality of health (Boddington & Räisänen 2009). The notion that health delivery – and associated programs, strategies, and policies – in some way needs to be "justified" raises a very practical and ethical issue. That is, the issue of "medicalisation".

How health is defined influences how we establish the breadth of issues that we consider to be health problems. Different definitions of health espouse different conceptions of what is and what is not a health problem, and subsequently what 'problems' we should (or should not) aim to address. Take the extreme example of "strong normativism". Under such a philosophical perspective, all minor deviations from the 'norm' are considered to be problematic and thus diseases. Whereas such deviations may not be considered health problems under other schools of thought (such as under naturalism), here they are confirmed as requiring a medical solution (Boddington & Räisänen 2009). The classification of states as health problems is inherently contentious, with how we define health and disease potentially inadvertently leading to the undertreatment, overtreatment, or mistreatment of society.

Boddington & Räisänen (ibid) capture this idea in their discussion of medicalisation, of which they identify two forms:

1. **Tunnel vision medicalisation** – most often associated with reductionist views of disease and health (e.g., health is the 'absence of disease'), this form of medicalisation can result in an exclusive focus on the physical body, consequently improvising the perception of the determinants of health and the search for wider health solutions; and,

2. **Social control medicalisation** – most often associated with strong normativist views of disease and health (e.g., health is a 'complete and positive state of wellbeing'), this form of medicalisation can result in the exhaltation of health above all other values, and all non-norms prescribed as medical issues, potentially justifying complete state control and interference in societal mechanics (thus diminshing personal automony).

Medicalisation is an ethical dilemma not only for medicine, but for other disciplines engaged in health delivery activities. This includes urban planning, which, by its very definition, has a natural propensity to influence both the design and fabric of the places in which people live and work, and in turn how people interact with those places. How these types of medicalisation might manifest in urban planning can be illustrated through the example of the health issue of obesity.

Firstly, 'social control medicalisation' could result from a planning authority feeling obligated to actively seek to minimise or reduce the incidence of obesity through the formation of spatial policies aimed at manipulating people's diets through the physical transformation of the urban food environment. While this may lead to improvements in population health, it might limit a person's autonomy and agency to consume certain types of foods (e.g., fast-food) and limit their ability to exercise their personal autonomy – to make choices and carry them out – because of the control and interference of their food (or even) wider living environment.

Alternatively, the planning authority might conclude that their responsibility towards obesity and its management lies in facilitating its treatment. From this, 'tunnel vision medicalisation' may become manifest as the focus of the

planning authority is exclusively on delivering healthcare services and related infrastructure. The focus on the negation of disease (defining obesity here as such) may risk overlooking the critical contribution of societal and cultural conditions to health. This, consequently, could result in solutions to obesity (or other health problems) beyond 'medical solutions' being ignored – such as tackling obesity from a self-management or social and environmental just perspective, for example.

Whether too much or too little emphasis is placed on disease (specifically its negation) in health delivery systems, of which urban planning plays its role, is open to debate. It is arguable that the huge challenge that faces society from obesity and other health issues will not be appropriately addressed if either of these extreme – normativist or naturalist – perspectives are adopted. Regardless of whether a planning authority pursues the adoption of a fixed definition, or alternatively a more flexible conceptual framework, of health, it is important that it allows for an operational, measurable, and evaluative conception of health.

3.5 Chapter summary

The purpose of this chapter was to explore the theory and meanings attached to the concept to of health. It has set out arguments for why it is important to consider the meaning of health, if not fully define the term for the purposes of theoretical or empirical effectiveness. Literature presents a multitude of separate ways in which the health can be defined, and its meaning understood. This chapter, while not exhaustive in content, has provided an overview and insight into three leading paradigms of health – (1) health as absence of disease, (2) health as wellbeing, and (3) health as a resource.

Institutions and researchers working in urban planning (both specifically on HUP and more broadly), overwhelmingly employ in their work the second of these paradigms (health as wellbeing). They also tend to actively promote this paradigm of health as *the* way in which health should be understood and applied in urban planning policies and practice. The definition and meaning of health are currently often overlooked, or assumed without question, in health and urban planning literature – including that focused on HUP. But as this chapter shows, there are both theoretical and practical advantages associated with each paradigm of health, as well as ethical and definitional considerations and implications linked to how one (be it an individual, institution or local planning authority) conceptualises and employs the concept of health in their work.

**Section Two
Concepts, challenges, and the
practice of healthy urban planning**

4. Healthy urban planning

This chapter presents a synopsis of the concepts, principles, and practice of healthy urban planning (HUP). It outlines the definition and meaning of HUP and its related concepts, and it provides an overview of the current knowledge around the practice of HUP. This chapter also looks at the broader links between urban planning and health, and it examines some of the challenges facing the utilisation of urban planning as a mechanism for health promotion.

4.1 Introduction

Urban planning has a long tradition in Britain, stretching back before the last century. The planning system itself, however, has only really existed in Britain since the mid-20th century. While its historical roots are diverse, the modern roots of the planning system can be traced back to the 18th century Public Health Movement (see, Chapter One). Today, health is once again gaining traction in the academic and policy debate surrounding urban planning. There is now a tangible growing support for healthy urban planning (HUP). In recognition of this, this chapter studies the concepts, principles, and practice of HUP.

4.2 Concepts and principles

This section of the chapter examines the concept and principles of healthy urban planning and its related concepts. It provides a conceptual referential framework for further discussions in this thesis.

4.2.1 Urban planning

'Urban planning' is as an umbrella term covering all those processes and activities that coordinate and regulate change in the urban and built environment (Cullingworth 1976; Hall 2002; Pinson 2007; Hall & Tewdwr-Jones 2011). Lynch and Hack (1984: n.p.) posit that urban planning is, 'concerned with assembling and shaping the – i.e., local or municipal – environment by deciding about the composition and configuration of geographical objects in the space-time continuum'. Although the concern of urban planning might be capable of being pinned down, its purpose is much more difficult to isolate as a single statement. It is fair to say that there is not a uniform theory about what urban planning is, nor how it should be applied or assessed (Greed 1994).

The concept of urban planning is broad and has been defined in many ways. It has been defined by some with regard to its object, i.e., the structure of the urban and built environment. Others have defined it with respect to its method, i.e., the activity and tools of decision-making (Campbell & Fainstein 2003). Keeble, a prominent post-war British planner, provided a classical definition of planning, specifically 'town planning', in his 1952 town planning text book. Planning is,

> '… the art and science of ordering the land-use and siting of buildings and communication routes so as to secure the maximum level of economic, convenience and beauty.' (p.9)

This above quote from Keeble's text book provides an urban design-oriented definition of planning. It places emphasis on planning's role as a coordinator and regulator of the physical elements – buildings, roads, streets – of the urban

landscape. Undoubtedly the ordering of the physical landscape is a crucial element of urban planning, however many modern planning scholars suggest that the object of planning extends beyond the physical structure of the town or city. Borrowing from the title of a 2010 book by Patsy Healey, Hart et al. (2015) observe that urban planning is about "making better places". This sentiment echoes a similar one made by Thomas Sharp over half a century ago. In the preface to this 1940 book, 'Town Planning', Sharp noted that the product of town planning is simply "a new and better way of life".

Today, it is widely accepted that urban planning incorporates social, economic, ecological, and political dimensions. A 2015 guide to planning published by the UK Department for Communities and Local Government (CLG) states that planning, 'ensures that the right development happens in the right place at the right time, benefitting communities and the economy' (p.4). The UK government also views urban planning as essential to delivering sustainable development (ibid), something which is echoed more widely in planning academia (Breuer 1999). In capturing the wide, varied role of planning, but doing so in a way that is intentionally vague so as not to be restrictive, the Canadian Institute of Planners defines planning as,

> 'the scientific, aesthetic, and orderly disposition of land, resources, facilities and services with a view to securing the physical, economic and social efficiency, health and well-being of urban and rural communities.
>
> Responsible planning has always been vital to the sustainability of safe, healthy and secure environments.' (2018: paragraph 1)

This definition, and the direction of action set out by it, requires urban planning to develop and implement spatial visions, strategies and plans that target the economic, social, political, and ecological needs of a particular area (UN-Habitat 2015).

4.2.2 Healthy urban planning

Healthy urban planning has grown in popularity in recent decades, marking something of a "health turn" in urban planning. Yet for all its plaudits, few publications have (at the time of writing) explored the concept in any real conceptual or theoretical depth. Duhl and Sanchez (1999) provide an early example of where authors have directly sought to answer the question of "what is healthy urban planning?". In the simplest terms, they answer, it means that planning: (1) is not unhealthy and (2) it promotes health (p.2).

A broader definition of HUP is provided by the National Heart Foundation of Australia (2004: n.p.). It defines HUP as,

> '… about planning for people. It puts the needs of people and communities at the heart of the urban planning process and encourages decision-making based on human health and well being.'

HUP seeks ways to facilitate the delivery of urban development that are equitable and sustainable, and which promote health objectives (Barton & Tsourou 2000). Contrary to traditional approaches to urban planning, which tend to focus more on the design rather than the users of urban spaces, HUP is an approach founded on the presumption that built environment professionals must both recognise the health implications of their decisions and actively pursue the creation of urban environments that promote healthy communities.

Similarly, built environment professionals need to appreciate that urban policies have health repercussions and should strive to formulate policies that support health improvement (ibid). The predominant focus of HUP is on outcomes, not processes; and it is concerned with a separate set of goals to previous (20th century) approaches to planning. For this reason, HUP has been presented as a new paradigm in urban planning (Duhl & Sanchez 1999; Barton & Tsourou 2000; WHO City Action Group on Healthy Urban Planning 2003; Barton & Grant 2013; Sarker et al. 2014; Royal Town Planning Institute 2014b; Kent & Thompson 2014).

There is no standard formula for HUP, because, firstly, the health needs of a population will undoubtedly vary from city to city, neighbourhood to neighbourhood and group to group; and, secondly, because the legal systems and procedures which planners much follow are distinct in each country. HUP is thus a methodological precept, not a law of planning. It can be implemented regardless of the urban planning system in place, with the actual practical element being a contextually dependent regime (Duhl & Sanchez 1999; Barton & Tsourou 2000).

HUP requires its own concepts and normative starting point. One such new concept is the 'Settlement Doctor', proposed by Hugh Barton at a 2011 conference on governance for health at the local level organised by the WHO. Here, Barton argues that the mainstream view of the 'planner' is in need of revision: planners should be evaluated and valued not simply as "plan-makers" but as "settlement doctors", who 'diagnose the potential effects of place shaping and prescribe remedial solution advice to politicians and policy-makers' (Barton 2012: 17).

As Ross (2007) puts it,

> 'If the first person you associate with good health is a doctor, then think again. Urban planners might come across as unlikely health practitioners, but the quality of the environments they create and manage significantly influences people's health.'

Ross sees the planner not as a passive player or reactive "firefighter" in finding solutions to health problems, but as a proactive and productive stakeholder in the health problem solving process. This stakeholder approach adds a "collaborative" dimension to the HUP process (see, Chapter Five). Another essential principle of HUP is interdisciplinary, interagency and intersectoral collaboration; involving shared recognition of the problems and shared determination to resolve them (WHO City Action Group on HUP 2003). Compared to traditional approaches to urban planning, HUP offers a people and change-oriented approach. The focus is shifted from land-use control and development management, to goals related to minimising impact on the biophysical environment, improving the quality of the urban environment,

delivering positive health outcomes for people and communities, and achieving social justice and health equity.

Such an approach involves "putting people at the heart of planning" and making the "inalienable" objective of urban planning health, wellbeing and quality of life for all people (Barton 2017; Barton & Tsourou 2000). Health should be the goal of urban planning, providing a coherent and evidence-based grounding for policy-making (WHO City Action Group on HUP 2003). Such an approach requires a clear focus not on the *manner* but the *matter* of decision-making in urban planning. Drawing from the theories and work of David Harvey (1973) and Susan Fainstein (2010), who were concerned with *outcomes,* Barton (2015) outlines his own and his fellow editors' belief that the motivation for HUP is securing health improvement through urban planning policies and practices (this view is also supported by Rydin et al.'s (2012) post-complexity approach to urban planning for health).

The narrative contained within the *Routledge Handbook of Planning for Health and Well-Being* (2015) calls for health not merely to be placed back onto the planning agenda, but for health to be made *the* agenda of planning. As a concept, HUP embraces an urban ecosystem thinking view of the city as a "system of systems" (water, sanitation, energy, healthcare, housing, economic, etc.); as opposed to viewing the city as an individual physical structure. The city and its citizens are held to share a symbiotic relationship, with the health of the city being closely linked to that of its citizens. It is therefore not a question of planning for health at the expense of environmental sustainability or economic development: environmental and economic success are crucial to achieving health and healthy communities (Hancock & Duhl 1988; Kenzer 1999; Wilkinson & Marmot 2003; Sarker et al. 2014).

4.2.3 The healthy city

The WHO has played a critical role in the recent health turn in urban planning, as set out earlier in Chapter One. Of note here is the WHO Healthy Cities programme (WHO-EHCN). This programme has served as a catalyst and information resource for much of the current interest in HUP (Barton & Grant 2013). The concept of HUP is both complementary and overlapping with many components of the WHO-EHCN's 'Healthy Cities' parameters (de Leeuw 2012). Some of the most influential contemporary works on the concept of the healthy city were authored by Trevor Hancock and Leonard Duhl.

Hancock and Duhl's 1988 paper on 'promoting health in the urban context' has proved particularly significant and contributed directly to the establishment of the WHO-EHCN. In this paper, Hancock and Duhl made clear that the concept of the 'healthy city', like that of the 'city', divides opinion as to its meaning and components. To begin, Hancock and Duhl set out that a healthy city is concerned with much more than mortality rates or the provision of health services. By the same account it is concerned with much more than the quality and supply of housing or the living conditions of urban citizens; although these factors are important determinants of health. For a city to be recognised as a "healthy city", it must be engaged in a continuous process of,

> 'creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.' (ibid: 24)

Healthy cities are thus not static, but kinetic; their shape is not permanent but in a stage of constant becoming, setting in motion a cycle of stages. Kenzer (1999) argues that this cyclic process must begin with a conscious awareness that the city is an arena in which the actions taken can either engender or harm health. The form that such action should take is hotly contested. It is dependent on individual preferences and professional context, and cannot, therefore, be categorically recorded.

Duhl (2005) posits that health, as a "thing", is too complex to be described quantitatively and is a multidisciplinary phenomenon, complete with multidisciplinary inputs and outcomes. An economist, for instance, might measure the health of a city in terms of the sum of its balance of trade (good and services exported less those imported); a planner might base their measurement on the amount of available greenspace, or the provision of sustainable transport options; a citizen might rate the health status of a city on the basis of its capacity to provide them with shelter, sufficient income, access to food and water, and their ability to live unrestricted lives; and so forth (Hancock & Duhl 1988).

Scholars, such as Hancock and Duhl (1988), Hancock (1993), and Kenzer (1999), generally agree that the healthy city concept is broad, relative and understood by people differently according to their personal interests, education, and cultural norms and values. As such, a healthy city must take account of all that which influences health and well-being (Duhl 2005). Given the variation in understanding, and the need to look at all the determinants of health and well-being, a healthy city must be process-oriented rather than goal-oriented (Hancock & Duhl 1988; Hancock 1993).

Furthermore, the healthy city is viewed from an ecological perspective: it is conceived of as being an ecological system, the components and functioning of this system providing a dynamic health context (ibid 1988). As an "ecological system", the city must be resilient and capable of coping and responding to 'breakdowns' and able to 'modify itself and change to meet the always emerging requirements for life' (Duhl 1986: 55).

The WHO-EHCN first adopted and subsequently revised Hancock and Duhl's conceptualisation of the healthy city. On the WHO's website, the concept of the healthy city is described in a way that retains much of the conceptual simplicity of its antecedent; it is said that a healthy city is not one which has achieved a certain health status, but rather one that is socially and politically conscious of health and is continuously striving to improve it (WHO 2016b). The emphasis on the creation of possibilities of health, rather than defining an end health state, is tangible in the related concept of the healthy community.

According to the US Department of Health and Human Services, a healthy community is:

> 'one that continuously creates and improves both its physical and social environments, helping people to support one another in aspects of daily life and to develop to their fullest potential' (Centers for Disease Control and Prevention 2016) .

Again, the focus here is not on actual health outcomes but the broader dimensions of physical and social determinants of health, the idea of a continuous process of improvement, and also a sense of autonomy and human rights. Central to the healthy community and the healthy city is the idea of community empowerment. Not only is this attributed to a lack of a fixed definition of health but also the reasoning behind why each city needs to define its own parameters of health. In other words, given the relative nature of health each populace must be free to identify what health means to them and have control over their own health experiences. Under the healthy cities concept, specific policies are neither prescribed nor promoted[24]; instead it champions the local context as the guiding force and processes employed (Werna & Harpman 1995).

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[24] Although much of the discussion about the healthy city focuses more on the process of building capacities for health rather than measuring the outcomes of this process, Hancock and Duhl (1988) stress that this does not negate the need to address in a functional sense what a healthy city is and how it can be measured. To this end, they provide a list of eleven "healthy cities parameters" for use as a checklist for measuring the salutogenesis of urban areas. These parameters are as follows: (1) a clean, safe, high quality physical environment (including housing quality); (2) an ecosystem which is stable now and sustainable in the long term; (3) a strong, mutually-supportive, and non-exploitative community; (4) a high degree of public participation in and control over decisions affecting one's life, health, and wellbeing; (5) the meeting of basic needs (food, water, shelter, income, safety, work) for all citizens; (6) access to a wide variety of experiences and resources with the possibility of multiple contacts, interaction and communication; (7) a diverse, vital and innovative city economy; (8) encouragement of connectedness with the past, with the cultural and biological heritage and with other groups and individuals; (9) a city form that is compatible with and enhances the above parameters and behaviours; (10) an optimum level of appropriate public health and sick care services accessible to all; and, (11) high health status (both high positive health status and low disease status).

4.2.4   Sustainable development

At an international level, there is broad consensus that the aim of urban planning should be to deliver, or at least contribute to the delivery of, sustainable development (United Nations 2008a). In the UK, central government, through the Planning and Compulsory Purchase Act 2004, has secured that the legislative aim of the planning system is to support the delivery of sustainable development. Although the concept of sustainable development is firmly enmeshed in British and European planning, its meaning is vague.

The basic decision-making principle of sustainable development is the integration of economic, social and ecological protection with conventional development goals (Blewitt 2015; Baker 2016). Instead of conventional development at the environment's and society's expense, or environmental or social protection instead of development, the idea is to achieve both development and environmental and social protection at the same time (Dernbach 2003).

Sustainable development as defined by the UN General Assembly, in resolution 42/187, is about,

> '… development that meets the needs of the present without compromising the ability of future generations to meet their own needs.'[25]

Since the idea of sustainable development was promoted at the 1992 United Nations Conference on Environment and Development (UNCED), also known as the Rio Earth Summit, it has persisted in academic and political debate. Yet, like the concept of 'health', the term 'sustainable development' – of which health is an integral component (Institute of Medicine 2014; Kjærgård et al. 2014; De Silva 2015) – has escaped any conclusive definition.

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[25] In *Our Common Future,* Chapter 1, IV Conclusion, para 1 (World Commission on Environment and Development 1987).

In both theory and practice, sustainable development is open to different interpretations. Despite the continuing salience of sustainable development as a norm of planning practice and policy-making, it is not without issue and remains a contested idea in thought and in action. Indeed, the contested nature of sustainable development has been examined, its multiple meanings mapped, and its value and operational capacity debated by multiple scholars (cf. Beckerman 1994; Campbell 1996; Jacobs 1999; Connelly 2007; Bourgeois 2014).

Urban planning can be used as an important mechanism to deliver sustainable development, through coordinating land-use and economic development in a way that protects the biophysical and social environment over the long-term (United Nations 2008a). It can facilitate the consideration and integration of various societal sectors – transport, business and finance, housing, health and social care, defence, and more – over different territorial dimensions and challenges, from local through to global challenges (Nadin et al. 2001; UN-Habitat 2009; Van Nguyen 2011; Baker 2016; Blewitt 2015).

Multi-sector led development is necessary for health, and sustainable development is seen as a lever to improve health and the quality of life of individuals and populations (Price & Dubé 1997). The relationship between the social, economic, and environmental aspects of sustainable development and human health is shown in figure 7.
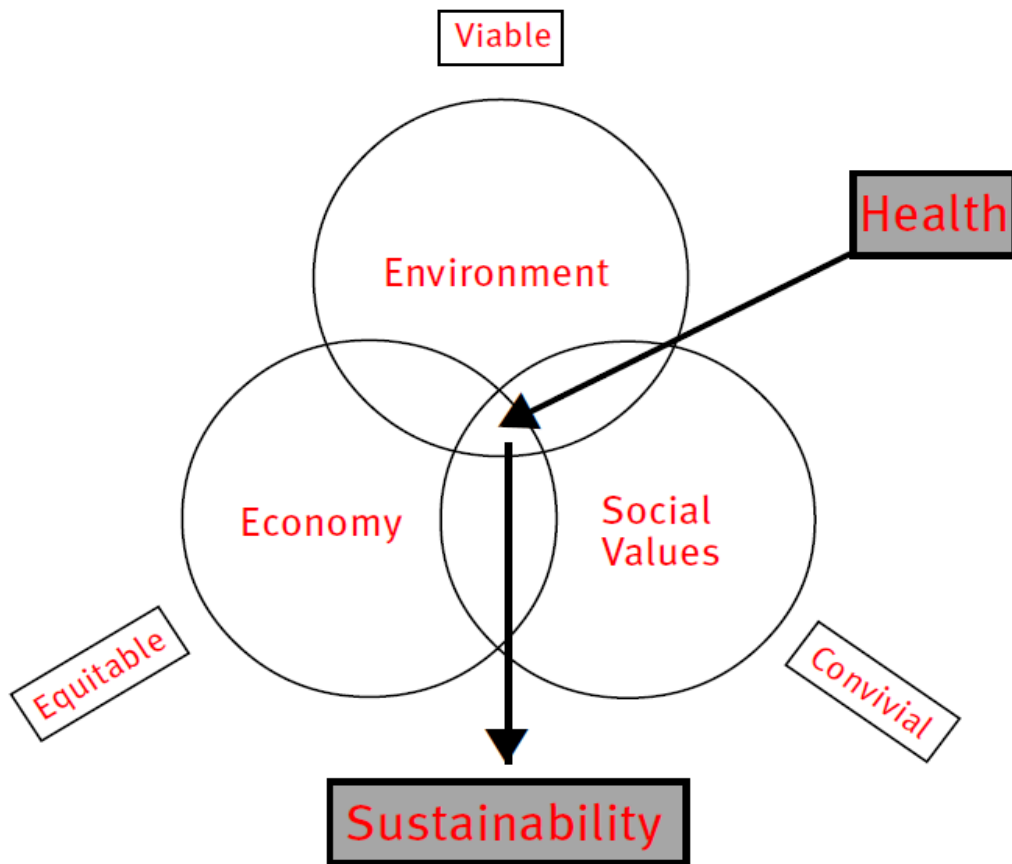
Figure 7 – A conceptual model of sustainable development (Price & Dubé 1997:35)

Like sustainable development, HUP is concerned with how people interact with their immediate and wider environment – not just with how buildings and economies function. Indeed, it calls for the positioning of health considerations at the centre of economic regeneration, urban development, and sustainable development efforts. HUP recognises the need to strike a balance between socio-economic and environmental pressures, thus drawing parallels with the task of planning for sustainable development (WHO City Action Group on HUP 2003).

4.3 Planning for health

This section of the chapter looks at the relationship between urban planning and health, including the links between the work of urban planners and health professionals, the recent shift towards integrating health into planning and other sector policies, and specific health objectives for planners.

4.3.1 The links between urban planning and health

Urban planning has a major influence in shaping urban form. Land-use policies and decisions made by planners help structure the built landscape, as well as the distribution of various entities within that landscape – roads, buildings, parks, among other things (Cullingworth et al. 2015). Urban form has long been thought to impact upon health, meaning it has immediate relevance to HUP and the drive to reconnect health and urban planning. This is because of the way planning policies and decisions interact with development to modify and shape the urban form of towns and cities (Northridge & Freeman 2011). There is a broad body of literature that presents scientific evidence on the links between urban form and health (as overviewed already in this thesis). Some of this literature has focused on how urban planning can contribute to improving population health through interventions on the social determinants of health, of which many have some connection to urban form and design (Wilkinson & Marmot 2003).

The relationship between urban planning and health is complex and difficult to encapsulate succinctly. Rydin (2012: xiii) explains that over the past century our understanding of how urban planning can affect health outcomes has significantly broadened. Today this understanding includes a greater range of specific health impacts (e.g., asthma, obesity, cardiovascular disease, cancer, and more) and aspects of urban planning (e.g., greenspace provision, building standards, air quality management, and urban climate control). Urban planning has even been tied to more distal determinants of health including

poverty (Allen et al. 2010; TCPA 2013), crime and terrorism (Coaffee et al. 2008), and climate change (CABE 2007; RCEP 2007).

The Settlement Health Map, presented earlier in this thesis, offers a conceptual way of thinking about and understanding both how human settlements work and the pathways through which they may act on people's health. From it is possible in infer that that urban planning, environmental policy (alongside socioeconomic activity and development patterns) and the determinants of health can interact in many complex, non-linear ways to bring about different health outcomes for communities and individuals. Barton and Tsourou (2000: 12) provide a useful picture of the diverse links between urban planning and health in the form of a table. This table, reproduced here below, sets out the relationship between the main planning policy areas and relevant determinants of health.

Determinants of health[26]	Planning policy areas								
	Building regulations	Housing policy	Economic development	Social services and benefits	Open space	Transport	Energy, water and drainage	Urban form	Urban regeneration
Personal lifestyles		*	*	*	**	**		*	*
Social cohesion		*	*	*	*	*		**	*
Housing	**	**					**	*	*
Work	*		**			*		*	*
Access		**	*	**	*	**		**	*
Food		*			*			*	
Safety	*	*				**		*	*
Equity	*	**	*	**	*	**	*	**	*
Air quality and aesthetics	*	*	**		*	**	*	*	*
Water and sanitation	**		*		*		**		
Soil and social waste	*		*		*				**
Global climate	**	*	**	*	*	**	**	**	*

This table does not highlight the subsequent regulation of levels of pollution and other factors, nor does it focus on the social, education and health services per se but their accessibility.

* Important influences on health
** Critical or prime influences on health

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[26] The determinants of health are organised by level (based on Whitehead and Dahlgren's model of the "wider determinants of health", see Chapter Two of this thesis); with all levels, from personal lifestyle choices to broad environmental variables, being affected.

The above table sets out the links between urban planning and many (but certainly not all) determinants of health. Although not congruent with each other, it is reasonable to assume that consideration of health in the process of urban planning is consistent with current health promotion thinking – including that outlined in the Ottawa Charter for Health Promotion; action areas which include creating supportive environments and producing healthy public policy (WHO, 1986).

4.3.2 Health in all policies

Government policies and programmes explicitly framed around public health, alongside other policies that touch on public health issues (education, transport, etc.), provide the broad framework for action on collective and individual health (Hunter 2003; Hunter 2007). Public health has been described as, 'the science and art of preventing disease, prolonging life, and promoting health through the organized efforts of society' (Acheson 1988: 4). The scope of interest for public health is ambitious, and ranges from healthcare provision, through disease and injury prevention, through to the promotion of healthy living environments (Detels & Tan 2015).

Despite the broad ambitions of public health, the policies of many national and local government public health departments focus primarily on healthcare provision. This approach, in turn, may lead to a disproportionate allocation of resources towards top-down, individual level initiatives aimed at the treatment of disease – e.g., through the provision of healthcare facilities, such as clinics and doctor's surgeries. The corresponding neglect of bottom-up, collective initiatives aimed at preventing disease (e.g., addressing the causes of disease, such as unhealthy diets or physical inactivity) may have a negative impact on the health of communities and populations over the immediate and long term (Evans & Stoddart 1994; Folland et al. 2016).

Although healthcare provision is an important determinant of health, evidence suggests that its influence on health status pales in significance compared to other "social" factors - e.g., financial income, education, diet, physical activity, sanitation, and other factors (McKeown 1979; Kunitz 1989; Marmot et al. 1991; Evans & Stoddart 1994; Allen et al. 2010; House of Commons Health Select Committee 2009). According to the US Institute of Medicine (1997), the importance of advances in healthcare provision as a determinant of health has been overemphasised[27].

Around the world, health and social care systems are struggling to cope with a combination of decreasing financial support and increasing demands for services resulting from ageing populations with multiple physical, psychological, and social care needs (Goodwin 2015; Borgermans et al. 2017) (for an overview of the state of health and social care in the UK, see Birrell & Heenan 2018 and OECD 2016). The growing demand for health and social care services may presuppose the development of larger, more advanced delivery systems. This means investing more resources – capital, financial, institutional – into healthcare systems (as well as social care systems). But shortcomings in this strategy, alongside the wider dominant focus on healthcare provision in public policy, have been identified.

Firstly, Evans and Stoddart (1994) claim that the extension of the healthcare system per se has a negative influence on the wellbeing and economic progress of societies; this is because it is has a net claim on societal wealth and does not address those factors that cause disease in the first instance. Secondly, reliance on healthcare systems to address the growing array of modern health issues (e.g., NCDs) is thought to be both misjudged as to their origins and misguided in terms of economic realities (Barton & Tsourou 2000). Indeed, the health threat facing urban populations has been observed as having the potential to cripple global healthcare systems (WHO & UN-Habitat 2010).

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[27] For example, Bunker et al. (1995: 1261) credit clinical services (both preventative services and therapeutic intervention) with only 5 or 5 ½ years of the 30 years increase in life expectancy witnessed in the US since 1900.

Many of the major causative factors of disease are beyond the control of the healthcare system. In practice, however, the healthcare system ends up "owning" and dealing with the problems that result from disease. This is despite evidence indicating that the answer to addressing the causes of public health problems may not lie in medical or clinical solutions, but rather in environmental and social solutions (Kickbusch & Gliecher 2012). Health issues and problems have social, economic, and environmental causes (Wilkinson & Marmot 2003). The cross-cutting and cross-sectoral nature of human health means that it is an 'exemplar of the interconnected policy-making required in the 21st century' (Kickbusch & Gliecher 2012: 13).

Health should be the business of all government policy areas (ibid), with the President of the Faculty of Health, Professor John Middleton, recently declaring that it is 'Time to put health at the heart of all policy making' in the UK (Middleton 2017). This was also the finding of a review, chaired by Professor Sir Michael Marmot, into health inequalities in England, and which concluded that health must be systematically integrated across national policies and frameworks – including 'planning, transport, housing, environmental and health systems…' (Allen et al. 2010: 134).

A similar finding was reported in a 2013 document published by The King's Fund, which sought to provide a resource for local authorities in improving the population health. The authors of this document identified the following "possible priority action" for local authorities,

> 'Local authorities need to ensure that the health impacts of different policies are assessed, and health considerations integrated into planning across all departments. This will ensure that health benefits are realised across the broad spectrum of local authority functions, rather than remaining as isolated strands of good practice.' (Buck and Gregory 2013: 52)

Today, there is broad academic and institutional agreement on the role of "health in all policies" (HiAP) in public health efforts (Kickbusch 2013; Rudolph et al. 2013; Bert et al. 2015; Becerra-Posada 2017). As introduced in Chapter One, HiAP is a strategy that seeks to deliver health improvement by addressing factors outside the health and social care systems; but it still focuses on factors that have important health effects, such as socioeconomic and environmental factors affecting lifestyle and health behaviours (Bert et al. 2015).

HiAP advances the notion that health is neither created by health ministries nor healthcare systems but is dependent upon the synergies between public health and other sector policies. It is, moreover, built upon the understanding that health is a perquisite for economic growth and that health improvement requires both health-sector specific policies (e.g., healthcare) and broader health-related policies (e.g., education, transport, urban planning).   The WHO explains that HiAP,

> 'systematically takes into account the health implications of decisions, seeks synergies of policymakers for health impacts at all levels of policy-making. It includes an emphasis on the consequences of public policies on health systems, determinants of health and well-being.' (WHO 2014b: i17)

Health in all policies is an instrumental part of the "new public health" agenda (see, e.g., Petersen & Lupton 1996 and Tulchinsky & Varavikova 2000). The new public health perspective is not singular, but plural. It incorporates a suite of health-related policy schemes held together by a common thread. That is, that much improvement in total population health can be achieved without continually expanding healthcare systems (and their budgets) (Awofeso 2004; Tulchinsky & Varavikova 2010). What is needed, instead, is a "whole systems" approach which extends beyond healthcare alone – but nor does it rely on economic growth and demographic change to deliver improved urban health outcomes (a perspective that is thought to be based on an over optimistic reading of the theory of the "urban advantage" (Rydin 2012).

A whole systems approach to health entails the application of comprehensive evidence-based management systems, the efforts of which converge on disease control *and* disease prevention; they promote initiatives aimed at addressing existing, evolving and emerging health risks; and, seek to enact collective and collaborative multi-sector action on health (Baum 1998; Awofeso 2004; Tulchinsky & Varavikova 2010). Public health policies and strategies thus must adopt both "downstream" and "upstream" thinking, bringing together clinical and non-clinical professionals from both health and other sectors, to address individual level and wider social constructs behind the manifestation of disease. Health must be considered in both directions: how health is affected by other sectors and how health affects other sectors (Kickbusch & Gliecher 2012).

The RCEP (2007) proposes that such an approach to public health must go beyond "appealing" to the individual to address their health behaviours; for example, asking them to eat healthy foods if they have an unhealthy diet. Rather, individual level initiatives must be reinforced by policy interventions designed to transform the infrastructural arrangements that incentivise and facilitate behavioural practices (p. 149). Achieving this requires the efforts of not just health professionals, but also the expertise and powers of other professions – which collectively affect the social, economic, and environmental determinants of health. In effect, it is about creating a socioeconomically and ecologically healthy settlement (Barton et al. 2010).

Urban planning's ability to regulate land-use development and mitigate conflicts about land-use futures, has led to calls that planners must form part of the mix of stakeholders – which also includes designers and developers – necessary to create healthy urban settlements (Royal Commission on Environmental Pollution 2007; Rydin et al. 2012; Royal Town Planning Institute 2014b; Barton 2015).

4.3.3 Urban planning health objectives

To achieve coherent HUP strategies it is necessary to establish shared concepts and understanding (WHO City Action Group on HUP 2003). In *Healthy Urban Planning – a WHO guide to planning for people* (2000), Barton and Tsourou promote a list of agreed upon and negotiated key health objectives for planning. These objectives, expressed as questions, are as follows:

Do planning policies and proposals encourage and promote:

1. Healthy exercise?
2. Social cohesion?
3. Housing quality?
4. Access to employment opportunities?
5. Accessibility to social and market facilities?
6. Local food production with low-input food production and distribution?
7. Feelings of community and road safety?
8. Equity, development of social capital and a reduction of poverty?
9. Good air quality, protection from excessive noise and an attractive living and working environment?
10. Improve water quality and sanitation quality?
11. Conservation and quality of land and mineral resources?
12. Climate stability?

(Adapted from ibid: 13-22)

This list provides a common set of criteria that can be applied across different scales of operation and decision-making, from sub-regional planning down to specific development projects. These criteria must be interpreted appropriately, and mechanisms implemented to secure consideration of health. At each scale of interpretation, however, be it the whole settlement or city region or neighbourhood level, there is a need for policy consistency and a range of issues need to be overcome in order to achieve this (Barton et al. 2010). One major challenge for HUP is the actual implementation of its

principles, something that relies extensively on development projects coming forward and gaining approval; this ongoing process of "project planning" can progressively shape settlements towards health-promoting environments (Carmichael et al. 2013; Barton et al. 2010; Sarker et al. 2014).

A series of "checklists" have been prepared by various organisations as a way of ensuring that development proposals conform to the principles of HUP, as well conforming with other relevant public health strategies and policies. In 2017, the UK London Healthy Urban Development Unit published a 'Healthy Urban Planning Checklist' aimed at promoting HUP by ensuring that the health and wellbeing implications of local plans and major planning applications (proposals comprising 10 or more residential units (or a site area of 0.5ha or more, or 1000m^2 of non-residential floorspace or a site area of 1.0ha or more) are taken into account. Outside the UK, there are many examples of HUP checklists; such as the (2017) 'Healthy Urban Development Checklist' prepared by the New South Wales (Australia) Department for Health and designed specifically for health professionals.

4.4 Theory to practice: the evidence around urban planning and health

This section addresses the question of whether urban planning practice is healthy? And if so, or even if not, what is the evidence to support this? There are two aspects of this question. Firstly, how is health considered within urban planning – both at the level of individual processes and at the level of national planning systems. Secondly, is there any empirical evidence to verify any measurable and enduring impact of urban planning efforts on health. This chapter will attempt to answer these questions in turn in the next section.

4.4.1 Consideration of health within urban planning

As to the first question it is important to emphasise that the consideration of health within urban planning can take many forms and occur at different scales, from the scale of individual processes up to the scale of a planning system (Corburn 2010). The preparation and formulation of Local Development Plans (LDPs) is an example of where health (and health effects) could be considered within urban planning. But health could equally be considered within the development management process, or within the context of specific planning-led projects or interventions. To date, the literature has primarily applied a broad-scale approach to the analysis of the consideration of health within urban planning. Some of the most comprehensive data and insights into the consideration of health within urban planning practice has come from the WHO-EHCN.

Evidence from the WHO-EHCN

As discussed earlier in this thesis, the WHO-EHCN has existed since 1986. It was launched as a strategic vehicle for bringing the WHO's strategy for 'Health for All' to the local level, and in 1997 the Network launched the HUP initiative as part of the move towards combining the agendas of health and sustainable development (WHO City Action Group on Healthy Urban Planning 2003). Evaluation has been a critical endeavour and integral feature of the Network's work since its inception. Tsourou (1998) conducted one of, if not the first, empirical studies into the development of HUP and the resonance of the WHO-EHCN's principles in European metropolitan planning frameworks. Tsourou's study, undertaken for the purposes of a doctoral thesis, involved surveying urban planners in European municipalities involved in the Network at the end of the second phase of the project (1993-1997).

One of the main findings of Tsourou's survey was that, notwithstanding some important strategic- and project-level innovations in urban planning, the general impact of the WHO-EHCN, and the HUP approach, had been limited up to that point in time. Analysis of interview transcripts revealed that most municipalities involved in the Network had not fully incorporated health principles into their planning processes. Public health and health-related interventions were, moreover, considered by those surveyed to be simply "interesting" matters for urban planners to consider in their work. It was also found that the lack of understanding among participating planners concerning the links between health and urban planning had contributed to a fragmentation of theoretical and practical interpretations of HUP. Overall, Tsourou posited that HUP remained a largely conceptual, as opposed to practically resolved, activity in European cities (Tsourou 1998).

Several studies have since used Tsourou's research as a baseline against which to evaluate the subsequent development of the WHO-EHCN and HUP. The results from these studies are many, but a principal observation is that they give some contradictory messages. On the one hand, the studies collectively paint an encouraging picture for the work of the WHO-EHCN and the integration of health within urban planning practice. Evidence suggests

that activities associated with and the overall understanding of HUP has improved in recent years. Indeed, evidence obtained from written material and in-depth interviews shows that positive progress has been made in terms of the conceptual and practical development of HUP (WHO City Action Group on Healthy Urban Planning 2003; Barton & Grant 2011).

Yet, on the other hand, these same studies argue that the integration of health within urban planning has not reached its potential in most European planning systems. And, moreover, significant barriers stand in the way of progress on practically implementing HUP (Tsouros 2013; Tsouros 2015). Again, notwithstanding demonstrable advancements in the conceptual and practical dimensions of HUP, some authors, such as Barton and Grant (2011), remain unconvinced of built environmental professionals' (namely, urban planners) knowledge of the health effects of urban planning – but also the nature of the wider relationship between urban form and health.

Another problem identified by Tsourou (2015) is the over-focus on designing and implementing individual initiatives and projects aimed at testing HUP principles, as well as improving the health of specific groups of individuals or communities. For example, many cities involved in the Network tend to emphasise action in the form of a series of specific projects, such as developing or improving urban parks or installing cycle lanes (WHO City Action Group on Healthy Urban Planning 2003). This emphasis is not, however, generally reflected in strategic action and thinking, including that linked to strategic urban planning that adopts an all-encompassing view of the city and the metropolitan dynamics. According to Tsourou (2015), the concepts of HUP and healthy cities continue to be elusive concerns for national governments and national planning systems.

The broader context

Beyond that published by members of the WHO-EHCN, there is, at the time of writing, limited literature available that has examined the practical (not just conceptual) application of HUP, and the broader integration of health within urban planning practice. In a 2009 report on *Planning Sustainable Cities,* the UN-Habitat observed, as part of a litany of complaints, that globally the current approach to urban planning and development has failed to properly address health and other related problems (such as climate change and pollution). The neglection of health concerns in urban planning and development has been discussed in relation to specific national contexts.

Frank and colleagues (2012), for instance, observed that in Canada available evidence suggests that the health effects of major transportation and land-use decisions are regularly made in the absence of an appropriate impact assessment that has explored the potential positive and negative consequences of proposals. Impact assessment is a tool used to identify and evaluate the future consequences of a current, proposed, or even past action (examples include Environmental Impact Assessment (EIA) and Health Impact Assessment (HIA). The inclusion of health within an impact assessment of plans, policies and programmes (PPPs) and other actions has been promoted as an avenue through which to ensure that health is considered in the decision-making process (Wismar et al. 2007; Fischer 2010; Vohra et al. 2013).

In a 2007 paper, which examined the health credentials of metropolitan planning frameworks, Thompson and Gallico (2007) explained that modern Australian cities face multiple health problems due partly to an historical failure to integrate health, wellbeing and equity as core considerations of urban planning (see also, Butterworth 2000 and Knox 2003). Additionally, in this paper, the findings of a content analysis of selected Australian and international metropolitan plans are presented (including analysis of the South East Queensland Regional Plan 2005-2026 (2005), The London Plan (2004), among others). This content analysis involved evaluating each selected plan in relation to certain health-related terminology ('health', 'safety', 'wellbeing',

among others) contained in the document. The analysis uncovered that health was embedded into the selected plans in an assortment of ways, and to differing extents. For example, the London Plan (2004) was found to have established health as a key interconnecting theme. Furthermore, the London Plan was found to set out a clear role for the LPAs in achieving healthy environments using strategic provisions in local plans and development assessment.

Overall, it is difficult to get a clear sense from the literature of what the general trends are regarding the consideration and treatment of health (and related issues) in the PPPs of urban planning. This in some ways is understandable. Reliable empirical data on the integration of health in urban planning practice are not readily available. In a 2013 paper published in *Land Use Policy*, Carmichael and colleagues provided a commentary on the state of evidence on health and urban planning in the UK. The authors explained that there is currently a paucity of empirical evidence on health and urban planning. They further noted that the absence of evidence had fuelled suspicion that health considerations have not been adequately incorporated into the formulation of LDPs.

As Carmichael et al. put it,

> 'there is a strong suspicion, supported by extensive non-systematic evidence, that local plans and related policy are not taking health on board.' (ibid: 259)

Seeking to test the validity of this suspicion, among other issues, a series of connected studies were commissioned by the National Institute of Health and Clinical Care Excellence (NICE) (circa. 2008) to investigate how LPAs incorporate health into their local development policies and decision-making[28]. Focusing particularly on England, these studies combined case study research and systematic reviews of extant evidence. Much of the work by the

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[28]NICE had the intention of producing a guidance document for local authorities and health agencies on how to maximise the promotion of health through the planning system. This guidance was to be prepared based on a review of the best available evidence, as well as the findings of and experience of those involved in the commissioned research. The guidance document was scheduled for publication in December 2011; however, at the time of writing, it still has not been published.

University of the West of England (UWE) undertaken for the NICE call for evidence was summarised in the aforementioned article by Carmichael et al. (2013). This article was based on the conclusions from two reports in particular (Reed, et al. 2010; UWE 2010) as well as the findings of the authors' own literature review.

While not being able to provide an authoritative picture of the whole planning system in England, Carmichael et al.'s article (and the research that underpins it) provides a general indication of the integration of health within plan and project appraisal, and LDPs – including Local Plans. In line with the focus of this thesis, an overview of the evidence on the integration of health into Local Plans (primarily in England) is presented below.

Health within Local Plans

Echoing what has already been said in this chapter, urban planning is a tool that the public sector can use to regulate and guide land-use development towards certain ends or visions. The inclusion of health into the mainstream of plan-making and plan implementation activities is a critical factor that will help to ensure that urban planning can help promote positive population health (WHO City Action Group on Healthy Urban Planning 2003; Royal Town Planning Institute 2009). This includes integrating health concerns into the preparation and formulation of Local Plans. In England, LPAs are responsible for preparing a Local Plan for their area. More information on the function of Local Plan in the UK planning system is available in Chapter Eight, but here it is worth noting that Local Plans typically define the spatial strategy and strategic planning framework that will guide the development of an area, and they set out specific policies against which planning applications will be determined.

Beside that by Carmichael et al., only two other studies seeking to obtain in-depth evidence about the integration of health within Local Plans in England have been identified in conducting this literature review(Reed, et al. 2010; Tewdwr-Jones 2011). This arguably limited evidence is, however, consistent

and suggests that there is a growing acceptance among policy-makers that health is a legitimate issue to be addressed in plans and policies. The goal of promoting healthier communities was also found to be a theme among some of these Local Plans examined. While many Local Plans acknowledged that policies and other factors impact on health, the implied causal links between plans, policies and health outcomes were generally neither fully established nor made explicit. Among other joint conclusions was the belief that if national planning guidance and policy were to formally establish health as a material consideration, this would strengthen the integration of health within Local Plans and increase its weighting in decision-making[29].

Several findings from the article by Carmichael et al. (2013) are also worth discussing here. To start, Carmichael et al. identified a significant variation of health integration among adopted Local Plans. Most of those Local Plans (but also Regional plans) analysed were determined to have inadequately considered the relationship between policy provisions and the determinants of health. In instances where health was found to have been considered, it was often the case that this consideration was limited in scope. For example, Local Plans primarily focused on two key health issues: health inequalities and physical activity. However, the consideration of the wider determinants of health (health behaviours, social environment, injury, among others) was criticised by Carmichael et al. as being poor – or mediocre at best.

The article by Carmichael et al. also indicates a general regularity between various levels of policy making – from rhetoric, to policy, through to detailed plans. For example, those Area Action Plans (AAPs) examined in authorities where the Local Plan featured health (fully or partially) had themselves explicit health-oriented policies. In one case (South Hampshire), the APP was found to have a much more comprehensive and explicit coverage of health issues than the adopted Local Plan. This is suggested by Carmichael et al. to show that there is consistency between policies, and reinforcement of policy principles (such as health) at each level.

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[29] Note that these two studies were conducted prior to the adoption of the National Planning Policy Framework (2012), which more formally introduced health as a material consideration within plan preparation and decision-making.

Although the planning system (at the time Carmichael et al. were writing their article) did not require effective integration of health, Carmichael and colleagues conclude that it was not the system per se that was impeding the inclusion of health into local plans. Rather, that some authorities perform impressively in terms of health, while others do poorly, suggests that "integration" is heavily influenced by institutional and structural norms and practices. This view is shared by other research, including that by Tewdwr-Jones (2011). Tewdwr-Jones posited that because some LPAs are "forward-thinking" in terms of health only serves to further reinforces the conclusion that the absence of a national policy requirement to include health provision in Local Plans provides LPAs with considerable freedom in interpreting HUP at the local level, and that this is an explanation for why there are significant differences in coverage in relation to health between Local Plans.

Work by UWE (2010) also found examples of LDPs (including Local Plans) that while not containing explicit policies on health do include elements that strongly promote health; such as policies that, if implemented, could contribute to positive health outcomes. This was particularly seen in some AAPs (e.g. London Borough of Redbridge and South Cambridgeshire), which have adopted broad policies on walking, cycling networks, lighting schemes and retail accessibility. Although adopted under the guise of sustainability rather than health, without any concrete evidence stating otherwise, there is no reason to suggest that good policies on sustainability would be less effective in achieving positive health outcomes than good policies with an explicit health perspective (ibid).

4.4.2 The health effect of urban planning

Books and articles that touch on the subject of the "health effect" of urban planning tend to refer to the introduction of building codes and improvement in sanitation during the 18th century as examples of early urban planning efforts that improved health (Peterson 1979; Ashton & Seymour 1998; Ashton 1992b). Much of this evidence is retrospective and observational; it often relies on proxy measures for health, such as the rate of disease (Ashton & Seymour 1998). From a critical perspective, it is unclear how observed relationships between, say, the introduction of building codes and reduced rates of disease translate into evidence of the health effects of urban planning efforts. This is partly because the evidence underlining this literature does not quantify or disentangle the impact of purposive policies and decisions (or the unintentional influence of urban planning efforts on health) from wider sources of impact (such as advancements in education or healthcare). As a response to this, more recent work has distinctively focused on unpacking what influence urban planning can have on health and how it could fulfil its potential to effect change.

There is a reasonable body of recent literature that has attempted to determine which urban planning interventions are most effective for improving health. Most literature of this sort has included an "umbrella" review summarising the available evidence regarding the links between urban environment (or urban form), urban planning and health. Authors of such work often try to understand the implications of their respective evidence reviews for urban planning, and the overall conclusion in most of these studies is surprisingly consistent: that there are many health risks associated with urban planning, and that the evidence of the relationship between urban planning and health is "particularly strong" with respect to certain environmental interventions – such as implementing traffic interventions that can reduce accidents and/or increase physical activity, and creating new green infrastructure that reduces air pollution and improve mental health (Duhl & Sanchez 1999; Northridge et al. 2003; Boyce & Patel 2009; Northridge & Freeman 2011; Kent & Thompson 2014; Barton 2017; Public Health England 2017).

According to Public Health England (PHE) (2017), available evidence pertaining to the health effects of environmental factors strengthens the argument for an upstream shift towards addressing key obstacles to healthy living and improving the salutogenic (health-promoting) design and effectiveness of urban environments to promote health. This includes the use of purposive urban planning interventions to improve the health of individuals and communities. As with the integration of health within LDPs, there are only a few academic publications (or other publications) that have set out examples of how the evidence and health concerns have been interpreted and integrated into the different urban planning elements and processes.

Some examples are provided the *Routledge Handbook of Planning for Health and Well-being* (2015). Part V of this book examines the way health issues and wellbeing strategies are being pursued through urban planning in a variety of countries and settings. For example, Thapar and Rao's chapter about the city of Hyderabad details the methods and evidence used by planners to inform the masterplan of the city; alongside the purposive interventions planners are using to restrict urban sprawl, improve infrastructure and create open space that will improve the health of residents.

Looking specifically at the UK situation (especially that in England), the TCPA have produced several reports, as part of their 'Reuniting Health with Planning' initiative, that have included case studies of where health has been integrated into urban planning practice (Ross & Chang 2012; Ross & Chang 2013). Similarly, a report by the Local Government Group (LGG) titled 'Plugging health into planning' (2011) discussed how English LPAs were through their work contributing to improving health and reducing health inequalities. For example, Bristol City Council were reported to have, in partnership with NHS Bristol, developed a "healthy planning protocol" that sets out how health should be considered by the planning-decision making process (p.47-49). Alternatively, the report recounted how Plymouth City Council has used Health Impact Assessment (HIA)[30] as a tool to assess and help understand and define

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[30] A Health Impact Assessment (HIA) can be defined as 'a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population' (WHO Europe 1999).

the health impacts (positive and negative) of specific community development proposals (p.56-57).

Taken together, these and other studies indicate that health interventions and strategies are being pursued through urban planning in a variety of ways. Barton and Carmichael (2015) suggest this variety is reflective of the diverse context of cultures, economic conditions, and governance arrangements that planners must operate within, but also the sophistication of the planning strategies, measures and policy instruments that planners create and implement. The authors also conclude that in instances where purposive urban planning interventions and strategies are deployed, urban planning has had a positive contribution towards health and wellbeing objectives. Nevertheless, concern remains as to the extent to which good intentions sometimes included in the PPPs of urban planning are being realised in practice; and what has been achieved on the ground. In other words: has urban planning made a difference?

Measuring output and impact

The causal health effect of urban planning touches on many possible methodological and empirical questions, many of which are beyond the scope of this thesis. Some relate to the determinants of health and how to measure the effect of those determinants. What methodological approach is the most appropriate, for example, when evaluating the effect of urban planning on health and what evidence constitutes grounds for accepting that urban planning had such an effect? Even after – or even because – acknowledging that the field of the determinants of health is complex and volatile, it remains clear that research design and the definition of adequate evidence is a quagmire of conceptual and methodological challenges (de Leeuw & Skovgaard 2005; Greenhalgh & Stones 2010; Muntaner et al. 2012; de Leeuw 2012).

Evidence and evaluation of urban planning efforts has attracted much attention in the planning literature, with authors writing extensively on the different approaches to and problems with existing and emerging forms of evaluation and assessment of the impacts and outcomes of such efforts (Hull et al. 2011). From a health perspective, a collection of authors have drawn attention to the inherent difficulties in measuring and understanding the health outputs and outcomes of urban planning (Sutcliffe 1995; Chapman 2010; Whittingham 2013). Key issues identified include that of selecting which health criteria are to be used to measure the impact of urban planning efforts, and how to disentangle this impact from that of other determinants of health.

Although there is an abundance of theory linking urban planning to health, empirical evidence supporting the implementation of urban planning and other environmental interventions to ameliorate and enhance health remains scarce and there is a suggestion that more is needed to aid the case for further policy change (Barton 2009; Northridge & Freeman 2011; Allender et al. 2011; Goodwin et al. 2014; Kent & Thompson 2014). Another pressing problem in the evaluation of urban planning efforts to improve health, is that LPAs do not always monitor the health impact of their policies and associated actions (Barton 2009; Reed, et al. 2010; Carmichael et al. 2013).

Furthermore, there is the problem of what "level" of evidence is required to support the efficacy and effectiveness of public health (including urban planning-led) interventions. In policy debate, explains Rychetnik et al. (2002), there exists the notion that a lack of high-quality information about an action or problem means that an action or problem is unimportant. This is also true of public health interventions, whereby there is special emphasis placed on obtaining evidence that definitively establishes a causal link between interventions designed to improve health and changes in health outcomes of individuals and communities.

By their very nature, public health interventions are often multifaceted, programmatic and context dependent. The approach to evaluating and the evidence used to support the adoption of public health interventions must be sufficiently comprehensive to encompass that complexity. This causes further

issues on two fronts: firstly, in terms of research design because many research designs are unable to accommodate the complexity and flexibility that characterises many public health interventions; and, secondly, the use of "evidence hierarchies" to compare evidence has to be regarded so that it does not translate into unrealistic or overly-excessive demand for "gold standard" evidence, particularly if there is good (or adequate) evidence to inform decision-making (ibid).

The quality of available evidence is important in public health and urban planning, but there is also a need for balance. Decisions in both professions, and even more so for joint decision-making, require a weighting of multiple factors: namely, the perceived magnitude and importance of the problem, the potential effectiveness and harms of the intervention, the feasibility of its implementation, its political acceptability, and the scale of demand for action (Rychetnik et al. 2002). There is also a need to factor into this equation the current availability of evidence, the quality of that evidence, and an understanding of what evidence can be obtained (de Leeuw & Skovgaard 2005; de Leeuw 2012). Considering the complexity of urban planning interventions and the wicked nature of most health problems, it is thought by de Leeuw that the "gold standard" of health research ("the randomised controlled trial") is untenable and conceptually inappropriate in this instance (de Leeuw 2012).

That there is little empirical evidence to directly demonstrate the health effect of individual or collective urban planning interventions remains an issue. Chapman (2010) describes the absence of evidence and systematic assessment of the effect of planning as a "missing link" in boosting the adoption of HUP principles. This is especially the case given the accentuation of evidence-based urban planning in recent years (Davoudi 2006; Nadin 2007; Krizek et al. 2009; Morphet 2011).Only through analysing the direct health impact of urban planning, by isolating the contribution made by it, can the success of urban planning in health terms be judged.

Establishing a clearer link between planning decisions and health outcomes is vital to the drive towards garnering more support and resources for future HUP initiatives and strategies (WHO City Action Group on Healthy Urban Planning 2003). Although there is limited (if any) available evidence measuring the direct impact on health, there are many evidence reviews (as discussed above) that show an association (if not causation) between the environment and health. According to Barton (2017), the accumulating evidence base provides a clear mandate in support of urban planning, to ensure that health concerns are built into PPPs, and to improve the health of individuals and communities (Braubach & Grant 2010; Public Health England 2017).

This brings us finally to the issue of "output", and what form this output should take in relation to HUP. Planners' efforts in integrating health into planning processes can, broadly speaking, be viewed through a process-oriented or goal-oriented lens. Alternatively, it is the difference between focusing on the promotion of health at each stage of the planning process or focusing on the impact on the end users (i.e. citizens' health). Unfortunately, literature does not provide a single solution to this issue.

The Healthy Cities concept outlined earlier in this chapter tends, for instance, to support a more process-oriented approach (de Leeuw 2012). Indeed, planners working in the English planning system interviewed in a study by Goodwin et al. (2014) appeared to broadly favour this understanding; most participating planners considered the 'health proofing' of the local planning process – that is, placing health at the centre of plans and associated decisions – as a positive and tangible output, due to the perceived implications for community health over the long term. Goodwin et al. similarly side with the planners on this point – in the first instance, at least. While health proofing can positively support sustainable population health improvement, the authors note that 'it is not a 'health' outcome per se' (p.125). The development of "good" planning policy should thus be regarded as an appropriate output in the initial steps on planning's causal pathway, rather than the actual health impact of policy (ibid: 125).

4.5 Chapter summary

The purpose of this chapter was to present a discussion of the concepts, principles, and practice of healthy urban planning (HUP). It has examined the concept of HUP itself, alongside several other related concepts – including the concepts of urban planning, the healthy city, and sustainable development. A review of the literature reveals that while the concept of HUP has received growing attention in recent decades, there has been a relatively limited examination of either its conceptual foundations or theoretical framework within which it is embedded.

That notwithstanding, available literature makes clear that HUP is a human-centric (i.e., primarily focused on the needs of people) methodology and process for delivering urban development that is both equitable and sustainable, and which promotes health objectives. While there is no standard formula for HUP, due to the variable social and regulatory contexts within which urban planning operates, literature does provide a common set of criteria (a "checklist") for guiding action on health in urban planning.

Finally, the literature reviewed suggests that while current evidence indicates that there is a linkage between urban planning and health, and despite some evidence of health being considered within the practical urban planning process (including in the preparation and implementation of PPPs), further research is needed to better understand how health is considered in urban planning practice and how urban planning has had (and is having) an effect on the health of individuals and communities.

5. Barriers and opportunities to health urban planning

This chapter examines the barriers and opportunities to the practical application of the concept of healthy urban planning (HUP). It starts by outlining the process and procedures of urban planning and explains what role these play in HUP efforts. This is followed by a discussion of a selection of barriers and opportunities to HUP and the promotion of health more widely through urban planning. These are namely those associated with complexity, collaboration, and politics. Discussion of these factors should provide a framework for studying and better understanding the practice and challenges to HUP in England.

5.1 Introduction

Healthy urban planning (HUP) as a process does not operate in isolation but is embedded and influenced by policy and practice shifts in the whole planning discourse (Barton 2017). To evaluate the performance and impact of urban planning, and for planners and other professionals to prepare and implement "realistic" plans and policies, it is essential to understand the realities of the planning and development process. That is, to recognise the factors that affect the way policies are produced and implemented (Mason & Mitroff 1981; Bruton & Nicholson 1987; Barton 2017).

In the discussion that follows, a number of factors that serve as barriers and opportunities to the practical application of the HUP concept are examined. These factors are not typically unique to the activity of "planning for health" but affect the broader functions and operations of urban planning in a similar fashion. Furthermore, the following list of factors identified and articulated is not intended to be an exhaustive set. Rather, it sets out those issues that need immediate consideration when planning or evaluating HUP efforts.

5.2 Urban planning: linear and rational or fluid and dynamic?

It may seem obvious that the concepts and practices of urban planning relate to and occur within the urban domain. But many of these same concepts and practices happen in peri-urban and rural areas, hence the phrases "town and country planning" and "rural planning". The process and procedures of urban planning take place at multiple spatial scales, from international to local levels, and are dependent on spatial scale and national context. Urban planning can be viewed as comprising a number of sequent stages, extending from the identification of problems and data collection through to the implementation and assessment of plans, projects, and programmes (Fabos 1985).

For much of the period between the early 1960s and early 1990s, the dominant model of urban planning practice and research drew on the rational-design perspective (Healey 1982; Taylor 1998). This perspective is more commonly associated with strategic planning. Brews and Hunt (1999: 891) describe the rational-design approach to organisational management as being a 'deliberate, linear, rational process'. The rational model has been central in the development of contemporary urban planning. Underpinned by systems theory, the rational planning model conceived of planning as a "rational" process of decision-making. In this process, technical experts follow a cycle of logical steps to reach an optimal, rational decision (Taylor 1998).

In *Urban Planning Theory Since 1945* (1998), Taylor outlines five rational steps of the planning process. These are,

1. Identification and definition of problems and/or opportunities;

2. Formulation and identification of alternative plan/policies;

3. Evaluation and assessment of alternative plans/policies;

4. Implementation of plans/policies; and,

5. Monitoring and mitigation of adverse effects of plans/policies.

The rational model of planning has many practical advantages. It provides, for instance, a clear, comprehensible, and systematic approach to formulating plans and policies (Taylor 1998). But rational-design approaches do suffer from shortcomings. Mintzberg (1994a, b) summarised these shortcomings as the fallacy of detachment, the fallacy of predetermination, and the formalisation fallacy. Rational planning has also been accused of failing to deal with real-world problems and real-world situations. Benveniste (1989) argues that rational planning does not address the inherently non-rational context and political realm within which planning happens.

Other limitations of the rational planning model include the discord between how decision-making occurs in theory and how decisions are actually made in practice (Lindblom 1959). This messy world of planning practice is dissimilar to the one found in comprehensive rational planning theories (Davoudi 2006). Criticism of the rational planning model also extends to the absence of guidance on stakeholder involvement in urban planning, and a lack of consideration given to the variety of distinct mechanisms and approaches subsumed within the concept and practice of urban planning. This includes, but is not limited to (Hopkins 2001: xiii),

- Land-use regulation
- Collective choice
- Organizational design
- Market correction
- Citizen participation
- Public sector action

Today, the concept of rational planning has been supplemented, if not superseded, by other models of planning – such as communicative and collaborative planning (Healey 1997). Bruton & Nicholson (1987) observe the reality of local urban planning as being complex and context dependent, much different to that proposed by the rational-design perspective. Far from seeing the local planning process as rational, administrative, and concerned with the production of local plans and development control, Bruton and Nicholson state (p. 13),

'The reality is that local plans and development control cannot be divorced from the much wider activity of local planning which is concerned to manage change in the environment within the context of attempting to secure social and economic change; the reality is that local planning is essentially a political process, characterized by complex interrelationships between land use and social and economic processes; by the redistribution of resources; by conflicts of interest; and by bargaining and uncertainty.'

This above statement suggests urban planning and its processes should be viewed in their wider socio-political context. Urban planning is also described as a social phenomenon and as being context dependent. Indeed, Suchman (1987, 2007) argues that agents (including planners) can be thought of as engaging in "situated action" – a concept that emphasises the interrelationship between human action and its context of performance. The interaction between urban policy making and its context is complex and there are many contingent factors to consider (Healey 2007). Many of these contingent factors are inherent in the urban planning process itself, such as technology or the type and size of plan being prepared. Other contingency factors are related to a local area or planning authority itself (e.g., local needs, institutional and structural norms, or working practices). Again, others stem from the broader physical and social context in which urban planning is embedded; specifically, geographical conditions, prevailing value systems, and political regime (Bruton & Nicholson 1987; Healey 2007).

The following sections will attempt to isolate and explain some of the contingent factors that affect urban planning practice, and by connection the practical application of HUP.

5.3 Complex and 'wicked' planning problems

Urban planners work in a context characterised by complexity and uncertainty, and this context is not amendable to technical or "scientific" solutions (Christensen 1985; Healey 2006; de Roo 2010; Portugali 2012). Complexity comes in many forms in urban planning. And this complexity is increasing as the planning system and context within which it operates evolve (de Roo 2010). The process and procedures of urban planning are complex for several reasons. Firstly, planning is complex because the planning system itself is complex: it is polycentric and has many normative aims, it involves a diverse array of institutions, and it must aim to reconcile private interests and public concerns (Fischer et al. 2013). Secondly, the planner's primary business is the business of urban change and development. This area of activity is again complex, being fluid and dynamic; incorporating massive spatial and temporal variations between different urban plans, projects and programmes (Hall & Tewdwr-Jones 2011). Thirdly, urban planning is complex due to the very complexity and dynamic, uncertain nature of the problems that planners must deal with.

The types of problems dealt with by planners present a classic example of "wicked problems" (Mason & Mitroff 1981; Bruton & Nicholson 1987; Wong 2011). Originally advanced by Professor Horst Rittel in the 1960s, the concept of a 'wicked problem' was developed to describe policy problems that cannot be resolved by conventional linear analytical approaches (Rittel & Webber 1973). A wicked problem can be defined as, 'a problem that cannot be definitively solved because there are competing ideas about it, leading to different and competing solutions' (Khoo 2013: 260). Wickedness, in this instance, is characterised by incommensurability and intractability, with wickedness increasing as complexity is heightened (ibid).

Commentators have called on planners to address specific problems that may be defined as "wicked problems". This includes the problem of obesity (Editors 2013). The problem of 'obesity' is redolent with wickedness; that is, in the sense that Rittel intended. Obesity has been described as a quintessential 'wicked problem' (Parkinson et al. 2017): its causes resembling a tangled web

of individual and social factors, alongside medical and social discourses, that foster and sustain excess weight and hinder successful treatment (Butland et al. 2007; HM Government 2016; HM Government 2011). Obesity is not a random health condition. Rather it is the manifestation of a person's individual, social and physical context and their conditions, which in themselves are affected by the state of the economy, the political environment, and the policies and practices of multiple sectors (Butland et al. 2007). Yet in attempting to tackle one aspect of the obesity problem, planners and other professionals risk revealing or producing new wicked problems (Editors 2013).

This example illustrates a key quality of wicked problems: that they are embedded in dynamic social contexts and are unique. They are also extremely difficult to optimally diagnose and solve due to their complex and changing nature. This is not least because in the search for solutions to wicked problems, fuzzy and fluid realities can emerge that are full of uncertainties and could potentially create other complicated problems (Peters 2017). Rittel and Webber (1973) outline the key characteristic of wicked problem as being the lack of an inherent rational logic, which further complicates a definitive formulation and clear solution criteria (ibid).

Dealing with wicked problems is by its nature more difficult and complex than dealing with more tractable, single-issue problems. Definition is a primary obstacle because wicked problems have no definitive formulation, plus defining a "thing" or "situation" as a problem is fundamentally a normative task. It is determined by one's experiences and values, but is also dependent on how a problem is understood and framed (Rittel & Webber 1984; Peters 2017). For Rittel and Webber (1973, 1984), although wicked problems might never be solved, a collaborative, participatory approach to problem solving can bring about better outcomes. Such an approach is supported in the planning and other literature highlighting the significance of complexity and 'wickedness' in problem solving (Wong 2011; Avery & Hughes 2012; de Roo & Rauws 2012). Through collaboration there is greater opportunity to develop a more comprehensive awareness of the attributes and complexities of the problem and to develop an appropriate response based on shared commitment (Wong 2011; Kickbusch & Gliecher 2012).

The complexities and uncertainties involved HUP was drawn attention to by Rydin and colleagues in a paper on 'Shaping cities for health', published in 2012 in *The Lancet*. In this paper, Rydin et al. stress that complexity thinking leads to a break from traditional rational-based thinking, and the necessary "fuzzification" of the boundaries between the *goals* of planning and the *means* of achieving those *goals*, that allow us to recognise that uncertainty and incompleteness are natural traits of the development plan preparation process. As a result, it is not possible to create a development plan capable of anticipating all future states of the world. This does not mean that attempts to do this are not valuable, although it is suggestive of a need for a novel approach to planning for health.

Wicked problems need innovative solutions and approaches to developing policy that support new ways of thinking and working (Kickbusch & Gliecher 2012). Based on work by Ian Sanderson (2006), Rydin et al. propose a new post-complexity approach to health-related urban planning policy-making – an approach in which policies are made on the basis of cities being complex systems. The emphasis in this approach is on communicative and collaborative planning (or open planning), but also experimentation. Rydin and colleagues call for:

- an incremental approach to planning for urban health based on the promotion of experimentation through diverse projects and the use of 'trial and error' to enhance understanding of how to improve health outcomes in specific contexts[31];

- a strengthened qualitative, stakeholder focused method of assessment for project outcomes (as opposed to a technical exercise performed by experts); and,

- consideration of the normative dimensions of policy interventions and the value-laden forms of reasoning and argument given expression in the policy-making process on urban health and city environments.

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[31] This point contrasts with Rittel and Webber's portrait of wicked problems, which states that wicked problems cannot be studied through trial and error as 'every trial counts' (Rittel and Webber 1973: 163).

Throughout each of these three components, there is a clear commitment to communication and collaboration. And to engaging stakeholders in inclusive dialogue and discussion to support the promotion of the health agenda itself and to facilitate detailed and problem-oriented argumentation on potential solutions (Rydin et al. 2012).

5.4 Collaborative working and partnership

Urban planning is a complex and ongoing process that encompasses thinking about and dealing with the shaping of future structures of urban spaces and producing frameworks for their transformation. It is furthermore (under the conditions of complexity) not a sequential process or policy cycle, but a series of events pursued over time (Rydin et al. 2012). The 'very tangible, complex and differential impacts' of local decision making, writes Kaiser et al. (1995: 23), lead to what is 'essentially an interactive progression of decisions rather than a single final decision on land use'. These events or decisions together form the 'planning project' (Healey 2010), which in itself involves communication and interaction between various public and private social actors – all of whom hold different stakes in the project's outcomes (ibid).

The procedures of urban planning are influenced by multiple actors, all operating at different authoritative and spatial levels, and across different policy sectors (Healey 1997; Greed 2014; Hart et al. 2015). In modern pluralistic, democratic, and complex societies (such as in the UK), urban planners do not have overall control of how urban and built environments evolve and change over time. Rather, urban planners are embedded into a larger discourse and pragmatic context. Put differently, the urban planner is but one participant in the overall 'urban game' (Portugali 2012: 230).

5.4.1 The planning game

The perspective that land-use development and planning is a game – "the planning game" – frames how the trajectory of urban change is shaped towards a final end by the interaction of different agencies (see, Lord 2012). To Kaiser et al. (1995), urban planning is a game inasmuch as it has both many rules (legislative and working procedures) and many players (land owners, market investors, government, developers, planners, designers, and users interest groups). A typical urban planning process, from the national level to detailed local plans or from data collection to the implementation of a

project or programme, will involve multiple players. Each player has their own aims and objectives and working strategy, which allows them to be distinguished into different actor or stakeholder groups (see, figure 8). Although each player and stakeholder group have their own respective aims (plus tasks and duties, and values, interests, and priorities), they all strive for the same goal – to maximise the utility they derive from their investment, be this social welfare, economic revenue, or something else.
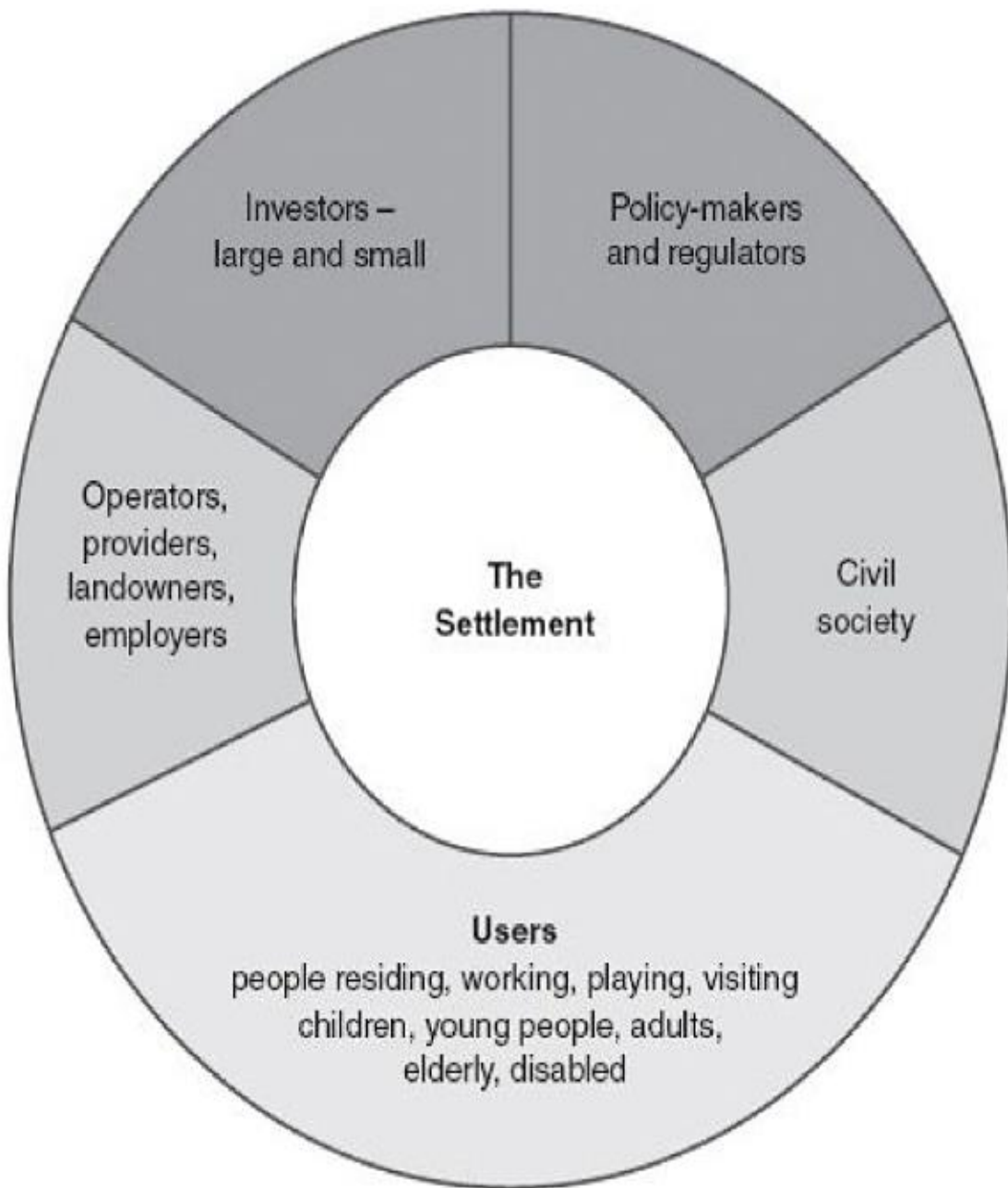
Figure 8 – Stakeholders in the planning of settlements (Barton 2015: 9)

In most democratic settings, the settlement (or urban) development process is defined by "pluralism"[32] (Barton 2017). The pluralistic nature of urban development means that it is a multi-agency process. It is heavily reliant upon the actions of a plurality of actors working across separate sectors and policy spheres. The distribution of power between these actors to decide when and where urban development happens is unequal (Bishop 2015). In recent decades, the share of power held by actors other than planners (such as investors and developers) has increased (Healey 2010; Greed 2014; Cullingworth et al. 2015). The planner is a not a free agent; he/she does not operate in a vacuum but within a complicated political situation. This situation exists at central and local government levels and is reflective of wider societal forces at these levels. As Rydin has commented, planning alone cannot externally control the market for or the pace and type of urban development; this is in part because the forces involved are massive (Rydin 1998).

Although urban planners have limited control over future patterns of urban development, Patsy Healey (1997, 2007, 2009, 2010) and other authors (see, Bishop 2015) have assigned the planner with the role of coordinating the diverse agencies involved in spatial decision-making, and increasing actor engagement and participation (especially among 'hard to reach' groups) in decisions regarding how places will be shaped for the future. This clearly normative role entails urban planners having responsibility for "consensus building" and "conflict resolution", and facilitating and informing effective "dialogue" and "collaborative working" between stakeholders to deliver optimal outcomes (Bishop 2015).

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[32] A pluralistic system can be broadly thought of as being a diverse one, where two or more groups, principles and sources of authority coexist.

5.4.2 The theory of collaborative planning

Collaborative planning has gained widespread acceptance among planning scholars and practitioners (Harris 2002; Bishop 2015). The idea of collaborative planning developed during the late 20th century, evolving out of debates around the desirability and effectiveness of rational approaches to planning and 'the neo-liberal, anti-planning morass of the 1980s' (Tewdwr-Jones & Allmendinger 2002: 214). Since then, it has enjoyed what Tewdwr-Jones and Allemendinger have described as an 'enthusiastic reception' and has been noted as an 'important direction for planning theory', with 'significant potential for practice', and a leading focal point for academic debate (ibid: 207,216). Innes (1995) considered collaborative planning as planning theory's "new paradigm". In the UK, successive Governments have promoted the virtues of participative practice as part of the "modernising planning" agenda (Townsend & Tully 2004).

The basic contention with the collaborative planning approach is that urban planners cannot and should not alone determine the future structures of places. This position is inspired by a relativistic understanding of space and place and by the phenomenon of complexity (Brand & Gaffikin 2007). Collaborative planners recognise that urban settlements are far too complex, and the plural and technical challenges too difficult, to be effectively dealt with by public decision makers only. They also reject the assumption that, 'space and time act as little more than objective, external *containers* within which human life is played out' (Graham & Healey 1999: 626) (emphasis in original). Instead, they understand space and place to be, as opposed to fixed or innate, dynamic and transitive; being continually created and recreated through the actions and meanings of social agents (ibid; see also Relph 1976, Agnew 2011, and Cresswell 2009 for an overview of the meaning and characteristics of space and place, and Fawcett & Sturzaker 2016 for a discussion on the significance of 'place' for planning practice).

Patsy Healey is one of many scholars to have helped to refine and popularise the concept of collaborative planning; others include John Friedman, Louis Albrechts, and John Forester. Healey has made a particular impact in the area of strategic spatial planning and in planning theory, including publishing works on collaborative and participatory governing processes in regional and local planning. In Healey's seminal 1997 text *Collaborative Planning*, a detailed argument is provided for why in modern, pluralist societies there is a need to reconcile plural interests across localities. This argument is accompanied by Healey's vision of 'collaborative planning'. What Healey (and others) define as collaborative planning draws on multiple philosophical and theoretical suggestions. These include Habermas' (1984, 1994) theory of "communicative action" and Giddens' (1984) "structuration theory", with the common denominator being an emphasis on participatory forms of democracy – and on 'the development of open dialogue encouraging the emergence of shared solutions' (Campbell and Marshall 2002: 17).

The theory of collaborative planning serves as a framework for understanding and practical action – action on how to gather and engage diverse stakeholders in an inclusive and effective argumentative process that is inherently collaborative and fosters co-exploration and co-development of visions and strategic plans for place futures (Healey 1996, 1997, 1998, 2003). Collaborative planning, at least theoretically, is seen to offer a useful and effective approach to planning in a context of uncertainty, but also when the definition of both ends and means is fuzzy (Fabbro 2005). It presents the ability to 'tackle complex problems with autonomous and cooperative ways of deciding and acting', explains Fabbro (ibid: n.p).

Under the collaborative planning model, urban change (or placemaking[33]) is achieved through collective reimaging of existing and emerging spaces. In this process, planners are charged with the task of facilitating and informing an

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[33] The term 'placemaking' is widely used both in and outside of the planning context, and is a term familiar to planners, geographers, sociologists, economists, and community groups alike. As such, the concept of placemaking is understood in many ways. According to the Project for Public Spaces, placemaking is about the 'planning, design and management of public spaces. More than just creating better urban design of public spaces, placemaking facilitates creative patterns of activities and connections (cultural, economic, social, ecological) that define a place and support its ongoing evolution' (Project for Public Spaces 2018).

equitable and effective debate on the future between competing interests in society[34] (Healey 1997).

From a policy perspective, Healey (1997: 309) writes,

> '… the traditional spatial planner is… transformed into a key of knowledge mediator and broker, using an understanding of the dynamics of the governance situation to draw in knowledge resources and work out how to make them available in a digestible fashion to the dialogical processes of policy development.'

Collaborative planning 'as an inclusive dialogic approach to shaping social space appears to accord with certain features of contemporary society', writes Brand and Gaffikin (2007: 283). This includes, namely, the emergence of postmodernist perspectives on the decreased certitudes and predictabilities of complex societies, and the shift to new modes of governance that acknowledge the need for increased stakeholder involvement (ibid). Although much scholarship in planning champions a more cooperative and inclusive approach to planning practice, collaborative planning theory (including that outlined by Healey) has not been without critique.

In a 2007 paper published in *Planning Theory*, Brand and Gaffikin (2007) expose a range of problems not only with the theoretical foundations of collaborative planning but also with collaborative planning as a model of practice. Their core argument against collaborative planning stems from its prioritisation with consensus. This is said to invariablly produce non-commital outcomes, due to a failure to accommodate more candid agnostic discourses which creates vulnerability to equivocation, euphemism, and surface agreement (ibid: 305; see also Harris 2002). For this and other reasons, collaborative planning has been described as utopian; since achieving inclusive dialogue and consensus in an "uncollaborative" world is difficult – if not impossible – to achieve (Upton 2002).

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[34] This role is encapsulated in other models of planning, such as "communicative" (Innes 1995), "deliberative" (Forester 1999) and that of the planner as a "critical friend" (Forester 1997).

5.4.3 Collaborative working for HUP

'Health is promoted most effectively when agencies from many
sectors work together and learn from each other.'
The Athens Declaration for Healthy Cities (1998)

In the wider discussion on HUP, much emphasis is placed on the tremendous potential of urban planning to influence and improve health outcomes. A constant in this narrative is that these two variables – urban planning and health – can be correlated, yet not in a simple or linear way. Improving any one facet of health requires coordinated action across many different policy domains. This point is taken up by Barton and Tsourou early on in *Healthy Urban Planning* (2000). The authors explain that action in the sphere of the physical environment must be compatible with and contribute to reinforcing action in other socio-economic policy domains (see also, Barten & Naerssen 1995). To achieve this, local governments must promote a collaborative approach to problem solving and policy engagement. This approach should aim to draw together the full breadth of stakeholders and policy actors able to deliver urban change for health in active dialogue (Barton & Tsourou 2000; Rydin et al. 2012).

Health and wellbeing are important components of the governance of public policy (Kickbusch & Gliecher 2012). "Good" governance for health requires a synergistic set of policies. Many of these policies reside in sectors outside the health sector, and their development and implementation must be supported by structures and mechanisms that facilitate collaboration. The meaningful engagement and dialogue between actors from different sectors is an intrinsic part of collaborative working, but can be problematic when the complexities of professional and personal identities, and language, culture, and norms, inhibit opportunities for partnership and policy coordination (WHO City Action Group on Healthy Urban Planning 2003; Ovseiko et al. 2014; Kim & Bang 2016; Peters 2018).

Government departments often work in silos – so-called "silo mentality" – and need to be bridged together to unlock the health potential of public policy (Kickbusch & Gliecher 2012). In literature, collaborative policy design and adaptive policy implementation are encouraged as a way to actively improve policy preparation and execution for health (Ansell et al. 2017). Collaboration is central to the process of HUP (Barton & Tsourou 2000; Rydin et al. 2012). The HUP concept, explains Barton and Tsourou (ibid), implies a need to place collaboration – including community participation and intersectoral cooperation – at the centre of the decision-making process. Indeed, the commitment of HUP to health and equity is matched only by the its commitment to collaborative working practices (ibid).

The focus on collaborative working is in part due to the Healthy Cities Project, from which the HUP concept evolved, and which aims to create horizontal integration between planners and health professionals. As Ashton (1992: 10) writes, in *Healthy Cities*, the intention of the Healthy Cities Project, and by association the HUP concept, is to enable mechanisms,

> '… for health promotion to be developed through healthy public policy and increased public accountability; it focuses on breaking down vertical structures and barriers and obtaining much better horizontal integration for working together.'

Many urban planners are now actively engaged in assisting the process of working towards achieving consensus on planning policies and the design of development (Barton 2015). The planner acts as a facilitator and negotiator, at the same time as protecting public and private interests. It is essential that the planner practices facilitation, not interference. It is not the role of the planner to impose their own values, but to enable other stakeholders to realise their own values (ibid). Collaborative working in HUP adopts (at least theoretically) a pragmatic and humanistic perspective, one that, 'does not view multiculturalism and diversity as problems to be overcome but rather as rich opportunities waiting to be seized' (Duhl & Sanchez 1999: 20). According to Duhl and Sanchez, the HUP dialogue makes room for stakeholders and

community members but requires catalytic leadership from planners. To become effective public and catalytic leaders, the planner must (ibid: 20).

> 'reach beyond the traditional boundaries to engage, discuss, and
> mediate   among broad groups of stakeholders.'[35]

Facilitation is thus a central component of HUP – not any facilitation, but facilitation that is informed by evidence and understanding of the issues and considers the stakeholders' context and aims to identify opportunities for partnership and collaboration (Duhl & Sanchez 1999; Barton & Tsourou 2000; Sarker et al. 2014). Urban planners need to engage in dialogue and bridge organisational, cultural, and disciplinary divides with other stakeholders in local government and society. In the literature on 'health and urban planning', stress is laid on the relationship between the urban planning and the public health domains.

Urban planners and health professionals (a fuzzy relationship)

In *The Routledge Handbook of Planning for Health and Well-being* (2015), Barton explains that urban planners have a normative responsibility to,

> 'reach out to stakeholders and try and draw them in…forging
> networks and helping build alliances.' (p. 9)

Most of the HUP literature discusses this "reaching out" in terms of the relationship between urban planners and health professionals. Corburn (2004; 2007; 2009), Rydin et al. (2012), Barton (2017), Sarker et al. (2014) and others emphasise the need for urban planners and health professionals to communicate with each other, in order to support the integration of health considerations within and the achievement of health improvement through the urban planning process. Urban planners and health professionals must engage in dialogue and a well-informed policy debate to identify health issues

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[35] Here Duhl and Sanchez draw on Luke's theory of 'catalytic leadership', and the conception that we have moved from a "modern" to a "post-modern" environment. In this post-modern world, collaboration is essential and emphasis should be placed on emergent, participative, and power-sharing approaches to the management of conflict in pluralistic societies (Luke 1998).

and build political alliances for urban health. Interdisciplinary communication can also underpin the exchange of ideas oriented to delivering urban health aims, helping to support the elaboration and advancement of a shared understanding of what urban health futures might look like and how such futures might be realised.

The relationship between urban planners and health professionals is fuzzy, and potentially subjective. It is difficult to objectively evaluate the alignment between urban planning and public health, in part due to the paucity of empirical evidence on this topic. In relation to the UK context, Tomlinson et al. (2013), writing in a paper on joining up health and planning, note that there are reported examples of good practice in joint-working between health and planning professionals. Yet, wider literature in this area tends to suggest that, in recent times, there has been insufficient crossover between these two fields of study and practice (Corburn 2007, 2009). Where joint or collaborative working does exist, this is most advanced in relation to the planning and delivery of healthcare facilities (e.g., hospitals and doctor's surgeries). Health professionals, moreover, are thought by some to not regularly deem urban planning to be their core business, nor do they have adequate understanding of the role, procedures and processes of urban planning; however, planners also suffer from a lack of knowledge of public health (Reed, et al. 2010).

This apparent absence of interdisciplinary working between urban planners and health professionals may account for shortcomings in the way that regulatory authorities think about HUP. The narrow terms in which those responsible for decision- and policy-making in urban planning view health (e.g., defining health as "the absence of disease") has been observed as a result of the lack of engagement between planners and health professionals (Carmichael et al. 2013). Jason Corburn, Professor of City & Regional Planning at University of California, Berkeley, has written extensively on the disjointed nature of the planning-public health relationship.

According to Corburn, this "disjoint" has created a disconnected approach to addressing the determinants of health; especially those associated with the manifestation of health inequalities (Corburn 2004). Corburn has also argued

that the current unsatisfactory working between public health workers and urban planners is, inter alia, the consequence of disciplinary resistance: a resistance (conscious or otherwise) by professionals on both sides of the disciplinary divide to engage with considerations about how their work could better be comprehended by the other (Corburn 2007, 2009, 2010).

It is only relatively recently, explains Corburn (2010), that public health departments have begun to investigate how land-use planning decisions and urban environments influence individual and collective health outcomes. But Corburn and others are optimistic about the prospects of the planning-public health relationship. It is said to be moving in the "right direction", although there remains further scope for more effective collaboration (Corburn 2009). This includes overcoming those boundaries that arise from disciplinary differences in the understanding of knowledge development, plus those that result from different working cultures and structures (norms, values and priorities), different terminology and lexicology (Sutcliffe 1995; Greig et al. 2004; Burns & Bond 2008; Fischer et al. 2010; Carmichael et al. 2013).

Strengthening the public health-urban planning relationship

Several different proposals have been put forward concerning how the collaboration and partnership between public health and urban planning can be strengthened. Before examining some of these, is it interesting to note that that some authors believe that there is a need not just for more collaboration but for more *proactive* collaboration. Carmichael et al. (2013), for example, argue that "good practice" in HUP occurs when public health professionals take a proactive role in collaborating with local authority planners. This call for "proactivity" is echoed elsewhere in literature, including by Guy (2007) who asserts that, in order to improve diet and health in areas of deprivation through urban planning, local health boards must adopt a proactive leadership role. Others have pointed to the use of a broker agency, such as the London Healthy Urban Development Unit (HUDU), to advise and facilitate partnership between health and planning departments on issues relating to health and the built environment (Carmichael et al. 2013).

Corburn (2004, 2007) argues that the "best" way to reunite urban planning with public health is, as opposed to devising interventions that tackle specific disease or health risks, to proactively create joint strategies that address the root causes of illness and disease. Based on an evidence review and case study research conducted in the UK (primarily in England), Carmichael et al. (2013) outlined a number of ways for stimulating more effective collaboration:

- Development of best practice guidelines;
- Joint strategy preparation;
- The development of 'health action zones' in towns and cities, which involve housing, transport, and economic aspects; and,
- The establishment of a WHO Healthy Cities Project, which can embed public health expertise into planning units (and vice versa).

From the above list, perhaps the biggest discussion topic in literature – barring the WHO-EHCN Project – has been the development of guidance and 'best practice guidelines'. One way of "joining-up" the work of urban planning and public health is through the compilation of practical guidance and strategic guidance[36]. Research suggests that both types of guidance are needed, as they together build a more complete picture of health – which local authorities can then respond to (Tomlinson et al. 2013). It has been found, for example, that in the UK multiagency and broad strategic local Sustainable Community Strategies (SCSs) can provide a key driver for HUP through establishing health objectives and guidance on how to deliver these through the local planning process (Reed, et al. 2010; Tewdwr-Jones 2011; Carmichael et al. 2013). Conversely, the effectiveness of these strategies is eroded when they contain little guidance on how to address specific health outcomes through urban planning (ibid). This, in turn, suggests that guidance can either support or hinder collaboration and HUP.

Tomlinson and colleagues provide a useful contribution to the discussion on the "guidance predicament" in a 2013 paper, looking at how Joint Strategic

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[36] In this sense, 'practical guidance' refers to guidance setting out suggestions and steps that planning authorities can take to deliver healthy urban planning. By comparison, 'strategic guidance' refers to guidance that provides a steer for identifying local health needs, developing a local 'health action plan', and establishing the health responsibility of local agencies.

Needs Assessments (JSNA) can inform spatial planning (and health and wellbeing strategies (HWBS). First introduced in England under the Health and Local Government Act of 2007, JSNA can provide a common foundation for health integrated local policies – which can address the wider determinants of health and reduce health inequalities (ibid). The JSNA can serve as a common foundation for joint action on health by providing a 'crucial evidence base' (p.255) of local health needs, and it can, as a "needs-based assessment", be used to inform the development of HWBSs and local plans. Yet, despite its potential to provide a step change in delivering a more collaborative response to the wider determinants of health, the authors observed a critical failure (at the time of writing) to fully exploit the potential of JSNA.

The prime source of Tomlinson et al.'s frustration is the manifold generic and structural deficiencies afflicting JSNA guidance; alongside organisational issues in local government and health sectors. Such "deficiencies" include the neglection of JSNA's role within the model of the wider determinants of health; the absence of discussion on key health issues, such as health inequalities and climate change; and how the findings and recommendations of the JSNA are to be translated into action in planning. In addition to failing to appreciate this crucial latter inter-relationship – that is, between theory and practice – JSNA guidance was found to be silent on recent national planning policy obligations relating to health, such as the de facto duty for planning authorities to cooperate with health bodies (p.259).

The absence of adequate guidance is suggested to have caused a gap to develop between the extremely wide theoretical scope and narrow practical focus of JSNA, with the latter being placed on health and social care. Interestingly, Tomlinson and colleagues see the shortcomings of guidance as not limited to JSNA. Rather, they see them as symptomatic of a wider national failure to have translated a 'welcome joining up of the rhetoric around health' (p.260) into the type of guidance needed by local authorities and others (including health bodies) to do this at the local level.

5.5 Political considerations

Politics is a ubiquitous cultural phenomenon. As a subject area, politics is vast and dynamic. Yet, the term 'politics' is undefinable – at least in consistent terms (Connolly 1974; Modebadze 2010). At the heart of politics lies disagreement, one which extends from how it should be studied[37] to what it means to be "political" (Miller 1980; Etzioni s2003). The term 'politics' can be variously defined, for the phenomenon to which it refers is fluid and both context and perspective dependent (Connolly 1974). Basic definitions of this term include 'the activities associated with the governance of a country or area, especially the debate between parties having power' or 'a particular set of beliefs or principles' (Oxford Dictionary 2018b).

More specifically, the term 'politics' is defined in political science literature as the study of '*power* and *authority,* and the exercise of power and authority' (Drazen 2000: 6) (emphasis in original). The term "power" means the 'ability of an individual (or group) to achieve outcomes which reflect his [sic] objectives'[38] (ibid). Comparably, authority exists, explains Lindblom (1977: 17-18), 'whenever one, several, or many people explicitly or tacitly permit someone else to make decisions for them in some category of acts'. Accordingly, Lindblom conceives of politics as involving a struggle over authority; 'In an untidy process called politics…', writes Lindblom, 'people who want authority struggle to get it while others try to control those who hold it' (ibid: 119).

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[37] According to Drazen (2000: 6), the study of politics is, 'the study of mechanisms for making collective choice. Asking how people or authority are attained and exercised can be thought of as a specific form of the general question of what mechanisms are used to make collective decisions.'

[38] The concept of power is widely used in many scientific fields, yet a clear definition of the concept remains elusive. One of the most commonly cited definitions of power is that by Max Weber (1947: 152), who defined power as, 'the probability that an actor in a social relationship will be in a position to carry out his own will despite resistance, regardless of the basis on which this probability rests'. Alternatively, Pfeffer and Gerald (1978: 3) define power as, 'a relationship among social actors in which one social actor A, can get another social actor B, to do something that B would not otherwise have done'.

According to Heywood (2013:2-5), politics is a defining feature of the human condition. Politics can be thought of as being inextricably linked to the phenomena of "conflict" and "cooperation". The existence of plural interests, needs and values creates conflict between different individuals and groups regarding the rules under which they live. To uphold the influence of these rules, members of society must collaborate and converge on, if not to find total consensus regarding, the contents and purpose of these rules. This process invariably involves a "search" for arrangements and compromises to resolve conflicts, a process undertaken with the understanding that not all conflicts can be resolved (ibid).

5.5.1   Planning and politics

Is planning political? How does politics affect urban planning outcomes? These questions have been asked and answered multiple times by planning scholars around the world. In planning literature, there are many examples of articles that have examined or commented on the dynamic interactions between urban planning and the operation of political processes (cf. Krumholz & Forester 1990; Newman & Thornley 1994; Kitchen 1997; Albrechts 2003; Tewdwr-Jones 2012; Tacoli & Satterthwaite 2013, and Kidd & Shaw 2014).

Greed (2014), for example, notes that the operation of the planning system is shaped by the perspectives of central government, and by the "power politics" that play out at the local government level. Relatively speaking, however, the interaction between planning and political domains remains to be fully elucidated and needs further investigation (Campbell 2001; Albrechts 2003). That said, what articles have been published and the studies they draw from (such as those indicated above), along with other developments in planning and political thinking, have contributed to a changing view of planning and politics in recent times.

For much of the early 20th century, as explained by Levy (2018), there was a tendency to ensure, or at least to attempt to ensure, that urban planning was isolated (or remote) from politics – a bid to keep planning "above" politics. This

custom of isolation (whether actual or contingent) declined as a realisation of the essentially political nature of the planning process and the importance of public acceptability increased (Cullingworth 1976). Over time, it became recognised that attempting to isolate planners from political realities rendered them less effective in managing the conflicts inherent in land-use change and development. This shift in thought was inspired by, among other things, an appreciation that it is within the political sphere that decisions about land and other issues are made (Levy 2018). In the 1960s, it became appreciated that traditional urban planning was having an inadequate impact on urban development. To be effective, and have a "real impact", planners needed to be more closely concerned with implementation issues; and implementation involves real world political issues, such as feasibility, conflict resolution and mobilisation (Catanese 1984).

Today, there is broad recognition that there is a pivotal and inherent relationship between planners and politicians, and between urban planning and political processes (and associated power dimensions) (Leone 2013; Levy 2018). The terminology of modern planning is now awash with politically charged phrases, such as "democratic planning" and "place politics", and this reflects the widely held belief that urban planning is not separable from politics (Healey 2010). It is interesting to observe, although this falls outside the scope of this review, that there is some debate as to whether urban planning is a political activity or a technical endeavour devoid of politics. The central argument of the belief that planning is apolitical is that "good" urban development,

> 'derives its "goodness" from technical considerations that are of
> such significance as to outweigh all other factors.'
> (The Editors RAPI Journal 1975: 3)

This school of thought assumes that considerations of a social, economic, or political nature are peripheral to technical criteria; however, it is said to fail to recognise that technical standards are 'a variable in the trade-off situation that most planning situations involve' (ibid: 3). According to Albrechts (2003), planning must be seen not as an abstract analytical or technical concept, but

as a concrete process: a process that is an inextricable part of and that reflects the wider social, cultural, economic and political reality.

What makes urban planning 'political'?

In *Planning Matter* (2015), Beaugard describes the dialogue of urban planning as being concerned always with "things". These things – be it a shopping mall, a road or a healthcare facility[39] – influence how deliberation in planning is structured and how it unfolds. And 'things' impart their influence through unseen political connotations, emotional resonances, and social connections (see, Winner 1980 and Joerges 1999). To that end, Beaugard (op. cit) argues that the politics of planning is, 'a "things-politics" in which the material world contributes directly to calucations of power and the distribution of resources and opportunities' (p. 70) (emphasis in original). Beyond defining the concern of planning politics, the previous sentences do not define what is 'political' about planning in the full sense of the term. That is, there is no demarcation of particular actions that are political from those that are not. In fact, it is inherently difficult to delineate the "politicalness" of planning in this fashion (Beaugard 2015).

Following the argument of Ake (1975) that politics is a normative concept, it is misleading to define "politicalness" in terms of whether someone, something or some act is or is not political. Ake argues that no matter whether it is concious or subconscious, all human actions are inherently political[40]; and accordingly the "politicalness" of an act is not a quality internal to that act but a characterisation of it dependening on (1) the context in which it is observed, and (2) the context in which it occurs (ibid: 271). In similar logic to Ake's approach, Albrechts (2003; see also, Levy 2018) frames urban planning – its policies and procedures – as a "political choice" (p. 251).

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[39] Health by itself and the planning of healthcare services and facilities is an emotional and political matter, because the provision of healthcare services in one area at the expense of those in another will invariably lead to "winners and losers" in terms of the provision and access to healthcare (Ward 1987; Immergut 1992; Borrell et al. 2007).

[40] According to Ake (1975: 271), 'there is no human act, even so simple as wearing hair long, that is intrinsically nonpolitical'.

Urban planning is a method for realising political goals, which is said to make it a political instrument. As such, urban planning is part of the machine of politics. But urban planning is not politics. Instead, planning is a political event or instrument to act in practical fashion to realise political aims. Put differently, urban planning represents the possibility of politics. As Albrechts (ibid: 251) observes,

> 'Planning is not an abstract analytical concept but a concrete socio-histoical practice, which is indivisibly part of social reality. As such, planning is in politics, and cannot escape politics, but is not politics.'

The central question here is not whether urban planning itself constitutes 'politics', but what what makes urban planning political. There are many characterisations of urban planning that may, or do, give it a political dimension. Greed (2014: 9-10) provides a threefold explanation of why urban planning is a highly political process:

Firstly, the focus of urban planning is on land and property; more specifically, the governance and management of land and property, and the allocation of scarce resources (especially land and how it is used, developed and the forms of ownership for it, and how it is occupied) (see also, Simmie 1974 and Rydin 1998, 2003). The allocation of scare resources is linked to the prevailing economic and political system.

Secondly, urban planning is political as it is a component of the agenda of national politics and ideology – serving as an arm of the bureaucracy. As a political process, urban planning is heavily influenced by ideology (cf. Forester 1985; Healey 1997; Fainstein 2000; Tewdwr-Jones & Allmendinger 2002; Adajian 2005; and Bishop 2015).

Thirdly, the planning process is political at the local level because stakeholders of this process seek for their interests and preferences to be well – if not best – served by the planning system. This results in individuals, such as local politicians, community members, and developers, vying to exert a measure of influence over planning decisions, and each other. Decision-making in planning is informed by the (often competing) interests and preference of

various stakeholders – for example, during the development management (or development control) process – given that it is concerned with the allocation of scarce resources and is informed by the (often competing) interests and preferences of various stakeholders, and the power dynamics of the decision-making process (ibid). The task of mediating and mitigating competing interests and preferences has led to the planner being seen as an "urban manager" or "social-policy maker" (Simmie 1974).

Considering the above, the next question to consider is how does politics affect healthy urban planning?

5.5.2   Political implications for healthy urban planning

Politics and power affect many elements of the urban planning process. Among these, HUP requires consensus-building and commitment, but also balancing interests and conflict resolution (Duhl & Sanchez 1999; Barton & Tsourou 2000). Urban planning policies and decision-making, as previously discussed in this chapter, are not the product of a singular actor, but a plurality of actors. The formulation and implementation of urban planning policies, and the decision-making that underpins these processes, are a product of compromise and bargaining, involving whole complex negotiations and contestations unfolding over time and encompass a plurality of interests and values (Guercini & Tunisini 2017). Although pluralism may be consistent with the holistic and cross-disciplinary model of spatial planning (Tewdwr-Jones 2012), the accommodation of and interaction between plural actors in the urban development processes can create issues for both traditional and health-oriented approaches to urban planning (Barton 2017).

In a highly localised system, political conflict concerning urban development (be it residential, commercial, or industrial in nature) can be a major barrier to HUP. Actors in the urban arena – builders, developers, financers, agents, and local government – produce 'a culture with norms and standard operating procedures, share information, and consider ideas within a network of often

conflict-ridden relationships, not just as rational economic actors' (Bates 2012: 512). In *City of Well-being* (2017), Barton presents a new direction on how to understand the procedures and barriers to HUP. Drawing on the concepts of "power" and "influence", alongside the idea of complexity, Barton argues that HUP is an issue of "power relations"[41]. Barton cites the often very disparate systems of values, interests and priorities that coexist within the economic and institutional environment as a key frustration and obstacle to achieving a collective vision in spatial development. He also draws attention to the need for awareness when it comes to the relationship between planning and the market, more specifically the power-relations that permeate and provide the foundations for the functioning of the development market (ibid).

Actors in planning and development processes all have a certain level of decision-making power. Regardless of what the ratio of one type of stakeholder to other stakeholders is, the division of power is not equal, and the balance of power is strongly in favour of developers, investors, and, to a lesser extent, policy-makers; by comparison, consumers or end-users – "citizens" – of the urban environment have little direct bearing on high-level decision-making processes (Barton 2017). Barton further argues that one consequence of the disproportionate distribution of power towards economic interests, rather than long-term environmental preservation or social interests, has led to the development of unhealthy environments in some places.

In a modern democratic political economy, local authorities may draw up plans and policies setting out their vision and strategy for future spatial development of an area However, to a large extent the realisation of that vision and delivery of that strategy is dependent on other stakeholders – namely, developers and investors (Rydin et al. 2012; Carmichael et al. 2013; Cullingworth et al. 2015). As such the execution and delivery of policy intentions is tied to the operational capacity of the market (Carmichael et al. 2013). Statutory processes of planning intervene in the on-going market processes of urban development.

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[41] In *Mastering the Politics of Planning,* Guy Benveniste (1989: 2) asks 'why is planning political?'. The answer, 'Because it makes a difference. When planning makes a difference, something is changed that would not have changed otherwise. This implies social power has been utilized'. Hence, for better or worse, planning actions interfere in and change the socio-physical world within which they occur.

And, because of this, regulatory authorities – such as, local planning authorities – may have less influence in improving health than those who, by comparison, can generate actual change in the urban environment and, in doing so, deliver health improvement (ibid).

Corburn's "politics of Healthy City Planning"

Issues of politics and power are intrinsically embedded within urban planning processes (Masser 1983). If so, and if there is a political dynamic always at play in planning, it follows then that efforts to implement HUP must take account of the political realities of planning. There has been a suggestion of the need for political stratagem in HUP, or even for a completely "new" politics of planning. Corburn is one of a select group of authors who have – at least, to date – written extensively about the principles and barriers to HUP, or as he phrases it "healthy city planning". Much of Corburn's work in this area focuses on reconnecting urban planning and public health (Corburn 2007), and confronting the challenges inherent in this task (Corburn 2004)[42].

In a 2010 book, *Toward the Healthy City*, Corburn wrote about the importance of moving 'toward a politics of healthy city planning' (p. 83). Several aspects of his argument laid out in this book and wider writing are especially relevant here. Firstly, Corburn contends that in matters relating to urban development and planning, too much emphasis is placed on issues associated with urban and physical design. This, he notes, results in an insufficient weighting according to the political and power dimensions of planning and placemaking, governance structures and institutional design, and epistemology.

Alongside being key determinants of health, these elements together control the operation of and consideration of health within urban planning processes. As such, there is a need to focus on the political dimensions of urban planning. Any belief that the "planning game" is in anyway a non-political and/or non-normative activity needs to be revised. This belief should be replaced by the

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[42] Despite the common ancestry between urban planning and public health, Corburn has written at length about the reasons why 'only minor overlaps between the two fields exist today' (Corburn 2004: 541).

belief that planning is an activity linked to (and of) politics, one involving conflict management and replete with all manner of competing norms, values, and perspectives.

Secondly, Corburn's claim that urban planning is inherently political is itself influenced by and assimilates many of the ideas and concepts around the politics of planning described above. Illustrative of this is Corburn's conceptualisation of urban planning as both a series of outcomes (e.g. housing, transportation systems, health infrastructure) and processes – processes that can (2004: 543),

> '(1) involve the use of abuse of power; (2) respond or resist market forces; (3) work to empower certain groups and disempower others; and (4) promote multiparty consensual decision-making discourses or rationalize decisions already made.'

Thirdly, Corburn contends that urban planners must not simply acquire awareness of politics and its importance to HUP, but they must develop political astuteness. Corburn argues that there is a need for planners to grapple with political issues, and for planners to experiment in institutional design. The purpose of this is to ensure that regulatory authorities can manage cross-disciplinary conflicts over political power, social justice, and health values, such as those emerging from clashes between state (and private-sector) sponsored development projects and the healthy objectives of the local community. Planners need to critically reflect and, if necessary, take critical action on existing norms and institutions that help determine how stakeholders of the planning process exercise power and respond to or resist market forces (2007).

Fourthly, Corburn's work contains challenges that planners need to overcome if they are to realise this new form of politics. Planners must, for example, move beyond retrogressive and responsive approaches, such as operating in accordance with the traditional reactionary principle (see, Martuzzi 2007 and Kriebel 2007). More specifically, Corburn points to the need to apply a "precautionary principle" (see, Kriebel & Tickner (2001) to ensure that factors in urban environments which may present a health risk are reduced or

removed. They (planners) must also refocus their commitment away from scientific rationality and technological determination and toward experimentation and innovation – realising that the science of the "healthy city" is cross-disciplinary and formed by social commitments to equity, just as much as available technologies. In an equivalent way, planners must avoid moral environmentalism and physical determination, and recognise that the physical environment is one of many factors that influence health outcomes. Health must be witnessed as being determined by a series of relational factors, spanning the physical, social, cultural, and political dimensions of place. Finally, the realisation of the new politics of HUP will require that the disciplinary specialisation, professionalisation and bureaucratic fragmentation of urban planning and public health is addressed. Together, this is seen by Corburn to be a major barrier toward compiling a collaborative healthy city research and action agenda.

5.6 Chapter summary

The main purpose of this chapter was to examine the factors that serve as barriers and opportunities to the practical application of the concept of HUP. Most literature refers to urban planning as being a process, not a unitary event. It is part of the cyclic activity of settlement development, and the interaction between urban planning and settlement development is complex and dependent upon many contingent factors. Such factors relate, for example, to the very nature of the task and problems that planners are required to deal with, and these are typically complex and dynamic and often have competing sets of ideas and thus solutions associated with them.

Other factors relate to the interdisciplinary nature of health problems and the need for different sectors (especially that of urban planning and public health) to work collaboratively at the local level, making use of diverse knowledge and skill sets and forming strategic partnerships on health. Finally, there are factors linked to the political nature of urban development and planning and (again) the complex social and political dimensions of decision-making for health. Literature makes clear that successful delivery of HUP (and health promotion) is reliant on planners and professionals not only recognising that these (and other) barriers exist but also that they develop strategies to reduce, eliminate or even convert them into opportunities for health.

Conclusions from and research issues suggested by the literature review

The second part (Part II) of this thesis has examined the theoretical, empirical, and conceptual perspectives that underpin the subject matter of this research – that is, the subject of healthy urban planning (HUP). To do this, a comprehensive review of the literature around the topic of "urban planning and health" was undertaken. By the author's own admission, the literature review presented in the preceding chapters cannot claim to be exhaustive. That notwithstanding, the findings of this review do provide an overview and valuable insight into the current state of knowledge and evidence on HUP. Here the conclusions from and research issues suggested by the literature review are discussed.

Conclusions and research issues

There are a number of conclusions that can be drawn from the literature review, as well as key research issues that this research project could focus on. Only those issues that are directly relevant to this research are discussed, and they are considered under four thematic headings – each directly relative to and inspired by the findings of the literature review.

The meaning of health in urban planning

Many authors have investigated the meaning of health. Some of these authors have undertaken an exploration of the concept of health with a view to understanding what it means in specific social, cultural, or even temporal contexts (e.g., Earle 2007 and Boddington & Räisänen 2009), whereas some others have constructed their own definitions and thus meanings of health (e.g., Parsons 1964 and Boorse 1977, 1997). What the literature demonstrates is that the meaning of health is a common but elusive question, one that has motivated much debate yet has not been fully answered. That the meaning of health remains contested – both in a broad sense as well as in a "Gallie" sense

(Gallie 1956, 1964) – does not make the question of meaning in this circumstance an empty question; many have argued that the meaning(s) actors attach to health has both theoretical and empirical importance, helping to shape at once how health is thought about and how its promotion and safeguarding is approached (Smith 1981; Boddington & Räisänen 2009).

While by no means an exhaustive list, three paradigms of health were examined in the literature review: (1) health as the absence of disease; (2) health as wellbeing; and (3) health as a resource. Together, these encompass many of the leading understandings of health currently used in academic and non-academic publications. This includes those used by the planning community; wherein the most prevalent meaning of health is that of "health as wellbeing", or more specifically the WHO definition (WHO 1946).

Although the general adoption of this definition illustrates an awareness of the need to attach meaning to the concept of health, discussion around the meaning of health remains limited in planning literature. That it is not to say there has been no discussion of the definitional issues surrounding health, because there has been (see, Whittingham 2013, Lawrence 2015, and Barton 2015). But again, this discussion has been to date limited in scope and study; this is especially true when compared to the discussion of the conceptual and empirical dimensions of other multifaceted concepts employed in planning, such as sustainable development (Parker & Doak 2012) or green infrastructure (Wright 2011).

The above implies that there is a need for further research on the meaning of health in urban planning. This research could interrogate both the meaning and the conceptual and policy space around the concept of health. This research could also include a focus on understanding stakeholders (namely, planners and health professionals) definitions and understanding health, how health is defined in national and local planning policy, and how these two sources of meaning relate and interact with one another.

The health role of urban planning

There is now a large – and growing – body of literature from both within and outside the medical community demonstrating that health is influenced by multiple factors. These factors are more accurately described as "determinants of health" and range from biological and genetic inheritance, through to personal (health) behaviours and environmental conditions. The places in which people live and work, the environmental conditions (social, biophysical, economic, among others) of these places, and how they interact with these places has a significant effect on their health experiences – and their health outcomes (Wilkinson & Marmot 2003; Schüle & Bolte 2015). Based on the conviction that urban planning can impact population health through its influence on urban form and environment, multiple sources have published guidance or articles describing the role and goals for urban planning regarding health (Barton & Tsourou 2000; London Healthy Urban Development Unit 2017; TCPA 2017). This literature includes criteria for HUP and key health objectives for planning; however, literature clarifies that there is no standard approach to HUP but a rich variety of approaches.

Adding to the discussion on health and its meaning, some authors have stressed that to establish coherent strategies for HUP it is necessary to first establish shared concepts and understanding. As with the concept of health, examination of the literature revealed that there has to date been only limited discussion on the conceptual and empirical dimensions of HUP. Based on the available literature, it is not clear how HUP and the "health role" of urban planning is understood by stakeholders and how it is set out in national and local planning policy. What research there has been on this subject from an English perspective has largely been conducted in the years preceding the introduction of the National Planning Policy Framework in 2012. Although the evidence from this research still holds relevance today, it is now some years old and tends to relate to a now superseded national policy framework.

The above implies a need for further research, but this time with a focus on interrogating how the HUP concept is defined by stakeholders, how the health role is understood by stakeholders and set out in policy, and how these dimensions relate and interact with one another.

The integration of health within urban planning policy

There are multiple avenues or modes through which health can be considered and integrated into the urban planning of towns and cities. This can include integrating health into the preparation and formulation of local and/or national planning policies. The consideration of health could also include ensuring that health concerns are factored into the decision-making process regarding the determination of applications for development proposals (RTPI 2009, 2014). Both forward planning and development management are critical components of any national planning system, with the former having a focus on setting the strategy for the future (for example, through the spatial strategy and policies contained within a Local Development Plan) while the latter is about controlling the spatial development that happens.

There are obvious links between these components of urban planning: forward planning provides the framework for decision-making about how an area should be developed, and people and places interact. In turn, this prompts consideration of and the basis for planning and managing development in an area so as to move towards specific goals (Greed 2014).

In the literature, researchers have to date applied a broad-scale approach to the analysis of how health is integrated within urban planning. Available evidence, of which there is only a limited amount, has predominantly come from studies of the WHO-EHCN who have conducted research, for instance, looking at the level of interest and understanding of health issues and HUP among municipal planners in European cities (as already discussed in section 4.4). The two related issues of integration and what effects planning policies for health (or more general planning policies) are having is something which has been much less investigated. This is despite the consensus that the inclusion of health into the mainstream of plan-making and plan implementation activities can help promote positive population health (WHO City Action Group on Healthy Urban Planning 2003; RTPI 2009). What research that has been done on this topic does, however, provide some interesting insights into the state of health integration within local planning policies – especially adopted Local Plans in England.

Research conducted for the purposes of a late 2000s call for evidence by NICE provided evidence to show that there is a growing acceptance among policy-makers that health is a legitimate issue to be addressed in plans and policies. While the goal of "healthy communities" has been found to be a theme among some of the Local Plans examined in this collective research, the implied causal links between plans, policies and health outcomes are generally neither fully established nor made explicit. The research is also consistent on the point that there is much variance in the integration of health within adopted Local Plans in England; with this suggesting that the integration of health within plans and policies is influenced by a combination of technical and structural factors, including institutional norms and practices (Reed, et al. 2010; Tewdwr-Jones 2011; Carmichael et al. 2013). This variance, coupled with limited available empirical evidence, results in a level of concern regarding the extent to which three situational factors are occurring: the extent to which health is integrated within Local Development Plans, whether health-related policies sometimes included in Local Development Plans are being translated into action, and the overall effects that urban planning is having on health (ibid).

Based on the above, there is scope for more research on the integration of health within planning policies (and the extent to which policy provisions are translated into action). This includes further investigation into how health is integrated within adopted Local Development Plans, but also national planning policy; this is especially the case considering that existing research has only analysed a relatively small number of adopted plans and policies, and because most of this work was undertaken in relation to a previous national policy framework and pre-dates the NPPF (2012) – which introduced new requirements regarding the inclusion of health and wellbeing within plan-making and decision-making processes. There is thus considerable scope for additional research on two fronts. Firstly, research that focuses on the integration of health within adopted Local Development Plans in England and helps to develop a better understanding of how local planning policies account for and support health objectives. Secondly, research that helps to clarify whether and to what extent the NPPF has influenced policy-makers attitudes and the contents of plans and policies with respect to health.

The factors affecting the success of healthy urban planning

Available research suggests that the success of HUP is affected by multiple factors. These factors, which can also be referred to as "barriers and opportunities", are both strategic and structural in nature. A collection of authors has discussed the various factors affecting HUP, discussing the effect the complexity and dynamism of health problems has on HUP implementation (Rydin et al. 2012); the extent to which available guidance assists LPAs in promoting health through urban planning (Tomlinson et al. 2013); whether local authorities are able to negotiate effectively with other actors within a pluralistic political system to deliver development that is beneficial for health (Corburn 2010; Barton 2017); and whether partnership structures are appropriate for the delivery of HUP (Sarker et al. 2014; Barton 2017). Literature makes clear that the success of HUP requires that urban planners and other stakeholders (including health professionals and researchers) not only recognise the existence of these factors but that they work towards developing strategies to reduce, eliminate or even convert them into opportunities for HUP.

Although literature is clear that urban planning (including HUP) is affected by multiple factors, only a small proportion of literature has explicitly investigated how those factors affect HUP. Most of the literature discussed in Chapter Five relates to urban planning more broadly, as opposed to specifically on HUP. This in some ways in understandable. HUP is part of urban planning and literature on the subject is still developing. As with the topics above, the need for more research exists as perhaps no formal conclusion can be drawn from the literature discussed in the review. So, there is a need for further research that aims to explore the affecting HUP, and which compares existing findings with new ones and aims to gain better insight into the process from the perspective of the stakeholders involved.

Towards the next stage of the research

The conclusions from and research issues suggested by the literature review, coupled with the material presented earlier in this thesis, were used to inform the direction of the empirical element of this research project. As the above demonstrates, there is a need for further research and discussion on HUP. Indeed, as Barton and colleagues write (2003:56), HUP '… represents a multifaceted field that still needs to be explored to its full conceptual depths as well as policy and practical implications.'. This observation, while made over a decade ago, still holds today. Before moving onto the empirical stage of this thesis, the next part (Part III) will set out the empirical methodology and data collection strategy that was used to gather empirical data that supplement previous findings and answer the research questions of this work.

Part III
Research paradigm, methodology and methods

6. The research strategy

This chapter details the research strategy adopted for the empirical component of this study. This includes outlining the chosen methodology, theoretical perspective, and research design (including the selected data collection methods), as well as the data sources that were used and how collected data were analysed. Because of the reflexivity and ethical dimensions inherent with social science research, it also addresses the reflexive and ethical considerations that were addressed and interwoven into the design of this study.

6.1 Introduction

A research strategy is common to most, if not all, research projects. What will differ is the relative comprehensiveness of the research strategy adopted. The research strategy gives direction to one's thoughts and efforts, facilitating the systematic conduct of research. Research strategy thus provides a conceptual and practical "step-by-step" for starting and completing research. Although there is widespread consensus on the importance of "strategy" to research, there is disagreement over the meaning of the term and constituent components of a 'research strategy' (Creswell 2003).

Based on Crotty's (1998) understanding of the research process, research strategy can be thought to comprise of four interconnected elements: epistemology, theoretical perspective, methodology, and methods. Despite being interconnected, the issues of methodology, perspectives, and approaches are separate and should not be conflated. Crotty refers to these four elements as 'different process elements' (p. 4), and they should be viewed as each having a place in the hierarchy of the research process.

Crotty's elements of the research design process (1988: 3)

1. Epistemology
The theory of knowledge; it informs the adoption of the theoretical perspective and selection of a suitable methodology and methods

2. Theoretical perspective
A theoretical perspective is a philosophical stance informing the methodology and thus providing a context for the process and grounding its logic and criteria

3. Methodology
The methodology is the strategic vision that links both methods and outcomes, it thus a strategy, plan of action, process or design

4. Methods
The techniques or tools used to collect and analyse data

The framework developed by Crotty is not without criticism, with Pernecky (2016) writing that it fails to fully capture the complexity of philosophical thought and the spectrum of possibilities in research design. That notwithstanding, Crotty's framework remains (even by Pernecky's own admission) a valuable tool for mapping and organising the different elements in the research process – and by extension the research strategy. This chapter sets out the research strategy for this study. It will first set out the research questions for this study, followed by a discussion of the "research paradigm" and then the methodology underpinning this research project. Having done this, the chapter will discuss the research design (including data collection methods), and how gathered data were subsequently analysed.

6.2 Research questions

Through the application of a systematic approach, incorporating empirical evidence and theory, this study sought to examine and deepen understanding of the intersection between health and urban planning; including the identification of the barriers and opportunities to healthy urban planning (HUP), and the priorities and implementation strategies to address these. To guide this research process, three principle sets of research questions were formulated. The research questions asked in a study are particularly important in selecting a suitable research strategy (Yin 2009). Research questions in this instance were formulated based on the study's aims and objectives, but also insights gained from a comprehensive review of the literature (as presented in Chapters Two to Five).

The three principal sets of research questions are presented below:

Firstly: ***What is the stakeholders' approach to healthy urban planning?*** How do they understand and interpret the role of planning in terms of improving population health? What is their position on an explicit 'health goal' in planning? How do they define and describe the concept of human health? Is there universal agreement among them on these (and other) matters? Or is this agreement more nuanced and reflective of subjective preferences?

Secondly: ***How is health embedded within urban planning policy?*** What expectations are imposed on local actors through national policy guidelines? How is the concept of human health defined and understood in local statutory development plans? What health policies are included in these plans?

Thirdly: ***What are the barriers and opportunities to and stakeholders' experience of healthy urban planning?*** How are issues relating to health considered in the local spatial planning process? Is this consideration effective? What factors – both macro and micro environmental factors – influence how health is considered in the local urban planning process? How do planning and public health professionals collaborate and cooperate to integrate health into urban planning? What factors support or hinder this

collaboration? Are there any priorities and/or implementation strategies to address barriers to health and planning integration?

These three principal research questions set out above guided the empirical investigation and data analysis in this thesis, but also the development of the research strategy underpinning these processes.

6.3 Research paradigm

Research comprises choices and consequences. The researcher's decision to adopt or not adopt a certain stance regarding the validity of knowledge, methods for data collection, and techniques of data analysis all make a tangible difference to their research and its outcomes. Crotty's model of the research process emphasises this consequential link, connecting the theory of research to the practice of research. It also reveals that underpinning research models, as well as individual researcher's approaches to their work, are a series of assumptions. This includes the researcher making an assumption about what knowledge claims are being made in the research, given that this guides the performance of the research (Creswell 2003). Such an assumption is deeply philosophical in its implications but also has a strong theoretical grounding.

In *The Foundations of Social Science* (1998), Crotty's discussion of the research process points to the three dimensions of epistemology, theoretical perspective, and methodology as together forming the "research paradigm". The research paradigm provides a conceptual, theoretical, and philosophical framework for examining problems and formulating solutions. It, in many ways, defines the nature of a research study, and thus the research paradigm is also a defining feature of this thesis. The three dimensions comprising the research paradigm in this research study are discussed below, starting with the epistemological stance of this work.

6.3.1 The epistemology of social constructionism

This section of the chapter sets out the epistemological view of social constructionism, which underpinned the study.

Ontology and epistemology

In philosophical terms, epistemology is linked to ontology and is concerned with what we know and how we know it. It is a "theory of knowledge" (Davies 1991); a theory associated with the study of the nature of knowledge and methods of obtaining and validating it (Burr 1995). Within the literature, there is not a unified definition of the term 'epistemology' nor is there an acceptance of what distinguishes epistemology from that of ontology. The term 'ontology' is often used to specify the form and nature of reality – and our knowledge of reality. Wand & Weber (1993: 220) refer to ontology as, 'a branch of philosophy concerned with articulating the nature and structure of the world.' Comparatively, the term 'epistemology' refers to the relationship between the individual and what is to be known. As Hirschheim and Klein (1989: 20) write, epistemology denotes, 'the nature of human knowledge and understanding that can possibly be acquired through different types of inquiry and alternative methods of investigation'.

It is germane to point out that Crotty (1998) views ontology and epistemology as being mutually dependent, if not simply synonyms of the same conceptual type. Crotty argues that 'ontological issues and epistemological issues tend to emerge together' (1998: 10). He further states that, 'to talk about the construction of meaning (epistemology) is to talk about the construction of a meaningful reality (ontology)' (ibid: 10). Not all writers agree with Crotty on this aspect, including May (1997) who maintains that both elements needs to be considered separately yet in an interconnected manner. Yet notwithstanding this, this research project follows Crotty's understanding on this matter.

The social construction of reality

To meet the needs and aims of this study, an objectivist stance on reality was rejected and instead a social constructivist stance embraced. The distinction between objectivist and constructivist stances or "worldviews" is difficult to explain in a purely literary sense. It is possible, however, to distinguish them along a dimension of transformation vs construction.

Objectivists consider reality to be a predetermined phenomenon, with the researcher transforming reality through certain methods and techniques into something from which knowledge can be discovered (Alvesson & Skoldberg 2010). Conversely, constructivists maintain that reality is extemporary not fixed, local yet specific, with the content and form reality takes being inherently dependent on the individual or persons of groups holding the construction of that reality (Guba & Lincoln 1994). There is, therefore, no way to measure validity, only the opportunity to say that one or a group of constructions of reality are more informed or sophisticated than others (ibid). The researcher is, moreover, assumed to be linked to the object(s) they are studying, with the findings of a study being "constructed" as it proceeds (Guba & Lincoln 1998). Reality is not simply constructed but "socially constructed". Although the contents of perceptions and thought may be local (i.e., internal to the individual), the construction process is social in that it incorporates social and cultural artefacts (Dahlbom 1992).

Social constructionism, as a meta-theoretical concept for viewing and deciphering reality, has a long-standing place within the literature – including in planning literature, wherein much research has been framed around the social construction of reality (Sharp & Richardson 2001; Bolan 2017; see, also Gunder & Hilier 2009 and Hjorth & Wilkensky 2014). Naidoo & Wills (2015: 440) view social construction as,

> 'the theoretical perspective suggesting that all knowledge and discourse (as well as ideology and representations) are socially constructed within a context in which different groups of people have differing interests and priorities, and therefore represent only a partial truth.'

Social constructionism can thus be used as a means of inquiry. As such, Gergen (1985: 267) defines social constructionism as an inquiry which,

> '… is principally concerned with explicating the processes by which people come to describe, explain, or otherwise account for the world (including themselves) in which they live. It attempts to articulate common forms of understanding as they now exist, as they have existed in prior historical periods, and as they might exist should creative attention be so directed.'

For Gergen, social constructionism contends that knowledge about the world is not a reflection or map of the world but an artefact of social interchange. Its roots lie in the historic debates between empirical and rationalist schools of thought, yet modern social constructionism goes beyond the dualism of these traditions and places knowledge within the process of social interchange (Gergen 1985). Because of this, social constructionism, as an orientation to knowledge, presents a challenge to conventional understanding (Alvesson & Skoldberg 2010).

A central assumption within this orientation is that reality and knowledge, including knowledge of reality, are not predefined objective articles awaiting to be discovered, but mercurial artefacts of changing human activity (Harris 2010). In the case of everyday life, this means that people's knowledge and understanding of the world around them is influenced by the meaning they attach to that world (Bryman 2012). "Meaning" is, however, not static but constructed through the social interchange between people and is influenced by cultural and political factors. Knowledge, meaning and understanding are thus contingent states of affairs which are locked in a continuous pattern of formation, deformation, and reformation (Burr 1995; Furlong & Marsh 2010).

Social constructionism is defined by its rejection of the rigid structuralism of the positivist paradigm. It is a more personal and flexible means of investigating phenomena, one that has been described as more receptive to and capable of capturing the "true" meaning of a situation (Carson et al. 2001). Take an interpretivist research approach for example. Research based on interpretivism, which is an underlying component of social constructionism,

employs an inductive (as opposed to deductive) stratagem. This stratagem recognises that it may be possible to obtain contextual knowledge about a study but this "knowledge" cannot be assumed sufficient to generate a fixed research strategy given the dynamic and unpredictable nature of reality (Hudson & Ozanne 1988). By extension of this idea, social constructionism guided research aims to develop a better understanding of the meanings created by human behaviour; rather than generalising and predictive cause and effects that it sees as being contextually and temporally bound (Neuman 2013).

Constructivism – the position that reality and all knowledge is social constructed – has a long-standing place in the field of urban planning (Bolan 2017). It is a classical philosophical theory which, when applied to the present study, argues for a relativistic perspective of socio-environmental reality; that is, that each social actor's (e.g. the planner's) perception and interpretation of their environment – physical, social, and cultural – is the reflection and product of their own position in that environment and the joint negotiations they enter into when determining meaning and actions (Blaike 2007). The relationship between the actor and the environment is therefore particular to each actor, but also, given the dynamic nature of social relations, actor's interpretations can change. From this it follows, in turn, that the promotion of one idea or view by one or several actors will (most likely) set in motion a concatenation of determinations that end in changes to the way other actors view and interpret the socio-environmental features of the context affected by the idea (Dominguez-Gómez 2017).

6.3.2 The theoretical perspective of postmodernism

A "theoretical perspective" can be defined as a framework of coherent assumptions, beliefs, and principles. More specifically, it comprises conceptions of institutional logistics of a societal totality, aspects of a complex structure, and dimensions of society (Alford & Friedland 1985: 389). When applied to research, a theoretical perspective represents a way of thinking about and representing the nature of science and claims to knowledge. It also serves as a guide in the sense that it provides a vision and context for the logic and criteria of the methodology, and consequent research methods (Crotty 1998). Consonant with the epistemological position of this work, the theoretical perspective of "postmodernism" was chosen as a lens through which to explore the interaction between health and urban planning.

Postmodernism can be understood as an artistic and cultural movement, theoretical perspective, and/or philosophical approach. It can also be viewed as a distinctive sensitivity regarding the production and representation of social scientific findings (Bryman 2012). In his lucid overview of the subject, Mavroudeas (2006) states that postmodernism's main thesis is the rejection of objective truth. Truth can be analysed in diverse ways, through different approaches, with all truths being equally legitimate. This is because that what is to be explained (signified) cannot be separated from its explanation (signifier). Knowledge and truth are partial, limited, and contingent. They are, moreover, socially constructed not universally objective; they are dependent on the reality to which they are associated, which is further complicated because different explanations shape different realities (ibid).

The idea of "grand narratives" (or "grand theories") as a system of viewing the world is rejected by postmodernism and replaced by a focus on more situational and provisional "mini-narratives"[43]. Narratives are "fragmented", and each fragment is given equal significance and studied on its own. The downgrading of material relations qualifies postmodernism as a form of anti-

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[43]Lyotard (1984: xxiv) famously defined postmodernism as 'incredulity towards metanarratives'.

foundationalism (May 1997). Because there are no universal standards against which, 'science may lay claim in order to validate its standards… objectivism gives way to relativism with the result that not only science, but also truth, goodness, justice, relationality, etc., are concepts relative to time and place' (ibid: 16). A major theme of postmodernism is relativism, which itself is characterised by the rejection of an absolute truth and the acceptance of truth as the manifestation of individual beliefs and values:

> 'For the relativist, there is no substantive overarching framework or single metalanguage by which we can rationally adjudicate or univocally evaluate competing claims of alternative paradigms… the relativists claims that we can never escape from the predicament of speaking or 'our' and 'their' standards of rationality.' (Bernstein 1983: 8)

Postmodernism's association with narratives, subjectivity, and the challenge against comprehensive rationalism, has led to it being identified both as a suitable approach to studying operation of planning in pluralistic societies and as a conceptual bridge to link change in planning to change in other fields (Hirt 2005). The planning process, as explored in Chapter Five, is characterised by pluralism and diversity, and by participation of multiple actors holding different "truths" about their area of concern. Postmodernism, therefore, provided a suitable vehicle for exploring the complex and dynamic interaction among "context, mechanism, and outcome" in the application of the concept of HUP – and urban planning more generally.

6.3.3 A case study methodology

"Methodology" has attracted considerable academic attention; indeed, it has given rise to an extensive body of literature. Within the literature, there are many competing definitions and interpretations of the term 'methodology' (Van Maanen 1983; Mackenzie & Knipe 2006). In Crotty's framework of the research process, methodology is understood as a strategic approach or vision that links a researcher's methods to their outcomes (Crotty 1998). Methodology can also be seen as the "philosophy of methods" (Jupp 2006); this philosophy being concerned with the direction, perspective and practical steps taken by the researcher to answering the question(s) being asked (Saunders et al. 2012). There are many recognised methodological approaches in the natural and social sciences (Spector 1981; Saunders et al. 2012), including in the field of urban planning (Silva et al. 2015).

The process of selecting a methodology is research specific, and is guided by the aim, purpose and epistemological and theoretical positions underlying that research (Crotty 1998). The intent of this research was twofold; firstly, to understand and interpret the factors that serve as barriers and opportunities to application of the concept of HUP; and secondly, to understand and interpret the intersection between urban planning and health in terms of its actors and related artefacts (e.g. public policies, reports, and academic and professional texts). To support this intent, the methodological approach selected for this research was designed around a multiple case study of local planning and health in England.

This methodological approach, which also made use of naturalistic and interpretative methods of inquiry, aimed to understand, and interpret, a subjective and changing phenomenon within its natural setting. It was, moreover, deemed an appropriate approach for this research for two main reasons. Firstly, it is epistemologically, philosophically, and theoretically in line with the author's stance on the meaning and creation of reality. Secondly, it enabled the exploration and interpretation of the intersection between urban planning and health within its natural setting of the "planning project" and through drawing on the perspectives of relevant social actors.

Qualitative research

In research, there are two main types of data: quantitative and qualitative. The most obvious difference between quantitative and qualitative data is that the former is numerical and the latter non-numerical (Babbie 2012). It follows, then, that most quantitative studies focus on the measurement of quantity – numerical quantification – and qualitative studies focus on the measurement of quality – or subjective meaning (ibid). According to Mackenzie and Knipe (2006), research guided by constructivist and/or interpretivist principles will typically adopt a qualitative approach; however, Mackenzie and Knipe assert that a quantitative approach can also be used alongside a qualitative approach if required. This study adopted a qualitative exploratory approach and used qualitative data collection methods to gather research data.

Qualitative research is a form of social inquiry. This social inquiry has been explained in many ways. Strauss and Corbin (1990: 17) provide a broad definition of qualitative research as, 'any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification'. The qualitative researcher is distinguished from the quantitative researcher by virtue of their pursuit for illumination, understanding and extrapolation of the phenomenon of interest, as opposed to the causal determination, predication, and generalisation of findings (Marshall & Rossman 1999). Qualitative research and analysis thus result in a different type of knowledge than that which arises from quantitative inquiry.

The adoption of a qualitative research methodology is not without considerations. In the *Basics of qualitative research*, Strauss and Corbin (1990) note that qualitative approaches are advantageous in situations where the researcher seeks to understand a phenomenon about which little is yet known. Qualitative research allows the researcher to gain a new perspective on and to gain more in-depth information about a phenomenon than might be possible through a quantitative approach. The ability of qualitative data to more comprehensively describe a phenomenon is a key factor in the adoption of a qualitative methodological approach (ibid). Alongside these considerations,

the researcher must also consider and be aware of the prominent characteristics (or feature) of qualitative research.

Hoepfl (1997: 49) provides a useful list, based on a synthesis of the literature, of the main features of qualitative research:

- The qualitative researcher acts as the "human instrument" of data collection, using a natural setting as the source of data, and observing, describing, and interpreting that setting in a neutral way;
- Qualitative research has an emergent, as opposed to predetermined, design, and researchers focus on this emerging process as well as the outcomes or product of the research;
- Qualitative research has an interpretative character, aimed at discovering the meaning events have for individuals who experience them, and the interpretations of those meaning by the researcher; and
- Qualitative researchers primarily use inductive data analysis.

Hoepfl points out that while the above are characteristics of qualitative inquiry, they are not absolute characteristics; rather, they are strategic ideals that assist in directing and provide a framework for developing specific research designs and selecting data collection methods. This above list highlights, if indirectly, another important dimension of qualitative research. That is, that qualitative research emerged from several or more different research traditions. This results in a situation where there is a great variation in approaches to qualitative research – something which is discussed in more detail in section 6.4.1. Using a qualitative methodology, this study had the intention of developing an understanding of what and how the dimensions of urban planning support or inhibit the application of the concept of HUP.

Case study research

To operationalise the chosen qualitative methodology in this research, a case study approach was adopted. The term 'case study' is, as pointed out by Lewis (2003), synonymous with qualitative research. Many published papers in the social sciences, including those from the field of planning, detail the use of a case study approach. Yin (2003: 13) defines a case study as,

> 'an empirical enquiry that investigates contemporary phenomena within its real life context especially when the boundaries between phenomenon and context are not clearly evident.'

Exactly what constitutes an empirical inquiry of the type definable as a case study is a matter of much debate. Nevertheless, it is generally accepted that the intention of case study research is to gain in-depth knowledge about phenomena in real-life settings (Bryman 2012). Case studies have many features, with Lewis (2003: 75) stating that one is the, '… multiplicity of perspectives which are rooted in a specific context (or in a number of specific contexts if the study involves more than one case)'. A case study is structured around context, not individuals; and it is based on the detailed study of a specific case or cases. Yin (2004: 14) describes a 'case' as a 'real-life set of events from which data will be drawn'. Cases can be singular or multiple, and a 'case' might be a process, program, event, organisation or institutional context, or an activity bounded in time and place (ibid).

One of the main strengths of case study research is its ability to capture multiple perspectives and to build more in-depth understanding of a phenomenon, or phenomena (Berg & Lune 2011); this is particularly true in situations where it is difficult to separate the phenomenon's variables from its context, yet nevertheless it is still important to examine both these variables and this context (Yin 2004). The process of "perspective capture" can involve multiple data collection methods and sources found in the same setting, or a single data collection method applied to those multiple data sources (Yin 2009; see below, section 6.4, for an overview of the data collection methods used in this research). These attributes make case study as a methodology for examining in detail plural interests, through the integration of multiple

methods, particularly useful in multidisciplinary fields, such as urban planning (Thomas & Bertolini 2014).

Literature on social science research raises important considerations that the researcher must bear in mind when adopting a case study approach. Some of the main considerations are discussed below.

Intrinsic case study or instrumental case study

There are several types of case study (Yin 2009). Stake (2005: 45) describes two principal types of case study – (1) the intrinsic case study and (2) the instrumental case study. An intrinsic case study is undertaken because better understanding is sought about this case. Put differently, it is '… not undertaken primarily because the case represents other cases… but instead because, in all its particularity *and* ordinariness, [the] case itself is of interest'. The purpose of an intrinsic case study is furthermore not to '… understand some abstract construct or generic phenomenon'; it is not concerned with theory building, but the intrinsic interest inherent in that which is being observed.

In contrast, the instrumental case study attempts to gain understanding of an issue or to refine theory. An instrumental case study is undertaken '… if a particular case is examined mainly to provide insight into an issue or to redraw a generalization'. The case, moreover, is '… of secondary interest, it plays a supportive role, and it facilities our understanding of something else'. Although the case is still examined in-depth, this is done for the purposes of pursuing the external interest; the choice of case is made based on advancing understanding of that other interest (ibid).

One or more cases

Case study research will always involve either one or more cases. Where a sole case is investigated, the study findings and conclusions are drawn from that individual case. Conversely, where multiple cases are selected findings and conclusions derive from the comparative analysis of the data gathered from the cases involved (Whitman & Woszezynski 2004). Single and multi-case case studies have both advantages and disadvantages. The use of a singular case study can for instance allow for more in-depth analysis,

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increasing the richness of the study findings – but there are also potential pragmatic advantages, for example reduced cost and time commitments (Bryman 2012). A case study using one case can also be advantageous in instances whereby the phenomena under investigation are spatially and temporarily fixed (ibid).

Nonetheless, authors have raised issues about the generalisability, relationality, and validity of single-case case studies. Generalisability relates to whether a case study can produce findings that are representative of the wider population being studied (Silverman 2010). Where multiple cases are selected, Yin (2009) argues that the case study can lead to more compelling and robust analytical results. This argument is supported by Stake (2005) who considers looking at multiple actors in multiple settings as a way of enhancing the ability to make generalisations. The generalisability and validity of a multi-case case study ("a multiple case study") can be furthered strengthened through the adoption of a structured case selection process (ibid; see also below, section 6.4). Stake (2005) notes that when the interest of the researcher is not on one case, several cases may be simultaneously studied to investigate a phenomenon, population, or general condition. A multiple case study can gather and analyse data within each case and across different cases and allow for wider discovery of theoretical evolution and research questions. But a multiple case study comes with its difficulties; this includes, for example, creating a more expensive and time-consuming process (ibid).

For this research, a multiple case study approach was chosen as the preferred way of capturing and communicating the rich detail of the intersection between and stakeholders' perspectives of local planning and health in England. The conduct of multiple instrumental cases provided a deep understanding of this phenomenon in several contexts, from which an overall generalisable set of conclusions were drawn. Using multiple instrumental cases encouraged a new understanding of each context and processes (Stake 2005), ultimately leading to the achievement of a richer experience and understanding of the phenomenon beyond that which would have been achieved with just one single case.

6.4 Research design

Research design relates to the framework used to guide the collection and analysis of data (Bryman 2012). It establishes two main factors: (1) what data is to be collected, and (2) what methods are to be used to collect these data. The research design in this research study was purposefully chosen to link the data that is collected with the research questions, and the research paradigm. As argued by Yin (2009), research design is not an arbitrary consideration but reflects a range of dimensions of the research process. This includes the selected methodology, which in this study took the form of a qualitative case study. The following section describes the process of data collection methods selection, and how they were employed in this study.

6.4.1 Designing a qualitative case study

Without wishing to repeat what has already been discussed, it is useful here, for the purposes of the research design, to introduce a further description of qualitative research:

> 'Qualitative research is multimethod in focus, involving an interpretive naturalistic approach to its subject matter… Qualitative research involves the studied use and collection of a variety of empirical materials – case study, personal experience, introspective, life story, interview, observational, historical, interactional, and visual text… qualitative researchers deploy a wide range of interconnected methods, hoping always to get a better fix on the subject matter at hand.' (Denzin & Lincoln 1994: 2)

The above description indicates that the nature of qualitative research is not singular but plural; it can be approached in many ways and can involve the use of multiple data collection methods. This flexibility (within parameters) is a feature of qualitative research shared also by case study research, which as a methodology does not require that the researcher adhere to a binding,

predetermined set of methods for collecting and analysing data (Merriam 2009). Case study research, actually, makes use of many data collection methods, from interviews and document analysis through to direct and participant observations (Stake 2005). The task for the researcher is to select those, and the number can be either few or many, data collection methods that meet the needs and circumstances of their study (ibid). It was realised by this author, early in the research planning stage, that several research methods would be required for the purposes of this work. The use of multiple data collection methods is not uncommon in studies where the research problem under consideration is complex, or where the researcher suspects that one method of collecting data may not comprehensively address the research problem (Creswell 2003).

This study employed three distinct data collection methods: (A) document review; (B) interviews; and, (C) a survey. The use of multiple data collection methods has been advocated by some planning academics (Gaber 1993), and is more widely assumed to increase the robustness of the evidence gathered (Bryman 2012). It is, furthermore, associated with the idea of "triangulation". Triangulation is described by Saunders et al. (2009: 146) as relating to, '… the use of different data collection methods within one study in order to ensure that the data are telling you what you think they are telling you'. The use of multiple data collection methods thus not only assists with the initial gathering of data but can also ensure the credibility and confirmability of the data (Strauss & Corbin 1990; Denzin & Lincoln 1994). This is achieved through gaining the advantages of each data collection method used – compensating the weakness of one data collection method against the strengths of the others – and by obtaining data from more than a sole source it allows for data to be validated through cross verification.

Figure 9 provides an overview of the research design used in this study, it outlines the data collection techniques used during Phases One and Two of the data collection process. Subsequent sections will discuss this process, setting out data collection methods used; the technique used in the analysis of data is described in section 6.5. But before this, the criteria for selecting the case study LPAs will be explained.
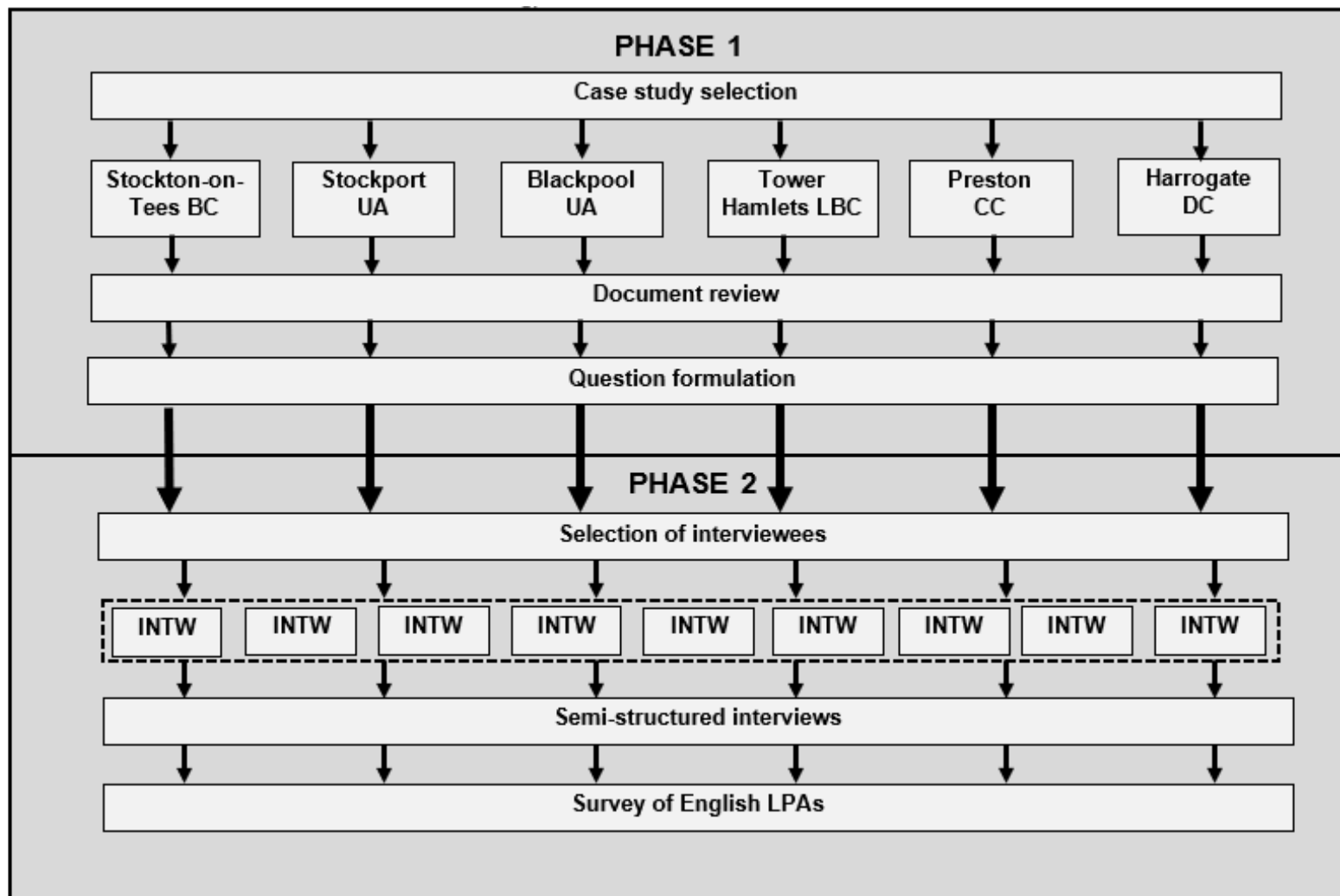
Figure 9 – Research design overview

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6.4.2 Case selection criteria

This study gathered empirical data from a sample of local planning authorities (LPAs) in England. In total, six LPAs were selected. To ensure that the process of case selection was not ad-hoc or random, a purposive sampling strategy was devised. This strategy incorporated what Yin (2009: 48) refers to as 'replication logic', which has the intention of allowing other researchers to follow the same process of case selection and to arrive (if not exactly) at the same conclusions as the original research.

The process of case study selection was guided by the following two principles:

1. To ensure a representative spread across the population of interest (i.e., English LPAs), a stratified sampling technique was used. In this study, the strata were the nine regions of England[44]. Within each stratum, the author selected several LPAs and then systematically assessed them in terms of their rural-urban classification, socio-economic standing, and general health status. This assessment was performed using data from DEFRA 'Rural Urban Classification of Local Authorities (2011)', CLG 'English Indices of Deprivation (2010 Index)' and ONS 'Life Expectancy and Healthy Life Expectancy (2011-13)' statistics.

2. It was also preferable to select local authorities whose Local Development Plan (LDP) had been submitted and, having been found sound by the Planning Inspectorate (PINS), adopted. To ensure that recent changes to national and local planning policy were captured by this study, examples of authorities whose Local Development Plan was adopted prior to and post the publication of the National Planning Policy Framework (NPPF) 2012 were identified. Given that the UK operates a 'plan-led system', decision-making in urban planning must conform with the provisions set

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[44] In England, the regions are the highest tier of sub-national division. There are nine regions in total, these being: South East, South West, North East, North West, West Midlands, East Midlands, East of England, Yorkshire and the Humber, and London.

out in the Development Plan unless material considerations dictate otherwise (see, Chapter Eight).

The departure point of the selection process was the latest information on Development Plan adoption as published by The Planning Inspectorate (PINS)[45]. This revealed – valid at 31 March 2016 – that out of 363 LPAs in England, 292 had submitted Local Plans for inspection. Further refining this figure to include only the two immediate years prior to the publication of the NPPF and before the commencement of this study revealed that 78 "pre-NPPF" and 15 "post-NPPF" LDPs had been adopted. In relation to the final case selection, it is important to stress that the case study research was not intended to support a quantitative analysis of urban planning and health. Rather, it was used as a vehicle for an in-depth qualitative study. There was consequently neither an imperative for the chosen local authorities to be representative in any statistically meaningful way, nor was there a necessity to have identified cases in which the most progress in incorporating health into planning had been made. Whilst the study would identify 'Good' practice when and if found; in many respects it was more important to explore what could be viewed as more common, or 'standard' practice.

Six case study LPAs were selected based on the application of the above criteria. This selection provided a reasonable spread across geography, government, and area types in England. It also captured a mix of cases providing examples of where the Local Development Plan has either been adopted before or after the publication of the NPPF 2012. The six LPAs selected to be included in the final case sample is set out in the table below.

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[45] The Planning Inspectorate (PINS) is an executive agency of the Ministry of Housing, Communities and Local Government (MHCLG) (formally known as the Department for Communities and Local Government).

Sample of case study LPAs

North East Region	North West Region	London Region
Stockton-on-Tees Borough Council	Preston City Council	Tower Hamlets London Borough Council
Harrogate District Council	Stockport Unitary Authority	
	Blackpool Unitary Authority	

6.4.3 Phase One data collection

The first phase of the data collection for this study was conducted to establish how health is incorporated in local and national planning policy and guidance. Phase one of the data collection employed one principle method: a document review.

(A) Document review

Documents are an important artefact of human civilisation. The preparation and use of documents to store and convey information is a practice common to most cultures and societies. May (1997: 157) describes documents as 'sedimentations of social practices', constituting particular readings of social events and therefore having the power to inform and structure decision-making. A document can also inform people about the aspirations and intentions of the period they refer to or those of some other organisation or institution (such as an LPA), and provide information about places and social relationships at a point in time when the reader was not present (ibid).

While documents are not universally recognised as a method of data collection, they are a source of data for an interpretive research approach. What is more, documents are a factor in many types of evaluation (Hurworth 2005). Yin (2009) notes that it is in only studies of pre-literary societies that documentary information (i.e., information contained within documents) is irrelevant. Documents are indeed often used as a data source in research, including case study research (Yin 2009).

The merits of documents as a source of data is contested between positivist and post-positivist schools of thought. Writing about this contest, May (1997) states that documents are sometimes dismissed as a credible data source in positivist circles because they are held to be impressionistic and unreliable. This assumption is, however, rejected by May; he claims that the use of documentation in research has methodological, theoretical, and technical foundations.

Strengths and weaknesses

Document review has both its strengths and weaknesses as a research data collection method. Goldman et al. (2012) provide a useful summary of some of the strengths and weaknesses of the document review method. Strengths include the often-ready availability of data; the high stability of document data; the precise nature of documents; the relative speed with which data can be obtained; the lack of external coordination from others; and that it typically requires limited financial investment.

In respect of the weaknesses of document review, Gladman et al. (2012) state that these namely relate to the potentially restricted or protected nature of documents; the possibility that documents are incomplete or inaccurate; that documents being analysed are context, culture and/or language specific; that there may be limited scope to examine the intent or meaning of document through recourse to the author; and that there is inherent difficulty in ascertaining the objectivity of a text.

Bearing the strengths and weaknesses of document review in mind, it was employed as a data collection method in this research. A primary advantage

of document review in this work stemmed from the thoroughness and comprehensiveness of the documents chosen. The documentation chosen in this work was national planning policy and guidance, and local development plan documents (namely, Core Strategies and Local Plans). These documents are comprehensive in nature, and their production is subject to much scrutiny and examination. For example, Local Plans prior to their adoption are subject to an extensive process of 'Examination in Public' – whereby the policies and evidence underpinning the plan is interrogated in great detail by a government appointed inspector(s). This in some ways helps to secure a degree of objectivity and reduce the potential for the documents reviewed in this study to be biased or their preparation unduly influenced by external parties.

According to Yin (2009), one major strength of document review is that documents are stable, unobtrusive, specific, and provide a wide spectrum of supportive evidence that can be used to corroborate and augment other evidence and data collected. Whereas the data gathered from interviews can be often affected by human subjectivity and error (see section below on interviews), the documentary material used in this study was not only useful in its own right but brought an element of stability to the study.

Document review process

According to Bowen (2009), a document review is a systematic method used for analysing and evaluating printed and electronic material. The range of documentation used in social research is extensive. It can include written and non-written documents, such as photographs, videos, and television programmes. Most commonly, however, social research is concerned with written "texts". This can include personal and non-personal materials, for example: emails, diaries, meeting agendas, meeting minutes, press releases and newspaper articles, advertisements, other academic and non-academic texts, public policies, plans and programmes, reports, and more (ibid).

There are two main points of distinction between a general review of documents and a "document review". Firstly, in a document review the emphasis is placed on texts as a source of primary data; as opposed to an overall review of literature, such as that presented earlier in this thesis

(Chapter Two-Five). Secondly, the documents of concern must be directly relevant to the research and have not been pre-produced by the researcher or some other party specifically for that research project.

In a document review, the researcher's role is limited to three main tasks. That is, gathering, reviewing and interrogating relevant documents (O'Leary 2004: 177). Because a document review does not involve the physical production of documentation, the steps involved differ from those of other data collection methods. O'Leary (ibid: 178) provides a useful summary of the main steps involved in a document review: (1) planning for all contingencies; (2) gathering relevant documents; (3) reviewing their credibility and validity; (4) interrogating their witting and unwitting evidence; (5) reflecting and refining this process; and (6) analysing the collected data. Reviewing (or analysing) documents involves coding content into themes, analogous with how interview transcripts are analysed (Bowen 2009).

The document review in this work was conducted broadly in line with O'Leary's six-step process. Several distinct documents authored by central government or the case study LPAs were gathered and reviewed. These were:

- National Planning Policy + Guidance
- Local Development Plans

A final issue to discuss here is that documentary evidence was not used in this study as a surrogate for other types of data. Atkinson and Coffey (2004) warn that a researcher cannot establish the specifics of how particular phenomena manifest day-to-day from documentary evidence alone. The rationale for conducting a document review is said by Bowen (2009) to be that it is used in combination with other qualitative methods to enable triangulation. In this research, the document review (and subsequent analysis) was used to inform and support the preparation and findings from the interviews and surveys.

6.4.4   Phase Two data collection

For Phase Two of this study, data were collected through two sources: interviews with stakeholders; and a survey of English LPAs.

(B)   Stakeholder interviews

Interviews are a widely used method of data collection in social research. They are also well recognised as a source of data appropriate for a qualitative, interpretative research approach (Yin 1994). The purpose of conducting interviews in Phase Two was to assist in developing an overview of the beliefs, knowledge, and understandings of stakeholders in relation to urban planning and health. To this end, semi-structured interviews were arranged with multiple stakeholders.

The interview

There are many ways in which one can define an interview. Put most simply, an interview is an activity in which conversation or questioning are used for the purpose of eliciting information (Yin 1994). Interviews are a common occurrence in social life, because there many different types of interview – such as media interviews or job interviews. The kind of interview that we are concerned with here is that of the research interview. In the social research interview, explains Bryman (2012), the aim is for the interviewer to elicit from the interviewee or respondent all manner of information. This ranges from information pertaining to the interviewees' own behaviour or that of others, to information about their norms, values and beliefs.

Strengths and weaknesses

The meaning of events, occurrences, experiences, and interactions between phenomena can be understood in many ways. This includes gathering evidence from those who were (or still are) involved in these events, etc. (Thompson et al. 2007). Qualitative, interpretative research places emphasis on understanding peoples' experiences and interpretations of their world, but also stresses the importance of simply acknowledging and understanding the

experiences of others (Patton 2002). It in this data gathering context that many social scientists rely on interviews as a mean of eliciting information.

A major strength of interviews is that they allow researchers to directly gather data about the views and opinions of relevant respondents, with the alternative approach being to infer this information from other data sources – such as documents. The dynamic of communicating directly with participants also enables any issues or queries relating to the study or arising from participants' responses to be, in theory, immediately clarified (Rubin & Rubin 2012). This can help ensure that the data gathered is rich in detail, providing insight that otherwise would be missed.

However, interviews are not without their weaknesses. Some key weaknesses of interviews include time consumption both in terms of conducting interviews themselves and the process of transcribing the collected data, the risk of interview bias and for socially desired responses, difficulties in undertaking objective and in-depth data analysis, and challenges in generalising from collected data. Other weaknesses include the risk that respondents may distort or fabricate the information provided or may suffer from memory decay leading to a loss of knowledge about an event (Bryman 2012).

According to Yin (1994: 85), interviews are, '… an essential source of case study evidence because most case studies are about human affairs or actions'. For the purposes of this research, the human "affair" or "action" of most concern was the interpretational issues and structural forces underlying the application of the concept of HUP, as well as the intersection between urban planning and health. Put differently, this research was interested in unpacking the meanings embedded in participants' understanding of this intersection, and its component parts; participants' opinions on the obstacles and solutions to HUP implementation; and participants' experiences of this. It was decided that interviews offered an effective and practical method for gathering this data.

Semi-structured interviews

Many types of interview exist, with the four main types being as follows (May 1997):

1. Structured
2. Focused
3. Semi-structured
4. Unconstructed

In this research, a semi-structured interview format was adopted. Kvale (1996: 6-7) defines semi-structured interviews as, '… interviews whose purpose is to obtain descriptions of the life world of the interviewee with respect to interpreting the meaning of the described phenomenon'. Like other types of interview, semi-structured interviews constitute a 'specific form of human interaction in which knowledge evolves through a dialogue' (ibid: 125). They can be conducted in many ways, including face-to-face interviews, telephone interviews, group interviews, among others. The choice of approach in this study was to conduct face-to-face interviews where possible, with telephone interviews conducted as a backup option – of the twenty-two interviews conducted in this study, twenty were face-to-face interviews and two were telephone interviews.

The choice of a semi-structured interview format in this study was rooted in its flexibility as a method of data collection. Like other interview formats, semi-structured interviews require the researcher to create an "interview protocol"; this sets out preformulated questions that are to be posed to interviewees, but, unlike structured interviews, these questions are used as a guide as opposed to verbatim. Semi-structured interviews permit the researcher to digress from the protocol during the interview process, thus allowing follow-up questions to be asked to clarify any ambiguities and previously non-formulated questions to be posed if necessary. They also give the interviewee the opportunity to address issues not included in the interview protocol, with this, in turn, providing the researcher with more information (Kvale 1996; Yin 2009; Rubin & Rubin 2012; Bryman 2012).

Participant selection

The selection of appropriate participants (or "interviewees") is an aspect of the interview process. This study employed purposive and snowballing techniques to select interviewees (Patton 2002). The selection process began with a purposive sampling strategy designed to identify "key" interviewees; these key interviewees being defined as stakeholders of the urban planning process, and included planning practitioners (policy-makers, planning officers, development control officers, among others) and health professionals (namely, Directors of Public Health).

A list of prospective interviewees was compiled based on a desk study. These individuals were then contacted via email and asked if they would be able to partake in an interview. This technique was supplemented, where necessary, with informal telephone enquiries and further emails to each local authority asking if they would be able to nominate and/or recommend any key interviewees. As the research progressed snowball sampling became increasingly used, with interviewees identified through the purposively sampled participants nominating other potential interviewees to the author (a process known as "peer nomination").

In total, twenty-two interviews were conducted for the purposes of this study[46]. Each interview was 40-60 minutes in length, although one interview lasted for over 180 minutes. Except for two telephone interviews, each interview was conducted as a face-to-face conversation and took place at the interviewees' place of work – this being in all instances a registered local authority building, such as a town hall or council offices. A single interview protocol was used. The preparation of the questions for this protocol being informed by the findings from the literature review, and the set of questions were formulated to encourage interviewees to explore issues relating to the study without placing boundaries on how the questions could be answered (Kvale 1996). The interview protocol is available at Appendix 1; however, the principal areas of questioning were:

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[46] In total, twelve planners and ten health professionals were interviewed.

- The definition and/or understanding of the 'health';
- The role and effectiveness of urban planning in delivering health improvement;
- The obstacles and opportunities for urban planning to perform this role;
- The extent and effectiveness of current collaboration/joint-working between public health professionals and planning practitioners; and
- The impact of the NPPF 2012 on the intersection between urban planning and health.

Asking a small number of broad questions was found in all cases to be an effective way of encouraging a discursive discussion around the subject. All interviews were recorded using a digital recorder and transcribed verbatim, with the author also taking handwritten notes during each interview.

(C)   Survey of English LPAs

A survey is a 'data-collection method in which individuals answer specific questions about their behavior, attitudes, beliefs, or emotions' (Mrug 2010: 1772). Surveys are frequently used by multiple disciplines, including behavioural and social sciences, public health, political sciences, and others. The use of a survey as a method for collecting data in this work had not originally been the intention of the author. Problems arose, however, during Phase Two of the study for which a survey was deemed the best solution. Specifically, the author encountered what is best described as a negative and sluggish rate of response to the initial purposive sampling used to select interviewees. Many of those contacted by email did not respond to the author, and the majority of those that did respond either expressed caution about being involved in the study or simply declined to be interviewed. To counter this issue, the author explained (with varying degrees of success) to prospective participants the significance of the study and the confidentiality of the information provided, but also opted to employ an additional (third) data collection method: the web survey.

Survey sample

When utilising a survey as a method for collecting primary data it is important to establish and define the population to be examined (Churchill & Iacobuccia 2009). There are four parameters included in the definition of the survey population: item, sampling unit, extent of the sampling, and time. The item and sampling unit in the survey conducted in this work are defined as those Local Planning Authorities in England. Hence, the extent of sampling concerned the whole of England. The survey population was defined as the 363 Local Authorities in England, as recorded in the PINS' inventory of Local Plans (strategic issues/core strategies) progress (31 March 2016). Regarding the respondents from whom the survey data was gathered, when distributing the survey (see below) a note was included in the email communication asking that the individual with the most relevant knowledge and experience of the subject matter covered by the survey be the person to complete it.

The web (questionnaire) survey

Surveys are frequently used in the social sciences to collect data from large – or even very large – populations (May 1997). One of the most commonly used survey techniques is the "questionnaire". Babbie (2012: 239) defines a questionnaire as, 'an instrument specifically designed to elicit information that will be useful for analysis'. Most questionnaires are designed to gather data about characteristics or attitudes of a defined population through a representative sample (ibid). Questionnaires are a particularly suitable method for collecting data in situations where the population of interest cannot – for reasons of practicality or due process, or both – be observed directly (Babbie 2012). The logic of the survey method in this research followed this rationale; that is, the utilisation of a questionnaire was determined to be an effective and pragmatic way of gathering data from many stakeholders.

Surveys (questionnaires) can be classified in several ways, including based on how they are deployed (the "survey medium") and the frequency by which they are administrated (ibid). Callegaro et al. (2015) identify that surveys can be deployed utilising either online (i.e., internet or web-based), paper, telephonic, and/or physical (i.e., face-to-face) means. They can also adopt different formats (structured or unstructured), be performed within short time frames (cross-sectional surveys) or over extended periods of time (longitudinal surveys) and utilise a random (respondents are approached at random by the researcher and asked to complete the survey immediately) or self-selected (respondents are allowed to choose to complete the survey on their own accord) sample of respondents (ibid). Having examined these alternative approaches, the author resolved to employ a web-based self-selection survey in this research.

Strengths and weaknesses

Recent decades have witnessed major changes in the way surveys (including questionnaires) are prepared and undertaken. A leading factor in this change has been the advancement and improvement in computer technology, and the advent and expansion of the internet – including internet ("online" or "web-based") platforms providing survey hosting services (Callegaro et al. 2015). Dillman (2007) describes the web-based survey as a process of collecting data through a self-administrated electronic set of questions. Web surveys have many advantages over other types of survey, such as traditional paper questionnaires. This includes the ability to access distant and/or difficult to contact participants, and the convenience of automated data collection – this further reducing the researcher's time and effort. Web surveys do, however, have disadvantages that must be carefully considered. For example, they have sampling and data issues, and problems with the design, implementation and evaluation of gathered data (Wright 2005).

Another limitation of using a web survey is the response rate; one reason for this being that a web survey will often have to compete for the attention of participants against an extensive landscape of online data-gathering activities (Callegaro et al. 2015). It is important, therefore, to compile a questionnaire that motivates the respondent to complete it. For example, the provision, and position of, information about and instructions of how to complete the survey are essential in this regard (May 1997). Question type and formulation are equally important considerations in the design of a survey, be it online or paper. To elicit information, surveys are composed of multiple questions. The main types of survey questions are close-ended and open-ended (Babbie 2012). Close-ended questions include those that ask the respondent to select an answer from a predefined list (e.g., age, sex, marital status, etc.), whereas open-ended questions are those that require respondents to formulate their own answers (e.g., "What do you think…?") (Mrug 2010).

Although close-ended questions are more popular in survey research, typically because they are easier to process and provide a greater uniformity of responses, they suffer from shortcomings, such as the set questions and proposed answers (if a multiple-choice format) not covering all possibilities of

a certain context (Bryman 2012). Translating questions into an open-ended format, where no answer choices are given, and respondents reply in their own words, can often elicit more complete, richer answers. This benefit of open-ended questions can, however, be sometimes offset by the increased difficulty in analysing and evaluating extensive data. The choice over survey design and question type should depend on the needs of the research project, although this may not always be the case in practice. In this study, the depth of information and insight sought was deemed not capable of being elicited from posing to respondents close-ended questions. For this reason, it was decided that a series of open-ended questions would be compiled.

Google Forms

The online web-based survey tool 'Google Forms' was used to create and implement the survey. This "tool" was chosen because it met the needs of the author, i.e., it was convenient and free of charge. It, moreover, allows the survey data to be stored and retrieved in an aggregate and anonymous format. A survey titled 'Local Urban Planning and Health: A Study of England' was launched via email invitation through the Microsoft Outlook email application in February 2017 to 363 English Local Authorities. This email included information about the survey and study, a request for informed consent (obtained by virtue of completion of the survey), and a link to the secure survey website that hosted the survey. There were eight questions on this survey, which are available at Appendix 2, and participants were given several weeks to complete the survey. Sixty-three (17%) Local Authority employees responded to this survey; this sample comprising forty-four planners and nineteen public health professionals.

6.5 Data analysis and interpretation

The data collected through the document review, stakeholder interviews and survey were interpreted by exploring and describing the themes that emerged during the analysis process. Data analysis was carried out through "content analysis" that included thematic coding, something explored in more detail below. This data extraction approach is well suited to the analysis of textual data (written documents, interview transcripts, survey responses, etc.). The analysis and interpretation of the data was undertaken with full awareness of the need to attend to the reflexivity of the author (see, section 6.6).

6.5.1 Content analysis and thematic coding

In qualitative research, the researcher is often faced with extensive data about their subject. It is the task of the researcher to examine and order this data to illuminate the relevant information it contains (Creswell 2003). There are numerous techniques that a researcher can use to analyse their gathered data. Data in this research project, as mentioned above, were interrogated through an in-depth content analysis that included thematic coding. Content analysis is a widely used technique for analysing qualitative data, specifically textual data – documents, interview transcripts, among others (Klenke 2016). Many definitions of 'content analysis' are given within the literature, with one useful definition provided by Berg and Lune (2011: 304): '[content analysis] is a careful, detailed systematic examination of a particular body of materials in an effort to identify patterns, themes, biases, and meanings'. Yin (2009) describes content analysis as a subjective process between the researcher and data.

Content analysis is and can be conducted for both quantitative and qualitative data, and it can be approached in either an inductive or deductive way. This present (qualitative) study adopted an inductive approach, deriving "themes and findings" directly from the data; with the analysis proceeding from the particular to the universal (Klenke 2016). More specifically, it used a variant of

qualitative content analysis as proposed by Elo and Kyngäs (2008). According to Elo and Kyngäs, content analysis involves two main analysis phases: (1) preperation of data and (2) organisation of data. There is a third phase which focuses upon the reporting of data, however this is not considered here as further details on the empirical findings are presented later in the thesis (Part IV).

Before outlining the two phases of content analysis followed in this research project, it is worth noting that, while Elo and Kyngäs may identify these discrete content analysis phases, there are no definite, sytematic rules for data analysis (Bryman 2012). The key feature of all content is to distil large volumes of information into clear and concise themes.

Phase One: preparing the data

At the start of the content analysis process is the task of data preperation, i.e., the preperation phase. Involved in this first phase are two principal decisions: the first is the prelude to analysis, it centres on the selection of the unit of analysis; the second concerns the choice of contents to analyse. There is much debate about how these decisions should be taken, however Robson (2016) concludes that they should be informed by the aim and research questions of that particular study. Three units of analysis were selected for the purposes of this work, these being Local Development Plans (and other relevant documents), interview transcripts, and completed surveys.

Together, these three units of analysis provided an extensive amount of information. Each interview, for example, was transcribed[47] into 18-20 pages of text (or 9,000-10,000 words), equating to around 418 pages (209,000 words) of transcript to analyse. To improve the managability of the analysis, the units of analysis were only examined in terms of their "health contents"; with the relevant content being broadly defined as that capable of answering or contributing to to the research questions. Finally, the preparation phase

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[47] In the preparation phase, the audio recordings of the interviews stored on the digital recorder were transcribed verbatim to produce a collection of interview transcripts – or written narratives.

requires the researcher to fully immerse themselves in the data. This can be achieved, for instance, by reading the written material several or more times. Dey (1993: 6) offers some broad questions that the researcher can ask when reading textual data – Who is telling? Where is this happening? When did it happen? What is happening? Why? The intention of asking these questions is for the researcher to learn "what is going on" and to develop a sense of whole (Elo & Kyngäs 2008).

Phase Two: organising the data

With the data preperation complete, the next step is to organise the qualtiative data. This process comprises coding, categorisation, and abstraction (Elo & Kyngäs 2008). To organise the data, the written material was read and the relevant contents coded into specific subjects and themes. The coding process included "thematic coding" to reorganise the data into a format from which findings could be extracted – or simply "lifted out". Thematic analysis is a way of discovering themes that are important for describing the phenomenon or phenomena of interest (Bryman 2012). This process involves the constant comparision of 'data, codes and categories within and across cases… moving from an initial tentative category towards progressively abstracted theoretical categories that are grounded in the data' (Toye et al. 2015).

A hybrid approach to the thematic coding was used in this work, consisting of a balance of deductive and inductive coding. This approach was determined as complementary to the research questions because it allowed established tenets from health and urban planning research to be integral to the process of deductive coding while allowing for the organic emergence of themes direct from the data using inductive coding. The coding process began with the formulation of categories based on a comprehensive literature review (presented in Chapters Two-Five). These pre-defined categories included (1) definition of health, (2) role of urban planning in health improvement, (2) effectiveness of urban planning, (3) collaboration between public health professionals and planning practitioners; and (4) barriers and opportunities for healthy urban planning. The data were first coded to these categories to

develop a holistic understanding on the intersection between urban planning and health. Simultaneously, codes were inductively developed to reveal unifying themes within these categories.

The cateogorisation of data into cohesive themes followed the procedures and advice presented by Ryan and Bernard (2003) and Braun and Clarke (2006). These authors propose that inductive coding proceeds from particulars (low-level codes) towards universals (high-level thematic concepts). The comprehensive data coding process was conducted using qualitative software - specifically QSR NVivo[48].

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[48] NVivo is a qualitative data analysis computer software package developed by QSR International. It is used for qualitative and mixed-methods research, especially where the data to be analysed is derived from interviews, surveys, and documents (books, journal articles, policies, among others).

6.6 Reflexivity and ethics

This section looks at the two issues of reflexivity and ethics, which were important considerations throughout the conduct of the thesis research.

6.6.1 Reflexivity

Reflexivity is an important concept in research. This is because it is directed at the most pressing threat to the accuracy of research outcomes: the interaction between the researcher and the research (Bryman 2012). Reflexivity is also an important tool for navigating the maze of ethical dilemmas that can arise during the course of a research important. While it may be important, the concept of reflexivity is contentious both in its application and meaning.

Nightingale and Cromby (1999: 228) define reflexivity as,

> 'an awareness of the researcher's contribution to the construction of meanings throughout the research process and an acknowledgement of the impossibility of remaining 'outside of' one's subject matter whilst conducting research'.

Reflexivity encompasses the researcher's conscious awareness of, '… cognitive and emotional filters comprising their experiences, world-views, and biases that may influence their interpretation' (O'Dwyer and Bernauer 2014:11). In this regard, reflexivity has recourse to the potentiality of the researcher's background, norms, beliefs, and values to have an influence over a research study. But it also recognises that the interaction between the researcher and the components of a study may affect its outcomes. Thus, reflexivity is about self-conscious examination of one's subjectivity and biases and reflection on how these impacts the research process – including the creation of knowledge (ibid).

In research that is led by a social constructivist perspective, reflexivity is particularly integral to the empirical process as it supports and gives effect to the notion that knowledge is socially and culturally constructed. Throughout the preparation of this thesis, but especially during the conduct of the empirical study itself, the process of reflexivity was engaged with to expose and address (or at least mitigate) the effect of the author's own value and belief systems and involvement in the research upon its outcomes. This engagement with reflexivity took two dominant form: relevant discussions with the author's supervisory team (which acted as "critical friends"), and by means of keeping an informal research diary that recorded relevant details about the interview process – namely, the research location and setting, length, interesting quotes and events, and how the author may have influenced the responses and overall results of each interview.

To illustrate this process of reflexivity in action, it is helpful here to consider some of the particular concerns and issues that were encountered in the interview process.

Reflexivity in the interview process

As mentioned above, reflexivity was engaged with throughout this research project. However, this engagement was particularly brought to bear during the conduct of the interview process. At this juncture, there are two salient factors to note. Firstly, as made clear in Chapter One, the empirical research underpinning this work was undertaken for academic purposes. Secondly, as stamped on the front cover of the thesis, the thesis was prepared to fulfil the requirement for a doctorate degree.

That the study was driven by a combination of intrinsic and instrumental motivations was not lost on those who partook in interviews. Neither was the fact that the task of "healthy urban planning" (whether or not recognised by the academised concept of HUP) is ambiguous, and that health is a sensitive and emotive topic of discussion. Through personal self-reflexivity and discussion with the author's supervisory team, it became recognised that these factors coupled with the interview process itself may have had a bearing on the way and nature of the data collected.

Not unsurprisingly, upon describing the aims and objectives of the work to participants (interviewees), their typical response was to question whether the author was intending to measure – whether qualitatively or quantitively, or both – the performance of the individual and/or the organisation (LPA) they were a member of with respect to actual population health outcomes. Participants were equally, if not more, inquisitive about the identity of the author and how they intended to use the data collected during the interviews. The significance of this was that the answers supplied by the author in this regard would influence how the participants would respond to the questions asked – and the type and nature of the details they would disclose in their answers. That the author often encountered this line of question revealed only further the necessary of reflexivity to the accuracy and integrity of the work.

In line with the above, it was felt only appropriate that the author, when asked to do so, explain more about the research and why they had selected this particular topic of study – with the content of this conversation following much the same vein as the "project details" section set out earlier in Chapter One. This process provided an opportunity for the author to build up a rapport with the participants, and in doing so help lessen the hierarchal nature of the relationship between the interviewer and interviewee (Nightingale and Cromby 1999). Another more serendipitous outcome of this conversation was that it enabled the author to develop a deeper understanding of the knowledge structures and the reasoning processes underpinning how choices are made in professional contexts.

Through this, the author also established a greater appreciation of the circumstances and space afforded to participants in the workplace and homeplace to learn about new or unfamiliar concepts – regardless of how topical they might be in academia or the media. Many participants expressed regret that a combination of work and non-work commitments severely hindered their ability to commit time and resource to what might be conventionally called "study". From this, the author became even more acutely aware of the fortunate position they enjoyed in having the essential organisational and resource (financial and time) structures in place to allow them to commit fully to expanding their knowledge and understanding of the

topic under study. Additionally, it facilitated further consideration of a difficult line that researchers must tread: the objective analysis of what participants actually know, but the responsibility not to subjectively criticise or assume what participants are expected to know.

On this issue of knowledge and understanding, it was often necessary for the author to emphasise to participants that there was no correct or incorrect answer to the questions posed. In some instances, participants would seek reassurance or affirmation that a response given was in fact the correct response. Again, the author had a responsibility in such cases to reconfirm that there were no correct or incorrect answers. That this situation arose was acknowledged by the author through entries recorded in their research diary, which were subsequently discussed with their supervisory team. It was recognised that the broad nature of the questions asked may have been a cause of anxiety and indecisiveness among a selection of participants. However, this in many respects provided justification for the selection of a small number of broad questions (as opposed to a large number of very specific questions). This was because questions of a broad nature (as noted earlier) proved an effective way of encouraging a discursive discussion around the subject. In turn, helping to better reveal the participants' "true" knowledge, understanding and experience of the subject matter.

Through engagement with reflexivity, the author became conscious of their position as both an insider and outsider during the interview and wider data collection process. Awareness, or even suspicion, of the equivocal and emotive nature of the subject matter being studied may explain why only a limited number of participants were recruited to take part in the interviews. This consideration was directly factored into the author's decision to utilise a questionnaire survey as a third data collection method. It was thought that a more indirect and anonymous method of data collection, whereby respondents could ensure that their identity was kept confidential from the researcher, would elicit more evaluative and discursive above that which could reasonably expected form the interviews.

Overall, reflexivity helped the author appreciate and identify how the design of the study and their involvement in it may affect how and what type of data is collected. Such recognition was also reflected upon when selecting and undertaking the analysis of the collected data, as noted earlier in this chapter.

6.6.2 Ethics

The author of this work was (at the time of writing) a member of the University of Liverpool (the University). Given that the research was conducted under the auspices of this institution, the research was undertaken in a manner compliant with the University's policies and protocols around research ethics and integrity. This research also complies with ethical guidelines for qualitative research developed by Kelly et al. (2003) and Creswell (2003). The ethical issues that can arise in qualitative research are many, with Creswell (2003) noting that there are ethical issues associated with data collection, data analysis, and the process of disseminating research findings.

In this study, the primary ethical issues faced were those of informed consent, participant confidentiality, and data protection and storage. To ensure the validity and integrity of this research, it was important to address these issues. A discussion of these ethical issues and how they were addressed is given below.

Informed consent and confidentiality

In this research study, ethical issues relating to informed consent and confidentiality were most prominent in the preparation, conduct and subsequent analysis of the data gathered from the interviews and the survey of English LPAs. This study relied on the voluntary participation of a range of stakeholders for both the interviews and the survey. It was important, from both an ethical and professionalism perspective[49], that the author secured the

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[49] As a member of the Royal Town Planning Institute (RTPI), the author endeavoured to ensure that the conduct of this research was in accordance with the institution's Code of

informed consent of all the study participants. The author, moreover, sought to ensure that all prospective study participants were provided with accurate information regarding the research itself – including its aims and purpose, how empirical data was to be used and disseminated (e.g., written up in this thesis and/or other publications), and that any involvement in the study was voluntary; this included the stipulation that they had the option not to answer any questions that they did now want to and that they had the ability to withdraw – either themselves and/or their data – from the study at any point in the process, without reason, and without negative repercussions.

Another major ethical issue was that of confidentiality. Every effort was made to ensure the confidentiality of all those who participated in this study to prevent the participants' identity being discovered. To ensure this, appropriate measures were taken to anonymise empirical (interview/survey) data before and after it was analysed. This anonymisation process involved assigning each participant with a reference number (used for identification purposes), but also a generalised "job title" (this based on participants' supplied information); in the absence of any identifying details and labels (name, age, employer, etc.) the assigned job title was used in the writing up stage of the data as a pseudonym for participants.

Data protection and storage

Due care and diligence were employed in the processing and storage of the collected research data, this being especially important in relation to the interview and survey data. All data were stored in a professional and secure manner, being saved in an encrypted format, and transferred into a safe storage system to protect against unauthorised access and use. Data were stored on the University's "M: Drive", a secure and protected storage drive, and any transfer of data was done using the University's secure email service. Only the author of this work had direct access to the research data; however, given that the data were stored on this storage drive, it followed that the

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Professional Conduct. This 'Code' sets out the standards, ethics, and professionals behaviour expected of Members – which is applicable to both academic and professional practice.

University also had access to the data files (although data encryption prevented it from being viewed). Limited amounts of unprocessed ("raw") data were also viewed by the author's supervisory team during the period of the work.

6.7 Chapter summary

This chapter has provided a thorough discussion and description of the research strategy underpinning this research, including its constituent parts and related issues. It discussed the philosophical and theoretical dimensions of this strategy, but also its practical, ethical and reflexive dimensions – including how empirical data were collected and analysed. In summary, this study was guided by a research paradigm built around a social constructivist epistemology, a postmodern theoretical perspective, and a qualitative case study methodology (which incorporates the design methods of a document review, semi-structured interviews, and an online questionnaire survey). Collected data were analysed using in-depth content analysis. The information provided in this chapter should ensure that readers are able to understand the research process followed.

Part IV:
A case study of England

Overview of empirical chapters

This thesis relates to the emergence of the concept of healthy urban planning (HUP), and its promotion as a tool for improving population health through urban planning. Three principal sets of research questions directed the performance of the empirical investigation and data analysis. While previously presented in Chapter Six, these questions are presented below for facility of reference:

Firstly: ***What is the stakeholders' approach to healthy urban planning?*** How do they understand and interpret the role of planning in terms of improving population health? What is their position on an explicit 'health goal' in planning? How do they define and describe the concept of human health? Is there universal agreement among them on these (and other) matters? Or is this agreement more nuanced and reflective of subjective preferences?

Secondly: ***How is health embedded within planning policy?*** What expectations are imposed on local actors through national policy guidelines? How is the concept of human health defined and understood in local statutory development plans? What health policies are included in these plans?

Thirdly: ***What are the barriers and opportunities to and stakeholders' experience of healthy urban planning?*** How are issues relating to health considered in the local spatial planning process? Is this consideration effective? What factors – both macro and micro environmental factors – influence how health is considered in the local urban planning process? How do planning and public health professionals collaborate and cooperate to integrate health into urban planning? What factors support or hinder this collaboration? Are there any priorities and/or implementation strategies to address barriers to health and planning integration?

To answer these research questions, and to help meet the aims of this study, it was necessary to look carefully at a sample of Local Planning Authorities (LPAs) in England; including examining their Local Development Plans (LDPs) and conducting interviews with relevant actors – namely, planning

practitioners and health professionals. Complementing this case study approach, an online nationwide survey (questionnaire) was produced and distributed to all LPAs in England. In total, some twenty-two persons were interviewed, sixty-three survey responses collected, and multiple documents reviewed as part of the empirical investigation for this research. Together, this created a solid empirical foundation from which to draw findings and conclusions.

The findings of the empirical data analysis are presented across three chapters, Chapters Seven to Nine. For the sake of clarity, the presentation of the findings will follow the sequence of the three principal sets of research questions set out above. Chapter Seven focuses on the first set of research questions – it deals with the stakeholders' understanding, attitude, and perception or their approach to HUP. Chapter Eight addresses the second set of research questions – it presents evidence on the embedment of health within national and local planning policy. Chapter Nine concentrates on the third research question – it evaluates stakeholders' experiences of and identified factors that serve as barriers and opportunities to the implementation of HUP.

As will become apparent during the discussions, data presentation is weighted more heavily towards some individual cases and participants than it is to others. This is for two reasons. Firstly, the availability and quantity of data for the different cases and data received from participants varied. Secondly, there was a variation in the quality of the collected data. Also, the empirical chapters are intended to present the research findings not as fragmented cases but as a single body of knowledge. For this reason, the presentation of the findings is structured around "theme"; as opposed to case. The main strength of this approach is that it is more facilitatory in the identification and evaluation of both the theoretical structure underlying and the descriptive and normative elements contained in the discourse that emerged from the data.

7. Stakeholders' approach to healthy urban planning

This chapter is the first of three chapters that together present a discussion of the empirical findings of this study. The focus of this chapter is on analysing and explaining the stakeholders' approach to healthy urban planning (HUP). This chapter begins with a discussion of the stakeholders' view on the health "goal and role" of urban planning. It then moves to a discussion on the stakeholders' definition and constructions of health, and how urban planning should aim to deliver health improvement.

7.1 Introduction

One of the objectives of this research was to obtain an understanding of the stakeholders'[50] approach to (or their knowledge, understanding, attitude, and perception of) healthy urban planning. This chapter presents a discussion of the findings of the first principle set of research questions posed in Chapter Six – what is the stakeholders' approach to healthy urban planning? Findings presented in this chapter are derived from analysis of the stakeholder interviews and web survey.

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[50] As explained in Chapter Six, stakeholders were defined as those individuals with involvement or interest in the local urban planning process and who participated in this study; namely, planning practitioners and health professionals.

7.2 Health and urban planning

Much has now been written on the virtues of HUP. But academic support for and understanding of HUP, and the wider links between health and urban planning, is only half of the equation. The other half of the equation is stakeholders' support and understanding of HUP. To realise the principles and goals of HUP it is fair to say that planners and other stakeholders of the urban planning process must also be supportive. It is, therefore, important to understand both the academic and stakeholder perspective of healthy urban planning, and to reflect on the implications of this for current and future practice and research. The stakeholders who participated in this study were asked whether they thought health should be a goal of urban planning. And, if so, whether or not it should form an explicit goal of urban planning.

7.2.1 General consensus

All those who participated in the study, either by completing the online survey or participating in interviews, provided a valid (non-missing) response to the question of whether health should be an explicit goal of planning. Only in rare cases, however, was this question answered through a 'yes' or 'no' statement. More commonly, participants answered this question through the several short statements – these statements being connected to the various elements of the question, each relating to one another in complex ways. What was initially posed as a descriptive question was transformed by the participants into a relational question, being deconstructed into three interrelated questions:

1. Should health be a goal of planning?

2. If so, should it be an "explicit" goal?

3. If so, or if not so, how is a 'health goal' best articulated in planning?

On the first of these three questions, there was a clear consensus among the participants that protecting and improving health not only should be but is a goal of urban planning. Both health professionals and planners frequently

noted that they felt it was important that health-related issues be considered in the urban planning process. For example, a Senior Planning Policy Office observed,

> 'Yes, I would like to see all planning policies and decision-making prioritising health and well-being. A healthy society is good for all other aspects of planning. A healthy place is undoubtedly a sustainable place.' (R27)

While there was a general agreement among the participants that health is (or at least should be) a goal of planning, such agreement did not extend to whether this 'goal' should be explicit or implicit, nor how it should be articulated. The two issues of "explicitness" (the degree to which the goal is fully expressed) and "articulation" (how the goal is communicated) conjured complicated and conflicting positions; participants wanted health to be a goal of planning but some, especially some planners, were cautious of the inclusion of an explicit health goal in planning.

Several planners expressed concern about the current capacity of LPAs to accommodate and realise an explicit health goal, and thus answered "no" to the second subsidiary question. This seems particularly the case given how, as some participants explained, the responsibilities of planners already extend far beyond "health", and resource constraints and competing priorities are currently threatening practitioners' ability to meet existing responsibilities (an issue explored in more detail in Chapter Nine).

One Senior Planning Policy Officer commented,

> 'There are many things planners need to achieve such as delivering new housing and saving the world's climate. Health and well-being are about the quality of the urban environment which all planners are seeking to improve. Rather than tell us what to do – give us the proper resources to achieve all of the many goals we already need to achieve.' (R28)

Most health professionals and planners did agree that health should be a goal of planning. Yet, thematic content analysis of interview transcripts and survey

responses revealed subtle nuances in thinking between individual participants on this issue. The analysis, moreover, indicated that there was a combination of ideological, epistemic, and pragmatic considerations underpinning participant's verdicts on the articulation of a health goal in planning.

Regarding the preparation of Local Plans, some participants posited that there is a 'need' to articulate health as an explicit, standalone (yet interrelated) policy goal. Others, however, highlighted the need for health to be communicated as an essential (and indispensable) part of the concept of sustainable development. These dissimilar views of articulation point to the notion of a specific planning "health goal" as being multiplicitous. Essential to this interpretation is the fact that participants proposed different approaches to framing and achieving a planning-related health goal, but all these approaches were directed towards a singular aim: to improve health outcomes through planning. To further illustrate this multiplicity, participants' responses can be classified and explored from two perspectives: first, health as the "golden thread" of planning and, second, health as part of sustainable spatial planning.

7.2.2 The golden thread

Although a generalisation, it is true that for many participants the notion of public health equates with urban planning. Most saw urban planning as having something to do with health. In fact, several health professionals noted that planners are important public health agents. Many answered the "health goal" question with reflection on the history of urban planning. Such a response was equally prevalent among both planners and health professionals. A common portrayal of the planning system was that it emerged from the Public Health Movement of the 18th and 19th centuries (mirroring the earlier discussion in Chapter One).

One Planning Policy Officer said,

> 'The origins of planning practice are rooted in public health and in enabling changes to the physical environment with a view to improving people's health. Local Planning Authorities still have a duty

today to address health and well-being (ageing, obesity and non-communicable diseases) through the form and layout of the physical environment, transport patterns and access to green space.' (RO3)

Extending this perspective, others understood the creation of an explicit health goal to be an expression of planning's interest in this social issue. Furthermore, health was seen as part of the ideology (even the physiology) of planning. When discussing this point, a Planning Policy Officer shared,

'I mean as planners, I know the agenda is about reintroducing health into planning, but for me it's always been there. For a planner, there has always been that aspect to planning about health and wellbeing. So, for me, it's about making it more explicit. It's like a golden thread running through planning: if you're planning well, if you're designing well, it has an impact on health and wellbeing. But this has never been explicitly identified, I think. So, that's what we're doing: making it obvious within the emerging plan – that there is that link!' (PO3)

There was also a general assumption that planning functions part by part with a priority on protecting and enhancing health. 'Yes, why bother if we don't seek to achieve health' (R44), was one Principal Development Plans Officer's response to the question under discussion. 'Planning has an almost utilitaristic role in delivering public goods, of which health is a key part' (R32), explained another Planning Policy Officer. A collection of participants chose to frame their case for articulating health as an explicit goal of planning in terms of the "wider determinants of health". An Advanced Public Health Practitioner explained, 'All the things necessary for health, such as air quality and food access and other health determinants, are controlled by the planning process.' They further noted that, 'Health should therefore be an explicit goal of planning because most of the levers for health and wellbeing fall within the remit of Local Authority planners' (RO8).

An instrumental rationale was also given for articulating health as an explicit health goal of planning, alongside a strong intrinsic motivation. An earlier quote above mentioned that "a healthy society is good for all other aspects of

planning". Both health professionals and planning practitioners stressed that health should be if not a prerequisite then an important consideration for planning decision-makers. It remains unclear, however, whether those stakeholders who held this (or a similar) view did so for pragmatic or more idealistic reasons. Another point to mention here relates to the semantic significance of having an explicit health goal. Building on the earlier point regarding an expression of planning's interest, a number of participants considered an explicit health goal to be a "good marker" of the growing salience of health as a concern of contemporary spatial planning. Additionally, "what is said" in Local Plans is crucial to the actual implementation of planning policy. A Planning Policy Officer, for instance, commented,

> 'I think in making health explicit, it makes people aware of the links. I think it is important, but it's always been there. Whereas if you hadn't made it explicit and asked for a design in a certain way, developers can target it. But, if what you're asking is explicitly spelt out in policy, well, that's the way to make sure it comes through in development.' (PO3)

More broadly, the inclusion of an explicit health goal or policy in Local Plans was thought to potentially translate into an increased emphasis on health in the development management process. As one Senior Public Health Professional said,

> 'Health as an explicit goal of planning? This is something I have certainly argued for. My experience in [name removed] showed that when it's just part of sustainable development, it often gets lost in the background noise of the planning process. By making health more explicit you make sure that you have more of an emphasis on the impacts on human health, and not just in a very mechanistic sense of "are buildings to spec, not damp, etc." By thinking about health on its own, I think you can have a richer discussion that pulls in some of those softer issues. As opposed to often the sustainability things

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being skewed towards the question whether something is environmentally ok?' (PO15)

7.2.3   A component of sustainable development

The concept of 'sustainable development' has strongly influenced the agenda of local and national planning policy in England for many years (Bell 2018). The prominence of sustainable development in the planning agenda appears to have influenced the verdict of a grouping of participants regarding the articulation of a health goal in planning. Although the perspective that health as a "golden thread" of planning tended to dominate the narrative space, some participants, while supporting the need for a health goal, held an antithetical view on a specific issue. That is: health should not be promoted as an explicit goal of planning, rather it should form a component goal of sustainable development.

A crucial point to make here is that this viewpoint does not simply equate health with sustainability. Instead, it sees health as central to the achievement of sustainable development; and sustainable development as central to population health. A few examples of participant's responses help to illustrate this point. One Strategic Planning Policy Officer said,

> 'I think [health] should form part of the sustainability agenda, because I think that generally if you achieve good planning and good sustainable places then health and wellbeing sort of go along with that. So, erm, I think it should be part of the sustainability agenda. Although it should be in your mind what would happen if you achieved good planning – obviously, we're looking to achieve sustainable planning and sustainable places.' (PO6)

Likewise, another planner noted,

> 'Sustainable development is definable in many different ways and you have to unpick what it means for your local area for it to become

locally meaningful…One of the key defining aspects for us is about being a sustainable place. Health sits within that.' (PO2)

Finally, a Senior Planning Officer said,

'Planning is responsible for creating sustainable places, health and well-being is an important aspect of social 'sustainability' but also has an impact on economic sustainability.' (R38) (emphasis in original)

Participants frequently mentioned that health is a key aspect of the definition of sustainable development. For example, a Policy Officer stated that, 'within proper sustainable development – if you look at the definition of sustainability – health should be a massively intrinsic part' (PO1). A more instrumental reason put forward for viewing health as a dimension of sustainability (rather than viewing sustainability and health as equal or separate entities), is that it is much more heuristic in constructing a discourse around health that takes account of both the strengths and limitations of planning with respect to improving health outcomes. One planner, for instance, stated,

'Yes, providing there is clear understanding of what planning can and can't address and the need for behavioural change and the involvement of other settings such as schools and businesses to address health issues. The improvement of health and well-being should be part of the broad concept of sustainable development.' (R32)

The above response alludes to the need for a holistic, multisector approach to addressing health challenges effectively. This is certainly something which academic and professional literature encourages. As a Health Professional explained:

'Health should be included as a key element of sustainable development in order to encourage a holistic approach. Health, economic growth, transport, the environment, access to services are all interlinked.' (R45)

Participants regularly observed that planning can play a significant role in improving health outcomes, but it cannot alone achieve this. It was explained

that planning must work in conjunction with existing, in addition to new, areas of sustainability policy and practice. Furthermore, this rationale was used to justify why health is an inherent part of the concept and practice of sustainable development. But this view led participants into a grey area. None of the participants were able to provide any indication as to either when "healthy planning" (or a "healthy place") becomes "sustainable planning" (or a "sustainable place), nor under what circumstances testing against health should be considered testing against sustainability (or testing against sustainability should be considered testing against health).

The relative significance of this aforementioned situation can be viewed in two ways. Firstly, as further complicating if not undermining the participants' rhetoric about health being a key aspect of sustainable development and adding to the perception that sustainable development (with its complementary social, economic and environmental aims) is merely a theoretical principle that lacks the capacity of practical fulfilment (see, Beckerman 1994 and Kingma 2007). Secondly, as far from obscuring and undermining this rhetoric but actually enriching it, and confirming participants' thesis about health as part of sustainable development. The choice of which view is ultimately dependent on the normative stance and reference frame of the observer.

7.3 The health role of urban planning

Although not all participants might be familiar with the HUP concept, it was envisaged that many would have some awareness and understanding of how urban planning might improve people's health. In line with this, participants were asked what they understood the role of urban planning to be in terms of improving health.

7.3.1 Urban planning's health role

During the interview process, many of the participants spoke at length about the role and responsibility of urban planning towards health. Indeed, most seemed particularly keen to discuss this subject; interviewees would often talk openly and sometimes for considerable periods of time about the philosophy and priorities for health within urban planning. This was not just restricted to interviews themselves, with the responses to the survey offering a similar picture. Collectively, the results from the interviews and surveys provide an insight into health professionals' and planners' perceptions and understandings of the "health role" of urban planning. This insight is discussed in greater detail below, distinguishing between the two main stakeholder types.

Planners

Most planners noted that there is a connection between urban planning and health. The majority mentioned that planning activities can affect people's physical and mental health. Others also indicated that the social wellbeing[51] of communities can be affected by the outcomes of the local urban planning process. The built environment was identified as being the main avenue, or pathway, through which urban planning impacts on health. One planner stated that 'at the end of the day, for planning, it comes down to the built environment. It's about trying to relate how you can improve health through the development

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[51] Social wellbeing can be defined as a 'positive attitude toward others, a sense of belonging to our communities, and a sense of contribution to society combined with the belief that society is able to development positively' (Lindahl et al 2013: 159). Social wellbeing is part of the WHO's (1948) definition off health and is closely linked to the social determinants of health.

of the built environment' (PO7). The fact (or at least the perception) that there is a relationship between the built environment and health was thought by many planners to engender a society-wide duty or responsibility to create a "healthy built environment". And if urban planning is an important instrument for shaping the built environment, it follows (according to participants) that urban planning has a duty or responsibility to contribute to this process.

Those adhering to this previous position felt that urban planning has a "social responsibility" to protect and promote health, and to minimise and mitigate the negative health consequences of land-use development. Some practitioners expressed that planning has a duty to lead efforts to ensure that built development positively contributes to public health. For example, one planner said, 'Planning SHOULD be at the forefront in terms of ensuring that development contributes to improving public health' (R40) (emphasis in original statement). Another said, 'Planners have a leading role to play in ensuring that the impact on health and well-being is considered when developing all planning policy and assessing new development proposals' (R13). Some participants emphasised that planners have control over the incorporation of health considerations into planning policy and development plans, and in development management and control.

Planning practitioners frequently suggested that the focus of urban planning's 'health responsibility' (or "obligation") is empowering communities to improve their health. In general, "empowerment" was related to "opportunity" and "choice" – some practitioners explicitly recognised that health outcomes are linked to (or even determined) by health-related opportunities and choices. For example, one Planning Officer said, 'In terms of planning, I see its role as being about the provision of opportunities – e.g. opportunities to be choose active travel over other modes of transport (facilitated by the location of development and infrastructure, to choose healthy food over unhealthy food' (R40). The purpose of HUP in this sense is centrally about the provision of enabling environments that support opportunities for and encourage people to pursue (or choose) positive health practices. Such environments were described as needing to contain a wide variety of basic elements, for example: accessible open and green spaces, available healthy food, sustainable transport options,

employment opportunities, positive air quality, community facilities, and opportunities for physical activity. Interestingly, especially given its proximity to health, only one planning practitioner identified "the provision of healthcare services" as an element of a healthy environment.

Many planners emphasised how urban planning can encourage the adoption of healthy lifestyles, but health professionals also mentioned this frequently. While it was often acknowledged that a healthy lifestyle involves many aspects, practitioners most often referred to urban planning's ability to influence two specific health behaviours – physical activity and diet. A Principal Planning Officer said, 'Planning should support development that encourages healthy living choices e.g. access to healthy food' (R13). In discussing the health role of urban planning, a Senior Planner said, 'it's about using land use plans to promote active travel (i.e. walking and cycling), introducing measures to resist the proliferation of take-aways on high streets or near schools etc.' (R24). A number of participants, for instance, noted that urban planning can, through facilitating the creation of a built environment that supports healthy lifestyles, perform a preventative health function that is beneficial to society.

The proposal that urban planning be used as a means to produce or modify people's health behaviours raised suspicion, or at least caution, among some planners. While these participants were supportive of health being a consideration in urban planning, they highlighted that there are complex and sometimes conflicting tensions inherent in the concept and realisation of HUP. Several planners noted that recognition of these tensions and the wider problems surrounding HUP is important. 'If planning is to contribute to making people healthy', said a Senior Planning Practitioner, 'we need to understand its contribution to health for what it really is, and understand what planning can and can't do, and what it should hope to do' (PO8). It was thought important to place planning's contribution to health in context. This context includes the practical aspect and problems associated with healthy planning, but also the ethical contours of the role played by planners in shaping health experiences and outcome.

One of the main dilemmas and problems associated with urban planning's involvement in health was noted by planners as being that of "limitations". Alongside the "practical limitations" of developing and implementing health-related policies and practices, it was observed that there are "ethical limitations" to healthy urban planning. This issue was most frequently discussed with respect to healthy eating, and the use of urban planning and building controls to manage or even limit the availability of fast food restaurants in an area[52] (see, also Chapter Nine). Some participants held strong concerns about this area of HUP, or what one participant labelled as "healthy food planning". Of especial concern was the perceived introduction of "paternalistic" protective planning policies designed to limit people's exposure and thus access to certain food types, but also what were described as "nanny state" efforts to control peoples' dietary and lifestyle practices.

The main ethical limitation associated with this, according to planners, is that food-related urban planning polices can affect individual autonomy and self-determination. Some claimed that, in general, people have the autonomous ability – "freedom of choice" – to control and direct their own health behaviours and are responsible for avoiding health risks (e.g., unhealthy food). One planner said, 'You can be a nanny state and say, "don't eat that or don't eat this", but people are free to eat or drink what they want. People are responsible for their own lifestyles, it is not a planning issue' (R47) (emphasis in original). Another suggested that the urban planning alone cannot address the powerful social and behavioural factors that underpin health issues:

> 'You could argue whether or not this is a planning issue? There is
> an element for planning to do something, in that they can try to
> stop the proliferation of hot food takeaways; however, I would

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[52] Recent years have seen a growing academic, political and media interest in the creation of healthy food environments (e.g., Butland et al 2007; Department of Health 2008; HM Government 2010). This includes the use of planning and other building control measures as a means of managing the proliferation of fast food restaurants, or 'hot food takeaways', within an area. Such an approach is supported by online Planning Practice Guidance (PPG), which states that LPAs can facilitate the creation of healthier living environment by having regard to the 'overconcentration and clustering of certain use classes within a specific area' (Reference ID: 53-006-20170728). Of relevance here, are A3 (restaurant and cafes) and A5 (hot food takeaway) use classes.

argue that it is a behavioural change thing, e.g., poorer families work longer and rely on takeaways for the ease. So, there are a lot of social challenges, and not just the planning issues.' (PO1)

A selection of participants related the need to limit the scope or reach of the health-related role of urban planning to the theme of "freedom". One said, 'Ultra Capitalism! Health and well-being outcomes are really down to society and freedom of choice. It's people's choice whether they live a healthy lifestyle and planning isn't responsible for this' (R24) (emphasis in original). This appeal to autonomy was also viewed by other participants as being an important consideration. Even if restricting an individual's liberty would potentially benefit their health, some felt that restricting freedom of choice fails to respect individual autonomy. One participant said,

> 'Planning shapes places. And, therefore, it can help to determine the environmental conditions in which people live, work, and move. It can provide opportunities for recreation and leisure and help to determine how people move between places and the choices they make in doing so. But there are limits to what planning can and indeed should aim to achieve: in a free society people are free to buy fast food if they wish.' (R43)

Finally, a small minority of planners insisted that urban planning has no business in interfering in what food people eat, where they eat it, and, just as importantly, where they obtain it. Others even consciously highlighted urban planning's lack of apposite means (regulatory or other) to increase healthy eating through the managing the location and density of fast food restaurants (see, Chapter Nine). For some, encouraging or influencing people's behaviours towards certain health risks (e.g., unhealthy food) is a key aspect of urban planning's health role. But it cannot be ignored that the advocation that planning participate in the shaping of behaviour through environmental intervention, or other means, was met with caution and ambivalence by some.

Health professionals

Like planners, public health professionals emphasised the connection between urban planning and health. Many noted that urban planning can influence both people's physical and mental health, placing emphasis on its role as a "determinant of health". One health professional said, 'What people don't realise, is that the planning system is an important part of their lives. It shapes the places in which they live and work. It can ensure that development does not have a negative impact on their health and wellbeing. The planning system is an important determinant of health in its own right' (R48). Health professionals mentioned frequently that urban planning has a crucial role to play in delivering positive public health outcomes. Some health professionals noted that urban planning should have "some" health role, although they did not elucidate further. Others, however, explained in detail the role of urban planning in health promotion.

This role was divided into three main, interrelated areas:

1. forming or changing health behaviours;
2. addressing biophysical determinants of health; and,
3. creating attractive, safe, and enabling environments that support healthy lifestyles and positive health outcomes.

This categorisation of the health role of planning into different domains, incorporating behavioural as well as environmental factors, can also be found in literature on HUP. Barton, in his book *Cities and Wellbeing* (2017), contends that to improve health planners must focus on addressing problems associated with the biophysical, socioeconomic and built dimensions of towns and cities (see also, Gelormino et al. (2015). As with most planners, health professionals recognised that a healthy environment is inextricably linked to the health of individuals and communities. They identified many of the same basic elements as planners with respect to what a healthy environment consists of. For example, access to green and open spaces, walkability and opportunities for physical activity, and a healthy food environment. A notable omission from health professional's descriptions of healthy environment was the provision of healthcare services.

One can only speculate as to why healthcare was overlooked. It could be that participants in this study saw the provision of healthcare infrastructure and services to be an inherent, or given, attribute of a healthy environment. But it could be that participants appreciated the determinants of health to be more complex and extensive than healthcare alone. Asked about this point, a Senior Health Professional said,

> 'There is a distinction in my mind between the need for health services, where health is brought into the planning process in a broad sense…The broader question that interests me, as a public health practitioner, is the fact that one of the key determinants of health is the built environment – and how the built environment interacts with greenspaces, and issue like that. So, there is that bigger, and what I consider to be the more important question about how you build to facilitate health in the wider sense, as opposed to just delivering healthcare services.' (PO15)

"Opportunity" and "choice" were also key ideals for many public health professionals. For some, HUP was about creating living environments for people that provide opportunities for healthy living. Regarding this, one participant noted, 'when we plan for health what we should be doing is building opportunities to be healthy into people's everyday lives. It's about providing opportunities to be physically active, to eat healthy food' (R49). Some health professionals stressed that the provision of opportunities should not threaten or inhibit individual's choice or their autonomy over their own health experiences. A senior health professional said,

> 'The idea of urban healthy planning is too authoritative. It's not really about planning, it's about choices. From experience, we know that telling people what to do or trying to force them to be healthy can be counterproductive. Public health and planning should be about choices, not control. Local planning policies should be about making healthier choices easier choices. It's not about forcing people to be healthy.' (PO19)

Some public health professionals spoke about the fallibility of choice. Included in this was the idea that people often make "irrational decisions" or "mistakes" concerning their health. As one health professional shared, 'people often make poor decisions about their health: they drink too much wine, they eat too much fatty food, they drive to the local supermarket rather than walk; things of that nature' (R50). Several health professionals took issue with a perceived misunderstanding within urban planning about how individuals make health-related decisions. Health participants explained that people's health (and wider) decision-making processes are not independent and exclusive of external stimuli; rather, they are embedded in the wider socio-physical environment. One practitioner said,

> 'Planners lack an understanding of how much space and place influences health and well-being. Key misunderstanding – that people have personal choice and so can choose how to be healthier regardless of the environment in which they live. Misunderstanding of how the power of place influences the choices we make.' (R51)

While the perceived disparity between health professionals and planners encompassed within this above quote is covered in the next section, here it is necessary to stress that this suggests a significant difference in understanding between the two professions on the issue of health and place. To this persuasion advocated in the above quote, an idea was attached that HUP is not about complete control over every parameter of peoples' health choices and experience; rather, it only has some reasonable control or influence – especially over aspects of the physical environment and built environment that determine population health. Put differently, HUP is about providing people with a structured autonomy; individuals are free to make their own choices and are responsible for their own health behaviours and experiences, but their decision-making space is given a limited structure. This structure is limited in the sense that it motivates individuals to make "healthier living choices" (e.g., provides adequate access to affordable healthy food options) but does limit their ability to make independent decisions (e.g., all access to unhealthy food options is eliminated).

Commonalities and differences

The notion of a distinct urban planning "health role" was the subject of much interest among those health professionals and planners who participated in this study. Results revealed that participants' views about this role (including the criteria used to determine it) were diverse and multifaceted. The dominant understanding among interviewees and survey respondents was what there exists a connection between health and urban planning. Furthermore, it was held that urban planning has a valid, important role to play in public health. Some health professionals and planning practitioners, however, did contest, if not its merit, the significance of this role. That said, most participants favoured the idea that urban planning has some health role. This is an important finding for two main reasons. Firstly, it suggests that planners and health professionals are mutually supportive of HUP – at least, in principle. Secondly, it challenges the dominant narrative (or stereotype) that planning practitioners do not see health as part of the remit of urban planning (Tewdwr-Jones 2011; Carmichael et al. 2013; Barton et al. 2015).

What is particularly interesting, is that most participants from both groups perceived urban planning not to have a health role in a clinical sense. That is, urban planning is not involved in directly addressing or treating disease and sickness illness, nor restoring individuals to non-diseased state. Instead, participants portrayed urban planning as having an indirect role to play in health. Planners and health professionals frequently considered that this health role is about creating "supportive" environments that enable or "empower" people to be healthy. Although participants across the two groups spoke about similar themes regarding the creation of "supportive" or "enabling" environments, a subset set out practical visions and approaches to the functioning of these environments that were at best fragmented and at worst deeply polarised. There was a tangible tension (if not philosophical chasm) within the participant discourse, namely between: social responsibility and personal responsibility, and between individual choice and government intervention.

These two matters together form the basis of a contested ground, and source of conflict for the views of many participants. There were several different variations of understanding on each of these aspects. On the one hand, there were those who believed that urban planning has a social responsibility to both consider and act to limit the negative health impacts of people's living environments and certain types of development (e.g. fast food restaurants). On the other hand, there were those who argued that urban planning, while endeavouring to benefit society, is limited in its power by a pluralistic theory of freedom and autonomy. In other words, individuals must have the unfettered option and convenience to partake (within reasonable limitations) in health behaviours and experiences that they determine to be appropriate, given that they alone must ensure their health and bear responsibility for their health outcomes.

7.3.2 Categorising the health role

Most of the participants in this study appeared to have some insight or knowledge of the associations between urban planning and health. Both health professionals and planners, collectively identified a series of broad health areas and specific factors that urban planning should address. There was a striking similarity in the areas and factors identified between health professionals and planning practitioners. One ambition of this research was to appreciate the stakeholders' understanding of healthy planning in broader, theoretical terms. It was decided that one way to aid this appreciation was to create a diagrammatic representation of what the stakeholders' considered were the key aspects of HUP. This is diagram is shown below as Figure 10.

Figure 10 provides a spatial, as opposed to tabular, diagram of participants' descriptions of the health role of planning. This figure particularly illustrates the complex and diverse "concepts" or "areas of responsibility" that make up this role, e.g., lifestyles, economy, urban form.
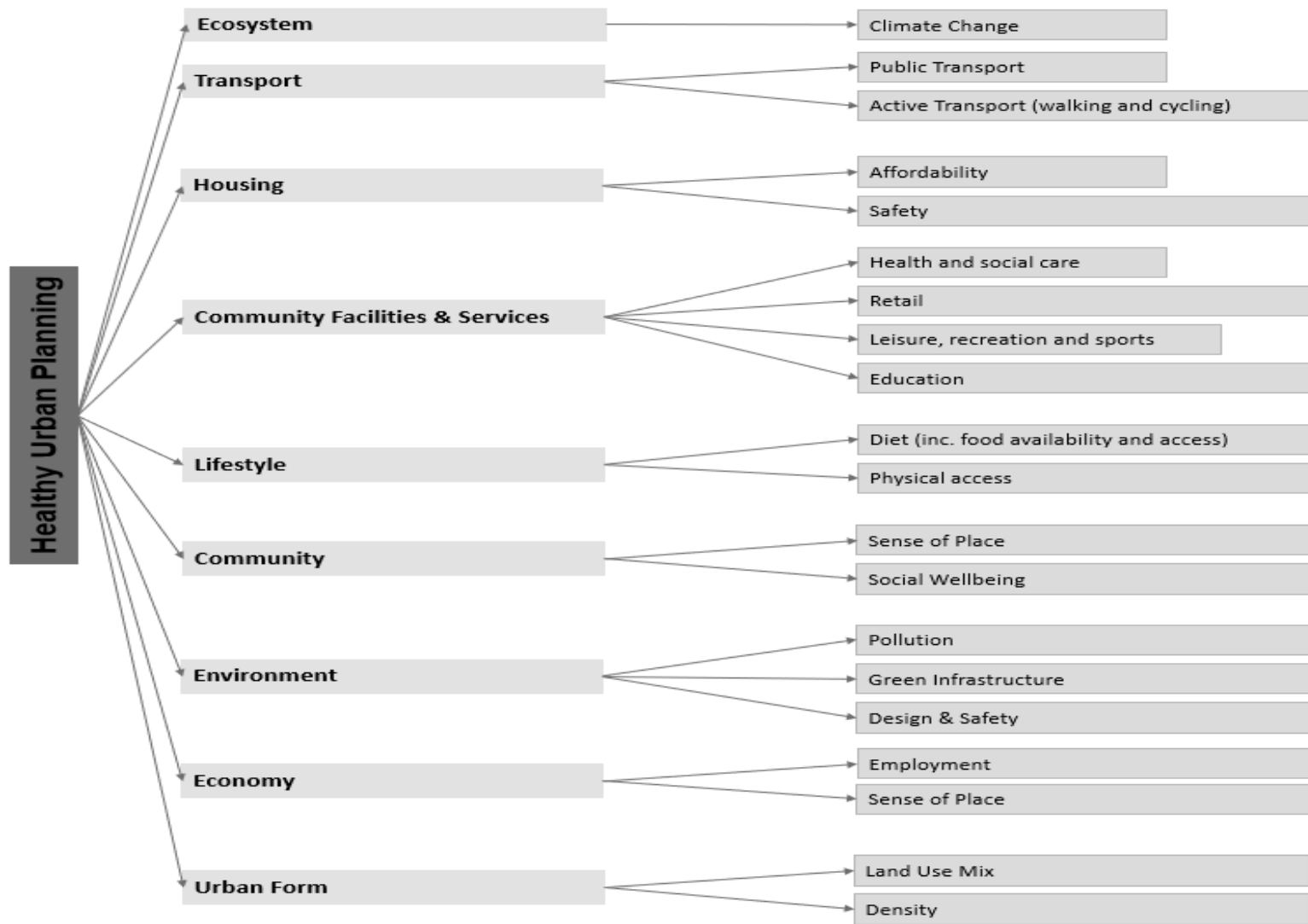
Figure 10 – A diagram of the key aspects of HUP

The above diagram demonstrates that the participants' conception of the concept of HUP is compartmental and stratified into three strata or levels: first, the main concept of healthy urban planning (or "the aim"); secondly, sub-concepts (or "the objectives"); and, thirdly, specific factors (deemed fundamental to achieving the objectives, and the aim). This deliberate, if unconsciousness, attempt to define the vague concept of HUP in terms of other concepts (and factors) is a practical demonstration of "construct formation" (Schoenwandt 2008). Figure 10 is a visualisation of this process – showing what participants deemed not only essential to a specific example of HUP but essential to urban planning and health more broadly.

7.4 Defining health

The concept of 'health' is polysemous. In other words, its meaning is ambiguous and can be interpreted in multiple and diverse ways (as detailed in Chapter Three). That there is such variety in meaning of health offers considerable latitude in terms of how one defines what is meant by health. Despite the potential importance of stakeholders' health views to understanding how health is integrated into urban planning, there remains (at the time of writing) a gap in understanding of these views. By directly asking study participants how they understand the concept of health, it was possible to capture their thoughts and views on health. These are discussed below, distinguishing between planners and health professionals.

Planners

Most planning practitioners defined health as "positive wellbeing". Health as wellbeing was frequently seen as going beyond the conventional biomedical definition of health (see, Reiss & Ankeny 2016 and Kingma 2017). For example, one participant said, 'Health is more than just the absence of disease or infirmity, health is linked to well-being and applies to physical, mental and social indicators' (R33). The dominant understanding among planners was that health includes physiological, psychological, and social dimensions. Some participants related health as wellbeing to the shared space of "a sense of fulfilment" and "a feeling of happiness". One planner said, 'Wellbeing encompasses physical, social and mental aspects to ensure that a person is happy and leads a fulfilling life' (RO4). It was also noted that wellbeing includes a 'sense of belonging and level of contentment' (R10) and is about 'how well people are and how they feel' (R22).

Regarding the interrelation between the various dimensions of health, participants often looked at health as the positive association between physical, mental, and social aspects. To be healthy an individual's internal properties (physiological and psychological) and external social domain must

be balanced, positively integrated and harmoniously combined (Raphael 2004). Many participants emphasised that their definition of health has a sense of "completeness" about it: for an individual to be classed as being in a state of health, they must possess a complete state of wellbeing. Results suggest that this understanding of health was shaped by the WHO's definition of health (see, Chapter Three). One participant said,

> 'According to the WHO, health is a state of complete physical, mental and social wellbeing (not merely the absence of disease or infirmity).' (RO3)

Another participant said,

> 'The concept of the wider determinants of health has been a broad driver for us. This has justified why planning is taking such an interest in improving resident's health and gives us that causal link of how planning can improve the health of residents. That's been the main definition of health that we have always used and introduced; I think that is kind of more of a WHO type of definition.' (P02)

Planning practitioners frequently mentioned that a state of health involves freedom from physiological and psychological disease (or disorder). In discussing this point, one Senior Planner explained that when someone is healthy, they are 'able to go about their daily lives without any physical or mental impairment' (R18). Health as wellbeing was often related to "functioning" (Parsons 1958). At the core of this concept of functioning was the idea that health enables individuals to perform personally-valued roles and responsibilities, thus '… allowing us to do the things we need and want to do' (R36) and enabling people to 'achieve their goals and live the life they want to' (R37). According to one participant,

> 'Health is when we are not sick and when we are able to live our lives independently, with minimal support from health services.

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And to do the things we want to do, with a long-life expectancy.'
(R32)

Another said,

'For me, health is when we are able to go to work, go shopping, support our family. Obviously, if you have cancer or are really sick then you're not healthy. But, for me, health is being able to do those things you need to and, those things that you want to do. Just because someone might feel ill doesn't necessarily make them unhealthy.' (PO11)

Some participants remarked on the dynamism of health. Here, health was seen as a dynamic, not static, state. One participant explained that, 'Health is a whole life process, you can't measure it over the 10-15-year lifespan of a plan' (R25). This view was linked to functioning and included the conceptualisation of health as the "ability to adapt and self-manage". Included in this conceptualisation were the ideas that health includes 'taking responsibility for your own actions and choices' (R47), and the capacity of an individual to 'make the right choices' (R24). A Planning Policy Officer said, 'Health and well-being means that you are eating sensibly, undertaking regular exercise and are feeling happy within yourself and are able to handle whatever challenges life throws at you' (R14).

While planners generally provided their own (or some other) connotation or interpretation of health, many consciously highlighted that health is a broad, diverse, and rich concept. It was frequently mentioned that the concept of health is ambiguous and unclear; its meaning difficult to comprehend and define precisely. Included in this ambiguity was the idea that health as a concept is "far reaching". Participants often noted that health is a "vague concept". Others relayed that health can be understood in many separate ways; the meaning of the concept itself being characterised as having the potential to be taken in different directions. One Planning Officer commented that the meaning of health is a source of conflict within their LPA, sharing that

'[health] is a major issue, because its definition almost depends on the person you are talking to. You have people saying, "this is health" and others saying "no, it's this". So, you know, it's difficult.' (PO1). Another participant provided a novel way of describing the equivocal nature of health. They said,

> 'It's a Humpty-Dumpty term: it means whatever one chooses it to mean. For me, "health" and "well-being" mean the same thing and therefore the phrase "health and wellbeing" is unnecessary dressing up. Attempts to define and measure it by social scientists are always doomed to failure.' (R34)

Although health may be open to interpretation with respect to its meaning, interview transcripts and survey responses suggest an absence of conscious consideration among some participants about its definition. One Senior Planning Policy Officer said, 'Health? Well, it's not something I've really thought about. You want to know what it means? I'm not sure if I can help you there. I guess you'll have to speak someone over in public health.' (PO9). This policy officer was not alone in their perception of the meaning of health being a public health matter; the results revealed that this view was echoed by others, such as a Development Plans Officer who commented that the author would 'have to ask public health' but that such a request 'shows that it's not in the forefront of my mind that I can confirm "yeah, that's what our definition is" (PO3).

There was a group (albeit a small one) of planners who either did not provide a response or struggled to provide one to the question on 'meaning'. Whether this struggle was the result of the question itself (e.g., its wording) *or the polysemantic (or* polysemous) and/or complex nature of the term health is difficult to determine. The results, however, point to the latter. Participants stated that, the meaning of health is, 'Too hard to put into words quickly' (R17), that it has 'no standard definition' (R12), and even 'When you say health, I don't know what you mean.'(PO7). Some interviewees described why they felt it was important that they – as planners – considered health in their work, but then gave confabulated descriptions of what is meant by 'health'. For example,

one participant stated that, 'Health is an important consideration for planning. In terms of our definition of health…I think we're Fairtrade, so that's how we understand it' (PO3). Another simply said, 'I don't know. It's difficult to remember that far back to school' (PO8).

Of itself this collection of quotes is something to arouse suspicion, but, even more, to raise an obvious question and fundamental point: how do you plan for something you do not know, you do not understand, and you cannot therefore measure? The notion of whether there is a need to define health in a literary or other sense was one of the lesser explored themes and ideas in the interviews and surveys. For some, there was "real value" and/or "practical worth" in either adopting an existing or compiling a clear unique institutional definition of health. A Project Plans Officer said,

> 'Much of what I do involves communicating with people – other planners, developers, local residents. I'm always talking to people. It really helps to have something down in writing that says, "this is this": "this is how many houses we need to build, this is where we're going to build them, and this is why we're going to build them". I think health's the same; if we had a clear definition of health in writing, I could go to developers and local residents and say, "this is health, and this is not health" – and we could then use this to measure and assess health outcomes.' (PO11)

However, there were others who observed the task of defining health to be "another obstacle" or "another challenge" to planning practice. For example, a Senior Planning Officer said, 'if we put a definition of health in our Local Plan, it would just be something else for us to argue with the [Planning] Inspectorate about' (PO8). Finally, a more pragmatic argument put forward for not defining health was the meaning is secondary to the outcome:

> 'It often gets dragged down into a more philosophical debate, but at a simple level: if health is being considered it will show in the general health of the populace.' (PO1)

Health professionals

Health professionals frequently related health to "positive wellbeing". Health as wellbeing was often described by health professionals in much the same way as planning practitioners. It was repeatedly explained that health is a complex process: a process which involves many interrelated components, these components interacting and affecting one another in numerous ways, and together contributing to the determination of health outcomes. Like planners, health professionals identified health as having physiological, psychological, and social dimensions. As one Senior Public Health Official explained,

> 'I like to picture health as process or system built up of different layers. Health has a human layer; this includes individual's biological characteristics, their behaviours. There is also a social layer; this includes people's social and familial networks, their relationships, their employment. This is the second layer and it is important because it impacts on people's health behaviours. The third layer is the environment; this includes all the biological factors and all the physical factors that make up where people live: the climate, the air quality, the water quality.' (PO19)

Some health professionals emphasised that health also possesses an affective component. They stressed the importance of a "positive attitude" or "positive outlook" for overall health. It was said that positivity is a key facilitator in the uptake and maintenance of healthy behaviours and lifestyles, as well as in helping to maintain positive social interactions. As one participant shared, 'It is often overlooked how important emotional wellbeing is to health. People's health is as much to do with how they feel as it their physical health. There is evidence that shows that the happier and more positive people feel, the healthier they will be. Emotion plays a key role in health and other behaviours' (PO20).

Similar to planners, health professionals often looked at the interrelationship between the various components of health as involving a positive association between physical, social, and emotional aspects. The ideas of "wholeness" and "completeness" appeared to be a key part of the overall interconnectedness of the health components. One health professional thought of health as, 'a state of whole physical, mental, social and emotional well-being' (R63). More commonly, however, health professionals said that health 'is when someone has complete well-being' (R62), that it includes 'a complete state of physical, mental and social wellbeing' (R61), and that it 'is a state of complete well-being both physical and mental and social. It is not merely the absence of disease' (R60).

This above understanding of health was related by several participants to that of the "wider determinants of health", but more specifically the WHO's definition of health. Certain participants even considered the concept of health to have been conceived exclusively by the WHO. For example, an Advanced Health Practitioner said, 'Health is a concept created by the World Health Organization. It means a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (R59).

Wellbeing was frequently related to "functioning", "capacity" and "adaptability and self-management". Some participants viewed functioning from a biomedical or clinical perspective, such as one survey response that read: 'Health relates to bodily functioning. To be healthy an individual must be both free from physical and mental illness and all their bodily systems must be functioning correctly' (R56). However, most described functioning in more normative terms. As a normative concept, "functioning" was used, among other ways, to refer to people 'leading healthy lives and being are able to make a valuable contribution to their community and to society' (PO13). Others defined functioning in terms of performance capabilities, or in terms of the ability of individuals to perform normative societal roles. One participant described health wellbeing as,

'A state in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to her or his community.' (RO8)

Another participant said,

'If you pushed me for a definition of health I would say "add life to years, and years to life" and the "capacity to function meaningfully in society.' (PO18)

In contrast with most of the planning practitioners involved in this study, around half of health professionals comprehended health from a biomedical standpoint. That is, they defined health as "absence of disease". Participants explained that health is a medical concept. And, as a medical concept, health relates to physiological functioning and disease. Several health professionals stressed that health is a value-free, objective condition. 'Health is a physiological concern', said one participant, 'it relates to bodily functioning and is determined by the present [sic] or absence of disease (e.g. CVT, diabetes or obesity)' (R54). Some health professionals made distinctions between the concepts of health and wellbeing, often describing the former (health) as an objective standard and the latter (wellbeing) as a subjective experience. Stressing the importance of the biomedical definition of health, some noted, but did not explain, that there were too many ideological and ethical questions, and potential risks associated with other definitions.

Few participants during the interviews spontaneously discussed or reflected upon the merits (and need) of precisely defining health. Commenting on the definition of health, one Senior Health Professional said, 'Well, we haven't gone to a particular definition of health, because I don't think that's what matters; we know what we're talking about. I'm not sure we have ever thought about the definition of health or whether it was worth finalising' (PO18). When probed on the subject, many health professionals responded that there is pragmatic or heuristic value in defining health; however, many admitted that

selecting or creating a single, unified definition would be difficult. As a Senior Health Professional shared,

> 'I think it would certainly help to have single definition of health, even if only something that would make explicit the kinds of considerations we want to consider. However, I think it would be very difficult to have a single agreed definition. But what you could agree is that there is a need for a definition of health that make its explicit what certain things fall under the heading of health, what needs to be considered, so that it's not then up to somebody to say, "Health? Well, that means I need to talk to my CCG [Clinical Commissioning Group] and ask them how many GPs I need". If and when it inevitably is, health becomes just another tick-box consideration.' (PO15)

During an interview with one health professional, they spent a considerable amount of time deliberating this issue before then explaining that health should be defined within planning as "absence of disease". They observed that, 'health raises many questions. I suppose planners could define health in any number of ways, but it is essential that to choose a definition of health that is operational – and one that can be easily understood. That is one of the main advantages of using the "absence of disease" as a definition for health in planning' (PO20).

Finally, other participants were disinclined to engage in a discussion about the ambiguity of health; some health professionals were resistant to discuss unfamiliar conceptions of health that conflicted with their own understanding. Some became particularly defensive regarding the authority of the WHO's definition of health, seeming to feel that alternative conceptions of health in some way denigrate their knowledge of health. One health professional even provided anecdotal evidence to suggest that all health professionals and planning practitioners exclusively employ the WHO definition of health in their work, therefore excluding all other definitions.

Commonalities and differences

The planners and health professionals who participated in this study defined and viewed health in a variety of ways. Interviews and surveys revealed that participants across the two stakeholder groups often spoke about the similar themes regarding health. However, the ideas associated with those themes were occasionally different (even sometimes conflicting) among and within the stakeholder types. For example, regarding the view of health from a function-oriented perspective, planning practitioners who mentioned this appeared to be referring more to functioning associated with the engagement in activities that are personally-valued and considered relevant to oneself, whereas some health professionals appeared to be referring to an individual's ability to benefit and contribute to the functioning of society. Yet, even with these differences, common themes emerged both overall and within the planning practitioner and health professional groups.

Health as *wellbeing* was the most frequently identified theme among the two stakeholder groups. Both planners and health professionals emphasised that health is a multidimensional concept that includes more than the absence of disease. Many stressed that health includes interrelated physical and psychological components, with some health professionals noting that it also encompasses an affective component. This normative view of health belongs to, or at least overlaps with, the WHO's definition of health. The WHO's definition of health emerged as being highly valued by those (both health professionals and planning practitioners) who mentioned health as wellbeing.

Another widespread theme was health as *functioning*. While some health professionals perceived functioning from a biomedical viewpoint (i.e., biological normal functioning, or the absence of disease), participants generally defined functioning in more normative terms, often linking function to the themes of *capacity* and *adaptability and self-management*. Most participants seemed to instrumentally value health, seeing it as "a resource for living" and not a "resource of living". Put differently, health was a held to be a necessary requirement or prerequisite for functioning. This suggests that the

concepts of wellbeing and functioning play a significant role in the way many planning practitioners and health professionals think about health. It is important to recognise, however, that health as "absence of disease" was mentioned by half of the health professionals; this contrasted sharply with planners, as none appeared to view health in these terms. The participants who mentioned health as absence of disease thought it to be a significant definition of health.

Overall, health professionals and planners held diverse and far reaching ideas about health. The range of ideas held by each individual participant was typically representative of several models ff health – e.g., biomedical (absence of disease), normative (WHO definition), and ecological (the ability to adapt and functioning). Indeed, most participants in this study combined ideas from at least two models of health. Some participants did, however, conform to a rigid definition of health, with these specific to a single model of health to the exclusion of other definitions. A cluster of health professionals and planning practitioners avidly maintained that the "WHO definition" is the sole definition of health, whereas a group of health professionals asserted that "absence of disease" is, and can only be, the definition of health.

That many participants touched upon the ambiguous and fuzzy nature of the health concept, is illustrative of the conclusion drawn from the review of literature set out in Chapter Three regarding the manifold tensions and contradictions associated with alternative definitions of health. Finally, difficulties in providing an answer to the question of "what is health?" were more acute and readily observable when interviewing planners. There was a distinct sense of uncertainty when interviewing some planners as to what the answer should be. Others regarded the meaning of health as being too recondite or removed from their work to warrant attention, although some health professionals also expressed a similar view. This suggests that 'health' remains a fuzzy notion from the perspective of most planners involved in this study.

7.5 Chapter summary

This chapter was the first of three chapters that together present a discussion of the empirical findings of this study. Its focus was on the analysis and explanation of the stakeholders' approach to HUP. Reference to this "approach" was used as a collective term for the stakeholders' knowledge, understanding, attitude and perception of HUP. Exploration of the stakeholders' approach has provided insight into their conceptualisation and assessment of the theory-practice nexus of "healthy urban planning" and associated considerations. Results indicate that planners and health professionals are generally supportive of the notion that the urban planning process should aim to improve health outcomes.

While there was a complete consensus that health should be a goal of planning, such consensus only extended to the vaguest generalities when it came to more specific propositions about HUP. There was a pluralism in the interpretation of the elements of healthy urban planning, both in terms of its conceptual foundations (e.g., the definition of health) and in terms of practical function (e.g., the role and scope of urban planning in improving health outcomes).

Looking at specific features of HUP through the lens of the stakeholders' approach shows its meaning to be fractured and splintered, thus revealing it to be less coherent as a single concept. This, in turn, provides both an early conclusion at this stage of the empirical analysis and an early sign of an emerging undercurrent of competition (in the "Gallie" sense of the concept (1956,1964; see, also Chapter Three) between the participants over the meaning and implementation of HUP.

8. The planning system and policy landscape for health in England

This chapter explores the planning system and policy landscape for health in England. It begins by outlining the legislative framework of the English planning system, before then looking at the policy landscape for health. The second element of the chapter concerns itself with uncovering what expectations national planning policy imposes on Local Planning Authorities (LPAs) with respect to health, and how health is defined and integrated within the Local Development Plans (LDPs) of selected case LPAs.

8.1 Introduction

This chapter presents the findings of the document review undertaken during this study. The document review, as set out in Chapter Six, took account of both national planning policy (and relevant guidance) and local planning policy, namely Local Plans and Core Strategies. It considered policy documents that had been adopted as at August 2017. Selected documents were reviewed in terms of their health content. That is, how health is defined and considered within them, and, where relevant, how policies and proposals relating to health are articulated and what health-related expectations they establish for a LPA.

To provide background and context for the presentation of the findings of this exercise, this chapter begins by outlining the main elements of the legislative framework underpinning the planning system in England. This is followed by discussion of national planning policy in England, including changes to this policy itself over recent years. The opportunity also taken to convey the changing ethos, ideology and procedural practices of plan-making in England.

The findings from the document review of national and local planning policy are also presented as part of this discussion.

8.2 The legislative framework

In the UK, each of the four nation states (England, Wales, Scotland, and Northern Ireland), plus the Greater London Authority (GLA), have statutory responsibility for urban planning in their territory. This has been the case since the early 2000s when the New Labour administration (1997-2010) implemented a package of devolutionary measures aimed at transferring planning powers from central government to the nation states and the GLA. As previously noted, the focus of this thesis is on the planning system in England. This section of the chapter explores the main elements of the legislative framework underpinning the English planning system.

8.2.1 Town and Country Planning Acts

Since the advent of the "modern" planning system in the mid-twentieth century, extensive planning legislation has been formulated by the UK government. Planning legislation is set out in multiple Acts of Parliament[53] and in Statutory Instruments (SIs). In England, the main current planning legislation (Planning Acts) comprises[54]:

- Town and Country Planning Act 1990
- Planning and Compensation Act 1991
- Planning and Compulsory Purchase Act 2004
- Planning Act 2008
- Localism Act 2011

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[53] An Act of Parliament (or statute) is a law made by the UK Parliament.
[54] The above is not an exhaustive list of planning legislation. Planning (and related) Acts of Parliament and other Statutory Instruments are available from: http://www.legislation.gov.uk/.

- Housing and Planning Act 2016

The Town and Country Planning Act 1990 (1990 Act) is, at the time of writing, the key piece of legislation underpinning the planning system in England. This Act consolidated previous planning legislation; it also superseded and made several changes to the legislation framework established by the 1947 Town and Country Planning Act. The 1990 Act, inter alia, defines for the purposes of development management the meaning of 'development'[55] and broadly divides the planning system into two streams of practice: (1) forward planning (i.e., future strategy creation and the preparation of statutory development plans) and (2) development management, also called development control (i.e., controlling and managing development in a local area or region to achieve a certain vision and objectives). This approach was amended by the Planning and Compensation Act 1991, which introduced a plan-led system of decision-making.

Over the past decade or more, the planning system has undergone considerable change. This has included a shift in the focus from the control and regulation of land use to the creation of place. While the 1990 Act remains the main legislative base for the planning system in England, it prescribes quite a narrow scope for urban planning and Local Development Plans (LDPs). Section 36 (1) states that LDPs should address,

> '… development and other use of land in their area, or for any description of development or other use such land, including such measures as the authority think fit for the improvement of the physical environment and the management of traffic.'

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[55] Section 55(1) of the 1990 Act defines 'development' as 'the carrying out of building, engineering, mining or other operations in, on, over or under land, or the making of any material change in the use of any buildings or other land'.

Planning and Compulsory Purchase Act 2004

In the late 1990s, the New Labour administration (1997-2010) initiated a process of reassessment and rearrangement of the UK planning system. The culmination of this process was the publication of the Planning and Compulsory Purchase Act (PCPA) in 2004 (2004 Act), and with it a movement away from a narrow land-use system to a broader, holistic spatial planning system. It makes provisions for spatial development, planning and compulsory purchase, and sustainable development. The 2004 Act marked a spatial turn[56] in UK planning, with the introduction of spatial planning broadening the scope of concern for local plans and associated decision-making.

More complex than traditional land-use planning, spatial planning aims to address the tensions and contradictions among sectoral policies – such as the conflicts between environmental, economic development, and social cohesion policies (Allmendinger 2007; Nadin 2007; Tewdwr-Jones 2012). The meaning of 'spatial planning' is clarified in (the now superseded) Planning Policy Statement (PPS) 1. PPS 1 defines spatial planning as going (paragraph 30),

> 'beyond traditional land use planning to bring together and integrate policies for the development and use of land with other policies and programmes which influence the nature of places and how they can function.

> That will include policies which can impact on land use, for example by influencing the demands on or needs for development, but which are not capable of being delivered solely or mainly through granting or refusal of planning permission and which may be implemented by other means. Where other means of implementation are required these should be clearly identified in

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[56] Since the start of the new millennium there has been a revival of strategic spatial planning in many parts of the world (Albrechts et al. 2003; Healey 2007; Davoudi 2018). In Europe, a major contribution to the spatial turn in urban planning came from the publication of the 'European Spatial Development Perspective (ESDP)' by the EU Informal Council of Ministers responsible for planning (CEC 1999).

the plan. Planning policies should not replicate, cut across, or detrimentally affect matters within the scope of other legislative requirements, such as those set out in Building Regulations for energy efficiency.'

Other changes made by the 2004 Act included the abolition of county structure plans and the introduction of Regional Spatial Strategies (RSSs), and the replacement of local plans, unitary development plans and structure plans with local development documents – the Local Development Framework (see below). More significantly, it introduced the legal obligation for the planning system to contribute to the achievement of sustainable development. Section 39 (2) makes clear that any person who or body which exercises planning functions must, '… exercise the function with the objective of contributing to the achievement of sustainable development'. This contribution applies both to policy-making and decision-taking, with section 19 of the 2004 Act requiring LPAs to undertake a sustainability appraisal (SA) of each of the proposals in their LDP during its preparation.

Planning Act 2008

Following the 2004 Act, reform to the planning system continued with the Planning Act 2008 (2008 Act). The 2008 Act was introduced with the intention of speeding up the process for approving major new infrastructure projects, for example energy facilities and airports. It established the Infrastructure Planning Commission and made provisions about its function, alongside other provisions – such as a provision about the imposition of a Community Infrastructure Levy (CIL). Section 206 of the 2008 Act gives the 'charging authority' the power to charge the CIL. The CIL, which became operational in April 2010, following the publication of the 'CIL Regulations', is a charge that local authorities can impose on new development as a way of collecting monies to fund new local infrastructure. This could involve LPAs spending contributions from new development on the delivery of local health

infrastructure (e.g., a medical centre) or other infrastructure (such as a school) that could assist in improving local health outcomes[57].

Localism Act 2011

Several changes to the 2008 Act were made by the Localism Act of 2011 (2011 Act), which was introduced by the then Conservative-Liberal Democrat coalition government (2010-2015). This included the replacement of the Infrastructure Planning Commission with the Major Infrastructure Planning Unit of the Planning Inspectorate (PINS). More significantly, the 2011 Act changed the power structure of government in England. It contains provisions for the transfer (or devolution) of decision-making powers from central government control to local authorities and local communities. In the foreword to the 'Plain England Guide to the Localism Act 2011', the then Minister of State for Decentralisation, Greg Clark noted (p.1),

> 'For too long, central government has hoarded and concentrated power. Trying to improve people's live by imposing decisions, setting targets and demanding inspections from Whitehall doesn't work… We think that the best means of strengthening society is not for central government to try and seize all the power and responsibility for itself. It is to help people and their locally elected representative to achieve their own ambitions. This is the essence of the Big Society.'

The 2011 Act introduced new powers and duties in relation to four principal areas: local authorities, communities, planning, and housing. For local

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[57] Developers can be asked to provide contributions for local infrastructure in several ways. The main two ways are, (1) section 106 agreements (so called because the s106 regime is based on that section of the TCPA 1990) and (2) CIL. A few factors distinguish CIL from the established section 106 regime, with the main distinguishing feature being that under a CIL agreement the explicit link between a new development and its social, economic, and/or environmental impacts is removed. This means that collected monies (from CIL) can be invested on broader local infrastructural priories, rather than only those priorities directly relating to the new development from which the monies are collected.

authorities, the 2011 Act, inter alia, put in place a new "Local Authority's general power of competence" (section 1). This measure granted local authorities the same broad powers as individuals to operate as they see best fit, so long as it is not prohibited by statute. From a planning perspective, the 2011 Act made three main changes to the planning regime in England:

Firstly, it legislated for the powers to abolish Regional Spatial Strategies (formally abolished by the Growth and Infrastructure Act 2013), and in doing so cemented the coalition government's commitment towards dismantling the framework of regional planning in England – the intention to abolish RSSs was first announced in May 2010, just over two weeks after the coalition government assumed office (House of Commons Communities and Local Government Committee 2011); section 109 of the 2011 Act incorporates the necessary legislation to dismantle regional planning (including revoking RSSs) in England.

Secondly, it imposed new a duty on LPAs to co-operate with neighbouring authorities in relation to the preparation of LDPs (section 102), but also in relation to the planning of sustainable development (section 110).

Thirdly, it makes provision about neighbourhood development orders and neighbourhood plans (schedule 9). The 2011 Act introduced new neighbourhood forums, made of up at least 21 local individuals (schedule 9, 61F (5), which have the power to prepare and submit neighbourhood plans (which set out a shared community vision for local development) and neighbourhood development orders (which grant planning permission for particular types of development in defined areas). Neighbourhood planning was described by the coalition government as, '… a new way for communities to decide the future of the places where they live and work' (CLG 2012:3). Neighbourhood planning came into effect in April 2012 under the Neighbourhood Planning (GENERAL) Regulations[58].

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[58] Available from http://www.legislation.gov.uk/uksi/2012/637/contents/made.

Housing and Planning Act 2016

More widespread changes to housing policy and the planning system came with the publication of the Housing and Planning Act 2016 (2016 Act) – the 2016 Act came into force in the months after the completion of the empirical work for this study, yet a collection of participants in this study voiced interest in (and even concern about) this legislation so it is worth briefly considering here. On receiving Royal Assent, the then Minister for Housing and planning, Brandon Lewis, said,

> 'Our landmark Housing and Planning Act will help anyone who aspires to own their own homes achieve their dream. It will increase housing supply alongside home ownership building on the biggest affordable house building program since the 1970s. The act will contribute to transforming generate rent into generation buy, helping us towards achieving our ambition of delivering 1 million new homes.' (Lewis 2016)

The 2016 Act introduced several supply side measures designed to speed up the planning process and increase the delivery of new housing, especially the delivery of new homes for ownership. Specific measures introduced by the 2016 Act include placing a duty on LPAs to promote the supply of starter homes in England; extending the 'right to buy discount'[59] to housing association tenants; requiring all LPAs to prepare, adopt and maintain an up-to-date LDP; requiring a local authority to compile and maintain a register of particular types of land in their area; and new powers for the Secretary of State to intervene in the local and neighbourhood plan making process and a new system of planning permission in principle.

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[59] Section 68 defines "right to buy discount" as 'a discount given to a tenant of a dwelling on the disposal of the dwelling to the tenant otherwise than in the exercise of a right conferred by an act'.

8.3 National planning policy

In England, the Ministry of Housing, Communities and Local Government (MHCLG)[60] is responsible for preparing national planning policy. National planning policy set outs land use policies for England and how these are to be expected to be applied. The first action in the document review was to undertake a review of the current (as of the time of writing) national policy framework with respect to its health content. Although the primary focus of the document review was on national planning policy as set out in the National Planning Policy Framework (2012) (NPPF/the Framework), the previous regime of Planning Policy Statements (PPSs) and Planning Policy Guidance Notes (PPGs) was also included in the review. The rationale for this was that several of the reviewed Local Development Plans (LDPs) were prepared in accordance with the now superseded PPSs/PPGs. To this end, this section of the chapter commences with an examination of the suite of PPSs and PPGs in place from the late 1990s to 2012.

8.3.1 Planning policy statements and guidance

In England, national planning policy guidance was first introduced in 1998 (Cullingworth & Nadin 2006). From 1997 to 2010, the New Labour administration produced a raft of written statements setting out the Government's policy on town and country planning; expressing national policy first in the form of 'Planning Policy Guidance notes (PPGs)' and later in 'Planning Policy Statements (PPSs)'. PPSs were accompanied by 'Mineral Planning Guidance notes (MPGs)' and 'Marine Minerals Guidance notes (MMGs)', with non-statutory planning circulars being published for the purposes of elaborating further on matters covered in in legislation and policy.

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[60] In January 2018, the Department of Communities and Local Government (DCLG) was renamed as the Ministry of Housing, Communities and Local Government.

A total of twenty-five PPSs and PPGs were produced – thirteen PPSs and twelve PPGs. PPSs (and PPGs) set out central government's national policies and guidance on different aspects of planning, but they also provided explanation on the relationship between planning policies and other sector policies which have an important bearing on issues of land-use development. For example, PPS 3 included a policy framework for delivering the Government's housing objectives; and Planning Policy Statement 12 set out policy on local development frameworks. Although not legally binding, the PCPA 2004 required that PPSs/PPGs be considered by a LPA when preparing development plans. They also were required to be treated as a material consideration in the determination of planning applications.

The general policies and principles of the planning system in England were originally set out in PPG 1: General Policies and Principles (February 1997). PPG 1 was subsequently replaced by PPS 1: Delivering Sustainable Development. Expanding on the earlier PPG 1, PPS 1 set out the overarching national planning policy on the delivery of sustainable development through the planning system. PPS 1 was meant to be read in conjunction with other relevant PPSs (and PPGs) and associated documents, including the 'planning and climate change' supplement to PPS 1. The policies set out in PPS 1 were required to be considered by a LPA in preparing a LDP, by regional planning bodies in the preparation of regional spatial planning strategies, and the Mayor of London in relation to the London spatial development strategy. They also formed material considerations in the determination of individual planning applications.

One of the most influential aspects of PPS1 was that it established in policy that development plans and decisions taken on planning applications should contribute to delivery of sustainable development. Paragraph 3 explicitly states that, 'Sustainable development is the core principle underpinning planning. At the heart of sustainable development is the simple idea of ensuring a better quality of life for everyone, now and for future generations'. The document outlined policies on four key areas, including social cohesion and inclusion,

protection and enhancement of the environment, prudent use of natural resources, sustainable economic development, and integrating sustainable development in development plans.

8.3.2   The health content of PPGs and PPSs

As set out above, national planning policy was from the late 1990s to 2012 mainly set out in a suite of PPSs and PPGs. Planning policy guidance on "health and planning" during this approximately fourteen-year period was mixed. In some cases, the link between urban planning and health was not clearly articulated or made apparent. PPS 12 (Local Spatial Planning) is a useful starting point for this discussion, given that it set out the Government's policy on the preparation of a LDP. Paragraph 1.5 of this document describes the planning system as existing to,

> 'deliver positive social, economic and environmental outcomes, and requires planners to actively collaborate with the wide range of stakeholders and agencies that help to shape and deliver local services.'

Here, it is plausible that the improvement of health may form one of the intended "positive outcomes" alluded to. Indeed, people's health is determined by the action and interaction of socio-economic and physical factors (Wilkinson & Marmot 2003). Additionally, the emphasis on collaborative working could include planners working with local public health leads and health agencies.

Although PPS 12 may allude to health objectives, there is a notable absence of direct reference to health in some other policy documents. For example, explicit reference to health is absent from policy on housing (PPS 3), development and food risk (PPS 25), and sustainable development in rural areas (PPS 7). All three of these themes or topics have links to health (Braubach & Grant 2010). Further policy documents do, however, cover to various degrees health issues. Take PPS 10 on 'Planning for Sustainable

Waste Management', for example. PPS 10 includes a specific heading titled 'Health', with paragraph 30 under this heading reading that, while the consideration and the implications, if any, for human health arising from waste management processes are the responsibility of the pollution control authorities, the planning system operates,

> '…. in the public interest to ensure that the location of the proposed development is acceptable and health can be material to such decisions.'

A similar statement on the possibility of health being a material consideration in urban planning is made in PPS 23 (Planning and Pollution Control). The first bullet point of paragraph 2 states that, 'any consideration of the quality of land, air or water and potential impacts arising from development, possibly leading to impact on health, is capable of being a material planning consideration…'. Broader reference to health is found in PPS 1 (Delivering Sustainable Development). When preparing a LDP, paragraph 27 (point iii) instructed LPAs to proactively seek to,

> 'Promote communities which are inclusive, healthy, safe and crime free, whilst respecting the diverse needs of communities and the special needs of particular sectors of the community.'

Some specific health-related elements that urban planning policies should include are set out in Paragraph 16, including ensuring that 'the impact of development on the social fabric of communities is considered and taken into account', seeking to 'reduce social inequalities', addressing 'accessibility (both in terms of location and physical access) for all members of the community to jobs, health, housing... and community facilities', and supporting the 'promotion of health and well being by making provision for physical activity'.

In the preparation of a LDP, PPS 12 (Local Development Framework, 2004 version) highlighted that a LPA 'should…take account of the principles and characteristics of other relevant strategies and programmes…These include

the community strategy and strategies for education, health, social inclusion, waste, biodiversity, recycling and environmental protection' (paragraph 1.9). The 2008 revision of PPS 12 encouraged a LPA to align its key spatial planning objectives within the Local Plan with those of the Sustainable Community Strategy [61] (SCS).

More broadly, the Local Government White Paper (2006) strongly encouraged local authorities to ensure economic, social and environment (including spatial) issues were considered in the plan-making process. While describing the need for LPAs to positively plan for economic, environmental and social outcomes, there was little direct provision for health in PPS 12 (2008 revision). There is only a single explicit mention to health in the document. That is, that green infrastructure is described in a footnote 3 as supporting 'natural and ecological processes and is integral to the health and quality of life of sustainable communities'.

The unfinished PPS for health

In 2009, a House of Commons Health Select Committee report, focusing on the causes and solutions to health inequalities, recommended that health be a key consideration in all urban planning activities. Specifically, the Committee called for the preparation of planning guidance (in the form of a PPS) on "health and planning" – especially focusing on encouraging active travel (walking and cycling) and enabling LPAs to manage the proliferation of fast food outlets.

A consultation paper on a new PPS titled 'Planning for a Natural and Healthy Environment' was published in March 2010. One of the main objectives of the proposed health statement was to ensure that the planning system delivered healthy, sustainable and climate resilient communities. To achieve this, it was

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[61] The Sustainable Communities Act of 2007 introduced the requirement for local authorities across England to prepare a Sustainability Community Strategy (SCS). The SCS is underpinned by the UK shared principles of sustainable development, including the aim of developing a strong and just society (HM Government, 2005: 16).

intended that the PPS would consolidate all other existing policies on the natural environment, open space, green space and sport, recreation and play provisions. In this respect, the draft PPS represented the first stages of central government efforts to streamline planning policy and guidance. Consultation on the draft PPS was set to end in June 2010, however the 2010 UK general election permanently halted the preparation of the document.

8.3.3   The National Planning Policy Framework

The Conservative and Liberal Democrat coalition government between 2010 and 2015 implemented a root and branch reform of the planning system in England. The centrepiece of this reform was the introduction of the National Planning Policy Framework 2012 (NPPF/the Framework), which superseded the entire raft of previous national planning guidance and policy found in PPSs/PPGs.

The Framework sets out the Government's planning policies and how these are expected to be applied[62]. Two further documents must be read in conjunction with the NPPF, these being (1) Planning policy for traveller sites (updated August 2015), and (2) National planning policy for waste (updated October 2014). When applying the Framework, decision-makers must also consult the online Planning Practice Guidance (NPPG)[63] which is designed to accompany the NPPF and was launched by the government in March 2014. One of the aims of the new planning practice guidance is to provide policy-makers and decision-takers with more information about how policies within the NPPF should be applied and interpreted at the local level.

In many respects, the NPPF provided a conceptual overhaul of national planning policy in England. More pointedly, it marked a shift in ideological

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[62]The policies in the National Planning Policy Framework came into force from the day of its publication, however the implementation of the Framework involved a transitionary period of twelve months for local plan preparation and decision-taking.
[63]Available at https://www.gov.uk/government/collections/planning-practice-guidance.

position and the adoption of a performance frame of reference within which all actions of the planning system were to be interpreted and judged. The Framework was introduced as part of a programme of sweeping reforms to public policy and governance arrangements, with many of these reforms pursued by the previous coalition government under the badge of "localism" or "the big society". This programme of reform extended to planning, with the coalition government early in its administration declaring that it would seek to create a more decentralised, streamlined and transparent planning system; this reflecting earlier commitments to "planning reform" outlined in the 2010 Coalition Agreement (HM Government 2010b).

The tone of the coalition's intentions, and the main rationale underpinning the NPPF, is clear in Greg Clark's, the then Minister for Decentralisation, oral statement to Parliament on the publication of the NPPF. In his statement, Clark (2012) pronounced that,

> 'A decade of Regional Spatial Strategies, top-down targets and national planning policy guidance that has swelled beyond reason to over 1000 pages across 44 documents, has led to communities seeing planning as something done to them, rather than by them. And as the planning system has become more complex, it has ground ever slower… Our reforms to the planning system… [make the] planning system much simpler and more accessible… [And] establish a presumption in favour of sustainable development that means that development is not held up unless to approve it would be against our collective efforts…'

As Clark highlights, the Framework replaced over a thousand pages of planning policy contained in forty-four separate documents. Indeed, by comparison the Framework is a much shorter, concise document – just fifty-nine pages in all. While most of the earlier "New Labour" national planning policy was superseded by the Framework, it is important to note that unless specifically revoked by the Framework, existing policies remain effective (see, Annex 3 of the Framework). The Framework provides policy and guidance on

two principal aspects of planning, these being the preparation of LDPs and the determination of planning applications. However, it does so in a much more concise and non-prescriptive manner than was done so by the previous system of PPSs/PPGs.

Certain themes dominate the texture of the Framework, with the 2011 draft of the Framework centring around the themes of "planning for prosperity", "planning for people", and "planning for places" (CLG 2011b). In the adopted Framework, the wording of these themes is changed but the intention is the same; the 2012 version of the Framework states that the planning system has three roles under its obligation towards sustainability: "an economic role", "a social role" and "an environmental role" (paragraph 7). With reference to actual policies contained within the Framework, their content is purposefully aspatial. This is to ensure that that the Framework can be applied across England regardless of location (Baker & Wong 2013).

8.3.4   Health and the Framework

Like the previous PPPs/PPGs, the Framework covers a range of topics. This includes housing, design, sustainable transport, climate change, flooding, among others. However, unlike the PPSs/PPGs, which set out guidance/policy over a number of documents, the NPPF is a single framework document. As such the approach to presenting the health content analysis findings is slightly different to the previous section. Here, we start with a consideration of the "presumption in favour of sustainable development" since it is a defining element of the Framework. Then we focus on examining the Framework's main health dimensions.

The presumption in favour of sustainable development

'The purpose of the planning system is to help achieve sustainable development.'

(National Planning Policy Framework 2012, p. i)

The above statement is taken from the Ministerial Foreword to the NPPF and establishes a narrative that looks at the planning system as a key tool for delivering sustainable development. This is confirmed in paragraph 6 of the Framework, which reads that, '… the purpose of the planning system is to contribute to the achievement of sustainable development'. Sustainable development is defined in the Framework as comprising economic, social and environmental dimensions. These dimensions, as explained in paragraph 7 give rise to the need for the planning system to perform multiple roles (repeated here verbatim for convenience):

- An economic role – contributing to building a strong, responsive and competitive economy, by ensuring that sufficient land of the right type is available in the right places and at the right times to support growth and innovation; and by identifying and coordinating development requirements, including the provision of infrastructure;

- A social role – supporting strong, vibrant and healthy communities, by providing the supply of housing required to meet the needs of present and future generations; and by creating a high-quality built environment, with accessible local services that reflect the community's needs and support its health, social and cultural well-being;

- An environmental role – contributing to protecting and enhancing our natural, built and historic environment; and, as part of this, helping to improve biodiversity, use natural resource prudently, minimise waste and pollution, and mitigate and adapt to climate change including moving to a low carbon economy.

These roles are intended not to be undertaken in isolation, rather they are held to be mutually dependent (paragraph 8). It is also stated that that, 'the planning system should play an active role in guiding development to sustainable outcomes'. Plan-making and decision-taking must be context-specific, taking into account local circumstances and responding to the 'different opportunities for achieving sustainable development in different areas' (paragraph 9).

Sustainable development is widely accepted as a desirable policy objective for urban planning (Kawakami et al. 2013). Although the Government's commitment to sustainable development in planning policy terms is arguably uncontroversial, the motivation and ambition behind the strategy for "sustainable planning" contained in the Framework has proved especially contentious (Rydin 2013). In fact, the participants in this study (both planners and health professionals) took particular aim at the sustainability credentials of the NPPF: universally viewing the Framework as promoting and supporting private sector economic development and being less concerned with delivering sustainable development and more focused on sustaining land promotion and housing industries by "greenwashing" their image.

Some authors, such as Rydin (2013), have proposed that the narrative of sustainable development established in the Framework has two dimensions. There is, firstly, a general acknowledgement and even encouragement within the NPPF (when looked at a whole) for LPAs to produce plans and for developers to prepare development proposals that support sustainable development objectives. Secondly, there is a presumption in favour of sustainable development contained within the Framework that flows from the former dimension yet is distinct and separate; forming a principle that that is both of a different order to that of a "general" presumption in favour of sustainable planning policies and forms of development, and one that is only engaged in specific circumstances. The "presumption in favour of sustainable development" (also known as the titled balance) is one of the most significant

and controversial elements of the Framework. According to paragraph 14, the *presumption* is not only at the heart of the Framework but should be

> '… seen as the golden thread running through both plan-making and decision-taking.'

CLG Minister Greg Clark explained in a 2011 blog post hosted on the HuffPost UK website that the presumption in favour of sustainable development represents a declaration of powerful simplicity: 'if a proposed development, or plan, does not give rise to any problems, then it should be approved without delay…'. On first reading, this is a potentially important and powerful statement; however, the application of the concept of and policy of "the presumption" is complicated and subject to specific rules and procedures.

To add some additional policy context to this, the presumption in favour of sustainable development (when read as a whole) concerns both plan-making and decision-taking. In a plan-led system, such as operated in England, plan-making provides the foundation and starting point for decision-taking. Paragraph 14 of the Framework contains the policy text on the presumption and is split into two parts. The first part deals with plan-making and states that LPAs should positively seek opportunities to meet the development needs of their area and should meet objectively assessed needs (with sufficient flexibility to adapt to rapid changes) unless (a) any adverse impacts of doing so would significantly and demonstrably outweigh the benefits (when assessed against the Framework overall) and (b) specific policies in the Framework indicate that development should be restricted.

This expectation for a LDP to allocate and promote sustainable forms of development has significant consequences for the second part of paragraph 14, which deals with decision-taking. Here, development that accords with the LDP is afforded (a) a general presumption in favour of the grant of permission (as it is likely to represent sustainable development) and (b) in circumstances where the development plan is absent, silent or relevant policies are out-of-date, proposals benefit from an additional presumption in favour of

sustainable development – meaning that it is necessary to determine planning applications within the frame of assessing whether any adverse impacts of granting planning permission would significantly and demonstrably outweigh the benefits of the proposed development.

There has been much academic and legal debate as to the true meaning, scope and real effect of the presumption in favour of sustainable development in English planning policy (see, CLGC 2011 and Bell 2018). It is not the purpose of this work to delve into the theoretical and methodological basis of the presumption in favour of sustainable development, nor comment on the legal issues that arise surrounding it. For the purpose of this work, it is of interest for its intrinsic value and, more importantly, for its far-reaching implications on urban planning practice in England – which include touching upon health-planning integration dynamics. Most planners interviewed in this study spoke at great length about issues regarding the role of the presumption in favour of sustainable development, the question of the titled balance, and the consequence for achieving social planning objectives.

This is significant because the objective of supporting healthy communities sits within the social dimension of sustainable development, as set out in paragraph 7 of the framework (see above). Before examining participants' observations and concerns about the presumption in favour of sustainable development and its implications for health, the next section identifies the policies and associated text of particular direct importance to health and HUP.

Health and the social role of planning

To achieve sustainable development, the Framework is quite clear that economic, social and environmental gains should be jointly and simultaneously achieved through urban planning (paragraph 8). The planning system's performance of "roles" in economic, environmental and social processes will undoubtedly have consequences for health; especially in instances where health is understood to be determined by the complex

interplay of economical, ecological and sociological factors. Specifically, however, the Framework situates health within the social realm of responsibilities for the planning system.

As set out previously, the planning system's "social role" includes, inter alia, "supporting strong, vibrant and healthy communities" (paragraph 7). The Framework introduces a further frame of reference for understanding the contribution of the planning system towards sustainable development. This is provided in the form of a set of core land-use planning principles, which underpin both plan-making and decision-taking (paragraph 17). When read collectively, these twelve principles have both obvious and more subtle connections to health. For example, 'conserving and enhancing the natural environment and reducing pollution' could afford a better environmental quality that tends towards improved health. The pathway between "biophysical environmental status" and "health" is not always a direct one, but possibly serves as proxies for other determinants; that is, differential exposure to conditions and environmental agents that have more immediate effects on health (Farmer & Albrecht 1998). Focus on how the planning system functions with respect to health is more explicit in the final (twelfth) core principle, which reads that there is a need to,

> 'to take account of and support local strategies to improve health, social and cultural wellbeing for all, and deliver sufficient community and cultural facilities and services to meet local needs.'

An additional health aspect of the Framework is that it includes a chapter on "Promoting healthy communities", something which previous national planning policy did not contain. Paragraph 69 of chapter eight states that, 'The planning system can play an important role in facilitating social interaction and creating healthy, inclusive communities. Local planning authorities should create a shared vision with communities of the residential environment and facilities they wish to see…'. This policy is supported and reinforced by further policy and decision guidance referring to the criteria for creating socially cohesive and healthy communities. These include paragraphs constructed around

developing and strengthening community cohesion and social inclusion through creating safe, accessible and crime and disorder free environments (paragraph 69); to those on education (such as ensuring sufficient provision of school places for local communities – paragraph 72) and community facilities including planning positively for the provision of retail, recreational, cultural, religious and medical services/facilities (paragraph 70); through to those on green infrastructure and public open space (such as creating, improving and safeguarding high quality green and open spaces – paragraph 73/77).

There are several other key areas of the NPPF with links to health include:

- Transport – including policies relating to the promotion of sustainable transport, with paragraph 69 stating that, 'Transport policies have an important role to play in facilitating sustainable development but also in contributing to wider sustainability and health objectives';
- Housing – including policies concerning the delivery of high-quality homes, e.g., paragraph 50 explains that a LPA should aim to deliver, 'a mix of housing based on current and future demographic trends, market trends and the needs of different groups in the community…' and set policies for meeting 'identified affordable housing';
- Design – the NPPF reflects the Government's commitment to the high-quality design of the built environment, e.g., paragraph 56 notes that, 'Good design is a key aspect of sustainable development, is indivisible from good planning, and should contribute positively to making places better for people';
- Climate change – the planning system can play a key role in helping reduce, adapt and mitigate climate change, e.g., paragraph 93 reads that 'Planning plays a key role in helping shape places to secure radical reduction in greenhouse gas emissions, minimise vulnerability and providing resilience to the impact of climate change…'; and,
- Natural environment – the planning system should contribute to and enhance the natural and local environment, e.g., paragraph 120 states that, 'The effects (including cumulative effects) of pollution on health,

the natural environment or general amenity, and the potential sensitivity of the area or proposed development to adverse effects from pollution, should be taken into account.'

The NPPF also requires LPAs to work with public health leads and health organisations to prepare a robust evidence base that accounts for future changes and barriers to improving health. As paragraph 171 states,

'Local planning authorities should work with public health leads and health organisations to understand and take account of the health status and needs of the local population (such as for sports, recreation and places of worship), including expected future changes, and any information about relevant barriers to improving health and well-being.'

This means, if not explicitly, that neither LPAs nor health organisations are exclusively responsible for regulating the health effects of land-use development on health. The rhetoric of the Framework encompasses mobilising planning authorities and health organisations to participate as equal partners *and* active partners in public health ventures. Equally, the NPPG says, '[A LPA] should ensure that health and wellbeing, and health infrastructure are considered in local and neighbourhood plans and in planning decision making'[64]. Engagement with relevant local health organisations is further encouraged to 'help ensure that local strategies to improve health and wellbeing and the provision of the required health infrastructure'[65]. Such health organisations include primarily the Director of Public Health and their team, but also The Health and Wellbeing Board and the local Clinical Commissioning Group.

The link between urban planning and health is explicitly acknowledged in the NPPG, as well as the concept of the built and natural environment as being key determinants of health and wellbeing. And it provides an extended list of

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[64] Reference ID: 53-001-20140306.
[65] Reference ID: 53-002-20140306.

issues that could be considered through plan-making and decision-taking processes. In respect of health and healthcare infrastructure, this includes how[66]:

- development proposals can support strong, vibrant and healthy communities and help create healthy living environments which should, where possible, facilitate physical activity and create spaces that support community engagement and social capital;

- local development plans promote health, social and cultural wellbeing, support the reduction of health inequalities, and consider the local health and wellbeing strategy and other relevant health improvement strategies in the area;

- the healthcare infrastructure implications of any relevant proposed development have been considered;

- opportunities for healthy lifestyles have been considered, e.g., planning for an environment that supports communities in making healthy choices, promotes active travel and physical activity, and promotes access to healthier food, high quality open spaces/green infrastructure, and opportunities for play, sport and recreation;

- potential pollution and other environmental hazards, which might lead to an adverse impact on human health, are accounted for in the consideration of new development proposals; and

- access to the whole community by all sections of the community, whether able-bodied or disabled, has been promoted.

Additional emphasis was added to the NPPG on the theme of creating healthy food environments in a July 2017 update[67]. The updated NPPG supports the preparation of policies aimed at managing the proliferation of certain use classes (especially class A5 – hot food takeaway) to create a healthier food environment. The guidance states that, '[A LPA] can have a role in enabling a healthier food environment by supporting opportunities for communities to

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[66] Reference ID: 53-002-20140306.
[67] Reference ID: 53-006-20170728.

access a wide range of healthier food production and consumption choices'. This feeds into the NPPG's overall emphasis on developing healthy communities which support healthy behaviours, support reductions in health inequalities, and enhance the physical and psychological health of the community.

While materially and rhetorically supporting national planning policies, what is arguably missing from the NPPG is guidance to support the implementation of key Framework policies related to health and wellbeing – including how a LPA should take into account local strategies to improve health and wellbeing when preparing plans and/or determining planning applications (NPPF, paragraph 17), assess the quality and capacity of health infrastructure (NPPF, paragraph 162), and work collaboratively with public health leads and organisations on local community health status and needs (NPPF, paragraph 171).

8.4 Observations and participants' evaluations

The previous two sections examined the consideration and integration of health within national planning policy in England. They specifically focused on two distinct national policy frameworks: (1) the framework created by the policy provisions set out within the now superseded suite of PPSs/PPGs, and (2) the current (at the time writing) policy framework under the NPPF. Based on the information contained in these two sections, a number of general comments and observations can be made about national planning policy relating to health.

To start with, national planning policy establishes that a LPA may address health issues in either or both of two ways. Firstly, through seeking outcomes in health and health inequalities. For example, by ensuring that health is considered in local plan-making and decision-taking. But also, by helping to create "healthy communities" that support reductions in health inequalities and support healthy behaviours. Secondly, by means of a more direct pathway, through the delivery of healthcare facilities as part of community infrastructure provision. On the subject of infrastructure, both PPS 1 (and PPS 12) and the NPPF set out an agenda focused on ensuring that the evidence base underpinning a LDP highlights community infrastructure needs and how these will be met, and that the healthcare implications of relevant proposed developments are considered and, in certain circumstances, that suitable planning contributions (including financial payments) to mitigate the impact of proposed development on local services and to support the provision of additional new healthcare services are secured through a Section 106 Legal Agreement (see, previous footnote 58).

While a planning approach based on the creation of "healthy communities" is certainly desirable to maximise positive health outcomes, the language of national planning policy towards health and the associated responsibilities of LPAs raises a number of questions. In particular, a question can be raised as to whether and what type of responsibility national planning policy establishes

on the part of a LPA towards assuring and demonstrating improvements in population health. This question emerges from the sometimes vague and at times conflicting nature of national planning policy.

Even some of the planners involved in this study acknowledged that they too have experienced difficulties when interpreting national planning policy, because it is ambiguous in stating its strategies – be it for health, sustainable development, or other goals – thereby making implementation difficult. Planners pointed to the equivocality of health in terms of a LPA's commitment to it as arising from the ambiguity of the concept and from divergences in perspectives and knowledge among actors involved in the urban planning process.

Health, being equivocal, is less accountable than if it were univocal. When interpreted in a normative sense and as a goal of planning, it is crude and can be misleading; when not interpreted in a normative sense, it can be reduced to a trivial measurement or mere statistic. The equivocality of health is given an additional dimension in that, although reference is made in the NPPF to supporting local strategies to improve health, the "health role" of urban planning is defined not in absolute terms but relative to a whole system of other roles[68]. It is the role of the planning system, as defined in paragraph 7 of the Framework, to support (inter alia) *healthy* communities as opposed to improving the health of *communities*. The equivocal character of healthy communities can be further recognised by considering that the concept of the 'healthy community' is defined in the NPPG[69] as

> '… a good place to grow up and grow old in. It is one which supports healthy behaviours and supports reductions in health inequalities.'

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[68] The understanding of health within the context of the Framework is further complicated by the fact that it is not defined within the document, not even in the Glossary which defines a range of descriptive and normative concepts; including affordable housing, green infrastructure, older people, local planning authority, among others.
[69] Reference ID: 53-005-20140306.

One planner commented directly on the direction of national planning policy towards creating healthy communities stating that, 'The Framework encourages healthy planning with a small h. It requires an unspecified consideration of health, not action on the part of local authorities to ensure that the health of communities is protected or improved by local plans and the decisions planners take'. This planner also drew attention to the fact that, although often used interchangeably, there is an important semantic distinction between "health" and "healthy".

The term *health* is a superlative noun, meaning that it states the position of one thing compared to all other things under discussion (i.e., this is an example of health and that is not). Alternatively, *healthy* is a comparative adjective; it describes the relationship between two subjects (i.e., this process is healthier than that one). This, in turn, has consequences for the types of health outcomes achieved through planning. For example, the concept of the healthy community as defined above describes "only" the community rather than the health of the members of that community. Overall, therefore, the implied responsibility for planning authorities is not to directly achieve any objectively defined health goals, but to contribute to and support an ill-defined aspirational target.

This observation regarding the responsibility (or responsibilities) placed on a LPA with regard to health leads to another observation on the topic of this chapter. The introduction of the NPPF was motivated by, among other matters, the Government's desire to simplify national planning policy to make the planning system more accessible to local communities and to increase the accountability and efficiency of urban planning activities. Previous PPSs and PPGs were looked upon by the Government as being too comprehensive, spreading policy guidance across too many documents and focusing on too many subjects. The introduction of the NPPF superseded swathes of the previous framework of national planning policy. It, moreover, sets out the Government's requirements for the planning system 'only to the extent that is relevant, proportionate and necessary to do so' (NPPF,

paragraph 1). More interestingly, however, while removing multiple aspects of previous policy (e.g., it removed the housing density standards set by PPS 3: Housing), the NPPF makes provision for new and additional health-related policies not included in the previous system of PPSs/PPGs.

Against this background, participants in this study were asked as to the effect of the introduction of the Framework on the consideration of health in urban planning. Participants were of the collective opinion that if we want to make use of the concept of health in urban planning, then there is a need for priorities and aspirations for health to be included in national planning policy. They seemed to agree that action and consideration of health can only be secured in practice by having a planning policy framework that sets clear expectations for health. Participants were generally positive in their response to the addition of health content in the Framework, with some viewing the NPPF as correcting, to some extent at least, a previous lack of policy guidance or a policy statement on health (see, also Carmichael et al. 2013). However, nearly all these participants' remarks were qualified with a "but" or "however" statement. The inclusion of references to health in the NPPF was described as being novel and useful, adding increased weight to health in planning processes. At the same time, however, core concepts and principles underpinning the NPPF were seen as seriously distorting opportunities and outcomes in favour of health.

The responses of participants regarding the NPPF display contrasting qualities, even seeming to suggest a paradoxical state of affairs. Despite increasing the profile of sustainable development and health objectives, the Framework was thought to underscore their subalternity in practice through the insertion of a "presumption in favour of sustainable development". Without overly repeating what has already been discussed earlier in this chapter, the *presumption* has proved to be an important and controversial element of the Framework. In many respects, its premise is not entirely novel as it builds on an existing presumption in favour of development that accords with a development plan (as established by the PCPA 2004). Many planners

in this study, however, were of the belief that the general presumption in favour of sustainable development contained in the NPPF had established a new starting point for the determination of development proposals: that the default conclusion when determining planning applications is to grant permission.

Here, planners directed the attention of the author of this work to the Government's previously stated expectation of moving to a '… system where the default answer to development is yes' (CLGC 2011a). Planners did acknowledge that the overall stance of the Framework with respect to decision-taking is that sustainable development should be approved and unsustainable refused. Yet notwithstanding this, there was a general feeling that this sentiment was not sufficiently reinforced throughout the NPPF, and that various sections and paragraphs of the NPPF even contradicted it. Under this banner of "in favour of sustainable development", planners and some health professionals took aim at whether, and to what extent, the Government's strategic priorities for delivering housing and economic growth may be delivered congruous with the intent of the Framework for the planning system to contribute to the achievement of sustainable development.

Indeed, many planners rehearsed paragraphs of the NPPF that place emphasis on approving development and achieving economic growth. For example, attention was directed to bullet point iii of paragraph 14 which states that development proposals that accord with the development plan should be approved 'without delay'; also, paragraph 19 which emphasises the Government's commitment to ensuring that 'the planning system does everything it can to support sustainable economic growth'. Furthermore, in the wording in the Framework's Ministerial foreword the concept of sustainable *development* is conflated with that of the concept of *growth,*

> '*Development* means growth…sustainable development is about positive growth…The planning system is about helping to make this happen.' (p. i).

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Some participants were despondent and discouraged because of the perceived lack of support for action by the government to address health issues arising from the impact of proposed and existing development. Others were visibly frustrated and agitated when reflecting on both the policies and politics that shaped recent planning system reform and the creation of the NPPF. As regards to the Framework's principles towards sustainable development, as captured in paragraphs six to seventeen, one planner remarked [PO12]:

> 'The Government has made a song and dance about their commitment to delivering sustainable development through the planning system, and the introduction of this presumption in favour of sustainable development. But everything the NPPF has to say about sustainability and these so framed economic, social and environmental "roles" is nothing but window dressing. The reality is, the Government's interest in planning is based around three things: economic growth, economic growth and economic growth.'

They continued,

> 'The big and small of it is that the presumption in favour is really a presumption in favour of development! Sustainability has nothing to do with it. Reference to sustainable development is only included so that when members of the community complain to developers about the types of development they are creating, they can simply go back to them and hark on about the fact that they have obtained planning permission under a system which only permits sustainable forms of development. Under the NPPF, economic considerations ride roughshod over any considerations of social and environmental benefits – or the lack of them.'

This response encapsulates a prevalent view among planners and health professionals. Regardless of their personal normative positions and motivational structures towards ensuring that the operation of planning

system improves population health, their efforts are stymied by the fragmented and sometimes ambiguous, competing policies and priorities of national planning policy. Some were more optimistic that the NPPF provided a stronger reference in negotiating and determining planning applications through a health lens, although they readily acknowledged that wider institutional and structural barriers remain to implementing HUP and improving health over the long term through the planning system in England.

8.5 Local planning policy

In addition to reviewing national planning policy, this study also examined the health content of the Local Development Plans (LDPs) of select case LPAs. A total of seven LDPs were reviewed, with the focus of this review lying primarily on the adopted Core Strategy or Local Plan[70]. These are set out in table below.

Local Development Plans Reviewed

Local Authority	Local Development Plan Title	Adoption date
Stockton-on-Tees Borough Council	Core Strategy	March 2010
Harrogate District Council	Core Strategy	February 2009
Preston City Council	Central Lancashire Core Strategy	July 2012
	Site Allocations & Development Management Policies	July 2015
Stockport Unitary Authority	Core Strategy	March 2011
Blackpool Unitary Authority	Blackpool Local Plan. Part 1: Core Strategy	January 2016
Tower Hamlets London Borough Council	Core Strategy 2025	September 2010

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[70] The LDPs reviewed in this work were those that were adopted at the time the review was undertaken. In the interim since the conduct of this review, and the finalisation of this thesis, newly adopted or emerging LDPs may be being prepared which will replace or review those reviewed in this work.

Prior to presenting the findings of the document review of the above LDPs, this section of the chapter will first outline the main local plan-making principles and procedures in England. This includes a brief discussion on the changes to this process that have occurred in recent years.

8.5.1 Plan-making

The English planning system is headed by the central government, principally the Secretary of State for the MHCLG. Most of the administration of the planning system is undertaken by local government, however. This involves, among other things, LPAs preparing LDPs, determining planning applications for development, and taking enforcement action against unauthorised development. Plan-making is a crucial component of urban planning, with the planning system in England incorporating a plan-led approach. This approach implies that all land-use planning decisions must be made in the context of the adopted LDP. Section 38(6) of the 2004 Act states, 'If regard is to be had to the development plan for the purpose of any determination to be made under the planning Acts the determination must be made in accordance with the plan unless material considerations[71] indicate otherwise'.

Local Development Plans are a principal element of the planning system in England. The 'development plan' is used as an umbrella term for the adopted development documents in place at the time that a planning application is determined. It will set out the vision and policy framework for guiding future development (typically over a fifteen-year time scale) of a defined area and may incorporate "saved" local plan policies (until they are replaced), plus any adopted development plan documents (DPDs). In England, a LPA is

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[71] A 'material consideration' is a matter that should be taken into account in deciding a planning application (or on an appeal against a planning decision). Material considerations must be genuine planning conditions – that is, they must be related to the purpose of planning legislation and reasonably relate to the application concerned. Examples of material considerations include highway safety, traffic, noise, air quality, government policy, heritage, social and economic factors, amongst others.

responsible for the preparation of the LDP; this will typically be a unitary authority or district authority, depending on whether it is a single-tier or second-tier local authority. Where applicable, a LPA may opt to develop a 'joint local development plan' with one or more neighbouring authority.

Since the new millennium, there has been two main systems of plan-making in England – (1) the Local Development Framework and (2) the Local Plan. Both systems of plan-making are discussed in turn below.

The Local Development Framework

Prior to the publication of the Planning and Compulsory Purchase Act of 2004, Local Development Plans typically comprised a single document that set out the local planning policies for an area; alongside a separate proposals map. The 2004 Act changed the approach to LDP preparation, replacing the old system of development plans (county level structure plans, district level local plans, and unitary authority level unitary development plans) with a folder or "framework" of development documents – the Local Development Framework (LDF). One of the envisaged advantages of the framework approach was that it would provide a platform for creating Local Development Documents tailored to the needs of an area, plus it could be readily revised and updated (especially when compared to the previous system).

According to (the now superseded) PPS 12, a LDF is (paragraph 1.4),

> 'a collection of local development documents produced by the local planning authority which collectively delivers the spatial planning strategy for its area.'

The set of documents contained within the LDF are prepared by a LPA for the purposes of setting out the spatial planning strategy for its area, with the documents collectively outlining the vision for and addressing the economic, social and environmental needs and opportunities of its area. The LDF comprised of a range of documents, namely:

- Development Plans Documents (DPDs) – which set out the approach to development in an area. They included a Core Strategy, Development Control Documents, Site Allocation proposals, Area Action Plans, Proposals Maps, and Statement of Community Involvement; and

- Supplementary Planning Documents (SPDs) – which add further detail to the policies found in the DPDs. They can be used to provide further guidance for development of specific sites or on specific issues (e.g. design). Examples of SPDs include those focusing on air quality, ecology, sustainability, planning obligations, noise, and transport.

The Core Strategy is the key compulsory local development document that had to be included in each LDF. The (now superseded) PPS 12: Local Spatial Planning set out the main requirements for what a Core Strategy should include (paragraph 4.1):

1. an overall vision which sets out how the area and the places within it should develop;
2. strategic objectives for the area focussing on the key issues to be addressed;
3. a delivery strategy for achieving these objectives. This should set out how much development is intended to happen where, when, and by what means it will be delivered. Locations for strategic development should be indicated on a key diagram;
4. clear arrangements for managing and monitoring the delivery of the strategy.

Every other local development document contained in the LDF was required to build upon the principles set out in the Core Strategy – especially those regarding the development and use of land in the LPA's area (typically covering a minimum of a fifteen-year time scale).

The Local Plan

Recent coalition government changes to planning legislation and national planning policy have reformed and reorganised the plan preparation process in England. The Localism Act 2011 and the NPPF 2012 together consolidated the process of preparing LDPs. For one, the term 'Local Development Framework' was replaced with the term 'Local Plan' – although (as of LATE 2018) both terms appear to be still in use. Paragraph 11 of the Framework reinforces the primacy of the Local Plan in decision-Taking, subject to any weight that may be attached to other material considerations. The Framework also grants LPAs increased autonomy over the production and contents of their Local Plan; especially when compared to earlier government guidance relating to the creation of a LDF.

The NPPF 2012 is less prescriptive and more interpretative than previous national planning policy. It sets out a framework (paragraph 1),

> '… within which local people and their accountable councils can produce their own distinct local and neighbourhood plans, which reflect the needs and priorities for their communities.'

The NPPF 2012 does not prescribe the number and structure of DPDs, resulting in a degree of variance of between LPAs. Paragraph 153 states that a LPA '… should produce a Local Plan for its area…Any additional development plan documents should only be used where clearly justified'[72]. The Local Plan typically comprises a single DPD – "the Local Plan" – or very few DPDs, such as a Core Strategy (or Strategic Policies and Sites Document) and Site Allocations and Development Management Policies Document. A

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[72] The National Planning Policy Framework 2012 may direct LPAs to produce a Local Plan for their area, but there is not a legal requirement to produce one. The Housing and Planning Act 2016 made a provision for the Secretary of State to intervene to arrange for the preparation of a plan to be written, in consultation with local people, for use in instances where no plan has been produced by early 2017 – or five years after the publication of the National Planning Policy Framework 2012.

LPA may, however, in line with paragraph 153 of the Framework, prepare additional DPDs and SPDs if it deems it necessary to do so.

Local plans are defined in the NPPF as follows (Annex 2; glossary. p.53),

> 'The plan for the future development of the local area, drawn up by the local planning authority in consultation with the community. In law this is described as the development plan documents adopted under the Planning and Compulsory Purchase Act 2004. Current core strategies or other planning policies, which under the regulations would be considered to be development plan documents, form part of the Local Plan. The term includes old policies which have been saved under the 2004 Act.'

Under the heading of 'Plan-making', the NPPF sets out a series of provisions relating to the preparation of Local Plans. This includes requiring Local Plans to be prepared with the objective of contributing to the achievement of sustainable development and be consistent with the principle of the presumption in favour of sustainable development (paragraph 151). They must be positively prepared, be aspirational, but also be realistic, addressing the spatial implications of economic, social, and environmental change (paragraph 154).

Local Plans are required to set out strategic priorities for the spatial area that they apply; this includes strategic policies around housing, retail, leisure and commercial development, infrastructure and community facilities, climate change mitigation and adaption, and ecological and historical conservation and enhancement (paragraph 156). Crucially, Local Plans need to be drawn up over an appropriate time scale (normally a 15-year time horizon) and they must (again) be positively prepared, adequate, up-to-date[73], and be based on

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[73] For the purposes of decision-taking, the NPPF (paragraph 14) states that 'where the development plan is absent, silent or relevant policies are out-of-date' planning permission for development applications should be granted unless there significant and demonstrable reasons for refusing permission'. It therefore effectively engages the presumption in favour of sustainable development (or titled balance) established by paragraph 14.

relevant evidence about the needs, characteristics, and prospects of their area (paragraph 157-177).

8.5.2 How do LDPs define health?

Of the seven LDPs reviewed, only two contained a definition and/or reference to the meaning of health. In the Central Lancashire Core Strategy (adopted 2012), for example, it is explained that health is created and lived by people within the settings of their everyday lives. The built environment is identified as being a crucial determinant of health, with its design and development considered to influence the adoption of healthy lifestyles and community cohesion (p.115). Paragraph 11.1 of the Core Strategy defines health in line with the WHO model of health (see, Chapter Three). The determinants of health are expressed in terms of the "wider determinants of health", with these illustrated through the adoption of Baron and Grant's (2006) Settlement Health Map (see, Chapter Four).

When asked about this choice of definition, a participant (PO13) from this local authority suggested it had been motivated by the City of Preston's status as a WHO-designated phase V Healthy City. As part of this designation, the local authority had been encouraged – even obliged – to adopt this particular definition of health; however, this was not seen as being a negative factor as it was said to align with the broader local authority understanding of health. Another aspect of policy that was explained by this participant was the fact that the respective Site Allocations and Development Management Policies (SADP) Plan (adopted 2015) does not refer to the meaning of health because it is linked to the Core Strategy, setting out detailed policies to be used when considering planning applications for new development. It, therefore, naturally adopts the meanings and understandings of concepts and terms used in the Core Strategy.

The notion that health has a spatial dimension and that the urban and built environment are an important determinant of health is more broadly visible in the Tower Hamlets Core Strategy 2025 (adopted 2010). Here, although no definition of health is presented, the "Settlement Health Map" is again presented as a spatial representation of the health concept. As with the Central Lancashire Core Strategy, the use of the Settlement Health Map clearly advocates a need to engage with health on the basis of a normative, holistic understanding of the concept. Discussion with a member of this local authority (PO2) revealed a recognition that the Core Strategy would have benefited from the inclusion of an actual "written" definition of health, if only to serve as a heuristic device for the purposes of structuring decisions and actions around health. However, given the ambiguity of the term and the diversity of perspective within the community about their health (and their health needs) adopting a particular definition would have been a much-complicated and politically fraught decision.

The remaining LDPs, for Stockton-on-Tees (Stockton), Stockport, Harrogate, and Blackpool, offer no recognisable definition of health, nor any identifiable information pertaining to its meaning. After reviewing the main policies and supporting text in these LDPs, the natural place to look was the documents' glossary. While Stockton's Core Strategy (adopted 2010) did not have a glossary, the other LDPs did and so these were examined for reference to health. In each case, the respective glossary set out the definition and/or meaning of a varied range of descriptive and normative concepts and terms. Descriptive concepts/terms included, for example, defining particular development use classes, employment land, and district and town centres. The most notable normative concept defined was that of sustainable development, which in all cases was defined in terms of the Brundtland definition (see, Chapter Four).

Again, relevant participants were asked about this omission of health from the LDP's glossary. Common responses were that there is no expectation on a LPA to define health either in the main body of the LDP or its glossary, there was no accepted definition of health, and/or because sustainable development is a legislative/policy aim of the planning system it must be defined. It was also advanced by one participant (PO1) that many planners and health professionals view health as sitting within the agenda of sustainable development, therefore negating the need to explicitly define it within the LDP (this view aligning somewhat with the second perspective on the articulation of a health goal discussed in Chapter Seven).

Extending this review to focus not just on how health is defined but more broadly what is meant by this term revealed that all the reviewed LDPs bring together either and/or all the following issues: better access to healthcare provision, promotion of healthier lifestyles, and adapting to and mitigating the impact of climate change. Although these three issues will require different responses in terms of urban planning, LDPs did not always draw out this distinction. In most instances, healthcare infrastructure needs were clearly distinguished; however, how healthier lifestyles would be promoted and how addressing climate change would benefit health was typically much less clear.

8.5.3   Visionary priorities and objectives for health

Whether classified as a Core Strategy or Local Plan, LDPs are required to contain a vision statement. This "statement" focuses on the potential inherent in the respective local area's future, or what the relevant local authority intends for it to be. It sets out the objectives of the local area's development, serving as a roadmap to guide development decisions, typically over the period of the plan, so that they align with the vision statement's philosophy and declared set of goals. In all but two cases, Harrogate and Tower Hamlets, health was found to be a key theme of the LDP vision statement. This does not mean, however,

that health issues are not covered in the vision statement or its subsequent strategic principles, priorities or objectives of the aforementioned cases, although the coverage in the respective vision statements is implicit and without recourse to health dimensions.

In the Harrogate Core Strategy (adopted February 2009), for example, health is not referred to in the vision statement, however the statement does focus on increasing the provision of public open spaces, sports facilities, and infrastructure to encourage physical activity. All these factors have relevance to health, with the provision of open space and physical activity being identified as determinants of health in their own right (Wilkinson & Marmot 2003). Retaining and improving access to health, education, food shopping, recreation, and other key services is moreover contained in the sixth strategic objective of the Core Strategy focusing on transport. The actual health benefits, however, that this objective and the wider Core Strategy is aiming to achieve are not distinguished. But this is not exclusive to this example, but a common finding among all the reviewed LDPs.

More broadly, the expression of health within the vision statement and associated goals was variable. This appeared to depend on the characteristics of the local area and population, for example whether the area was economically prosperous or had higher deprivation and health inequalities. Several planners interviewed as part of this study supported this assumption, directing the author to the baseline analysis upon which respective LDPs were predicated, noting that (usually under the heading "population") statistics suggestive of the recognised health issues of the local area would be included. In most but not all cases this held true, with Stockton, for example, acknowledging health inequalities to be a problem in its area, and identifying access to health and other facilities/services as being a particular issue. The vision statement contained in the Stockton Core Strategy is reflective of this, incorporating the improved provision of healthcare and other facilities and the delivery of safe, healthy, and sustainable communities as part of a wider economic regeneration and development agenda.

Analogous with this is the Tower Hamlets' Core Strategy 2025, whose vision statement centres on long-term sustainable regeneration of the area; the achievement of this being identified as enabling the creation of vibrant and regenerated locally distinct places with sufficient facilities and services (including healthcare provision but also wider aspects, such as open space) that will support human health and wellbeing (p.26-28). However, this Core Strategy does contain broader strategic objectives aimed at "creating healthy and liveable neighbourhoods" (e.g., SO10 and SO11).

In the Stockport Core Strategy (adopted March 2011), the visionary direction towards health is markedly broader in comparison with the other reviewed LDPs. Here, urban planning is identified as being the "spatial mechanism" for delivering the local authority's Sustainable Community Strategy; which has an explicit focus on delivering improved public health outcomes in the area. To achieve the aims of the SCS, the Core Strategy sets out its own, more specific, vision. This translates the various dimensions of the SCS into specific goals and subsequent strategic objectives. Emphasis in the vision statement is placed not so much on the issue of improving health directly through healthcare provision, but on empowering the local population to live healthy and sustainable lifestyles. This being achieved through the delivery of development that is economically, socially and environmentally sustainable.

Interestingly, the basis of this distinction between healthy *and* sustainable lifestyles was explained to the author to have been engendered by debate between the local health and planning sectors. The former wishing to have health articulated as a distinct goal in the Core Strategy, and the latter maintaining that it should sit within the wider objective of sustainable development. Through collaborative working, the two sectors were able to reach a compromise whereby the two goals would be distinguished as separate for the purposes of the vision statement yet delivered in a linked and integrated manner. A point which raises the importance of collaborative

working in terms of delivering health promotion through urban planning (something which is further discussed in Chapter Nine).

This aside, it was stressed by one planner that the introduction of broad vision for health within a LDP that emphasises not only improving population health through healthcare provision but also empowering local communities to improve their own health is essential to long-term sustainable health outcomes. It was noted, however, that the outcome of this "introduction" is likely to be more symbolic in nature, as the operational effects of such a visionary declaration are likely to be mitigated by multiple contextual factors (again, see Chapter Nine for further discussion regarding this).

8.5.4 Formal policies for health

Three of the LDPs reviewed contained a formal policy on health, these being Preston, Blackpool and Tower Hamlets. Blackpool's Core Strategy, for instance, contains Policy CS15: Health and Education, which sits under the overarching theme of "Strengthening Community Wellbeing". In the text supporting this policy, it is explained that improving the health and education of Blackpool's population is a major challenge and that the gap in health and education inequalities between the town and the rest of the UK is continuing to widen (p.84). The policy itself communicates Blackpool Council's commitment towards supporting development that encourages healthy and active lifestyles. Particular emphasis in this policy is placed on increasing the provision of accessible healthcare and education facilities. This highlights that this policy was designed to reflect the specific health needs and demands of the local area. By comparison, the LDPs of Preston and Tower Hamlets encompass formal health policies that encourage healthy lifestyles and health outcomes over broader dimensions of health.

In Tower Hamlets, for example, the Core Strategy possesses several key spatial themes, including (like Blackpool) "strengthening neighbourhood

wellbeing". Here, however, this theme is translated into Policy SP03 which is intended to deliver a more comprehensive and wide-ranging set of health outcomes. The aim of this policy is to deliver a 'healthier, more active and liveable borough' where people have access to excellent and accessible health, leisure and recreational facilities. To that end, Policy SP03 is designed to support health outcomes across several different domains. This includes working in partnership with health agencies to identify and deliver opportunities for healthy and active lifestyles (such as through providing walking and cycling routes); addressing noise and air pollution; and delivering new and improving quality, usability and accessibility of existing health facilities (p.49-51).

Broader still, is Policy 23: Health in the Central Lancashire Core Strategy which pointedly asserts itself to integrate public health principles and planning. It also notes that it will help to reduce health inequalities through collaborative working between planning and health agencies to support healthcare infrastructure, seeking developer contributions towards new or enhanced facilities, requiring HIA on all development proposals on strategic sites and locations, and safeguarding land for food production and actively managing the development and location of fast-food takeaways. What is especially interesting, from a HUP point of view, is that the policy's supporting text expressly recognises that urban planning can have a positive, and by inference, negative effect on the wider determinants of health (p.115). Thus, "health and wellbeing" is identified as one of the main cross-cutting themes of the Core Strategy. Furthermore, in line with the requirements of the city's Healthy City designation, it is stated that health considerations must be integrated into the urban planning process.

The remaining LDPs did not contain formal health policies, although this does not mean that health issues were not covered nor could positive health outcomes be delivered through the application of the policies in these plans. Included in LDP policies was the intention of creating improved and better access to healthcare facilities and services. This was usually considered as

part of policies towards "communities" or "community facilities". Some LDPs do tend to give healthcare provision more prominence than others – for example, Stockton and Blackpool. The extent to which healthcare facilities and services were features of infrastructure policies varied. This variance could be linked to the current or projected shortfall of such facilities and services, as suggested by the supporting text for Policy CS15: Health and Education of the Blackpool Core Strategy – and also by discussions with planners and health professionals.

Sustainable development, sustainable lifestyles, health and social inequalities and addressing climate change were common themes among the reviewed LDPs. In particular, Stockport Core Strategy acknowledges that health issues can be addressed through a host of policies. This includes Core Policy CS1 which sets out that the LPA will have regard to enabling inclusive social progress, ensuring economically, socially and environmentally sustainable development, and addressing the key issues of inequalities and climate change. That the adopted Core Strategy refers to healthy lifestyles within its vision statement yet does not contain any formal "health policies" was defended by one participant who worked in this authority. In short, and as has been suggested in literature (UWE 2010, Tewdwr-Jones 2012), there is no reason nor evidence to suggest that "good" policies on sustainability are any less effective in achieving desired health outcomes than policies with an explicit health perspective.

8.6 Chapter Summary

This chapter is the second of three chapters that together present a discussion of the empirical findings of this study. The focus of this chapter was on developing an understanding of how health is considered and defined in planning policy, and what expectations policy imposes on local planning actors in terms of health. Here, the intention was not to conduct and set out in detail an in-depth analysis of national and local planning policies, rather it was to provide an overview of the health contents of planning policy across these two levels. To this end, the first part of the chapter examined the health content of the national planning policy framework. This included examining both the policy framework established by the present (at the time of writing) NPPF, as well as the previous regime of PPSs and PPGs. It was discovered that national planning policy establishes two main avenues through which LPAs may address health issues: firstly, through seeking outcomes in health and health inequalities, and, secondly, by ensuring that health is considered in local plan-making and decision-taking.

This review of the national level further revealed that through the introduction of health as a dimension of the planning system's "social role" towards achieving sustainable development, the NPPF has (to some extent at least) corrected a shortcoming in national planning policy in respect to the relatively limited scope of its consideration in the previous regime of PPSs/PPGs. Nevertheless, misgivings about the perceived political nature of the NPPF, its emphasis on economic growth and housing development, and the inclusion of a "presumption in favour of sustainable development" were raised by multiple participants. In particular, this latter factor coupled with the vague and confusing (if not contradictory) nature of the NPPF, especially in terms of health, was considered by several participants to be a limiting factor on the delivery of health through local urban planning.

The second part of the chapter focused on planning policy at the local level, reviewing LDPs from selected case English LPAs. Here, the review examined

how is the concept of health is defined and articulated within LDPs; focusing particularly on the vision statement and subsequent objectives, principles or priorities contained in the respective LDPs. Whether the reviewed LDPs contain formal health policies was also examined. Overall, the review uncovered that in only a few instances did LDPs provide a definition and/or reference to the meaning of health. It also found that health is handled and treated in LDP policies in a variety of different ways, with not all plans containing policies exclusively focused on health.

However, there is no evidence to suggest that policies structured around sustainable development, if applied successfully, would not be capable of securing positive population health outcomes. Finally, that there was such a variance in the inclusion of health in LDPs supports the notion that framework of national planning policy in England affords LPAs considerable scope in terms of how they integrate health into their plans and policies, as well as the idea that because some authorities perform impressively in terms of health, while others do poorly, suggests that "health integration" is heavily influenced by institutional and structural factors (Tewdwr-Jones 2012; Carmichael et al. 2013).

9.   Factors affecting the delivery of healthy urban planning

The purpose of this chapter is to examine the factors that stakeholders identified as affecting the delivery of healthy urban planning (HUP). These 'factors' serve as barriers and opportunities to the application of the concept of HUP. This chapter begins with a discussion of the stakeholders' view of the effectiveness and effect of urban planning in relation to health. It then moves to a discussion of the factors affecting the delivery of HUP, including considering how the findings of this research compare with those from those of previous research.

9.1   Introduction

In this chapter, the discussion on the research findings shifts its focus from ideation to implementation. The chapter first looks at stakeholders' views on the effectiveness and effect of urban planning in relation to health. This is followed by an examination of the stakeholder identified factors – i.e., barriers and opportunities – that affect the application of the concept of HUP. Together, this should provide further insight into the factors that promote or hinder the mobilisation of the HUP concept in urban planning practice.

9.2 The effectiveness and effect of urban planning

In the literature, there is scarce evidence relating to the effectiveness and effect of urban planning in respect of health outcomes (see, Chapter Four). Much work remains to be done before the problem of causality can be resolved. Until such time, much of the evidence that there is remains of qualified value for the purposes of its application in plan-making and decision-taking (Sarker et al. 2014).

Against this backdrop, and in line with its methodological approach, this study sought to explore the stakeholder's thoughts and perceptions about this matter; seeking to both investigate the effectiveness and effect of urban planning in health terms. Here, what is meant by effectiveness is: the degree to which issues relating to and any potential health implications of the plan-making and decision-taking processes are considered and addressed within urban planning before actions are taken. Correspondingly, effect is understood as the actual change to health which is a result or consequence of urban planning actions.

9.2.1 The effectiveness of urban planning

The question about the "effectiveness and effect" of urban planning is a two-part question. In the first part, participants were asked to provide an assessment of whether health issues and any potential health implications of plan-making and decision-taking are effectively considered and addressed within urban planning before actions are taken. Most answers were limited to "the effectiveness of urban planning varies from authority to authority", with relatively few participants elucidating why this might be. What is more, the majority of participants spoke about the effectiveness of urban planning in broad terms. That is, they did not acknowledge or distinguish between the

plan-making and decision-taking (development management) process in their response.

Views on the effectiveness of urban planning at the local level were surprisingly similar between both stakeholder groups; namely, that it is highly variable and inconsistent. This observation accords with previous studies that found no single standard with regard to how health is considered and addressed in urban planning in the UK (Reed, et al. 2010; Tewdwr-Jones 2011; Carmichael et al. 2013). While most participants described the effectiveness of urban planning as having a variant quality, such observations were (or at least appeared to be) constructed on normative foundations underpinned by personal, qualitative experience, hearsay, and anecdotal evidence. To explore this claim, interviewees, as it was not possible to do so with the survey respondents, were asked (in a non-judgemental and non-leading manner) about the rationale behind their response on this matter.

Of the twenty-two stakeholders interviewed, only two citied specific material from which they had gathered information about HUP (or health and urban planning more broadly) and that could substantiate their initial response. Interestingly, both these stakeholders – a planning practitioner and a health professional – were from the same case LPA and, even more interestingly, they discussed the same material – specifically research of the UK planning system and health undertaken for the purposes of a late 2000s NICE call for evidence, as well as material published by the Town and Country Planning Association (TCPA)[74]. Whether this was coincidence or not is difficult to determine. What it does suggest is an element of engagement or knowledge exchange between both sectors in this instance.

The remaining twenty interviewees appeared to have inferred from their personal or professional experience, or a combination thereof, that there is a variance across LPAs in relation to effectiveness. Two interviewees (both

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[74] These two participants specifically referenced the following two TCPA reports: 'Planning Healthier Paces – report from the reuniting health with planning project' (2013) and 'Planning Healthy Weight Environments – a TCPA reuniting health with planning project' (2014).

planners) did, however, subsequently acknowledge that they were unsure as to the effectiveness of urban planning in this context. This in some ways is understandable, not least because reliable empirical data on the integration of health in urban planning practice is currently not readily available (as explained earlier in Chapter Four). Discussion about the possible implications or consequences of built environment professionals not being fully aware of the effectiveness of urban planning (be it in relation to health or other issues) was met with a retort from one planner, who stated that (PO12),

> '… as with everything in planning, there will be good examples and bad examples.'

They were also doubtful that no more than a handful of planning practitioners with no connections to academia would have the inclination, or 'be very keen', to invest resources (namely, time) in researching or observing how their own or other LPAs consider and address certain issues in their work, especially not that of health which was perceived as carrying only limited weight in decision-making (PO12). While not representative of all built environment professionals, this statement does indicate that although the idea of HUP may be gaining training traction the message of active investment of public and private resources to achieve it is not universally recognised.

Returning to the idea of "variance", there are two important points to make here. Firstly, that variance in urban planning effectiveness was not quantified but generalised and thought to be certain. Secondly, that it was held to be a consequence of an assumption of the planning system's performance (both past and present). Several planning practitioners explained that the planning system is not homogenous, but heterogenous; it consists of multiple LPAs located in multiple places, each with its own capabilities and demands. This heterogeneity, in turn, leads to differences in performance, effectiveness and potential (including regarding the awareness and consideration of health). As one Planning Policy Officer enthusiastically explained,

'You don't have to be a planner to realise that the planning system is complicated! Every place in the country has its own council, with its own team of planners dealing with its own set of problems. Add to that the fact that planners have to apply overly complicated policies within an already complicated system and, well, you're going to get differences in performance. There's nothing new in the idea that some councils deal with some issues better than others.'

They continued,

'I know [name removed] you're interested in the health side of things, but health is like any other issue in planning: some authorities will handle it in ways that are better than others. Councils will always want to improve the lives of local people – that's what they're there to do – but they need to deal with whatever the most pressing issues in their area are first. So, whether that's funding, health, jobs, or housing, they'll put their effort into addressing that first. Only then can they start to think about softer issues, such as libraries or parks. And, if you think about it, it's doubtful in the current climate whether health is going to be very high on the agenda of local authority planners.'

Similar to the previous point, while LPAs and built environment professionals may desire to improve people's quality of life, health considerations are not universally viewed as being absolute but rather something that must be balanced against other considerations (such as funding and financial viability). From this, it is possible to infer that there are both institutional and structural factors that influence "effectiveness" and make it difficult for LPAs to address health issues effectively (see the sections below). Unfortunately, it was not possible to explore in detail the effectiveness of participants' own working practices and those of the LPA they work for, as all proved reluctant to engage in discussion of such matters.

Notwithstanding this, four interviewees did share information about what they understood to be good practice examples of LPAs which have effectively integrated health into their work – or as one health professional put it, 'placed the agenda of healthy planning at the heart of what they do' (PO19). Those cited were in the South East (Tower Hamlets, London), South West (Plymouth, Devonshire) and North West (Stockport, Greater Manchester) in England. Having provided specific examples, these four interviewees were probed as to the basis of their selection. Based on the responses given by these interviewees, it would not be unfair to say that their selections were, or appeared to be, based more on assumptions of fact or on speculative or conjectural factors rather than empirical data. For example, a Strategic Planning Officer said,

> 'I can't give you any figures if that's what you're asking [laughs]? I suppose that pick comes down to a couple of us going to an event on health and planning organised by the Town Planning and Country Association [sic]. The Director of Public Health and some guys [sic] from [name removed] planning department were there… we got talking to them, and they really seemed to get the point that there is a health angle to what we do.' (PO6)

As a final point on the question of effectiveness, it is interesting to note that many participants (both health professionals and planners) qualified their responses with reminders that the integration of health within urban planning has not reached its potential. Comments stating that 'planners do focus on health more today than they used to. However, there is much more that can be done' (R17), 'health is an area of planning practice that needs to be better developed' (RO2), and 'planning is effective, but only to a limited degree' (R55) suggest just that – that the effectiveness of urban planning in considering and addressing health is evolving, becoming more developed, but further efforts in that direction are needed.

9.2.2 The effect of urban planning

The second part of the question posed to participants asked what (if any) effect urban planning has on population health outcomes. Analyses of the data reveal a general sentiment of hope among participants that urban planning is having a positive effect on health, but some participants were more binary than others in their thinking. Approximately one-third of participants were unequivocal in their views that urban planning is having a positive effect on people's health. By comparison, a third of participants said that the effects of urban planning in relation to health is negative. One planner even expressed a sense of disbelief that others might hold a different opinion to their own on this issue, stating that, 'I can't believe that anyone would argue that planning is having a positive impact on people's health across the UK at present' (R47). It was also found that those perceiving urban planning as having a positive effect on health were disproportionately planners, while those who felt it was having a negative health effect were more often than not health professionals.

Among the remaining third of participants, most exhibited a distinctly more ambivalent stance toward the health effects of urban planning practice. The notion that urban planning could be used as a mechanism for reducing health inequalities and improving population health was accepted by this group, although its members appeared ready to acknowledge the current limitations of our understanding regarding the relation between health and urban planning, and the lack of conclusive evidence about this relationship. When asked about this, a Planning Policy Officer expressed that, 'I would really like to think that planning was making an actual difference to people's lives. But without any evidence to show me what planning is doing, what it is achieving for health, I can't say – I can only hope'. They continued, 'there now seems to be quite a bit of guidance out there on planning for healthy neighbourhoods, you know, stuff on creating parks and open spaces. However, there doesn't seem to be much evidence on actual outcomes' (PO7).

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This selection of (or third of) participants felt the amount and quality of available evidence to be insufficient to make any firm conclusions regarding either the effectiveness or the effects of urban planning on health. What the possible implications and consequences of having only limited empirical evidence on the effectiveness and effect of urban planning for HUP are discussed in the sections below; here it suffices to say that the current state of evidence regarding what is known about the health impacts of urban planning was thought by both stakeholder groups to be impeding the development of a more health-oriented planning system.

Overall, the gathered data indicates that the practical application of HUP and the health effects of urban planning is a "black box". While participants provided some insight into the state of consideration of health in urban planning, the effect this is having on health remains largely hidden from both the health professionals and planning practitioners in this sample. When asked about this, a Senior Public Health Professional hesitantly answered that,

> 'Basic questions about what impact the work of local authority planners is having on health remain unanswered…. On the one hand there is a lack of awareness among planners about health and among those working in public health about how planning works, and how to measure planning outcomes. But, on the other hand, the issue remains that we still don't fully understand what it is we're trying to measure. Is health this one thing or it is many different things? Should we be measuring health in terms of a single factor, or should we be measuring physical health separately from mental health? I'm not sure we've reached a stage where we can provide answers – it's something we should definitely be focusing more of our attention on.' (PO13)

The challenge posed by ambiguity of terms and concepts was reflected in another response by one of the planners. It was stated that,

'… the effectiveness and effect of planning are difficult things to measure. We have enough problems getting the resources together to make plans and manage the number of planning applications that the boys [sic] in development control are now having to deal with. Monitoring and measuring the impact of our Core Strategy or how the proposals we've granted permission for have affected the local community creates even more resource issues.

You also have the problem that everyone in the department has a different opinion on what we should be including in our AMR [Annual Monitoring Report]. If we were to include health indicators in the AMR, we'd first to have agree what it is we're exactly trying to measure – how would we exactly measure health, would we measure how many miles of cycle paths we have or how many acres of open space? You tell me.' (PO8)

These two above statements, which are representative of several others, point toward an inherent tension in the practical application of HUP. That is, the absence of clarity as to what the exact goal of HUP is and what is expected of LPAs to achieve this goal; what competencies they are expected to attain and what criteria should be used to assess these competencies and judge their performance.

9.3 Collaboration between planners and health professionals

Issues relating to partnerships, collaboration and joint working across health and urban planning sectors are highlighted as a key barrier to effective integration of health within urban planning. In line with this, the discussion now turns to the gathered evidence concerning collaboration between planners and health professionals.

9.3.1 The strength of collaboration

The data from this research project suggests that, in practice, the planning process is only exceptionally a truly interactive experience for planners and health professionals. Health professionals were especially deemed to rarely fully participate in local plan making or development management processes. This conclusion was strongly reinforced by comments made by both sets of stakeholders. For example, a Planning Officer suggested that, '… despite changes in the role of local authorities in terms of public health, the planning and public health team remain very separate. Attempts to include public health in the plan-making process have proved difficult and have come to very little. Planners are forced to pay lip service to health as they can't get any meaningful dialogue with or direction on health issues from the health department' (R40).

While not all health professionals supported this view, many did. When questioned about the health-urban planning interface, one Senior Public Health Professional stated that,

> 'There definitely are those working in public health who appreciate the historic links between the two sectors. And many recognise the importance of planning for community health and wellbeing. To date, however, there has not been enough involvement from public

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health in planning matters. Without the evidence or knowledge to assess the health impacts of planning decisions, how can planners deliver healthy development? We, as health professionals, need to become much more actively engaged in planning.' (R63)

It is noticeable that, although planners acknowledged the failure of the health sector to proactively engage in urban planning, health professionals equally acknowledged the weaknesses of urban planning in addressing health priorities. 'You can't just blame local health departments for the lack of working between planners and health workers. My experience has been that planners simply don't prioritise health or have a good awareness of wider health issues. Planning departments need to start inviting public health into discussions about their plans and development proposals. Until that starts to happen, I can't see anything changing soon', observed one Public Health Practitioner (R61). There was a dominant contingent of health professionals who took a similar position to this, arguing that only a low priority is afforded to health in local urban planning and more engagement is needed by planners in health matters.

Notwithstanding those who adopted a more balanced stance, the emerging dialogue on collaboration would often seemingly arrive at an impasse in thinking. That is, planning professionals tended to lay the blame for the perceived inadequate collaboration between health and planning sectors with their health colleagues; while health professionals tended to blame planning professionals for this situation. Throughout the interview transcripts and survey responses, however, there was an evident unifying theme that seemed to galvanise thinking: the need for a more effective and proactive relationship between planners and public health professionals. Unlike other aspects, there was a jointly held belief that "better" engagement between public health professionals and planners is vital to facilitating improvements to optimise health outcomes in urban planning.

9.3.2   Arrangements for collaboration

Several perspectives on the necessary arrangements and structures for collaborative working between planners and health professionals were provided by the participants. These are discussed in more detail below.

Communication and information exchange

The role of communication and information exchange has been cited as important to the success of urban planning (Forester 1997; Healey 2010). Greed (2001) describes communication as being vital to both self- and place-representations and the acts of decision-making/taking in urban planning. A central theme of the literature on information sharing and communication from both within and outside the planning domain is that communication is beneficial for the reasons that, firstly, in and through communication actors are able to make sense of complex problems through combining knowledge and (de)constructing meanings (Hatch & Schultz 2002) and, secondly, that communication enables actors to reach understandings of the situation, coordinate their actions and act in concert (Habermas 1984).

Communication is widely held to be lacking between planners and health professionals. On a fundamental level, the results obtained in this study add to the evidence supporting this observation. Data from the interviews and surveys provided significant evidence of communication problems. The perceived dissatisfaction with the current state of communication was most frequently voiced by planners, who variously claimed that they were unsure of who they would contact to discuss a health-related issue should they want to, or if instructed to do so. 'We're like ships in the night', quipped a Planning Policy Officer, 'we work in the same building, but we rarely meet; never mind talk to each other about health issues – or any other issues for that matter' (R42). This complaint echoes a common experience heard in various forms from many planners that effective, intentional communication, or even basic

functional communication, between planners and health professionals is missing.

In the few instances where respondents said that communication lines, in their local authority, were open between planners and health professionals, most expressed concern that existing arrangements for communicating and exchanging information do not always work as effectively as they could do, or as intended. Participants from both groups distinguished between, and contrasted, formal and informal forms of communication.

Two main formal arrangements for communication were described, these being formal consultations in LDP preparation and on proposed development[75]. Informal communication, by comparison, included casual "face-to-face" conversations or conversing in a less official manner via email or telephone. Health professionals and planners in several areas expressed concern over the success and efficacy of formal mechanisms of communication, and had a clear preference for more informal means of communicating and conveying information (a finding in line with that set out in a study by Reed et al. (2010).

The formal consultation in forward planning and development management processes, for example, was commented on by some as being overly goal oriented and function related, hierarchically structured, and restrictive. These factors, either individually or in aggregate, were thought to have an almost dehumanising quality, reinforcing the divide and sense of "otherness"[76]

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[75] Local planning authorities (LPAs) are required to undertake statutory consultations on proposed development prior to a decision being made on an application, as prescribed by planning law (specifically the Town and Country Planning (General Development) Order (as amended). Statutory consultees may include the Health and Safety Executive, Natural England, Environment Agency, Historic England, among others. In addition to statutory consultees, LPAs may also consider whether planning policy reasons exist to engage with other (non-statutory) consultees who are likely to have an interest in a proposed development. These may include County Archaeological Officers, the Design Council, and local authority environmental (or more general) health officers. Similarly, planning law (specifically the Town and Country Planning (Local Planning) England Regulations (as amended), requires LPAs to consult relevant statutory and non-statutory consultees for their opinions when preparing a Local Plan (or other Development Plan Documents).

[76]'Otherness' is a concept that has been widely explored and developed in the social sciences, especially in sociological studies. It is used here in its most fundamental sense, as a concept

between the planner and the health professional, and creating professional categories that become intractable. The simplest expression of this assumption, underlying not only planners' conceptions but also that of health professionals, was that formal means of communication can result in a 'them and us' situation (PO20). This observation was made as part of a wider discussion with a health professional who also noted that the involvement of the health sector in planning processes tends to follow the same structured process: materials are collected, processed and formulated into a "message" to be shared with planners through a traditional (hierarchical/functional) system.

Standardisation of the communication process was thought to finalise the dialogue and reduce the range of voices and ideas influencing the planning process. Formalisation of the communication process was further believed to hinder the possibilities for creative space and thinking about solutions to health problems. From one health professional's point of view, the design and management of urban areas for people and health is something that the health sector does not fully engage with because it is not *their* process, but one offered to them and controlled by formal structures and well-defined rules (PO20). Existing formal mechanisms of communication were noted by a few planners to provide a positive level of certainty in that their existence ensures "some" communication occurs, although a common complaint made by planners was that health professionals often provide critical information too late in the planning process, with information often coming at the determination stage rather than the pre-application stage of a proposed scheme where it could better inform discussion with applicants, and that they lacked understanding of what information was required by planners.

The central contention of respondents' line of thought with regards to this issue seemed to rest less on what information was being shared and more so on the communication of unshared information – and how the balance and extent of

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that signifies a quality of being different (Levinas 2006). For a detailed analysis of the concept, see Greene (2012).

shared and unshared information influences the output (i.e., the decision). A handful of respondents noted that within any given planning process involving two or more actors there will be information that remains unshared, with this being especially the case where actors from different sectors are involved. This (intentional or not) hoarding of information was said to be influenced as much by the mechanisms of communication as by individuals' motivation (or lack thereof) to communicate with others.

Formal communication channels (such as consultee responses to development proposals) were observed as delivering and communicating information according to "fixed" principles and mechanisms. This, as one planner put it, 'limits both the amount and the type of information we [planners] receive from public health' (PO1). For this and similar reasons, respondents indicated a preference for interpersonal communication channels (telephone, email, face-to-face conversations).

Informal, interpersonal communication (or "direct communication") was viewed as being more flexible and proactive, offering a diverse platform through which actors can share greater amounts of information that both better reflects their attitudes and thoughts and better express and relays "tacit knowledge"[77] relevant to the circumstances of the situation. Through informally communicating with one another, such as over the phone or in person, respondents further noted that it may be possible to cover the shortage of formal communication.

Finally, informal communication was perceived as being much more cohesive than formal approaches. Through simply talking to one another, several respondents (both health professionals and planners) contended that it would be possible to create a deeper sense of belonging and identity between the

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[77] Tacit knowledge is commonly understood to include personal knowledge embedded in individual experiences and involve intangible factors, such as beliefs and value systems. Nonaka (1995: 215) writes of tacit knowledge as being 'highly personal and hard to formalise making it difficult to communicate to others or share with others' and that it 'is deeply rooted in an individual's action and experience, as well as in the ideas, values, or emotion he or she embraces'.

two professions. This, in turn, could further support the development of a social norm around communication and information exchange, one that establishes that these two social activities are normal (i.e., correct), and expected; building a greater sense of willing for health professionals and planners to engage with one another.

The workforce: numbers, dedicated staff and champions

Participants shared different perspectives and engaged in discussion as to how current collaboration between public health and planning could be strengthened or improved to better meet health objectives. The interviews included surprisingly detailed discussion about organisational staffing, structure, and operations that affect collaboration (including communication) between planners and health professionals, and other factors that influence the formation of planning policy on health. A general point was occasionally made that the planning sector, from the local to the national level, is struggling with increasing resource issues. This included human resource issues such as overall staff numbers, but also staff recruitment and training. Many felt that staffing in local authorities, including within planning and health departments, had been negatively affected by political policies.

Specifically, some interviewees spoke at great length about the impact of recent austerity policies and measures enacted by the UK government for the purposes of, inter alia, curtailing the nation's growing budget deficit and improving economic functioning[78]. Planners were particularly distressed about the current availability of LPA planning officers in England. A Planning Officer whose portfolio responsibilities includes staffing, passionately explained that,

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[78] The most recent UK government austerity programme was adopted in circa 2010 and is a fiscal policy designed to reduce the nation's budget deficit and the role of the welfare state through a programme of sustained public spending reductions and tax rises. The effects of austerity policies have proved extremely controversial and divisive, dividing opinion among academics, commentators and politicians alike. For a more in-depth discussion of the austerity programme, see Taylor-Gooby (2012), Grimshaw & Rubery (2015), and Berry (2016).

'Tory[79] cuts to local county budgets have had a real impact on staff levels across the authority...planning has been particularly affected, because it's one council function that the Tories and many others believe we could do with less off – so when it comes to managing our budget, it's the first on the list to lose money. We've had to let a number of our planning staff go. We even used to have a dedicated sustainability officer, but he's gone now.' (PO12)

Although this statement tends to be about general resource issues, the planner and others explained that the workforce in most LPAs was decreasing and that a consequence of reduced staff levels in planning departments, in addition to general capacity constraints and workload issues[80], was less collaboration between planners and other stakeholders; this was said to include not only collaboration with health professionals but also developers and members of the public. One Senior Health Professional described how insufficient numbers of planners in their local authority planning department had led to increased workloads for each planner, contributing to the discussion and engagement of planners with others on 'less tangible issues' such as health and inequality being 'shelved' (PO17). They further stressed that the issues caused by under-staffing were something that both academics and central government needed to become more cognisant of if the agendas of sustainability, health, and equality were to succeed in their vision.

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[79] The term 'Tory' or 'Tories' is frequently used to describe members of the Conservative Party (officially the Conservative and Unionist Party), a right-wing political party in the United Kingdom.

[80] It is difficult to substantiate the claims of participants with respect to staff levels and the associated impacts of this; however, research published in a report by the think tank Planning Futures suggests that there has been a continuation of cuts to planning department budgets and staff numbers in recent years – with each LPA, on average, losing almost 15% of their planning staff between 2006 and 2016 (Planning Futures 2017).

Despite the general finding above regarding staffing and workforce issues, more than half of participants articulated a desire for the recruitment and/or training of what can be referred to as "dedicated staff" in their local authority whose remit would include working proactively on and shaping policy relating to HUP. Both planners and health professionals noted a similar need for planners in local authorities with a responsibility for public health, and for public health staff, including those in Clinical Commissioning Groups (CCG), with a specific responsibility for engaging in planning processes.

Of the case study authorities examined, interviewees from only one case study authority stated that a "dedicated" post exists in their authority. A Senior Public Health Professional from this authority noted that they have in place a fixed 'Healthy Planning Officer', the role whom is to raise the profile of and embed health principles within planning activities (PO21). They were also said to provide a degree of "health quality control" on all aspects of planner's work and act as a steer to ensure that planning processes can be checked for their consistency with core health objectives. Again, however, the issue of resource scarcity arose because as funding, workforce and other resources decrease, combined with a perceived increase in daily workload, the specific health-oriented focus of the person holding this post was commented on as being gradually eroded over time – with the responsibility for health integration within planning becoming ever more subsumed within a broader, expanding portfolio of responsibilities.

A similar, though not identical, proposal to that of "dedicated staff" was advanced by a group of participants as way of improving both the collaboration between planners and health professionals, and the integration of health within urban planning. This proposal involved "joint appointments" between local authority public health and planning departments of permanent staff – but it could also include joint appointments between the Director of Public Health and the Head of Planning. The value in joint appointments between the health authority and LPA has been stressed elsewhere (Carmichael et al. 2013), and as one planner in this study suggested,

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'What we need is people who are employed and who work between the two sectors, who actively try to connect planning and public health together. And who can translate what one group is saying into language that the other side can understand.'(PO3)

There were many reasons put forward as to why having in place jointly appointed personnel would be advantageous over having dedicated staff in each sector. Perhaps the main reason for it was that putting in place a dedicated HUP officer was thought to harbour the potential to lead to further silos and create additional segmentation, with dedicated staff working towards goals that are important to the success of their individual role, but not the sector overall. Expertise and specialisms among staff were noted as being beneficial, but it was remarked that the functions of specialist staff can often get caught up in a siloed mentality and tend to lead towards internal competition and political dynamics within a department that are detrimental to success[81].

The answer to overcoming any potential isolated or silo working was to establish jointly appointed posts, whereby those holding them would work in and across health and planning departments and, in doing so, build links between these two agencies. A few participants stressed the importance of champions, specifically "healthy planning champions", as essential to providing necessary inspiration and leadership, but also for building capacity and breaking down institutional inertia where it may exist. Indeed, the importance of "champions" for HUP has been identified in literature(Healey 2010; UWE 2010; Barton 2017).

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[81] An interesting example of this possibility realised in practice was provided by one interviewee, who explained that they had two years previously recruited a dedicated "sustainable planning officer" in their department. While providing much needed expertise and direction with respect to sustainability and sustainable development issues, they expressed regret that this post had become increasingly siloed and that the person holding it was often 'pulling in a different direction to the rest of us, instead of pulling with us to achieve something we can be proud of' (PO5).

Interestingly, respondents from two of the case study authorities provided verbal evidence that joint appointments such as this exist in their local authority. One Policy Officer even identified with this epithet,

> 'That's what people say I am. My role is co-funded by the Director of Public Health, [name removed], and the head of planning, [name removed]. I think it is about 50/50 health to planning coverage; leaving me stuck in the middle. I am more a translator between the two – planners and public health each have a very specific identity and language and will talk acronyms until the cows come home. And you can see the set who're not talking glaze over as they lose the will to live, because they don't really understand what the other team are trying to get across.' (PO1)

A key issue by this and other participants was in regard to the articulation of ideas and the accessibility of information, with planners highlighting that health professionals typically lack an understanding of the specific language, culture, norms, and operation of planning which then inhibits opportunities for partnership and policy coordination. Planners, in particular, were accused of regularly using incomprehensible jargon – "planning speak" – which was intelligible to those unversed in it, and in doing so failing to recognise that their own professional terms and definitions deny opportunities for collaboration. Thus, the joint appointee – or champion – must function as both educator and facilitator of communication and action.

Whether this is so, is a highly normative question and one to which finding the answer is outside the scope of this work. But it is interesting to note that several health professionals expressed a similar sentiment as to planners' understanding of public health, and it has been said elsewhere that the complexities of professional identities, languages and nomenclature, and working practices can strongly frustrate efforts for inter-sectoral collaboration and joint working (see, Chapter Five).

A space for health

When it comes to health, there was a widely held view among participants that a collaborative response is a better strategy than an isolated response. This was considered to mean, among other things, that planners should work in partnership with health bodies and other local agencies (such as education, social services and licensing) to promote opportunities for concerted action on public health. Although most interviewees and survey respondents spoke about the need for better communication between these two sectors and/or the appointment of dedicated/joint staff, or even jointly appointed "healthy planning champions", a few extended this consideration by focusing upon the cultural and institutional context that underpins collaborative working.

Speaking about this, a Senior Health Professional observed that,

> 'Having in place jointly appointed staff, or champions as people increasingly refer to them, is one way to improve the interaction between planning and public health. They can help improve communication and translate the jargon of one profession into standard English that others can understand. But difficulties still exist in filling such posts, and they can be unsustainable; you'll often end up in a situation where health is seen as "that person's responsibility", which can lead to too much pressure being placed upon a single individual.

> Individuals can help to catalyse collaboration, but I think we also need something more – something framed around actually building a culture or environment for health, block by block. We need to build an organisational and institutional context that focuses on getting health results, that capitalises on, and that is responsive to the differences and similarities between different local authority agencies.' (PO16)

This point on collaboration pertains chiefly to communication and language, although in focusing on the cultural context it extends more generally to

organisational and institutional cultures. Effective collaboration requires and involves concrete contact, dialogue and exchange, where the individual and organisational structure and culture play a major role (Brand & Gaffikin 2007). Granted, in any collaborative expression, collaboration and exchange requires both motivated individuals and a supportive environment. But collaboration on health was thought by some participants to bring these factors into especial sharp relief. 'There's something different about working on health, which is difficult to describe. Where on other issues we can get by without any real discussion between people, with health we need that interaction and we need a setting that allows us all to work together', noted a Planning Policy Officer (PO3).

Several planners alluded to the need for an institutional and/or organisational setting that facilitates a more multidimensional model of communication, comprising formal and informal mechanisms, and which stimulates creative thinking on the part of those involved. The objective here, it was suggested, was to create an urban planning-health environment that continuously stimulates actors to try to push the health agenda, and to think about future possibilities and capabilities. Such a setting can help unify professionals from diverse backgrounds within a single 'space for health' (PO1), although there was a recognition of the difficulties or even a doubt about the possibility of achieving a truly shared understanding of health both as a concept and as an issue for practice given the plural, multi-sectoral and cultural nature of the planning process (see, Healey 1997).

There is a need, therefore, for a setting and framework for collaboration rooted in institutional realities of the fragmented space around health and planning. Some for this reason, commented that the focus of collaboration should be on reaching an achievable level of mutual understanding and capacity building, possibly delivered by dedicated and/or joint appointed staff, but at the same time retaining awareness of that which is not understood and capitalising on the different skill, knowledge and social systems of stakeholders.

9.4 Health and the urban planning process

The literature examined earlier in this thesis reveals that there is growing support for the integration of health within urban planning. However, the urban planning process is thought to harbour many obstacles to this integration process. Authors contend that the application of HUP in urban planning practice is complicated by multiple factors, including planning and other sector policies, objectives, regulation, communication, working methodology, and capacity (both knowledge and material). Participants in this study also offered valuable insight into the factors that can serve as barrier and opportunities to the application of HUP in urban planning practice. This was alongside sharing a variety of other thoughts and lived experiences that together highlight the difficulties in achieving normative goals in urban planning and how the process could be improved to better support the delivery of HUP.

It proved difficult to disentangle some factors as distinct ones, although to help contextualise and "make sense" of the data they were distilled into two main (and several sub-) categories. These are explored in detail below.

9.4.1 Decision-makers and decision-taking

Who (and what) makes the decisions?

Decision-taking in urban planning comprises multiple actors, each with their own aims, objectives and working strategy (Kaiser, Godschalk, et al. 1995). On the one hand, there is the "planner" whose roles and responsibilities are directly focused on urban planning activities. This can often include (depending on if the planner has a specialism) validating, processing, assessing and determining planning applications. On the other hand, there is a collection of stakeholders who have different purposes and agendas; with these typically comprising disparate priorities, wants and expectations (Fainstein 2010).

While interested, concerned and/or physically involved in the planning process, not all stakeholders have direct control over the decision-taking process. Certain stakeholders are, however, specifically positioned and their role purposively established to exercise decision-making rights over (some) planning matters. In particular, planning committees[82] are established by LPAs to determine applications for planning permission. Although less discussed by participants, analyses suggest that the features and characteristics of the "common dynamic" between planners and planning committees are of importance to and have far-reaching implications for HUP (and other public health measures).

Broadly speaking, most planning applications are determined in-house by LPAs under delegated powers – meaning that planning officers determine applications themselves without having to obtain a decision from the planning committee. A large contingent of planners recognised that the applications they process can, either individually or cumulatively, have an effect on the health of individuals and communities. But, as one participating planner phrased it, 'the big impacts on health and quality of life come from the decisions made by the members' (PO7). Why this planner believed that this is the case is difficult to ascertain, although it may relate to the nature of the applications that are typically decided by committees.

Applications sent to planning committees are generally complex, controversial and/or major proposals, or those requested by a member of the Council or an objector to be taken to Committee. The use of planning committees in urban planning is significant, but the real importance here, from a health perspective, lies not so much on the fact that decisions are made by committees, but on characteristics or attributes of the decision-making process – namely, the

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[82] In the UK, planning committees comprise local authority councillors – representatives of wards or divisions and the people who live within them – and can be established to determine applications for planning permissions. However, most planning applications are assessed against local planning policies and determined under delegated powers by a local planning officer, typically the head of planning services.

underlying structures and drivers that influence those decisions; and, the beliefs, assumptions and knowledge brought to bear in making them.

The process by which planning committees make decisions is complicated. Simply put, planning officers have a responsibility to their respective Council to exercise professional judgement in making a recommendation on planning applications, which they then provide to the members serving on the planning committee in the form of an "Officer's Report". This report is then factored into the judgement of the Committee, who are capable of determining planning applications as they see fit, including deviating from the recommendations of the planning officer. Both planning officers and councillors are obliged to make their decisions within the extant adopted policy and legal framework.

Several planners observed that when researchers and other disciplinary professionals consider and analyse urban planning, too much focus is placed on the post-determination stage (that is, after decisions about policies or applications have been made). More attention needs to be directed towards the decision-making process itself, with a Planning Policy Officer pointedly remarking, '…people's health is influenced as much by the decisions we make as by the actual physical development. Developers only build what we give them permission to build' (PO1).

Within the legislative and policy requirements of decision-making, it was suggested that there is much room for flexibility and discretion in both formulating statutory development plans and determining planning applications. Participants described multiple factors that influence how decisions are made. The two which appeared to be considered to be of most consequence were: (1) politics and (2) knowledge and understanding.

Politics, politics, politics

Urban planning has been perceived as being both technical and inherently political (Masser 1983). It is political (in its broadest sense) inasmuch as it involves choices about the use of land that inevitably produce winners and losers. Local urban planning is also seen as being political because in order for statutory development plans to be prepared and implemented, and for planning applications to be determined, some governance is required; and, this governance takes place in a highly politicised environment (Levy 2018). Alongside the need for on-going partnership between planners and health professionals, participants viewed political commitment as critical to the success of achieving health objectives through urban planning. Existing research has revealed that the inclusion of priorities for health in urban planning and other corporate documents does not always guarantee that health outcomes will be fully considered in development decisions (Carmichael et al. 2013).

One of the determining factors that can ensure health issues are integrated and given priority in urban planning is political; specifically, in the context of the working of the local politics, whether the members of a planning committee are committed to and prioritise health above or equal to other considerations – such as economic considerations, including employment and council revenue generation. As a Senior Health Professional put it,

> 'Part of it is to do with educating members about health, but another part is to do with influencing them. It's about getting the local councillors and members on-board. Ultimately, you can have all the policies and supporting evidence you need, but it may well be that certain elected councillors might still not be on-board. Yes, having policies in place is important – but political buy-in is far more important. If you have the members onside you can make a difference; but if you don't then they may have other priorities, and it is those priorities that really matter – they shape the Council's

decisions on applications and how the built environment develops around us.' (PO21)

Planning was widely understood to have a political dimension, and there was a view that both planners and health professionals need to build the support for health within local politics – if not, work in partnership with councillors to ensure that health is afforded a high priority or the same parity as other dimensions (as already suggested above). Here, one of the participants suggested that the efforts of LPAs in preparing LDPs are not always rewarded because the personal preference of the decision-makers (specifically planning committee members) and politics can get in the way:

'Whether the health impacts of a development proposal are addressed will depend on political factors in addition to policies. We can write the policies and provide officer's recommendations, but the final decision comes down to the members. Many a time we'll end up with a decision that has obviously been made by the members based on their own political interests and values – rather than on the merits of the scheme in front of them.' (R31)

The influences on decision-making in planning were variously described and explained, but it was clear that (as alluded to above) urban planning was felt not to operate in a political vacuum. It was seen as being part of wider political machinations, wherein the policies and processes that planners follow are manufactured by state agencies (who have their own political ideology) and predetermined for them or imposed upon them in a top-down fashion. Several planners followed this line of thought, suggesting that wider external politics impacts on how issues are integrated and computed by planners (and decision-takers) in their work. But to a large extent what participants (including health professionals) appeared to feel was particularly pertinent to the consideration of health in urban planning was 'internal politics' (PO16), or the micro-politics of the immediate decision-making context.

Internal politics was generally described as relating to the beliefs, values and principles of those involved in urban planning. Such politics were viewed as being both internal to each individual and internal to each LPA, or each planning committee. Here, it was explained that power struggles often emerge between and among planners and decision-makers (who can also be planners) over the meaning, responsibility and how to best deal with issues that arise during the planning process.

To 'get health into the planning agenda', as one planner explained, there is a need to be aware and understand what local politics and elected members think is important. In other words, 'what their prioritisation is' when it comes to making decisions (R31). Irrespective of their "internal politics", one Planning Policy Officer explained that planners, committee members and other decision-makers are duty-bound to contribute to delivering sustainable development[83]. They were, however, quick to point out that it would be naïve to assume that local politics actively promotes sustainable development, that it underpins its activities, and that it recognises the link between sustainability and health (PO1).

An interesting case was given by one planner (PO12) regarding the construction and operation of a large, international fast-food chain outlet near a school in their local area. Although recommended for approval by the assessing planning officer, as it was said there were no technical or planning grounds on which to recommend refusal, the impact on the Council's priority to promote healthy lifestyles (including healthy eating) had raised much concern among consultees and members of the public. While promoting healthy lifestyles was a priority of the Council, the respondent suggested that health had been automatically dismissed as a valid or material reason for refusing the application by members of the planning committee. Here, it was

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[83] Here, the participant was specifically referring to the provisions of the NPPF (2012) concerning sustainable development. The author was directed to paragraph 6 which states that the '…purpose of the planning is to contribute to the achievement of sustainable development', and paragraph 186 on decision-taking which reads 'Local planning authorities should approach decision-taking in a positive way to foster the delivery of sustainable development…'.

felt that health implications of this proposal had come into competition with and been outweighed by economic issues (especially job creation) that the members more readily identified with. In summarising the participant's argument, the members of the planning committee had issued a political statement, not a proper planning determination, and found an answer to the issue of the proposal that was more synchronous with their own preferences and value systems.

A final point raised by this participant, but also others, is that the political time horizons of incumbent councillors and members, which tend to be shorter than the working timescales of planners, may influence decision-making. 'Both the members and some of my colleagues lack the imagination and the skill to picture and understand the impact that development will have on communities now and in the future. They operate on too short a timescale!' (PO3). Several planners commented that they are trained to take a longer-term view on the impact of their work, whereas elected committee members (and also health professionals) take a much shorter-term view. Short political time frames were thus also identified as having the potential to constrain the possibility of achieving longer-term health and sustainability outcomes.

Knowledge, understanding and interpretation

Earlier in this thesis (Chapter Seven), the definitions and views attached to the concept of health by the participants were discussed in detail. This highlighted that, inter alia, while differences exist between planners and health professionals, participants collectively provided many and varying definitions of health, some focusing predominantly on psychological and physiological aspects, and others more on the social functioning of individuals. The question of "the meaning of health" spawned a wide variety of responses, as well as much discussion between the author and the interviewees. Underlying the many answers to this question was a central theme: that the subject knowledge of decision-makers is important, but what is equally if not more

important is individuals' conceptual understanding and interpretation of concepts themselves.

The ideas of knowledge, understanding and interpretation have been debated in academic circles (see, e.g., Perkins 1993 and Bolisani & Bratianu 2018). Without delving too far into this conversation it remains convenient to establish what these variables mean in the context of this immediate discussion, although this will be done in order and as part of the proceeding analysis.

The notion of "knowledge" has been variously described and lies at the centre of much epistemological and ontological discourse (Pernecky 2016). It usually refers to one or several aspects, notably facts and information and/or people's intellectual awareness, comprehension or familiarity with something. An individual's "subject knowledge" thus encompasses their theoretical background concerning a subject (Bolisani & Bratianu 2018). Planners and health professionals alike noted that as a general trend there is a deficiency in knowledge about the relation and interaction between urban planning and health. Knowledge of this kind was suggested as being missing among the general population, but perhaps more pressingly among those directly involved in urban planning. "Missing" knowledge was observed as being a major barrier to better integration of health within urban planning. Here, two main explanations were postulated as to the primary aspects of knowledge that were lacking and the consequence of insufficient consideration of health in the planning process.

Firstly, it was proposed that a genuine lack of knowledge about what health is in terms of its determinants leads to the omission of health from the planning process. 'Without knowledge of something… people are uncomfortable about engaging with it, so they'll often choose to ignore it – rather than risk making a mistake', commented a health professional (PO12). Interestingly, although perhaps not so unsurprisingly, this accusation of ignorance regarding health was most frequently levelled by health professionals at planners. It was felt that while perception as to what is "good and bad" for health was developing

in LPAs, planning as a discipline does not have sufficient theoretical grounding in health to fully engage with and integrate it into their work.

This was explicitly acknowledged by a number of planners, with many stating that knowledge of health in planning (and among key stakeholders, especially elected planning committee members) was incomplete and in need of strengthening. Several participants explained that if any idea or concept is to be promoted through the planning process, knowledge of it is essential. Without prior theoretical knowledge of or comprehension about a concept it was considered unlikely that an effective assessment of the current situation could be performed, a plan of action prescribed, and a plan for ensuring the implementation of actions formulated.

Secondly, planners were keen to stress that there is a general lack of knowledge in society about urban planning. Planners directed this criticism towards the public but also (again) towards key stakeholders of the planning process, including planning committee members and health professionals. Health professionals, for instance, were perceived as lacking knowledge of how consultation and statutory assessment processes (such as EIA or SA/SEA) are undertaken in urban planning. This was viewed as being an additional barrier to HUP, as it was within the context of consultation and assessment that health professionals were considered, by planners, to have the potential to make an especially valuable contribution. Inadequate or underdeveloped knowledge regarding the functionality of urban planning, especially that relating to its "limitations" (i.e., what it can and cannot do), combined with incomplete knowledge of health, was thought to lead to an exclusive focus on the negative impacts of urban planning and spatial development on health, preventing more balanced consideration of both the negative and the salutogenic (health promoting) potential of these activities.

An additional, second dimension of this central theme was understanding and interpretation. Understanding and interpretation are recognised as being intertwined with, yet of a different order to, knowledge. The difference between our knowledge of something – be it a concept, object or process – and our

understanding and interpretation of it is a highly nuanced and subtle affair. However, there is an important distinction to be made. An explanation is provided by Perkins (1993), who explained that understanding is an active process – one that requires connecting facts and relating emergent information to what is known, and weaving elements of knowledge into a cohesive, integrated whole. Put more directly, understanding concerns not only the acquisition of knowledge but how that knowledge is applied.

"It's not just what we know; it's how we do it" paraphrases a sentiment heard in various forms from many of the interviewees. How concepts and terms are understood and how they are interpreted was viewed as being a critical to the dynamic process in which stakeholders plan for or promote particular aims and objectives through urban planning. Participants did, however, identify a common tension in urban planning between knowledge and understanding (and interpretation), or between knowing and doing. Several aspects of this tension were discussed during the interviews, with the concept of sustainable development being commonly used as an illustrative example. Planners repeatedly noted that the planning system has an obligation towards contributing to the achievement of sustainable development; as set out in paragraph 6 of the NPPF (2012). This policy requirement was described as creating much division among and between planners and other stakeholders. At the heart of this tension, and as suggested by the participants, are conflicting ideas about how sustainable development should be understood, and how its principles should be interpreted and applied in practice.

A number of planners explained that many individuals that they work with adopt a broad, holistic understanding of sustainable development; one that encompasses economic, environmental and social dimensions. Despite this (or maybe because of it), this broad conception was said to lead to difficulties in agreeing exactly what "sustainable development" means. This situation was further complicated by how broadly sustainable development is defined in the NPPF, and the uncertainty as to what is needed to deliver this aim. A planner commented that this was because the NPPF's content on sustainable

development reads more like a set of aspirations rather than a set of objectively defined needs. Interpreting these aspirations in specific contexts was said to commonly lead to contested and uncertain outcomes. A chief reason for this was explained as being due to the way in which interpretation in urban planning occurs. While the NPPF may prescribe a requirement towards sustainable development, the "correct" interpretation of it is not a binary test (unlike "sustainable/not-sustainable") and requires a more nuanced consideration.

The interpretation of sustainable development is measured in terms of its consistency with the NPPF, but also how well it maps onto the referent of that expression. This "referent" (i.e., object of reference) is defined and influenced by many factors, objectives and interests. The correct understanding and interpretation of sustainable development is thus highly individualistic and difficult to determine. A negative outcome of this was described as being instances where individuals' reference point for sustainability is weighted towards economic objectives, meaning that despite having a broad understanding of sustainable development it remains common to see economic factors (notably, job creation) presented when the topic of the "sustainability" of a development proposal is examined. It was argued that in the absence of sufficient knowledge about sustainability (but the same was equally said of health), only a limited understanding and interpretation of it could be achieved.

9.4.2 Weighting and limitations apply

Playing the weighting game

Many planners analogised the process of planning to that of the idea of "balance". As one participant stated, 'the problem is that in planning everything always comes down to balancing one factor against another factor. People don't understand how much decisions and outcomes in planning hinge on the findings of the planning balance' (PO17). Most planners thought of the concept of the "planning balance" as being fundamental to the planning system. Put most simply, the planning balance comprises the determination of development applications by weighing against each other the merits and harms of the proposals with other material considerations (e.g., the proposals compliance with the adopted/emerging development plan) – but the principle also applies to the formulation of planning policies, whereby the impact (both singular and cumulative) of policies on, for example, particular sectors and groups of society needs to be weighed.

Balance was closely tied with the objective of sustainable development[84], and the presumption in favour of sustainable development as set out in paragraph 14 of the NPPF. Without the operation of the planning balance, i.e., the weighing of economic, environmental and social aspects, the objective of sustainable development was considered undeliverable.

It was suggested that in an ideal planning scenario, the stability – or equilibrium – between economic, environmental and social objectives and development is maintained. 'The Framework is quite clear on this point: none of the roles set out in paragraph 7 are supposed to predominate', said a planner (PO2). Planning is thus again seen as being about the pursuit of balance, and by implication, not about preference for permitting development

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[84] Here, reference was made to paragraph 6 and 7 of the NPPF – with the latter paragraph stating that sustainable development incorporates economic, environmental and social dimensions, which in turn give rise to the need for the planning system to perform a number of roles.

above other considerations; equally, it is not about preventing development purely because application proposals might conflict with sustainability objectives (although that conflict must be weighed as a factor in determining whether a development application should be permitted). This was put in somewhat different language by a planner who explained that,

> 'balance in planning is all about compromise and hammering out a deal whereby there is enough fat for all parties involved. The developer wants their pound of flesh, and we – as the council and members of the public – want our own pound of flesh.' (PO5)

This equilibrium was, however, described as being difficult to achieve in practice, and if achieved often likely disturbed by the overweighting of one consideration (need, want, or other goal) over another. Both inputs and outcomes of the planning balance are affected by the circumstances of each case taking into account relevant factors. The starting point for the balancing exercise is the development plan[85], with a LPA having to determine whether a development proposal complies or conflicts with the development plan when read as a whole. Alongside this, but not necessarily independent of it, a LPA must assess each individual proposal against other genuine planning considerations (i.e., "material considerations"). Material considerations can involve all the fundamental factors (social, economic, environmental, policy, etc.) involved in local urban planning. Where it is decided that a consideration is material to the determination of a development application, the assessment of weight to be given to that consideration is a matter of planning judgement.

It was palpable that within this "judgement" planners and health professionals clearly believed that certain considerations habitually attract more weight than others. Planners noted that decision-makers are likely to comprehend and identify with more quantifiable, tangible economic objectives than those framed by more intangible, less quantifiable, social considerations. Here, the

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[85] Section 38(6) of the Planning and Compulsory Purchase Act 2004 stipulates that a planning application should be determined in accordance with the development plan unless material considerations indicate otherwise.

feeling was that social factors are not afforded sufficient weighting in the planning balance:

> 'A fundamental issue [name removed], across the country, is that the push by the government for housing-led economic growth has created a situation wherein elements vital for… and the overall impact of development proposals on health are seen as less of a material consideration than the economics of a development proposal – for example, the viability of a project or any potential planning gains a planning authority can secure.' (PO1)

The likelihood of this weighting imbalance was considered to be further exaggerated in those instances where the "presumption in favour of sustainable development" (or the "titled balance") in paragraph 14 (bullet point 4) is engaged. Planners contended that the NPPF (when looked at as a whole) contains a general presumption in favour of sustainable development, although a new dimension to this presumption was described as arising if, and only if, the development plan is absent, silent or relevant policies are out-of-date (this could include, for example, housing policies being determined out-of-date where the planning authority is unable to demonstrate a robust five-year housing land supply – as required by paragraph 47 of the Framework). When engaged, the titled balance was thought to "tilt" the balance further in favour of approving development applications:

> 'The presumption in favour of development, because that's what it is: a developers' charter… states that permission should be granted unless any adverse impact of doing so would significantly and demonstrably outweigh the benefits of doing so. Not only does this bolster the strength of the developer's position, it also adds to the difficulty of the planning authority in demonstrating any harms that a proposal might have on factors other than economics – this includes health and wellbeing. The quality of the evidence demanded by the Planning Inspectorate to demonstrate harm goes up several notches.' (PO3)

This approach in favour of sustainable development as set out in paragraph 14 of the Framework was thought to reflect the desire of the central UK government to stimulate economic growth and reduce the bureaucracy – or "red tape" – associated with planning and development. Indeed, several planners made explicit mention to the commitment to economic growth included in paragraph 19[86] of the Framework. Overall, there was a sense that planners often have little regard for the non-economic impacts of development proposals when determining planning applications. If central government or any other party (including planners) is determined to see health objectives more robustly achieved, more weight needs to be placed on health considerations in planning decisions (including those relating to both policy preparation and application determination).

The limitations of planning

A further consideration pertains to what can be referred to as the "limitations of planning". Planners were often cognisant of the limitations of the practical urban planning process, and the associated consequences for HUP. Limitations in this context were identified by planners (but also some health professionals) to encompass a wide variety of aspects, including complexity and evidence-based decision-making; management and resources; and structural limitations. These limitations themselves encompass more detailed variables which overlap and interact with each other, meaning that they are as difficult to separate completely as to consider simultaneously. As discussed below, these limitations affect both the performance and the potential of achieving health goals through planning policies and practice.

A particular point raised by some planners referred to the complexity of health problems, and the contextual issues (social determinants of health and psychosocial aspects) that drive both the nature of the problem and the

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[86] The opening sentence of paragraph 19 of the NPPF states: 'The Government is committed to ensuring that the planning system does everything it can to support sustainable economic growth'.

solution required. The issue of obesity was frequently explored within this frame of reference, with one planner stating,

> 'We're regularly told, whether by the government or the media, that there's an urgent need to tackle obesity crisis in the country. And, as part of the wider mix of factors, planning is increasingly seen as an avenue through which to tackle obesity…but there are a number of problems with this. Firstly, we have the fact that obesity is incredibly complex…and, secondly, the information and evidence base to support decisions is missing.' (PO3)

The complexity of health problems also led to them being referred to as "wicked problems" (Rittel & Webber 1984). A number of planners acknowledged that complex or wicked problems, including those linked to sustainability and health, have not traditionally been effectively addressed by the planning system. Notwithstanding the inherent challenges posed by complex/wicked problems to understanding and to action (Khoo 2013), participants identified an additional evidential dimension to this problem space. Contributions from planners revealed that there was a general acceptance that urban planning cannot alone address health problems given their typical complexity, although there was a desire to strengthen the input of planning in the health promotion process. It was proposed that one way to do this is to develop the evidence base required to formulate and implement policies and strategies for health.

Evidence was felt to be held in high regard in urban planning (especially in development management) and was even described by one planner as being 'something of a king for planners' (R15). This sense of almost reverence about evidence was perhaps idiosyncratic of the evidence-based decision-making and analysis encouraged by national planning policy[87]. One Planning Policy

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[87] Here, participants directed the author to paragraph 158 of the NPPF, which sits under the heading of 'using a proportionate evidence base' and asks that 'each local planning authority should ensure that the Local Plan is based on adequate, up-to-date and relevant evidence about the economic, social, and environmental characteristics and prospects of the area'.

Officer (PO1), whose remit includes consideration of public health, pointed to the growing academic evidence for the social determinants of health and interventions for health promotion. This was said to include advocating a modal shift in transportation away from private car use towards walking and cycling, which can improve the physical health of populations; or providing green infrastructure and public open spaces for the purposes of boosting mental and social wellbeing.

At the same time, however, it was recognised that there is insufficient evidence for the effectiveness and effect of planning policies and decisions for promoting healthy communities and producing positive health outcomes. A lacuna of evidence to demonstrate, either directly or inferentially, the health effect of urban planning was thought to be a limitation, as it impacts on the proclivity of the planning system to tackle complex/wicked problems and for advocates to secure the necessary commitment and resources for achieving this. This view was neatly illustrated in participant's responses made regarding the implications of evidence for HUP, and planning practice more generally. The sentiment expressed towards strengthening the evidence-base to inform development of HUP contained an interesting perspective.

Planners, in contrast with most health professionals, indicated a general ambivalence vis-à-vis the value of evidence in terms of enriching knowledge and understanding of the links between health and urban planning. Rather, planners took a seemingly more pragmatic approach to evidence: valuing it not for its academic quality but for its political significance, and especially the implications of material (i.e., relevant and robust) evidence for decision-making. In the words of one (planning) survey respondent,

> 'Evidence is critical to informing and underpinning planning decisions. When you're asking planners "have you considered the health impact of that proposal?" or trying to make Inspectors at appeals and inquiries take into account softer social outcomes, you first need to ensure that you have evidence that is robust and that can be defended through the judicial planning system. A big

part of planning is being specific in your polices about what you want to achieve, but a bigger part is having the evidence behind your policies so that you deliver them and defend any decisions based on them!' (RO3) (emphasis in original)

Demonstrating the relationship and effect of planning decisions (broadly defined) on health is considered an essential part of HUP advancement. Planners spoke about the need to build the evidence-base on health as arising from the push towards more scientific and less ideological policy- and decision-making in urban planning. The potential of evidence to help achieve social goals (including health goals) has seen an enormous increase in interest in recent years (see, Parkhurst 2017 and Parkhurst et al. 2018). This notion of evidence being an "agent of social change" was reflected in participants' comments that material evidence can help decision-makers make informed decisions. Several planners hypothesised that evidence has a distinctly political function – or "political power" – to play in planning inasmuch as it influences opinions and intentions of those concerned, increasing the likelihood that those responsible for decision-making will produce desired decisions (even where these decisions are at odds with their beliefs, although this viewpoint has been contested elsewhere (see, Baekgaard et al. 2017).

Notwithstanding issues associated with who decides what counts as "good" or "credible" evidence, several planners attributed the situation with regards to evidence as being a consequence of the inadequate partnership and collaboration between health professionals and planners. The health sector in this respect was viewed as being a repository of information and knowledge, and through effective collaborative-working with urban planning, could act as a source of information for planners. Alongside this, another primary reason given for the deficiencies in evidence in urban planning was the perceived neglect and shortcomings of monitoring systems in urban planning.

Monitoring has long been considered to have an important function in the operation of the planning system (Ratcliffe 1981). Following the preparation and adoption of the Local Plan, many participants (mainly planners) felt that it was good practice, and essential to the ongoing improvement of policy-making, to consciously scrutinize the way in which it is working. This *monitoring* exercise reviews the performance of the Local Plan regarding its effectiveness and efficiency and includes evaluating the extent of the implementation and/or impact of different planning policies (either individually or as a policy package).

To manage the implementation of planning policies over time, it was thought to be crucial that a LPA has in place an effective monitoring system. Some planners noted that the main monitoring mechanism used by their LPA was the compilation of an Authority Monitoring Report (AMR)[88]. The AMR was described as setting out a LPA's monitoring strategy in relation to the Local Plan, providing an assessment of the extent to which policies set out in the plan are being achieved, and highlighting the progress made with (if relevant) the emerging Local Plan timetable amongst other matters. Others stated that their LPA produced this legislatively required information but published it in several documents and not as a single report.

Whatever the chosen mechanism for monitoring, all planners readily acknowledged that, while having planning policies aimed at health outcomes is required, how "health policies" are to be implemented and how the effective monitoring of health outcomes should be achieved is unclear. This is despite the planning system imposing an expectation on a LPA to ensure that their policies are deliverable and viable throughout the entirety of the relevant plan

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[88] LPAs are required to publish information annually that sets out, inter alia, the progress with their Local Plan preparation, reports on activities relating to the duty to cooperate, and describes how the implementation of policies in the Local Plan is progressing (as required by Regulation 34 in the Town and Country Planning (Local Planning) (England) Regulations 2012). Under the Planning and Compulsory Act 2004, LPAs were required to submit an annual report to the Secretary of State that contained the aforementioned information; however, this requirement was amended by the Localism Act 2011 (section 113) which allowed LPAs to publish an Authority Monitoring Report (AMR) (formally the Annual Monitoring Report) annually rather than on a fixed date, and also gave them the flexibility to publish a number of component documents as and when information becomes available, which together make up the AMR, as opposed to a single report. The LPA must make the AMR available to the public.

period, and the statutory requirement for LDPs to include a framework for monitoring the implementation of policies. Notwithstanding the latter, a review of Local Plans by Tewdwr-Jones (2012) revealed that most LPAs identify generic indicators for monitoring and evaluating the health effects of urban planning policies. The use of generic proxy measures for health – such as mortality rates, obesity, cancer rates, among others – although valuable in appraising general population health, cannot guarantee that what is being measured is the health outcomes of planning policies; nor are the results obtained from using these indicators an appropriate methodological basis for a direct measure of successful policies.

The use of indicators not felicitous for quantifying (or qualitatively describing) the health effects of planning policies, was actively interpreted by planners (and some health professionals) as being a limitation of the monitoring process in urban planning. One planner, for example, observed that monitoring is 'broadly accepted' as important in the planning profession, but that it is 'often neglected and limited in practice' (R37) (see, Wong and Watkins (2008) for an overview of the problems of measuring the outcomes of the planning system in England). Wider concerns were also expressed that inadequate monitoring of planning policies was leading to problems with implementation, and that health policies were being "properly" applied in practice.

Many of the complexities and difficulties with measuring urban planning outcomes discussed by the participants largely reflected those identified elsewhere in literature (Wong & Watkins 2008; Wong & Watkins 2009; Rae & Wong 2012). These included the lack of precision surrounding and the normative complexities associated with defining urban planning objectives and the contextuality (geographical, institutional, political context) of measuring and interpreting outcomes. There was also the practical complexity of developing reliable and robust indicators for and the time- and resource-intensive nature of collecting data (especially longitudinal data on) health outcomes at geographical scales to evaluate policy-led health outcomes in action. The overall quality of monitoring was thus considered a concern and limiting factor

in the obtainment of evidence to support the development of planning policies and planning-led strategies aimed at health outcomes.

In keeping with the pragmatic nature of planners' attitudes to evidence, difficulty in monitoring health outcomes was not viewed as a categorical reason not to promote the health-benefitting properties of urban planning nor deter the production of health-related planning policies. Planners, moreover, considered that it may be helpful for LPAs to better involve other stakeholders in the creation of monitoring systems, this being achieved through collaborative-working by different parts of the local authority. As also emerged from the dialogue on monitoring, as well as the wider participants' discourse, was a sense of common experience among participants that pointed to a deeper and more fundamental reality, with implications for achieving health objectives through the planning system: that is, the ability of the planning system to play a visible and active role in health promotion is limited.

The organisation and legal/policy architecture of the planning system was expounded as establishing structural limitations as to how urban planning can engage with, and support, development of healthy communities. A Senior Planning Officer said,

> 'The planning system can make a useful contribution to building sustainable places and improving local communities' health and wellbeing, but the scope of that contribution… and the scope for getting more from planning is limited by the processes and mechanics of how planning works.' (PO12)

There was a call by several planners for a "reality check" on academic, institutional and political expectations of the planning system. This regarding sustainable development, social justice, health and health inequalities, and other normative goals. Participants, albeit mainly planners, provided multiple hypotheses and reasons to explain the structural limitations organisational and legislation/policy places on efforts to promote health outcomes in urban planning. Many planners felt that because the role of the planning system is to

regulate land use it is limited in its ability to deal with the spatial distribution and concentration of environmental factors that affect health. The planning system was commented upon as regulating land use via the granting or refusal of planning permission, and was thought to be limited as to how it can regulate the quality of and enforce how the spaces in the urban and built environment are occupied and used.

Urban planning is an instrument designed to direct spatial development in such a way as to achieve certain land-use and other goals. In regulating spatial development, however, current legislation and policy does not afford planners total control to dictate how and where development should happen. Or, as put by one planner: 'planning is about regulation, not control' (RO9). Planners repeatedly emphasised that there was a need among researchers, politicians and other local authority agencies to recognise and understand that LPAs are largely dependent upon the private sector to implement their policies. The LPA was described as being but one player among many others involved in the development process, resulting in the LPA, as a regulatory authority, potentially having less influence than other actors who generate actual physical change within the built environment.

The role of the planning system in promoting healthy eating was cited as a classic illustrative example of the limitations of planning system. There has been, as previously discussed in this thesis, much recent debate about the function of the planning system in tackling diet-related health problems (notably, obesity), and the use of food-sensitive planning in creating environments that cultivate healthy eating habits through providing access to nutritious and affordable food types. A key aim of the strategy to develop healthy food environments is to manage both the creation and proliferation of fast-food restaurants in towns and cities (NHS London 2013).

The most common initiative mentioned by participants involved targeting the availability and access to fast-food outlets by curtailing the quantity of A5 use class (hot food takeaways) premises in an area. This includes those either created through new development or through the change of use (class) of

existing premises. Despite the support expressed by many participants with regard to this initiative, urban planning's role in this area was contended to be limited in two main ways. Firstly, the planning system is considered simultaneously forward-looking and reactive in how it deals with applications for A5 use class development. It is forward-looking in the sense that LPAs can have in place specific policies or policy documents[89] aimed at "healthy eating" that are prepared for the future, yet it can only apply policies as a reaction to development proposals being brought forward by other parties (and those policies are only typically revised as new information invalidates them).

The planning system's ability to address the health impact of fast food is thus predominantly focused on controlling the development of new fast food restaurants. However, the corollary to the reactionary nature of the planning system is that LPAs capacity to address health problems associated with existing fast food restaurants is reduced. Planning cannot, therefore, effectively restrict access to extant unhealthy food sources, other than, for example, by taking enforcement action against proprietors for the unauthorised use of their business premises (for example, if a premise sells/serves alcohol when it does not have a A4 (drinking establishment) use class licence). Other issues included the fact that there is no legal or policy definition of what constitutes an unhealthy or healthy restaurant, and that efforts to remove a fast food premises from a locality could result in them being replaced by an even more unhealthy food source.

Indeed, a health professional gave a real example of where they believed that this "unhealthy transition" had occurred. The shift towards healthy eating actively promoted by their local authority had, they said, resulted in demand for fast food declining in certain areas. Because of this, it was perceived that a

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[89] A number of local authorities across England have prepared and adopted specific policy documents aimed at controlling and regulating the development of A5 class uses (hot food takeaways). These documents typically take the form of a 'Hot Food Takeaway Supplementary Planning Document'. Supplementary planning documents are intended to build upon and provide more detailed guidance about policies contained in the Local Plan. Although not legally part of the Local Plan itself, they are material considerations in the determination of planning applications.

number of fast food outlets had closed and/or been replaced by other types of food establishments[90]. Where there had once been fast food outlets selling both unhealthy and healthy food (however defined), there is now a growing variety of A3 use classes (cafés and restaurants) which specialise exclusively in sale of patisseries and confectionary – food types commonly accepted to be generally energy dense, sugar rich foods. Such establishments were appraised as having a role congruent with that of traditional fast food outlets/hot food takeaways in promoting unhealthy eating and contributing to dietary-related illnesses (especially obesity and diabetes).

Planners regularly pointed out that the planning system is not designed to deal with the detail of how individual businesses operate, but rather with how land is used (something which many planners said health professionals lacked understanding of). The proactivity of urban planning is further limited in this respect as a LPA cannot unilaterally control the foods and menus provided to customers within premises if they are legally compliant. In the absence of any legal/policy definition of unhealthy food, it is difficult (if not impossible) for planners to prevent, for example, a fast food establishment selling what many would recognise as food that is not health promoting. Accordingly, both planners and health professionals acknowledged that the actions and efforts of urban planning, whether about dietary or other health problems, need to be deployed as part of a wider strategic response. This includes working with developers, designers and others involved in the development of the urban and built environment, and the combined use of public health interventions and other regulatory controls (such as licensing systems which are directly

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[90] Planning permission is not always needed when the existing and proposed use for a building/premise fall within the same 'use class'. Or, if the Town and Country Planning (General Permitted Development) (England) Order (as amended) states that a change of use is permitted to another 'use class'. For example, at the time of writing, a hot food takeaway (A5) could be changed to a shop (A1), professional and financial service (A2), or restaurant and café (A3) without having to secure traditional planning permission as this would constitute permitted changes of use.

concerned with how certain spaces and structures within the built environment (including buildings and businesses) are used and operated).

9.5 Chapter summary

This chapter was the third and final of three chapters which together present the empirical findings of this study and had the purpose of identifying the factors that serve as barriers and opportunities to the application of HUP in urban planning practice. Identification of these "factors" was derived from the data generated from in-depth, semi-structured interviews and surveys. The set of factors examined in this chapter is therefore not exhaustive, but is reflective of the experiences, views and attitudes of the participants who partook in this research.

As way of a referential anchor, or starting point, for the analysis and exploration of these factors, the chapter began with a discussion of participant's thoughts and perceptions regarding the effectiveness and effect of urban planning on health outcomes. This revealed a common (but not universal) perception that the "effectiveness and effect" of urban planning is highly variable and inconsistent, and that the integration of health within planning practice has not yet reached its potential. It also showed that in many instances empirical evidence to substantiate participant's responses was missing, that responses were often founded on tacit knowledge and anecdotal evidence, and that combination of paucity of robust evidence and a lack of clarity as to what the goal of HUP is (and what is expected of LPAs to achieve this goal) creates difficulties and tensions in achieving it.

The scope of the task for the planning system in respect to health was considered by participants to be essential yet inescapably problematic. A fundamental characteristic of HUP, and from which "problems" derive in part, is that its success is contingent upon multiple factors. Some of the factors identified by participants were internal, closely connected to institutional, regulatory, policy and procedural dimensions. This included communication and information exchange between planners and health professionals, which contributes to the wider dynamic of collaborative working between health and planning agencies; also, the actors (including their norms, issues, influences

and power) and process of decision-making which can impact the extent to which health is integrated into decisions and actions performed by LPAs. Other factors included those which are external, connected to actors, regulations, processes and structural dimensions outside the immediate local planning setting. This included the influence of legislation, national planning policy and the function of central government in directing the organisation and operation of the planning system. Overall, participants contended that urban planning cannot be divorced from the institutional and structural context within which it occurs, nor should it be explored, or academic and political expectations of urban planning be formed without recognition of the conditions, restriction and limitations imposed by this context space.

Part V:
Conclusions and
recommendations

10. Conclusions and recommendations

This closing chapter of the thesis provides a final discussion on the empirical findings of the study, alongside setting out the conclusions and recommendations of the investigation. It begins by rehearsing the subject matter and observations upon which this work is based, including returning to the research questions that this study sought to answer. It then recapitulates and theorises the main themes related to the definition and application of healthy urban planning (HUP); particularly those that together provide a conceptual level of understanding of the process of HUP application and serve as a framework for analysing the integration of health into the local urban planning process. Finally, it considers the practical implications of the study and proposes avenues for future research.

10.1 Introduction

Urban planning is a constantly evolving field of practice and study. New developments in theory, legislation and policy continually create new and revised expectations as to its function and purpose. While its antecedents may be traced deep into the past, it was not until the beginning of the 20th century that urban planning became widely accepted as a mechanism for managing and regulating land use. Spurring this development was the 18th century Public Health Movement, in which social reformers and policy-makers placed health at the centre of a political and philosophical public discourse (Freestone & Wheeler 2015). The determinants and notion of health became a central question. This question was posed not only internally, however; even as the infrastructure of towns and cities became improved, and knowledge of health advanced, machinations on the theme of the "healthy city" emerged as urban

planning in England took on a more systematic form and the introduction of legislation helped legitimise its decisions.

Throughout the long history of urban planning, there has been a constant concern for population health (Porter 1999; Barton 2017) . The position of health within urban planning has, however, been challenged by reform and transformation over recent decades, whereby the planning system has trended toward the "new normal" of supporting economic growth and other non-social agendas (Corburn 2010). More recently, however, a countertrend has set in. Because urban planning shapes the urban and built environment through setting out policies and strategies for development across defined areas, it directly influences the distribution and consumption of resources. Urban planning, by inference, influences how people experience place, how they interact with it, and how they are in themselves affected by the places they live and work in (Duhl 1986; Barton 2015). Such observations are significant for a number of reasons, however it is particularly important because health is widely understood to be determined by multiple "wider" and "spatial" determinants (Smit et al. 2016; Wilkinson & Marmot 2003).

A "new" trend that has emerged in recent years – encouraged by academics and institutions alike – which advances the view that urban planning is crucial both as an element in the shift towards more sustainable patterns of development and as an instrument of population health improvement. One concept frequently now used to articulate this view is that of "healthy urban planning" (HUP). This concept is inhabited by a human-centric philosophy which emphases health and wellbeing (Duhl & Sanchez 1999; Barton & Tsourou 2000; Barton 2017). Taking this as its point of departure, this research project investigated the intersection between health and urban planning. The purpose of this work was to help inform the future advancement of the concept of HUP by developing a further theorisation of it.

Explored through a social constructivist, postmodernist lens, mobilised through a multi-site qualitative case study, this research sought to identify those tangible (e.g., public policy) and intangible factors (e.g., norms,

knowledge systems, values, cultures, and institutions) that affect the integration of health within urban planning in England. The theoretical underpinnings and findings of this research process have been discussed at length in the preceding chapters. Here, in this final chapter, attention is drawn to the main themes and perspectives that emerged from the research, as well as any pragmatic and future research implications.

10.2   Research questions revisited

This section of the chapter revisits the research questions introduced in Chapter Six (Section 6.2). In doing so, it demonstrates what the main findings of this thesis are that resulted from answering these research questions. The first addressed principal research question was the following:

1.   What is the stakeholders' approach to healthy urban planning?

The first principal research question was directed at exploring the stakeholders' approach to HUP. The notion of the "approach" was used as a collective term for stakeholders' knowledge, understanding, attitude and perception of HUP. Exploration of the stakeholders' approach provided insight into how participants conceptualise and assess the theory-practice nexus of HUP. The findings demonstrate that planners and health professionals are generally supportive of the idea that one of the goals of urban planning should or is to protect and improve population health.

Despite agreement on urban planning having a "health goal", consensus among participants extended to only the vaguest generalities when it came to more specific propositions about HUP. There was a pluralism in the interpretation of the many elements of HUP, both in terms of its conceptual foundations (e.g., the definition of health) and in terms of practical function (e.g., the role and scope of urban planning in improving population health outcomes). Looking at HUP through the lens of the stakeholders' approach exposes its meaning and application to be fractured and splintered, revealing that it becomes increasingly less coherent as a concept the more its various dimensions are interrogated.

## 2.	How is health embedded within planning policy?

The second principal research question was directed as uncovering the health content of selected national planning policy and guidance documents, and local planning policy. The notion of "health content" related to how the concept of health is defined and considered within the selected documents, and, where relevant, how policies and proposals relating to health are articulated and what health-related expectations they establish for a LPA.

The first part of the review focused on the national level. It revealed that through the introduction of health as a dimension of the planning system's "social role" towards achieving sustainable development, the NPPF has (to some extent at least) corrected a shortcoming in national planning policy in respect to the relatively limited scope of its consideration in the previous regime of PPSs/PPGs. Nevertheless, misgivings about the perceived political nature of the NPPF, its emphasis on economic growth and housing development, and the inclusion of a "presumption in favour of sustainable development" were raised by multiple participants. In particular, this latter factor coupled with the vague and confusing (if not contradictory) nature of the NPPF, especially in terms of health, was considered by several participants to be a limiting factor on the delivery of health through local urban planning.

The second part of the review focused on planning policy at the local level, reviewing LDPs (Core Strategies and Local Plans) from selected case English LPAs. Here, the review examined how the concept of health is defined and articulated within LDPs; focusing particularly on the vision statement and subsequent objectives, principles or priorities contained in the respective LDPs. Whether the reviewed LDPs contain formal health policies was also examined. Overall, the review uncovered that in only a few instances did LDPs provide a definition and/or reference to the meaning of health. It also found that health is handled and treated in LDP policies in a variety of different ways, with not all plans containing policies exclusively focused on health.

However, there is no evidence to suggest that policies structured around sustainable development, if applied successfully, would not be capable of securing positive population health outcomes. Finally, that there was such a variance in the inclusion of health in LDPs supports the notion that framework of national planning policy in England affords LPAs considerable scope in terms of how they integrate health into their plans and policies, as well as the idea that because some authorities perform impressively in terms of health, while others do poorly, suggests that "health integration" is heavily influenced by institutional and structural factors.

## 3.	What the barriers and opportunities to and stakeholders' experience of healthy urban planning?

The third principal research question focused on revealing the factors that stakeholders consider act as barriers and opportunities to the application of HUP in urban planning practice. As starting point in answering this question, the work examined what participant's thoughts and perceptions regarding the effectiveness and effect of urban planning on health outcomes were. This revealed a common (but not universal) perception that the "effectiveness and effect" of urban planning is highly variable and inconsistent, and that the integration of health within urban planning has not yet reached its potential. It also showed that in many instances empirical evidence to substantiate participant's responses was missing, that responses were often founded on tacit knowledge and anecdotal evidence, and that combination of paucity of robust evidence and a lack of clarity as to what the goal of HUP is (and what is expected of LPAs to achieve this goal) creates difficulties and tensions in achieving it.

The scope of the task for the planning system in respect to health was considered by participants to be essential yet inescapably problematic. A fundamental characteristic of HUP, and from which "problems" derive in part, is that its success is contingent upon multiple factors. Some of the factors

identified by participants were internal, closely connected to institutional, regulatory, policy and procedural dimensions. This included communication and information exchange between planners and health professionals, which contributes to the wider dynamic of collaborative working between health and planning agencies; also, the actors (including their norms, issues, influences and power) and process of decision-making which can impact the extent to which health is integrated into decisions and actions performed by LPAs.

Other factors included those which are external, connected to actors, regulations, processes and structural dimensions outside the immediate local planning setting. This included the influence of legislation, national planning policy and the function of central government in directing the organisation and operation of the planning system. Overall, it was ascertained that urban planning cannot be divorced from the institutional and structural context within which it occurs, nor should it be explored, or academic and political expectations concerning it be formed without recognition of the conditions, restriction and limitations imposed by this complex contextual space.

10.3   Emergent themes and perspectives

The preceding chapters have included detailed analysis of the primary and secondary data gathered as part of this study, as well as covering the literature that informed the research. From this, multiple themes connected to the pursuit of HUP were identified. This section aims to provide a cogent discussion of the pertinent themes and emergent perspectives that connect existing theory with this empirical research. These themes concern knowledge and conceptual understanding, functional identity and functional structure, and ethical, political and pragmatic intersections. Together, these comprise a framework for exploring, understanding, and reflecting upon the HUP concept.

10.3.1   Knowledge and conceptual understanding

The first theme focuses on the role and relationship between knowledge and conceptual understanding that specifies how the concept of health is perceived, comprehended, interpreted and used by those actors involved in urban planning. As a concept and term, "health" is useful but at times misleading. It reflects the marked tendency of people to conceive of human conditions and states as they might be, should or ought to be, and to question how they can be theorised in linguistic terms and be conceptualised to formulate an approach that captures their constituent elements and the events that engender them. Health is useful in that it presents a lexical referent for a "thing", allowing for other information to be stored and be about (Dolfman 1973). Growth in the discourse around HUP has been in part catalysed by the fact that the idea of "health" is common to a wide diversity of disciplinary and political interests. Thus, it provides a common referent around which these disciplines and interests can attempt to align, coordinate, or co-opt their varying agendas.

However, as the literature and empirical evidence analysed in this thesis attests, a crucial property of health is modality. Contrary to univocal terms, the

expression of health is not limited – either culturally or temporally – and modality allows it to express a vast range of thoughts and feelings (Dolfman 1973). Health is applied and understood in many ways, with its meaning being capable of being thought of as contextually dependent – and the dependence on the empirical and normative claims being made, or relied upon, by partisans of the term creates difficulties in distinguishing its proper usage (Simmons 1989; Frenk & Gómez-Dantés 2014; Adamson 2019). In this situation, it is fair to say that health is, or at least has the potential to be, misleading. Health is misleading, not merely because its general usage tends to crystalise dynamic normative and empirical frames of reference in a literary metaphor, but also because this metaphor provides a veneer for comprehension that can mask the underlying currents of conflict and understanding that affect its usage.

The combination of a nascent scholarship, the absence of definition in national planning policy, and a lack of genuine deliberation provides some explanation for why the meaning of health has to date been minimally represented in planning literature. Literature discussed throughout this thesis (mainly that in Chapter Four) reveals a primary focus on the knowledge of planners and other stakeholders with regards to health and urban planning. It has looked mainly at these actors' knowledge as it pertains to the determinants of health, the links between health and urban planning, and how health sits within the urban planning process. Conversely, their definition and understanding of health that is pragmatically applied in and to specific action-contexts, and which form the background of particular health or general urban planning actions, has been relatively unexplored. Where discussion of the meaning of health has been presented, such as in the *Routledge Handbook of Planning for Health and Well-being* (2015), this "meaning" has been largely discussed in abstraction from the practical sphere of urban planning, and with neglect of the polysemic contest as to its meaning.

There is an interesting debate that one could have regarding knowledge and conceptual understanding, and specifically the significance of the latter. Overall, previous studies have painted a complicated picture of planners'

knowledge and decision-makers priorities that ultimately questions whether their existing subject knowledge is sufficient to realise the aim and objectives of HUP The empirical findings of this study largely support the observations and conclusions made in earlier research, with "missing" knowledge being identified as a barrier to the integration of health within urban planning. Here, however, an additional argument is added based on the evidence in this investigation: although knowledge is improving, the gap between what planners know and what they are expected to know may be at risk of widening, and health-urban planning integration further frustrated, because the engagement of health often generates more questions than it answers.

One such question relates to actors' conceptual understanding of health. This research project was undertaken with an appreciation that health is both a dynamic concept and a dynamic term. It was known that health is used in many different phrases, for instance in the idiomatic expressions of healthcare services, health project, health planning, etc. Yet, what was not known, and what this research sought to investigate, was what meanings actors attribute to this term. Put simply, it questioned whether actors hold a particular notion of health, and if so, how do they define and explain it? Within which framework do they interpret it, and what do they do for it? To ask these questions, however, one must have recourse to those observations that challenge their utility as analytical tools. Firstly, there is the methodological position that disputes the merit of seeking to define or explore the definition of health. For some authors, such as Hesslow (1983), the definition of health is inconsequential for health activities. Secondly, there are those that argue that health is a human concept, the meaning of which is readily identifiable and intuitive. Barton and Tsourou (2000: 27), for example, observe that health, '…is something everyone understands intuitively and which everyone can identify; it is an inherently human concept'.

Taking these observations in reverse order, the empirical findings in this work revealed that health, as a singular concept, gives way to multiple meanings and whose comprehension and identification is far from intuitive. Participants

responses (paraphrased here) included "health is a vague concept" and "the definition of health is a key issue because it is flexible". These, and other, responses demonstrate that health is indeed an ambiguous concept, the meaning of which is not unified but open to much interpretation and debate – both within and between specific actor groups. Not all participants (particularly planners) were conscious of what condition or state the term health is a referent for, nor how this condition or state should be defined. Furthermore, a group of participants drew attention to the mechanistic quality of the definition and understanding of health in directing health actions (such as in preparing planning policies and monitoring the health outcomes of these).

This, in turn, brings us back to the former of the two identified observations. That health, as described in literature and evidenced by this research, has no universally agreed definition or authentic usage and this has led it to being described as a "contested concept" (Starfield 2004; Marinescu & Mitu 2016). While the absence of an agreed, consistent definition and interpretation of health led to accusations by a number of participants that this denigrates its purchase in policy-making and decision-taking, examples in literature illustrate that similar criticism has been targeted at the concept of sustainable development (see, Jacobs 1999).

Based on empirical evidence and published literature, however, this work rejects this conclusion. Instead, it contends that the concept of health is contested, valuable and not empty, and as a term enjoys a multiplicity of meaning. The meaning of health that actors apply has both theoretical and pragmatic value, as well as encompassing ethical and social implications. "Meaning" and the interpretation of this meaning is thought to guide thinking to help frame and understand the components and parameters of health issues and their solutions; but also, the assignment of responsibility for health and health promotion (Smith 1981; Boddington & Räisänen 2009).

The work presented in this thesis suggests that in the context of urban planning there is clear distinction between what *seems* to be a correct application of health and what *is* the correct use of the concept. If there is no

way of distinguishing between what *seems* correct and what *is* correct, then it stands that there will be no way to determine whether a specific use of health violates any actual standard of correct usage. National planning policy and current literature on "health and urban planning" sets out an aspiration for health, not an objectively defined standard that can be used to unambiguously dictate a course of action. A perspective that emerges from this is thus that, if health is understood as being a contested concept whose application is a normative affair, then the resulting evaluative standard for its correct usage is the essential novel thinking of what is the correct use of the concept when it is or was applied (Goldberg & Pessin 1997).

The study and practice of HUP must thus be conceived, constructed, and its politics evaluated through the lens of subject knowledge and conceptual understanding. This approach recognises the individual importance and intrinsic relationship between these two dimensions, yet simultaneously appreciates the nuanced distinction between and the potential for the latter to transpire apart, in conflict and/or without full recourse to the former.

10.3.2 Contextual determinants

Contemporary understanding of HUP often refers to it as a new paradigm. In the abstract, the objectives of this paradigm may seem clear enough, and as Duhl and Sanchez (1999: 2) state, HUP has two overlapping objectives: (1) ensuring the urban planning process does not harm health and (2) ensuring that the urban planning process promotes health. Stated this abstractly, however, these objectives have an unwitting capacity to veil a complex practical problem.

To recognise this problem, we need to return to the literature, and acknowledge that HUP is presented as a methodological precept, not a theorem. The formulation of this concept can be read as an effort to articulate a framework of motivations and responsibilities for urban planning, with these founded on human-centric principles and priorities for equality and

sustainability. It is an aspatial and atemporal concept, not equivalent to the rules and regulations of particular urban planning regimes and is conceived so as to be applicable regardless of regulatory or legislative context. This contextual independency is thought to enhance the facilitation of the adoption, representation and application of the HUP concept (Barton & Tsourou 2000; Barton et al. 2015).

The results from this and other studies suggest that the context-free space of the discourse around HUP is beneficial yet challenging. This partly due to the actuality that implementation is contextually dependent (Duhl & Sanchez 1999). In other words, the chain of actions and operations aimed at achieving *a* or *the* goal of HUP is conditioned by the current context situation. The form that this "situational context" can take is in itself conditioned and defined by spatial and temporal factors – including dominant and sub-dominant linguistic, normative, valuationary and expectationary perspectives. It is not surprising, then, that participants of this study understood the direction and elements of HUP in different ways. Beyond a consensus that health is or should be a goal of urban planning, for example, participants expressed different opinions on how health is to be articulated, appropriated and implemented in urban planning practice.

Following differences in whether health should be positioned as an explicit or underlying element of sustainable development, another differentiation became apparent in and through participant's assumptions about health and their instruction as to the role urban planning role and prospects for achieving their concept of health – with these considerations both consequential and interconnected, resulting in a position where (and building on the previous section) conflict is a logical outcome and constant in the discourse of HUP.

This problem is further complicated when the institutional and structural complexity of modern urban planning is taken into account. Urban planning is complex on several dimensions. It is a complex activity, it has a complex operational infrastructure, and the planner deals with complex, dynamic and uncertain problems (Christensen 1985, de Roo 2010). Finding root causes to

the problems they are presented with, and constructing correlating strategies and solutions that match the aspirations and expectations of relevant actors, demands that the planner be both attuned and have recourse to the macro- and micro-societal processes (e.g., government structures, regulations, legislation and national/local policies) and pluralistic social realities (e.g., norms, values, and beliefs) that have a decisive influence on the "planning project" (Healey 2010).

In this frame of reference, there is value in repeating what has already been outlined earlier in the thesis. The evidence from this study indicates that in many respects the pursuit of healthier forms of urban planning (whether framed as HUP or not) is essential yet inescapably problematic. What fundamentally characterises the activity of "planning for health" is that its success is contingent upon multiple factors. Participants in this study identified a number of these factors, which collectively add to and extend the existing list established in literature. The locus from which some of these factors originate is internal, closely connected to institutional, regulatory, policy and procedural dimensions. This included, for example, actors' own and collective perceptions, norms and values, their individual and institutional needs, definition of the "situation" (including its constituent elements – e.g., the meaning of health), and their agency and political power within the urban planning process. Communication and information exchange between planning and local health agencies also falls into this category, with this providing the collaboration dynamic experienced in urban planning between apposite groups.

Other factors included those which are external, connected to actors, regulations, processes and structural dimensions outside the immediate local urban planning setting. This included the influence of government, political views on urban planning, and national planning policy. Certain political configuration and ideology was observed, if not in these exact terms, to produce both the character of national policy on and the "proper" function of the planning system. The particular national ideological configuration

dominant in the discourse of urban planning more recently has been framed around a neoliberal agenda favouring the withdrawal of government from and minimal regulatory policy on urban planning, the establishment of incentives (punitive or otherwise) to deliver increased housing supply, and accelerated policy reform aimed at simplifying and democratising the planning system (see, Tewdwr-Jones 2012; Hodkinson et al. 2013). Thus, the resulting national policy product was viewed as having a utilitarian character, not rich or detailed enough to drive systematic inclusion of strongly normative, rather than merely technical, dimensions of issues into the urban planning process.

Here, from the complexity of the subjective and material world – complex because it affords so many, potentially infinite, configurations of thought and practice – articulations of HUP and efforts to integrate health into urban planning practice can be viewed as examples of "situated action" (Suchman 1987, 2007). Put differently, it is suggested by this and other research (e.g., Corburn 2010) that the subject matter and evaluation of urban planning cannot be divorced nor disconnected from the wider realities and context that it is embedded in, yet which can sometimes be viewed as being latent, as opposed to constant. The perspective this research develops further, in light of its empirical findings, is an emphasis on interrogating the individual idiosyncrasies and the direction of relationship, or possible endogeneity, between micro-institutional and normative dimensions of HUP. This interrogation of this particular dynamic should be combined with the evaluation of wider institutional and structural factors of HUP.

10.3.3 Ethical and practical intersections

The concept of HUP engenders a diverse collection of understandings and perspectives, which themselves extend across multiple factors, and are sometimes at variance with one another, and have an impact on interpretation and application. This diversity of conceptualisation offers considerable latitude in terms of what is deemed to be an authentic or legitimate example of HUP.

In the narrowest sense, and notwithstanding the broad aspirations for the concept set out in literature (see, Barton & Tsourou 2000), HUP can be recognised as being any planning-related activity linked to health. For example, the creation of policies aimed at promoting physical activity or healthy eating. Yet even in the medical model of health, human health is not identified exclusively with physiological functioning but includes psychological wellbeing. On this broader reading, any activity that contributes to promoting psychological health and reducing mental illness also counts as HUP.

However, seemingly influenced by the World Health Organization model, the emergent participants' conception of wellbeing has defined it not simply as the absence of mental illness, but "flourishing" (see, Ryff 2014). Wellbeing here is operationalised through such constructs such as "social wellbeing", which includes recourse to "optimal functioning" – including personal empowerment and opportunity. From this more encompassing perspective, HUP activities are those which improve any dimension of health, e.g., physiological wellbeing and personal functioning. Thus, a broad working definition of HUP, based on the findings of this research, is: activities which (a) promote physical health, and/or (b) alleviate mental illness, and/or (c) promote social wellbeing (including individual and community functioning, empowerment and opportunity).

Having acknowledged what might be considered a HUP approach to urban planning practice, but having rejected the idea of a singular approach, the next matter to attend to what regulates the application of this approach. HUP applies the principles of sustainability and social justice to assist in, if not wholly direct, decision-making about and within urban planning. Many of the decisions made on these grounds also delve into other key concepts, such as equality, community, progress, opportunity, choice, balance and power. Deciding on which development proposals to permit or how certain policies are to be formulated clearly involves not only practical considerations but also ethical questions. One of the most difficult examples is whether a local authority should permit development for economic purposes that could support

employment and thus empower individuals through financial resourcing to live healthy lifestyles, but which would ultimately harm the biophysical environment that supports wider population health. Another is whether to permit development which could harm the health of individuals living within or near the development yet would generate income for the local authority (e.g., through developer contributions) to deliver much needed health infrastructure to support wider population health.

The role of HUP in the urban planning discourse is to provide a context in which interactions and actions can take place on the basis of the principles set out above. As a consequence, the role of HUP is irreducibly ethical, it must envision the conditions within which the healthy society becomes possible. This envisionment is in itself an attempt to capture the thoughts about and specify all the possible states and the transitions of a system, characterised by both qualitative and quantitative state variables. To envision allows one's focus of attention to settle on a sequence of linked sets of eventualities. Envisionment as an emergent process schema is also an individual matter, and depends on the earlier experiences, opinions, and thoughts that the individual possesses. From a health perspective, envisionment is an emergent property because it involves individuals, consciously or not, making choices and claims about what it means for someone to be in a state of health, what is meant by health itself, and what epistemic criteria must be satisfied to make the former two claims (Adamson 2019).

It can be argued that the normativity immanent in HUP is not just ethical but political in nature, in that it involves choices about what is included and what is left out, whose interests and viewpoints are served and whose are not, which aspects of health are made problematic and which are taken for granted, and what assumptions are made about – whether spoken or unspoken – about the purposes of urban planning in a pluralistic society. Put differently, it is political because it comprises the possibility of creating "winners and losers" and involves actor relationships caught up in realties of influence and power (Levy 2018).

But an even further dimension can be added when it is recognised that decision-making in urban planning, which can involve multiple actors and agencies, is not only ethical and political but moral. According to Barton (2017), the planner's role as decision-maker is entwined with moral implication. When making decisions regarding development proposals or strategic planning, planners are said by Barton to have a moral obligation to, firstly, aim for representative equality of different actor's interests and goals, and, secondly, to work in partnership with, not against, dominant actor interests and goals so as to capture the power of these actors to deliver social ends.

The ethical and political structures, and even regulatory requirements of urban planning, demands that the planner operationalise the notion of "planning balance". Through the concept of balance, the planner can attempt to ensure the equanimity of the urban planning process through properly and effectively arranging, proportioning, regulating and equally considering competing interests and goals, and the weight to be given to any potential benefits and harms of particular proposals. Here, the subtext of the principle of providing outcomes that advance and protect pluralistic interests is analogous with sustainable development. Under the current system of legislation and national planning policy, the function of urban planning is unequivocally defined as "contributing to achievement of sustainable development". The "contribution" of urban planning has three complementary strands – economic, environmental and social – and these are not to be addressed in isolation or unilaterally, but as part of a holistic and comprehensive planning effort. This issue of achieving objectives in a harmonious way is not only a contemporary planning dilemma.

Many participants in this study recognised the very enterprise of urban planning to be overwhelming implicated in the logic of balance and imbalance. In 'Town and Country Planning' (1959), Abercrombie laid out the objectives of planning as 'beauty, health and convenience' (p.104). Such themes translate broadly into the ideologies of sustainable development, for which economic,

environmental and social categories are well known. The core of Abercrombie's argument on this matter is simple. There are necessary conditions that communities need to thrive and survive, the role of the planner is to deliver these conditions in a balanced way, and "the balance" is not an absolute balance, but a dynamic and temporal proposition. The "planning balance" therefore, by its very nature, requires willingness to be imperfect while striving for an ideal – be it health, sustainability, or otherwise. If we reverse the meaning of this perspective – such that imperfection implies making choices about things that are not "concrete" and not independent of ideological and political considerations – then it becomes apparent that the scope for using urban planning as a mechanism for health provision and disease prevention is (at least in theory) limited, since the legal and regulatory structure of the planning system confers a right and responsibility to ensure the proper protection and safeguarding of all individual and group rights and interests. This means more than that planners maintain and enforce planning law and policy, but the planners are, themselves, subject to rules of law and policy and cannot themselves disregard or remake the law or policy to suit particular goals or needs.

The subject of limitations has been covered in various detail in previous chapters. It is important to consider here how these come into play when applying the concept of HUP, as well as when evaluating such efforts. These limitations converge around issues of "ethical collision" and "pragmatic utility". Studies and texts have, to date, not tended to provide analysis or findings that provide insight into how stakeholders of urban the planning process understand health . This study sought to correct this shortcoming by exploring planners' and health professionals' approach to this matter. As previously discussed, this exploration revealed not only a variance of health meanings but also a diversity of expression in terms of the role of urban planning in population health. A conclusion to be drawn from this work is that the debate about the "health role" of planning is not conclusive nor reductive, as the choice between two or more categorial perspectives is not free from normative

judgement, since it implies that there are external criteria for prioritising one preference over another. Amidst the plurality of values and motivations, the ethical collision that can occur is when the values and motivations of planners or LPAs are dissonant with those expressed by individuals or communities, which will invariably encompass known but also novel values and motivations regarding their health.

What emerged from this work were the possible tensions between the lived experience of communities and the desire amongst the wider public health discourse to "empower" them in their own health through intervention in the urban and built environment. The need to regulate the health conditions of the urban and built environment was felt by some participants to have the propensity to obviate individual responsibility, as well as the individual themselves. Hence, the emergent requirement to limit urban planning was based on a pluralistic theory of the need for freedom and autonomy – and the associated plurality of meaning associated with health.

Freedom, in this context, can be perceived as having access to a wide range of diverse options through which individuals can express their diverse valuations. People require social and physical settings, governed by social norms recognised and endorsed by others, to create and express their different valuations. Because people conceive of and value health in different ways, freedom requires the availability of various social spheres that embody these different modes of valuation. Freedom thus requires multi-sphere differentiation: boundaries not just between the state and place, but between these institutions and other domains of self-expression, such as lifestyle, diet, physical activity, employment, etc., (Anderson 1993).

This position does not, nevertheless, negate the role of urban planning – in either its strategic forward role as well as in its regulatory function – to protect and promote health. Seeking positive health outcomes through urban planning was recognised by participants as having ethical merit, too. But to add to the complexity of the situation, participants alluded to the need to not only view

the task of planning for health through an ethical lens but also through the lens of pragmatic utility.

The pragmatic utility of HUP becomes evident when examined against the contextual and situational process of urban planning. Although this work did not investigate urban planning practice in great detail, it obtained data of this phenomenon through appealing to the experience of the study's participants. This revealed a consensus, supported by other authors (Carmichael et al. 2013), that the planning system in England enables planners to guide but not dictate spatial development. The processes of urban planning, moreover, do not operate in isolation from those of other agencies and external forces; rather, they are embedded and influenced by policy and practice shifts in the whole spatial development discourse. This includes market forces, meaning that planning is limited to what the market can, in its broadest sense, deliver (Rydin et al. 2012; Cullingworth et al. 2015).

Local authorities, in turn, are thus limited in what they can demand and achieve given that planning is only one key driver of the urban and built environment change process. Statutory processes, such as those of urban planning, work by intervening in an on-going, continual market-led process of land development. In this sense, the capacity and efficacy of urban planning to deliver healthy outcomes must be examined in this context. The implementation of urban planning policy relies on development projects coming forward and being approved which can then progressively move the shape of settlements towards more salutogenic, sustainable states.

This collectively leads to a perspective that acknowledges and deals with not only the material but also addresses the ethical and pragmatic intersections manifest in HUP. When researching and evaluating the integration of health into the urban planning process, there is a need to view it through the lenses of context and subtext so as to impart a deeper understanding of the unfolding narrative of theory and practice.

10.4 Recommendations for practice and research

This section builds on the findings in the previous three chapters, alongside the previously presented thematic framework, introducing a series of pragmatic recommendations and issues to be addressed in support of the development of healthy urban planning, and the wider pursuit of ensuring that health is effectively integrated into the local urban planning process. These recommendations and issues are distinguished below into those concerning practice and policy-making, and those concerning research and investigation.

10.4.1 Practice and policy-making

The following recommendations and issues are framed in accordance with the emergent issues from this research, namely: seeking greater clarity about the role of urban planning in health, cultivating a collaborative culture for health, building an evidence base for action, and adopting a Health in All Policies (HiAP) approach as a strategic tool for integrating health into the policies of all local government agencies.

Formulating greater clarity towards health in planning

The overarching objective of the English planning system is to contribute to the achievement of sustainable development; of which supporting strong, vibrant and healthy communities is an essential component. This is acknowledged in the National Planning Policy Framework 2012, as well as in previous national planning policy as expressed through Planning Policy Statements (PPSs) and Guidance Notes (PPGs), including PPS 1: Delivering Sustainable Development. The subject of "Health and Wellbeing" is also afforded its own distinct category in extant national planning practice

guidance. It is clear that not all aspects of national planning policy and associated practical guidance will have immediate relevance to health outcomes (e.g., brownfield land registers), but many will. In contrast with the older PPSs/PPGs, a number of aspects of current national policy and guidance have pronounced links to health (e.g., transport, open space, sports and recreation, and noise).

This identification of "linkage" is not consistent, however, with other health-associated aspects of policy/guidance (e.g., climate change, light pollution, renewable and local carbon energy, and water quality) failing to make this link. But this does not mean these aspects and/or categories of national policy and guidance do not promote policies and practices that will support health outcomes; rather, they are simply not formulated in such a way as to make the expression of a health dimension clearly evident. There is, however, a further complication to this. For those areas of national policy and guidance that do (and those that do not) recognise potential health implications, neither the respective policy nor guidance identifies what benefits or better outcomes should come to the health of individuals or communities.

National planning practice guidance on health and wellbeing is a good example of this. It establishes that there is a role for health and wellbeing in urban planning, specifies areas of specific focus (namely, creating a healthier food environment), sets out who the main health organisations are that planners should collaborate with, how health infrastructure should be considered in planning decision making, and very broadly defines what a healthy community is. This lays the basic foundations of a health role for urban planning, but it does not provide guidance or clarity on the standards and objectives necessary to realise this role.

Many of those who participated in this study held the view that the wording of current national planning policy and guidance is too vague and indefinable, making it impractical to implement due to the lack of certainty it engenders as to whether the aim of the planner is to plan for *health* or *healthy* outcomes; and, if the latter, what level of healthiness constitutes an acceptable value, and

how this value should be determined and assessed? There was a strong view among the participants that with respect to health the obligation on local planning bodies is merely aspirational and neither a standard to be uncompromisingly pursued nor objectively verifiable. A significant number of participants felt that there is a need to correct this shortcoming, advocating stronger references to health objectives, outcomes and success criteria within national planning policy and guidance. The purposes of this being to provide a clearer steer to local planning bodies as to what health objectives and targets have to be met, the stages by which they should meet them, how resources should be allocated to achieve those targets, and the process by which to monitor results.

Participants' reflection on the policy/guidance situation raises a difficult-to-answer question: would stronger health-related planning policy at the national level result in more robust local policy frameworks with greater capacity to deliver development which would bring about better and more measurable differences in population health outcomes? This question echoes that asked by Tewdwr-Jones (2011) in his examination of the extent to which the planning system supports health, wellbeing and social care objectives. As with Tewdwr-Jones, this research uncovered an unequal treatment of health in LPA's LDPs. Although five of the six Local Plans reviewed in this investigation included the aim of improved health outcomes or broader reference to health in their vision or strategic objectives (or principles), it was found that this is not always translated through into policies which specifically position health outcomes as a policy objective.

There is a variable approach taken to health and health outcomes in LDPs. What participants in this study alluded to, if not explicitly mentioned, is that the uncertain and cross-cutting nature of the current (but also previous) national planning policy and guidance frameworks permits considerable scope for interpretation in relation to health. Another possible reason for the variance in health coverage in LDPs could be the absence of specific requirements in policy/guidance regarding health, something which contrasts with other policy

areas – such as housing, economic needs, flood risk, and transport. It is important to acknowledge here, however, that the NPPF (and associated NPPG) actively promotes the consideration of health in urban planning, and that its permissive, interpretative approach to national planning policy does not prevent nor inhibit LPAs from producing local planning policies that explicitly address health issues and outcomes.

The main policy recommendation that emerges is that clarifying national planning policy expectations for LPAs in relation to health, including in terms of plan-making and decision-making, would be advisable not only from a certainty perspective but also from the viewpoint of operational efficiency. This, in turn, could create a greater sense of certainty among local planning bodies and planners about health as a material condition in planning decision-making, thus encouraging them to think about their decisions and practices from a health standpoint. The aim here would be for clarity, not substantive change nor the introduction of prescriptive requirements that might set limits that are either overly complex or demanding to achieve, or that would set limits for health and limit the creativity of planners to achieve it. Rather, the aim would be to help planners and other stakeholders to understand what health objectives have to be met, how they should be met, how they should allocate resources to achieve them, the process by which to monitor results, and the consequences of not integrating health into their practices and policies.

Cultivating a collaborative culture for health

Evidence from the interviews and survey conducted for this research indicates that the form and extent of collaboration between the urban planning and health sectors varies considerably. It does, however, appear that strong interaction on the subject of health between planners and health professionals is the exception rather than the norm. Issues relating to collaborative working, including the necessary facilitatory arrangements and structures that underpin it, can stymie the effective integration of health into the urban planning process. Part of the reason for this relates to the complexity of health and the communicative dimension of collaboration. It is useful here to consider briefly these two aspects separately, before considering the relation between them.

To start with, the role of communication and the exchange of information and knowledge has been cited as important to the success of urban planning at the local level (Forester 1997; Healey 2010). Communication is beneficial as it is, firstly, in and through communication that actors can better make sense of complex problems through combining knowledge and ideas (Hatch and Shultz 2002), and secondly, it enables actors to reach understandings of a situation, coordinate their actions and act in concert (Habermas 1984). As a complex phenomenon, health is defined by its complexity. Health is also defined by the relationships between its many determinants, which span multiple spheres of biophysical and societal systems. Without communication there is thus no dialogue, and without dialogue, there cannot be a transference of knowledge and proper negotiation about meaning and appropriate course of action for health (Thomas 2006).

Health is not the domain of the health sector alone. The causes and solutions of health issues are often found outside the health sector, requiring the engagement of sectors beyond health and movement towards a "whole systems" or "health in all policies" approach (Kickbusch 2013; Bert et al. 2015). Collaboration is recognised as essential to the effective integration and achievement of desired health and other social objectives through the urban planning process (Kickbusch & Gliecher 2012; Rydin et al. 2012). The findings

from this study support the findings from other studies that partnership and intersectoral collaboration between the health and planning sectors is not as effective and structured as it could or should be (see, Barton 2017; Burns & Bond 2008; Corburn 2009; Guy 2007). Findings from this study further confirm that collaboration between planners and health professionals is problematic due to the subjectivity of the thing (i.e., health) that is being collaborated on, and the complexities and conflict inherent in professional and personal identities, language and knowledge systems, norms and cultural values, and working practices.

The immediate recommendation that can be made is that public health and urban planning develop a more robust collaborative approach and allocate appropriate resources to enable this to be done. An element of this will involve liaison and collaborative-working across the two sectors to investigate and formulate strategies or solutions to overcoming obstacles to effective engagement. This could involve, for example, training or educational measures to improve practitioners' understanding of the structure, organisation, function and operational limitations of agencies beyond their own.

To this end, health and planning agencies should consider the value added in appointing "dedicated staff" and/or establishing "joint appointments" – the latter position being bilaterally funded and tasked by the relevant health and planning bodies. The remit of dedicated staff would include raising the profile and embedding health principles into the plan-making and decision-making dimensions of urban planning, as well as checking these dimensions for their consistency with health objectives. More advantageous still, those jointly appointed agency members through working in and across both sectors could additionally build intersectoral links, providing necessary inspiration, leadership, and build capacity and breakdown institutional inertia where it may exist.

While the previous recommendation is in line with that already advanced in the literature, this research makes an additional yet complementary recommendation. Collaboration means not only working jointly to build common understanding for a proposal or project, but also seeking a higher-order level of actions enabled through the creation of mutual goals, trust and reciprocity facilitated through involvement of others in the planning of that proposal or project. In health promotion terms, collaboration is a means not an end; it is a method of forging a more rational approach to the creation and establishment of the necessary mechanisms for creating healthier communities.

There is thus a need for an institutional and organisational culture of collaboration built on a multidimensional model of communication, comprising formal and informal mechanisms, which stimulates creative thinking on the part of those involved, and is rooted in the social and political realities of the fragmented space around health and urban planning. The focus of collaboration in this setting should be on reaching an achievable level of mutual understanding and capacity building, possibly delivered by dedicated and/or joint appointed staff, but at the same time retaining awareness of that which is not understood and capitalising on the different skill, knowledge and social systems of stakeholders. Ultimately, the mechanisms and processes for securing such a setting would have to be developed in-situ, being responsive to and reflective of the institutional and organisational context within which it is to operate.

Building an evidence base for action

The role of evidence in underpinning urban planning is critical and one that is now understood (Morphet 2011). In this work, the role of evidence in urban planning was considered with reference to the wider context of evidence-based policy- and decision-making now applied to public policy – including urban planning. Evidence in urban planning is seen as essential to "getting a handle on the problem" (Osborne & Hutchinson 2004), and for helping identify how places work, how people live, and what level and types of needs they have (CLG 2007). There is currently a growing focus on evidence-based policy making, most prevalently in medicine but also in other spheres of public policy (again, including urban planning). Morphet (2011) observes that evidence-based policy making has been used in three main ways, namely to identify:

1. What needs to be done?
2. What approach has worked here or elsewhere?
3. Did this approach solve the problem or improve the outcome?

Evidence in urban planning is used in a variety of circumstances and for a variety of purposes. In some instances, for example, evidence has been used to identify issues where action is needed and to determine whether these issues comprise single or multiple problems, requiring input from one or more government agencies and a response founded on one or more approaches (CLG 2007). Evidence has also been used to demonstrate the logic for intervention or greater resourcing for agencies charged with addressing social, environmental and/or other issues (Osborne & Hutchinson 2004). This second-dimension ties in with use of evidence as a device to identify what approaches or interventions have worked elsewhere, and to ascertain the effectiveness of these and what can be learned for future policy and practice (ibid). Establishing and ensuring the effectiveness of actions and interventions is a common objective condition today of funding and criteria for developing strategies to address issues; perhaps most significantly, in public health where evidence-based decision-making has an established history (Brownson et al. 2018).

Despite misgivings about the nature and role of evidence-based policy-making and practice (Healy 2002), planners should give it particularly high priority. This is due to the continued compulsion of the UK Government to encourage its infusion into public policy, particularly into urban planning (Lord & Hincks 2010). Recent reform of the UK planning system has taken place with the effort to create a more collaborative, communicative, and evidence-based approach to urban planning. While evidence-based planning is not new, a renewed focus has been placed on "evidence" through the 2012 version of the NPPF (and the associated NPPG). Principally, paragraph 158 headed "Using a proportionate evidence base" requires a LPA to ensure that its Local Plan is based on adequate, up-to-date and relevant evidence about the economic, social and environmental character and prospects of the local area. Evidence is a crucial consideration in urban planning, running through all the stages of its process, including decision-taking. Notwithstanding the importance of "planning judgement", decisions in urban planning must be based on robust evidence, on facts, and objective tests to allow for effective allocation of resources and optimal outcomes.

This tendency towards evidence-based policy-making, and practice, is pertinent to efforts directed at using urban planning for health promotion. Evidence-based practice in relation to health is never straightforward (Little 2003). Such practice is considered especially problematic for health promotion, not least because its political and social nature engenders contests between bureaucratic, community, institutional, and political stakeholders (McQueen & Catherine (Eds.) 2007; Tannahill 2008). A pressing practical problem for health promotion is an absence of evidence. More specifically, an absence of evidence concerning how and what should be done (e.g., the effectiveness and evaluation of health promotion processes) and not just that something should be done (e.g., the assessed needs of communities) (Brownson et al. 2009; Brownson et al. 2018). The findings from the review of literature in this study further support this from a health and urban planning standpoint, see Chapter Four.

Evidence was held in high regard by those planners and health professionals who participated in this study, however it was readily acknowledged that extant evidence on the effectiveness and effect of urban planning on population health outcomes remains inadequate. The paucity of evidence to demonstrate the direct or causal link between planning actions and health was thought to negatively affect the proclivity of urban planning to address health issues and to secure the necessary political and organisational support to do so. Planning decisions were recognised to be bound by legislation and regulation, together defining the criteria for what constitutes a "material consideration" in urban planning. Not only does this place well-defined (and not-so-well-defined) limitations on the role of urban planning in delivering health outcomes; it also sets out broad criteria that need to be satisfied in order to establish not only the materiality but also the weighing to be given to specific considerations (Davoudi 2006).

Without empirical evidence it is difficult to demonstrate the relationships and effect (potential or actual) between urban planning policies (and consequent decisions) and population health outcomes. Furthermore, some planners who were interviewed expressed uncertainty about whether potential health-related benefits or harms of development proposals would be considered as "material considerations" in subsequent planning decisions, by Officers or Appeal Inspectors. Although what counts as a material consideration is ultimately a matter of legal argument, the inclusion of references to health in the NPPF would benefit from the assembly of more robust evidence to inform policies and is important in justifying decisions about health (and instilling greater confidence in Officers to defend these decisions either against challenge from applicants and/or at Appeal) (see, also Ross & Chang 2012) .

The intention here is not to suggest that planners (and health professionals) are unconcerned with evidence; indeed, as stated above, they are. Rather, it is to put forward a recommendation for further investment of intellectual and financial capital into building an evidence base for action. This would include finding or generating evidence on what interventions or practices can improve

health, and what compliance and what factors determine their success, with part of the aim of this being to reveal the advantages and limitations of proposed and/or implemented approaches to health promotion. There is, moreover, a need to focus resources on fully assessing the potential impacts of policy and decisions during and throughout the policy-making and decision-taking processes, for example through the effective use of impact assessment tools (such as SEA, EIA and/or HIA) to maximise the opportunities for positive health outcomes throughout the urban planning process.

Effective and viable monitoring frameworks and evaluation systems are also required, being capable of capturing data about and subsequently illuminating on the health effects (both in situ and ex situ effects) of policies and decisions (including development resulting from decisions). Such monitoring would need to be predicated around the use of indicators that are reflective and responsive to the health needs of an area, but it must also enable evidence to be collected that can be analysed so as to reveal the links between urban planning and health, and more broadly to identify ways to improve future policies and practices for health promotion.

Health in All Policies (an emerging opportunity)

Significant changes to the health system in England have taken place in recent years. The combined implications of the government's proposals for public health in England, as set out in *Healthy Lives, Healthy People* (2011) (and subsequent consultation papers), and the impact of changes contained in the Health and Social Care Act 2012 (2012 Act) on the structure and delivery of public health in England are only now starting to be understood (see, Peckham et al. 2015). Included in the 2012 Act were new responsibilities for public health placed on local authorities from 1 April 2013. These responsibilities covered health improvement, health protection, and the provision of public health commissioning advice to Clinical Commissioning Groups (CCGs). To deliver these new responsibilities local authorities received a ring-fenced grant, coming with clearly defined conditions setting out prescribed functions and non-prescribed functions. One prescribed function that must be performed by each local authority is that they have a role in delivering public health.

The planning system is central to making this happen through contributing to the achievement of sustainable development, actively creating a high-quality urban and built environment that provides access to local services and facilities that reflect the community's needs and support its health, and by ensuring that health issues are considered and weighed in the balance as part of the assessment of a planning application. Urban planning affects and interacts with most local authority functions. It is therefore best to view urban planning not simply as an intervention in itself but as an enabler to achieving wider health aims and developmental outcomes. This position was indeed one that planners who participated in this study supported. Many planners, however, expressed frustration about the perceived growing instrumentalisation of the planning process to serve broader local authority objectives without a proper recourse to the need for integrated, cross-sectoral plans and policies and the financial or other resources necessary for implementation.

Health falls within this category of objectives. The promotion and protection of public health is not the sole responsibility of local government, nor is it the responsibility of a single discipline or agency. Instead, health is a responsibility that must be shared and one that must be seen as a framework from which all government agencies operate. The three-way relationship between urban planning, the health sector and local government has yet to be realised. To do so will require not only better engagement between urban planning and health sectors, but also a more collaborative and inclusive approach towards the delivery of public health activities – whether they aim to protect health, improve health, or improve the delivery of healthcare services. Reaching out to and drawing together other sectors requires understanding of their goals and agendas, developing a universal language, and identifying and apportioning outcomes and co-benefits; as well as creating a shared evidence base, and the ability to initiate and lead intersectoral actions. Central to intersectoral action on health is the development of policy coherence, synergies and coordinated activities with multiple sectors for better population health (WHO 2015).

There are several or more different approaches and mechanisms to establishing policy coherence on health at the national and local government levels (for an overview of these see, Wismar & Martin-Moreno 2014). It is essential, whichever approach is adopted, that the translation of high-level political commitment on health is done through a mechanism that can produce intersectoral action in a sustainable manner (WHO 2015). The recommendation here is that the Health in All Policies (HiAP) approach is adopted by local authorities as a tool for bringing together multiple agencies, including those responsible for health and planning, and strategically incorporating public health objectives into all discussions and actions. HiAP offers an effective mechanism and concrete tool for making health commensurate with, and influential alongside, other competing or conflicting sectoral interests.

10.4.2 Research and further investigation

This thesis was predicated on the notion that investigation of the conceptual, epistemological and practical spheres of the concept of HUP is essential to securing the added benefits of urban planning to health that are set out in theory and policy. The research situated English urban planning within its regulatory-situational context to reveal the interaction between it and (1) the organisation and structure of its processes, (2) the arrangement of the planning system, and (3) the dominant health ideology and goals as expressed through state policies, and the participants' preferences. The combination of these components makes visible the articulation between health and an often-invisible set of conditions that are shaped by macro- and micro level institutional and structural factors.

Through the case study methodology employed in the investigation, this research was able to develop a deeper understanding of the complexity of the urban planning and health interface. This included generating new knowledge and understanding gained through the exploration of the dynamic contextual environment within which the health-planning interface is currently being developed, especially in terms of the interplay between legislation and policy which is creating a revised framework for the focus and regulation of planning activity.

The freezing of this "contextual dynamic" is advantageous in that it allows us to unpack the key factors affecting HUP application. It, moreover, can help to ensure that these factors are understood in a way that reveals their complex and contingent nature, thus allowing for the generation of effective solutions and recommendations for current and future conceptual and practical development. A strength of this research is its novelty of perspective, because it explored the components of the health-urban planning interface from a theoretical but also strategic and structural perspective. Particular attention was paid to the extent to which conceptual meaning, policy, regulation and

stakeholder understanding affect the integration of health within urban planning.

The notable weakness of this approach follows from its strength in that by having its focus on that strategic level, the research was unable to map and analyse the factors that affect the subprocesses, and supporting tools and services (e.g., impact assessment), that together comprise the overall urban planning process. Another weakness was that research relied on a relatively small sample of cases and participants to reveal the range of thoughts and ideas about the given topic. The findings are drawn from the chosen cases and participant interviews/surveys of the state of HUP and health-urban planning integration in England, but they do not give a complete picture of each local authority's situation.

In light of this, the foremost recommendation is that further research should be undertaken in the area of healthy urban planning. Further research is needed to uncover and examine the elements that sit behind the theory and practical application of HUP and what that means with respect to the health promotion capacity of the planning system. To that end, the thematic overview presented in section 10.3 could serve as the basis for a methodological and conceptual framework for further investigations on HUP in the context of its complex interactions with the evolving form and structure of urban planning regimes. However, this framework will inevitably have to be revised in due course as new studies on the topic emerge and new data emerges.

A more specific point to raise is that the literature and empirical evidence presented in this thesis revealed a funnel of contestation as one moves from the normative and policy spheres of HUP, in which there is little contest about the merits of "planning for health", through to its theoretical and practices sphere, where conflict in meaning and interpretation is readily observable in writings and findings of this work. The contested nature of HUP must thus be recognised in any future research, which far from being resistant to the ambiguity of the concept, must be eminently amenable to it and indeed embrace it. In doing so, it should not seek to set limits for HUP, rather it should

aim to help practitioners to understand the conceptual and policy space around the concept and how awareness of this can improve the potential to secure a wider range of HUP benefits in practice by retaining its broader purposes and objectives as the HUP concept continues to evolve and be used by different interests.

10.5 Chapter summary

The final chapter of this thesis sought to provide a summary analysis and synthesis of the study, underscoring the main conclusions reached from the work and setting out the main recommendations for practice and research. As discussed, the empirical findings in this study consolidate results from earlier studies and add new evidence and understanding to the emergent field of HUP. This thesis also offers another angle to the existing discourse on the need to integrate health into the urban planning process; one that hints at a dilemma at the heart of HUP. There is a basic assumption that with sufficient time and guidance it is conceivable that health can be fully integrated into the processes of and subprocesses of urban planning. This work does not entirely dispute this claim, although it wishes to nuance it in recognition of the complex, pluralistic nature of HUP itself.

The empirical findings of the study alone, but especially when combined with existing theoretical contributions, reveal a funnel of contestation as one moves from the normative and policy spheres of HUP, within which its merits are not disputed, through to its theoretical and practical spheres, where conflict in meaning and understanding is both observable and arguably a natural response to the complex and ambiguous nature of the concept. The aim of HUP may appear straightforward and determined: to promote and not harm human health. However, such abstraction creates a binary that veils a complex relational web in which multiple structural, institutional and agential factors interact to construct novel interpretations of HUP and shape the relationship between health and urban planning.

Indeed, much of this complexity derives from the fact that the concept of health does not have attached to it a discrete, universally accepted meaning; rather, this same basic concept (health) has multiple meanings attached it – with individual meanings not simply vanishing when contradicted by fact, authority,

or competing theories, but often becoming more entrenched and their dismissal more vehemently resisted by their partisans.

The urban planner's dilemma is therefore not simply restrained to the negotiation of health objectives into urban planning. This "dilemma" also entails ensuring that the urban planning activities aimed at health promotion are both appropriate and effective, at the same time as grappling with the potential incompatibility of different ways of thinking about their work and having a handle on the regulatory and structural framework which governs their actions and activities. Acknowledgement of such a dilemma does not negate the need to aim for the effective integration of health into urban planning, although it must be recognised that HUP deals with a permanently contentious issue: the making and meaning of health. Furthermore, there is a need to ensure that future efforts towards and interrogations of the practice of "planning for health" are undertaken in acknowledgement of the wider context and realities in which it is embedded and cannot be divorced from.

Despite advances in our understanding and treatment of health problems, health remains a pressing issue across the world. There is now a need to reaffirm and act upon the link between urban planning and health (RTPI 2008). Regardless of how this is done, health must be part of the equation of urban planning. In the words of Ellis et al. (2010: n.p), 'The health and well-being of communities cannot be an afterthought. It must begin with the planning process'. And, regardless of whether it is termed healthy urban planning, healthy spatial planning, healthy city planning, or simply planning, there is a strong argument to continue to pursue the agenda conceived by Hugh Barton and others to put health back at the heart of urban planning.

Appendices

Appendix 1 – Interview protocol

Health and local urban planning in England – a case study	
Interviewee	
Position	
Local authority/organisation	
Date & time	
Interview Protocol	

- To begin, please could you tell me about your role?

- What do you understand the role of the planning system to be in promoting and supporting positive health outcomes?

- How effective do you think urban planning at the local level is in promoting and supporting positive health outcomes?

- Are there any barriers and/or facilitators to 'healthy urban planning'?

- Is there enough collaboration/joint-working between public health professionals and planners? If not, why?

- In your opinion, what impact has the introduction of the National Planning Policy Framework (2012) had in terms of the consideration of health in urban planning?

- What do you understand by the term 'health'?

- Do you think that health should be a goal of urban planning? If so, should it form an explicit goal of planning?

- Other:

Appendix 2 – Survey questions

The local planning process and health in England – a case study
Survey Questions
1. Please state your position in the local authority. 2. What do you understand the role of the urban planning system to be in promoting and supporting positive health outcomes? 3. How effective do you think urban planning at the local level is in promoting and supporting positive health outcomes? 4. Are there any particular barriers and/or facilitators to 'healthy urban planning'? 5. Is there sufficient engagement between public health and planning sectors? 6. In your opinion, what impact has the introduction of the National Planning Policy Framework (2012) changed the consideration of health issues in planning? 7. What do you understand by the term 'health'? 8. Do you think that health should be a goal of urban planning? If so, should it form an explicit goal of planning? 9. Other comments:

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