

reuniting the evidence base for health and planning –

lessons from an ESRC seminar series

Laurence Carmichael, Karen Lock, David Sweeting, Tim Townshend and Thomas Fischer look at the lessons on the health and planning evidence base, evidence-sharing and integration that have been emerging from an ESRC seminar series bringing together academics and planning and public health professionals

The transfer of public health functions from the NHS back into local authorities in 2013 represents an opportunity to improve the health and wellbeing of the population through planning. This is in line with policy set out in the National Planning Policy Framework (NPPF), issued in 2012, which at various points mentions the need for planning to support local public health and healthy communities.

However, consideration of the determinants of wellbeing and local population health needs in planning decision-making is impeded by a number of barriers. These are rooted in the contrasting knowledge bases, institutional settings, professional networks, and legislative and policy environments in which planning and public health practitioners traditionally work. A multi-disciplinary series of eight ESRC-funded seminars (over the period 2015-2017) has been bringing together academics and practitioners across England to address these challenges and consider opportunities for inter-sectoral collaboration.

The seminars have repeatedly highlighted two issues. The first is the demand from planning and public health professionals to improve both their

mutual understanding of the uses of evidence and the methods and instruments available to achieve this. The second is a call for better approaches to sharing evidence and good practice that are fit for purpose within an increasingly resource-poor local authority environment. How might these issues be addressed?

Mutual understanding of the uses of evidence – a necessary step towards policy integration

The fundamental issue is that planners operate within a rigid statutory system of adopted policies and plans, while public health practitioners are more accustomed to advocating proactive strategies in response to population health needs. To be able to work together effectively, they need to better understand each other's professional backgrounds, work-related processes and legal and policy frameworks, and how these influence the conceptualisation and use of evidence in practice.¹

The central purpose of planning is to achieve sustainable development through plan-making and decision-taking.² It exists to promote economic

growth and social progress, to deliver high-quality homes and healthy communities, to meet the challenges of climate change, and to enhance the natural environment. Evidence in planning is based on case studies and is shaped by guidance and key laws (such as the Planning and Compulsory Purchase Act 2004). In essence, the evidence base for supporting built environment interventions is linked to planning processes, instruments, visions, objectives and delivery mechanisms. Moreover, the planning process is about understanding and acting with planning practices, vocabularies and stakeholders, and implementing and co-producing outcomes.

Although the public health function in local authorities is also shaped by strategy and policy, the fundamental aim of public health practice is often articulated more broadly. For example, 'Public health is about creating the conditions in which people can live healthy lives for as long as possible.'³ Public health decisions are taken based on the consideration of current local knowledge, uncertainties, and social and economic issues, and will always consider the research evidence base.

Evidence in public health is often defined in scientific terms and draws on research from a wide range of disciplines, such as economics, various social sciences, epidemiology, health services research, and medical sciences. It covers topics ranging from individual risk factors and health outcomes (including physical activity, diet, obesity, and sexual health, and the harmful effects of alcohol, illicit drugs, tobacco, gambling, unemployment and poor housing), to interventions, policies and service delivery.

It has long been recognised that a better understanding of systems thinking is required in order to fully consider health impacts that may be related to various social, economic or environmental factors – see, for example, the obesity system map identified in the Foresight report of 2007.⁴ Indeed, there is already a strong and growing evidence base linking aspects of the built environment and health.⁵ Public health knowledge can help support the creation of sustainable communities – one of the key purposes of planning – through facilitating walkable environments, enhancing transport and traffic planning, improving housing, and supporting the availability of high-quality green spaces and other opportunities for increased physical activity and improved mental health.

With regards to the instruments and methods available to achieve a better integration of health into planning, different types of impact assessments play an important role. On the one hand, there is Health Impact Assessment (HIA), which is applied in a wide range of policy, plan and project situations.⁶ However, it is not a statutory instrument. On the other hand, Strategic Environmental Assessment (SEA) for plans and programmes and Environmental Impact

Assessment (EIA) for certain projects are statutory instruments and can play a key role in integrating health into planning. SEA is applied to local, transport, waste, energy, minerals and other plans, and the underlying European Directive (Directive 2001/42/EC) explicitly asks for human health to be considered.⁷

In the UK EIA is applied about 700 times every year to large projects giving rise to significant environmental impacts. The new EIA Directive (Directive 2014/52/EU), which will come into force in May 2017, for the first time explicitly requires human health to be considered, possibly through a type of integrated EIA/HIA.⁸

Better approaches to sharing health evidence and good practice to inform planning policy

However, given the divergent disciplinary traditions, processes, governance and institutional arrangements that are in place, integrating public health and planning priorities is a challenging task. Traditionally, planning decisions are made on a case-by-case basis, considering information on local factors relevant to a specific area. In contrast, public health considers evidence at a broader population level, which may not have direct links to a particular development, or a geographical location, and thus may not appear to be directly relevant to planning. Public health practitioners and planners need to work more closely locally to address this mismatch, to better translate the wider evidence base to a local context, and to find appropriate ways to evaluate local policies and innovations, thus increasing the 'local evidence base'.

There are, however, already good examples of how to integrate public health evidence into planning practice. One approach is to allow public health evidence to filter through the planning process, in essence mainstreaming it through strong policy hooks. Bristol's development management policy 14 (Policy DM14)⁹ requires an HIA for developments likely to have a significant impact on health and wellbeing. The policy is the result of a long-standing co-operation between Bristol City Council and the WHO Collaborating Centre at the University of the West of England (UWE), Bristol. It promotes co-operation between health colleagues and planners, supporting greater understanding among the professional groups.

From Conwy County Borough Council, we also learn that leadership at executive level is key to promoting the use of HIA. The local public health team has a strong advocacy and influencing role to play, but HIA needs to be championed by the council executive team too, to promote awareness among council officers of their contribution to health and wellbeing impacts.

Another way to integrate advances in public health evidence bases is to adopt specific 'healthy' planning policies – for example restricting hot-food takeaways in close proximity to schools and youth



High-quality public space in Copenhagen – public health knowledge can support the creation of sustainable communities

facilities, where they have been proved to influence behaviour harmful to health. It has been demonstrated that a policy hook is not always necessarily needed to impose healthy planning on developers. In *Copeland v London Borough of Tower Hamlets*,¹⁰ the Administrative Court ruled that, in failing to take into account the proximity of a secondary school with a healthy eating policy as a material consideration, Tower Hamlets Council had acted unlawfully in granting planning permission for a takeaway, even though there was no Council planning policy relating to this issue.

In Bicester, a novel way forward is being taken by developing a strong consortium approach to place-based and proactive planning and design, implementing the principles put forward in the Farrell Review¹¹ on improving levels of connectedness between institutions and professions, as well as levels of public engagement. Residents are given the opportunity to learn how to *make the ordinary better* within planetary boundaries, by participating in creating healthy living together, from the promotion of warm and comfortable homes, to active lifestyles, social activity and internet connectivity. Another key aspect of place-making in Bicester is that monitoring is already required by planning consent, through which the success of measures can be assessed.

At a strategic level, Public Health England recommends the integration of Joint Strategic Needs Assessments and Health and Wellbeing Strategies as part of the evidence base informing the development of Local Plans, hence influencing the shape of the local physical environment.

Challenges and opportunities for inter-sectoral integration

Looking forward, one of the challenges in moving towards a more inter-sectoral approach to health and planning is the need for new approaches to professional training and organisational capacity-building in every local authority. Realistically, wide-scale change across England is unlikely within the current context of ever-decreasing local finances. However, opportunities remain in each area for public health to support the delivery of sustainable development policies and plans, and to input evidence strategically into key local planning policies where they can have important effects on the local population, be they transport, housing, green space or air quality policies.

As evidence on the role of the built environment on health mounts, finding ways to integrate public health data and evidence into planning policy-making can have wider policy and governance implications. The viability clause in the NPPF has given rise to much debate as to whether it causes sound planning decisions to be circumvented. Understanding the long-term impacts of new development on health could help rebalance the meaning and testing of viability, potentially contributing to redressing the balance of power. Using Joint Strategic Needs Assessments and sharing health data to inform Local Plans could support the mainstreaming of systems thinking, or at least inform more complex built environment interventions.

Engaging with communities to generate the health evidence base for Local Plans could also contribute

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Public health practitioners and planners need to work more closely to translate the wider evidence base to a local context

to a more participatory, proactive planning system. And despite the fact that further research is needed to consider its effectiveness and also to develop its use at a strategic level, HIA has been identified as a useful tool to facilitate the inclusion of health considerations and integrate local knowledge into planning decision-making, in particular in the context of SEA and EIA (see, for example, Glasgow City Council's City Plan 2, of 2009, which included an HIA for one part of the city – the HIA of the draft East End Local Development Strategy¹²).

None of these changes will happen overnight. However, the seminar series has demonstrated that there is an appetite for change – and that closer working between public health and planning professionals has the potential to deliver real benefits and healthier communities.

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Notes

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