Matthew Carmona

52. Building healthy places – just start somewhere!

It is often said that we are the first generation who will live longer than our children. Others say that our children will still live longer than us but will be plagued by poor health for much of their later lives. Neither seems very appealing, but to what degree is the built environment to blame?

The recent House of Lords Select Committee on National Policy for the Built Environment (which I advised) was certainly convinced that as a nation we need to take more concerted action. It argued: "Our evidence has illustrated that a poor quality built environment and poor quality places can have significant negative impacts for health, wellbeing, prosperity and happiness". They concluded that "Some of the UK's most pressing health challenges—such as obesity, mental health issues, physical inactivity and the needs of an ageing population—can all be influenced by the quality of our built environment".

A wicked problem

But the link between health, wellbeing and place is what we term a 'wicked' problem; meaning that it is difficult to even properly identify and frame the problem, let alone address it. This is because of the sheer complexity of the issues, the diffuse lines of responsibility for solutions, and the absence of clear and tangible links between intervention and outcomes.

If we take the problem of our increasingly alarming levels of obesity and the knock on implications these have on our health, including on levels of heart disease, cancer and diabetes, then we might postulate two possible policy responses. First, the medical solution. We could, for example, invest in research leading to the development of an anti-obesity pill to be taken en-masse to solve the growing problem. On the face of it, this solution would seem to deliver a tangible and direct benefit from a single clearly defined product, with clear knock-on commercial benefits for UK plc. And we could all continue to lead our unhealthy lifestyles!

By contrast, second, there is a preventative solution. We could, for instance, design (or re-design) the built environment to encourage us to do more exercise through walking and cycling more and thus avoid getting fat in the first place. It sounds simple, but this second solution is in fact infinitely more complex involving numerous interconnecting elements, diffused responsibilities, difficult to trace impacts, and the vagaries of human action. Moreover, there is no guarantee that even if we did make the environment more conducive to leaving our cars behind, that we would necessarily do so. Despite humanoids largely relying on walking to get around for 2.8 million years, and only on our cars for the last 100 or so of that, our reliance on cars is a habit that is now very difficult to break.

The wicked nature of the problem means that the potentially transformative nature of a high quality built environment (as seen in cities such as Copenhagen or Montpelier) remains poorly understood by politicians, the public and industry; and socially (and environmentally) unsustainable processes of

urban growth and management continue on the basis of flawed and outmoded knowledge and a failure to understand, let alone capture, the value of healthy places. If that persists then we will have only the one solution to our future health problems, the medical one.

COPENHAGEN, A CYCLE FRIENDLY CITY

A good crisis (or two)

If, as we hear regularly on the news, we have a public health crisis in the UK , and the option of living increasingly 'medicalized' lives doesn't seem particularly attractive, the good news is that it is never too late to start what will inevitably be a long-term process of changing the built environment, and our lifestyles, accordingly. At least that was the key message of the inspirational BIG MEET 6: Healthy Places' conference organised at UCL by the Place Alliance

There is also a new imperative wrapped up in a second crisis relating to the funding situation of the NHS. Thus when we hear that 10% of the NHS budget is already directed towards treating diabetes (largely type 2), and that this is due to rise to 17% over the next 25 years, then it is time for our national decision makers to sit up and take notice. Winston Churchill famously said that we should 'never let a good crisis go to waste', and so with a conflation of two crises this must be the incentive we need to make the necessary investments in the built environment that will deliver the much larger and sustained savings in our medical bills not too far down the line. The House of Lords Select Committee report, for example, quotes evidence that it received from the BRE that improvements to the housing stock alone could generate huge savings to the NHS "in the region of £1.4 to £2 billion per year for England"

This is certainly a case that Ann Marie Connolly was very keen to make at the conference, arguing that strong evidence has convinced Public Health England (for whom she is Director of Health Quality and Impact) that a focus on the short trips that could easily be made by active modes of travel (predominantly walking and cycling) could have huge potential health and health cost benefits for society. Sustrans, for example, have suggest that 23% of trips under a mile and 33% between one and two miles, are taken by car, and that making routes more direct and more attractive might significantly reduce this[1]. For Ann Marie such interventions offered a particularly strong economic case for action.

For her part, Jessica Allen of UCL's Institute of Health Equity convincingly demonstrated that the health costs of a poorly designed built environment (e.g. increasing physical disability, poor mental health and higher levels of traffic accidents) are not only real, but fall inequitably on the already most deprived in society. Furthermore, these inequalities seem to be persisting through time, and correlate very strongly with life expectancy. Consequently, if we want to prioritise our limited resources to have the greatest 'return on investment', it is clear where we should start: in those neighbourhoods that already suffer from the poorest quality built environment combined, most likely, with the worst health outcomes.

But where do we go from there? Our discussions revealed a number of important insights that suggest where; starting with one that might seem somewhat unpalatable for a researcher such as myself.

Not rocket science (it far more complex than that!)

Sarah Wigglesworth argued that we don't need research but action, as we already largely know what is necessary to create and retrofit built environments for clear health benefits. Despite this, based on her own research she recommended prioritising:

- Stewardship of attractive local centres with a range of facilities
- Access to safe and attractive green spaces
- Investing in a pedestrian and cycle friendly public realm
- Adopting sufficiently generous internal space standards in new homes
- And, of particular importance for older people, designing in opportunities for socialisation.

ACCESS TO SAFE AND ATTRACTIVE GREEN SPACES

Whilst each prescription sounds simple, buried within each is a hugely complex series of challenges that need to be addressed and overcome, particularly when relating the health agenda to the places where most of us live: existing rather than new areas. These concern the lack of funding, fragmented responsibilities, rapidly changing lifestyles (e.g. internet shopping), poor management practices, and the physical limitations of many places, etc., etc., etc.; indeed all the sorts of things that led the late great Professor Sir Peter Hall to comment that, by comparison with the great scientific challenges of our time (he used the example of getting a man to the moon), these sorts of multi-faceted human, governance and design problems are infinitely more complicated.

Nick Grayson from Birmingham City Council (the first 'Biophilic City in the UK) argued, that real progress on the healthy places front is hampered by a collective low ambition that besets local authorities. Thus instead of recognising the potential for nurturing a real net gain through development practices, there tends instead to be a much more limited 'no net loss' approach. This, he suggested was a consequence of our models to urban governance that are still rooted in a Nineteenth century view of the city, rather than in the sorts of whole systems thinking about complex organisations (e.g. local authorities) and complex environments that is necessary today to break down the silos that exist between planning, public health, transport, environmental health, leisure services, and so forth. Others agreed, arguing that a cross-sectorial Place directorate approach within local government was required in order to better coordinate services around an agenda such as healthy places, and better capture and internalise the savings generated by investing in the built environment e.g. an expenditure on one budget, such as transport, leading to a larger saving in another, such as social care.

Get inspired

For this reason, hearing about the success of the '20's Plenty for Us' campaign was hugely inspiring. At the heart of this is the very simple proposition that by slowing down vehicles we make streets more walkable, less polluted, safer and more liveable and attractive. And, rather than doing this through a 'bums and spines' approach (by installing speed bumps in selected locations) we simply impose a universal speed limit of 20 miles per hour in urban areas and eventually drive a new social consensus about what is acceptable. Thus, Rod King (father of 20's plenty) argued, with every 1mph reduction in speed we see a 6% reduction in casualties alongside very significant on-going benefits for health at very little public cost. The idea has been taken up by local authorities around the country and 20mph zones now cover 14 million people with 250 local campaigns helping to ensure that the initiative remains "community led but establishment endorsed".

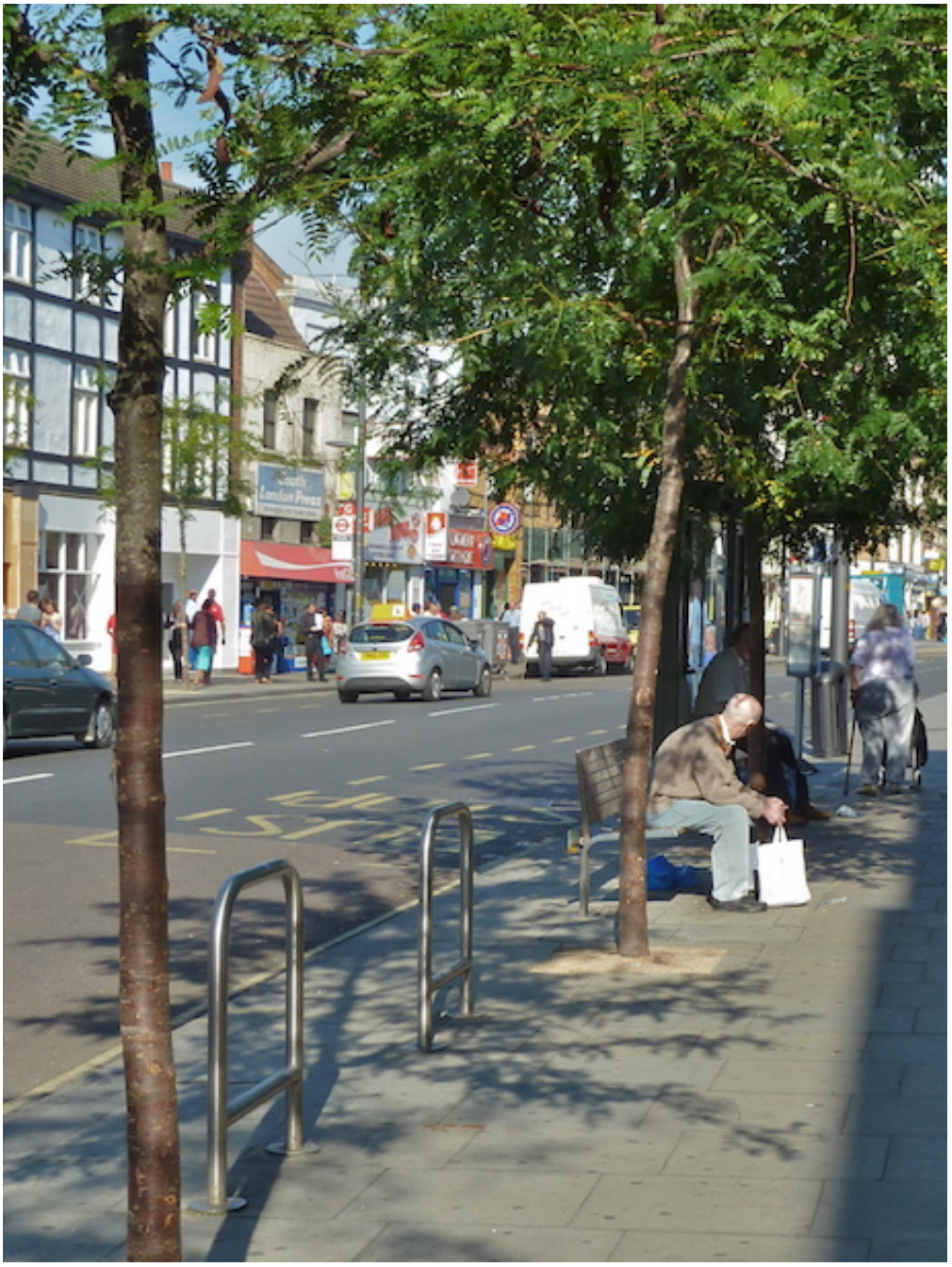
'20's Plenty' is potentially a quick win for many places, but a long-term perspective and investment in healthy places will also be required. A helpful metaphor was provided by Rhiannon Corcoran of the University of Liverpool who argued that cities are human ecosystems that need nurturing (just like natural ones), with perceptions of place quality and community well-being strongly linked to what places look and feel like. Thus living in an environmentally unattractive neighbourhood can very quickly make residents feel worse about themselves, and this can result in a spiral of decline; both personally, and ultimately of the whole place.

At BIG MEET 6 a number of case studies were offered providing concrete evidence that it is possible to be both proactive and long-term in this area in order to raise ambitions, and position the health agenda centre stage. The first, from Stoke-on-Trent, was presented by Daniel Masterson, a man with the title Healthy Urban Planning Officer. Stoke-on-Trent is a city with multiple endemic planning, health and environmental challenges, but has recognised the importance of the historic link between health and planning and now has someone to continually bang the drum. In doing so, Daniel offered three simple lessons that might seem obvious, but typically are not implemented:

- Get in early into the development process building the health agenda firmly into planning and reducing the risk to developers by making aspirations clear
- Policy is not enough, to deliver on the agenda officers need to negotiate health outcomes on a development by development basis
- Local politicians and senior officers need to be brought on board by showing them just how a health-based approach can make a real difference.

Second, and moving down south, Bruce McVean from Transport for London demonstrated the sophisticated model that TfL have been developing as a means to trace and ultimately influence how healthy (or not) streets are. In this, 'Whole street', approach the ambition is to give greater choice so

that citizens can choose more healthy patterns of mobility over less healthy alternatives. Ten criteria are measured for a 'healthy street': the extent to which people choose to walk or cycle; that active travel extends across all walks of life; roads that are easy to cross; availability of shade and shelter; creation of places to stop and rest; reasonable levels of noise; people feeling safe; that there are things to see and do; people feeling relaxed; and, that the air is clean. The tool, it is hoped, will help to drive more informed decisions about future street investments and bring health aspirations firmly into the mix.



HEALTHY STREETS INCLUDE PLACES TO STOP AND REST E.G. WALWORTH ROAD

Third, and moving from the whole street to its parts, Rupert Bentley Walls, who for ten years worked as Arboricultural Officer in the London Borough of Hackney, demonstrated how the humble tree can bring beauty, shade, pollution reduction, and sense of place to city streets, as well as a means to engage communities in their built environment. This he did by encouraging local residents to look after and protect his newly planted trees; in the process imparting a sense of ownership, both of the tree and the place, and helping to reverse those previously mentioned negative associations with place that can play into an equally negative sense of personal well-being. Hugging a tree, it seems, really can have an impact on our health!

Do something!

A final contribution came from Matt Bell, of the Berkeley Group, one of the nation's largest housebuilders. Matt was extremely honest, arguing that for house builders the health agenda is not yet on their radar, largely because local authorities never raise health as a concern. In a room full of professionals and others already sold on the critical importance of place to the health agenda, the intervention was a brave one and a salutary reminder of the journey that still needs to be travelled, not least to join up health and planning.

For Berkeley, the journey is likely to be shorter than for most housebuilders, as the company are very clear that they are building social as well as physical infrastructure, and already have the wellbeing of residents as a key corporate objective, building on and developing out of their now well established place-making credentials. Thus, Matt Bell argued, we should shape high quality places that (Abraham Maslow style) reflect a pyramid of need. This starts with the new homes themselves; these in turn should be an integral part of a mixed-use environment; this should be designed as a real place that reflects the best place-making practices; it should be carefully managed over time to allow the place to mature with grace; and ultimately a sense of community should emerge that, hopefully, will act as a key bulwark against ill health. In other words, get the place right and the public health agenda will look after itself.

PLACEMAKING, BERKELEY-STYLE

Returning to the NHS, the Healthy New Towns demonstration programme offers real potential to move a stage further and to explore the potential of integrating a more explicit health based approach from the start of new development. Across the ten demonstration projects the intention is to combine good place making and community building practices with new ways of delivering healthcare and smart technologies, for example to support older people to live longer in their own homes. In the context of tabula rasa developments it should certainly be possible to plan for both the built environment and health and wellbeing service delivery without the sorts of legacy constraints that dog so many established neighbourhoods. But this leaves the question, what then where this is not the case?

BIG MEET 6 concluded that in both our personal and professional lives we just have to start somewhere if we are to avoid the hugeness, complexity and wicked nature of the healthy places problem from overwhelming us, creating a ready excuse to do nothing. The event provided plenty of ready made examples of where we might begin, and the surfeit of reports in this area that have recently been published from a diverse range of organisations over the last few years suggest a growing momentum and set of practices that can be imitated. I, for one, have bought a Brompton and have started cycling to work (at least part of the way) and am writing this article to help spread best practice. What will you do? Do something!

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[1] http://www.sustrans.org.uk/sites/default/files/documents/guidelines_16.pdf (http://www.sustrans.org.uk/sites/default/files/documents/guidelines_16.pdf)

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