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Healthy People, Healthy Places:

Incorporating a Health Focus into the Practice of Planning

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Healthy People, Healthy Places:

Incorporating a Health Focus into the Practice of Planning

by

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Healthy People, Healthy Places:

Incorporating a Health Focus into the Practice of Planning

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A significant number of studies have identified clear links between chronic health issues, including asthma, obesity, and diabetes, and the design of the built environment. As shapers of the built environment, urban planners can play a central role in ameliorating these current health epidemics. Indeed, during the early history of the planning profession the fields of planning and public health were closely connected, and improved public health was seen as a key mission of the planning profession. Today, however, public health issues are not a central concern in planning, neither as a normative value of the field nor as a core element of daily planning practice. Instead, health is a value-based cause taken up by concerned practicing planners, who face numerous challenges in incorporating a health focus into their daily work.

This research argues that there is a need for a focus on health outcomes within the planning field, based on the initial mission of planning discipline and current research showing the impact of the built environment on public health. Through a nationwide survey of planners and interviews with planning and health professionals in five cities, findings show that collaboration between health and planning departments is key to

instilling a health focus within the practice of planning. Planners who seek to promote a health focus in planning are pursuing this value-based imperative through a variety of ad-hoc strategies, since existing regulations and professional guidelines are inadequate in terms of facilitating collaboration between public health and planning in order to systematically address health issues related to land use and the built environment. Research also shows that collaboration between planning and public health departments, when this does occur, is often initiated and driven by processionals in the public health discipline. Though planners and health professionals who have sought to collaborate have faced institutional, political, and awareness challenges, there are opportunities that can be leveraged to overcome these obstacles. These opportunities include the professional expertise available in the public health field, the availability of health data in order to reframe planning issues, and the potential of individual champions of health to drive health considerations in planning projects, and promote health as a normative value. Ultimately, individual planners who see the creation of healthier communities as central to their professional practice pursue collaborative strategies with health professionals despite the challenges they face. From the perspective of collaborative planning theory and theories of institutional change, this individual engagement and initiative by planners through their everyday practice has the potential to effect institutional change by forging a focus on health as a normative value central to the planning discipline.

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Chapter One: Introduction

1.0 Health Trends: A Cause for Concern

Over the past few decades, researchers have increasingly raised concerns and presented evidence regarding the state of public health in the United States. Data from the Centers for Disease Control and Prevention (CDC) show that obesity rates in the United States have increased at an alarming rate over the past two decades. In 1985, no state had an adult obesity rate[1] over 14 percent; by 2010, however, the adult obesity rate in every state had increased to at least 20 percent. Yearly data collected between 2011 and 2013 show that obesity rates have continued to increase in many states (CDC 2014). Asthma rates have also increased, primarily among African American children, for reasons that medical practitioners are struggling to understand (CDC 2011). Obesity and asthma epidemics have been linked to other health problems, including type 2 diabetes, heart diseases, and chronic obstructive pulmonary disease. Exposure to pollutants in air, soil, and water has been found to lead to respiratory diseases, infectious disease, and some types of cancer after long-term exposure (U.S. EPA 2012). At the same time, health care costs in the United States are continuing to increase, prompting a search for solutions to the public health crisis in fields outside of the public health and the health care industries (Braveman et al. 2011).

This increased attention to public health has emerged, in part, because of the growing understanding of the many interrelated causes of the rise in chronic disease rates,

[1] Where data was available. The definition of obesity from the CDC is a body mass index (a measure of weight in relation to height) of 30 or higher.

including family and home conditions, socioeconomic status, access to health care, genetic and behavioral factors, access to and consumption of unhealthy foods, amount of physical activity, housing conditions, social cohesion, and indoor and outdoor air quality. In particular, evidence suggests that the built environment, defined as all buildings, spaces, and systems that are created, modified, or used by humans, plays a critical role in driving this decline in several indicators of human health (Badland et al. 2014). The built environment influences the physical, social, and mental health of communities, in part, by limiting physical activity opportunities, social cohesion, and safe and convenient access to hospitals and clinics (O'Keefe and Scott Samuel 2002). Due to these links between the built environment and human health, the planning and public health disciplines must work together to ensure that health is a factor that guides land use decisions (Botchwey et al. 2014).

1.1 Problem Statement

New research has emerged over the past two decades that addresses the links between planning processes, the built environment, and public health. In addition to the wealth of research reported in public health and medical journals, planning journals are also increasingly publishing work that explores connections between health and the built environment, the historical links between the two fields, and methods that may facilitate the inclusion of health in planning. In 2014, an issue of the *Journal of Planning Education and Research* published a special Green Health Symposium focused on health and schools. The American Planning Association (APA) has maintained a Planning and Community Health Center dedicated to understanding how the built environment impacts

public health, and the 2014 APA National Conference had a major focus on health, with the Acting Surgeon General of the United States delivering the opening keynote address. As Parry and Stevens wrote in 2001 in an article investigating the inclusion of health in policy-making processes, "the long tradition of never having considered the impact on health of public investment has ended" (Parry and Stevens 2001 p. 1177).

However, current research has tended to focus on the justification for integrating the fields of health and planning, rather than developing mechanisms for integrating health into everyday planning practice. Studies have explored the ways that planning decisions shape the built environment and, in turn, how specific aspects of the built environment (such as land use mix, sidewalks, use and locations of parks and green space, food outlets, transit, building conditions, and more) encourage or discourage healthy behaviors of residents and impact health outcomes. Research emerging from the field of environmental justice has explored the impacts of polluting industries on human health, and studies focusing on health disparities have considered the geographical distribution of health outcomes among different demographics, such as income and race, and emphasized the need for equitable planning and development in order to close the gap on health disparities.

However, research that documents and explores the challenges and opportunities for integrating health concerns into daily planning processes is lacking (Badland et al. 2014). In particular, little is known about the obstacles and best practices for furthering collaboration between public health and planning in practice. Although planning researchers recognize the importance of bringing a health focus to planning, and are encouraging practitioners to consider health in their planning work, the question remains: how can the field of planning—and primarily planners at the local level—more effectively incorporate health goals into their daily practices?

In this dissertation, I suggest that there are ways by which established planning processes may provide planners with the opportunity to incorporate public health goals in their daily work, ensure a more equitable distribution of resources to support health, and contribute to healthier people and communities. When planning for health, planners need to consider how to create healthier places for all races, ages, and income groups: achieving social equity should not be thought of as a separate process from achieving healthier cities. However, although a concern for equity informs the normative position that I take with this research—namely that the profession of planning should view health as a key societal value that must be extended to all people through planning practice—it is not the main focus of this dissertation.

Instead, I seek to explore the mechanisms through which planning can develop a new "focus on health" in daily planning practice in order to achieve the goals of health equity. By "a focus on health" I mean that the field of urban planning—which I define to be the profession responsible for civic processes that create "more convenient equitable, healthful, efficient, and attractive places for present and future generations" (American Planning Association 2015e)—must comprehensively understand the health implications of the design of the built environment, and promote plans and projects that improve health outcomes. There are a variety of ways to achieve such a focus on health, including regulation-, incentive-, and interest-based means. Depending on the context of a given jurisdiction, a combination of mechanisms may be required to create change within the daily work of planners and incorporate a focus on health. However, regardless of institutional context and forms of incentives to develop a focus on health, effective forms of collaboration between planners and health professionals on an everyday basis is necessary in order to ensure that health is most productively considered during work on plans, policies, and development projects.

Due to my focus on collaboration between health and planning practitioners, I distinguish a "focus on health" from the often-voiced call for a "reintegration of the fields" of planning and public health. Such a focus on "reintegration" implies that the two fields would unite into one, similar to how both fields originated. Instead, I argue that planners and health professionals represent different and equally important knowledge bases, values, and perspectives that need to be both included *and* understood to further a health focus in planning processes, thus justifying a need to maintain both fields. Ultimately, regardless of the regulatory context, forms of incentives, and interests that inform any particular planning project, such a focus on health in planning—and similarly, a focus on land use and the built environment in health work—can be strengthened through thoughtful and intentional collaboration and partnerships between the fields.

1.2 Research Goals, Questions, and Methods

This study focuses on the poorly understood challenges that must be overcome in order to develop a focus on health in planning through improved collaboration with the public health field. These challenges include the political processes that are at the heart of how the planning profession operates today; the place-based effects of decision-making; the role of political and institutional leadership; challenges to collaboration at the staff level; and a lack of common understanding of health impacts of the built environment between the two fields. Thus, the everyday practice of planners is limited by the priorities and structures of the states, municipalities, and departments where they work, as well as by the values, goals, and structures of the planning field more broadly.

Through my normative position that health should be a key driver in planning decisions, therefore, I examine the various ways that health has been considered in daily practice in planning departments in the United States, with emphasis on the Health Impact Assessment (HIA) process. HIA has generally been considered a potential best practice tool for bringing a health focus into planning practice, and many cities across the world are looking to HIA processes to consider health implications of land use planning, housing, and transportation. However, whether HIA is the best method for including health in planning and land use decisions has not been widely explored. Additionally, although HIA is considered a potentially useful tool for the planning profession, how to actually further collaborative approaches to health-focused planning practice remains unclear. Although researchers and many global and national organizations endorse HIA as a means of furthering this health focus, challenges associated with a lack of resources and lack of experience with HIA are leading public health and planning departments to search for alternative methods.

In this study, I focus in particular on the lessons learned by urban planners and public health professionals who have already sought to implement collaborative processes and work together in an effort to include health in planning decisions. By investigating the daily practice of planners, and specifically their collaboration with public health practitioners, I seek to shed light on how, why, and to what extent they have been able to develop a health focus in their work. Specifically, the goal of my research is to contribute to an understanding of:

1. How planners work within, are limited and shaped by, and navigate through established planning processes and institutional structures to include a focus on health in their work;

2. The role individual planners can play in integrating health into planning processes and the catalysts for this type of institutional change; and
3. If and how HIAs can be a useful tool for planners to use to incorporate a health focus into their work.

Ultimately, my research describes mechanisms through which the field of planning can adjust its priorities and focus to include attention to health within proposed plans, projects, and policies. Defining the primary terms used within this research is critical, as they can be conceptualized in different ways by different disciplines, and the definitions I use within this research are summarized in Table 1.1. The questions that guided my research are as follows:

1. How is the concept of "health" currently understood, framed, and represented in decision making within planning departments throughout the country?
2. How are health concerns included in planning processes? Specifically,
    - How are HIAs implemented or otherwise included in planning processes?
    - Why are HIAs not implemented or otherwise included in planning processes?
    - What other mechanisms exist to include health?
3. What are the principal opportunities and challenges for planners in terms of integrating health concerns into planning processes and documents?

Table 1.1: Definitions Used in Research.

Term	Definition Used
Built Environment	The built environment is all buildings, spaces, and systems that are created, modified, or used by humans.
Health	Often health is understood in a very narrow way, typically as being free of injury or illness. Expanding this definition, both within this research and within society as a whole, is necessary in order to fully understand the breadth and depth of factors that have an impact—either positively or negatively—on human health. For my research, I am using the broader social determinants definition of health from the World Health Organization, understood as not merely the absence of disease or illness but as a complete state of physical, mental, and social well-being (WHO 1948). To achieve this for all, a focus on the social determinants, which are the conditions in which people are born, grow, live, work, and age, is critical (WHO 2009b).
Planning	Urban planning is the professional field responsible for helping create communities that provide choices for how people work, live, and play (American Planning Association 2015e). Planners work with local governments, citizens, and private businesses and developers to construct these choices, and in this regard planners have the responsibility of ensuring that the environments within which people work, live, and play are healthy and accessible to all, and the mission of the field of planning is ultimately to protect and promote the welfare and well-being of the public. The basic element of urban planning is the plan, which can exist at a variety of scales. For this research I focused on planners who work in the more traditional comprehensive planning and community development realm (as opposed to transportation planning, historic preservation planning, or environmental planning).

Through investigating these questions, an overarching question for this research emerged: how does the institutional structure of planning impact collaboration between planning and health, and what are catalysts that can further collaboration?

To conduct my research, I integrated qualitative and quantitative methods in order to provide "a better understanding of the problem than if either dataset had been used alone" (Creswell and Plano Clark 2007, p. 7). My research followed the "explanatory" design approach, described in Creswell and Plano Clark (2007), which is used to expand initial quantitative results through gathering qualitative data in a two-phased process. Methods that were used with this research approach were surveys (quantitative) and interviews (qualitative).

1.3 Theoretical Framework and Structure of the Dissertation

In my research I draw on normative and communicative action theories in planning to explain the challenges and opportunities for facilitating a health focus within the planning profession through collaboration between the health and planning fields. Normative theory provides a justification for supporting health in the planning process by considering health as a key value for all of society, and also provides the foundation for my own position on the issue of healthy city planning. Normative planning theory focuses on the "ends" of the planning processes, which are rooted in the values of the profession and of individuals: I maintain that health, and the equitable distribution of health outcomes across a city, is a core value embedded in the core mission of planning.

Although normative planning theory, and primarily the work of Susan Fainstein, provides a basis for asserting a value-based outcome of planning, the means used to achieve this outcome is also critical. In this regard, I draw on work in communicative action theory, including Patsy Healey, John Forester, and Judith Innes, which focuses on the planning process itself. This theoretical perspective provides insight into the

institutional structures, relations of power, and forms of communication that shape planners' ability to collaborate with other groups, such as health professionals, as a means of promoting collective understanding. Communicative action theory holds that such understanding derives from deliberate sharing of knowledge and values between stakeholder groups.

Within communicative action theory, I draw more specifically on the literature that emphasizes the collaborative rather than consensus-building and conflict resolution approaches to communicative planning. This "collaborative planning" branch of communicative action theory focuses on the potential of dialogue and shared learning to impact institutional values and knowledge systems, and in so doing, influence changes in the very priorities of the institutions themselves. This is particularly important in the context of health and planning: although public health was a priority concern that shaped the field as it emerged in the 19th century, other priorities replaced health as the field evolved, including social reform, rational planning through zoning, urban renewal, and protection of the natural environment. As planning has evolved into a discipline with rigid boundaries, these disciplinary priorities have influenced the knowledge systems and values of not only the field, but also of individual planners. While improved collaboration between planning and health is critical to facilitate a focus on health in planning, therefore, it is necessary to also consider how personal priorities, values, and knowledge formations influence such inter-institutional collaboration in order to understand the opportunities for an institutional change in planning. As suggested in research on institutional change within collaborative planning theory—in particular, work by Patsy Healey and Michael Neuman—collaboration can lead to changes in identities and social constructions preferred by actors in the collaborative process, which can then lead to more fundamental changes in institutions themselves.

It is important to note that some cities and states have certain regulatory frameworks in place that *require* planners to assess specific health impacts, which will therefore require planners to pay attention to health concerns in planning processes. Also, there are established, institutionalized, and disciplinary links between the fields of planning and health, primarily through the specialization of environmental planning. There are national policies in place, such as the National Environmental Policy Act (NEPA), that are theoretically aimed at protecting health but have mainly been concerned with environmental health, such as air and water pollution. However, this research frames health more broadly and aims to understand how *collaborative processes* may shape the way planners understand, conceptualize, value, and integrate health into their daily work. Regardless of the institutional and regulatory context, therefore, my broader goal is to consider how daily planning practice may contribute to broader institutional change so that health is seen as a priority, both for good practice and for the good of society.

In the subsequent Chapter Two, I examine the need for a health focus in the practice of planning and the opportunities and challenges that exist for collaboration between the fields. I present the disciplinary context of my study, focusing on the evolution of the fields of planning and health, starting with their early histories as closely related fields, moving to their separation into professional silos, and concluding with the present-day discussions surrounding the need for collaboration between the two fields. The development of Health Impact Assessments, which has been promoted as a promising method to bring a health focus into planning, is also explored in this chapter.

In Chapter Three, I explore how normative and collaborative planning theories can help us understand why and how mechanisms for collaboration may facilitate a focus on health within planning institutions. I argue that a focus on the process of planning and

a specific end goal are both critical in terms of shaping the values and knowledge of individual planners, and of the institution of planning itself.

In Chapter Four, I describe the methods used in this research. A nationwide survey served to provide an understanding of the state of health integration and inclusion within planning departments, and was also used to select cities for in-depth interviews with planning and health professionals. These in-depth interviews were conducted in five cities: San Francisco, California; Columbus, Ohio; Seattle, Washington; Cincinnati, Ohio; and Orlando, Florida. The goal of these interviews was to gain a more comprehensive understanding of challenges to collaboration, as well as opportunities that can be leveraged for collaboration, and, more broadly, to drive institutional change to develop a health focus in planning.

In Chapter Five, I turn to an analysis of the principal challenges faced by planners and public health officials in their efforts to prioritize health within planning processes. Based on findings from both surveys and interviews, I argue that these challenges stem from the ways in which social constructions and values shape planners' conceptualization of their role in improving health, which in turn shapes everyday planning practice.

In Chapter Six, I present stories of collaboration between planning and public health departments told through the personal experiences of planners and public health professionals. These stories highlight the challenges practicing planners and health professionals face when striving to collaborate but also the ways these challenges were overcome. The technique of storytelling is used here to illuminate differences in knowledge and perspectives, which helps illustrate how leadership decisions shape what is considered "rational" in terms of incorporating health concerns into planning processes, but at the same time, demonstrate how planners' agency and everyday

practices can unsettle these seemingly one-sided relations of power between authorities and planners.

After reviewing the challenges and stories of collaboration, I turn, in Chapter Seven, to the opportunities to facilitate collaboration between health and planning. These opportunities do exist, despite seemingly insurmountable challenges. The opportunities outlined also stem from lessons derived from survey and interviews.

In Chapter Eight, I provide a series of recommendations for developing a health focus in planning based on my analysis of challenges and opportunities in Chapters Five, Six and Seven. Drawing on the theoretical framework of collaborative, communicative, and normative planning theories, I argue that opportunities for improved collaboration with the public health field can be leveraged through a variety of strategies. However, I argue that institutional changes are also required in order to facilitate a focus on health in the discipline, as challenges to collaboration are contingent on deep-seated institutional structures, identities, and priorities. Finally, in Chapter Nine, I present conclusions to this research, including implications for planning practice and theory.

Chapter Two: The Links Between Health and Planning: Past and Present

2.0 Introduction

In this chapter, I present the evolution of the disciplinary goals, areas of interest, and perspectives on the built environment impacts on health in the fields of planning and public health. Planning was once unified with public health due to concerns over infectious disease, but the two fields separated due to changes in dominant disciplinary paradigms and priorities. However, recent research shows the need for health to become a focal point within all fields and industries that impact the built environment. With emerging chronic disease concerns over the past two decades, planning—as a field that impacts the built environment—needs to once again foreground a concern for public health. This chapter also examines strategies that have been developed to incorporate health into planning processes, including Health Impact Assessment (HIA). However, as shown in the literature, there are limitations to HIA as a means of introducing a broader, more fundamental health focus to planning.

2.1 The Evolution of Public Health and Planning

Though they emerged in tandem to address infectious disease issues in 19th century cities, the fields of public health and urban planning have since followed very different trajectories with evolving goals and paradigms. However, the more recent research on connections between the two fields suggests there are opportunities for

alleviating the current health issues that are linked to the way our 21st century cities are planned, designed, and built.

Overcrowding in the cities of the 19th century presented a slew of problems that cities of earlier decades had not yet dealt with. Early 19th century studies in Europe by doctors and social reformers, including Rudolf Virchow, Edwin Chadwick, and Friedrich Engels, showed that morbidity and mortality rates were unevenly distributed among neighborhoods by economic and social class (Rosen 1993, Susser and Susser 1996). One of the earliest reports linking public health to the built environment was the Shattuck Report of 1850. Considered groundbreaking within the health field, the Shattuck Report assessed health problems and living conditions in Boston and offered a set of recommendations that included ideas for the layout of cities. The authors advocated that public health boards be allowed to regulate the siting of noxious land uses, highlighting the importance of comprehensive planning and infrastructure for sanitation improvement within cities (Sclar and Northridge 2001, Perdue et al. 2003). In the late 1800s, Andrew Mearns in London and Jacob Riis in New York penned publications describing tenement life in each city and highlighting the squalid living conditions of the underclass, bringing mainstream attention to housing and health issues faced by the poor (Hall 2002). The belief at the time was that the diseases brought about by the built environment were the primary causes of urban poverty.

Fears of violence and disease outbreaks spurred changes in the built environment in cities of the late 19th and early 20th centuries. During most of the 19th century the theory of miasma, which hypothesized that a poor atmospheric state was responsible for infectious disease, was modified to name poor sanitary conditions as the cause of the poor atmospheric conditions that brought about infectious disease (Rosen 1993). This modified theory established causality between health and the built environment, although

how to improve conditions to reduce outbreaks and eradicate health disparities was a source of disagreement among public health workers and planners. The myriad of proposed solutions to these disease epidemics—including improvements to housing and urban sanitation systems, implementing garbage collection, and constructing public baths—underscore the complexity of the environmental issues that were leading to poor health (Susser and Susser 1996).

Physical and policy-driven solutions to these environmental issues did not come easily. Health workers pushed for municipal regulations to revise land use patterns and keep cities clean, but reform was abated due to slow-moving local governments (Lopez 2012). However, by the turn of the 20th century, solutions to epidemics started to take shape in practice through zoning regulation and building codes. Street cleaning and waste management programs were established, justified by the sanitary improvements thought necessary to prevent the spread of infectious disease (Rosen 1993, Laurian 2006). In the Lower East Side of New York City, the elevated train network was expanded and tenement housing regulations were established: legislation in 1901 required windows, toilets, and kitchens in each housing unit (de la Barra 2000, Hall 2002).

Social reform, based largely on what members of the urban elite considered "moral," shaped planning and public health activities during this time (Laurian 2006). Slums in urban neighborhoods were considered immoral and blamed for not only disease but for violence and crime as well. Advocates for new housing and improved infrastructure believed that if the immoral and "pathogenic" slum environments were improved, then the people who lived there—who were also considered pathogenic and immoral—would also be reformed (Fairfield 1994). Spurred on by the fears of the elite, protecting the welfare of the public was therefore integral to both fields.

However, as living conditions improved and the threat of infectious disease declined, the planning and health fields deviated and began focusing on separate issues (de la Barra 2000). Although early health and planning practitioners understood the relationships between the built environment and physical and mental health, their approaches to reform were based largely on moral and normative rationales. As public health started to improve and tenement dwellers were deemed to have assimilated into civilized life, both fields turned their focus away from the moral and social issue of health disparities (Hall 2002).

In the 20th century, new theoretical baselines and fundamental shifts in the foci of both fields, accompanied by efforts to formalize each profession, caused the fields to detract from their once common goal of protecting the health of the public through the design of the built environment. The theory of miasma, which proved unable to explain why public health problems remained even with improved sanitary conditions, was replaced in the early 20th century by germ theory, which focused on how diseases originated rather than the pathways by which diseases traveled (Rosen 1993, Susser and Susser 1996). Thus, public health professionals in the early 20th century began to emphasize immunizations and laboratory research to protect individual health rather than focus on the built environment, and physicians replaced planners and engineers as the dominant professionals in the public health field (Duhl and Sanchez 1999, Lopez 2009).

By the mid-20th century, public health no longer focused primarily on the environment but rather sought out medical advances that facilitated the treatment of individuals, considered the "hosts" of disease. The central concerns of public health issues had become food sanitation, childhood vaccinations, and prenatal care: vast departures from the public infrastructure planning and construction that dominated the field in the late 19th century (Perdue et al. 2003). Later, with infectious diseases under

control in the developed world, the main public health paradigm evolved once again. A biomedical model of disease that attributed health to individual behaviors and lifestyles, rather than the distribution of disease across populations, began to dominate. As chronic disease dominated the discourse in the field, individual behaviors such as smoking, diet, exercise, and hereditary factors were linked to rates of morbidity and mortality (Susser and Susser 1996) and became central objects of public health practice. Linking chronic diseases to environmental factors did not emerge until the late 20th century.

Around the same time that public health adopted germ theory in the early 20th century, urban planning—in an effort to establish legitimacy—moved towards a rational-scientific framework for analyzing urban problems (Laurian 2006). Planning focused on becoming an institutionalized profession, driven by data and founded on scientific and objective reasoning (Brooks 2002). Zoning became the principal tool of the rational-scientific paradigm dominant in the field. Though the intent of zoning included protection of public health through land use patterns, it mainly served to separate the well off from the least well off through the inequitable technique of exclusionary zoning (Maantay 2001). By the mid-20th century, concerns involving the protection of society through health improvements were largely disappearing from planning and land use endeavors.

At the same time as health concerns began to decline in the new rational-scientific approaches to planning, architects began to dominate the planning field. By the mid-20th century, this influence of architects pushed the field towards a greater concern for design and aesthetics in order to pursue the normative vision of a "good" city (Peterson 2003). The planning field began to promote large scale economic development, urban renewal, and highway construction projects that ended up cutting off inner city neighborhoods, creating suburbs, inciting sprawl, and severing social ties: all of which had a negative, and unacknowledged, impact on health (Corburn 2009).

In the later part of the 20th century, however, health entered the planning profession through a renewed focus on "environmental health." Major environmental planning regulations were adopted during this time, including the National Environmental Policy Act (NEPA) in 1969 and the Clean Air Act in 1970. However, these regulations focused largely on the health of the natural environment rather than the implications of pollution for human health. Currently, sixteen states plus the District of Columbia, Puerto Rico, and New York City have created state and local-level NEPA-like regulations ("little NEPAs"). These regulations are intended to require environmental considerations to be included in state and local decision-making processes (Marchman 2012). These regulations may create additional activities for planners operating in these states to undertake while also focusing primarily on the environment rather than prompting a broader focus on human health in the planning profession.

2.2 Making the Case for Reuniting Health and Planning

By the late 20th century, both fields had become disconnected in research and practice: both from each other and from their original intent of protecting human health through built environment interventions. Even as late as 1994, the two fields were following very different research agendas. A literature search of planning and public health journals by Greenberg et al. (1994) found that planning research focused mainly on land use and links to economic development while public health research was still mainly concerned with individual health issues (see also Sloane 2006). However, the early 21st century has seen a revival of research addressing these disconnects and literature calling for a new agenda to reconnect the fields, although each field has taken a

somewhat different approach to this reunion. Health scholars have tended to focus on the importance of considering social determinants and taking a broad view of health, while planning scholars have primarily conducted research attempting to determine causality between built environment factors and health indicators and to educate planners on links between planning and health (for example, see Lawrence 2002, de Hollader and Staatsen 2003, Moore et al. 2003, Hirschhorn 2004, Boarnat 2006, Spielman et al. 2006, Lopez 2009, Friel et al. 2011, and Northridge and Freeman 2011).

The complex issues facing society today have created chronic human health problems that will require collaborative efforts to improve them, including changing environmental conditions. Air pollutant emissions from motor vehicles can vary based on neighborhood design and spatial location (Marshall et al. 2005, Marshall et al. 2009, Hankey et al. 2012). Poor outdoor air quality can also directly impact indoor air quality, a key concern for vulnerable populations who spend a significant portion of their time indoors (Shendell et al. 2007). In addition to negative respiratory effects, poor indoor and outdoor air quality can also limit the motivation and opportunity for physical activity (Gorman et al. 2007).

Activity patterns, including decisions to walk, bike, drive, or take public transportation, are influenced by the physical design of the built environment. Physical activity, or a lack thereof, has, in turn, been linked to rising rates of obesity, which is associated with type 2 diabetes and heart disease. Although a link exists between the design of cities and types of physical activity, there is a lack of research that fully explains this relationship or synthesizes interventions (see Handy et al. 2002, Sallis et al. 1998, Dannenberg et al. 2003, Harris et al. 2013). Complicating the matter, communities that are designed to be walkable for recreation and for daily needs are also higher density, which can contribute to a higher concentration of air pollutants (de Nazelle et al. 2009).

As attributes of the built environment are associated with both physical activity and air pollution exposure, neighborhoods must be designed such that intentions to decrease the risks from one factor do not unintentionally increase the risks from other factors (Hankey et al. 2012). Additionally, there are many indirect health concerns that arise due to the design of the built environment, including access to jobs, healthy food, and transit, and opportunity for social interaction.

However, causal relationships between sprawl, community design, housing quality, physical activity, obesity, and diabetes are difficult, if not impossible, to determine due to a plethora of complicating factors. This highlights the need for a more holistic focus on health to develop neighborhoods and cities that promote opportunities for healthier lifestyles. Although evidence suggests that land use decisions can affect health, primarily in terms of chronic disease, research conducted thus far by planners and engineers has focused largely on health outcomes that are quantifiable. In reality, this is a narrow view of how planning impacts health (Boarnet 2006). Findings from the Harlem Children's Zone Asthma Initiative demonstrated that community-based interventions such as housing improvements present opportunities for interdisciplinary collaboration, and the authors promote social equity as a qualitative measurement of health (Spielman et al. 2006).

Findings from recent studies suggest that planners and health professionals must look to a new agenda that critically and holistically analyzes current processes and proposes policies and plans that promote equitable and healthy communities. In the same way that a principle of prevention, rather than treatment, has begun to emerge within the public health field, planning has started evolving away from the notion of separated land uses that prioritize the automobile to a new recognition of the importance of compact and walkable places for economic growth and environmental sustainability through

movements such as Smart Growth and New Urbanism. Research in planning is also starting to focus more on comprehensive land use analysis to determine how policies, plans, and projects impact these types of real and perceived health concerns in order to support any changes in how planning is practiced (Barton 2005).

Even though the fields of public health and planning evolved in different directions, the recognition that land use planning can impact health never fully disappeared. In 1978, health professional O.B. Kaplan published an article in the *American Journal of Public Health* describing his experiences working to minimize health impacts of noise, garbage, and pollution through the land use planning process (Kaplan 1978). Since then, the meaning of "health" has been broadened to include the nuisances, pollutants, and genetic markers that affect individual health, as well as the social determinants that can impact entire communities. The social determinants approach to health underscores the need to involve disciplines outside of the public health field in the effort to ensure good health outcomes, especially as a good deal of evidence exists that shows connections between social determinants of health and the built environment.

2.3 The Social Determinants of Health Perspective

In 2009, the World Health Organization Commission on Social Determinants of Health stated that health is determined by the "circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces" (WHO 2009b). However, these circumstances are associated with the natural and built

environments as well. The social determinants approach proposes that improving a wide range of living conditions (including housing, transportation, jobs, education, and food access) will improve human health (Friel et al. 2011). This expanded definition of health provides a timely opportunity for the planning field to engage with health professionals, especially as social determinants of health are linked to many built environment factors.

Many World Health Organization (WHO) member countries have made declarations that have identified health as being integral to policy decisions through the Healthy Cities movement. In 1986, the Ottawa Charter identified Healthy Public Policy as one of five key health promotion actions (WHO 1986). The 1998 Athens Declaration for Healthy Cities made connections between health, equity, and sustainability, focusing on policies and plans that improve social, environmental, and economic determinants of health (WHO 1998). The Belfast Declaration of 2003 acknowledged that key determinants of health lay outside of the health sector, thus promoting partnerships between fields (WHO 2003). The 2009 Zagreb Declaration expanded the definition of health beyond access to health care and disease prevention, and committed to promoting partnership with all government sectors to advance health in their policies (WHO 2009a).

In the United States, health has been included within planning processes in a very narrow and specific way for over four decades due to NEPA, which initially grew out of concerns that federal projects were harming both the environment and human health. An original tenet of NEPA was to prevent damage "to the environment and biosphere and stimulate the health and welfare of man" (Corburn and Bhatia 2007 p. 324). In order to consider human health during the planning process, NEPA created the Environmental Impact Assessment (EIA) tool in 1969. EIA is now frequently used in planning, as it has become integrated into planning processes in the United States through NEPA legislation (Walker 2010).

However, EIA has changed from its original intent to comprehensively examine broader health concerns associated with issues such as overcrowding or auto dependence to become more narrowly focused on individual environmental pollutants (Corburn and Bhatia 2007, Northridge and Sclar 2003). A review of 42 EIAs in the United States found that EIA is more typically applied to concerns regarding the natural environment rather than to human populations. More than half of the EIAs examined contained no mention of human health impacts at all. Instead, the health impacts that were analyzed were fairly narrow, typically focusing on carcinogenic effects, and did not examine cumulative effects of multiple toxins or pollutants (Steinemann 2000). Thus, by adopting a social determinants view within planning, the commonly accepted definition of health in the environmental planning can be expanded to better reflect the original intent of NEPA.

The social determinants perspective has gained widespread traction in the public health field within the past decade largely through work of the WHO. However, research regarding the impacts of the social environment on public health goes back many decades (Yen and Syme 1999). Yen and Syme explored early sociological studies, which argued that community characteristics have implications for social cohesion, which in turn has known health implications, and that certain geographical areas remain consistent in disease rates over time even as individuals move in and out (ibid.). This points to a need to investigate not only physical but also socioeconomic characteristics of communities to fully understand the social structures, such as income stratification, employment status, educational attainment, and race, that contribute to health outcomes and create policies and programs that emphasize the environments in which people live, rather than individual behavior. While individual behaviors are important for maintaining good health, there are obstacles—especially for vulnerable populations, including children—that limit the ability to make healthy choices (Braveman et al. 2011).

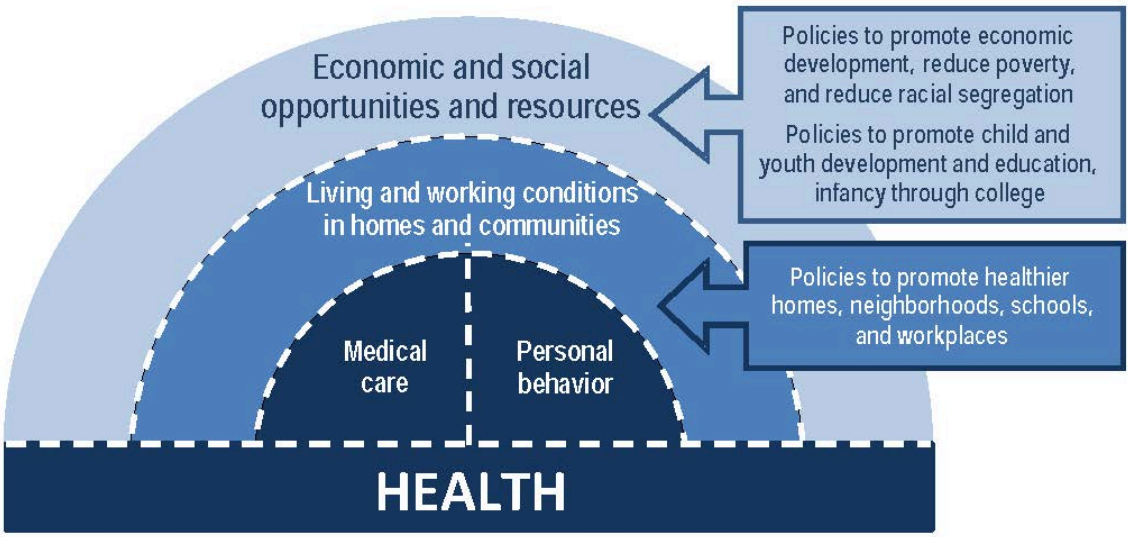
Using the social determinants framework allows researchers and practitioners in many fields to understand the variety of conditions that have an impact on public health. The framework relies heavily on sectors of society other than health to identify community needs and inequities; work to create changes in policies, programs, and plans; and attempt to improve the conditions of daily life to reduce these inequities (Marmot et al. 2008). In 2008, the WHO Commission on Social Determinants of Health put forth recommendations for action. These included increasing the focus on measuring the problem, expanding the knowledge and evidence base, furthering training opportunities for policy makers and practitioners on the social determinants of health, and raising public awareness (ibid.). While the social determinants of health framework is focused on reducing health inequities across the globe, the goals set forth are applicable to any city facing a range of health concerns due to economic, social, and physical conditions.

Such a new focus on social determinants of health, however, will require major changes in a range of policies, including those that impact land use and the design of the built environment. It will also require a new set of health indicators in order to measure progress, which will require partnerships between public health and other fields, including urban planning. When adopting the social determinants framework for a planning process in New South Wales, Australia, Ziller and Nesbitt found that selecting the social determinants-based indicators first, rather than relying on readily available health data, ensured that the indicators were based on need and not convenience. This also required partnering with other agencies, using alternative data, and collecting new data in order to measure the selected indicators (Ziller and Nesbitt 2005). Similarly, a review of livability indicators from numerous domains used the social determinants framework to identify specific connections to health in areas such as the natural environment, employment, and local food access (Badland et al. 2014).

Urban planners are tasked with understanding both the social and physical dimensions of cities in order to plan for current and future land use patterns, which can be strengthened through partnerships with public health professionals and other health stakeholders (Northridge et al. 2003). Though planners play a role in ensuring that our built environments are designed and developed in ways that positively impact public health, a variety of other partners—including government officials, public health professionals, developers, and the general public—must engage in processes that ultimately determine how cities and communities are shaped. A review of literature by Embrett and Randall found that governmental policy agendas are slow to adopt policies to improve the social determinants of health, indicating that there is a gap to be filled within the policy creation arena for a variety of topic areas that impact health (Embrett and Randall 2014).

Another study found that the diffuse nature of the social determinants of health perspective creates challenges for policies and programs that have become departmentalized for accountability reasons, which illustrates the risk-averse nature of governments (Carey and Crammond 2015). Health professionals need an awareness of the complexities of policy-making processes in order to work within these constraints; similarly, non-health professionals such as urban planners need a heightened awareness of the impacts of non-health sectors on the social determinants of health. Fortunately, recent research suggests that the understanding that the built environment plays an important role for public health (as depicted in Figure 2.1) is becoming more mainstream. At the same time, however, sustained and meaningful collaboration between planning and health departments in particular is still relatively uncommon.

Figure 2.1: Determinants of Health.



Source: Braveman et al. 2011

Both scholars and practitioners are increasingly calling for a reunification of the field of planning and public health, and in particular for better collaboration between planning and public health staff (see e.g. Letts and Milroy 1991 and Greenberg et al. 1994). However, most of the research oriented towards reconnecting the two fields has focused on providing justification for the 'why'—drawing on historical trajectories of the fields, current evidence of health implications of the built environment, an expanded definition of health, and the need for a systems approach due to the complexity of 21st century cities and problems—but have failed to focus on the 'how.' Implementing collaborative processes between planning and public health staff in practice has proved quite challenging. One method promoted within the planning and public health literature as a way to overcome this challenge is Health Impact Assessment.

2.4 Health Impact Assessment: A Potential Strategy for a Focus on Health in Planning

The development of Health Impact Assessment (HIA) has been primarily driven by the public health field, but it is increasingly seen as an evidence-based tool that can help bridge the gap between planning, health, policymaking, and research (Douglas et al. 2001, Rajotte et al. 2011). HIA has become well accepted in many countries as a method for integrating health concerns and impacts into policies, projects, and plans (Kemm et al. 2004). When conducted properly, HIA can provided evidence of the expected health impacts of proposed policies, projects, and plans that affect the built environment, with the ultimate goal of modifying the proposals to create positive health impacts, or at least minimize negative ones. Figure 2.2 outlines common characteristics of an HIA. The most widely accepted definition of HIA comes from the World Health Organization's Gothenburg Consensus Paper of 1999:

> A health impact assessment is 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 1999, in Cole et al. 2005).

Figure 2.2: General Characteristics of a Health Impact Assessment.

- Takes proposed projects, plans, or policies as the starting point for analysis.
- Comprehensively examines potential health effects, both positive and negative.
- Is based on a broad definition of public health.
- Is a collaborative, multidisciplinary process.
- Uses a structured framework to evaluate a wide range of evidence pertaining to ways that a proposed policy, plan, or project might impact health.

Source: Adapted from Cole et al. 2005

Most HIAs that are performed today take a prospective approach, conducted before important decisions are made during the planning phase of policies, projects, or plans (Mindell et al. 2004). The timing of HIA can affect the likelihood that recommendations will influence policymaker decisions as the ultimate goal is to bring health into discussions and maximize the potential of policies, projects, and plans to positively influence health (Dannenberg et al. 2006, Suther and Sandel 2013). A study evaluating the effectiveness of HIA in Australia and New Zealand found that most HIAs have either a direct or indirect influence on decision-making processes (Haigh et al. 2013).

Typical HIAs follow six steps commonly used in impact assessment practice: screening, scoping, analysis, recommendations, reporting, and monitoring and evaluation (see Wernham 2011, Wendel 2012, Suther and Sandel 2013). Although these steps are characteristic of most HIAs, there is no one prescribed analysis process that is followed, and the monitoring and evaluation step is often overlooked due to resource constraints (Dannenberg et al. 2008). Additionally, HIA can take a number of forms. A desktop HIA provides a broad overview of health impacts and may take a few weeks to complete, though it often excludes direct input from community members. A rapid HIA is also

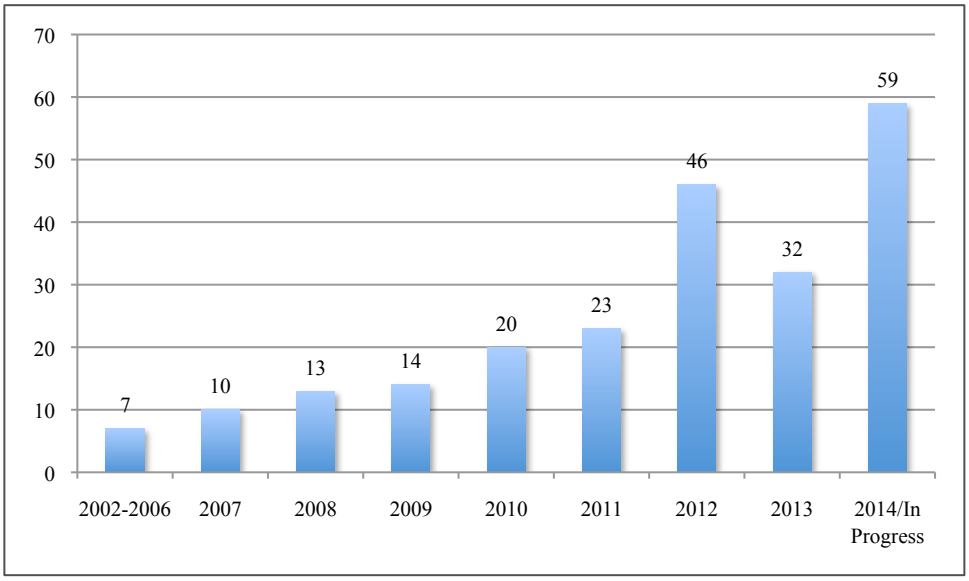
conducted relatively quickly while still having some level of community participation and input. A comprehensive HIA includes more robust community engagement and gives an in-depth assessment of health impacts, potentially taking many months to complete (Forsyth et al. 2010).

A primary benefit of the HIA process is this flexibility in form as well as its ability to integrate various methods and data. Some HIAs are based primarily on quantitative data, while some include more qualitative information, such as data gathered during interviews or focus groups, which is not easily measured (Forsyth et al. 2010). Although quantitative estimates are useful to determine the significance of potential health impacts and may be more readily accepted as evidence by policymakers, few standardized tools exist for this type of estimation and some important impacts to health are not easily quantified. An evidence-based approach to HIA implies that decisions should be based on the most meaningful evidence available; however, relationships between determinants of health and causal pathways can be complex, have multiple effects, and be difficult to locate, quantify, and analyze (Mcintyre and Petticrew 1999, Taylor and Quigley 2002).

HIAs conducted in the late 1990s and early 2000s in the United Kingdom and Europe provided the first concrete examples in practice (Scott-Samuel 1998, Cole et al. 2005). While the United States has been much slower to adopt the HIA process, the past several years has seen an increase in the number of completed HIAs within the U.S. An examination of completed and in-progress land-use and planning-related HIAs found in the Health Impact Project Database (The Pew Charitable Trusts n.d.) and the UCLA Health Impact Assessment Clearinghouse (HIA-CLIC n.d.) illustrates this growth. Although only seven HIAs had been completed by 2006, there were over 30 completed in 2013 alone, with 59 more listed as completed in 2014 or in progress (see Figure 2.3).

Published HIAs can serve as an important resource for health and planning departments looking to initiate the practice (see Corburn and Bhatia 2007, Roof and Glandon 2008, Hoehner et al. 2012, Maclennan et al. 2012, Ross et al. 2012, and Haggerty and Melnick 2013).

Figure 2.3: HIAs Completed by Year.



Categories from Health Impact Project Database: Housing, Transportation, Built Environment, Physical Activity. Categories from UCLA Health Impact Assessment Clearinghouse: Community Planning, Housing, Land Use Planning, Parks and Recreation, Transportation.

The public health field has typically led the HIA process but there are benefits to engaging the field of planning. First, an important component of HIA is the involvement of stakeholders and the general public in participatory processes that are aimed at gaining local knowledge of health concerns. Planners develop particular expertise in designing and conducting participatory processes and can contribute that experience to the process

(Rutt et al. 2008). A prospective HIA in Britain found that when it came to the public participation aspect of the HIA, it was difficult for public health experts to convey in simple terms the health impacts of the proposed projects. Health professionals can work with planners to craft health language that is easy for both planners and the general public to understand (Curtis et al. 2002). The inclusion of planners in HIA processes also provides an opportunity to bring public health issues to the attention of policymakers through their established relationships with planners (Rutt et al. 2008).

However, there are also challenges to including planners in HIA processes. An argument against full planning participation in or ownership of HIA is that they are often done on topics outside of the realm of planning, such as tobacco sale regulations or mental health counseling (Forsyth et al. 2010). Despite this, planners could still be involved in HIAs that are conducted on land-use related plans, projects, and policies. Another large constraint is that few planners or public health professionals or officials have adequate knowledge of each other's fields, which could make the process of conducting an HIA challenging (Carmichael et al. 2012).

The introduction of any new tool into the planning process is likely to garner some pushback or frustration, especially on the part of planning staff (Forsyth et al. 2010). In order for planners to prioritize health on top of their current workload, more straightforward tools and methods are needed. HIA has the potential to provide this, but the lack of fully defined structure, guidelines, and process for HIA—while also considered an asset—is a current limitation of the tool when seeking to engage stakeholders outside of the health field (ibid., Hebert et al. 2012).

HIA can have benefits for capacity building and communication, not just between public health, planning, and other city agencies, but with the community as well (Dannenberg et al. 2006). By integrating urban planners into HIA processes, the HIA will

benefit from planners' perspective on how the built environment, land use, and health are connected, and what potential indicators could be used to monitor plans, policies, and projects once they are implemented in order to determine actual health outcomes (Northridge and Sclar 2003). In theory it is generally agreed that it is a useful tool for planners to engage with, but in practice a more permanent and widespread adoption of HIA could prove difficult.

2.5 Creating Structural Changes: Challenges and Opportunities for Reuniting Public Health and Planning

A review of health and planning related literature suggests that the time has come for the fields of health and planning to collaborate with the common goal of improving conditions of the built environment under a comprehensive focus on public health. However, the best way to achieve this goal is still unclear. Some factors of health are beginning to be included within planning documents in many cities. The American Planning Association conducted a survey in 2010 to identify adopted comprehensive plans that explicitly included public health goals and to document the types of public health topics that are included. Most respondents indicated that health was addressed in specific plan elements, including land use, transportation, recreation and open space, and bicycle and pedestrian components, but not as a framework for the plan as a whole (American Planning Association 2011). This indicates that the field of planning practice, in general, has not fully adopted the social determinants of health view advocated for by the WHO and the public health field.

An in depth look at integration between health and planning in Norway concluded that taking a broader view of health in planning may be a premature goal due to

challenges that it presents to currently established planning processes. Planners may acknowledge health but, with the exception of including health language in comprehensive plan elements, are unsure how to fully incorporate it into their work (Hofstad 2011). Although planners do recognize that their profession has an influence on health, their priorities lie elsewhere (Barton 2005). Redefining the field of planning to focus on health will not be as simple as making slight improvements to existing processes; it will essentially mean an overhaul of the entire definition of planning in order to prioritize health (Chapman 2010). Allowing public health professionals to take part in planning processes is a first step in addressing this challenge. This would also help with rethinking and reshaping established processes to intentionally incorporate knowledge from outside of the planning field. Thus, in order to begin to incorporate health into land use decisions in an effort to create institutional change and redefine how planning is practiced, collaboration between the fields is needed.

The field of planning has become segmented, with varying specializations of planners focusing on different built environment aspects, such as housing and transportation. A renewed focus on health within planning will require collaboration not only between planning and other disciplines—primarily public health—but also within the field of planning (Trowbridge et al. 2013, Badland et al. 2014). Due to the complexity of health effects that stem from land use and planning decisions, a systems approach will be needed to begin to make positive impacts to chronic disease epidemics. Such an approach would take the form of a comprehensive strategy for combating health issues that includes interdisciplinary collaboration and strategies that are targeted to change both policy and individual behavior (Huang et al. 2011).

Other popular paradigms within the planning field also provide opportunities for more deliberate inclusion of public health concerns. Recent planning interventions that

focus on community design, such as Smart Growth and New Urbanism, cite walkability and accessibility among their goals, but primarily in response to the increased auto dependence in the United States; health, in its more broadly defined social determinants form, is not yet stated as a specific goal of these programs. Beginning in the early years of the 21st century, planning has also developed a focus on "sustainability" as a means of promoting human welfare and protection of the natural environment. However, human health is not explicitly and widely factored into sustainability (Kozlowski and Hill 2000). The basic assumptions of these movements could be expanded to include a more purposeful, rather than peripheral, focus on conditions that affect human health.

2.6 CONCLUSION

Reviewing the literature shows how the fields of planning and health have developed and provides guidance for the future directions of both fields. Breaking down the silos that have been created in order to enhance communication between planning and health departments is a critical step to achieving healthy planning policies. Pursuing a planning discipline that is directed towards improving public health will require effort not only from public health professionals and planners, but from policymakers as well (Thomson 2008).

Within planning, the definition of "health" must be expanded. Healthy cities involve more than just promotion of physical activity, which has largely been the focus of research in the urban planning field. As Northridge and Freeman write, "healthy urban planning means planning for people in cities. It promotes the idea that the city is much

more than buildings, streets, and open spaces; it is a dynamic social space, the health of which is closely linked to that of its residents" (Northridge and Freeman 2011 p. 593).

The past decade has seen a resurgence in calls to reconnect the fields of urban planning and public health, largely due to the growing recognition that land use decisions can have great impacts on the physical, social, and mental health of communities. It is now accepted that most influences on public health lay outside of the health sector (Mcintyre and Petticrew 1999). Additionally, there is increasing interest in the potential for changes in the built environment to alleviate current health issues, including obesity, asthma, air and noise pollution, and mental health (Forsyth et al. 2010a). To improve health, policies in other sectors, such as housing, education, transportation, and land use, must be informed by various environmental, economic, and social determinants of health (Douglas et al. 2001).

However, strategies are missing to move this research into action in practice. Joint development of tools and guidelines for assessment and evaluation, and mechanisms for public input, all with the agenda of advancing and addressing urban health and health equity, is a critical next step (Friel et al. 2011). A tool that currently exists, Health Impact Assessment, is a potential model for integrating health within plans and policies but research indicates that other methods may be more effective and less resource intensive.

Regardless of the method, collaboration between health and planning departments is critical to bring a health focus back to the planning field in general. Research suggest that planners do view the inclusion of health within planning processes as a positive opportunity to promote the betterment and welfare of society: the very reason why urban planning initially arose as a discipline. However, there are obstacles against inter-institutional collaboration, which, in turn, prevent a more widespread focus on health in planning. In the next chapter, I present a theoretical framework that provides insight into

both the importance of striving for a focus of health within planning and the potential of collaboration as a process to achieve this, and how the institution of planning itself has the opportunity and ability to adapt and change through the sharing of knowledge and values.

Chapter Three: Communicative Planning, Collaboration, and Change in the Planning Field

3.0 Introduction: The Basis for a Theoretical Exploration of Research Questions

Previous planning research has attempted to identify correlations between aspects of the built environment—including transportation options and land use mix—and health indicators, generally revolving around opportunities for physical activity. The dominant approach in this research is based on the theoretical assumption that an aspect of the built environment influences certain behaviors, which can have a specific impact on health (see Frank and Engleke 2001, Angotti and Hanhardt 2001, Frank et al. 2003, Frumkin et al. 2004, Baker 2005, Laurian 2006, Rodriguez et al. 2007, Joh et al. 2012, Koohsari et al. 2013, Besenyi et al. 2014). This type of research provides the basis for movements such as Smart Growth and New Urbanism, where health goals are typically addressed through creating walkable and bikeable communities. However, this view of health is narrower than the view prescribed by the social determinants of health perspective, which emphasizes an approach to health promotion that explores the role of a broad set of social and environmental factors. From this larger understanding of factors that shape healthy communities, planning needs to change its understanding and approach to public health at a more profound, institutional level rather than simply focusing on specific built environment factors that shape health outcomes (Barton and Grant 2011, Badland et al. 2014).

My research focuses on the challenges and opportunities for incorporating this social determinants perspective on health in planning. I seek to understand how planners conceptualize the relationship between health and planning goals, the current and potential use of HIA, and the challenges and opportunities that face planners who are working to incorporate health into their work. However, in order to identify the obstacles and opportunities for change and thus promote a focus on health within established planning processes, both in daily practice and in terms of institutional priorities, it is necessary to understand how planning practice and practitioners view and respond to health concerns. Even though the growing evidence of the connections between public health and the built environment argues for a greater focus on and different approach to addressing health outcomes in planning (Botchwey et al. 2014), it is not yet clear how these changes will take place.

This lack of understanding of change in the planning field stems, in part, from a lack of a common theory to define both the goals of planning and the appropriate roles for planners in working towards these goals. As the practice of planning has changed over time, theorists have developed a number of frameworks to help explain and guide planning practice (Allmendinger 2002). In terms of public health and planning, the review of the evolution of both field in Chapter Two revealed that the values, theories, and focuses of each field have shifted and evolved over time. As the field of planning evolved, priorities became more inwardly focused, which has led to a greater need for improved collaboration across departments and agencies in order to incorporate health in planning processes (Barton and Grant 2011, Koohsari et al. 2013). However, this turn away from a health focus in planning also requires a shift in how the planning field understands health in order to holistically adopt the social determinants of health perspective that is promoted by the public health field (Kent and Thompson 2012).

In this chapter, I explore how theory helps explain relationships between the values of planners and their view and understanding of planning goals. This leads to the question of how planners' view of health may impede changes in planning practice to adopt a focus on health, and, conversely, how planners' daily practices may contribute to change despite these obstacles. This review of theory positions my research questions within a larger discussion of the purposes and practice of planning.

Although the diversity of theoretical approaches to conceptualizing planning practice, planning goals, and institutional change only underscores the complexity of the field of planning as "an art, a science, and a field of design" (Neuman 2012 p. 139), this theoretical heterogeneity also provides an opportunity to draw from a number of theories to begin to explore the drivers of institutional change through planning practice. In this chapter, I first draw on theoretical work in communicative action theory and normative planning theory to understand how the goals and processes of planning are currently conceptualized, in order to bridge these two theoretical perspectives in planning. The work of communicative action theorists focuses on the planning process itself and provides insights into the factors that shape communication, and hence collaboration, between planners and other actor groups. This work also provides insights into the role of planning practice in shaping institutional change. In particular, the collaborative "school" in communicative planning focused on understanding the potential of communicative practice to initiate change in planning process. Normative theory, on the other hand, makes an argument that planners' values are critical elements in determining the desired outcome of planning. These scholars, often seen to be in conflict with communicative action scholars, are focused on the normative goals of planning as an instrument for producing equitable societies, rather than focusing on the planning process itself. However, the normative school in planning theory points to the need to review the role of

rationality and power within planning processes in order to understand the limitations of planners' agency in terms of effecting institutional change. I conclude with a review of the limited literature on institutional change in planning, suggesting that further work is needed in this area to critically understand the effectiveness of potential drivers of change for individual planners, for planning processes, and for the institution of planning itself.

3.1 Communicative Action Theory and the Means to an End

Communicative action theory provides a basis for understanding the process of planning. The communicative school of planning theory evolved primarily out of pragmatism and the work of sociologist and philosopher Jurgen Habermas. Pragmatism is a philosophical tradition that integrates empiricism (which is experience and sensory perception based) and rationalism (which is deduction and intellect based), and emphasizes "practical judgment situated in specific contexts" (Healey 2009 p. 279). It is a philosophy of action, rather than one of knowing or being (Hoch 1984).

Working in the pragmatist tradition, Jurgen Habermas developed his theory of communicative rationality, which promotes cooperation and collective understanding rather than action designed to achieve personal goals (Bolton 2005). Communicative rationality differs from scientific rationality in that culture, values, and experience are included in the search for agreed upon actions. This theory holds that consensus and truth cannot be reached through overt exercise of power, but instead through dialogue within the public sphere where people can learn from one another. Thus, the theoretical basis of communicative rationality lends itself to conceptualizing a planning practice that is less focused on technical knowledge and instead emphasizes the significance of reflective and

inclusive processes when searching for truth and consensus (Habermas 2004, Bolton 2005).

Several planning theorists have drawn on Habermas and pragmatism to develop the communicative action school that aims to improve the process of planning (Forester 1989). Communicative action theory for public participation emphasizes the means of planning processes rather than a specific and normative end goal, and calls for collaborative processes in which all stakeholders are involved in order to ensure fair and equal participation and to reach consensus (Watson 2003). Forester also sees participatory processes themselves as opportunities for transformative learning for the participants. He describes participatory rituals as "encounters in which 'meeting those people' comes first, even if it serves the secondary objective of 'solving our problem'" (Forester 1999 p. 132). Learning about others through these rituals allows the participants to see one another in new ways, redefine and clarify problems and opportunities, and reorder priorities, leading to mutual understanding, discovery, and transformation of identity (ibid.). Moreover, through dialogue facilitated by reflective processes lies a potential to transform existing power relations and thus effect changes to established planning practices and institutions (Healey 1999).

3.2 Normative Theory and Goals for Planning

While communicative action theory provides a framework to understand how the *process* of planning can facilitate a focus on health so that it becomes the everyday norm for the activities of planners, other planning scholars, including Susan Fainstein, maintain that the field should focus on the *outcome* of planning first in order to establish a shared

understanding of the goals of planning, including the goal of healthy environments for all. Essentially, normative theory emphasizes that planning should be based on desirable ends, thus foregrounding the role of values in shaping the preferred outcomes of decision-making (Brooks 2002, Fainstein 2005, Fainstein 2010). A central tenet of normative planning is the concept of distributed justice, which concerns the equitable and socially just distribution of goods in society, including conditions that further healthy lives. Friedmann asserts that planners must ask themselves: "Given the reality of what is happening now, can planning powers intervene to shift the balance of forces toward goals of social justice and inclusion in the ongoing processes of urban and regional restructuring, and with what tools at hand?" (Friedmann 2008 p. 250).

Brooks describes two types of normative theory in planning: functional and ethical. Functional normative theory is based on technical rationality in planning practice and is linked to normative ends. As the understanding of the relationship between values, goals, and decision-making in planning has increased, functional normative theory has become a less dominant planning paradigm. Ethical normative theory, on the other hand, is based on assumption of shared values among actors (Brooks 2002). However, over time planning scholars have come to question this assumption, as values of various stakeholders have been found to differ. While normative planning is based on the imperative of fair distribution of goods and reduction of inequities, this concept does not take into account the *causes* of injustice, which stem from the power relations that shape institutional structures (Marcuse 2009). In practice, therefore, a normative approach to planning premised on "right" and "just" outcomes is likely to encounter difficulties. This is because these desired outcomes are dependent on values, and these values may conflict.

While values are very personal and can change over time, core values that the planning profession must uphold relate to the original mission of the field. While seemingly impossible for all planners to share the same set of values, normative theory suggests that the principles on which the planning profession was founded—namely protecting and improving the health and welfare of all people—is a core value that must be shared and promoted within the profession. Highlighting the moral and ethical reasons for planning for public health may be critical to driving a focus on health, as health is still not a leading policy priority in local governments (Rydin 2012).

Ultimately, the normative theoretical understanding of planning as grounded in values, equity, and outcomes does not provide a sufficient framework for understanding how, in practice, planners should bring alternate perspectives into their work. Furthermore, whether and how health is valued by planners, and whether the individual values of planners can help or hinder a shift to a deliberate focus on public health within planning, is not well understood. And, although health and wellbeing are often positioned as a central purpose of planning, how this oft-stated normative goal is put into practice remains unclear. These limitations of normative planning calls for an integrated theoretical framework that incorporates both the attention to daily planning practice emphasized by communicative action theory coupled with the focus on shared values and common goals called for by normative planning theorists.

3.3 Means, Ends, or Both: A Discussion of Theoretical Conflicts, Rationality, And Power

Communicative action theory appears to be in direct conflict with normative theory, which is rooted in the assumption that the shared value of equity should define the outcomes of planning. Planning scholars have made various arguments for and against both theories and their applications to planning practice. Patsy Healey, a communicative action theorist, argues that the problem with focusing on substantive issues in planning practice (the end goals) is that it maintains normative assumptions of what is "good or bad, right or wrong" (Healey 1993 p. 233). Instead, the "process route" explores communicative forms of planning, specifically communicative rationality, as ways of moving forward together in order to jointly develop shared values. Another critique of normative theory challenges the assumption that there is, or should be, one set of values at the core of the planning profession (Brooks 2002). Although communicative rationality represents an ideal that is never achieved in practice, Innes and Booher, maintain that communicative processes are ultimately the primary means of planning (Innes and Booher 1999).

However, similar to Fainstein, planning scholar Diana MacCallum takes issue with the "means" focus of communicative action theory. She suggests that plans—which are a product of planning processes—embody a means-ends argument, standing as independent products from the people who produced them and providing a guide for the future (MacCallum 2008). MacCallum sees a problem of "translation" between the collaborative planning process and the necessary outcome of strategic or comprehensive planning; in other words, the comprehensive *plan* itself. She suggests there is a contradiction between the need to produce a logical and conventional plan and the stated

ideals of participatory processes, which do not prescribe rational outcomes. She argues, therefore, that conventional plan production in fact is a highly rational process, and that the production of such rational plans negatively impacts the adherence to participatory ideals (ibid.). While she does not directly criticize communicative action theory itself, MacCallum does see a need to focus on the problem of translation between process and outcome, which, she argues, communicative action theorists neglect to consider.

Other critiques have also emerged in terms of how communicative action theorists treat the concept of rationality. For communicative action theorists, rationality is defined as communicative rationality: if certain conditions are met that allow for open dialogue among stakeholders of a particular issue, any consensus reached will be inherently rational (Innes and Booher 1999). Vanessa Watson takes issue with this concept of rationality by arguing that not only are there "multiple rationalities" at play within planning processes, but that these rationalities are often in conflict. Watson argues that consensus-seeking planning processes are highly problematic when dealing with fundamental differences (including class, gender, ethnicity, age, race, religion, or sexuality) that are not easily resolved or generalized (Watson 2006). These fundamental differences of values, needs, or desires, both within and between groups, pose challenges to planning processes that operate under assumptions that interaction, communication, and debate can lead to voluntary and consensual agreement (Watson 2002). According to Watson, these differences are much deeper than assumed by communicative action theorists and can lead to conflict rather than consensus (Watson 2003). Additionally, the communicative rationality promoted by Habermas and communicative action theorists may be difficult to sustain when different groups have different definitions of "rational". When considering what Watson terms "conflicting rationalities," which can also be

thought of as conflicting goals and values, it appears that consensus may not be possible in the way assumed by communicative action theorists.

Other critics of the assumption of consensus through communicative rationality focus on how power, not communication, shapes rationality. Flyvbjerg writes that "power *defines* what counts as rationality and knowledge and thereby what counts as reality" (Flyvbjerg 1998a p. 227, emphasis in original). He argues that the power relations within planning processes ultimately shape what is thought of as "rational" and what types of knowledge are considered valuable for planning decisions. Such critics refute the claim that achieving a universal rationality is possible due to multiple rationalities and multiple ways of thinking about planning, which in turn are shaped by power (see Flyvbjerg 1998a, Flyvbjerg 1998b, Huxley and Yiftachel 2000, Rydin 2007). Therefore, consensus-seeking planning processes are highly problematic due to fundamental differences among people that are not easily resolved or generalized (Watson 2006). Alexander further raises the issue of *who* planning is for, noting that planning is a political and often adversarial process that, in practice, may be value-laden and absent of rational decision-making (Alexander 2009).

Despite these critiques, and even though they do recognize that different groups have different needs and values, communicative planning theorists operate under an assumption that the communicative process will resolve conflicts and produce a rational outcome that will address these differences, so long as planners recognize how to anticipate these needs. For example, consensus building is a method of deliberation whereby a wide range of stakeholders, representing varied interests, knowledge, and information, are brought together for discussion (Innes 1996, Innes 1998) under the premise that agreement can be achieved. However, according to Watson, the role of planners has not been sufficiently addressed in terms of how their own values affect these

consensus-building processes (Watson 2003). This, in turn, highlights the importance of defining a normative end that can be achieved through a means that emphasizes collaboration, discussion, and knowledge sharing. As the professional priorities and daily practices of planning shape the values of planners, collaboration between planning and health is necessary to define the role of planners and develop a health focus in planning. Accomplishing such a shift, however, will require a reframing of the profession itself, which has evolved to become less attuned to collaboration with agencies that are seemingly outside of the scope of planning.

3.4 The Collaborative Approach to Communicative Action

While the critiques of communicative action theory associated with assumptions of rationality, power, and consensus are important, the communicative action school has provided significant insights into the collaborative dimensions of planning. Innes and Booher argue that collaborative processes are effective for dealing with conflict as well as addressing growing differences in values and knowledge among stakeholder groups (Innes and Booher 1999). In a similar vein, Healey also emphasizes the collaborative and transformative, rather than consensus-building and conflict resolution, dimensions of communicative action theory. Even though she is a proponent of communicative action theory, Healey departs from Habermas' ideal of consensus, arguing that such agreements should be seen as temporary, rather than final or concrete, accommodations (Healey 1993). Healey suggests that communicative processes furnish opportunities for continuous learning and discovery and provide a platform to uncover mutual interests (ibid.). Thus, from the perspective of this collaborative emphasis in communicative

action theory, the communicative process itself provides a means to establish new practices and ideas, thereby prompting changes to existing practices and processes which might have broader, institutional impacts (Innes and Booher 1999).

Healey also argues that collaborative approaches to planning can serve to build institutional capacity within local governments in order to facilitate new initiatives and achieve change (Healey 1998a). Collaborative planning emphasizes the role of knowledge derived from other fields, agencies, and groups in shaping planning processes and broadening stakeholder involvement. Healey suggests that building this institutional capacity takes priority over building places, neighborhoods, and cities (ibid.). However, this perspective again places the means before the ends as premised by communicative action theory. Primarily in contexts where power is diffused among various levels of government, such as in the United States, conflicts will inevitably arise if collaborative efforts that aim for agreement and transformation are not in place (Healey 1998b). Through collaborative processes, differences in values and concerns among stakeholders are drawn out at the outset as the planning framework is still being developed (ibid.). It is assumed that through collaboration and discussion, common goals—previously undefined—will emerge, thus resolving anticipated conflicts.

However, such a continuous process of discovery makes it difficult to define what the practice of planning should try to accomplish. In practice, resource constraints will likely not allow for processes with ill-defined ends. Ultimately, this emphasis on the process of planning in the theory of collaborative planning points to a deficiency in the literature regarding the interests and values that compel stakeholders to engage in collaboration to begin with, as well as a lack of critical consideration of the characteristics and types of stakeholders invited into the process. As previously discussed, planning is not a value-neutral activity, and stakeholders bring their own

values to the table as well. Even though collaborative processes can serve to transform these values, it is unclear whether having defined, normative "ends"—which is not implicit within communicative action theory or collaborative planning—is an impetus for collaboration, or not. It is possible that stakeholders are drawn to collaborate with others who share their values in pursuit of a common goal, even though they might come from different perspectives and knowledge bases. A survey of community development and health practitioners found that mutual respect, shared values, and common goals were critical factors to successful collaboration across sectors, indicating that these values and goals were shared prior to collaborating (Mattessich and Rausch 2014). Additionally, it is unclear how vastly differing values and a disagreement on outcomes may impact collaborative process. Thus, defining a common goal or outcome, coupled with a process to achieve the goal or outcome, may prove more effective in creating lasting change within cities and planning institutions.

In order to achieve the "ends" of planning, there must be a process in place (the "means") to reach those ends. The collaborative turn in communicative action theory can provide the foundation for conceptualizing a process to achieve planning outcomes. Healey herself argues that collaborative planning can be thought of as a method to refocus planning systems to respond to governmental pressures (Healey 1998b); these pressures may represent an outcome-oriented, though context-dependent, basis of planning processes. However, although collaborative processes are critical in order to bring together various perspectives, the lack of a focus on these "ends" may derail the effectiveness in creating institutional change.

Although communicative and collaborative processes indicate a way by which planning goals can be further discussed, conceptualized, and achieved, "consensus" may not be an appropriate goal when seeking to instill a health focus into the field of planning.

"Health" can mean different things to different people and is therefore a highly personal construct. There cannot be consensus in terms of reaching for a certain level of "health" for an individual or a community. Also, while communicative processes are in fact useful and necessary in planning and decision-making, the process of communication itself cannot be favored to the exclusion of an understanding of underlying social and political processes (Huxley and Yiftachel 2000). Rather, the role of the planner is to critically examine each situation—whether a plan, project, or policy—and work with stakeholders to incorporate the appropriate perspectives and knowledge to create healthy places that are appropriate, culturally or otherwise, for the people who live, work, and play in these places. By focusing on such collective production and sharing of knowledge in order to meet a specific outcome, collaborative relationships can be formed that, in turn, can begin to forge a health focus of planning. In the following section, I explore the research in planning that engages with questions of institutional change in order to further conceptualize the role of collaborative planning in effecting broader changes within planning institutions.

3.5 Drivers of Change in Planning Practice

The most effective mechanisms for change within the planning profession are not well understood in planning theory, in part because no agreement has been reached on the definition of "institutions" or the process by which they change (Kingston and Caballero 2009). Change can be spontaneous or deliberate, bottom-up or top-down, informal or formal; the ability to change, specifically within an institution, is also context dependent, which adds to the complexity and limits the development of a commonly agreed-upon

conceptualization of institutional change (ibid.). Thus, does change within planning institutions occur by implementing practices to achieve defined, specific, and normative goals? Or does a reflexive process where values and knowledge are explored and transformed lead to changes within the planning field?

Patsy Healey links communicative action with a theory of "institutionalism," which she defines as "the embedding of specific practices in a wider context of social relations that cut across the landscape of formal organizations, and to the active processes by which individuals in social contexts construct their ways of thinking and acting" (Healey 1999 pp. 112-113). While this does not specifically address how daily practices of planners are linked to changes within the planning field, it begins to show how individual values are created and constructed. Healey draws on Giddens' social theory of structuration when presenting her perspective on institutionalism. In structuration theory, a main proposition is that "the rules and resources drawn upon in the production and reproduction of social action are at the same time the means of system reproduction (the duality of structure)" (Giddens 1984 p. 19). Essentially, Giddens suggests that the values, networks, and processes of institutions evolve over time (Neuman 2012) in tune with social action. As institutions develop, patterns of individual actor behavior slowly inscribe their meanings into the institution (Giddens 1984). As daily activities change to reflect new knowledge, they become routine. Old values are replaced with new values, which help restructure the institution until gradually, a new institution is created (Neuman 2012). According to Healey, "institutionalist social theory is not merely about the forces shaping practices. It emphasizes how practices shape these forces, sometimes as unintended consequences, but often through conscious, strategic transformative action" (Healey 1999 p. 114), such as in the case of practicing planners who take the initiative to promote a health focus within their departments.

However, Fainstein argues that negotiation and communication alone is not enough to change consciousness and policy around a given issue; other factors including leadership and power are needed in order to put new ideas into practice (Fainstein 2000). In order to create change within the practice of planning, there are a variety of drivers that may have an impact aside from processes of collaboration between stakeholders. Specific to including a health perspective, these drivers include the use of incentives, the role of professional organizations that support planners, prioritization of health issues that emerge within cities, and regulatory frameworks that structure daily work. There are multiple opportunities within the practice of planning and the individual activities of planners where change can be facilitated, though the success of these measures with respect to adopting health goals within planning has not been well defined.

First, the use of incentives to encourage action or change behavior is one way to modify actions of planning departments, and specifically the way that planners and the planning field consider health. Local government leaders may be persuaded by the economic argument for healthier built environments, as higher rates of chronic disease are associated with economic costs. For example, one study estimated that the United States spent $190 billion on health care costs related to obesity in 2012 alone (Harvard School of Public Health n.d.), which makes a compelling argument for prioritizing interventions that improve built environment conditions to promote physical activity and healthy food access. Additionally, incentives such as awards or accolades for planning documents that consider health may motivate planning departments to adapt current planning processes. The American Planning Association's (APA) National Planning Awards, which encompass a number of categories including transportation, environmental planning, and urban design, could have a dedicated award for the inclusion of health-related goals within plans (American Planning Association 2015d).

Local chapters of professional organizations can also play a role in encouraging planners and planning departments to adopt a new focus or modify current processes. With respect to health specifically, these groups may be an underutilized driver of change within the planning profession. Individual APA chapters are the primary contact points for practicing planners to engage with on a local level, and these chapters offer conferences, workshops, and networking opportunities (American Planning Association 2015c). While APA National has a strong focus on healthy communities, individual chapters could become more involved in education, outreach, and programming to specifically support health inclusion within planning processes.

Another factor that may drive change in terms of how health issues are framed and prioritized is the real and perceived impacts of specific health issues. Recently, various media outlets have published lists of the healthiest and unhealthiest cities, causing some cities on the unhealthy list to work to change that image. In 2007, after being included in a list of the nation's most obese cities, Mayor Mick Cornett of Oklahoma City declared that the city was going on a diet to lose a collective one million pounds. With Cornett leading the charge, city officials worked to redesign the city, including adding new sidewalks, bike trails, a water sports venue, and senior health centers, and planning for a new streetcar line and a central park. By 2012, the city had met the mayor's goal and Oklahoma City is now one of the fittest cities in the country with one of the strongest economies and lowest unemployment rates (NationSwell 2014). Thus, real and perceived chronic disease epidemics in cities may drive elected officials and city leaders to create changes to improve health.

Additionally, there are regulatory frameworks that require planning departments to perform a separate review process related to environmental issues. Through NEPA, federal agencies are mandated to consider the environmental impacts of their decisions by

preparing Environmental Impact Statements that describe the positive and negative impacts of proposed actions (U.S. EPA 2015). In addition to NEPA, many states have state-level requirements that are similar to NEPA, requiring additional analysis of plan and project impacts (Council on Environmental Quality 2013). Leveraging these existing federal and state environmental regulations may provide additional opportunity to raise planners' attention to other issues, including health, which has clear links to the environment.

Ultimately, the mechanisms through which institutions, including planning departments, change are unclear. There is a range of drivers, many of which are contingent on geographical, political, and jurisdictional contexts, which may encourage change towards the development of a focus on a health perspective in planning, and it may take a combination of these drivers to impart a focus on health within any given planning department. However, as pointed out within the growing literature on social determinants of health (see Ziller and Nesbitt 2005, Marmot et al. 2008, Badland et al. 2014, and Embrett and Randall 2014), collaboration between health and planning departments is crucial to stimulate such change because of the exceedingly complex connections between human health and land use and built environment factors (Northridge et al. 2003). It is through collaborative processes with other stakeholders that individual planners can share their knowledge and values, learn from one another, and begin to reframe how they see themselves and their roles, specifically in terms of adopting a health focus.

3.6 CONCLUSION

Ultimately, there are a variety of factors that may drive institutional change, including the development of a focus on health in planning. These factors are largely context dependent, including current health issues prompting jurisdictions to take action as well as regulations that force change within planning processes, although more individualized approaches, including national recognition programs, may prove effective as well. However, numerous examples of collaboration between planning and health departments under different institutional and public health contexts are emerging, suggesting a need for a greater focus on understanding the role of collaboration for fostering change in the planning profession.

The collaborative "school" within communicative action theory proposes that collaborative processes lead to mutual learning and discovery that can shape planning practice, with planners facilitating the sharing of knowledge between various stakeholders. Even though it has been argued by many planning theorists that the Habermasian ideal of resolution of conflict and consensus by all stakeholder groups is unachievable, the theoretical perspective on collaboration provided by Healey provides a means to better understand the significance of value formation through collaborative processes. Through collaborative processes between stakeholder groups, knowledge and values can be presented and shared in order to achieve the normative outcome of a focus on health within planning. In order for planning to holistically endorse a normative focus on health, therefore, it is necessary to examine the challenges to and opportunities for change found in the daily practices of collaboration.

The complex interplay between daily practices of planning and normative goals calls for a theoretical framework that conceptualizes the links between the process and the outcomes of planning practice. In planning theory, the normative and communicative approaches have dominated the field, although they are thought of as conflicting rather than commensurate (Yifchatel 1999). Normative planning focuses on the outcomes of planning by prescribing "what the relationship between the variables in question should be in order to produce results that are deemed desirable" (Brooks 2002 p. 22). Fainstein grounds the desired outcome in her concept of the "just city" which concerns the equitable and socially just distribution of goods in society (Fainstein 2005), including values related to health. Meanwhile, communicative action theory focuses instead on the process of planning in an effort to achieve consensus and agreement among various stakeholders on an undetermined outcome (Forester 1999, Watson 2003).

While the desired outcome of planning that includes a focus on health goals can be justified through normative planning theory, this theory neglects to specify the best way to achieve this outcome. In turn, this desired outcome will depend largely on the ability of planners and the planning field to collaborate and communicate with other stakeholders, which is the focus of communicative planning theory. Seeking to build a conceptual connection between these theoretical positions, collaborative planning theory recognizes that values are integral to the planning process, which leads to an emphasis on incorporating multiple knowledge systems and values instead of striving to achieve consensus. Through collaborative processes, knowledge and values from the public health field can slowly shift the planning field towards a focus on health, which in turn may help fulfill the normative goal of the field: to protect and promote the welfare of society. Thus, by drawing these theoretical perspectives into an overarching theoretical framework for my research, I seek to explain both value-based and structural challenges

and opportunities for a health focus within the field of planning. The next chapter outlines the methods used in my research to explore both these challenges and opportunities.

Chapter Four: Methodology: Understanding Health and Planning Collaboration in Practice

4.0 INTRODUCTION

In this chapter, I review the methods used in this research and the reasons why these methods were selected. I first present the design of this research study and the methods I selected. Next, I describe each phase of the research, including a more in-depth discussion of the research tools used and my preliminary analysis of the data collected in each phase. A nationwide survey served to provide understanding of the state of integrating health issues within planning departments. The first round of interviews were conducted in San Francisco, as this city is an early example of collaboration and has been promoted in literature as a best practice. The next round of interviews was with four other cities of varying sizes and structures in order to gain a more comprehensive look into catalysts for collaboration.

When researching any topic, selecting appropriate research methods and constructing an appropriate research design is critical. My research questions lend themselves to both qualitative and quantitative research methods: my assumption that health is currently being included in some way in planning processes in cities throughout the country should be tested quantitatively, while a deeper understanding of how and why health is incorporated into planning processes should utilize qualitative methods. As both methods will prove useful, a mixed methods research design is the most appropriate for this research (Creswell and Plano Clark 2007).

4.1 RESEARCH DESIGN, METHODS, AND GOALS

My study uses the mixed-methods "explanatory" design described by Creswell and Plano Clark (2007), as I first utilized a quantitative method (surveys), followed up with a qualitative method (semi-structured interviews). This type of design can be used to first form a subset based on quantitative results and then perform in-depth research with this subset through qualitative processes (Creswell and Plano Clark 2007). The implementation of explanatory mixed-methods research is straightforward, as the research is conducted in distinct phases. A single researcher, rather than a research team, can conduct this type of research. However, this type of design may also be time consuming, and selection of a subset to be further investigated through qualitative processes cannot occur until the quantitative processes have been concluded and data has been analyzed (ibid.) I found both of these limitations to be true in my own research.

The study design and the timeframe for data collection are shown in Table 4.1. The ultimate goal of this research is to describe what it might take for the practice of planning to adjust its priorities and incorporate a focus on public health within the planning field. A principal way to achieve this is to catalyze collaboration between health and planning, in order to make health more of a priority within planning.

The intent of the Phase I survey was to generalize findings on how planning departments throughout the country are incorporating health into planning processes, and to provide foundational data on a still-emerging topic. The survey also provided a means to select interview participants for later phases of the research. To this extent, I used the survey to understand which planning departments in medium to large sized cities throughout the country are incorporating health issues into policies, plans, and projects that impact the built environment, and whether these cities are utilizing Health Impact

Assessment in conjunction with the planning department. The cities that I selected to interview in Phases IIa and III were based on the survey responses.

Table 4.1: Phases of Research.

Research Phase	**Timeframe**	**Data Collection Method**	**Data Source**
I	January-December 2013	Surveys (development, distribution, and initial analysis)	Planning directors of cities nationwide with population greater than 75,000
IIa	January-May 2014	Interviews (in person and phone)	City of San Francisco planners and public health professionals (past and present)
IIb	February-May 2014	In-depth survey result analysis to determine Phase III cities (using SPSS)	Survey from Phase I
III	May-August 2014	Interviews (phone)	Subset of four cities (Columbus, OH; Seattle, WA; Cincinnati, OH; Orlando, FL) planners and public health professionals (past and present)

For cities that had undertaken an HIA with the involvement of the planning department, the interviews explored how these cities were able to achieve this, and what challenges or obstacles had to be overcome. For cities that had not attempted an HIA with the involvement of the planning department, the interviews explored reasons for lack of participation in the HIA process. The interviews provided an understanding of what has

worked, and not worked, in terms of: integrating HIA into planning processes; understanding health and planning collaboration opportunities beyond the HIA process; and understanding barriers to using HIA and focusing on health more generally within planning departments.

4.2 PHASE 1: NATIONWIDE SURVEY

During the first half of 2013, I created a web-based survey (see Appendix A) to send to planning and community development directors in cities and municipalities throughout the country to answer the following research question:

1. How is the concept of "health," and specifically "Health Impact Assessment," currently understood, framed, and represented in decision making within planning departments throughout the country?

This survey drew on a national probability sample of planning departments, in medium to large size cities, defined as cities with a 2010 U.S. Census population over 75,000 (Saha and Paterson 2008). The rationale is that cities of this size should have the capacity within their planning departments to support the inclusion of new tools and strategies (ibid.), such as those related to public health. Additionally, by 2050 it is projected that 70 percent of the global population will reside in cities, making the city—rather than the county—a good unit of measure for this research (WHO, Urban Population Growth n.d.). The preferred survey respondent would either work directly with the health department or oversee planners who work directly with the health

department. A 50 to 60 percent survey response rate is ideal in order to generalize findings with the entire population of cities over 75,000 people (Draugalis and Plaza 2009).

During the summer of 2013 I compiled an email contact list for the 433 cities with a population of 75,000 or greater per the 2010 Census. I searched city websites and documents to find contact information for the planning director as a first point of contact; if that was unavailable I collected contact information for community development directors or planning managers.

I began constructing the survey in March 2013. I designed the survey to measure: how planning departments are considering public health issues within their work; what internal and external factors may be contributing to the inclusion of health issues; frequency of collaboration with the responsible health department; and if and how the city is utilizing the Health Impact Assessment process. In constructing the survey it was important to keep it relatively simple and easy to administer, while also being able to obtain key information from the respondents.

I started the process by listing hypothesized drivers of collaboration between public health departments and planning departments that could impact the feasibility of considering public health issues within planning processes. These drivers were identified based on literature on planning and health integration as well as planning theory, including communicative, collaborative, and critical planning theory as reviewed in Chapter Three. The drivers include: city context; position of planning department; community involvement; external factors; resource availability; relationships and partnerships; regulatory or legal framework; familiarity with Health Impact Assessment; political support; and city government structure. A list of these drivers, including the major survey questions that stemmed from each driver, is shown in Table 4.2.

Table 4.2: Hypothesized Drivers of Collaboration, Theory Base, and Corresponding Survey Questions.

Driver	Theory Base	Authors	Major Survey Questions
City Context	Normative planning	Fainstein 2005, Fainstein 2010, Marcuse 2009, Watson 2006	Are there any existing health concerns in the city, perceived or real (e.g. obesity, asthma)? Do any other contextual or demographic factors (education level, income, race/ethnicity) in the city influence the inclusion of health issues into planning? How do city staff members (e.g. planners) get data on health issues?
	Power and rationality in planning	Flyvbjerg 1998a, Huxley and Yiftachel 2000	
	Health and planning integration	de la Barra 2000 Barton 2005	
Position of Planning Department	Power and rationality in planning	Flyvbjerg 1998a, Huxley and Yiftachel 2000	What are the opinions of the planning department when it comes to the integration of health issues? Does the planning department incorporate health issues into planning processes?
	Health and planning integration	Corburn 2009	
Community Involvement	Communicative action theory	Forester 1989, Forester 1999, Healey 1999, Healey 2009	Does the community provide health info to planners and through planning processes?
	Co-production of knowledge	Sandercock 1998, Sandercock 2003, Watson 2006, Rydin 2007	
	Health and planning integration	Corburn 2003	
External Factors	Power and rationality in planning	Flyvbjerg 1998a, Huxley and Yiftachel 2000	Is the planning department influenced by other cities or groups/entities in terms of the incorporation of health into plans and planning decisions?
Resource Availability	Co-production of knowledge	Sandercock 1998, Sandercock 2003, Watson 2006, Rydin 2007	Is there available time, money, training, etc. for planners working on HIAs or health issues?

Table 4.2 (continued): Hypothesized Drivers of Collaboration, Theory Base, and Corresponding Survey Questions.

Driver	Theory Base	Authors	Major Survey Questions
Relationships and Partnerships	Communicative action theory	Forester 1989, Forester 1999, Healey 1999, Healey 2009	Has the city attempted, completed, or currently working on an HIA with planner involvement?
	Collaborative planning	Innes and Booher 1999, Healey 1998a, Healey 1998b	Is there currently a relationship between the planning department and public health? Was there historically a relationship between the planning department and public health?
	Power and rationality in planning	Flyvbjerg 1998a, Huxley and Yiftachel 2000	Is there currently collaboration between the planning department and other departments that are focused on health?
	Health and planning integration	Maantay 2001, Sclar and Northridge 2001, Laurian 2006	Is the basis for planning/health collaboration voluntary or regulatory? What is the level of involvement of elected officials (city manager, mayor, city council) in planning processes (is there support at the city government level?)
Regulatory or Legal Framework	Rational planning	Lindblom 1959, MacCallum 2008	Are there regulations or ordinances that support impact assessments (e.g. state-level NEPA-like laws)?
	Power and rationality in planning	Flyvbjerg 1998a, Huxley and Yiftachel 2000	
	Health and planning integration	Northridge and Sclar 2003, Corburn and Bhatia 2007	

Table 4.2 (continued): Hypothesized Drivers of Collaboration, Theory Base, and Corresponding Survey Questions.

Driver	**Theory Base**	**Authors**	**Major Survey Questions**
Familiarity with Tools/HIA	Rational planning	Lindblom 1959, MacCallum 2008	If HIA is used within the city, who is involved in conducting them?
	Co-production of knowledge	Sandercock 1998, Sandercock 2003, Watson 2006, Rydin 2007	Are there specific triggers in place for forms of HIA (i.e. a regulations that mandate HIA)?
	Health and planning integration	Curtis et al. 2002, Corburn and Bhatia 2007, Roof and Glandon 2008, Rutt et al. 2008	Are HIAs used for private/public projects (episodic) or within planning processes (systemic) or both?
City Government Structure	Rational planning	Lindblom 1959, MacCallum 2008	Does the city have a health department?
	Power and rationality in planning	Flyvbjerg 1998a, Huxley and Yiftachel 2000	What is the reporting structure of the health department and planning department(s)?
Political Support	Rational planning	Lindblom 1959, MacCallum 2008	Is there political support of public health consideration in planning decisions?
	Power and rationality in planning	Flyvbjerg 1998a, Huxley and Yiftachel 2000	
	Health and planning integration	Laurian 2006, Ponder and Dannenberg 2008	

Based on these drivers identified through the literature, I brainstormed a large list of more specific questions on the inclusion of health into planning processes. Through my consultation and testing phases I began narrowing the questions, choosing to

eliminate many questions that asked for general information that a planning director or manager, primarily one in a larger city, may not readily be able to answer (primarily questions concerning more general practices of communication between planning and public health departments and general health concerns of the community).

Phase I survey testing was performed between April and July 2013 with a Microsoft Word version of the initial draft of the survey; the main goal of this phase was determining the clarity and relevance of each question. I consulted with the manager of the American Planning Association's Community Health and Planning Research Center, as well as a former Centers for Disease Control and Prevention director and respected researcher on the relationship between public health and the built environment. I revised and cut questions per their comments and suggestions. I also tested the survey with a number of colleagues, dissertation committee members, planning professionals, and people outside of the planning profession to ensure clarity of questions. Several questions were eliminated that did not ultimately contribute to answering the research question, and that may have been too specific for a planning director to readily answer.

Phase II survey testing was performed between July and September 2013 with the online version of the edited survey, primarily with colleagues and individuals outside of the planning profession. The main goals of this phase were to refine each question, ensure the flow of the survey was logical, and ensure that the survey was easy to access and respond to. The survey was created and distributed online using the website SurveyGizmo, which allowed me to select the most appropriate design and format for each question. The survey contained a series of questions split into five subsections:

1. Public health issues related to planning and the built environment in your city or region;

2. Collaboration between planning and the public health department in your city or region;
3. The use of Health Impact Assessment in your city;
4. Political support for engagement with health issues within planning processes in your city; and
5. General information (including demographic and contact information).

Survey respondents were asked to answer each question to the best of their ability, but were also able to skip questions or answer "don't know". The survey questions can be found in Appendix A.

To distribute the survey, I composed an introductory email that included the survey link (see Appendix B) and sent individual, personalized emails to each of the 433 contacts I had collected during the summer of 2013. I sent the initial survey solicitation email on September 18, 2013. I sent two reminder emails to non-respondents (also in Appendix B), on September 25 and October 3, 2013, informing potential participants that the survey deadline had been extended. For emails that bounced back, I found appropriate alternate contacts within the planning department and resent the email solicitation. When I closed the survey in November 2013, I had received responses from 145 cities. I was unable to reach four cities due to server failures on their part, bringing the contact pool down to 429, and my response rate to 33.8 percent. Table 4.3 summarizes the final survey response rate.

Table 4.3: Survey Response Rate.

Completed	145
Not Completed	284
Server rejecting email	4
Total	433
Total minus rejected	429
Response rate (completed over new total)	33.8%

I assessed some characteristics of respondent cities versus characteristics of non-respondent cities to understand how survey respondent cities fit within the larger pool of medium to large sized cities. When looking at the respondents by region and population (Table 4.4), they are all within a reasonable range. The Northeast region has the lowest rate at 29.5 percent while the South region has the highest at 36.7 percent.

Table 4.4: Response Rates by Region and Population.

Region	Total Cities in Original Sample	Number of Responding Cities From Each Region	Percent From Region Total vs. Responding	Total Population in Original Sample (2010)	Population of Responding Cities (2010)	Percent Population Total vs. Responding
North-east	44	13	29.5%	15,529,431	2,541,350	16.4%
Mid-west	74	24	32.4%	15,887,415	4,977,039	31.3%
South	139	51	36.7%	30,972,131	14,396,461	46.5%
West	172	57	33.1%	34,907,572	13,867,574	39.7%
Total	429	145	33.8%	97,296,549	35,782,424	36.8%

Comparing responding and non-responding cities yielded results that are reasonably expected (Table 4.5). In general, responding cities had higher population (from the 2010 Census), higher population growth, and slightly higher educational

attainment (at least a high school diploma), while also having very slightly lower incomes and higher poverty rates.

Based on these characteristics, it appears the dataset obtained through the survey is fairly representative of medium to large U.S. cities. It is logical that survey respondents tended to work in larger, faster growing cities: these cities may have the resources necessary to consider health, or the community health outcomes that warrant attention and would compel a planning director or manager to complete a voluntary survey looking at health and planning.

Table 4.5: Comparison of Responding and Non-Responding Cities.

	Population 2010 (average)	Population growth 2000-2010 (average)	Educational attainment (2011 5 year ACS)	Median Household Income (2011 5 year ACS)	Individuals Below Poverty Level (2011 5 year ACS)
Responding	246,775	20.2%	85.1%	$52,504	17.2%
Non-Responding	216,599	15.7%	84.1%	$54,587	16.1%
Total	226,798	17.2%	84.4%	$53,883	16.4%

The survey response rate, although lower than I would have preferred, was in line with similar surveys published in respected planning journals (including the *Journal of the American Planning Association* and the *Journal of Planning Education and Research*). I found seven published articles that had similar study populations and a similar number surveyed as this study. Four articles utilized mail surveys (with an average of a 57.1 percent response rate, ranging from 48.3 percent to 61.2 percent) while the other three articles utilized email or web based surveys. Of the web surveys, study

results were similar to my survey with an average of a 31.7 percent response rate, ranging from 26.4 percent to 34.3 percent (see Jepson 2004, Anselin et al. 2011, and Guo and Schloeter 2013).

Based on feedback I received from some of the individuals I solicited to take the survey, lack of staff capacity, an inundation of survey requests, and the web-based contact method itself were potential reasons for a lower response rate than expected. Additionally, non-respondents may have been uninterested in the public health topic, there may be no resources in their cities for new initiatives such as public health, or public health is not a priority within their cities at this time. Based on this information, combined with the fact that it was a cold-contact survey, the survey response rate seems adequate to begin to draw conclusions on ways that public health is currently considered within planning processes.

An initial review of the survey data from SurveyGizmo necessitated some modifications to the data. Six responses were deleted from both Questions 1 and 2—which asked respondents to rank the top three public health issues and built environment issues, respectively, facing their communities—due to more than three issues being selected per question. Questions 8, 9, and 10 proved to be difficult to analyze. The intention was for responses to be based on the answers provided in Question 7, though it was clear that there was some confusion with these questions. I believe that this was due, in part, to limitations of the SurveyGizmo tool, as I was unable to set up the question in a way that would have been clearer. Question 12—which was set up similar to Questions 1 and 2, asking respondents to select the three most critical resources needed to facilitate health and planning collaboration—had similar issues to Questions 1 and 2, and four responses were deleted.

4.3 PHASE IIA: INTERVIEWS

As discovered in literature reviews and through the survey in Phase I, the city of San Francisco, California, is considered a "model case" of successful coordination and collaboration between a city health department and planning department. San Francisco has also had extensive experience with Health Impact Assessments, including HIAs that involved the planning department. Results from the survey found that San Francisco has been conducting HIAs since 2004: four years earlier than reported by any other city.

This phase of research was designed to uncover how the city of San Francisco has been able to foster relationships between its planning department and its public health department in order to incorporate health issues into planning processes through the use of Health Impact Assessment and other methods (for example, the city-developed Healthy Development Measurement Tool, now called the Sustainable Communities Index, which has been adapted for use in other cities and projects). The methodology used in this phase of research was in-person and phone interviews with current and former staff members and leaders from the city's planning and public health departments. The objective of these interviews was to tease out best practices that could be applied to other cities, and also to understand if and how the HIA process itself has been able to influence the planning department to embody public health issues into daily activities, outside of the HIAs themselves. While San Francisco may be seen as a special case—due to factors that are not readily replicable, such as size and organization of the planning department, the culture of the city, and the political environment of the city—the successes and challenges that the city has faced with its history of public health and planning collaboration can still be important lessons for other cities seeking similar collaboration.

For the planning and health interviews in San Francisco, I used a snowball sample approach to identify appropriate and recommended interviewees, starting with the individual who responded to the survey. The general email outreach that I sent regarding interviews for this research is located in Appendix C. In total, I was able to get the perspectives of eight different individuals relating to the health and land use planning story of San Francisco. Interviewees included current and past planning staff and public health staff, all of whom have been involved in some form of departmental collaboration. At the suggestion of one interviewee, I also interviewed a former planning commissioner. I made three contacts with each recommended individual in order to schedule an interview, and was successful in all but one instance.

Though I started with the same general questions for everyone, during each interview I tailored the questions to each interviewee utilizing a qualitative, semi-structured interview format. I did not ask all questions to all interviewees; rather, I treated each interview as a conversation and used the questions to help guide the conversation. The general guides that I created are located in Appendix D, with separate guides for the San Francisco planning department and the San Francisco health department. Four interviews were conducted in person, three over the phone, and one was email based. The interviews were recorded, with the permission of the interviewees, in order to transcribe the conversations. Each interview lasted approximately one hour. The interviews were transcribed and analyzed to draw out themes and key points.

4.4 Phase IIb: Analysis of Survey for Phase III Interview Selection

While San Francisco may present a well-known case where the city has been able to achieve some level of on-going collaboration between planning and public health over time, many other cities have more recently embarked on exemplary collaboration and partnerships as well. These cities also offer great insights and lessons based on their experiences with Health Impact Assessment and other methods for collaboration.

As a starting point, I used the survey responses as the pool from which to select cities to investigate in the next phase of research. As one question asked specifically about the use of HIA, I was able to isolate the survey responses that indicated that an HIA had been conducted in their city with or without the involvement of planning (N = 35). Using this data, I undertook an analysis with two objectives: first, to narrow the pool of survey respondents into a smaller subset of cities to contact for interviews; and second, to start a rubric of land use and built environment HIAs that have been conducted in respondent cities to gain a basic understanding of the roles planners have played within these HIAs.

There are two readily available databases that compile information on completed and in-progress HIAs in the United States. The Health Impact Project (HIP), a collaboration of the Robert Wood Johnson Foundation and The Pew Charitable Trusts, maintains an online map and list of HIAs collected from a variety of sources (The Pew Charitable Trusts n.d.). A second database, UCLA's Health Impact Assessment Clearinghouse (HIA-CLIC n.d.), has a searchable function for completed HIAs, though this database does not appear to have been recently updated.

I completed a three-step process for sourcing more information for each of the 35 respondents that indicated an HIA had been completed in their city. I first searched the HIP database for any HIAs the city had conducted or been involved with, specifically looking for land use or built environment related HIAs. Second, I searched the UCLA database for any HIAs that may not have been included in the HIP database. Last, I did a general Internet search for the city and "Health Impact Assessment." I then gathered all of the HIA documents (primarily the land use or built environment HIAs for the 21 cities that had indicated planners were involved in the process) and scanned the documents to analyze what "type" of assessment it was for each related document I found (full HIA, rapid HIA, pilot HIA, or another type of assessment) and what the role of the planning department was in the process, based on text in the document.

For several of these cities (10), I was unable to find evidence through the databases or a general web search that an HIA was conducted or in progress; several had other health undertakings that did not meet the definition of an HIA that I am using for this research.[2] After excluding these cities, I was left with an extensive analysis of planning, land use, and built environment related HIAs conducted in 25 cities (see Appendix E). In this analysis, I also tracked which cities operated under state-level "little NEPA" laws. Of the 16 cities that indicated their planning department had been involved in an HIA, seven are located in states with state-level regulations; of the nine cities that indicated an HIA had been done without involvement of the planning department, seven have state-level regulations. While this was not specifically a factor used to narrow down cities, it does appear that there may be some correlation between the existence of state-

[2] An HIA is an evidence-based tool that is increasingly promoted as a means of assessing the health impacts of projects, policies, and plans in a variety of sectors using a variety of strategies. While this is a definition that allows flexibility within strategies and format of the end product, assessments that are done using this framework are generally labeled as such.

level laws and Health Impact Assessment, though HIA still operates as a voluntary process.

Based on this analysis, I created a short list of cities to consider for a set of follow-up interviews to support research questions two and three:

2. How are health concerns included in planning processes? Specifically,
    - How are HIAs implemented or otherwise included in planning processes?
    - Why are HIAs not implemented or otherwise included in planning processes?

3. What are the principal opportunities and challenges for planners in terms of integrating health concerns into planning processes and documents, and how do these challenges and opportunities shape the application of HIA strategies in planning processes?

Initially I eliminated nine cities where the survey respondent did not agree to follow-up interviews, as well as San Francisco where interviews were conducted in Phase IIa, which left 15 contenders for follow up interviews. I eliminated cities where an HIA had not been done on an area or comprehensive plan, as planners are less likely to be involved in this type of plan. This left 12 cities where land use HIAs had been conducted, with and without planning involvement.

Although the main purpose of conducting a nationwide survey was to understand how health is, or is not, being considered within planning departments throughout the country, and to determine a subset of planning departments for future research phases, the survey data itself could be analyzed further. Although the survey questions were not adequately set up to facilitate robust statistical analysis to find correlations, basic analysis techniques yielded interesting trends in the results. With the intent of ensuring a more

methodological process for narrowing down the 12 cities to four to five cities for Phase III interviews, I conducted a brief analysis in IBM SPSS Statistics Version 22.

My survey was constructed in such a way that many questions were "select all" and opinion based, so a full statistical analysis proved to be extremely difficult. However, there were several survey questions that could be used to test the relationships between these variables and whether or not the city has conducted an HIA, namely: whether or not the planning department currently collaborates with public health; the type of government structure in the city; and the scale of the health department responsible for the city (for example, city, county, or state). The intent of the analysis was to determine if any of these translated variables had a statistically significant relationship with whether a city has conducted an HIA.[3]

After multiple consultations in April 2014 with the University of Texas Department of Statistics and Data Sciences, I concluded that multinomial logistic regression was the best approach. This type of model is used to predict the probabilities of different possible outcomes of a categorical variable, which is how most of my survey data is classified (Kwak and Clayton-Matthews 2002). The survey question regarding whether the city has conducted an HIA was the dependent variable for this analysis (noted as "HIA Status"). The independent variables were the variables described above, noted as "Current Collaboration," "Responsible Health Department," and "Type of Government." My data were recoded as follows:

[3] As my survey was not set up in a way that yielded the types of data (e.g. continuous variables) that could produce a more robust analysis, the process of this type of statistical analysis was intentionally stunted and used only as a potential gauge to narrow down the interview pool. As my data was set up in a way that was unfamiliar to me from a statistical analysis standpoint, it took me some time to sort this out and consequently set back my research slightly.

- HIA Status: 1 = Yes, 2 = No
- Current Collaboration: 1 = Yes, 2 = No
- Responsible Health Department: 1 = City, 2 = County (Note that State and Other were eliminated due to very small responses)
- Type of Government: 1 = Strong Mayor, 2 = Weak Mayor, 3 = Council-Manager, 4 = Other

The result of the statistical analysis is shown in Table 4.6. In this analysis, I found a statistically significant relationship at $p = 0.05$ between the independent variable "Type of Government" and the dependent variable, as $0.029 < 0.05$ in the Likelihood Ratio Tests. I used this result as a way to start to narrow down cities for Phase III interviews. San Francisco has a strong-mayor type of government, where the elected mayor has administrative authority, and I felt that it was important to keep some form of characteristic stable among the cities I interviewed. Therefore, I eliminated the cities that reported in the survey that they had a type of government other than strong-mayor.

In the HIA analysis shown in Appendix E, there were six cities where the survey respondent both agreed to a follow up interview and reported having a strong-mayor government. Three of these reported having involved planners in HIA processes (Seattle, Washington; Columbus, Ohio; and Duluth, Minnesota); the other three reported that planners had not been involved in any HIA processes undertaken by the city (New Haven, Connecticut; Orlando, Florida; and Cincinnati, Ohio). Fortuitously, these six cities represent a good range of geography and size.

4.5 PHASE III: INTERVIEWS

For the six cities identified for Phase III interviews, I sent initial emails to the survey respondent from each city asking for an interview (see Appendix F), with a copy of a survey results summary I prepared (see Appendix H). I sent a follow up email approximately one week later, and made phone calls approximately one week after that. After three attempts, I was able to schedule interviews with planning staff in four cities: Orlando, Columbus, Cincinnati, and Seattle. I also asked each of the initial four interviewees for contact information for other suggested contacts, in both the planning department and the responsible public health department. From this snowball sampling method, I ultimately interviewed three current and former planning and public health staff from Columbus, three from Cincinnati, five from Orlando/Orange County, and four from Seattle/King County.

Similar to the process I used during the interviews in San Francisco, I started with the same general questions and during the semi-structured interview I tailored the questions to each interviewee. Again, I did not ask all questions to all interviewees and I treated each interview as a conversation. The general guides that I created for the Phase III interviews are located in Appendix G. I again created separate guides for the planning departments and the health departments. All interviews in this phase were conducted over the phone and recorded, with the permission of the interviewees, in order to transcribe the conversations. Similar to PhaseIIb, each interview lasted approximately one hour. The interviews were transcribed and analyzed to draw out themes and key points.

Table 4.6: Results of Statistical Analysis Showing Relationship Between Type of Government and Completed Health Impact Assessment

Effect	Model Fitting Criteria	Likelihood Ratio Tests		
	-2 Log Likelihood of Reduced Model	Chi-Square	Df	Sig.
Intercept	41.327[a]	.000	0	
"Current Collaboration"	42.633	1.306	1	.253
"Type of Government"	50.313	8.986	3	**.029**
"Responsible Health Department"	41.922	.594	1	.441

The chi-square statistic is the difference in -2 log-likelihoods between the final model and a reduced model. The reduced model is formed by omitting an effect from the final model. The null hypothesis is that all parameters of that effect are 0.

a. This reduced model is equivalent to the final model because omitting the effect does not increase the degrees of freedom.

4.6 CONCLUSION

I utilized a variety of methods and analytical processes in order to begin to understand relationships between planning and public health departments and mechanisms used to engage planners in collaboration with health professionals, including Health Impact Assessment. First, a nationwide survey provided an understanding of the current state of a focus on health within planning departments. The first round of interviews were conducted in San Francisco, as this city presented an early example of health and planning collaboration. The practices and methods used in San Francisco have also been promoted in literature as a best practice for the inclusion of health in planning. The next round of interviews were conducted in four cities that had similar characteristics

to San Francisco (strong-mayor government, experience with HIA, and current collaboration between planning and health) in order to obtain a more comprehensive look into catalysts for collaboration—that can lead to institutional changes to incorporate a health focus within the planning profession—that can be generalized to a broader spectrum of cities.

As hypothesized during my survey development phase, the institutional context of a city may play a role in how successful a health focus in planning can be. Thus, in the nationwide survey, I asked specific questions related to leadership support to understand how power relations might come into play in facilitating a focus on health within planning. I also asked questions about the existence of regulatory frameworks in each city, and if collaboration or the use of HIA was impacted by these frameworks in any way. Additionally, during the interviews I engaged interviewees in conversations about both leadership support and the institutional context of each city, including specific regulations and how they might impact health. These were hypothesized drivers that may have a great impact on the ability of planners and health professionals to collaborate.

While interviewee cities were not specifically selected for follow-up interviews based on the existence of state-level environmental laws, two cities (San Francisco and Seattle) are located in states with these state-level requirements. However, based on conversations with interviewees, these regulations do not appear to have helped or hindered collaboration between the departments. It does not appear, based on the results from the survey and from interviews, that mandated collaboration or required Health Impact Assessments on planning decisions based on state or local regulations would influence the broader incorporation of a health focus into the field of planning: only 5 percent of survey respondents indicated that one factor influencing collaboration was a

law or ordinance that required it, and only one of these respondents indicated that their planning department had been involved in an HIA.

Rather, interviewees indicated that a value-based approach, grounded in understanding local health concerns and the impact of the built environment, might be more helpful. While the existence of state or local regulations that go beyond NEPA requirements to consider environmental impacts may be a useful framework to look to in the future, these regulations also require a good deal of resources to fulfill and typically occur as an entirely separate planning process. Future research could look at how these regulations could be expanded to consider a range of health issues more in line with the social determinants of health approach, but for my research I focused primarily on how planning departments overall, and the planning field as a whole, could adopt a more holistic focus on health goals related to the planning and design of the built environment. Within both the survey phase and the interview phases of my research I encountered positive feedback from survey respondents and interviewees. It became clear that planners are starting to not only see connections between health and the built environment, but to also understand the importance of considering health within their planning work. This is critical as it is planning staff and leadership—not researchers—who are responsible for this in practice. The practitioners I spoke with seemed genuinely interested in and energized about fostering this type of collaboration between planning and health. Perhaps interviewing a skeptic or two would have helped balance the data, but as I relied on a snowball sampling for recommended interviewees this opportunity did not arise.

While in general there was palpable energy around the topic of incorporating a health focus within the practice of planning, it became clear that there is no one-size-fits-all process that can achieve this. The following chapters present results and analysis from

these research methods, starting with the challenges currently faced by cities to incorporate a focus on health.

Chapter Five: Challenges to a Health Focus for Planning

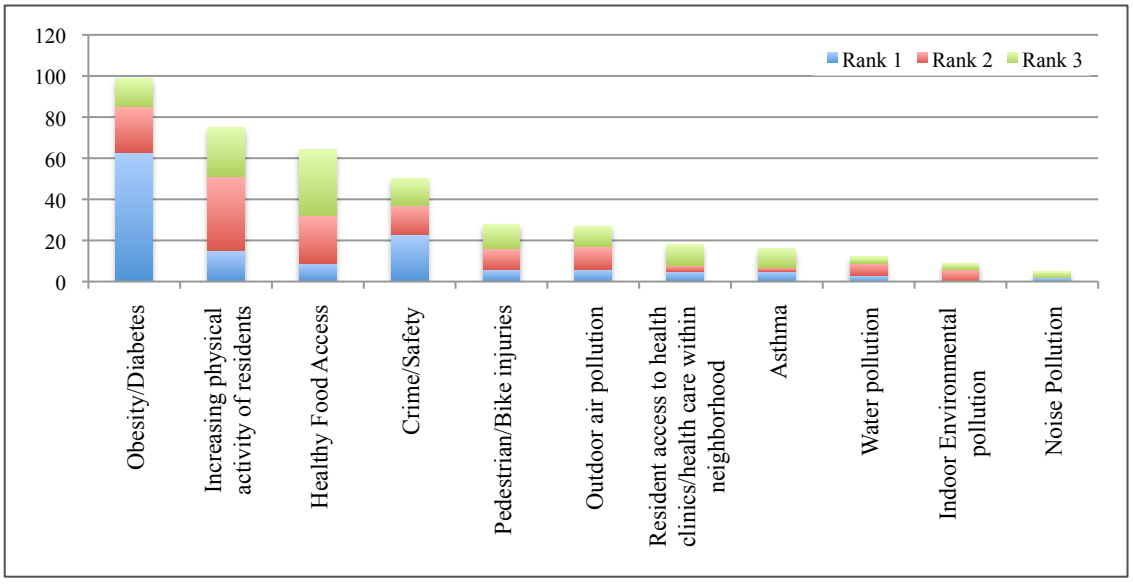
5.0 Introduction

Findings from my survey and interview research illuminated a variety of challenges faced by cities that attempted to incorporate a health focus into planning processes. My research showed that there are differing understandings of health between the planning and health fields, and within the planning field itself, which in turn drive different perceptions of the significance of health. Survey findings suggest that practicing planners, not just researchers, recognize the interconnected nature of the critical public health and built environment issues that face cities today. Planners overwhelmingly indicated obesity and diabetes, increasing physical activity, healthy food access, and crime and safety as one of the top three public health issues facing their communities (see Figure 5.1). With the exception of crime and safety, the priority issues mentioned by planners closely align with the current public health issues that are discussed widely in research and popular media, even though crime and safety continues to be a central issue in most communities. That is not to say that these are not the real issues facing the communities, but perceptions of respondents could be impacted by national public health trends.

Also overwhelmingly, survey respondents chose access to transit, access to goods and services, and affordable housing as the top three built environment issues, over the existence of brownfields and the lack of green and healthy housing (see Figure 5.2). As brownfields and sustainability are more traditional planning issues, this could indicate that planners are beginning to understand the importance of a broader set of issues that

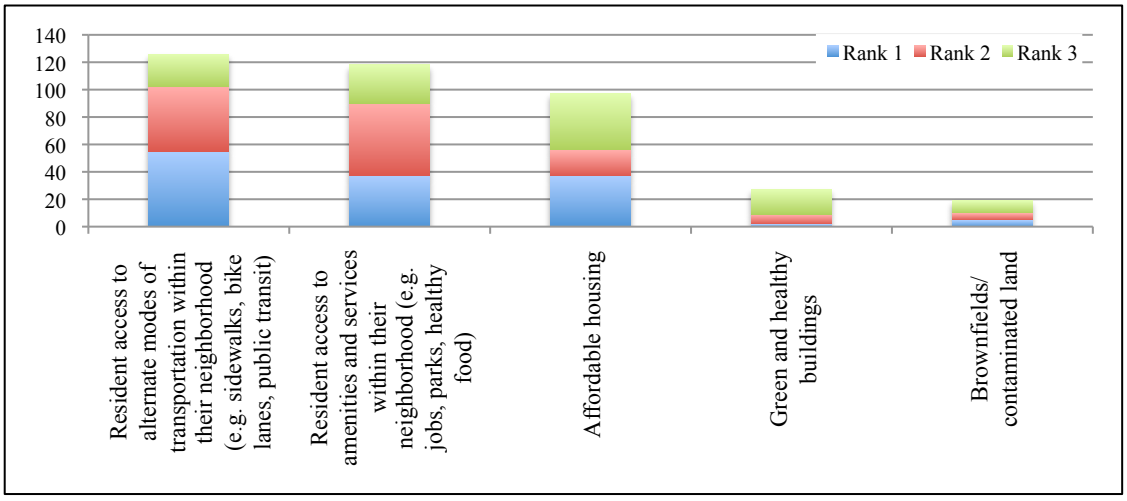
also have links to the social determinants of health perspective. It could be argued that the health and built environment categories presented in the survey overlap in many respects (in other words, healthy food access is also a built environment issue and affordable housing is also a health issue), but it is still interesting to note that respondents tended to list the same set of issues as impacting their cities, regardless of their geographic location.

Figure 5.1: Planning-related Public Health Issues Perceived to be Most Serious Faced by City.



Respondents ranked the top three with 1 being the most serious issue (N = 139).

Figure 5.2: Built Environment Issues with Public Health Implications Perceived to be Most Serious Faced by City.



Respondents ranked the top three with 1 being the most serious issue (N = 139).

An important factor shaping these differing understandings of health is the lack of a common language between the fields, including a lack of a common definition of health and lack of a more universal comprehension of how planning processes and the built environment impact health. This lack of a common language and understanding then leads to conflicting values and priorities between the fields, and even among planners. That is to say, social constructions of health serve to shape the how planners view their role in addressing health goals, and thus the ways that planners think about health and planning practice.

As planners and health professionals develop differing values and priorities, limitations arise that complicate collaborative work between the fields. Conflicting ideas of what the role of the planner should be with respect to addressing health issues develop between planners and health professionals. This, in turn, complicates the ability to pursue collaborative work that could lead to a planning process that fully embraces an expanded

definition of health. These conflicts also lead to failures to fully develop processes and methods that would serve to better integrate the fields, and which would allow for a holistic approach to health and equity. Ultimately, social constructions that shape how planners view their role also shape the ways that planning is practiced (Healey 1999).

5.1 How Conceptions and Prioritization of Health Shape How Planners See Their Role

My research showed that planners and decision makers do not consistently value or include health and equity within practice. This inconsistency appears at a variety of levels, from individual planners to planning leadership to elected officials. Individual values and interests—rather than consistent and overarching values and interests of the planning profession—appear to drive the push for collaboration. Additionally, the lack of common goals and definitions between the fields of planning plays a part in shaping the way that planners see their role.

The variations in the perceptions of the value of health may stem from a lack of incorporation of alternative forms of knowledge in planning departments. It is important to acknowledge and learn other ways of knowing to forge an equitable planning practice: communication and discussion within multiple groups is necessary in order to take the multiple needs of society into account (Sandercock 1998). How planners view the importance of health is shaped by their personal knowledge and values, by the values of their departments and cities, and by the values held by the field of planning itself. Differences in knowledge and values related to a health focus in planning then lead to a second challenge of how best to implement a health focus within planning practice.

5.1.1 Competing Jurisdictional Interests and Priorities

Health is unevenly prioritized within jurisdictions, and there are often competing issues that take priority over health. A survey question on ways public health is prioritized within cities by government officials garnered a low response rate as compared to other questions. The low response rate may indicate that respondents either were not certain of how health is prioritized, or that city governments in general are not prioritizing public health concerns. The most frequently selected response to the question of ways that health was prioritized, was "inclusion in other city documents" (48 percent), which could include comprehensive or general plans (see Table 5.1).

Table 5.1: Ways that Health is Prioritized by Government Officials.

Ways health is prioritized by government officials	**Number/percent selected**
Inclusion in other city documents	62 (48.1%)
Inclusion in city mission statement	32 (24.8%)
Other	22 (17%)
Don't know	21 (16.3%)
Used as a metric for prioritizing municipal capital projects	16 (12.4%)
Adoption of a city-wide health ordinance or framework	14 (10.9%)
Public health is not considered a priority within my city	14 (10.9%)

"Other" included things such as different types of city public health initiatives (food-related issues came up several times), funding and resources, and partnerships with health professionals (N = 129).

Interviewees raised similar issues regarding prioritization of health within planning departments and city governments. In Florida, the reporting structures and priorities are not analogous between the county health departments and the local planning departments, which makes collaboration more difficult. An interviewee from the Florida Department of Health has noticed that planners across the state are receptive to the idea

of including health but the issue of resource availability is an impediment: "Getting the funding to look at health in their projects [is a big challenge]. [Planners will] move forward and you'll…propose that an HIA be conducted and [planners] say 'great! If you can find the money to do it!'" (Orlando Interviewee D, personal communication, July 16, 2014). In San Francisco, the needs of the real estate development community are believed to take precedent over health. A former planner saw this community as having a larger impact on planning decisions than any other local group or agency, noting "it is very difficult in San Francisco to challenge developers" (San Francisco Interviewee F, personal communication, March 13, 2014). Even for planners who have an interest in considering health outcomes, jurisdictional priorities may be impeding these practices.

The prioritization of issues by elected officials and leadership can also impact how city staff, including planners, view and define their own roles. Cities, and even planning departments, are failing to adequately prioritize health, instead focusing on seemingly competing issues such as economic development. Continuing to promote the forms of development that have created the built environments in place today will serve to perpetuate the chronic health issues that have developed. A study of planning practices in New South Wales, Australia, found that the local government emphasized short term economic growth and housing development over a more social approach to planning that considered more long term health and sustainability goals (Sainsbury 2013). While the concerns of health trends are growing, local governments are still not likely to make health a policy priority for urban planning (Rydin 2012). This can influence the priorities that planners place on their own work and which values they communicate to partners and stakeholders outside of the planning department.

5.1.2 Differing Values of Health at all Levels

Meaningful collaboration between planning and health, when not strongly supported and prioritized by city leadership, can be difficult to achieve. Research highlighted how inconsistent priorities, values, and knowledge can exacerbate the challenge of collaboration between health and planning. From survey results, 93 percent of respondents indicated that planners in their cities are currently engaging in work that considers health issues, which—in light of other survey results—is telling. As the majority of survey respondents believe that they are currently incorporating health into their work, this could indicate that respondents self-selected into the survey due to an individual interest in the health impacts of planning decisions, regardless of whether their planning department is currently collaborating with health professionals (see Table 5.2). While ad-hoc health consideration may be occurring, or is perceived to be occurring, current literature argues that a systematic and comprehensive inclusion of health concerns into planning has not yet been achieved (Botchwey et al. 2014).

Table 5.2: Ways that Planning Departments are Considering Health.

Ways planning department considers health	Number/percent selected
Addressing public health topics in general or comprehensive plans	113 (77.9%)
Considering public health topics within implementation of plans or projects	103 (71%)
Addressing public health topics in zoning codes	71 (49%)
Conducting impact assessments (e.g. health, environmental, social)	41 (28.3%)
Adoption of a public health ordinance or framework for planning processes	5 (3.4%)
Planners in my city do not engage in work that considers public health issues	10 (6.9%)

(N = 145).

Inconsistent prioritization of health issues at various levels of leadership is illustrated in the case of San Francisco. Within city government, key champions and staff members from the planning and public health departments acted more-or-less as revolutionaries who strongly valued the inclusion of health and equity concerns into planning, and were aggressive about fostering collaboration between the departments. One interviewee indicated that as personal interest and values served to drive this collaboration, not all staff were on board, noting that "these agencies are made up of people, and the people are more-or-less value-driven, inclined to be disruptive or support social equity—or not" (San Francisco Interviewee H, personal communication, April 15, 2014).

Differing values play a part in how planning staff members embrace their role in creating healthier cities, with the individuals who believe in a health focus for planning being more likely to foster relationships with health partners. Within Seattle, similar perspectives were raised regarding conflicting interests. An interviewee from the planning department has noticed some health department staff making efforts to maintain

relationships between the departments: "[Certain health department staff] are pretty good about checking in with us about which projects we're working on, and wanting to be involved. So some of it is personality" (Seattle Interviewee D, personal communication, August 29, 2014).

Conflicting values and priorities are also seen at the leadership level. Planning institutions are governed by priorities that can vary depending on factors such as city context and the personal agendas of leadership. Elected officials and leaders, who help set direction for jurisdictions, are not yet fully engaged in the issue of health and land use. Survey findings show a general lack of prioritization of health by elected officials. Seventy-five percent of survey respondents indicated that their city mission statement does not include a reference to health, 89 percent indicated that their city does not have a citywide health ordinance or framework, and less than half cited political support as a resource that could be leveraged for the incorporation of health within planning processes. Nearly 60 percent of survey respondents also indicated that the knowledge of elected officials on connections between health and the built environment is a barrier to the inclusion of health in planning. This could be due to lack of interest or a lack of understanding of the links between planning and health.

However, even support by elected officials may not lead to action on promoting collaboration between planning and health. Political support and leadership at all levels is also critical to ensuring that policies and plans that consider and improve public health become industry standards, rather than struggles. An interviewee from the Orlando planning department noted that elected officials are generally supportive of the department's work, but have failed help promote the health connection: "They have been supportive of what we have done…I think that they intuitively get it, and I don't think

anybody has objected to what we're doing. But…it's never been sold as a 'Get Healthy Orlando'" (Orlando Interviewee A, personal communication, June 27, 2014).

Lack of support creates even more challenges. In San Francisco, during the peak of collaboration between health and planning (approximately 2004 to 2009), the political and department leadership was not perceived to be particularly encouraging. That time period saw several changes of leadership, including the mayor and the planning director. Said a former planning commissioner, "it was hard to move forward once leadership changed" (San Francisco Interviewee G, personal communication, April 7, 2014). In general, interviewees believed that the directors of both departments did recognize the benefit that each department had for the other but were not willing to make significant changes to their practices.

Literature on integrating planning and health argues that support from leadership can heavily influence collaboration between planners and health professionals. A 2009 study in England, developed at the request of the United Kingdom Department of Health, looked at how planning and transportation professionals view public health. The research specifically sought to understand planners' perceptions on guidance from the public health field in terms of modifying factors of the built environment to promote healthy behavior. The study found that while planners in England saw public health as critical to consider in planning practice, planners have many other factors to consider as well, and unless health has legislative support it is unlikely to take priority (Allender et al. 2009). The World Health Organization European Healthy Cities Network, which was initiated over two decades ago, identified strong local leadership as a driving force in the integration of health into not only planning, but the larger agenda of city government. The influences of local governments on the health and wellbeing of citizens are

widespread, ranging from the adoption of policies and interventions to cultivating local partners (Tsouros 2013).

More active and involved leadership can have a great influence on the prioritization of health within city government. Support of elected officials is important, but more than just support is needed in order to more completely address health concerns. City leadership can use their influence on citizens and city staff to emphasize the importance of applying a broad definition of health to many sectors, including city planning and development (Tsouros 2013).

The need for a health focus within planning is based largely on a normative perspective that health should be a common value of the planning field, though it is clear that in practice, values of planners and city leadership differ dramatically. However, simultaneously considering normative ends with communicative action-oriented means can open up conversations between diverse stakeholders who should all be striving to serve the common good of improving societal well-being. Collaborative processes that serve to educate practitioners and leaders on current public health and planning practices can help to transform values into support for a larger public good.

5.1.3 Discrepancies in Practical Knowledge and Language

The lack of shared values among staff and elected officials, and between and within the planning and health fields, can lead to differences in knowledge of the current issues linking health to land use practices. This lack of knowledge is another challenge that must be addressed in seeking to holistically incorporate a focus on health within planning processes. Survey results showed that planning department leadership and staff

view the general support of city leaders as strong, but that knowledge about the connections between health and planning among elected officials is lacking, with 57 percent of respondents seeing knowledge as a barrier to inclusion of health in planning. Lack of knowledge can lead to a lack of a common language and goals between the fields as well as differences in understanding of the role the built environment plays in health outcomes. This can lead to a significant impact on how health is, or is not, being incorporated within planning practice.

In many cases, planners are already working within existing processes to improve health: they are just not using terminology that would facilitate good collaboration with health professionals. One key outcome from the first HIA conducted in Columbus was a new framework for drafting area plans created by the new planning director. Said an interviewee from the health department, "in that template we did get some health things in there that weren't necessarily called 'health,' but recommendations for wider sidewalks, recommendations for better connectivity between public transit and the front door of buildings" (Columbus Interviewee C, personal communication, June 30, 2014). An interviewee from Seattle noted, "The [planning] department has acknowledged [health] and seen its value. But we still don't use those words in our intentional statements about what we do" (Seattle Interviewee A, personal communication, June 20, 2014).

While planning staff and leadership may not fully appreciate the need to deliberately use public health language in planning processes, health professionals do largely understand why it is important for public health terminology to be integrated into planning and land use decisions. A systematic literature review by Kent and Thompson found that a challenge to planning and health collaboration is defining the role that health professionals can and should plan within planning processes (Kent and Thompson 2012).

Though including health within the planning agenda is generally understood to be important, uncertainty as to how this should operate in practice remains. The public health field has refocused from treatment to prevention and health promotion, while the planning field is still unsure how to incorporate health and characterize what a healthy built environment looks like (ibid.).

The lack of a common language between the fields of planning and health makes it difficult to identify where the largest health disparities lie, and therefore what groups are the most disadvantaged in terms of healthy built environments. In Orlando, the opinion of the local planning department is that planners have been working on health issues for a long time without specifically calling it "health." Said one interviewee, "in many ways, health professionals and planning professionals have the same goal in mind—to make our communities better so that people can live healthier lives. And we can call it different things, but in the end it comes down to health" (Orlando Interviewee A, personal communication, June 27, 2014).

At the same time, conflicting definitions exist when it comes to health. Planners tend to gravitate towards walkability and mixed-use development, and while those issues do impact health, the broader definition of health—which takes into account social determinants as well as physical conditions—must be considered as well. Said an interviewee from the Columbus planning division, "In my mind I interpret [supporting health-related objectives] as making our neighborhoods more walkable, bikeable, and transit-friendly" (Columbus Interviewee A, personal communication, May 28, 2014). A planner in Seattle explained, "every time somebody comes at me with stuff about soda and tobacco, my ears turn off. I know that's a big issue, and I know it's a huge thing in terms of health outcomes, [but] it's not a really great area to focus collaboration" (Seattle Interviewee A, personal communication, June 20, 2014). A common understanding of the

health goals that planners can influence is currently lacking. Promoting a basic understanding of the work of each department can mitigate this lack of understanding. Said the same planner from Seattle, "I think one of the big things is that health planners, and sometimes public policy people, have a hard time knowing what planners are already doing, and how they do things, and therefore communicating the importance of it" (Seattle Interviewee A, personal communication, June 20, 2014). A former planning commissioner in San Francisco stated that planning and health have "very different approaches and tools and they use language differently, which is often the biggest problem" (San Francisco, Interviewee G, April 7, 2014). HIA has been widely promoted as a tool to address this challenge, though it is also a very resource-intensive process.

These differences in understanding the meaning of health is complicated by the increasingly complex conception of health in the public health field. Currently, what planners consider "health" is narrower than the social determinants view used by the health community. In 2010, the American Planning Association conducted a survey of members where 27 percent of respondents indicated that their jurisdiction's adopted comprehensive plan explicitly addressed public health topics. Only half of respondents to this survey were from city governments (American Planning Association 2011). In the 2013 survey for my research—in which all respondents were from city governments—80 percent responded that built environment and health topics were being addressed within comprehensive plans. While the two surveys are not directly comparable, the discrepancy in results could be interpreted to mean that the definition of health understood by an individual planner can vary. Some planners may believe that some facet of health is being incorporated within their current efforts, though the explicit language and definition of health used is not clear. What one respondent thinks is a health-related topic, another may not; this is an especially important point for the APA survey, where the respondent set

was quite diverse in terms of role, sector, and scale of jurisdiction. The great difference in these findings in surveys only a few years apart shows that health is a complex topic that impacts many issue areas and whose interpretation varies from individual to individual. A better question to have asked in both surveys—and a key issue for future research—is whether a representative from the health department has been engaged in city planning processes.

Interviews conducted with planners for my research also illuminated a narrow view of health in the planning field. While the Columbus planning division does support the inclusion of health concerns in planning—as one interviewee stated, health is "part and parcel of what we do" (Columbus Interviewee A, personal communication, May 28, 2014)—the definition of health that emerged through that interview was fairly narrow. An interviewee from the Columbus health department also noted:

> I think if you ask the planning department what health means…and not to say that this isn't what it is, but I'm guessing they would say its active transportation and it's walkability and that's probably what I thought it was too before I dove into it, but it's so much more than that. Its housing and its parks and recreation and physical activity opportunities other than active transportation. Its local foods and food access and everything the planning division does impacts all those areas (Columbus Interviewee B, personal communication, June 11, 2014).

As discussed in Chapter Two, the goals of the planning and health professions began to diverge in the early 20th century, which has contributed to the differing language and understanding today. Literature on planning and health integration also cites differences in language and definitions as a barrier to collaboration. The integration of planning and health cannot reach full potential without mutual goals and a common language (Hofstad 2011). A challenge to integration is for each field to learn from and build upon each other's definitions and theories (Hoehner et al. 2012). Research shows

that there is not only a narrow definition of health being used within planning, there is also a lack of understanding of how planners should engage with health topics, and which topics are most applicable to their work.

5.1.4 Lack of Understanding of How to Incorporate the Health Perspective

The inclusion of health issues in planning processes appears to depend on whether planners perceive health to be an issue that can easily address in their work. Findings from my surveys show that planners in general are not fully aware of the best ways to engage with health topics within their current responsibilities. Nearly 60 percent of survey respondents indicated that a barrier to including health within the planning process is an understanding of the appropriate actions to take. Said an interviewee from the Seattle health department,

> There are a lot of people on [the planning] staff that are very focused on how do we make Seattle a much more bikeable and walkable community, and I think the challenges [for planners] are probably similar to a lot of places: they have a lot of work to do and it's nice to say, well we should build health and equity into planning and sometimes it's like, well what does that look like? What does that mean? We just need to be better prepared to talk about that. I think [for planners] it just goes back to "well what does that mean in my day-to-day work? How does that affect me when reviewing a plan, what do you want me to do with that information?" And I think that's where we just have to keep thinking on it (Seattle Interviewee B, personal communication, July 21, 2014).

In Cincinnati, the planning division has struggled with how to turn desired health outcomes into policies in their comprehensive plan. One interviewee from the planning division asked, "how do we turn [specific health issues] into something that we can use in a plan to help guide us as a city? How do we take a problem from the specific to the

general?" (Cincinnati Interviewee A, personal communication, June 13, 2014). Though incorporating health language into the comprehensive plan was a big win for health and planning collaboration in Cincinnati, the city is still determining the best way to leverage the health-related goals and policies to benefit the citizens of Cincinnati.

Health professionals are generally hopeful that planners will be receptive to collaboration in order to improve built environments. An interviewee from the Orange County Health Department in Orlando said "I think the planner should, in their everyday work, always have health impacts in the back of their mind" (Orlando Interviewee C, personal communication, July 15, 2014). Ideally, planners would automatically incorporate health concerns within their work by partnering with health professionals regularly, but there are barriers, including language and clear processes to include health, that are currently preventing this.

Within their daily practice, planning departments are not ensuring that planning staff members have the opportunity to understand why and how health should be considered. There is limited training available for planners on health issues: 42 percent of survey respondents indicated that planners in their jurisdictions have access to voluntary training opportunities, where interest in the health issue would push participation. Only four percent have received mandatory training in health-related issues (see Table 5.3). An interim solution to the lack of training of planners would be to hire staff with some health training, but only seven percent of survey respondents indicated that their departments currently employ planners who also have a health background. Additionally, only 17 percent responded they have staff whose specific responsibilities include considering health in planning, likely through collaboration with health departments. These results indicate that planning departments are not appropriately structured to directly understand

or consider a broader definition of health or how health outcomes are impacted through planning decisions.

Table 5.3: Current Availability of Resources to Consider Health in Planning.

Available resources to consider health in planning efforts	**Number/percent selected**
Partnerships with external organizations	79 (54.9%)
Quantitative or qualitative community health data	70 (48.6%)
Funding (e.g. grants, state or local funding, private donations)	62 (43.1%)
Voluntary training opportunities on health related issues	61 (42.4%)
Political support	60 (41.7%)
Assigned planning staff to work on public health issues	39 (27.1%)
Mandatory training opportunities on health related issues	6 (4.2%)
Other	6 (4.2%)

(N = 144).

Ultimately, my study shows that differences in values, interests, and understandings pose limitations for collaboration between health and planning in practice. Even though a general goal of both planning and public health is to ensure that community needs are met by protecting the health and welfare of society, in practice this has not been successful. However, although the lack of common understanding and values present challenges to collaboration between the fields—and between departments—opportunities also exist for individuals who value health and equity, from either profession, to push for collaboration.

5.2 What is the Role of the Planner in Shaping Practice?

The second main theme identified through my research involves the differences in the perceived role that the planner plays in creating built environments that are healthy for all, and how this perceived role shapes practice. Differing values between planners and health professionals lead to challenges for planning practice, including a lack of explicit methods to use to incorporate health, and differing opinions on collaboration and sources of knowledge. Changing and adapting values and knowledge of individuals can have a great impact on the institution of planning itself (Healey 1999), but a lack of well-defined methods to achieve this can impact daily planning practice and decision-making processes. Additionally, incorporating other forms of knowledge is essential to transforming the practice of planning, which, in turn, is necessary in order to develop a focus on health in planning (Rydin 2007). A lack of consistent consideration of public health knowledge and perspectives leads to great disparity in how planners view their responsibility for improving health outcomes.

5.2.1 Lack of a Defined Method to Sustain Collaboration

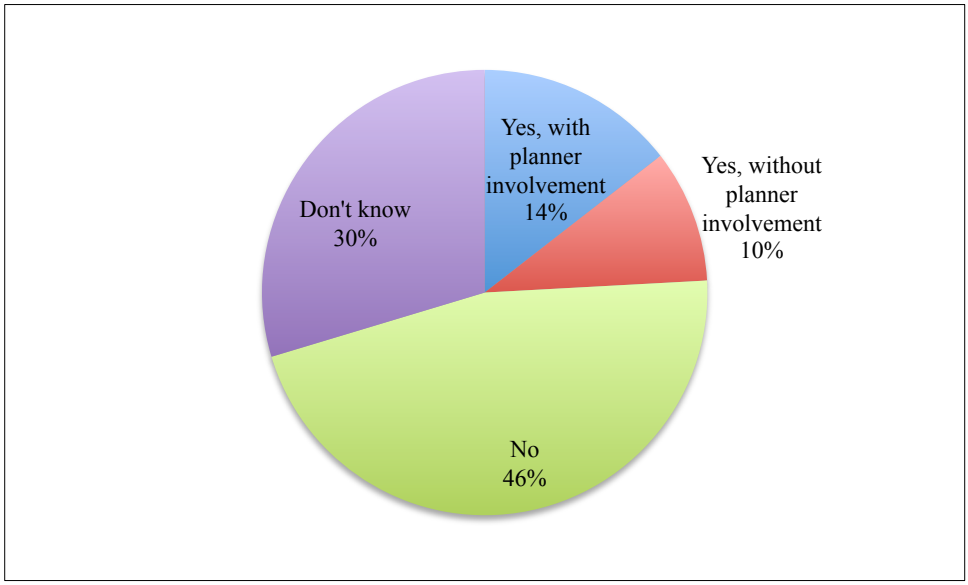
Inconsistent collaboration between the fields of planning and public health does not foster an environment where processes and methods that would serve to sustain collaboration between the fields and allow for a holistic approach to health and equity are promoted. The tools and methods that currently exist have not been fully embraced by planners, and this is not allowing health to be wholly included within planning practice.

HIA, a tool designed to look at issues of health and health equity, is underutilized within planning practice, and the health profession is not consistently successful at

engaging planning or even using HIA as intended and defined. In order to begin to understand how widespread the practice of HIA has become within planning departments, a number of questions on this topic were asked in my survey. Only 14.5 percent of survey respondents indicated their planning department had been involved in an HIA. The majority of these HIAs (71 percent) were initiated on a voluntary basis, and the majority (62 percent) were performed on a plan as part of a planning process.

Nearly 76 percent of responding cities answered that they have not conducted an HIA or they did not know if their city had conducted an HIA (see Figure 5.3). This complements the literature that suggests that HIA as a process is not yet as widespread in the U.S. as it has become in places such as Europe and Australia; the U.S. overall has been slower to adopt the method of HIA than other countries (Rutt et al. 2008). Additionally, a review of HIAs in the U.S. in 2008 found that no HIAs had been conducted on a comprehensive plan (Dannenberg et al. 2008). Though this has changed in the past several years—both with an increase in HIAs for comprehensive and area plans and an increase of HIAs in the U.S. in general—adoption of HIA practice still lags other countries, where it has become an integral part of governmental cross-sector actions and activities that promote public health (Cole and Fielding 2007).

Figure 5.3: Health Impact Assessment Conducted in Respondent's City.



(N = 145).

However, while promoted in literature as a process that should be widely used to integrate the fields, interviewees attested that HIA might not be an enduring method, suggesting instead that it is best used as a catalyst to get the two departments collaborating. A former public health staff in San Francisco stated that "Health Impact Assessment was just, in many ways, a tool to get in the door, but our commitment wasn't to that particular tool. Our commitment was to the integration and collaboration" (San Francisco Interviewee H, personal communication, April 15, 2014). A former staff with the San Francisco planning department mentioned that "A Health Impact Assessment by itself is not going to [foster collaboration]. It makes a statement, it creates a point in the process, but I think it's what we do behind it" (San Francisco Interviewee F, personal communication, March 13, 2014). According to an interviewee from the Seattle-King County Health Department, "We were really early adopters and interested in [HIA], and

then [the interest decreased] I think partly resource-wise, but also we would do screening and think, 'is this really the right place?'" (Seattle Interviewee B, July 21, 2014). HIA processes are typically resource intensive to undertake, so while cities that have used them to integrate health into planning do see the benefits in creating linkages between the departments, many cities are relying on other tools as more longstanding solutions and means of collaboration.

Procuring resources appears to be a concern of planning departments when considering forming new partnerships with health departments, suggesting that lack of resources could be a large barrier to a more widespread adoption of HIA by planners. As gleaned from the interviews, practicing planners and health professionals do not necessarily feel that HIA is the proper way to institutionalize health and planning collaboration: there are other, less resource intensive catalysts to collaboration that have been proven successful. Gottleib et al. similarly reviewed other strategies to achieve healthy public policy and determined that the use of other approaches may reduce the need for the use of HIA (Gottleib et al. 2012).

Interviewees mentioned an array of tools and approaches other than HIA that were being used to integrate health into planning processes. Health in All Policies (HiAP) is an approach that has been embraced by the health field as a way to achieve health equity in all types of policies. This approach has also been promoted by the American Public Health Association, and is defined as "a strategy for addressing the complex factors that influence health and equity, also referred to as the social determinants of health, which include educational attainment, housing, transportation options, and neighborhood safety" (American Public Health Association 2014). Interviewees who mentioned that HiAP was a goal in their work were all employed by health departments (San Francisco Interviewee B, personal communication, February 26, 2014; Seattle

Interviewee B, personal communication, July 21, 2014), indicating that the planning field has not yet embraced this approach. Interviewees also cited sharing of data and joint mapping projects as catalysts for collaboration between departments (San Francisco Interviewee B, personal communication, February 26, 2014; Cincinnati Interviewee B, personal communication, July 15, 2014; Seattle Interviewee C, personal communication, August 1, 2014).

As more standardized tools are lacking, cities are using existing tools on a more ad-hoc basis, which may not be complementary to existing planning processes. This leads to the notion that integrating a health focus into planning is too cumbersome or resource intensive. The lack of resources and institutional support is an often-cited barrier to this endeavor (Ponder and Dannenberg 2008). There is also a perception that health issues are too difficult to address within existing planning processes. However, as noted by Ziller, "clearly the role of planning is to do better than this" (Ziller 2009 p. 30). The field of planning should strive to include the perspectives of other fields into its work, most importantly the perspectives of public health.

5.2.2 Hesitance to Incorporate Alternate Knowledge

Similar to many fields, planning has evolved as a silo of practice, though current research lays out compelling arguments for an expanded role of planning to consider health within built environment and land use issues. Not only do health professionals need to play a role within built environment policies and practice, but planners and other agencies must also consider health in all government policies (Perdue et al. 2003). A University College London (UCL)-Lancet Commission looked at how the built

environment can be shaped to improve health outcomes, and recommended an expanded approach to urban planning that considers a range of health interventions (Rydin et al. 2012).

Current issues undertaken by planners are less health-focused and more in line with what has evolved to be a "traditional" planning role. This is supported by survey findings, which indicated that the health and built environment issues most frequently addressed by planning departments include transportation and land use issues that are more consistently aligned with the planning profession—such as access to alternative transportation, access to services, and affordable housing—as opposed to issues that have more direct links to health, such as obesity, asthma, air and noise pollution, and access to health care (see Table 5.4). Interviewees have also found that planners hesitate to incorporate different perspectives into their work. Said an interviewee formerly with the Columbus public health department, "I remember one time it came up, putting a little sidebar into the neighborhood plan that just gives a few health statistics and talks about why these decisions are important to health. And that didn't go anywhere" (Columbus Interviewee C, personal communication, June 30, 2014). A planner with the East Central Florida Regional Planning Council felt that the role of planning could easily be expanded, "because that's the role of planners anyways, to do the best job that they can for a project or a policy and having everybody on board" (Orlando Interviewee E, July 29, 2014).

My research also showed that many planners and planning leadership are reluctant to work on problems beyond the more traditional land use issues due to perceptions of workload limitations. Planners cited lack of resources, such as staff time, data, and analytical tools, as a main challenge to engage with what was thought of as "non-traditional" issues. Seventy percent of survey respondents cited adequate resources as a barrier to collaboration with public health; additionally, less than half of survey

respondents indicated that data, assigned planning staff, and/or funding was available to their planning department to help integrate health into current practices.

Table 5.4. Issues Addressed by Planning Departments.

Issues most selected (greater than 50%):

Issue addressed by planning department	**Number/percent selected**
Access to alternate modes of transportation	127 (88.2%)
Access to amenities/services	108 (75%)
Affordable housing	90 (62.5%)
Pedestrian/bike injuries	73 (50.7%)
Increasing physical activity	72 (50%)

Issues least selected (30% or below):

Issue addressed by planning department	**Number/percent selected**
Obesity/diabetes	32 (22.2%)
Outdoor air pollution	29 (20.1%)
Noise pollution	25 (17.4%)
Access to health care	24 (16.7%)
Indoor environmental pollution	19 (13.2%)
Asthma	7 (4.9%)

(N = 144).

Interviewees shared similar concerns. In San Francisco, the impression from interviewees from both planning and public health was that most planners resented the additional work stemming from the collaboration with public health in the late 1990s and early 2000s. Past collaboration has not been well maintained, largely due to a lack of resources and the skepticism of the staff. An interviewee from the San Francisco planning department stated that the department does not have the capacity to maintain collaboration, and that after their Eastern Neighborhoods Community Health Impact

Assessment (ENCHIA) process was completed planners were assigned to other projects (San Francisco Interviewee A, personal communication, February 25, 2014).

In both Columbus and Cincinnati, a primary barrier to collaboration has been staffing changes. An interviewee from the Columbus health department felt that due to a reduced staff, the planning department is "reluctant to take on anything that is a little bit extra. I think it was just 'we're already doing it, we're stretched too thin, and we can't do one more thing'" (Columbus Interviewee A, personal communication, May 28, 2014). An interviewee from the regional planning council in Orlando observed, "A lot of it just has to do with what needs to get done, the amount of funding available, and the amount of time and personnel. I really think it depends upon the resources available to the various jurisdictions and their agencies that allows them to actually get out and collaborate more" (Orlando Interviewee E, personal communication, July 29, 2014). Regardless of interest or values, current planners and health professionals see resource availability within planning departments as a major barrier to collaboration.

Individual planners and entire departments have struggled with defining the importance of a sustained collaboration with public health, and the field of planning overall is also perpetuating the hesitance to branch out and take on non-traditional issues. The narrowed focus of planning that evolved throughout the 20th century also poses challenges to collaboration. A former staff member from the San Francisco planning department noted, "From the planning perspective, we have become so technocratic, we have narrowed our boundaries, we have become so focused on the administrative issues and existing issues that there's no room for addressing places and people in a more comprehensive manner" (San Francisco Interviewee F, personal communication, March 13, 2014). Another interviewee, formerly with the San Francisco Department of Public Health, agreed, stating: "We're maintaining the silos. We're maintaining the silos in

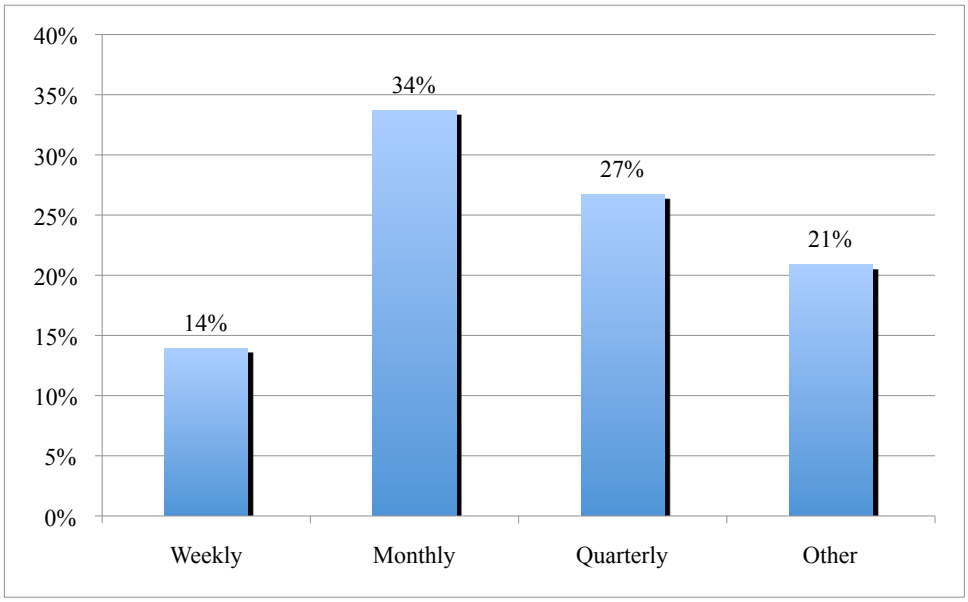
academia, and we're maintaining the silos in government, and maintaining the silos among the civil society groups" (San Francisco Interviewee H, personal communication, April 15, 2014). In Columbus, the public health department has seen other built environment-related departments—primarily the building and zoning department—embrace health, but the planning department is lagging (Columbus Interviewee B, personal communication, June 11, 2014). The changing priorities throughout the evolution of the planning field are perpetuating the unwillingness or inability of planners to fully engage with other issues important to the discipline, including public health.

5.2.3 Differing Notions of Collaboration

The hesitance of planners—and the field of planning—to incorporate new and alternative knowledge leads to an inconsistent view of what collaboration with health professionals should look like in practice. This, then, leads to a failure to ensure that any collaborative process is implemented and maintained.

My research found that collaboration between departments is not occurring on a regular basis. Sixty percent of survey respondents indicated that there is some form of collaboration between planning and health departments in their jurisdictions, but exactly how the departments are collaborating—and how often—is not consistent. Monthly and quarterly communication was reported most often in the survey (see Figure 5.4). This is indicative of "one-off", irregular communication between planning and public health on a project-by-project or plan-by-plan basis, rather than a regular public health partnership or consultation in planning activities.

Figure 5.4: Frequency of Collaboration between Planning and Public Health.



Most frequent "Other" responses included "as needed," "episodically," "annually," and "irregularly" (N=86).

Interviews also confirmed that communication between departments has been inconsistent, and, without a regular process or regular staff to continue collaboration, communication has tended to wane. The collaboration that occurred in San Francisco was on a specific project basis and the relationship between planning and health never evolved to a true, lasting partnership. Said one public health staff member in San Francisco, "In terms of my interface with the planning department, the neighborhood planning is kind of tapering off at this point" (San Francisco Interviewee C, personal communication, February 26, 2014). Said an interviewee from the Columbus planning division, "I had more regular communication with [the first health coordinator] and other health department staff that were also kind of involved in some related topics, they formed these committees of food access, they were in the food business, and pedestrian matters. But then some of their staff sort of went away. We haven't really had regular

engagement lately" (Columbus Interviewee A, personal communication, May 28, 2014). A former staff of the Columbus health department explained the waning communication: "There was an early win in that first year that we had with planning, and then our relationship did kind of fall out because there were a lot of things happening [in the planning division], even though it wasn't called 'health'" (Columbus Interviewee C, personal communication, June 30, 2014). In Seattle, collaboration does not occur on a regular basis; instead, it is project-dependent. Said an interviewee from the planning department, "Our [planning] projects kind of come and go, and some of our projects are done in six months and some take four or five years to complete. So it's kind of hard to maintain a relationship over that five years. But then if we have a new project starting up, sometimes we don't always remember to deliberately engage health staff" (Seattle Interviewee D, personal communication, August 29, 2014). Though collaboration in the cities interviewed has not been maintained on a regular basis, interviewees generally agreed that when the two departments are able to collaborate, the relationships were good and they are able to assist with each other's work.

Interviews showed that health professionals typically instigate collaboration with the planning department. In all five cities studied, either a health department leader or staff member who understood or became aware of links between health and the built environment pushed to form relationships with their local planning department. In Columbus, a former health department employee noted that their health commissioner "bought into the connection between health and the built environment, [saying] 'this makes so much sense, we keep telling people to be physically active but our neighborhoods aren't conducive to physical activity, they're not safe'" (Columbus Interviewee C, personal communication, June 30, 2014). The health commissioner then advocated for a position to be created that would focus on health and the built

environment in the health department. A current Columbus health department employee and trained planner acknowledged that learning about built environment-related health outcomes has changed his perspectives, noting: "Now I've drank the Kool Aid and I'm on the [health] side of it and pushing [for collaboration]" (Columbus Interviewee B, personal communication, June 11, 2014). As the political and departmental structures in cities vary (for example, local vs. county health departments), collaboration will naturally assume different forms. Still, interviews showed that health professionals have consistently been asking for a seat at the table during planning processes and that in many cases, planners are not fully receptive. Said the interviewee from the Columbus health department, "I think it takes a little bit of pushing to stay in the conversation from the health side of it. Because otherwise I think it just kind of gets forgotten" (Columbus Interviewee B, personal communication, June 11, 2014).

The literature also shows that health professionals tend to take the initiative to influence planning decisions. Four case studies from Michigan, Colorado, Ohio, and Washington described how health professionals worked to educate planners, developers, and city officials in links between health and the built environment and how they engaged in land use planning processes. These case studies showed that the involvement of health professionals in the planning process was ultimately found to be valuable by their partners (Ponder and Dannenberg 2008). However, the practice of planning in general is perceived as keeping public health concerns at the periphery of more traditional planning activities (Hofstad 2011).

While health professionals are pushing for a seat at the planning table, planners often forget to call their health partners or are unreceptive to their attendance at planning meetings. Through the interviews it also became apparent that collaboration is not always strongly supported or willingly maintained by planning departments. This was most

evident in Columbus, where an interviewee from the planning division stated, "I don't know that the health department needs to be in this business to tell you the truth. If they wanted to do it and they find their role where they are doing something, then I think [collaboration] should be institutionalized. But I'm not convinced that that's where we should go here" (Columbus Interviewee A, personal communication, May 28, 2014). In Seattle, an interviewee from the health department noted that it is difficult to get local planning departments to remember to work with them, "Especially in places where you don't see or hear about the health department, or other types of health organizations, because you're not physically on the ground, we don't have a clinic, don't have an office" (Seattle Interviewee B, personal communication, July 21, 2014). Without incentive or desire to collaborate, planners are generally not reaching out to health departments to invite them into processes. When discussing how best to cultivate relationships between the two departments, one public health interviewee from Cincinnati commented, "It has to be institutionalized, ongoing meetings, because if it's meetings that people call and then people go away, they stop calling the meetings and then you're out of luck" (Cincinnati Interviewee C, personal communication, August 28, 2014). Planners and health professionals alike have seen many challenges to establishing regular collaboration between the departments.

5.3 Conclusion

The surveys and interviews illuminated several barriers to collaboration between planning and health. The values of planners play a key role in how planning is practiced, including how alternate forms of knowledge—such as the expert knowledge of health

professionals—are incorporated in planning processes. Research showed a lack of awareness among planners of an expanded definition of health and discrepant attitudes towards the need to incorporate health within the planning process. The actual inclusion of health within planning is, at best, inconsistent, and largely influenced by the values of a small minority of planners. As discussed in the study in New South Wales, Australia, policies and priorities promoted by authorities are value-laden, not rational (Sainsbury 2013), and these values influence the individual values of planners.

My interviews suggest that planners in many cities believe that they are doing enough to incorporate health into their work. This may be due to a lack of understanding of the various multifaceted linkages between health and the built environment that go beyond physical health to mental health, social health, and health equity. As a public health interviewee in Columbus said: "A lot of what I have heard from [planners] is 'well I can't imagine what we're doing has a negative health impact.' They just assume that since what they are doing is, as far as they know, best practice, that's good enough. Why do we need to do an HIA on it?" (Columbus Interviewee B, personal communication, June 11, 2014). Because of this discrepancy between how planners think they address health and how they actually address health, it is critical to bring in the expertise and perspective of health, through collaboration with health professionals, to ensure that a full spectrum of health issues are being considered.

My research also showed that the current collaboration between health and planning departments is not consistent, which indicates that health is not a primary focus of planning departments or the planning field. The inclusion of health is currently grounded in the interests of individual planners to decide whether or not to take it on as a cause, as well as the availability of standardized tools or processes that would streamline the incorporation of a new topic—such as health—into a planning process that has

become isolated from the interests of other fields. Thus the seemingly separate responsibilities in each field contribute to the fields' current lack of collaboration (Frank and Engelke 2001), and the narrowed functions of governmental planning and health departments have effectively prevented shared goals and processes from emerging (Crawford 2010).

However, despite the barriers to collaboration between the planning and health fields, a number of opportunities for collaboration were also revealed through stories relayed by interviewees. The next chapter presents these stories and shows how planners and health professionals have worked to overcome challenges to collaboration in five cities: San Francisco, California; Columbus, Ohio; Seattle, Washington; Cincinnati, Ohio; and Orlando, Florida. These stories illuminate the ways in which planners and health professionals have worked to incorporate health within planning. The stories suggest that through their agency and creativity, planners view the inclusion of health within planning processes as a positive opportunity to promote the betterment and welfare of society: the very reason why urban planning initially arose as a discipline.

Chapter Six: Stories from the Field

6.0 INTRODUCTION

Many cities across the country are exploring ways to facilitate collaboration and partnerships between planning and health departments, despite the challenges discussed in the previous chapter. In this chapter, I present stories told by participants of such collaborative efforts in order to understand how planners and health professionals tackled these challenges. This is not an attempt at a comprehensive or objective retelling of planners' experiences; rather, this chapter reflects the great significance of stories in and for planning processes. Stories have inherent power and are deployed in many ways to shape planning policies and practice. In the present case, stories of relatively effective collaboration, such as those relayed in this chapter, are re-told by proponents of health integration in planning to further their case. Elements of both success and failure emerge through these stories.

Additionally, storytelling is a central concern in planning research and practice because it reveals differences in knowledge and viewpoints between various groups in society, and therefore can be thought of as a tool that planners and planning scholars can use to understand differences in an attempt to meet the needs of multiple stakeholders (Sandercock 2003). In this instance, sharing these stories is essential since my research uncovered that epistemological differences between planning and public health professionals represent central challenges to developing a health focus in planning. The stories relayed here serve important roles in terms of framing often-conflicting

perceptions and understanding in the ongoing conversation around establishing a health focus in planning.

Also, through stories, values of the storytellers are shared and conveyed (Forester 1999). For the purposes of my research, it is therefore important to relate the stories of attempts to integrate public health and planning in order to understand how health is valued by planners, and what this in turn reveals about planners' commitment to a health focus in planning. Thus, relaying these stories from each city and each interviewee helps illuminate what happened and why in an effort to determine what each story means to the larger context of planning and health collaboration.

In this chapter, I explore the evolution of the collaboration between planning and health in each of the five cities interviewed: San Francisco, Columbus, Seattle, Cincinnati, and Orlando. The efforts of health professionals and planners that are outlined below show desires for and challenges to collaboration, and the experiences of cities that—through a variety of means—have generally embraced and understood the importance of considering health within planning processes. These stories show how all of these cities, with very different regulatory and institutional structures and public health contexts, have been able to successfully collaborate which led to health, in some way, being included in planning processes.

As shown in Tables 6.1, 6.2, and 6.3, these five cities vary in size, demographics, and structure, showing that successful collaboration can occur at a variety of geographic, political, and economic scales. The demographic data shows a wide range of size, median income, population density, and ethnicity. Though there are marked differences, each of these cities has had some success in bringing the health perspective into their planning processes, which indicates that cities of varying demographic compositions are starting to understand the links between health and the built environment. Additionally, these stories

show that the impetus for health and planning collaboration does not specifically depend on the number of planners employed or the population of a city (see Table 6.3). Mechanisms for collaboration exist that can be applied to a range of city contexts.

Table 6.1: Size and Income Characteristics of Interview Cities

City	Population (2010)	Land Area (square miles)	Population growth 2000-2010 (average)	Median Household Income (2011 5 year ACS)	Population Density (per square mile)
San Francisco	805,235	46.87	3.70%	$72,947	17,179
Columbus	787,033	217.17	10.60%	$43,348	3,624
Seattle	608,660	83.94	8.00%	$61,856	7,251
Cincinnati	296,943	77.94	-10.40%	$34,104	3,810
Orlando	238,300	102.40	28.20%	$42,755	2,327

Table 6.2: Race and Ethnicity Characteristics of Interview Cities

City	White	African American	Asian	Other	Hispanic or Latino
San Francisco	48.5%	6.1%	33.3%	12.2%	15.1%
Columbus	61.5%	28.0%	4.1%	6.5%	5.6%
Seattle	69.5%	7.9%	13.8%	8.8%	6.6%
Cincinnati	49.3%	44.8%	1.8%	4.0%	2.8%
Orlando	57.6%	28.1%	3.8%	10.6%	25.4%

Table 6.3: Departmental Characteristics of Interview Cities

City	Size of Department that includes Planning (approximate)	Size of Health Department (approximate)	Health Department Location
San Francisco	125	7,000	City/County[a]
Columbus	15	400	City[b]
Seattle	400	1,500	County
Cincinnati	75	400	City[b]
Orlando	200	520	County[c]

[a.] In the state of California, health departments are county agencies. However, in the case of San Francisco, the city and county boundaries are aligned, and the government is referred to as "the City and County of San Francisco."

[b.] The state of Ohio has city health departments for some of the larger cities, and county health departments for other areas of the state.

[c.] In the state of Florida, the health department is a state agency with county offices. Referred to as a "centralized state," the central health department office in Tallahassee provides policy direction, training, and consulting services to the 67 county offices. This type of model poses benefits and challenges: county health department staff has access to a team of experts at the state level, but essentially reside in a "limbo" where neither the county nor the state provides all of the necessary resources and the priorities of each county may conflict with the priority of the state, with the county health department offices caught in the middle.

The interview cities also exhibit differences in the health issues creating the most impact. Although the data shown in Table 6.4 are at the county level and do not account for disparities among income or ethnic groups, in general it appears that the social, physical, and economic issues facing each city vary drastically. For example, in San Francisco the overall obesity and physical inactivity prevalence is low, but housing and income inequality pose great threats to residents, especially compared to the top performing counties in the United States. Conversely, Columbus has a high prevalence of obesity and physical inactivity, but lower crime and income inequality. Though the main health threats vary, a focus on health overall has become important within the health and planning departments in each city interviewed. The information gleaned from the interviews in these five cities shows that collaboration between health and planning

departments is possible in many types of cities that are facing a variety of health challenges.

Table 6.4: Health Issues Impacting Interview Cities (County-Level Data)

City	Air Pollution Particulate Matter[a]	Adult Obesity	Severe housing problems[b]	Violent crime per 100,000	Physical Inactivity	Income Inequality[c]
San Francisco	8	15%	27%	703	15%	6.8
Columbus	13.5	30%	18%	485	24%	4.8
Seattle	11	22%	19%	343	15%	4.6
Cincinnati	13.3	29%	18%	501	24%	5.7
Orlando	10.9	25%	25%	730	23%	4.5
Top U.S. Performers (90th percentile)	9.5	25%	9%	59	20%	3.7

Source: County Health Rankings, Robert Wood Johnson Foundation

[a.] Measured in micrograms/cubic meter

[b.] Such as overcrowding, costs, or lack of kitchen/plumbing facilities

[c.] Ratio of household income at the 80th percentile to income at the 20th percentile

By exploring the evolution of imparting health in land use decisions within these cities, it appears that collaboration can be a starting point to overcome a lag of support of health goals within the planning profession overall, and can also lead to a more lasting focus on community health within individual cities and planning in general. Based on these stories, which present myriad approaches to collaboration, ways of overcoming the challenges illuminated in Chapter Five are further explored in Chapter Seven.

6.1 San Francisco, California: A Pioneer of Healthy Planning

As discussed in Chapter Four, San Francisco, California was selected as the first city in which to conduct interviews for several key reasons. First, the collaboration between the planning and health departments has been held up as a best practice example within literature. Second, as confirmed in the survey, San Francisco was an early adopter of HIA, with the planning department having been involved in land use-related HIAs since 2004. Finally, as the health and planning departments have worked together on some level for over a decade, it is likely that many lessons can be gleaned from these experiences.

The San Francisco planning department is organized in three primary divisions: Current Planning is responsible for zoning and permit review; Environmental Planning reviews proposed projects for environmental impacts on both the city and the residents; and Citywide Planning develops policies and land use controls, and manages the city's general plan and neighborhood area plans. Environmental Planning and Citywide Planning have both collaborated with the health department. The health department includes a wide variety of health programs, including the Program on Health Equity and Sustainability (PHES), housed within Environmental Health. PHES has approximately ten staff members and is the main group that conducts and trains others on Health Impact Assessment, maintains a variety of tools including the Sustainable Communities Index (SCI), and works on air quality and noise monitoring. In this capacity, PHES works with both the Environmental and Citywide divisions of the planning department[4].

[4] While this research focuses on the relationship between PHES and Citywide Planning, a separate collaborative process has been occurring between PHES and Environmental Planning. This collaboration has a more recent focus on public health, as well as more traditional environmental health. With grant funding from the Bay Area Air Quality Management District, environmental planners are working with staff from PHES to map particulate levels and health risks to identify areas of the city with poor air

The evolution of the relationship between health and planning in San Francisco, and what tools and methods have been utilized as part of this collaboration, is described from the perspective of the interviewees. In general, all interviewees see the starting point for collaboration—namely the Eastern Neighborhoods area plan and the associated Health Impact Assessment—as a successful undertaking by both departments. However, while the impression of this process on a national level is one of lasting success[5], this is understood differently by the local health and planning professionals who were engaged in this process or who currently work for the city. An observation that emerged when reviewing interview transcripts from the San Francisco interviews is the differing perspectives from planning and health regarding how the process has evolved within the city: current and former planning staff were generally more skeptical of the ability of the San Francisco planning department to fully embrace the need to include health in planning, while current health staff were more positive about the situation, with one PHES staff member commenting that "we've gotten to a point where I think they see the value in our work" (San Francisco Interviewee C, personal communication, February 26, 2014).

The Program on Health Equity and Sustainability within the health department initiated the conversation on health and land use within the city of San Francisco in the late 1990s as a response to a number of community concerns. According to a former PHES staff, "We saw in 1999 the broader set of land use issues and the city's institutional issues that were contributing to the poor health of this low-income neighborhood in San

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pollution. Planners and public health staff are currently working together to require developers of projects in these areas to meet rigorous compliance factors as required by Article 38, an ordinance which requires enhanced ventilation in buildings in order to protect residents living in areas of the city with poor air quality (San Francisco Interviewee D, personal communication, February 26, 2014).

[5] Several interviewees from other cities also cited the relationship between the health and planning departments in San Francisco to be one that could serve as a model for this type of integration.

Francisco" (San Francisco Interviewee H, personal communication, April 15, 2014). These concerns mainly involved low-income neighborhoods and residents of the city in the context of environmental justice. Friction in some of the city's eastern neighborhoods emerged in the late 1990s, as the formerly industrial land started to be seen as valuable for new development.

At that time, the PHES program worked to start initial conversations within the planning department. PHES staff was hoping that planning would strategically invite them into their processes at critical points, but the initial conversations did not result in a role for the health department within land use planning. Noted a former planner, "It is very difficult to raise questions about inequities, in any planning context" (San Francisco Interviewee F, personal communication, March 13, 2014). At that time, there were no development plans for the area: planning began working on area plans for several of the Eastern Neighborhoods, while PHES staff continued to push for the inclusion of neighborhood health concerns into the process. The health department investigated using the environmental review process to connect health to the neighborhoods, but instead, as environmental review does not take into account social and economic conditions, the idea of Health Impact Assessment surfaced.

Key planning staff working on the area plans were aware of the work of the PHES staff to connect health to land use, and their desire to become engaged in the planning process. Interviewees conveyed that most planners in the department viewed collaboration with public health as an unwelcomed additional activity. However, recognizing the importance of health, the lead planning staff for the Eastern Neighborhoods plans opened up conversations with PHES staff, even though the planning director and mayor at the time were not fully supportive. Starting around 2004, staff from both departments worked together on a Health Impact Assessment, referred to

as the Eastern Neighborhoods Community Health Impact Assessment (ENCHIA). ENCHIA was one of the first HIAs conducted by PHES, and the first that engaged planning: while PHES shaped and defined the HIA, long range planning staff from Citywide worked closely with the health department, and the planning department was named as a co-author on the document. The efforts of the ENCHIA process, which was intended to create a community vision for health within the Eastern Neighborhoods and to define health objectives, measure, and indicators, are reflected within the Eastern Neighborhood area plans. ENCHIA was completed in 2007, and four area plans were adopted by the city in 2008. Additional area plans within the Eastern Neighborhoods area adopted after 2008 also utilized collaborative processes to include health.

The efforts in the first decade of the 21st century in San Francisco, primarily the multi-year ENCHIA process, are generally considered to be the apex of collaboration between Citywide planners and the Program on Health Equity and Sustainability. One former planner noted that collaboration "went from non-existent, to a peak of interactions in and around 2009, to an increasing trivialization by planning" (San Francisco Interviewee E, personal communication, March 8, 2014). Other interviewees agreed that, though public health staff continuously pushed for it, the collaboration that had been so strong during and immediately after the ENCHIA process has not been maintained. There appear to be several reasons that this occurred.

First, elected officials and department leadership were not perceived to be fully supportive of this collaboration. Throughout the ENCHIA process, from approximately 2004 and 2009[6], there were several changes in leadership, including the mayor and the planning director. None of the planning directors during this time—of which there were

[6] It is important to note that the ENCHIA process was wrapping up around the time of the economic crash in 2008. The unstable economy and a perceived need to focus on other issues may have played a role in a shift away from health concerns within planning and development.

three—were thought to be encouraging of the process, instead ranging from resistant to apathetic. In general, interviewees believed that the while directors of both departments understood the benefits of collaboration, they did not advance it. As noted by one interviewee, currently it is more a situation of "respectfully avoiding each other's issues to minimize conflict" (San Francisco Interviewee F, personal communication, March 13, 2014).

Changes in public health leadership as well have created an environment where collaboration is not overtly supported. Had directors from both departments come together to form a partnership and define ways that planning and health could work together, perhaps the strong collaboration could have been furthered and maintained. One interviewee felt that while certain staff from each department worked to include health within planning documents, there was pushback due to perceptions of what the planning commission or planning director would approve.

For collaboration to be maintained, especially in such a large department, maintaining personal relationships between planning and health staff is critical. Key champions and staff members from both planning and public health have moved on from the departments; these staff members were more-or-less revolutionaries who strongly valued collaboration and aggressively fostered collaboration. One interviewee indicated that while personal interests serve to drive collaboration, not all staff members are typically on board. In order to further the relationships and collaboration, as ENCHIA leaders did, "you have to be willing to call people out" (San Francisco Interviewee H, personal communication, April 15, 2014). Added another interviewee, "So much of local politics is personalities. And I would say that a lot of both the successes and failures in this regard [depended on] the personalities of the people who were involved" (San Francisco Interviewee G, personal communication, April 7, 2014). As the collaboration

that occurred was on a specific plan basis, the relationship between planning and health has not yet evolved to a true, long-lasting partnership, but according to one interviewee, "I think it's an area that we're trying to develop, to acknowledge" (San Francisco Interviewee F, personal communication, March 13, 2014)

Other reasons for the decline in collaboration include limited resources, such as limited staff time, tools, and methods, and the type of work being conducted. The relationship between Citywide Planning and PHES has evolved from engagement on a high profile neighborhood planning process to work on the few active neighborhood plans, as well as ad-hoc data collection and sharing between the two departments. An interviewee from the planning department stated that they do not have the capacity to maintain collaboration: after ENCHIA, planners were assigned to other projects (San Francisco Interviewee A, personal communication, February 25, 2014).

Within San Francisco, ENCHIA—thought to be a successful and comprehensive Health Impact Assessment—appears to have been more of a spark to begin collaboration and relationship building than a method to use for assessing all proposed plans and projects. Said one interviewee, "I think that is one potentially strong way to use HIA, to start that conversation. Presuming you have two parties that want to have that conversation and are just not sure where to start" (San Francisco Interviewee G, personal communication, April 7, 2014). Though one interviewee formerly with the planning department believed that HIA "should be legally required full policy integrations at both project and comprehensive policy/community planning" (San Francisco Interviewee E, personal communication, March 8, 2014) the general consensus among interviewees is that HIA has its benefits within the land use arena; for example, HIA can be effective for high profile projects or when there are truly unknown health impacts, but it is not likely

to be the single best way to facilitate lasting collaboration between planning and health departments.

An interviewee from the public health department mentioned, "Tools that we can use on a day to day basis have grown out of [ENCHIA]" (San Francisco Interviewee C, personal communication, February 26, 2014). The quality of life, sustainability, and health indicators defined through the ENCHIA process evolved into another tool in San Francisco, the Healthy Development Measurement Tool (HDMT), which has recently been renamed the Sustainable Communities Index (SCI). PHES staff members see the SCI as a tool that can be used on a more regular basis, unlike a Health Impact Assessment. The process for using the SCI within a planning process starts with a baseline conditions assessment for the plan area using SCI indicators, and comparing that analysis to the city as a whole. Based on this, strengths and weaknesses are identified for the plan area and the data is shared with the planning department to incorporate health considerations into the draft plan. A former planning commissioner praised the tool, stating, "I think what it does an outstanding job of is flagging the complexity of these [health and built environment] factors. That everything you do in development, even if the decision is just not to touch something, has consequences" (San Francisco Interviewee G, personal communication, April 7, 2014).

The public health interviewees cited more tools that they saw as critical to help push health into land use planning. These tools include data and mapping that are shared with the planning department, as well as a broader Health in All Policies approach that the public health department is trying to infuse into all aspects of their work. Said one interviewee of the role of public health, "We [use] our tools and evidence to create accountability so planning would do what they were always supposed to be doing, which

was good planning. So that's a meaningful and instrumental and powerful role that public health can play" (San Francisco Interviewee H, personal communication, April 15, 2014).

In San Francisco, the ENCHIA process brought planning and health together in a collaborative effort to integrate health into the Eastern Neighborhoods plans, initiated at the behest of the community and the health department. Champions from the health department's PHES program and Citywide Planning pushed this collaboration along, despite a lack of strong support from department directors and elected officials. In conjunction with the planning department, the health department undertook an HIA of the draft neighborhood plans that truly engaged the community. Out of ENCHIA came the Sustainable Community Index (SCI), intended for use during future planning efforts to evaluate the plans and make recommendations targeted at improving health. City planners and public health staff members cite the Eastern Neighborhoods plans as extremely impactful efforts in integrating health and planning, and other cities have looked to the SCI tool as a model. However, collaboration, though still existent in some respects due to personal interest and relationships, has waned, with planners largely reverting to their silos and health staff remaining willing and available for any help that the planning department may require.

6.2 Columbus, Ohio: Champion for Healthy Places

The city of Columbus is the second largest of the case study cities in terms of population, the largest in land area, and the largest city in the state of Ohio (United States Census 2010). Columbus Public Health and the Department of Development are two of the city's 17 departments. The planning division is housed in the Department of

Development, which also includes code enforcement, economic development, housing, and land development (The City of Columbus 2015a). For a city of its size, the planning division is relatively small, and roughly one-third of the division is comprised of historic preservation staff. Due to recent staffing changes, there are only two neighborhood planners, who also act as the primary contacts for other city departments. The health department consists of a variety of programs, including Healthy Places. The mission of this program is to enhance healthy and active living and create a built environment to facilitate this through community design processes (The City of Columbus 2015b). Currently the Healthy Places program has three staff members that engage in policy and advocacy work in partnership with various city departments, including planning and transportation.

The Healthy Places program is the link that connects the health department and the planning division. The health commissioner conceived the program in 2006 after a meeting with the National Association of City and County Health Officials (NACCHO). It took over a year to get approval from the mayor's office, and during that time the health commissioner worked to bring directors from various departments on board and explain to them the importance considering health. Due to this, relationship building had begun even before anyone was hired for the position.

Funding for the position came from the health commissioner's discretionary fund, reflecting her commitment to a position that focuses on connections between health and land use. When Healthy Places got started, the health department hired the recently retired planning director as a consultant. Commented one interviewee:

> [The former planning director] did a lot of research and he already knew about a lot of the processes going on in city departments, and so he was able to design a program in the health department that essentially took advantage of all the processes that were already going on in the city, whether it was the planning

> program or the zoning process and the transportation planning process, and find ways to insert someone from the health department into those processes so that we can at least get our priorities heard (Columbus Interviewee B, personal communication, June 11, 2014).

In order to further close the gap between health and land use, a trained planner has always staffed the position of Healthy Places coordinator. The coordinator receives training and support for more typical public health work from other health department staff and, in turn, trains the health department on built environment and land use issues.

Early on in the program, the Healthy Places coordinator connected with elected officials and leadership to raise awareness of the program's activities. Soon after the program started, the coordinator and a planning staff member received funding to attend a training session on Health Impact Assessment targeted at planning and health department staff. The first HIA—a fairly basic and short document—was done on a neighborhood plan, the Northeast Area Plan, which was already in draft form. One interviewee commented that the HIA was "a review of whether the recommendations were appropriate, relative to making the community healthier" (Columbus Interviewee A, personal communication, May 28, 2014).

The HIA process within the Columbus Healthy Places program has evolved to evaluating draft neighborhood plans and writing letters of support for the plans to city council, encouraging elected officials to adopt the plans and describing how health goals were incorporated. These reviews are typically completed while there is still time to make changes to the plan, and comments on some of the first reviewed plans focused primarily on physical activity, such as sidewalks and bike infrastructure. A framework for area plans, created by the planning director after the first Northeast Area Plan HIA was conducted, provides guidance for walkability, connections to transit, and streetscapes.

While the definition of health being used in these reviews is narrow, it is at least a starting point for planners to begin to understand connections between health and the built environment.

Staffing turnover of the coordinator position caused the health department to miss recent opportunities to participate in neighborhood planning processes. Typically, the coordinator is involved from beginning to end of a neighborhood planning process, including attending and developing surveys for public meetings. One interviewee noted that the Healthy Places coordinator is generally involved "as a stakeholder at the table, influencing, helping [the planners] gather health data to incorporate into their current conditions study, and also helping them develop recommendations to address those health problems" (Columbus Interviewee B, personal communication, June 11, 2014). Once the draft plan is ready, the health department reviews the plan, doing what they refer to as a "mini HIA," and prepares letters of support to send to council members. Approximately 15 mini HIAs have been completed since 2007. Explained one interviewee:

> [The mini HIAs explore] general benefits of physical activity and some health data for that given neighborhood they were doing a plan for, and then the great things that were in the place that would have a positive impact. So that's why it could even just be called a letter of support with an HIA spin on it. Because it didn't really talk about the negative impacts (Columbus Interviewee B, personal communication, June 11, 2014).

The mini HIAs performed on neighborhood plans helped develop relationships between health and planning staff. However, the process used—a checklist to evaluate the plans coupled with letters of support from the health department—may have diminished some of the potential of the method. Said one interviewee, "I think it was successful in that…it created some connections between our departments. But in the end, I'm not sure if it really did much. It wasn't really a community process" (Columbus

Interviewee A, personal communication, May 28, 2014). Explained one interviewee, "You don't want to do a [full] Health Impact Assessment on every single thing, it's too time intensive. But if you can get the working relationship down, that's what's important...you figure out what makes sense and that's why we went to the checklist" (Columbus Interviewee C, personal communication, June 30, 2014).

The Healthy Places program is involved in built environment-related activities with other departments as well, primarily the building and zoning department. The coordinator reviews rezoning and variance applications, and requests voluntary improvements for active design features and other health improvements that might be made to the site design. Initially developers complained, but as one interviewee explained, "The health comments never held up an approval or denial, but people did start paying attention and we saw developers, just by seeing those comments, start to incorporate [health improvements] on a regular basis" (Columbus Interviewee C, personal communication, June 30, 2014). Said another interviewee, "[The voluntary improvement process] has led to a lot of those things just being incorporated into the code. Now bike parking is required, sidewalks are required, those pedestrian connections from the sidewalk to the entrance are required" (Columbus Interviewee B, personal communication, June 11, 2014). The Healthy Places program has seen a lot of success within many city departments, primarily the zoning and transportation staff who started to adopt some of the health language.

However, within the past couple of years, the planning staff has not collaborated as frequently with the Healthy Places program, due largely to staffing changes in both departments. The current Healthy Places coordinator is still dedicated to connecting with the planning division and remaining involved in the neighborhood planning process, but the planning division cites lack of staff capacity as to why the process has waned. Said an

interviewee from the planning division, "We've just been busy enough with so many different things lately that I'm kind of not worried about it" (Columbus Interviewee A, personal communication, May 28, 2014).

In Columbus, the Healthy Places program—initiated by a champion of health and built environment integration—was an important driver of collaboration between the health department and the planning division. Employing a planner within the health department appears to be a beneficial way to bridge gaps between the two professions, though the program has been more successful with collaboration between health and other departments, such as transportation and zoning. As discussed by one interviewee, "The benefit to having a position in the health department is somebody's always watching. In an ideal world yes…health would be talked about in all the plans and all the products coming out of the [planning] department but in reality that doesn't happen" (Columbus Interviewee C, personal communication, June 30, 2014).

Specifically for collaborating with the planning division, the modified Health Impact Assessment process was thought to be the catalyst that initially connected the two departments. Said one interviewee, "I think the role of HIA is…let's follow this process once and create this interdisciplinary thought process, start working together interdepartmentally, and then let's figure out what works for us moving forward. It might not be a typical HIA process, it might be something else. But I think HIA is the kickoff to doing that" (Columbus Interviewee C, personal communication, June 30, 2014).

6.3 SEATTLE, WASHINGTON: HIA EVOLVING TO HIAP

Seattle, the largest city in the state of Washington, was the fastest growing city in the United States in 2013 (Balk 2014). Seattle is the least racially diverse of any city investigated in this research, and is second to San Francisco in terms of having the least number of residents below poverty level. However, in recent years King County, which encompasses Seattle, has seen some of the greatest disparities in health outcomes between ethnic groups, including physical inactivity, as compared to other large counties (Heim 2010).

The Seattle-King County Health Department has a small program, Healthy Community Planning, which focuses on land use and transportation policies in 39 jurisdictions, including Seattle. They do outreach to local health departments to offer assistance on including health data within planning processes, reviewing policies, and writing or research for policies that have a health connection such as biking, walking, parks, and food access. Currently, the Healthy Community Planning team is working with several jurisdictions on updates to their comprehensive plans, and they prioritize their outreach to areas with the poorest health outcomes and to smaller cities with fewer resources. The county abides by an Equity and Social Justice principle that drives the work of this team and ensures that resources are made available to consider connections between land use and health.

The Healthy Community Planning Team is the primary team within the health department that works with the Seattle Department of Planning and Development. The long-range planning group within the planning department consists of approximately 30 staff members who work on comprehensive planning and neighborhood planning; the

work of this group has recently started to include more robust outreach in order to develop community capacity. Planners in this group work on many interdepartmental and interagency teams, and the city of Seattle has its own Race and Social Justice Initiative that guides the work of the planning department and ensures that community needs are highlighted within planning processes.

The Seattle-King County Healthy Community Planning team initiated collaboration between planning and health in the city of Seattle. In 2006, a staff member from this team invited a manager from the long-range planning group to attend a Health Impact Assessment training put on by the American Planning Association, the Centers for Disease Control and Prevention, and the National Association of City and County Health Officials, which required a health professional and a planner to attend together. Said one interviewee, "The very first thing [we worked on together] was near a light rail station. [During the planning phase] we elected to do a Health Impact Assessment for the design of the area surrounding that station" (Seattle Interviewee D, personal communication, August 29, 2014). This pilot HIA helped both the planning department and the health department become more familiar with the process, and also helped the planning department see the benefits of engaging with health professionals. Though collaboration does not occur on a regular basis—instead, it is project-dependent—the work over the past several years has led to a good relationship between the two departments. Said the same interviewee from the planning department, "It's not that we have regular meetings, but we do engage health staff when we're working on projects…they've been able to help identify health related issues around the planning that we were doing" (Seattle Interviewee D, personal communication, August 29, 2014).

The planning department was asked by city council to assess their neighborhood plans, which included documenting how the plans related to public health issues. This, in

turn, required collaborating with health department staff to include health-related reports for each neighborhood. This effort was completed in 2009 (Seattle Planning Commission 2009), and in 2010, the planning and health department jointly applied for a federal neighborhood planning grant from the CDC to develop a new tool, the Healthy Living Assessment. One interviewee noted that the collaboration between planning and health "was a series of different things, ultimately cemented by the CPPW [Communities Putting Prevention to Work] grant where we began to integrate more fully an analysis of physical determinants and social factors affecting health outcomes" (Seattle Interviewee A, personal communication, June 20, 2014).

More recently, the planning department and the Healthy Community Planning team were partners in a three-year U.S. Department of Housing and Urban Development (HUD) Sustainable Communities grant, working on transit-oriented development around new rail stations with the Puget Sound Regional Council and the King County Transportation Department. The health department initially proposed to conduct a Health Impact Assessment on one of the study sites, but, according to an interviewee from the health department, "The more that we started getting involved in the project we decided that…we were just going to be part of the team that was going to develop the plan…rather than getting a design at a later time and then making an assessment of it. We were just going to help build in health to whatever design they wanted to come up with" (Seattle Interviewee B, personal communication, July 21, 2014). Health ended up being featured fairly significantly within the design plan, including a set of recommendations for healthy, livable, and equitable neighborhood development. As a result, planners in Seattle have seen the benefits of considering health. Explained one interviewee, "[Health] sort of came because of that original relationship between the health department and us. And folks began to see that that made sense, and so it kind of expanded" (Seattle

Interviewee D, personal communication, August 29, 2014). The use of HIA has waned with the growing collaboration, due in part to the Healthy Living Assessment and the health department's decision to take a Health in All Policies approach to their work.

Interviews reflected the general sentiment that the relationship between planning and health remains fairly strong. In particular, planners can see benefits to collaboration with health professionals. Research and data on health outcomes is thought to enhance the recommendations that the planning department is currently making. Therefore, building relationships with health is seen as important within Seattle in order to help them plan better, and more equitable, neighborhoods. As one interviewee explained, "It's not that we didn't address some of those same issues before, but it's how we characterize them now" (Seattle Interviewee D, personal communication, August 29, 2014). However, how to translate the connections between health and land use into practice remains a challenge:

> Both how we treat health and how we deal with equity in planning work, I don't think it's fully settled yet. We're still trying to figure out how we incorporate those more systematically into our work. Especially the equity question is extremely complicated and messy, and so trying to incorporate that into planning *and* into health concerns is just another challenge (Seattle Interviewee D, personal communication, August 29, 2014).

All interviewees agreed that planning should play a role in improving the health of communities and residents, but that it will take time for planning as a whole to evolve to where health is more engrained, especially in cities with large planning departments. Said one interviewee from the health department, "[Planners] see us adding value and are involving us. Because it's such a big organization it's like moving a giant ship, how slowly it turns. And so the ability for them to be sort of nimble and flexible and adapt, it's hard" (Seattle Interviewee C, personal communication, August 1, 2014). But the planning

department in Seattle is getting there. In the words of one interviewee, "We acknowledge [health] and so…we have made a conscious decision to use this framework and use these analytics in our planning work. That's a valuable and very strong measure of support" (Seattle Interviewee A, personal communication, June 20, 2014). Using a lens of health is providing a powerful way to address existing planning issues in Seattle.

6.4 Cincinnati, Ohio: Collaboration through the Comprehensive Plan

Cincinnati, Ohio is a small city in terms of both land area and population, and is the only city investigated in this research where population declined between the 2000 and the 2010 Census. The Division of City Planning, housed within the Department of Planning and Buildings, is also small; the division has ten planners on staff, two of whom focus on historic preservation. One planner is currently the sole liaison with the Cincinnati Health Department. The Community Health and Environmental Health Services division of the health department is the primary interface with the planning division and contains several programs, including health promotion and chronic disease prevention, which look at the impacts of the built environment on health. A Planning and Evaluation program was established within this division by the health commissioner and is led by a staff member with a background in community planning.

In 2009, staff from the Planning and Evaluation program attended a training on Health Impact Assessment led by the CDC, which helped the staff members better understand connections between health and the built environment, and advocate for collaboration with the planning division. In 2010, health department staff conducted the first Health Impact Assessment on an urban renewal plan being produced by the planning

division. Said an interviewee, "That is really what started our relationship with the city planning department. We kind of tagged along as the Health Impact Assessment committee. They didn't invite us, and so often happens, we were *kind of* welcomed" (Cincinnati Interviewee B, personal communication, July 15, 2014).

This new relationship between planning and health led to the endowment of a HUD Community Challenge Planning Grant in 2011. The grant provided funding to conduct community health assessments and new research on mortality rates and life expectancy by neighborhood. To date, the planning division has not been engaged in a Health Impact Assessment process, but there has been success in incorporating a health focus in other ways, including within the city's first comprehensive plan in over three decades. Plan Cincinnati was adopted in 2012 after a three-year process, and one of the 14 plan goals is specifically related to health. Health department staff sat down with planners to craft the language that went into the plan, ensuring that perspectives and knowledge from the health side were incorporated.

Staff from the health department viewed planning staff and the planning director as very receptive to the idea of incorporating health into the comprehensive plan, and all interviewees saw this collaboration as very successful. Up until this point, collaboration between the two departments had occurred on a project-by-project basis. Now that the plan has been adopted, the health department and planning division intend to work closely together to develop indicators for the comprehensive plan. Said one interviewee, "The fact that we were able to get explicit health language in the city plan [is a big success]. And right now it still hasn't played forward yet *how* people are going to use that" (Cincinnati Interviewee C, personal communication, August 28, 2014).

Although the collaboration between the planning division and the health department in Cincinnati is relatively new, planners have already managed to incorporate

health prominently within the new comprehensive plan, and the health department has led a number of Health Impact Assessments. Still, the two departments continue working to determine the best way to collaborate in a more structured way. Noted one interviewee, "What's driving us is, how do we make Cincinnati more walkable and how do we implement our comprehensive plan. And again, health is a piece of that. It's just one of the good things that comes from that" (Cincinnati Interviewee A, personal communication, June 13, 2014). Added another interviewee, "Planners have a sensitivity to health. They're open to it and they're thinking about it. It's not 'we've got the plan, good.' It's 'how are we implementing it, how can we really do this to improve health?'" (Cincinnati Interviewee C, personal communication, August 28, 2014). Prior to collaborating on the comprehensive plan, the relationship between health and planning had been non-existent, and since then great strides have been made to develop relationships among staff and work to meet mutual goals.

6.5 Orlando, Florida: City, County, and State Level Integration

Orlando, Florida, is the smallest city investigated in this research, but it is by far the fastest growing: between 2000 and 2010 the city grew in population by almost 30 percent. The planning division in the city of Orlando is housed within the Economic Development Department, which employs nearly 200 staff members and includes permitting, code enforcement, and transportation planning (City of Orlando n.d.). The planning division is comprised of approximately 20 staff, organized by specialization. The comprehensive planners, who work on long-range planning and growth management, typically interface with the public health department. One planner from this group has

been assigned to work directly on health issues with Environmental Health staff from the Orange County Health Department, which has jurisdiction over the city of Orlando. The Environmental Health section is the regulatory arm for the health department as it pertains to public health law, and also engages with land use issues that may impact community health.

The Orlando planning division is engaged in a program that has supported public health for over a decade. Get Active Orlando, started in 2003 with funding from the Robert Wood Johnson Foundation, is a city initiative to promote healthy eating and active living. Healthy Planning is one of three focus areas of the initiative, which also includes Healthy Food and Healthy People. The Orlando planning director was a founding member of this initiative and a member of the executive committee. The initiative originally focused the underserved Parramore neighborhood but has since expanded to focus on Orlando as a whole. Partners for this initiative include the Orange County health department office, the East Central Florida Regional Planning Council (RPC), the Winter Park Health Foundation, and several other health and land use organizations. According to one interviewee from the planning division, "Orlando has long recognized the connection between the built environment and the health of our community. Get Active Orlando has played an instrumental part in examining policies, projects, and promotions in support of healthy living" (Orlando Interviewee A, personal communication, June 27, 2014).

The city of Orlando planning division and its partners in the Get Active Orlando initiative continue to support the community through sharing best practices and promoting healthy living opportunities through various community partnerships. More recently, the planning division has been engaged in other opportunities to investigate health and land use with some of the partnerships developed through Get Active Orlando.

In 2012, a planning division staff member attended a two-day training on Health Impact Assessment, sponsored by the RPC and the Winter Park Health Foundation. A wide range of partners from across the Central Florida region attended the HIA training. The health foundation invited people from the broader health community, including researchers and personal trainers, but the RPC saw a need to also engage health departments, planners, and transportation professionals. The RPC has emerged as a leader of efforts to connect health and planning. Said one interviewee, "It's always been one of our goals [at the RPC] to make sure that we are at the table in various arenas from emergency management to land use planning, and recently within the past few years we've gotten into health and school issues" (Orlando Interviewee E, personal communication, July 29, 2014).

Following the HIA training program, a number of participants formed a steering committee that is housed at the Health Council of East Central Florida and which includes representatives from the Orlando planning division and the RPC. The steering committee selected a city park in Orlando that was going through initial phases of a new master plan as a pilot Health Impact Assessment project led by the planning director for the RPC. According to one interviewee, the importance of engaging a regional planning organization is so that "in the future, the East Central Florida Regional Planning Council could conduct HIAs in a multijurisdictional setting. So it's not just training the City of Orlando that basically could only do it in the City of Orlando" (Orlando Interviewee B, personal communication, June 27, 2014). The Orlando planning division was also a major partner in this HIA along with the Environmental Health section of the Orange County health department.

Strengthening connections between health and planning has become a goal on the state level, as well. A practicing planner was hired by the Florida State Health

Department in 2007 to train staff in the 67 county health departments on links between health and planning. By the end of 2008, training had been completed in all counties, and county health staff members were encouraged to connect with local planners through a program called "Take your Planner to Lunch." A number of new collaborations across the state emerged through that effort, and the impact of this training program was also felt in Orange County. As one interviewee described, the county health department has had "a historic, more involved partnership with the county [planning department], but the city relationship has been great" (Orlando Interviewee C, personal communication, July 15, 2014). The Environmental Health section has now collaborated on a number of initiatives with the Orlando planning division, including recently partnering on a grant application to the CDC to fund Health Impact Assessments. While the county health department and the planning division do not currently hold regular meetings, the relationship has evolved to a point where they collaborate on each other's initiatives whenever possible. This intermittent collaboration is seen as effective, though the ability to collaborate on a regular basis is likely impacted by different reporting structures of the planning and health departments.

Interviewees agreed that shared interests and values can go a long way to facilitate collaboration between planners and health professionals, and that planners have a great role to play in promoting health within land use. Education efforts have made a big impact on collaboration across the state: education of health professionals across the state has spurred relationship building within many of the counties, including Orange. Within the Orlando planning division, staff interest and funding opportunities led to a focus on improving physical activity and food access for city residents and visitors, and involvement in a pilot Health Impact Assessment. Planners continue these efforts, though the connections to health outcomes are not made explicit. Said one interviewee from the

planning department, “We’ve been very active in building bike and pedestrian trails, we’ve been increasing sidewalks, we’ve been pushing for mass transit. All these things arguably are benefitting the community from a health perspective, but I’m not sure anybody has sat back and said, ‘what a great opportunity, lets market it all as making Orlando healthier’” (Orlando Interviewee A, personal communication, June 27, 2014).

6.6 Conclusion

The stories from these five cities show that collaboration can occur through a variety of mechanisms and in a variety of contexts. As shown in Tables 6.1 and 6.2, the cities range widely in terms of demographic and socioeconomic characteristics. They also range widely in number of planning department staff (Table 6.3) and current health concerns (Table 6.4). This indicates that the structural composition of a city or a department alone does not determine the success or failure of collaboration.

However, some cities have enjoyed more continuous success than others when it comes to incorporating a health focus into plans and planning processes, as well as collaboration between the health and planning departments. From the stories relayed by interviewees, this relative success is largely due to a commitment by specific individuals within each department to incorporate a health focus in planning. For example, San Francisco, an early leader of these efforts, has experienced difficulty in maintaining collaboration between the departments primarily due to turnover of the staff and department leadership who advocated for collaboration initially. While some existing state and local regulations require the city’s environmental planners to address specific health issues—primarily with regard to air quality—adopting a social determinants of

health perspective and integrating health department data into the work of the entire planning department does currently not appear to be a departmental priority.

In some jurisdictions, state and local regulations create additional requirements for planning processes and may have an impact on planning outcomes. Environmental and land use regulations that may impact planners' activities in the interview cities are shown in Table 6.5. For example, the states of California and Washington have state-level "little NEPA" laws that require additional environmental impact review for certain projects. The planning and project review processes in these cities may be more resource intensive due to these requirements, though they may also present an opportunity to integrate a stronger public health perspective into existing impact review. As discussed previously, in San Francisco, the health department initially looked to the city's environmental review process, which is required under the California Environmental Quality Act (CEQA), as a way to incorporate health concerns. However, the health impacts regulated under CEQA were very narrowly defined and the health department took a different approach based on collaboration and a voluntary HIA process.

Table 6.5: Regulatory Frameworks and Tools to Consider Health in Interview Cities

City	State/Local Regulatory Frameworks for Environment and Land Use	Primary instruments/tools used by planners/health professionals
San Francisco	California Environmental Quality Act (CEQA); California Air Resources Board (regulatory enforcement); Article 38 (local)	Sustainable Communities Index, HIA, and Health in All Policies (public health); Environmental Review (planning)
Columbus	n/a	Modified ("Mini") HIA process (public health and planning)
Seattle	State Environmental Policy Act (SEPA), Model Toxics Control Act, Race and Social Justice Initiative (local)	Health in All Policies and HIA (public health); Healthy Living Assessment and Environmental Review (planning)
Cincinnati	n/a	HIA (public health); data sharing (public health and planning)
Orlando	Developments of Regional Impact Statute (Chapter 380 Section 6)	HIA (public health and planning)

Sources: U.S. Council on Environmental Quality; Florida State Legislature; Interviews

Current regulatory frameworks, while helpful for assessing environmental impacts of plans and projects, are not developed to consider and assess a full range of human health impacts. The ways that collaboration has or has not been able to create sustained change within each planning department has differed, and does not appear to be related to top-down regulations. As an interviewee from the Seattle planning department noted, “From a practical or political point of view, I just didn’t see that folks in this state would be willing to accept a whole new layer of that kind of [environmental] review. So it sort of made sense for [health to be incorporated] little bit more informally. I just believe it will be a tough sell to add [health to] what people see as a regulatory hurdle to

new development" (Seattle Interviewee D, personal communication, August 29, 2014). Despite both operating under state-level laws that are similar to the federal NEPA law, San Francisco and Seattle have had different experiences with respect to continued collaboration between planning and health. In San Francisco, collaboration has not been maintained to the degree that it occurred during the Eastern Neighborhoods planning process, while in Seattle, the planning department in general sees health as a primary goal in their work.

The evolution of collaboration between planning and health in the five cities studied show that there is no "one size fits all" way to encourage or enable the departments to work together towards a goal of healthier cities and built environments. Instead, as the stories from these cities suggest, a desire for an outcome of planning processes that is focused on a variety of health-related goals—rather than a strict regulatory requirement—was a primary impetus for collaboration between the departments. Though the health departments were shown to be largely responsible for providing this impetus, health as a goal for land use planning also became the goal of planners engaged in the collaborative process. This outcome-oriented focus, in turn, emerged from individuals involved, but also shaped the values of planners engaged in the process (Brooks 2002). It became clear through the interviews that these individuals believed strongly in planning for healthier cities: several interviewees discussed how the values and interests of individuals, in both departments, played a role in facilitating and maintaining collaboration. Having a normative end goal of planning that focused on health, then, allowed the departments in each city to determine the best pathways to meet this goal.

Even though the initial motivation to integrate planning and health within each city differed, key commonalities emerged from my interviews that have implications for

other cities seeking collaboration between the departments. One commonality is that the health departments—at local, county, and state levels—have initiated the collaboration with planning departments. Primarily, the instigator has been a health department leader or staff member who previously understood or became aware of the links between health and the built environment, and who pushed to form relationships with local planning departments. Planning departments responded in various ways: some had staff members who also understood these connections and were receptive to collaboration. Others were more resistant to collaboration, due largely to resource limitations, although they expressed interest in planning processes that include a health focus.

Another commonality is the opinions of interviewees on the merits of Health Impact Assessment. In practice, interviewees generally agree that HIA, in its current form, is not the best tool to use to ensure that health is considered within proposed plans and projects. Interviewees in cities with more experience with HIA, such as San Francisco, Columbus, and Seattle, have noted that the tool serves as a spark to get planning departments, and other agencies, thinking about the health implications of projects. However, these cities have evolved to trying to include health department staff and health considerations at the beginning of planning processes, rather than conducting a parallel HIA process with or without planners. Interviewees in Seattle, in particular, pointed to the success in San Francisco with integrating health into the Eastern Neighborhoods plan through the ENCHIA process, and based their Healthy Living Assessment on the Sustainable Communities Index that stemmed from ENCHIA. While neither city is currently focused on HIA, they are using other tools to work towards considering health within land use decisions.

The processes, primary instruments, and tools that each city followed to incorporate health goals into planning varied, are shown in Table 6.5. The level of

collaboration between the planning and health departments in each city also appear to be based on a variety of factors: the interest levels of staff and leaders in both departments; discussions of health issues faced by city residents; staff and resource availability; and experience with the available tools. However, even though the processes, instruments, and tools differed, each city has managed to facilitate productive dialogue between planning and public health in a form of "collaborative planning" theorized by Healey. As Healey (1998) suggests, such a collaborative approach can build capacity within governments to facilitate change. Indeed, in each of cities studied, the drive to build a health focus into planning processes has been influenced, more broadly, by a desire to build capacity within each department. This has led to more sustained changes to planning processes in some of the cities, while in others, planners have largely reverted to pre-collaboration processes (though relationships built with the health departments in these cities do still exist to some extent). This points to the importance and agency of individuals within planning and health departments both in initiating and maintaining collaboration over time, thus resulting in a permanent focus on health in their departments.

The stories of health and planning collaboration in these five cities illustrated ways planners and health professionals overcame challenges in order to strengthen collaboration between their departments. These experiences show that opportunities exist to overcome challenges, facilitate collaboration between the planning and health fields, and achieve the normative goal of a health focus within planning practice.

Chapter Seven: Opportunities for a Sustained Health Focus in Planning

7.0 INTRODUCTION

There are a number of challenges faced by planners and health professionals with respect to initiating collaboration between departments and fields. However, despite these challenges, individual planners and health professionals have found ways to overcome them and initiate practices that allow for departments to work together with a common goal of creating healthier cities and citizens. In this chapter, I examine the main opportunities for collaboration identified through survey and interview research and discuss how these opportunities may be sustained in practice.

The primary challenges involve how planners perceive their role in creating healthy places and addressing health goals, and how this perception then informs planning practice. To overcome the challenge of conflicting values, planners will need to modify their values and interests to embrace the health perspective. This can occur by positioning health as an objective, fact-driven, and common-sense value that can help planners achieve their goals, rather than being seen as an additional action to be undertaken. Developing processes that allow planners and leadership who already value health to share their knowledge and experiences with colleagues can also help promote a health focus in planning.

Allowing the existing values and interests of individuals that prioritize health to filter through planning processes can then lead to reshaping the way that planning is practiced more universally. New attitudes and knowledge can prompt changes in daily activities, which can then slowly change the entire institution of planning (Neuman

2012). Leveraging established relationships and emphasizing shared values between departments can begin to create a professional environment where health feels like a natural extension of planning, rather than an afterthought or a burden. To take advantage of the opportunities discussed below will require dedication, but based on the attitudes and opinions of the planners and health professionals interviewed for this research, this is not an insurmountable task.

7.1 Reshaping How Planners View their Role

Planners and health professionals have differing ways of thinking about the role of health in planning. Competing interests and priorities, uneven perspectives on the inclusion of health within planning processes, discrepancies in knowledge and awareness, and a lack of understanding of how best to incorporate the health perspective can create circumstances where the two fields are unable or unwilling to collaborate.

However, my research revealed several potential ways to mitigate the challenge of different knowledge and understandings. These opportunities are largely related to reshaping the way that planning staff and leaders perceive themselves, and how they view the role they can play in incorporating a focus on health in planning. The sharing of different types of knowledge is critical to creating planning processes that are inclusive and reflexive, and that take into account the multiple perspectives of a heterogeneous group of stakeholders (Sandercock 1998, Rydin 2007).

7.1.1 Champions for Health

The knowledge and passion of champions for health represent an important resource for addressing the competing interests and priorities between planners and health professionals. In nearly all of the five cities investigated, interviewees consistently mentioned one or two individuals who were primarily responsible for facilitating the relationship between the health and planning departments. These individuals—primarily health professionals—championed efforts to bring a health focus to the planning departments through increased collaboration. The champions typically had prior knowledge of the connections between health and the built environment, or they had been exposed to these connections and found ways to raise the issue within their city or region.

Such champions can serve to bring leaders together in support of integrating health, the built environment, and land use. In Columbus, a committed leader and champion (the health commissioner) was integral to obtaining funding for a Healthy Places program to examine connections between health and the built environment. Noted an interviewee from the health department, "the most important thing early on was that our actual health department leadership was extremely supportive of this. It was mostly initiated by our health commissioner" (Columbus Interviewee B, personal communication, June 11, 2014). The ability of the health commissioner to form relationships with other department directors in order to educate them on links between health and planning is also seen as a key factor to the success of the Healthy Places program.

Champions can be in leadership positions, but can also be staff members who seek to make connections with their counterparts in other departments. Champions can

help broker training opportunities and relationships between planning and health department staff in order to initiate collaboration, either through the HIA process or the more traditional planning process. A department that has a passionate champion for this effort who can bring together staff to undertake this work may benefit from a more successful collaboration. In Seattle, for example, "it was actually the health department [who initiated collaboration]," said a current planning department staff. "It was seven or eight years ago, [a health department staff] invited me to attend a conference in [Washington] D.C. [that brought] planners and health officials together to start talking about collaborating" (Seattle Interviewee D, personal communication, August 29, 2014). The Seattle case suggests that such opportunities to receive joint training may help align interests and priorities between departments.

Interviewees agreed that the support and influence of a champion from the health or planning department it is critically important. Merely one or two individuals who recognize the importance of health and planning collaboration, and who are willing to work to instill that priority throughout the city, can be instrumental to achieving a meaningful partnership between the departments. Said a former planning commissioner from San Francisco, "In order for advocates to be effective you've got to have a champion in local government. And if you don't have that champion, it's going to take you forever to get anywhere" (San Francisco Interviewee G, personal communication, April 7, 2014).

The great importance of these champions in forging changes to the daily work and priorities of health and planning institutions could, on the one hand, be said to reflect the relationship between power and rationality in planning (Flyvbjerg 1998a). These champions have tended to be in positions of leadership within their departments and have used this position to push for their normative, value-based vision of including health

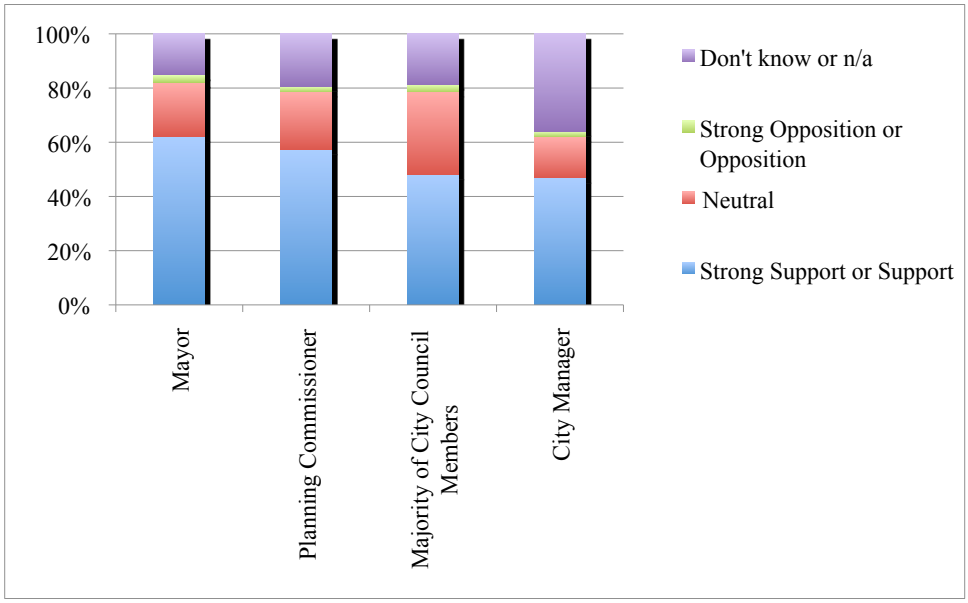
considerations within planning. This helps validate the argument from this body of theory of power in planning that powerful voices, such as these champions in leadership positions, help shape knowledge and ultimately drive collaboration. On the other hand, this research also shows that staff member in lesser positions of authority also can forge a new understanding of priorities within departments, suggesting that the associations between power and rationality in planning is more nuanced than that expressed in the literature surrounding the "dark side of planning." Agency also rests with individual planners in forging change, including newfound commitment to inter-agency collaboration (Forester 2001). However, although a champion or two may prompt such collaboration, other ingredients are also necessary to *maintain* the collaboration, notably more widespread knowledge and interest among the broader planning and health department staff and leadership.

7.1.2 The Power of Leadership and Elected Officials

Once the effort of integrating a health focus into planning has been championed and initiated, department directors and elected officials can either help or hinder the process. The power of department and jurisdiction leaders and elected officials is another great resource to leverage early momentum for collaboration between health and planning departments. While my research has shown that collaboration between planning and health departments has occurred despite challenges and dissuasion from leadership, support from those in positions of power represents an opportunity, especially if those in positions of power become more knowledgeable about the links between health and planning.

Survey results show that there is wide support among leaders and elected officials to integrate a health focus into planning (see Figure 7.1). This, in turn, suggests there is a great opportunity to call on these leaders to push this further within cities. Cities interviewed had different experiences with support—or lack of support—from leadership and elected officials, but the general consensus was that department leaders and elected officials can have a major impact on the ability of a city to integrate health into planning and built environment work. Said an interviewee from the San Francisco department of public health, "I think [having political leaders] is really important. I think that's what often just accelerates things…Ultimately having those leaders, champions, that's really what helps jumpstart" (San Francisco Interviewee B, personal communication, February 26, 2014). Leadership support of staff efforts to integrate health and planning, or leadership initiating the integration themselves, is an important, and currently underutilized, resource.

Figure 7.1 Perceived Strength of Support by Elected Officials for the Inclusion of Health in Planning.



(N = 145).

When leaders understand the benefits and values of collaboration between health and planning, they can also help educate and inspire planning staff. Said an interviewee from the Seattle health department, "We struggle with staff to get something on the agenda but then you'll have an elected that says something or went to something, and they bring it up and then everything changes" (Seattle Interviewee C, personal communication, August 1, 2014). Other planning initiatives promoted by leadership may also have links to health that can be illuminated and further developed. Seattle's Race and Social Justice Initiative, for example, has received strong support from elected officials and department leaders, and the planning department is leveraging this initiative to more strongly incorporate health into their daily work. Said a current planning department

staff, "our work is pretty profoundly affected by [the Race and Social Justice Initiative], in a very positive way. It made sense that we would apply the health lens to our planning work, and as part of our work to increase equitable outcomes" (Seattle Interviewee A, personal communication, June 20, 2014). Because individual planners have leveraged this leadership-directed focus on race and social justice, understanding of the links between planning and health—and health inequities—is now broadly accepted within the Seattle planning department, which, in turn, has translated into the development of shared values between departments.

Ultimately, this research shows that actions taken by department leadership and elected officials to encourage and advance collaboration between health and planning department staff can have a strong influence on the daily activities of both planners and health professionals. Having supportive leadership, as well as champions, can be very powerful and effective in the efforts to integrate planning and public health. Similar to the influence of champions, this important role of political and institutional leadership in furthering collaboration supports the suggestions of "dark side" planning theorists, including Flyvbjerg, that the rationalities driving planning processes are shaped by power. That is to say, the ways that power is leveraged within planning processes can shape what is assumed as rational and, therefore, significantly determine what is ultimately prioritized in planning practice (Flyvbjerg 1998a). From this theoretical perspective, leaders can use this link between power and rationality to push an agenda within the planning departments, and the city as a whole, to embrace a stronger focus on health goals in daily planning work, and thus ultimately shape department values. However, given the agency of planning staff to shape planning processes through their daily work (Forester 2001), a broader understanding of the importance of planning for public health is also needed at a staff level to ensure regular collaboration with health

professionals. This, in turn, points to the importance of knowledge sharing as a means of promoting a health focus in planning.

7.1.3 Informal Spaces for Knowledge Sharing

Creating and facilitating processes and spaces to share knowledge on connections between health and planning can help planners recognize the importance of collaboration and realign their values to include the health perspective. Green and Klein found that regular communication through a variety of channels can be key to helping skeptical planners see the benefits of working with health partners (Green and Klein 2011). Similarly, Barton and Grant found that programs that support knowledge sharing and value discussion could facilitate the integration of the fields of planning and health (Barton and Grant 2011).

Informal touch-points can help planners and health professionals make an initial connection and discuss the potential for and value of more formal opportunities for collaboration. In the state of Florida, the health department's "Take your Planner to Lunch" Program has resulted in successful collaborations between health and planning departments across the state (Orlando Interviewee D, personal communication, July 16, 2014). In Seattle, planners and health professionals see each other frequently in meetings held external to either department. Said an interviewee from the Seattle-King County health department, "We're fortunate that we sit on some committees and so do our [planning department] partners in Seattle. And so we're working on other things with them. We're staying engaged along the way" (Seattle Interviewee B, personal communication, July 21, 2014).

Planning departments can encourage informal education sessions, such as departmental "brown bag" lunches; the inclusion of health in these sessions is a way to bring that knowledge to planning staff. Past knowledge-sharing processes between the departments in San Francisco were seen as effective, but are no longer occurring. Said an interviewee from the health department, "We did some [knowledge sharing] back in the day of the Eastern Neighborhoods, but we haven't done anything like that in a really long time. I used to do peer review sessions. A lot of people from the planning department would come. But it's kind of died down" (San Francisco Interviewee B, personal communication, February 26, 2014). According to interviewees, staff members could easily revive these sessions and leverage other opportunities for sharing knowledge. Ultimately, informal knowledge sharing in such spaces as brown bag sessions, informal lunches, coffee meetings, and meetings called by other partners, can help planners begin to appreciate the impact of planning for health on cities and citizens.

Such an emphasis on the critical role of knowledge sharing in shaping planning processes and priorities is a key tenet of communicative action theory, which foregrounds processes of communication and stakeholder participation in forging consensus and improved planning outcomes. John Forester, Patsy Healey, and other proponents of communicative action theory emphasize the transformative potential of participatory planning processes that build on deliberative and democratic dialogue and knowledge sharing. From the communicative action perspective, mutual learning can lead to mutual understanding, which carries the potential to change the values and priorities of those involved in the communicative process (Forester 1999, Healey 1999). Thus, not only can informal knowledge sharing lead to more structured and productive everyday collaboration, communicative processes that emphasize mutual learning could also serve

as catalysts to create lasting changes to established planning processes, resulting in a renewed focus on health.

7.1.4 Health as a Neutral Way to Frame Planning Issues

Using the health perspective as a common-sense, fact-based way to frame planning issues and justify planning recommendations can also help planners gain more trust from community members and decision makers. Communities not explicitly engaged in planning processes often feel that their needs are ignored or dismissed, which can lead to lack of trust and respect between community members and the practitioner or researcher (Corburn 2003). Because of this, several interviewees noted that they deploy empirical research and data on community and individual health outcomes as a way to establish legitimacy and support their arguments.

In particular, the public health perspective provides a powerful means to analyze and explain complex planning and land use issues. The inclusion of health data provides human-focused evidence that is often missing from planning recommendations, but which provides empirical weight to the conversation because of the assumed objectivity of health data. In Columbus, for example, an interviewee from the health department explained that the "transportation [department] was really supportive because…health was usually a pretty neutral talking point" (Columbus Interviewee C, personal communication, June 30, 2014). This points to an opportunity for planners to leverage not only the data, but also the language and community connections of health professionals, to validate health-focused recommendations they seek to provide to decision-makers.

In addition, a health perspective also serves to garner the trust of residents, which may strengthen the position of health-focused planners to influence the planning process. In the Seattle planning department, for example, building relationships with the health department and using health language are seen not only as key to planning healthier neighborhoods, but also to furthering the participation of residents in order to develop a more equitable city. As one planning interviewee explained, "I think people began to see that using those terms that the health department provided to us helped engage the community in a different way when working with them" (Seattle Interviewee D, personal communication, August 29, 2014). Other respondents in my study echo this perspective: according to a former planner in San Francisco, "In previous decades the plans would look at number of people, number of businesses, but it wouldn't look at social conditions, it wouldn't look at economic conditions, it wouldn't look at economic disparities, and much less public health. So public health became a way for us to really do the job that we needed to do" (San Francisco Interviewee F, personal communication, March 13, 2014). And, in the words of an interviewee from the San Francisco public health department, "what public health is often doing is contributing empirical evidence to the obvious and the intuitive. Health evidence doesn't really change the issue, it helps legitimize the issue" (San Francisco Interviewee H, personal communication, April 15, 2014). Thus when planners approach collaboration with health staff as a means to access health data, language, and expertise, and as an opportunity to uncover the true needs of a community, they are better able to frame planning issues from a perspective of public health, prompt further collaboration, and ultimately forge a commitment to health in their department.

Again, these findings support the supposition of "dark side" planning theorists such as Flyvbjerg (1998a) and Huxley and Yiftachel (2000) that knowledge which is associated with powerful rationalities may shape planning processes. However, these

findings also suggest greater agency on the part of planners in terms of appropriating such knowledge and taking advantage of the links between knowledge and rationality in order to forge alternative agendas. By framing health data as appropriate and common-sense knowledge, they are able to position such knowledge as a powerful rationality that may shape the "genre" of plan-making (MacCallum 2008) towards a stronger focus on health. In pursuing such a strategy of associating health data and health perspectives with a dominant rationality, planners are also forging a normative position where health is considered critical priority for planning. As normative theory is primarily concerned with how values shape planning outcomes, and how outcomes must be fairly distributed across society (Brooks 2002, Fainstein 2005, Fainstein 2010), the findings from this research, again, complicate easy assumptions about the "dark" links between interests, knowledge, and rationality. Also, the research problematizes the dichotomous debate between communicative action and normative theories in planning, suggesting that planners may have the agency to shape normative values through their daily practice.

7.2 Reshaping the Practice of Planning

A second challenge is how the interests and values of planners shape their thinking about how the practice of planning should address health. Encouraging planners to embrace and value health as a central tenet of planning is critical, as is giving planners the opportunities to put these values into practice. Fortunately, planning and health departments across the country have developed practices that can serve as models for how collaboration between the departments can occur. Promoting these experiences is an important means of expanding knowledge of linkages between land use and health and

highlighting practical ways to foster collaboration. Once the socially constructed identities and values of planners have been changed, this collaboration can then lead to more systemic changes within the planning field itself (Healey 1999).

7.2.1 Leverage Established Relationships

In many cases, existing relationships between planners and health department staff have not been fully developed. Resource constraints, including staff time and data, were mentioned consistently as a reason for a lack of consistent collaboration between city health and planning departments. One simple way to overcome this constraint is for planners to invite health partners to the "planning table," as 55 percent of survey respondents indicated that they have partnerships with external organizations that could be leveraged in order to consider health in planning. Also, health department partners can act as a resource for planners. Said one interviewee from the Orange County Health Department in Orlando, "I think maybe opening up the process, coming out of a smoke filled room and from behind the curtain and inviting folks in…I think if there could just be some solicitation or partnership on the front end that you can get some of those other perspectives [including health] in the comp plan" (Orlando Interviewee C, personal communication, July 15, 2014).

When initiating their first comprehensive planning process in over three decades, the Cincinnati planning division put the concept of incorporating alternate knowledge into action by reaching out to other departments to alert them to the new comprehensive plan. The health department ended up playing a major role in the development of the new comprehensive plan. Plan Cincinnati was adopted in 2012 after a three-year process, and

includes a good deal of health language and recommendations. Said an interviewee from the planning division, "We have 14 goals [in the plan] and one of them is to become a healthier Cincinnati…we have a strategy that we want to decrease mortality and chronic and acute diseases, and we want to make sustainable access to fresh, healthy food a priority in all neighborhoods" (Cincinnati Interviewee A, personal communication, June 13, 2014). Thus, the action of leveraging the perspectives of other departments paved the way for health to become a major theme in the comprehensive plan.

Many interviewees from health departments indicated that they would welcome planners contacting them to work together. A public health interviewee in San Francisco suggested that "planners [could] think about how health impacts their work and then reach out to the health department about how they can get to the table, in some of the health department decisions…That's almost the opposite of our approach, which I think would be amazing" (San Francisco Interviewee B, personal communication, February 26, 2014). Since health professionals within city, county, and state governments are ready and willing to become more involved in the planning process, planners should view health professionals as a resource rather than as a roadblock.

The collaborative turn in communicative action theory provides a framework for such an approach, recognizing the role that alternate forms of knowledge plays in processes of continuous learning and discovery (Healey 1993, Innes and Booher 1999). For planners to recognize the value of health, and reach out to existing and new partners to leverage their expertise, could be instrumental in building new capacity within the planning department. This could also potentially lead to more fundamental and institutional changes within the field of planning itself; though a theory base for institutional change within planning is currently lacking this is an important new area for

exploration as the field of planning seeks to address issues previously presumed to be out of scope for the profession, such as public health.

7.2.2 Embrace Shared Values

While the planning field overall has not yet fully embraced a health focus, the values and interests of individual planners may align with the notion of healthier built environments. A public health staff member from San Francisco articulated the role that public health can play for reshaping the practice of planning: "I think one thing that we try to do is be helpful. My goal is not to be perceived as another stakeholder, but [as] another city agency that can be helpful for us to achieve this larger vision for San Francisco, which I think often very clearly articulates health as a value" (San Francisco Interviewee B, personal communication, February 26, 2014). These personal values can be promoted throughout planning departments through conversations with others who share them. Planners interviewed from San Francisco felt that the overall public health mindset is not strong within the San Francisco planning department, but one interviewee from planning noted that a personal interest in health might prompt planners to talk to each other—and to health department staff—about issues that impact health (San Francisco Interviewee D, personal communication, February 26, 2014).

Recognizing and embracing shared values of health between the departments can help grow the relationships needed for successful collaboration. Said an interviewee from the Columbus planning division, "I think that ultimately…personalities and relationships are really crucial to moving things forward. Having a higher level champion and the front line staff to keep it going [are necessary for collaboration]" (Columbus Interviewee C,

personal communication, June 30, 2014). Taking advantage of not only existing relationships but also existing shared values can help initiate and sustain processes of collaboration.

In Cincinnati, planning and health staff found that building relationships around a shared mission and values—in this case, crafting a successful comprehensive plan for the city—helped build sustained collaboration. Said an interviewee from the planning division, "Once you build the relationship is just becomes easier to [collaborate]. So when they need our help they know that they can contact us, and that we will help them out because we are invested in their mission as much as they are" (Cincinnati Interviewee A, personal communication, June 13, 2014). Beyond this, finding commonalities on which to build relationships can facilitate future collaboration efforts. An interviewee from the Orange County Health Department in Orlando noted: "If we hadn't taken the time on the front end to build those relationships and bring partnerships, sometimes funding, to work with our counterparts in other agencies, we wouldn't have had nearly any of the opportunities or success that we've had" (Orlando Interviewee C, personal communication, July 15, 2014).

Ultimately, while interviewees agreed that support of elected officials is important to the integration of health into planning, they also agreed that staff relationships are critical to push collaboration forward. However, in order build these relationships, staff members will need to both understand and take advantage of shared values. In most cities, while the health staff primarily pushed the relationship with their planning counterparts, the planners who shared their values were more apt to embrace this relationship. In general, my research found that planning staff understood the importance of collaboration, but could think about health more often and more regularly invite health department staff to participate in the planning process.

The existence of shared values between department staff and leadership also reflects a shared normative vision for a focus on health goals within planning processes, and leveraging and embracing these values also reflects a desire for relationship building and collaboration that will serve to put this vision into practice. The opportunity to embrace these values to incorporate a health focus into planning reflects the importance of defining both the process aspect of planning (the "means") and the outcomes of planning (the "ends") when entering into collaborative processes with other departments. Though the "means versus ends" debate has drawn a great deal of commentary (see Healey 1993, Forester 1999, Fainstein 2005, and MacCallum 2008), both theories have certain limitations that indicate that, if taken together, a strong and inclusive field of planning that has intentions of focusing on complex social issues, such as health and health equity, could emerge.

7.3 CONCLUSION

Despite very real challenges to collaboration between planning and health, opportunities exist that can be leveraged to allow for the insertion of a health focus into the planning field. As evidenced by the historical evolution of the field of planning, the values of the profession—and individual planners—do indeed change and influence planning practice (Sloane 2006). Thus, reshaping the ways that planners view their position within the intersection of health and the built environment is key to establishing and maintaining collaboration with health departments. Existing champions for health, as well as the influence of department leaders and elected officials, offer opportunities to facilitate collaboration. Existing touch points between planners and health

professionals—such as committee and coffee meetings—can be utilized as informal spaces for sharing knowledge. And, framing health as a neutral factor and embracing health data and language can help bring credibility to existing plans and planning processes and integrity to the profession of planning.

However, changing how planners view their role is inextricably linked to changing the values of the field of planning, and ultimately changing how planning is practiced. Recognizing that health professionals constitute a source of knowledge can help bridge a resource gap that survey respondents and interviewees named as a barrier to the inclusion of health in planning processes. Leveraging existing relationships between health professionals and planners, or taking steps to establish new relationships, can lead to more regular collaboration. This can be especially simple to facilitate between planning staff members who share the values of health professionals and already understand the importance of considering health impacts of planning.

Cities that have been able to establish processes of collaboration have viewed the shared work as very successful. Survey findings showed that departments currently collaborating highly valued the level of trust and respect that has grown between them. Based on this, it appears that once planning departments and health departments begin to work together, the process is seen as generally positive and useful. Said an interviewee from the Cincinnati planning division, "To be honest with you, I'm not sure how we [initially] made that connection [with the health department]. But I think once we made that connection we both recognized how important it was" (Cincinnati Interviewee A, personal communication, June 13, 2014). Taking advantage of available opportunities to educate planners and bring health professionals into the planning process can begin to establish and sustain collaboration between the two departments, and the two fields. Building on these insights and experiences of planners and health professionals, in the

next chapter I present four general recommendations and a number of specific action strategies for establishing successful, sustained collaboration.

Chapter Eight: Recommendations: Collaboration and the Development of a Health Focus in Planning

8.0 INTRODUCTION

For planners to effectively engage with health in their work, not only should they value the incorporation of health in planning, they should also be offered practical opportunities to make health a central element of the planning process. The challenges and opportunities presented in the previous chapters show that planning staff and leadership across the country are generally aware of the impacts of planning decisions on health, supportive of collaboration with health professionals, and willing to adopt a health focus in their work. The survey results indicate that in medium to large sized cities, there is a fairly good chance (60 percent) that the planning department has already engaged in some form of collaboration with the local, county, or state health department. However, this engagement also appears to be sporadic and ad-hoc rather than based on a methodical approach to collaboration. The ability to systematically and regularly include health in planning processes requires an effective and productive process of collaboration between the two professions.

In this chapter, I provide four overarching recommendations and a series of specific, actionable strategies for promoting a focus on health in the planning field. The appropriateness of each of the specific strategies is context-dependent, contingent on the perception and state of public health concerns of any given city, the regulatory and institutional context on the municipal and state levels, staff and leadership interest in both departments, and resource availability. However, the following recommendations are

important starting points to facilitating collaboration between planning and public health and ultimately create lasting change within the institution of planning.

8.1 Frame Health as a Critical Facet of Planning

Planners who understand and value health can help infuse a health focus in their department, which may then perpetuate a health focus in the planning field in general. Drawing on normative planning theory, the common value of healthy cities and environments should fundamentally determine the outcome of planning processes (Brooks 2002). However, the means to achieving this end goal is equally important to consider: facilitating the understanding of health as a critical aspect of *why* planners plan cities and communities, and *who* they plan for, creates an opportunity to engage planners in collaboration with health professionals.

One way to bridge this gap is to bring in consultants and experts to help initiate collaboration. When the Healthy Places program began in the Columbus health department, the health commissioner hired the recently retired planning director as a consultant; he was able to design the Healthy Places program in a way that leveraged existing processes in other departments. In Florida, the practicing planner hired by the state health department helped ensure that one person in every county health department had been assigned responsibility for a "health and the built environment" program. Planners working in health departments can help bridge gaps between health and planning departments, but planning departments could also hire health professionals in order to bring additional knowledge to planning processes and provide an in-house resource for planning staff.

Opportunities for educating planners and raising awareness in the planning profession should be sought out and promoted. This can include undergraduate and graduate education as well as continuing education for practicing planners. In particular, continuing education is especially important as many practicing planners are trained in fields such as architecture, urban design, and policy, and do not have a traditional planning education. Cross-training health and planning professionals in each other's language is another way to strengthen connections between the professions. Pilkington et al. found that targeting training efforts at students offered a more widespread and fundamental method of dispersing public health knowledge among practitioners who influence the built environment (Pilkington et al. 2013). A public health interviewee from Seattle stated, "I love the idea of dual degrees or just having public health students being able to take a basic 101 planning class or vice versa. Or vice versa for planning to be able to take a public health 101 class…understanding the terms, what the roles and responsibilities are, and some of the barriers" (Seattle Interviewee B, personal communication, July 21, 2014).

There are also specific actions that can be taken by groups who support planners and health professionals to help frame health as a more prominent responsibility of planning. The American Planning Association has a professional institute, the American Institute of Certified Planners (AICP), which requires members to meet certain education requirements and pass a written examination (American Planning Association 2015b). Additionally, AICP-credentialed planners can also receive Advanced Specialty Certification in specific areas of planning (American Planning Association 2015a). There are untapped opportunities for the certification to include health and built environment questions within the written examination, and a health-related specialty certification can

also be developed. Interested planners should advocate for these changes through their local chapters or APA at the national level.

Related to this, dual degree programs for health and planning, and courses on health and the built environment, are slowly being introduced in universities across the United States, but there is a great opportunity to expand these offerings. Georgia Tech's Built Environment and Public Health Clearinghouse has resources, trainings, and sample syllabi that practicing planners as well as planning faculty can use and adapt (Georgia Tech BEPHC 2015).

Additionally, as health departments across the country are starting programs focused on land use and the built environment, some are hiring planners to help bridge the gap between the health and planning departments. Similarly, planning departments can hire individuals with experience or education in public health to serve as an educational resource as well as a liaison with the health department. Department leadership will need to seek out these individuals and understand the importance of a broad perspective and backgrounds for planning work.

A majority of interviewees discussed education and awareness as crucial to initiating and sustaining collaboration between health and planning, primarily for current and future planners. Rather than framing the inclusion of a health perspective as a burden and another box that needs to be checked, educating planners can help them see partnering with public health advocates as an integral part of daily activities. Interviewees noted that the planning profession, as evidenced in conference programming and research, is slowly embracing a focus on health. However, since it took decades for planning and health to evolve away from each other, it will take time to reestablish close and consistent relationships between the two disciplines.

8.2 EDUCATE LEADERSHIP

Education and awareness of planning leadership is crucial to facilitating sustained collaboration and to taking actions to ensure that health becomes a central focus within planning departments. Such education and awareness can produce future champions of health, inspire elected officials and department leadership to make health a priority, and encourage planners and health department staff to develop and sustain long-term relationships.

Education of leaders can be instrumental in harnessing the power and influence of their positions, as this group is integral to pushing the health agenda forward in all disciplines. Government can play a key role in equitably distributing health benefits, but this will require leaders to empower both city staff and citizens with the knowledge of the links between health and the built environment (Friel et al. 2011). Northridge and Freeman noted that political influence, among other mechanisms for improving health, can be funneled through planning departments to increase opportunities to access healthy environments (Northridge and Freeman 2011). As a planner from the East Central Florida Regional Planning Commission said, "You need to have the education of the directors and the elected officials—the decision makers—on how health and everything is all intertwined. And then how to incorporate that into everyday planning, because if they're not understanding what the implications are of their decisions, and how to look at it from a different level, it's never going to move within the jurisdiction or the agency" (Orlando Interviewee E, personal communication, July 29, 2014). Elected officials in other cities within Orange County, Florida have been instrumental in implementing various health initiatives. Commented one interviewee from the county health department, "That's so

important, to get the elected officials on board…if we don't have that political support it just causes frustration" (Orlando Interviewee C, personal communication, July 15, 2014).

However, if political support is absent, leaders and champions within departments can also be influential. During the ENCHIA process in San Francisco, the lead planners and managers for the Eastern Neighborhoods plans initiated conversations with health department staff even though the director and mayor at the time were not fully supportive. Said a former planner from the San Francisco planning department about support during the ENCHIA process, "I wouldn't say [the planning and health directors] were really eager to work together but both I think recognized the work that had been accomplished and the benefits to each other's department. So it was a respectful recognition of the advantages of working together" (San Francisco Interviewee F, personal communication, March 13, 2014).

Based on my research, it is apparent that elected officials are increasingly seeing the benefits of collaboration between planning and public health departments. Said a former health department staff member from the city of Columbus, "The health representative on city council was also really supportive of the Healthy Places program. And so she was happy to bring up why [issues] related to health" (Columbus Interviewee C, personal communication, June 30, 2014). Support from the top is needed to help push collaboration between health and planning staff. Even when staff understands the connections and share values, an issue may be "getting permission from people above to really integrate," said the former Columbus health department staff (Columbus Interviewee C, personal communication, June 30, 2014).

This recommendation will likely require motivated and dedicated planning and public health department staff to help push education opportunities to their department and city leaders. Planners and health professionals can coordinate and host training

sessions or informal information sessions for department leaders and elected officials concerning the links between health and the built environment in their particular city. Staff from both departments can also seek out external training sessions on health and the built environment hosted by organizations such as the American Planning Association, the Centers for Disease Control and Prevention, the American Public Health Association, and the National Association of City and County Health Officials, and invite leaders and elected officials to attend with them.

Additionally, as discussed in previous chapters, many cities have state or local regulations that could allow health to be considered more broadly within land use decision-making processes. Planners and health department staff should investigate these opportunities and approach department and city leadership to discuss how best to leverage these existing regulations to incorporate a broader focus on health.

More education of elected officials, leadership, *and* staff is needed to promote sustained collaboration between health and planning and for the field to begin to make an institutional shift. As an interviewee from the Columbus health department noted, "Ultimately it's a huge learning process. Somebody's got to learn how to do something they have never done before and someone has got to be telling them how to do it." Educated leaders play a big role in breaking down the silos that the planning and health fields have evolved into.

8.3 Break Down Silos

As discussed in Chapter Two, the fields of planning and public health have become increasingly inward-looking which, in turn, hampers inter-institutional

collaboration. Consciously breaking down the silos that the fields have evolved into can facilitate collaboration and ultimately facilitate a health focus in planning. Planners can rely on both educated leaders and established relationships with health professionals in order to incorporate the health perspective into planning work. If a planning department does not have current relationships established, they can reach out to local health departments or agencies. Health departments and health professionals should serve as a resource for planners, and consistently inviting health professionals into planning projects as partners or consultants can help maintain and strengthen the collaborative process.

Practicing planners can also draw on professional organizations that cater to planners, including the American Planning Association and the Urban Land Institute, to make the case for collaboration and foster a health perspective in planning. These professional organizations already support research on the links between health and the built environment and best practices for creating healthier places, and they provide resources to practicing planners and others whose work impacts the built environment. Said one interviewee from the Seattle-King County Health Department, "I would hope, as any professional, that you're always learning the latest and best practices in your own profession, and there is certainly the national movement towards integrating health into more policies. It's just becoming part of what [planning] work is" (Seattle Interviewee C, personal communication, August 1, 2014). Being aware of trends in the profession should be a key aspect of the work of planners and planning departments.

Interviewees generally agreed that planners have an important role to play in the movement to link health and the built environment, that reconnecting the fields is an important endeavor, and that the planning profession can benefit from a focus on health. In order to achieve this, planners will need to embrace health as a central goal in order to break down the silos between health and planning. A former staff member with the

Columbus Health Department stated, "I would hope that the planner would be just as invested in health as somebody from a health department. And realize that everything, every decision that they're making is affecting health. They are the new public health professionals" (Columbus Interviewee C, personal communication, June 30, 2014).

To begin to create opportunities to collaborate, planners can take initiative as well. Planning staff can seek out health department staff—especially those with specific interests in the built environment—and request informal meetings to discuss shared interests and build relationships. Additionally, planners can invite health department staff to join planning meetings at the outset of plan- and project-related decision-making processes. The recent comprehensive planning process in Cincinnati is a best practice example of this. Health is featured prominently within Plan Cincinnati due to up-front engagement between the planning division and the health department to include health perspectives and challenges within the plan's goals and strategies.

Also, department leadership can help facilitate collaboration and keep staff accountable by integrating goals related to collaboration between the departments into performance review processes for planning staff and leadership. Requiring this type of process shows leadership support for collaboration and also helps break down barriers between the departments. In addition, professional organizations can help facilitate communication between the fields. Local APA Chapters can host events on health and the built environment in conjunction with APHA chapters, or chapters of other health focused organizations, to both educate planners on health goals as well as build relationships between planning and health professionals.

To help break down disciplinary silos, individual planning staff should reach out to their health department counterparts to initiate or continue conversations on how the built environment impacts health, and how each profession can serve as a resource for the

other. One interviewee from the Columbus planning division said, "Ultimately I think [collaboration] really is staff's responsibility. And the elected officials' job is to hear it out and see what they can support and adopt, but it's our job to bring it to bear. There is no way that a change could occur without different staff [from different departments] being on the same page" (Columbus Interviewee A, personal communication, May 28, 2014). Ultimately, changing planners' perception of their roles in creating healthy places is necessary in order to institute productive and sustained collaboration between planning and health.

8.4 Create and Incorporate Tools that Work with Planning Processes

My research suggests that a lack of tools and resources is an obstacle to collaboration between health and planning, with 70 percent of survey respondents citing inadequate resources as a challenge in their own work. This highlights the need to create tools that facilitate collaboration, that can be easily integrated into planning processes, and that do not require extensive resources. This is supported by other research, which has highlighted the need to develop practical tools that help promote partnerships between the health and planning disciplines (see Frank and Engelke 2001, Corburn 2007, Friel et al. 2011, Trowbridge et al. 2013).

Health Impact Assessment, broadly recommended as a tool that should be utilized more within planning process, has been found to be effective in catalyzing collaboration between planning and health departments, and planners should consider suggesting an HIA be conducted for a specific plan or project, especially if there is currently no collaboration between health and planning departments, or if the plan or project is high

profile or has unknown health impacts. Planners should also participate in any HIAs conducted on land use-related issues.

On the other hand, HIA can be resource intensive. Although health considerations are seen as increasingly important by practicing planners and health professionals alike, it seems unlikely that HIA will be the only or even best way to develop a health focus in the planning field. Interviewees in cities with experience with HIA, such as San Francisco, Columbus, and Seattle, noted that the tool is a good catalyst to prompt planning departments, and other agencies, to think about the health implications of projects. However, these cities have since largely evolved to incorporating health department staff and health considerations at the beginning of planning processes, rather than pursuing a parallel HIA process. Interviewees from Orlando/Orange County and Cincinnati—where HIA is still a relatively emerging process and is still being pursued—noted that the inclusion of local planners may in fact impact the neutrality of the process, and that planners from a different city, or planners who work at a regional scale, may be more appropriate partners in the HIA process. Interviewees generally agreed that there are other, and perhaps better ways, than HIA to develop a health focus in the planning process. Suggested an interviewee from the Orange County Health Department in Orlando, "If [health data] were considered in a planning process then I'm not sure the HIA would be pertinent. I know there are people that have done HIAs on comp plans but I think if you've got the data, and you consider it on the front end, then you're kind of duplicating the process" (Orlando Interviewee C, personal communication, July 15, 2014).

Instead, cities have started drawing on the principles of HIA to create their own tools more tailored to their needs and that more effectively fosters collaboration. For example, an effort to determine how best to collaborate led the planning and health

departments in Seattle to partner on a grant to develop a different method—called the Healthy Living Assessment—to bring health goals into the neighborhood planning process. One interviewee from the planning department described this method:

> The intent [of the Healthy Living Assessment] was to develop a tool using health metrics and a lens to bring people and place together to address equity and create equitable development. It's basically a process that includes gathering data for a number of indicators and that data gathering includes community questionnaires to get how people use a community and what they believe the assets to be…We use it in communities where we see health disparities. But it's still within our community planning piece (Seattle Interviewee A, personal communication, June 20, 2014).

Community engagement is another tool at planners' disposal that can be leveraged to incorporate health concerns and improvements into plans. In San Francisco, a former planning department staff member noted that the community engagement process as part of their Eastern Neighborhoods plan "provided the real glue and substance to have the conversations. It took a substantial conversation from public health, planning, and the community folks to figure out how relevant [health] was" (San Francisco Interviewee F, personal communication, March 13, 2014). Health professionals should be involved in not only meetings with city partners, but meetings with the general public as well in order to help gather and interpret health perspectives on planning issues.

New approaches to data collection and sharing can also facilitate collaboration between health and planning. In Cincinnati, the planning and health departments collaborated on a project to determine mortality rates and life expectancy data by neighborhood, an important endeavor as health data is primarily not available at such a fine scale. Planning became an important contributor to this project. Said an interviewee from the planning division, "One of the greatest ways that I think that we as planners can

be helpful to the health departments is with our data. We have mapping skills so we can take that data and we can show it on maps along with [health department] data, and show correlations" (Cincinnati Interviewee A, personal communication, June 13, 2014).

In addition, there are other ways that planners can work with health partners to develop and share tools to evaluate the health impacts of plans and projects, and to incorporate health goals more broadly into planning processes. Planners can take inventory of the current tools and processes used within planning department to determine if and how health goals could be included. Existing tools and data sets, including land use data, maps, and impact assessment processes, should be shared with health partners to understand how health data can be incorporated. Additionally, planners can investigate the tools and methods used in other cities, such as Seattle's Healthy Living Assessment or Cincinnati's comprehensive planning process, and adapt these to their local and state context. Also, state and local regulatory frameworks may already provide opportunities to include health goals, or they may be amended to promote a greater focus on health. Planners should familiarize themselves with existing regulations and consider whether these can be leveraged to incorporate health in planning processes.

Ultimately, planners and health professionals used existing methods or developed new tools for collaboration that worked best for them, given their specific needs and institutional structures. While HIA was used in all these cities, it has not become commonly used and it does not appear that more widespread application of HIA is essential to promoting a health focus within planning. Said an interviewee from the Orlando planning department, simply developing "a checklist or some other kind of guideline that helps communities and staffers, and even the [project] applicants themselves and their architects and designers, look at a project, look at how it's laid out, look how it's been planned, and look at it through the lens of creating a healthy place"

could be a helpful tool for planners (Orlando Interviewee A, personal communication, June 27, 2014). Such tools should be shared more widely with other cities in order to facilitate collaboration and ultimately promote a health focus in the planning process.

8.5 Conclusion

This research has shown that collaboration between planning and health departments can occur within a wide variety of contexts, and I have provided a set of recommendations that can be applied across all sizes and structures of planning departments. Framing health as a critical component of planning processes through education and training opportunities is a key first step to engage with the broader planning field. Education of leadership, both within planning departments and of elected officials, is also necessary in order to garner the needed support to help strengthen opportunities for collaboration between planning and health departments. Breaking down disciplinary silos by implementing collaborative processes is also critical to instill an overarching focus on health within the practice of planning. Additionally, appropriate tools and methods that planners can used to develop a health focus in their daily practice must be developed and replicated widely. Implementing strategies that support these recommendations can help planning departments, and the planning field overall, move towards practices that consider health at every step in the planning process.

Chapter Nine: Conclusions: Towards a Health Focus in Planning

Clear evidence has emerged over the past few decades that point to important links between built environment factors and the prevalence of chronic diseases. However, recent research in both the fields of public health and planning suggests that the planning field can, in fact, contribute to ameliorating current health issues that are associated with the ways that our cities are planned, designed, and built.

Because of the important associations between the built environment and public health, my research found that planners by and large support the inclusion of health concerns in the planning process. Even though the five cities differed in terms of *how* health became integrated in the planning process, key commonalities emerged from the interviews and survey research. In all five cities, the health departments—at local, county, and state levels—initiated the collaboration with planning departments. As previously discussed, the instigators were health department leaders or staff members who understood the links between public health and the built environment and who pushed to form relationships with local planning departments.

Planning departments responded in various ways to this outreach by public health professionals. Some departments kept to "business as usual" due largely to resource limitations, but in other departments, staff members appreciated the connections between health and the built environment and collaboration was initiated. In fact, my surveys showed that 60 percent of cities currently pursue some form of collaboration between the planning department and the responsible health department (local, county, or state). Although the frequency and length of collaboration varies, it is encouraging that such a high percentage are collaborating, especially considering that only 33 percent of cities

indicated that they have a local health department, and considering that most methods promoted in literature, such as zoning reform and HIA, require close collaboration between planning and public health (Sclar and Northridge 2001).

Due to the potential of HIA for planning, the original intent of my research was to investigate applications of HIA to determine "best practices" for building relationships between planning and health departments. Following an extensive literature review, it initially appeared that HIA could help institutionalize considerations of health within planning processes and should be adopted by all planning departments. Indeed, interviewees largely agreed that HIA represented one possible mechanism for bringing health considerations into the planning realm. However, as evidenced by the survey results, HIA is not widely used by planners and, in practice, interviewees generally agreed that there are less resource intensive ways to ensure that health is not only considered within plans and projects, but that plans and projects are amended to promote and protect public health. Adopting a Health in All Policies approach to planning work, sharing data and knowledge, and simply initiating regular conversations between health professionals and planners are all opportunities to integrate the health perspective without undertaking a more strenuous analytical process. The opportunities and recommendations discussed in the preceding chapters are less specific than the prescribed steps of an HIA process, but are essential ingredients for developing lasting collaboration and a deliberate health focus within planning processes. Each opportunity and recommendation may not apply to each specific city context, but individual cities, departments, and staff should consider which are most applicable and feasible to support their pursuit of integrating health goals into planning processes.

Although planning theorists have long debated the merits of focusing on the "ends" versus the "means" of planning, my research shows that these two theoretical

frameworks can, and should, be integrated to explain certain phenomena and illuminate strategies for action. Starting with a normative end goal of a health focus in planning leads to the equally important question of how to achieve this in practice. In each city interviewed, it was this focus on the potential for planning to mitigate public health concerns that sparked an interest in collaboration between the planning and health departments, which led to the question of how to achieve such collaboration in practice. In turn, the imperative of productive interdisciplinary engagement points to the need for understanding the challenges and possibilities of collaboration, especially since conceptions of "health" within the planning field, and planners' own view of their role in regards to public health, are shaped by disciplinary knowledge formations and values.

In my research, I use normative theory to support my assumption that the field of planning must pursue a value-based "end" (a focus on public health) due to the emerging chronic disease trends that have clear connections to land use and the built environment. My research shows that such a shared, value-based "end" was a critical reason why planning and health departments initially began to collaborate. However, interviewees also indicated that the *process* of collaboration in and by itself was an important factor in developing this commonly agreed-upon, value-based end. The stories from five cities showed that successful collaboration and knowledge sharing led to a commitment to a health focus among participating planners, suggesting that collaborative processes have the potential to place health at the core of planning. Turning to the perspective of collaborative planning theory, collaborative processes including interdisciplinary dialogue and sharing of knowledge formations and values between public health and planning staff can prompt new awareness among planners. In turn, such increasing awareness of the role of planning as a potential catalyst for healthier cities can eventually lead to a focus on public health in all aspects of the planning profession.

The knowledge, expertise, opinions, values, and perspectives of both planners and health professionals will be critical in order to implement health considerations within existing planning processes. Both fields bring different, and equally valuable, perspectives and knowledge to processes that ultimately shape the way cities are designed and built. As an interviewee from the Florida Department of Health noted, "I think we have to have planners at the table, because there are things that health people aren't going to think of. Just like in planning, they don't automatically think of health. I think we need to have planners at the table as at least informants, but preferably as partners" (Orlando Interviewee D, personal communication, July 16, 2014). While the exact methods used to foster collaboration are context-dependent and therefore will differ, fully embracing a focus on health will require a shift in the values that serve to define planners' identities and institutional priorities. Ultimately, my research suggests that the institution of planning plays a role in shaping the values and perceived roles of planners, but that individual planners' values and perceptions of self may also contribute to reshaping the planning field.

However, while collaboration has long been promoted as essential for a health focus in planning, little has been written about the myriad and complex challenges to collaboration faced by planners who are striving to bring a health focus into their work. In my research, therefore, I sought to understand how collaboration can be catalyzed in practice, and how individual values of practicing planners may influence collaboration. By documenting the evolution of collaboration in five cities, I was able to identify opportunities to facilitate collaboration despite the many challenges planners face in their daily work. The practice of inviting health representatives to participate in and contribute to planning processes is a good first step to establishing collaborative processes between planning and health, bringing health knowledge to the attention of practicing planners,

and breaking down the silos that each profession has evolved into. Recognizing that health professionals can serve planning processes as a source of knowledge can help bridge a resource gap that survey respondents and interviewees named as a barrier to including health concerns and considerations. Though tools such as HIA have been touted as instrumental in bridging the gap between planning and health, many interviewees felt that other methods—such as data sharing, engaging the community, and simply working in conjunction with each other—were more effective methods.

Ultimately, public health is no longer solely the responsibility of health professionals. Planners, urban designers, architects, and developers all play a part in shaping the built environment, which requires them to pursue a form of practice that serves to improve public health. The institution of planning must make a return to the premise upon which it was founded and look at all decision-making processes involving plan-making, policy development, and project design through a lens of public health. The momentum that this premise has gained over the past two decades—as evidenced by literature as well as this research—provides a solid foundation to continue and expand this effort. As explained by an interviewee from the San Francisco planning department, planners must develop "a recognition that bottom-line what we do [as planners] impacts public health. Remembering the public health origins of planning, and with collaboration making ourselves a little bit more conscious in integrating the health impacts of the work we do" (San Francisco Interviewee A, personal communication, February 25, 2014). Efforts by planners to partner with health professionals to bring a health focus into the planning field can have a great impact on reversing troubling chronic disease trends and making places, neighborhoods, and cities healthier places for all.

Appendices

APPENDIX A: SURVEY QUESTIONS

A Nationwide Survey to Measure Local Government Efforts to Integrate Public Health Issues into City Planning Processes

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You are invited to participate in a research study entitled "A Nationwide Survey to Measure Local Government Efforts to Integrate Public Health Issues into City Planning Processes."

There is growing recognition in the planning field that our built environment and the land use decisions that shape it can have great impacts on the physical, social, and mental health of communities, and that health is no longer solely the responsibility of health departments.

This survey is being conducted by the Center for Sustainable Development and the Community and Regional Planning program at the University of Texas at Austin, and was developed in consultation with the American Planning Association. This survey is being distributed to planning and community development directors and managers in cities with a population of 75,000 or greater throughout the country to gain insight on their experience with Health Impact Assessment (HIA) and the incorporation of health issues into planning practice. The study will measure how cities throughout the country are considering health within policies, plans, and projects that impact the built environment, specifically in terms of the use of HIA.

The findings of this study will help planning departments and practicing planners by providing recommendations for working with decision makers to integrate health issues into the planning process. Your answers are very important, as they will help identify "best practice" information for other cities and municipalities throughout the country. Thank you for your participation!

INSTRUCTIONS

Please answer all questions to the best of your abilities. Answer the questions based on your personal experiences and perceptions. Some of these questions will ask for your personal opinion and others will require you to answer based on the priorities and activities of your planning department. If you see fit, please pass the link to this survey on to a more appropriate planning staff member to complete. Please feel free to make any comments about these questions or your answers at the end of the survey. This survey has five sections for you to complete and should take you 15 to 20 minutes.

Definitions – for the purposes of this survey, the following terms are defined:
"Built environment" refers to all buildings, spaces, and systems that are created, modified, or used by humans.
"Public health" refers to the science of preventing infectious and chronic disease through the promotion of healthy behaviors, communities, and environments.
"City" refers to the city or municipality that you work in.

If you have any questions or encounter any problems please contact the researcher, Sara Hammerschmidt, doctoral fellow at the Center for Sustainable Development, at saramh@utexas.edu or 512-791-8924. The results of the survey will be made available to you upon request.

CONFIDENTIALITY

No identifying information will be revealed in any way in the survey results write up or any resulting papers or publications. Your survey responses will remain strictly confidential.

SECTION 1: PUBLIC HEALTH ISSUES RELATED TO PLANNING AND THE BUILT ENVIRONMENT IN YOUR CITY OR REGION

(This section contains 12 questions)

1) In your view, which of these planning-related public health issues are the THREE most serious facing your community (in terms of impact on community residents, with 1 being the most serious)? Choose up to three issues.

	Rank top three (1, 2, 3)
Asthma	
Obesity/ diabetes	
Pedestrian/bik e injuries	
Increasing physical activity of residents	
Healthy food access	
Resident access to community health clinics/health	

care within their neighborhood	
Outdoor air pollution	
Indoor environmental pollution (e.g. mold, lead, radon, formaldehyde)	
Water pollution	
Noise pollution	
Crime/safety	

2) In your view, which of these built environment issues are the THREE most serious facing your community (in terms of impact on community residents, with 1 being the most serious)? Choose up to three issues.

	Rank top three (1, 2, 3)
Resident access to alternate modes of transportation	

within their neighborhood (e.g. sidewalks, bike lanes, public transit)	
Resident access to amenities and services within their neighborhood (e.g. jobs, parks, healthy food)	
Brownfields/ contaminated land	
Green and healthy buildings	
Affordable housing	

3) Are any of these issues currently being specifically addressed in your community by any local or state government or non-profit agency (select all that apply)?

- [ ] Asthma
- [ ] Obesity/diabetes
- [ ] Pedestrian/bike injuries

- [ ] Increasing physical activity of residents
- [ ] Healthy food access
- [ ] Resident access to community health clinics/health care within their neighborhood
- [ ] Outdoor air pollution
- [ ] Indoor environmental pollution (e.g. mold, lead, radon, formaldehyde)
- [ ] Water pollution
- [ ] Noise pollution
- [ ] Crime/Safety
- [ ] Resident access to alternate modes of transportation within their neighborhood (e.g. sidewalks, bike lanes, public transit)
- [ ] Resident access to amenities and services within their neighborhood (e.g. jobs, parks, healthy food)
- [ ] Brownfields/contaminated land
- [ ] Green and healthy buildings
- [ ] Affordable housing
- [ ] Other (please specify):

- [ ] Don't know or n/a

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4) Are any of these issues currently being addressed or considered in any way by the planning department (select all that apply)?

- [ ] Asthma
- [ ] Obesity/diabetes
- [ ] Pedestrian/bike injuries
- [ ] Increasing physical activity of residents
- [ ] Healthy food access
- [ ] Resident access to community health clinics/health care within their neighborhood
- [ ] Outdoor air pollution
- [ ] Indoor environmental pollution (e.g. mold, lead, radon, formaldehyde)
- [ ] Water pollution

- [ ] Noise pollution
- [ ] Crime/Safety
- [ ] Resident access to alternate modes of transportation within their neighborhood (e.g. sidewalks, bike lanes, public transit)
- [ ] Resident access to amenities and services within their neighborhood (e.g. jobs, parks, healthy food)
- [ ] Brownfields/contaminated land
- [ ] Green and healthy buildings
- [ ] Affordable housing
- [ ] Other (please specify):

- [ ] Don't know or n/a

5) How (if at all) is the planning department incorporating any of the above listed public health and built environment issues into planning efforts (select all that apply)?

- [ ] Conducting impact assessments (e.g. health, environmental, social)
- [ ] Addressing public health topics in general or comprehensive plans
- [ ] Addressing public health topics in zoning codes
- [ ] Considering public health topics within implementation of plans or projects
- [ ] Adoption of a public health ordinance or framework for planning processes
- [ ] Other (please specify):

- [ ] Planners in my city do not engage in work that considers public health issues

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6) In what ways is public health considered a priority by government officials within your city (select all that apply)?

- [ ] Used as a metric for prioritizing municipal capital projects
- [ ] Inclusion in city mission statement
- [ ] Adoption of a city-wide health ordinance or framework

☐ Inclusion in other city documents (please specify which documents):

☐ Other (please specify):

☐ Public health is not considered a priority within my city

☐ Don't know

7) Do these groups or entities (external to your planning department) influence the consideration and/or incorporation of public health into your planning department's activities or goals?

***Please note that the groups or entities you select here will be referred to in Questions 8, 9, and 10.**

	Yes	**No**	**Don't know**
Your city, county, and/or state health department	○	○	○
Planning departments in other cities	○	○	○
Health departments in other cities	○	○	○
Other departments within your city	○	○	○

Health-focused organizations external to city government	○	○	○
Local or regional community organizations	○	○	○
Real estate/property developers	○	○	○
The general public	○	○	○
The media	○	○	○

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8) On a scale of 1 to 5 (with 1 being great influence and 5 being no influence), how do the groups selected in Question 7 shape or influence the movement towards a common understanding of the role of public health in planning within your planning department?

	COMMON UNDERSTANDING OF THE ROLE OF PUBLIC HEALTH					
	1	**2**	**3**	**4**	**5**	**n/a**
Your city, county, and/or	( )	( )	( )	( )	( )	( )

state health department						
Planning departments in other cities	( )	( )	( )	( )	( )	( )
Health departments in other cities	( )	( )	( )	( )	( )	( )
Other departments within your city	( )	( )	( )	( )	( )	( )
Health-focused organizations external to city government	( )	( )	( )	( )	( )	( )
Local or regional community organizations	( )	( )	( )	( )	( )	( )
Real estate/property developers	( )	( )	( )	( )	( )	( )
The general public	( )	( )	( )	( )	( )	( )
The media	( )	( )	( )	( )	( )	( )
Other (as specified in Question 7)	( )	( )	( )	( )	( )	( )

Comments:

9) On a scale of 1 to 5 (with 1 being great influence and 5 being no influence), how do the groups selected in Question 7 shape or influence the movement of public health issues to higher priority within your planning department?

	PUBLIC HEALTH ISSUES AS A HIGHER PRIORITY IN PLANNING					
	1	**2**	**3**	**4**	**5**	**n/a**
Your city, county, and/or state health department	( )	( )	( )	( )	( )	( )
Planning departments in other cities	( )	( )	( )	( )	( )	( )
Health departments in other cities	( )	( )	( )	( )	( )	( )
Other departments within your city	( )	( )	( )	( )	( )	( )
Health-focused organizations external to city government	( )	( )	( )	( )	( )	( )
Local or regional community organizations	( )	( )	( )	( )	( )	( )
Real estate/property	( )	( )	( )	( )	( )	( )

developers						
The general public	( )	( )	( )	( )	( )	( )
The media	( )	( )	( )	( )	( )	( )
Other (as specified in Question 7)	( )	( )	( )	( )	( )	( )

Comments:

10) On a scale of 1 to 5 (with 1 being great influence and 5 being no influence), how do the groups selected in Question 7 shape or influence discussions regarding the inclusion of public health issues in planning strategies and practices in your planning department?

	DISCUSSIONS REGARDING INCLUSION OF PUBLIC HEALTH ISSUES					
	1	**2**	**3**	**4**	**5**	**n/a**
Your city, county, and/or state health department	( )	( )	( )	( )	( )	( )
Planning departments in other cities	( )	( )	( )	( )	( )	( )
Health departments in other cities	( )	( )	( )	( )	( )	( )
Other departments within your city	( )	( )	( )	( )	( )	( )

Health-focused organizations external to city government	( )	( )	( )	( )	( )	( )
Local or regional community organizations	( )	( )	( )	( )	( )	( )
Real estate/property developers	( )	( )	( )	( )	( )	( )
The general public	( )	( )	( )	( )	( )	( )
The media	( )	( )	( )	( )	( )	( )
Other (as specified in Question 7)	( )	( )	( )	( )	( )	( )

Comments:

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11) What resources are available to support your planning department's efforts to consider public health issues in planning processes (select all that apply)?

- ☐ Funding (e.g. grants, state or local funding, private donations)
- ☐ Quantitative or qualitative community health data
- ☐ Voluntary training opportunities on health related issues
- ☐ Mandatory training opportunities on health related issues
- ☐ Assigned planning staff to work on public health issues
- ☐ Partnerships with external organizations
- ☐ Political support
- ☐ No resources are available

☐ Don't know

☐ Other (please specify):

12) In your view, what are the THREE most critical resources for your department to have in order to consider public health issues in planning processes (please rank up to three resources, with 1 being the most critical)? These may differ from the resources that are currently available within your department.
(please specify any other critical resources not listed in the blank boxes)

	Rank top three (1, 2, 3)
Funding	
Quantitative or qualitative community health data	
Voluntary training opportunities on health related issues	
Mandatory training opportunities on health related issues	
Assigned planning	

staff to work on public health issues	
Partnerships with external organizations	
Political support	

SECTION 2: COLLABORATION BETWEEN PLANNING AND THE PUBLIC HEALTH DEPARTMENT IN YOUR CITY OR REGION

(This section contains 3 questions plus sub-questions depending on your answers)

13) Does your city have its own public health department?

- ○ Yes
- ○ No
- ○ Don't know

What agency assumes primary responsibility for addressing public health issues in your city?

- ○ County health department
- ○ State health department
- ○ Other (please specify):

- ○ Don’t know

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14) Is there currently any form of collaboration or partnership (formal or informal participation in plan-making, discussions, meetings, etc.) between the planning department and the public health department that has primary responsibility within your city?

- ○ Yes
- ○ No
- ○ Don't know

What was the impetus for this collaboration or partnership (select all that apply)?

- ☐ Mandated by a law or ordinance
- ☐ New resources became available
- ☐ Pressure from the public
- ☐ Pressure from decision makers
- ☐ Staff desire
- ☐ Don’t know
- ☐ Other (please specify):

What is the approximate frequency of formal meetings/informal phone or email communication?

- ○ Quarterly
- ○ Monthly
- ○ Weekly
- ○ Don't know
- ○ Other (please specify):

On a scale of 1 to 5 (with 1 being very successful and 5 being not successful), how would you rate the following elements of this collaboration between the planning department and public health department?

	Collaboration with public health department					
	1 (very	**2**	**3**	**4**	**5 (not**	**Don't**

	successful)				successful)	know or n/a
Shared definitions/understanding of what health means	( )	( )	( )	( )	( )	( )
Shared goals for health inclusion in planning processes	( )	( )	( )	( )	( )	( )
Trust/respect between departments	( )	( )	( )	( )	( )	( )
Regularity of face-to-face or phone meetings	( )	( )	( )	( )	( )	( )
Consensus with decision-making	( )	( )	( )	( )	( )	( )

Comments:

15) Has there been any form of collaboration or partnership (formal or informal participation in plan-making, discussions, meetings, etc.) between the planning department and the public health department in the past that is no longer happening?

- Yes
- No
- Don't know

Why was this collaboration or partnership suspended?

SECTION 3: THE USE OF HEALTH IMPACT ASSESSMENT IN YOUR CITY

(This section contains 1 question plus sub-questions depending on your answer)

16) Has your city conducted a Health Impact Assessment (HIA) that has included the involvement or participation of the planning department?

- ○ Yes
- ○ No, but HIA has been conducted/attempted without the involvement of planners
- ○ No, my city has not conducted or attempted to conduct an HIA
- ○ Don't know

In what year did your city first start conducting Health Impact Assessments (enter year or "don't know")?

Which department or entity primarily conducts Health Impact Assessments (select all that apply, if HIAs are conducted jointly)?

- ☐ Public health
- ☐ Planning
- ☐ Transportation
- ☐ External organization (e.g. led by a university, community-driven, led by a non-profit – please specify):
- ☐ Don’t know
- ☐ Other (please specify):

Have the HIAs that are or have been conducted with involvement of a city department been initiated on a:

- ☐ Voluntary (initiated by one or more departments) basis?
- ☐ Regulatory (mandatory due to a law or ordinance) basis (please specify the ordinance or legislation)?:

☐ Both (please specify the ordinance or legislation)?:

☐ Don't know

What types of projects are or were HIAs performed on (select all that apply)?

☐ Public projects (local, state, federal projects)

☐ Private projects (e.g. initiated by developers, property owners, or non-governmental organizations)

☐ Within planning processes (e.g. comprehensive plans, neighborhood plans)

☐ Local/state policies

☐ Don't know

☐ Other (please specify):

What scale of plans, policies, or projects have HIAs in your city been conducted on (select all that apply)?

☐ Individual project scale

☐ Block or neighborhood scale

☐ City or regional scale

☐ Other (please specify):

SECTION 4: POLITICAL SUPPORT FOR ENGAGEMENT WITH HEALTH ISSUES WITHIN PLANNING PROCESSES IN YOUR CITY

(This section contains 3 questions)

17) How do elected or appointed officials in your city provide support for the inclusion of public health issues into planning processes (select all that apply)?

☐ Initiate or vote in favor of planning, transportation, and/or built environment policies that include support for public health

☐ Initiate or vote in favor of initiatives or ordinances that require health considerations in all planning decisions

☐ Request health impact data when approving projects, plans, or policies that impact the built environment

☐ Hold meetings with community members to discuss health impacts of proposed projects, plans, or policies

☐ Don't know

☐ Elected or appointed officials in my city do not provide support for the inclusion of public health issues into planning processes

☐ Other (please specify):

18) What do you see as barriers to the inclusion of public health issues into planning processes in your city (select all that apply)?

☐ Knowledge of elected officials regarding connections between planning/land use and health

☐ Adequate resources to consider health implications of planning decisions

☐ Identifying connections between planning and public health for making decisions is not a priority in my city

☐ Political support to consider public health issues within planning processes

☐ Understanding of appropriate actions to take in order to include public health issues within planning processes

☐ Don't know

☐ Other (please specify):

19) Please rate the strength of support for the inclusion of public health issues into planning processes by each elected or appointed group or individual in your city (if there are other elected officials that are not listed or if you have any comments, please note this in the text box in the far right column):

	Strength of support	

	Strong support	Support	Neutral	Opposition	Strong Opposition	Don't know or n/a	
Mayor	( )	( )	( )	( )	( )	( )	___
City manager	( )	( )	( )	( )	( )	( )	___
Majority of city council members (please note in last column if support varies greatly between council members)	( )	( )	( )	( )	( )	( )	___
Planning commissioner	( )	( )	( )	( )	( )	( )	___
Other elected official involved with public health and planning decisions in your city (note which official in last column)	( )	( )	( )	( )	( )	( )	___

SECTION 5: GENERAL INFORMATION

All personal or identifying information will be kept confidential. This information is necessary to request potential follow-up communication in order to gain a deeper

understanding of how health is incorporated into planning processes, and will also help the researcher to better understand the responses received.

20) How would you describe the type of government structure in your city?

○ Strong Mayor (In the strong-mayor form the elected mayor is given almost total administrative authority and a clear, wide range of political independence, with the power to appoint and dismiss department heads without council approval and little, or no public input)

○ Weak Mayor (In a "weak" mayor-council system, the mayor has no formal authority outside of the council; he/she cannot appoint and/or remove officials, and lacks veto power over council votes)

○ Council-manager government (The elected legislative body/city council, appoints a professional manager to oversee the administrative operations, implement its policies, and advise it. The position of "mayor" is a largely ceremonial title, and may be selected by the council from among its members or elected as an at-large council member with no executive functions)

○ Don't know

○ Other (please specify):

21) What is your job title?

22) How many years have you been in your current position?

23) How many years have you worked in the planning field?

24) If you have an area of specialization within planning, please note here (e.g. transportation, community development/neighborhood, land use, economic development, historic preservation, housing, comprehensive/long range):

25) Do you have a degree (bachelor's, master's, and/or PhD) in urban planning?

- ○ Yes
- ○ No

What is your educational background?

---

26) What is the city where you work?

27) What is the state where you work?

- ○ Alabama
- ○ Alaska
- ○ Arizona
- ○ Arkansas
- ○ California
- ○ Colorado
- ○ Connecticut
- ○ Delaware
- ○ District of Columbia
- ○ Florida
- ○ Georgia
- ○ Hawaii
- ○ Idaho
- ○ Illinois
- ○ Indiana
- ○ Iowa
- ○ Kansas

- Kentucky
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- Nebraska
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- New York
- North Carolina
- North Dakota
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Rhode Island
- South Carolina
- South Dakota
- Tennessee
- Texas
- Utah
- Vermont
- Virginia
- Washington

- West Virginia
- Wisconsin
- Wyoming

28) What is your gender?

- Male
- Female
- Prefer not to answer

29) What is your age (you can leave this blank if you prefer not to answer)?

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30) How many planners (approximately) does your department employ?

31) Is the planning department in your city organized by specialization or work assignments (e.g. preservation planners, environmental planners, long-range planners)?

- Yes
- No
- Don't know

Which specialization(s) typically work with the public health department (if applicable)?

32) Is there a designated individual (or individuals) within your planning department with job responsibilities specific to considering public health issues within the current planning processes?

If yes, please indicate approximately how many individuals have job responsibilities specific to considering public health issues in the blank text box.

- Yes:
- No
- Don't know

33) Do any of the planning staff in your department have a background in public health (e.g. a public health degree, formal public health training, work experience in a public health department)?

If yes, please indicate approximately how many planning staff have a background in public health in the blank text box.

- Yes:
- No
- Don’t know

34) Is there anything else you want to make known about the inclusion of public health issues into planning processes in your city?

35) Are you interested in an emailed summary of the survey results when available?

- Yes
- No

Please provide your email address.

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36) Are you willing to participate in a follow-up phone interview?

- Yes
- No

What is your name?

Please provide either your email address or phone number as a preferred method of contact.

Thank You!

Thank you for taking this survey! Your response is very important to this research.

APPENDIX B: EMAIL OUTREACH FOR SURVEYS

Email #1
Email Subject: A Nationwide Survey of Planning Directors on Public Health Issues

Dear [Name],

In an effort to understand how planning departments consider public health issues within their work, I am conducting a study with planning and community development directors from medium and large sized cities across the country. As a doctoral candidate in Community and Regional Planning at the University of Texas, I am very interested in the role planners can play in creating built environments that improve health outcomes for all residents. This survey was developed in consultation with the American Planning Association and I intend to use the findings to help planning departments and practicing planners by providing recommendations and strategies for integrating health issues into the planning process. **If you feel another staff member in your department is better suited to complete this survey, please feel free to forward this email.**

The purpose of this email is to ask for your participation in the study by completing an online survey. Your input as a planner is very important, as it will help document "best practice" information for other cities and municipalities throughout the country. It should take you approximately 15-20 minutes to complete this survey. The questions are mainly multiple choice regarding your insights on the relationship between public health, planning, and the built environment. Topics covered include: your experience with collaboration between planning and public health departments; any application of Health Impact Assessment in your city; your experiences seeking political support for the consideration of health issues in planning; and relevant demographic information.

If you are willing to participate, simply click on the link below, or cut and paste the entire URL into your browser to access the survey:

http://edu.surveygizmo.com/s3/1300016/A-Nationwide-Survey-to-Measure-Local-Government-Effort-to-Integrate-Public-Health-Issues-into-City-Planning-Processes

Please complete the survey by **Wednesday, October 2nd.**

Your participation in this survey is voluntary and you have the right to withdraw at any time. Your responses will be kept strictly confidential. If you have any questions or would prefer to complete a paper copy of the survey, please feel free to contact me, Sara Hammerschmidt, at saramh@utexas.edu or 512-791-8924.

Thank you for your participation!

Sara Hammerschmidt
Doctoral Candidate, Community and Regional Planning

Doctoral Fellow, Center for Sustainable Development
The University of Texas at Austin
512-791-8924
saramh@utexas.edu

Email #2: First reminder email
Email Subject: A Nationwide Survey of Planning Directors on Public Health Issues

Dear [Name],

I wanted to send you a reminder for the survey I sent last week, looking at the role planners can play in creating built environments that improve health outcomes for all residents. **I added functionality to the survey to allow you to save your responses and finish them later**, which hopefully will make the survey more convenient for you to take. You will find this "save and continue" option at the top of the screen, starting on page 2.

Your response is very important to this research and the planning field in general as we work to create healthier environments for all, and I would appreciate it if you can find 15 minutes in the next week to take this survey. There has been great response so far, and your answers will contribute immensely to the results.

Again, you can forward this to another staff member if you feel he or she would be better suited to respond, or you can provide me with contact information and I can contact him or her directly.

http://edu.surveygizmo.com/s3/1300016/A-Nationwide-Survey-to-Measure-Local-Government-Effort-to-Integrate-Public-Health-Issues-into-City-Planning-Processes

Please feel free to contact me with any questions or concerns: saramh@utexas.edu or 512-791-8924.

Thank you!
Sara Hammerschmidt

Email #3: Second reminder email
Email Subject: A Nationwide Survey of Planning Directors on Public Health Issues

Dear [Name],

In an effort to understand how planning departments consider public health issues within their work, I have been conducting a study with planning and community development directors from medium and large sized cities across the country. Due to the great response rate thus far, I am **extending the survey deadline** to allow more cities the opportunity to participate!

Please consider taking 15 minutes of your time to respond to this survey that examines the role planners can play in creating built environments that improve health outcomes for all residents. **The extended, final deadline is Friday, October 11th**.

http://edu.surveygizmo.com/s3/1300016/A-Nationwide-Survey-to-Measure-Local-Government-Effort-to-Integrate-Public-Health-Issues-into-City-Planning-Processes

If another planning staff member is better suited to respond, you can either forward this email or provide me with his or her contact information.

Thank you for helping with this important and timely research, and feel free to contact me with any questions: saramh@utexas.edu or 512-791-8924.

Thank you!
Sara Hammerschmidt

APPENDIX C: EMAIL OUTREACH INTERVIEWS: SAN FRANCISCO

Email subject: Request for an interview for dissertation research

Dear [Name],

I am working on my PhD in urban planning and my research focuses on the integration of health concerns into planning processes. As the first phase of that research, I conducted a national survey of planning departments on their experience with HIAs and what they perceive to be challenges/opportunities to the inclusion of health in planning processes.

As the next phase of my research I'm looking at doing case studies of select cities who have engaged planning department in HIAs and cities who have *not* yet engaged planning in HIAs. As a precursor to those case studies, I am doing some research into the case of San Francisco--as you have the most history with HIA and with the integration of health and land use in general--using the city as a sort of "model case" within my research from which to tease out lessons, challenges, and potentially best practices. I'm hoping to interview 2-3 folks from the planning department and 2-3 from public health who work together on issues of health, land use, and the built environment.

I was wondering if you would have an hour or so for an phone interview with me within the next couple of weeks, specifically on the evolution of the relationship between planning and public health and how you were engaged in HIA processes or other collaborative efforts. Would there be a good time for you to talk with me?

Let me know if you have any questions about this, and I look forward to hearing from you!

Best,
Sara

APPENDIX D: INTERVIEW QUESTIONS: SAN FRANCISCO

Interviews with San Francisco Planning Department

Theme 1: What is the significance of different aspects of collaboration, between whom (history, current, interdisciplinary staff)?

1. What has been the role of the planner in collaboration between the public health department and the planning department (leader, follower, partner)? What is your particular role? Who typically interfaces with the public (planning or public health)? How much has the planning department as a whole bought into this collaboration/integration?

2. How would you characterize the quality/level of collaboration between the San Francisco public health and planning departments?
    a. The survey results indicated that collaboration has waned over the past few years – do you agree? Why do you think this may have happened?

3. Can you speak about the advantages and challenges of the collaboration?
    a. In your experience, what has happened when there were disagreements? Are there negotiations? How do you work through it?

4. Do you see collaboration between planning and public health as important to advancing a health agenda within planning and land use, either within the city of San Francisco or within the planning profession in general? Why or why not?

5. According to survey results, two recent hires in the planning department have public health backgrounds. Do you know if this was intentional in order to foster more of a health perspective? [For public health]: Does the public health department have staff with planning backgrounds?

Theme 2: How/to what extent did the Health Impact Assessment serve as a driver of health/planning integration (as theory, as planning method, as narrative setting agenda)?

1. Can you tell me what you know about the history of HIAs in SF and the role of the planning department?
    a. When and how did the planning department become involved in the HIA process?
    b. What determines whether or not planning is involved in an HIA (besides those that are not tied to land use)?

2. What would you say has been the most successful and the most challenging thing about involving planners in HIA processes? [For example, improved community engagement; improved communication between departments; expedited review processes; pushback from development community; challenges getting community input; challenges with collaboration] How was the challenge negotiated?

3. Did involving planners in HIA processes lead to better integration of health in planning? How? [e.g. Is there better coordination between departments, better community engagement, changes in planning decisions to take health into account?]

4. Based on survey results, only 24% of cities responded that an HIA has been conducted; of that 24%, 60% of cities responded that those HIAs involved the planning department (14.5% of total survey population). So as SF is a leader in health/planning integration, I would like to ask for your thoughts on the potential role of HIAs in other cities.
    a. Do you have opinions or suggestions for the potential role of planners in HIA processes in other cities based on the SF experience?
    b. How do you see the role of Health Impact Assessments for longer-term integration of public health issues into planning?
    c. How do you think planners could become more involved in HIA processes if they are initiated by other departments?
    d. Are there other, perhaps better, methods or tools than HIAs to achieve stronger collaboration between public health, i.e. better integration of health concerns in planning?

Theme 3: To what extent has "health" in general become infused into planners' daily work and thinking in recent years, and why/why not?

1. Besides HIA, what other methods or strategies have been employed, or what policies have been adopted, to integrate health issues into planning department activities? What have you seen as successful and not successful with these methods?

2. Now a question about the thinking about (i.e. consideration of) health, among planners in SF. Outside of conversations with the public health staff, have you noticed whether planners are talking more about the public health implications of projects/plans? How/where do you see this conversation happening? Informally? In internal meetings? In public meetings? What do you think is the reason for this?

3. Now a question about how health is reflected in planning documents, if at all. What types of planning documents are health concerns incorporated within? Could you share those with me?

4. How do city government officials impact (positively or negatively) integration of health concerns into planning/land use? BOTH in terms of thinking and talking about health, and actually incorporating health in planning practice.

5. How much is the integration of health issues into planning driven by demands from other stakeholders (the public, civil society organizations, departments, etc.)?

6. Do you think other issues in the planning department are prioritized over public health? Which ones?

7. What do you think it would take to make public health a major part of the agenda of the entire planning department in San Francisco?

8. In what ways do you see the planning *profession* in general as having the ability to be more integrated with public health issues?

Interviews with San Francisco Public Health Department

Theme 1: What is the significance of different aspects of collaboration, between whom (history, current, interdisciplinary staff)?

1. What has been the role of the planner in collaboration between the public health department and the planning department (leader, follower, partner)? What is your particular role? Who typically interfaces with the public (planning or public health)? How much has the planning department as a whole bought into this collaboration/integration?

2. How would you characterize the quality/level of collaboration between the San Francisco public health and planning departments?
    a. The survey results indicated that collaboration has waned over the past few years – do you agree? Why do you think this may have happened?

3. Can you speak about the advantages and challenges of the collaboration?
    a. In your experience, what has happened when there were disagreements? Are there negotiations? How do you work through it?

4. Do you see collaboration between planning and public health as important to advancing a health agenda within planning and land use, either within the city of San Francisco or within the planning profession in general? Why or why not?

5. Does the public health department have any staff with a planning background?

Theme 2: How/to what extent did the Health Impact Assessment serve as a driver of health/planning integration (as theory, as planning method, as narrative setting agenda)?

1. Can you tell me what you know about the history of HIAs in SF and the role of the planning department?
    a. When and how did the planning department become involved in the HIA process?
    b. What determines whether or not planning is involved in an HIA (besides those that are not tied to land use)?

2. What would you say has been the most successful and the most challenging thing about involving planners in HIA processes? [For example, improved community engagement; improved communication between departments; expedited review processes; pushback from development community; challenges getting community input; challenges with collaboration] How was the challenge negotiated?

3. Did involving planners in HIA processes lead to better integration of health in planning? How? [e.g. Is there better coordination between departments, better community engagement, changes in planning decisions to take health into account?]

4. Based on survey results, only 24% of cities responded that an HIA has been conducted; of that 24%, 60% of cities responded that those HIAs involved the planning department (14.5% of total survey population). So as SF is a leader in health/planning integration, I would like to ask for your thoughts on the potential role of HIAs in other cities.
    a. Do you have opinions or suggestions for the potential role of planners in HIA processes in other cities based on the SF experience?
    b. How do you see the role of Health Impact Assessments for longer-term integration of public health issues into planning?
    c. How do you think planners could become more involved in HIA processes if they are initiated by other departments?

d. Are there other, perhaps better, methods or tools than HIAs to achieve stronger collaboration between public health, i.e. better integration of health concerns in planning?

Theme 3: To what extent has "health" in general become infused into planners' daily work and thinking in recent years, and why/why not?

1. Besides HIA, what other methods or strategies have been employed, or what policies have been adopted, to integrate health issues into planning department activities? What have you seen as successful and not successful with these methods?

2. How do city government officials impact (positively or negatively) integration of health concerns into planning/land use? BOTH in terms of thinking and talking about health, and actually incorporating health in planning practice.

3. What do you think it would take to make public health a major part of the agenda of the entire planning department in San Francisco?

4. In what ways to do you see the public health profession in general as having the ability to be more integrated with planning/land use issues?

APPENDIX E: HIA INVESTIGATION ANALYSIS FOR PHASE III INTERVIEWS

City	State-Level "little NEPA"	Type of Government	Planners Involved Per Survey	Planning/Land Use/Built Environment Related HIAs	Year Completed	Scan Source	Type of assessment (based on document)	Scope	Role of Planning (based on document)
Albuquerque, NM		Strong	Yes	Bernalillo County Pedestrian and Bicyclist Safety Action Plan HIA	2012	Health Impact Project Database	Full Report	Area Plan	Unknown
Knoxville, TN		Strong	Yes	Knox County Health Department Community Garden HIA	2010	Health Impact Project Database	Pilot/Smaller Scope	Policy	none (first HIA by county HD)
				Plan East Tennessee HIA	2013	Web Search	Full Report	Regional Plan	Unknown
Eugene, OR		Council-Manager	Yes	HIA on Transportation Policy Recommendations in the Eugene Climate and Energy Action Plan	2010	Health Impact Project Database	Full Report	Policy	Unknown
				Northgate TOD Plan HIA	In progress	Web Search	Full Report/In progress	Project	Collaborator
Seattle, WA	Yes	Strong	Yes	Seattle Healthy Living Assessment	2011	Web Search	Toolkit	Citywide	Co-leader
Columbus, OH		Strong	Yes	Columbus Northeast Area Plan HIA	2007	Health Impact Project Database	Pilot/Smaller Scope	Area Plan	Co-leader
Billings, MT	Yes	Weak	Yes	South Billings Master Plan HIA	2012	Health Impact Project Database	Full Report	Area Plan	Co-leader
Denver, CO		Strong	Yes	Federal Boulevard Framework Plan HIA	In progress	Health Impact Project Database	Full Report/In progress	Area Plan	Unknown
				South Lincoln Homes HIA	2009	Health Impact Project Database	Full Report	Project	Consultant (data)
				Central Park Boulevard Commuter Rail Station HIA	2012	Health Impact Project Database	Full Report	Area Plan	Stakeholder/audience
				Westerly Creek HIA	2009	Health Impact Project Database	Full Report	Area Plan	Stakeholder/audience
Nashville, TN		Strong	Yes	Urban Agriculture HIA	In progress	Web Search	Full Report/In progress	Policy	Unknown
St. Paul, MN	Yes	Strong	Yes	St. Paul Light Rail HIA	2012	Health Impact Project Database	Full Report	Policy	Technical Advisor
Grand Rapids, MI		Council-Manager	Yes	Michigan Street Corridor Plan HIA	2012	Health Impact Project Database	Full Report	Area Plan	Partner/collaborator
Raleigh, NC	Yes	Council-Manager	Yes	Blue Ridge Road Corridor HIA	2014	Health Impact Project Database	Full Report	Area Plan	Stakeholder/audience
				New Bern Avenue HIA	In progress	Web Search	Rapid	Area Plan	Partner
Portland, OR		Commissioner	Yes	SE 122nd Ave Pilot Project/East Portland	2011	Health Impact Project Database	Full Report	Area Plan	Partner
				West Hayden Island Health Assessment Report	2012	Web Search	Full Report (Health Assessment - draft)	Policy	Partner
Thornton, CO		Council-Manager	Yes	South Thornton Revitalization Subarea Plan HIA	2010	Health Impact Project Database	Full Report	Area Plan	Partner
Honolulu, HI	Yes	Strong Mayor-Strong Council	Yes	Ho'opili Health Impact Assessment	2011	Web Search	Full Report	Project	Consultant
				Gary/New Duluth Small Area Plan HIA	In progress	Health Impact Project Database	Full Report/In progress	Area Plan	Partner
Duluth, MN	Yes	Strong	Yes	6th Avenue East Duluth HIA	2011	Health Impact Project Database	Full Report	Project	Not involved
San Francisco, CA	Yes	Strong	Yes	Eastern Neighborhoods Community HIA (ENCHIA)	2007	Health Impact Project Database	Full Report	Area Plan	Partner
				Western SOMA Community Plan HIA	2009	Health Impact Project Database	Full Report	Area Plan	Partner
				Executive Park Subarea Plan HIA	2007	Health Impact Project Database	Full Report	Area Plan	Consultant
				Treasure Island Community Transportation Plan HIA	2009	Health Impact Project Database	Full Report	Area Plan	Consultant
				Pedestrian Strategy-San Francisco HIA	2013	Health Impact Project Database	Incorporated within planning	Policy	Partner
				Rincon Hill Area Plan HIA	2004	Health Impact Project Database	Rapid	Area Plan	Stakeholder/audience
				Trinity Plaza Housing Redevelopment HIA	2003	Health Impact Project Database	Rapid	Project	Not involved
				Still/Lyell Freeway Channel/Excelsior District	2004	UCLA HIA Clearinghouse	Full Report	Project	Not involved

City	State-Level "little NEPA"	Type of Government	Planners Involved Per Survey	Planning/Land Use/Built Environment Related HIAs	Year Completed	Scan Source	Type of assessment (based on document)	Scope	Role of Planning (based on document)
Pompano Beach, FL	Yes	Council-manager	No	Broward County HIA: Impacts of Allocating Resources toward Access to Healthy Foods Strategies in an Underserved South Florida Community	2012	Health Impact Project Database	Full Report	Policy	Not involved
New Haven, CT	Yes	Strong	No	HIA of Phase I of the Downtown Crossing Project Promoting Pedestrian and Bicyclist Physical Activity and Safety	2012	Health Impact Project Database	Full Report	Project	Advisory committee
Orlando, FL	Yes	Strong	No	Loch Haven Park Improvement Plan HIA	2013	Web Search	Full Report	Project	Not involved
				Parramore Community HIA	In progress	Web Search	Full Report/In progress	Area Plan	Intended audience*
Ann Arbor, MI		Council-manager	No	Urban Forest Canopy as a Climate/Health Adaptation HIA	2014	Health Impact Project Database	Full Report	Policy	Not involved**
Milwaukee, WI	Yes	Strong	No	Milwaukee Estuary – Lincoln Park Area of C oncern Phase II HIA	2012	Web Search	Full Report	Project	Not involved
Wilmington, NC	Yes	Council-manager	No	Comprehensive Greenway Plan HIA	2013	Web Search	Full Report	Area Plan	Partner/collaborator
				Northampton Square Housing HIA	2012	Web Search	Full Report	Project	Not involved
Boston, MA	Yes	Strong	No	Oasis on Ballou HIA	2012	Health Impact Project Database	Full Report	Project	Not involved
San Diego, CA	Yes	Strong	No	San Diego Bus Rapid Transit Station HIA	2013	Health Impact Project Database	Full Report	Project	Not involved
Cincinnati, OH		Strong	No	Interstate 75 Focus Area Study HIA	2010	Health Impact Project Database	Full Report	Area Plan	Consultant
Note: These tables look at cities that responded "yes" to the survey question "Has your city conducted an HIA." This is not comprehensive of HIAs performed by each city; this is based on existing databases and web searches for HIAs or equivilant that deal with urban planning/land use issues that directly impact the city									
*This HIA was announced in January 2014. Not clear if planning department will play a role.									
**University of Michigan Urban Planning students were part of the project team									

City	State-Level "little NEPA"	Type of Government	Notes
The following indicated that an HIA had been conducted in their city but I could not find evidence and the survey respondent did not authorize follow-up communication			
St. Louis, MO		Strong mayor but shares contracting authority	The Page Avenue HIA was conducted in Pagedale, an inner ring suburb of St. Louis but no indication that either the public health or planning departments of the city of St. Louis was involved
Las Vegas, NV		Council-manager	The survey indicated an HIA was conducted or is in process for a private development project but could find no indication through web searches
Green Bay, WI	Yes	Strong	Not much information was provided in the survey to support the "yes with planning" response; no indication of city of Green Bay involvement in an HIA, with or without planning, was found in web searches
Des Moines, IA		Council-manager	No indication of city of Des Moines involvement in an HIA, with or without planning, was found in web searches
The following indicated that an HIA had been conducted in their city but further research could find no specific indication and warrants the possibility that they are using a different definition of Health Impact Assessment			
Peoria, IL		Council-manager	Peoria County Community Health Needs Assessment (out of Peoria City/County Health Department, used comprehensive plan as input)
Deltona, FL		Weak	Volusia County Community Health Assessment
Avondale, AZ		Council-manager	Healthy Community Design Toolkit: Avondale's general plan was used for model language and HIA was promoted throughout (Maricopa County has conducted several HIAs but not within Avondale)
Federal Way, WA	Yes	Strong	HIA specifically was not found but Federal Way is using Communities Putting Prevention to Work grant to work on a Bicycle and Pedestrian Master Plan, Twin Lakes Commercial District Subarea Plan, and policies to encourage healthy eating
Warwick, RI		Strong	HIA specifically was not found but there is a neighborhood health differentials assessment for the City of Warwick from the Rhode Island Department of Health
Fontana, CA	Yes	Weak	HIA specifically was not found but Health Risk Assessment is required by CEQA as part of EIR (as noted in the survey response)

APPENDIX F: EMAIL OUTREACH INTERVIEWS: ADDITIONAL CITIES

Email subject: Interview request: follow-up from planning and public health research survey

Dear [Name],

Thank you for taking my survey on the integration of public health into city planning processes, specifically through the use of HIA, last fall. Attached is a preliminary summary of the results from the survey – I had a great response! Hopefully this information can be useful in your own work in [city].

In the next phase of my research, I will be conducting case studies of select cities where the planning department has been engaged in HIAs, and of cities that have *not* yet engaged planners in HIAs.

Since your department has not yet been involved with an HIA, I would like to hear your perspectives on the potential of this method and also learn about other forms of collaboration between public health and land use planners in [city]; OR Since your department has been involved with an HIA, I would very much like to learn about your experience with that process and your perspectives on the potential of this method.

I'm hoping to interview 2-3 staff members from the planning department and 1-2 from your county public health department who work together on issues of health, land use, and the built environment.

Would you have some free time in the next few weeks for a follow-up interview with me? Your experience and perspective would significantly strengthen this study and further my own understanding of processes of collaboration associated with public health and planning. Also, could you recommend others on the planning staff and in the health department who I could speak with about this topic?

I will contact you via phone in the next week to follow up on this email. Thank you in advance for your time and invaluable assistance with this project, which I hope will be of much utility for everyone seeking to improve the health of our cities.

Best Regards,

Sara Hammerschmidt
Associate, Urban Land Institute Building Healthy Places Initiative
PhD Candidate, Community and Regional Planning
The University of Texas at Austin
saramh@mail.utexas.edu

APPENDIX G: INTERVIEW QUESTIONS: ADDITIONAL CITIES

Seattle, WA and Columbus, OH; (planners have been involved in HIA)
Orlando, FL and Cincinnati, OH (planners have not been involved in HIA)

Interviews with Planning Departments

Theme 1: What is the significance of different aspects of collaboration, between whom (history, current, interdisciplinary staff)?

1. What is your position within the department? Do your responsibilities require collaboration with other departments?

2. Are there certain specializations within the planning department that primarily work with the health department on land use issues?

3. In what ways do planning and public health work together?
    a. How often would you say that collaboration between the two departments occurs and on what types of project?
    b. Who initiated this collaboration? Have there been any obstacles?
    c. Has there been any mandate from elected officials to collaborate, was it grassroots (staff desire), or another reason?
    d. Has your planning department embraced public health as a goal or initiative of the department?

4. How do you think relationships between the two departments can best be maintained?
    a. Are there any personal relationships that you are aware of that have formed between planning and public health that is helping maintain connections between the departments?
    b. What happens when the advocates within the departments move on?
    c. Are processes working to be institutionalized or maintained in some way? Is this a concern in your city?

Theme 2: How/to what extent did the Health Impact Assessment serve as a driver of health/planning integration (as theory, as planning method, for agenda setting)?

5. What can you tell me about Health Impact Assessments conducted in your city? What do you consider to be a Health Impact Assessment? What types of HIA have you conducted (desktop, rapid, full, integrated within other types of impact assessment)?

    a. Who initiated the HIA process (what department, staff desire, grassroots efforts, directive)?

b. What role did planning play? (if Seattle, Columbus, Duluth) If planning did not play a role (if New Haven, Orlando, Cincinnati), were you approached to?
c. Are you currently conducting any HIAs?
d. Do you have any other thoughts on the use of HIA? (e.g. best used as a initiator of collaboration, used on all projects through full integration/mandate, used only on "big projects" with a major question needing to be answered)

6. For Seattle, Columbus, Duluth: What would you say has been the most successful and the most challenging thing about involving planners in HIA processes? [For example, improved community engagement; improved communication between departments; expedited review processes; pushback from development community; challenges getting community input; challenges with collaboration] How were the challenges negotiated?
    a. Did the HIA lead to better integration of health in planning?

7. What do you think is the biggest success and biggest challenge with planning and health integration in your city, either within an HIA process or other forms of collaboration?

Theme 3: To what extent has "health" in general become infused into planners' daily work and thinking in recent years, and why/why not?

8. San Francisco is seen as a leader in public health and planning integration, but current and former planners do not feel that the department has embraced public health as a responsibility or goal of planning – there isn't much conversation about health within the department. Does that also ring true in your city? What are your opinions on the ability of health to become an overarching goal for planning, akin to sustainability?
    a. What do you understand health to mean in relation to the built environment and land use? How do you think health is thought of within your department?

9. My survey found that type of government is correlated to whether or not a city has done an HIA. How does the government in your city impact (positively or negatively) integration of health concerns into planning/land use? BOTH in terms of thinking and talking about health, and actually incorporating health in planning practice. How much is the integration of health issues into planning driven by demands from other stakeholders (the public, civil society organizations, departments, etc.)?

10. What do you think it would take to make public health a major part of the agenda of the entire planning department in your city? (e.g. directives, community support, resources, staff desire) Would it work best to come from the top down or the bottom up?

a. What does a successful collaboration or integration of health and planning look like to you?
b. Are other issues in the planning department are prioritized over public health? Which ones?

11. In what ways do you see the planning *profession* in general as having the ability to be more integrated with public health issues?
    a. How do you see education playing a role in the integration of health issues with planning? Is this a concern or consideration for your department?

12. Do you have any planning documents that consider or incorporate health that you could send me?

Interviews with Public Health Departments

Theme 1: What is the significance of different aspects of collaboration, between whom (history, current, interdisciplinary staff)?

1. What is your role within the health department, specifically as it relates to working with planning/working on land use issues?

2. Are there certain specializations within the planning department that the health department primarily works with on land use issues?

3. In what ways do planning and public health work together?
    a. How often would you say that collaboration between the two departments occurs and on what types of project?
    b. Who initiated this collaboration? Have there been any obstacles?
    c. Has there been any mandate from elected officials to collaborate, was it grassroots (staff desire), or another reason?
    d. How do you, in the health department, view the role of the planner within the integration of land use/built environment issues and public health?

4. How do you think relationships between the two departments can best be maintained?

5. If a county health department: As you are responsible for a number of cities, how does that impact the ability to collaborate with specific city planning departments? Are there any characteristics of cities, or planning departments, that facilitate collaboration?

Theme 2: How/to what extent did the Health Impact Assessment serve as a driver of health/planning integration (as theory, as planning method, for agenda setting)?

6. What can you tell me about Health Impact Assessments conducted in your city?What types of HIA have you conducted (desktop, rapid, full, integrated within other types of impact assessment)?
    a. Who initiated the HIA process (what department, staff desire, grassroots efforts, directive)?
    b. What role did planning play? (if Seattle, Columbus, Duluth) If planning did not play a role (if New Haven, Orlando, Cincinnati), did the health department reach out to try to engage them at the onset?
    c. Are you currently conducting any HIAs?
    d. Do you have any other thoughts on the use of HIA, primarily with the engagement of planning? (e.g. best used as a initiator of collaboration, used on all projects through full integration/mandate, used only on "big projects" with a major question needing to be answered)

7. For Seattle, Columbus, Duluth: What would you say has been the most successful and the most challenging thing about involving planners in HIA processes? [For example, improved community engagement; improved communication between departments; expedited review processes; pushback from development community; challenges getting community input; challenges with collaboration] How were the challenges negotiated?
    a. Did the HIA lead to better integration of health in planning?

8. What do you think is the biggest success and biggest challenge with planning and health integration in your city, either within an HIA process or other forms of collaboration?

Theme 3: To what extent has "health" in general become infused into planners' daily work and thinking in recent years, and why/why not?

9. San Francisco is seen as a leader in public health and planning integration, but current and former planners do not feel that the department has embraced public health as a responsibility or goal of planning – there isn't much conversation about health within the department. Does that also ring true in your city/county?
    a. What do you understand health to mean in relation to the built environment and land use?

10. My survey found that type of government is correlated to whether or not a city has done an HIA. How does the government in your city impact (positively or negatively) integration of health concerns into planning/land use? BOTH in terms of thinking and talking about health, and actually incorporating health in planning practice. How much is the integration of health issues into planning driven by demands from other stakeholders (the public, civil society organizations, departments, etc.)?

11. What do you think it would take to make public health a major part of the agenda of the entire planning department in the city/cities you work with? (e.g. directives, community support, resources, staff desire) Would it work best to come from the top down or the bottom up?
    a. What does a successful collaboration or integration of health and planning look like to you?

12. In what ways to do you see the public health profession in general as having the ability to be more integrated with planning/land use issues?
    a. How do you see education playing a role in the integration of health issues with planning? Is this a concern or consideration for your department?

Nationwide Survey of Planning Directors on Public Health and Planning

This document presents findings from a nationwide survey looking at the inclusion of health concerns within city planning activities. These findings are still preliminary and may not be reproduced without explicit consent of the researcher.

Survey Overview and Key Findings

In October and November of 2013, a survey of planning directors and planning staff in medium to large sized cities across the country (population of 75,000 and greater per the 2010 Census) was conducted using the Survey Gizmo survey tool. 433 surveys were emailed out with 429 received (4 were continuously rejected by email servers). 145 surveys were completed, though upon scrutiny of the data some responses were thrown out for certain questions (noted with N values in the analysis below). The objective of the survey was to collect information on a variety of facets regarding the inclusion of health concerns in city planning activities, including:

- perceptions of top health and built environment issues facing the community;
- characteristics of current or past collaboration between the planning department and the city, county, or state health department;
- necessary resources for the inclusion of health within planning processes;
- barriers to the inclusion of health within planning processes; and
- the use of Health Impact Assessment as a tool to objectively analyze health impacts of proposed projects, policies, or plans.

The final survey response rate was 33.8%. The Demographics of Respondent Cities section below provides more details on response rate and characteristics of responding and non-responding cities.

Overwhelmingly, **obesity/diabetes, increasing physical activity, healthy food access, and crime/safety** were chosen as one of the top three public health issues perceived to be faced by the respondent's community. With the exception of crime/safety, the issues chosen are fairly "trendy" current public health issues, and crime and safety is an ongoing issue. Not to say that these are not the real issues facing the communities but perceptions of respondents could be impacted by national public health trends. Also overwhelmingly, **access to transit, access to goods and services, and affordable housing** were chosen as the top three built environment issues (over brownfields and green/healthy housing).

When asked about *ways* planners are addressing (if at all) the built environment and health issues, 80% responded they were addressing them in comprehensive or general plans and 71% responded they considered them within plan or project implementation. About 7% responded that planners in their cities do not engage in work that considers health issues: respondents may have self-selected into this survey based on their interest or experience with health issues.

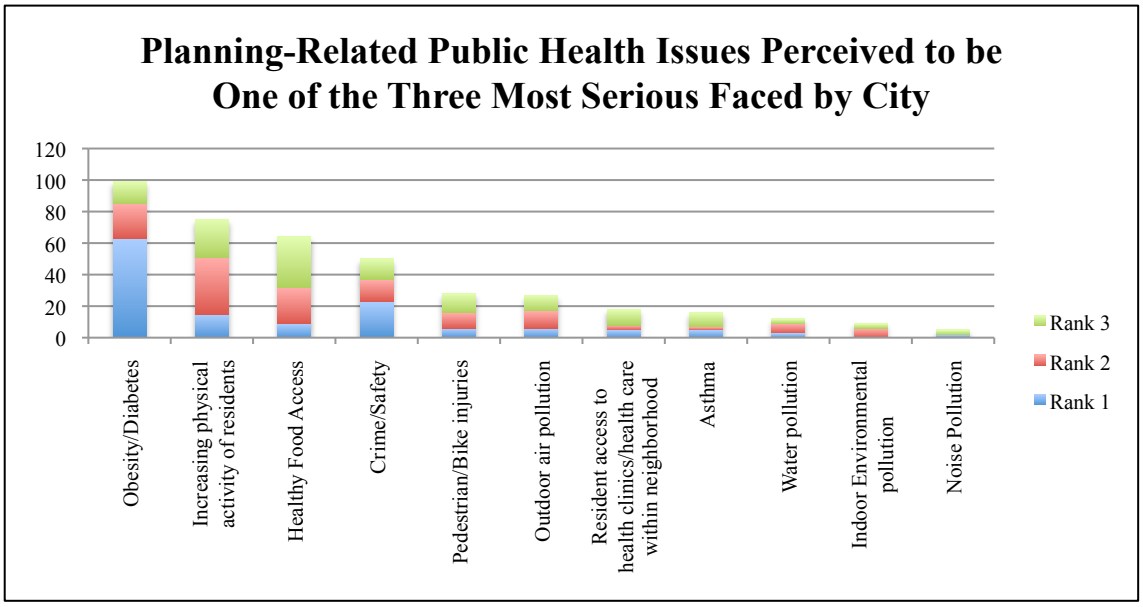
When looking at external groups or entities that have influenced the incorporation of public health into planning departments' activities and goals, local groups were selected the most often: other city departments (external to health or planning) (76.6%); local health department (74.5%); health focused organizations external to city government (69.7%); general public (68.3%); and local/regional community organizations (66.2%). Sixty percent of cities responded that there is some form of current collaboration between the planning department and the responsible health department.

In terms of Health Impact Assessment specifically, nearly 76% of responding cities answered that they have not conducted an HIA or they did not know if their city had conducted an HIA. This complements the literature that suggests that HIA as a process is not yet as successful as it has become in Europe and Australia. 14.5% of survey respondents indicated that their planning department has been involved in an HIA. When asked what department(s) lead HIAs, planning was selected most frequently (57%). 48% responded that public health also leads, and 29% responded that an external organization leads. The majority of these HIAs (71%) were initiated on a voluntary basis, and the majority (62%) were performed within planning processes.

Detailed Findings

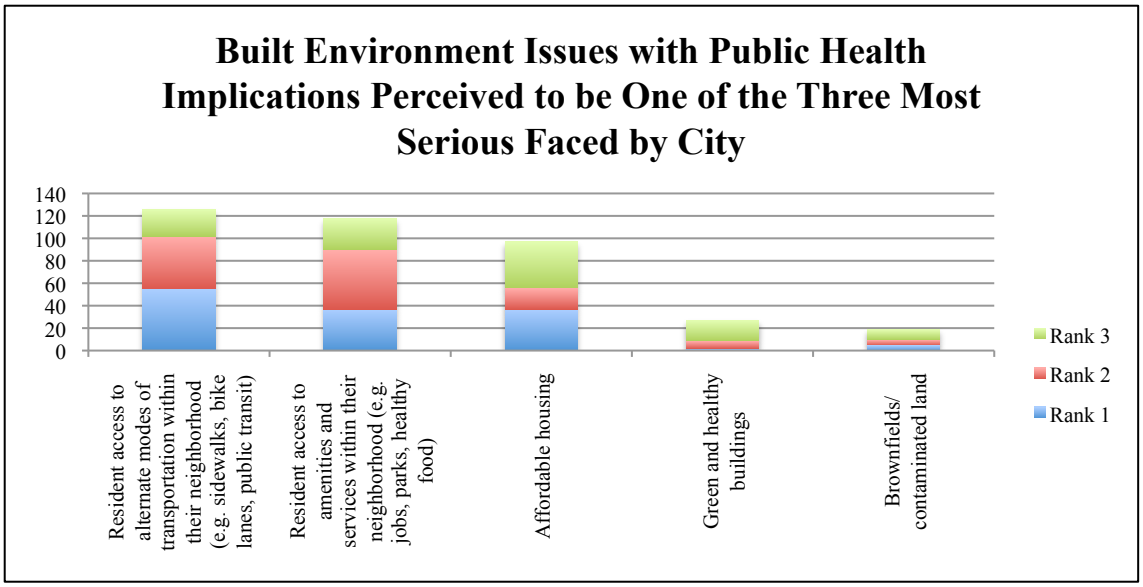
Perceptions of health/built environment issues facing community

Obesity/diabetes, increasing physical activity, healthy food access, and crime/safety were overwhelmingly chosen by respondents as one of the top three public health issues perceived to be faced by the community.



N = 139

Access to transit, access to goods and services, and affordable housing were overwhelmingly chosen by respondents as the top three built environment issues perceived to be faced by the community.



N = 139

Addressing health/built environment issues within cities

When asked whether any government or non-profit agency was addressing any of the public health/built environment issues, the issues selected the most often (greater than 50%) were:

Issue addressed by gov't/non-profit	Number/percent selected
Access to alternate modes of transportation	115 (83.9%)
Crime/safety	113 (82.5%)
Affordable housing	107 (78.1%)
Increasing physical activity of residents	95 (69.3%)
Healthy food access	88 (64.2%)
Access to amenities/services	88 (64.2%)
Obesity/diabetes	83 (60.6%)
Water pollution	79 (57.7%)
Pedestrian/bike injuries	73 (53.3%)

N = 137

The issues least selected (~30% or below) were:

Issue addressed by gov't/non-profit	Number/percent selected
Indoor environmental pollution	44 (32.1%)
Asthma	39 (28.5%)
Noise pollution	34 (24.8%)

N = 137

Issues selected most frequently (over 70%) are typical issues facing cities today that also have serious health implications (access to alternate modes of transportation, crime/safety, and affordable housing). The trend appears to be switching away from more environmental focus of pollution and brownfields; though the question asked to select all, perhaps these more environmental issues are not as much on planners'—or government agencies' and local non-profits'—radar in general.

In terms of number of issues selected as being addressed by city government or non-profits, on average 27% of respondents chose between 5 and 8 issues, 27% chose between 9 and 12 issues, and 25% chose between 13 and 16 issues.

When asked whether the planning department was specifically addressing any of the public health/built environment issues, the issues selected the most often (greater than 50%) were:

Issue addressed by planning dept.	**Number/percent selected**
Access to alternate modes of transportation	127 (88.2%)
Access to amenities/services	108 (75%)
Affordable housing	90 (62.5%)
Pedestrian/bike injuries	73 (50.7%)
Increasing physical activity	72 (50%)

N = 144

The issues most often addressed are the more typical planning issues that also relate to transportation and land use. In general, responses indicated fewer issues being specifically addressed by planning departments. The issues selected the least often (30% or below) were:

Issue addressed by planning dept.	**Number/percent selected**
Obesity/diabetes	32 (22.2%)
Outdoor air pollution	29 (20.1%)
Noise pollution	25 (17.4%)
Access to health care	24 (16.7%)
Indoor environmental pollution	19 (13.2%)
Asthma	7 (4.9%)

N = 144

Ways Planning Departments are Incorporating Health

Though health issues such as asthma, obesity/diabetes, and pollution exposure may not be *directly* addressed by planning departments, there is indication that at least general concerns of public health are being included within planning. When asked about *ways planners are addressing (if at all) the built environment and health issues* the following responses were given:

Way planning department considers health	Number/percent selected
Addressing public health topics in general or comprehensive plans	113 (77.9%)
Considering public health topics within implementation of plans or projects	103 (71%)
Addressing public health topics in zoning codes	71 (49%)
Conducting impact assessments (e.g. health, environmental, social)	41 (28.3%)
Planners in my city do not engage in work that considers public health issues	10 (6.9%)
Adoption of a public health ordinance or framework for planning processes	5 (3.4%)

N = 145

A very small number (under 7%) responded that planners in their cities do not engage in work that considers health issues: respondents may have self-selected into this survey based on their interest or experience with health issues. The majority of respondents indicated that public health is addressed within general or comprehensive plans and/or within implementation of plans or projects.

Prioritization of Public Health by City Government

When asked about *ways public health is considered a priority within cities by government officials*, provided responses were not selected as frequently in general as with other questions. The low response rates may indicate that respondents either were not certain of how health is prioritized or that city governments in general are not frequently prioritizing public health concerns into overall city efforts (though also not specifically stating that health is not a priority).

- The most frequently selected response was "inclusion in other city documents" (48%), which could include comprehensive or general plans.
- 17% indicated "other", which included things such as different types of city public health initiatives (food-related issues came up several times), funding and resources, and partnerships with health professionals.

Ways health is prioritized by government officials	Number/percent selected
Inclusion in other city documents	62 (48.1%)
Inclusion in city mission statement	32 (24.8%)
Other	22 (17%)
Don't know	21 (16.3%)
Used as a metric for prioritizing municipal capital projects	16 (12.4%)
Adoption of a city-wide health ordinance or framework	14 (10.9%)
Public health is not considered a priority within my city	14 (10.9%)

N = 129

External influences of health considerations

When looking at external groups or entities that have influenced the incorporation of public health into planning departments' activities and goals, local groups were selected the most often. Planning and health departments in other cities do not appear to be great influences over local planning department health-activities. The media and property developers are also not reported as large influences.

External influence	Number/percent selected
Other departments within city government	111 (76.6%)
City, county, and/or state health department	108 (74.5%)
Health-focused organizations external to city government	101 (69.7%)
The general public	99 (68.3%)
Local or regional community organizations	96 (66.2%)
Planning departments in other cities	47 (32.4%)
The media	36 (24.8%)
Real estate/property developers	26 (17.9%)
Health departments in other cities	16 (11%)

N = 145

Resources for health considerations in planning departments

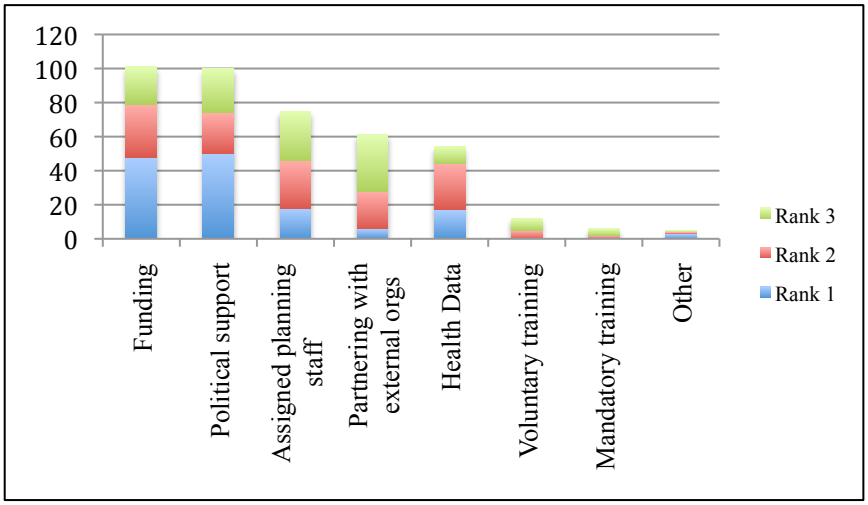
When asked about available resources to support planning department efforts to include public health considerations, none of the choices were overwhelmingly selected (in total). External partnerships, health data, funding, voluntary training opportunities, and political support were reported as the most available resources.

Available resources to consider health in planning efforts	Number/percent selected
Partnerships with external organizations	79 (54.9%)
Quantitative or qualitative community health data	70 (48.6%)
Funding (e.g. grants, state or local funding, private donations)	62 (43.1%)
Voluntary training opportunities on health related issues	61 (42.4%)
Political support	60 (41.7%)
Assigned planning staff to work on public health issues	39 (27.1%)
Mandatory training opportunities on health related issues	6 (4.2%)
Other	6 (4.2%)

N = 144

The top three most critical resources that respondents believe are necessary to have in order to consider health within planning processes (% listed within top three):

- Funding (71.1% listed in top three)
- Political support (70.4% listed in top three)
- Assigned planning staff (52.8% listed in top three)

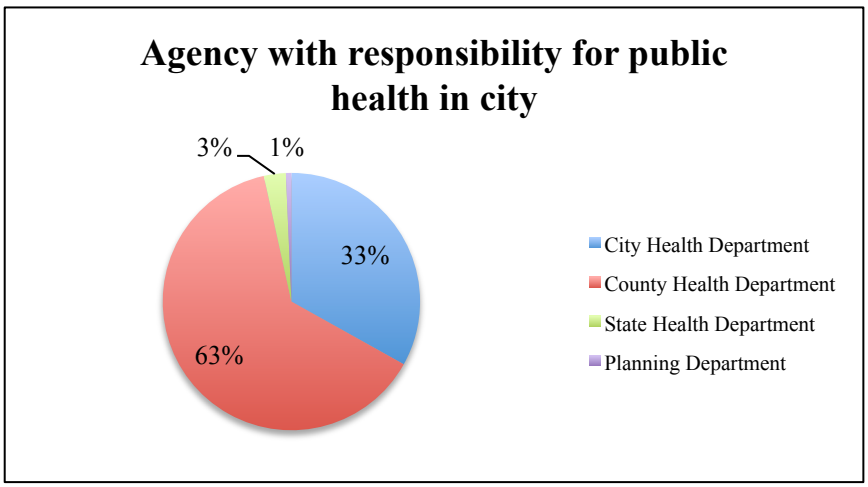


N = 142

Respondents indicated that they need assigned planning staff in order to include health issues within planning activities, but also indicated that, in general, they do not have assigned planning staff (25.7% have assigned staff vs. 52.8% see it as critical). This could indicate de-prioritization of public health versus other issues.

Location of health department with responsibility for city

The majority of respondents (96%) indicated that either a city (33%) or county (63%) health department assumes primary responsibility for health issues within their city.

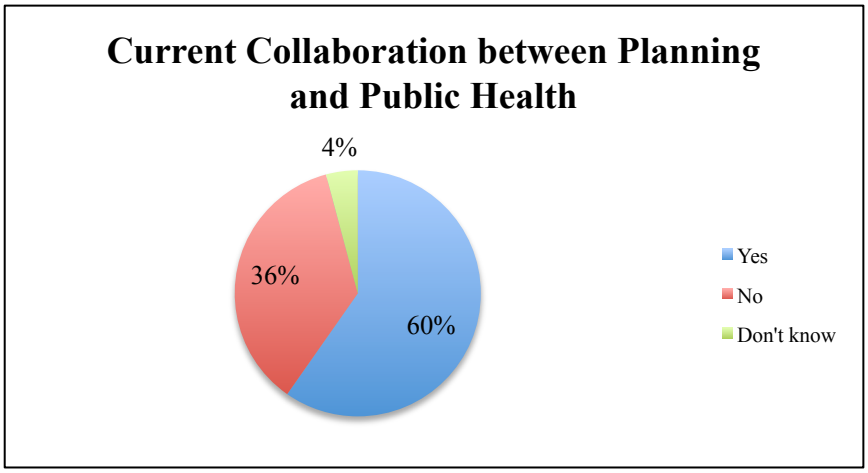


N = 145

Collaboration between planning and public health

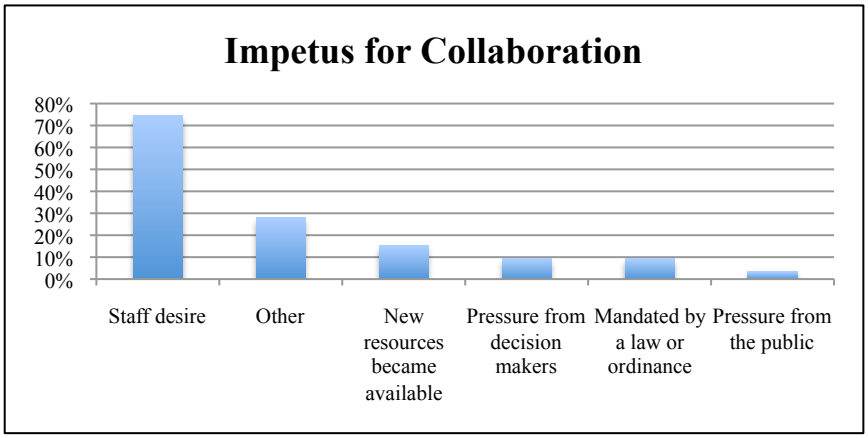
Characteristics of Current Collaboration

When asked about any current collaboration between planning department and responsible health department, 60% of cities responded yes and 36% responded no.

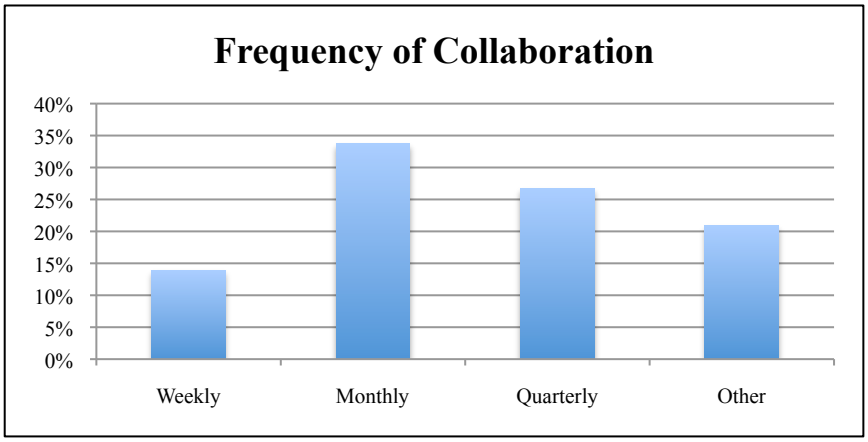


N = 144

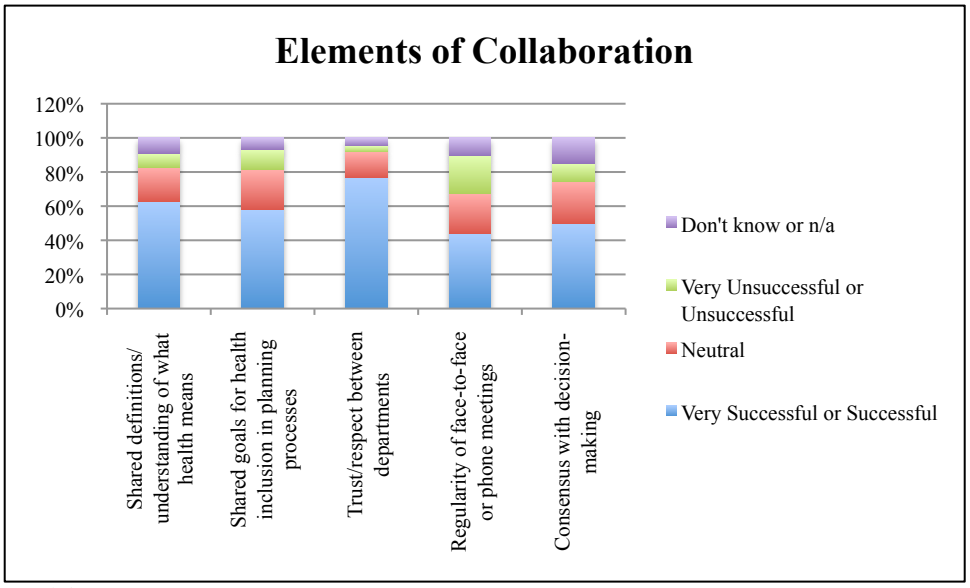
Of the "yes" responses (N = 86), the most frequently selected response for the impetus for this collaboration was staff desire (nearly 75% selected that option). Communication frequency varied widely as well, with monthly and quarterly communication selected the most often. This is indicative of more "one-off" communication between planning and public health on a project-by-project or plan-by-plan basis, rather than regular public health involvement in planning activities. A series of elements of collaboration between public health and planning were also found to be generally successful. Trust/respect between departments was rated the most successful (77% Successful or Very Successful); regularity of meetings was rated the least successful (22% Unsuccessful or Very Unsuccessful).



N = 86; Most frequent "Other" responses included collaboration during comprehensive/area planning processes, partnerships with external organizations, and health department initiation or funding.



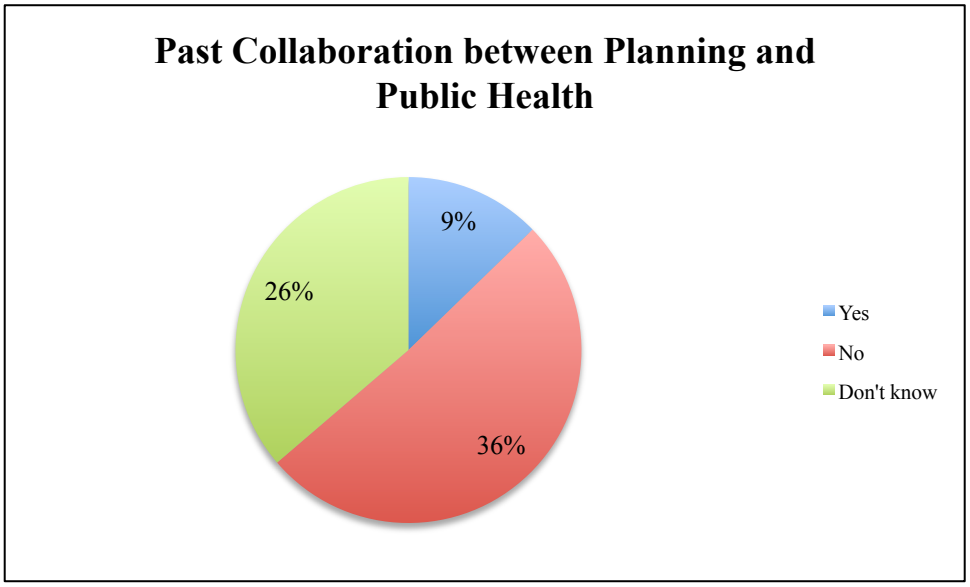
N = 86; Most frequent "Other" responses included as-needed or episodically, annually, and irregularly.



N = 86

Past Collaboration

Few respondents (N = 13) indicated that they were aware of past collaboration between public health and planning that had been suspended. Reasons for this suspended collaboration included changing priorities, completion of a project, and the end of grant funding.

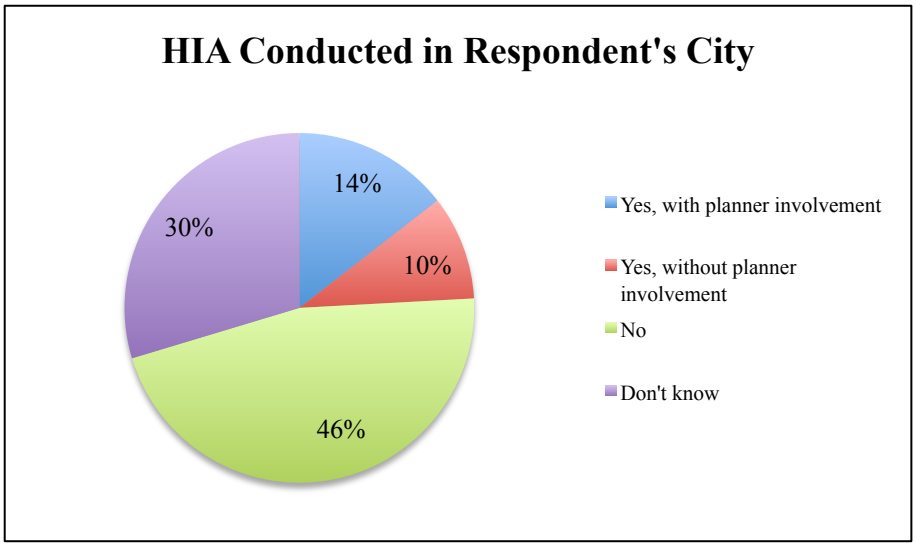


N = 145

Inclusion of Planners in Health Impact Assessment

Over 14% of survey respondents (N = 21) indicated that their planning department had been involved in a Health Impact Assessment (HIA). Nearly 10% (N = 14) indicated that their city had conducted or been involved in an HIA, though the planning department was not involved. This low percentage is in accordance with planning and public health literature that indicates that HIA as a process is still not widely adopted in the United States.

A rather high percentage (nearly 30%, N = 43) indicated that they did not know if an HIA had been conducted; this could be explained by a number of factors including level of familiarity with HIA and connectedness to the city as a whole to know whether or not any other department has conducted an HIA.

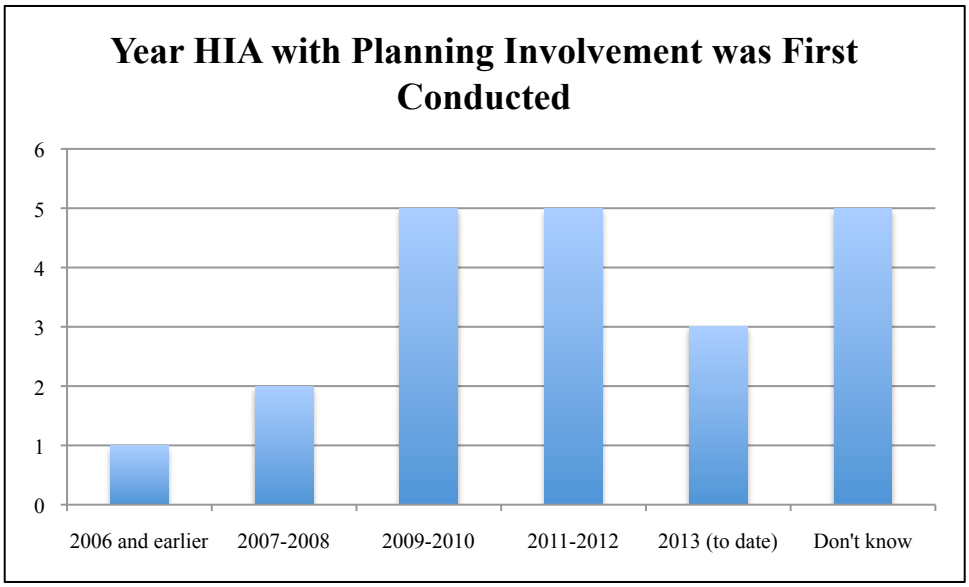


N = 145

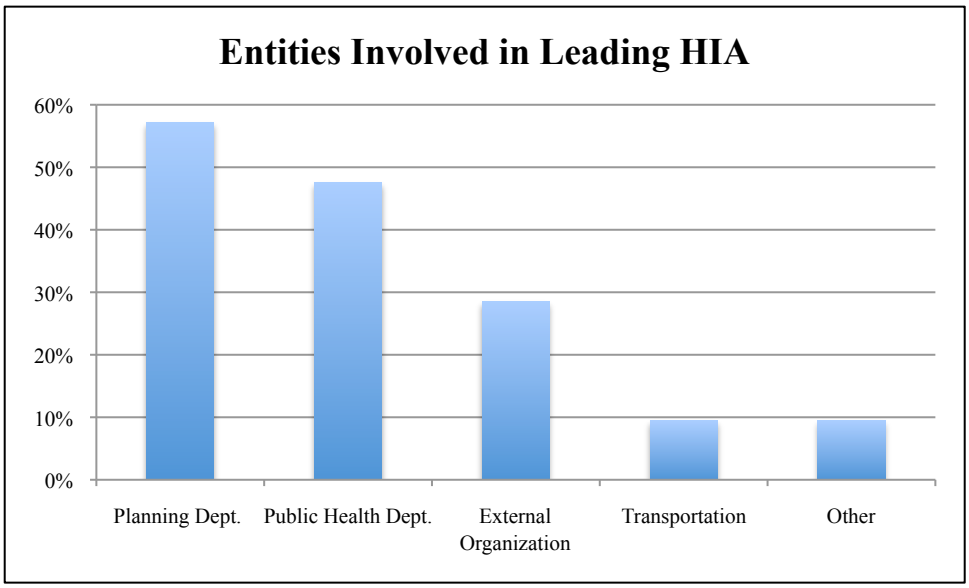
The following charts and bullets apply to the 14% (N = 21) who indicated that at least one HIA had been conducted with the involvement of the planning department. This dataset indicates that HIA is starting to become a more utilized tool, used primarily on city, regional, or area plans, and largely initiated on a voluntary basis.

- In more recent years, more planning departments started engaging in their first HIA (13 of the 21 were started in 2009 and later).
- When asked what department(s) lead HIAs, planning was selected most frequently (57%). 48% said public health also leads, 29% said an external organization. Five cities (24% of respondents) indicated that planning and public health are both involved in leading HIA, and five other cities indicated that planning alone leads HIA. The latter finding warrants scrutiny, as typically land use-related HIAs are joint efforts between multiple departments or organizations.

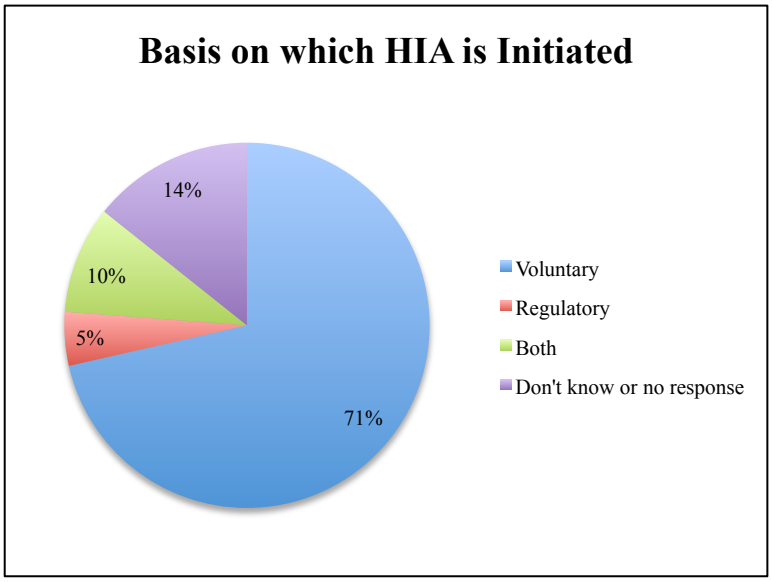
- The majority (71%) of HIAs were initiated on a voluntary basis.
- The majority (62%) of HIAs were performed within planning processes; 33% were performed on public projects; 24% were performed on local/state policies and private projects.
- Responses were fairly evenly split on scale of HIA – block or neighborhood scale was the most common (52%), followed by city or regional scale (43%), and individual project scale (38%).



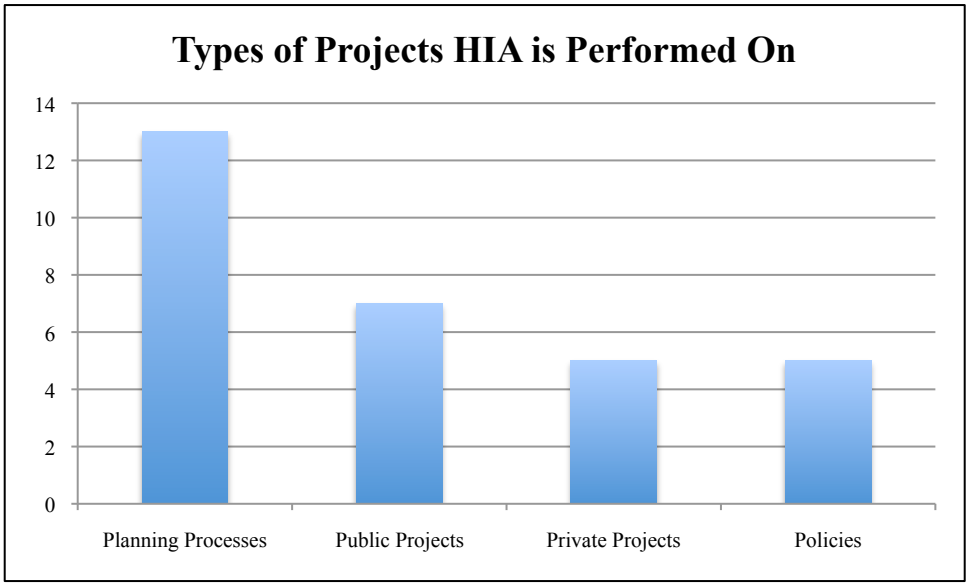
N = 21



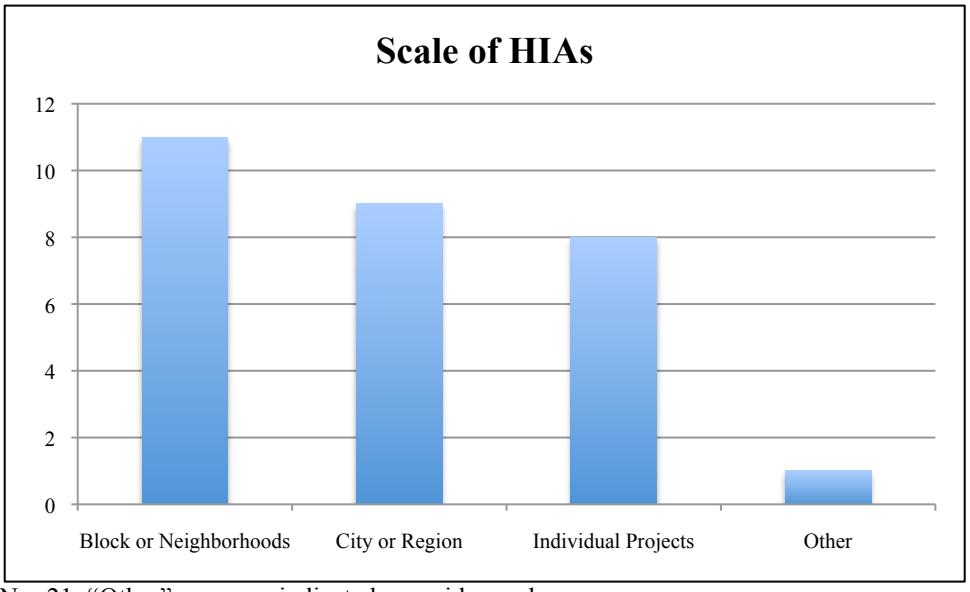
N = 21


Basis on which HIA is Initiated
14%
10%
5%
71%
Voluntary
Regulatory
Both
Don't know or no response

N = 21


Types of Projects HIA is Performed On
14
12
10
8
6
4
2
0
Planning Processes
Public Projects
Private Projects
Policies

N = 21



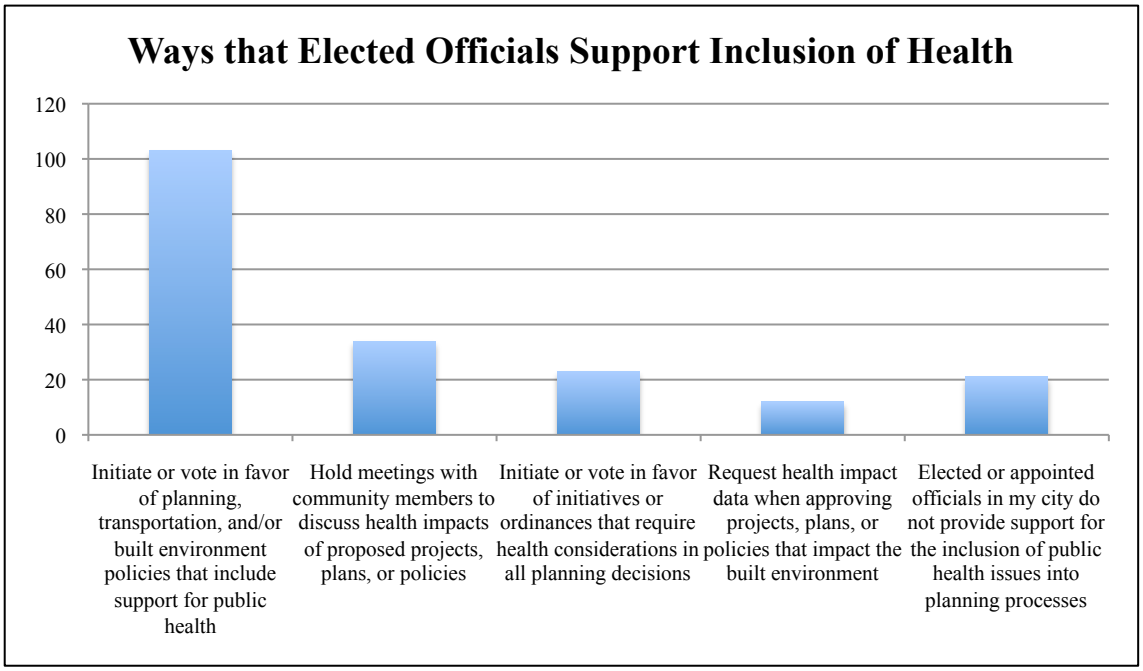
N = 21; "Other" response indicated a corridor scale

Support for and Barriers of the Inclusion of Public Health into Planning

Elected Officials, Public Health, and Planning

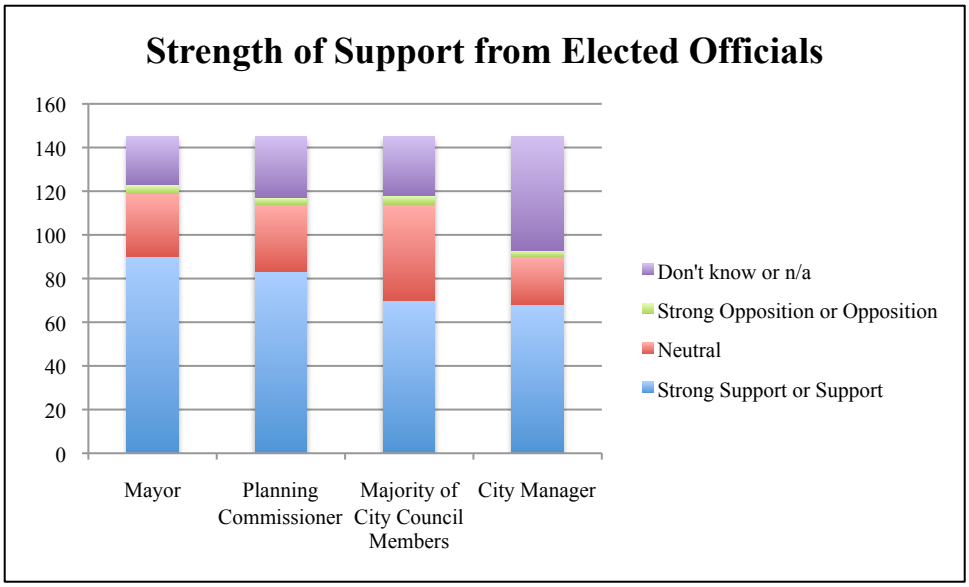
When asked how elected officials show support for the inclusion of public health into planning:

- 73% (N = 103) indicated they initiate or vote for policies that include support for health
- 24% (N = 34) indicated they hold public meetings (2nd most selected)
- 15% (N = 21) indicated no support for the inclusion.



N = 142

Perceived strength of support from elected officials was generally very favorable. Mayors and Planning Commissioners were perceived to be largely supportive (62% and 57%, respectively, selected Strong Support or Support). There is very little perception of opposition to the inclusion of health in planning processes from elected officials.

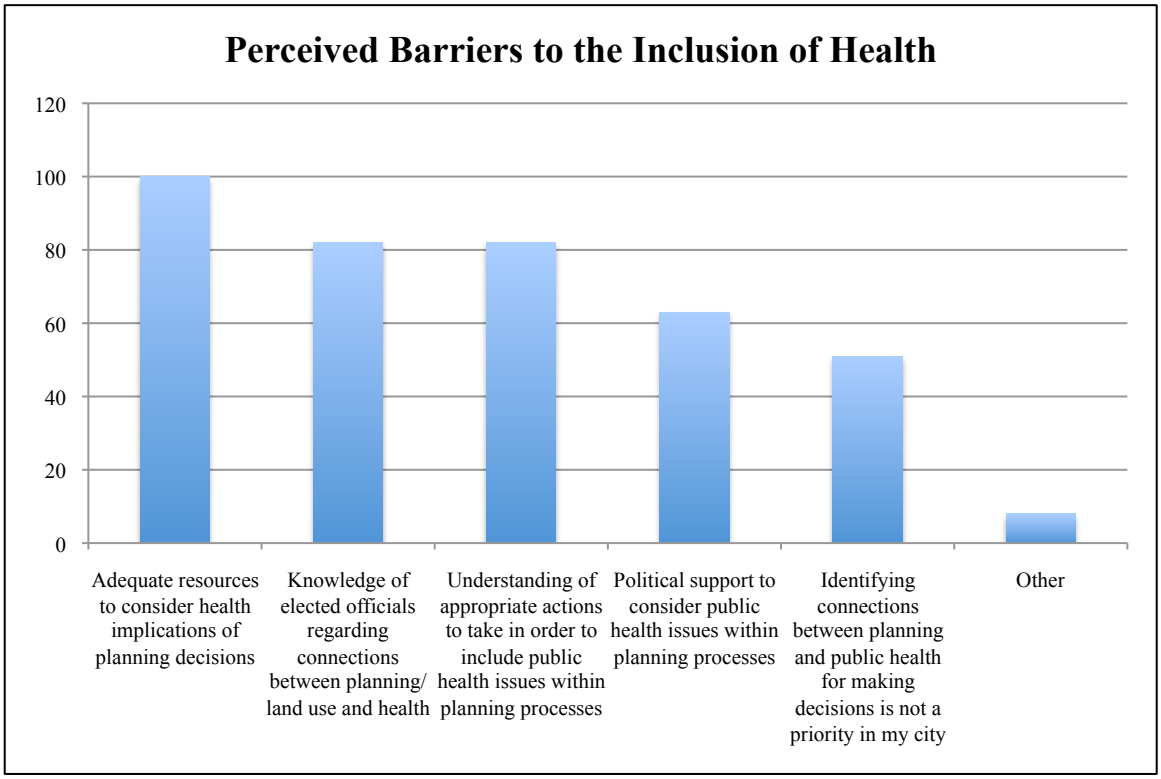


N = 145

Barriers to Public Health inclusion in Planning

When asked about barriers to public health inclusion in their cities, top responses were:

- Adequate resources (69%)
- Knowledge of elected officials on connections between health and planning/land use (57%); and
- Understanding of the appropriate actions to take in order to include public health within planning processes (57%)

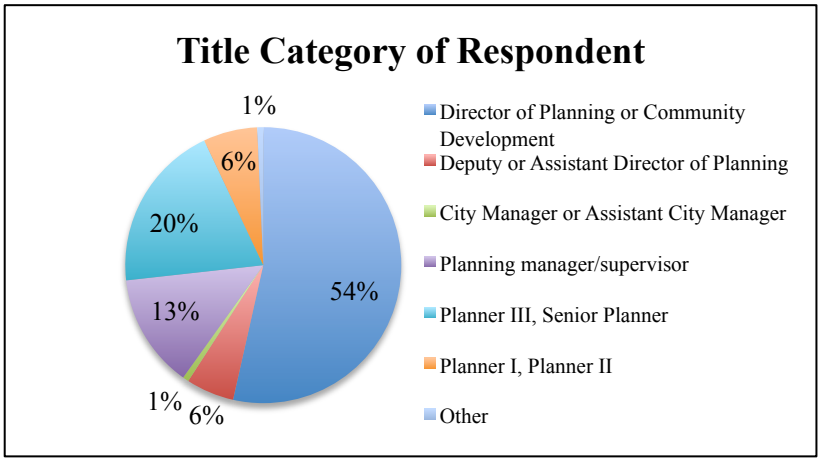


N = 143; "Other" barriers included lack of localized health data, private sector opposition, conflicts between state and local agencies, and lack of specific resources (funding and staff)

Demographics of Respondents and Cities

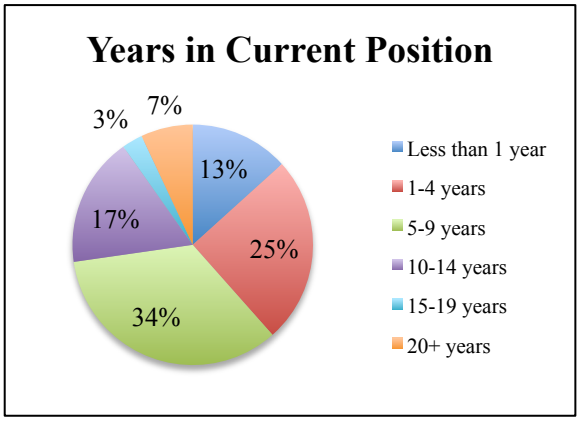
Characteristics of survey respondents

The majority of respondents (74%) were at a managerial or director level.

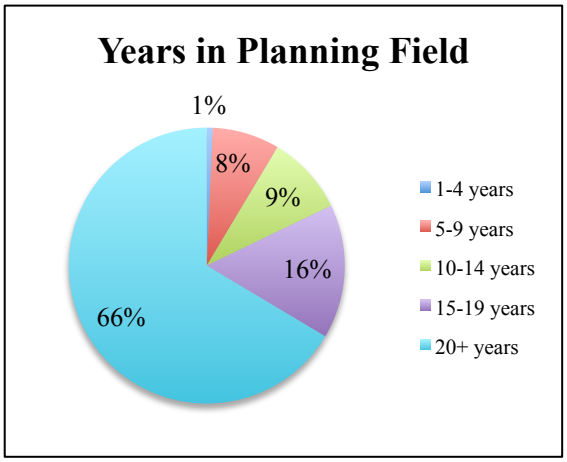


N = 142

The median number of years the respondent has been in his/her current position was 6 years.
The median number of years the respondent has been in the planning field was 25 years.

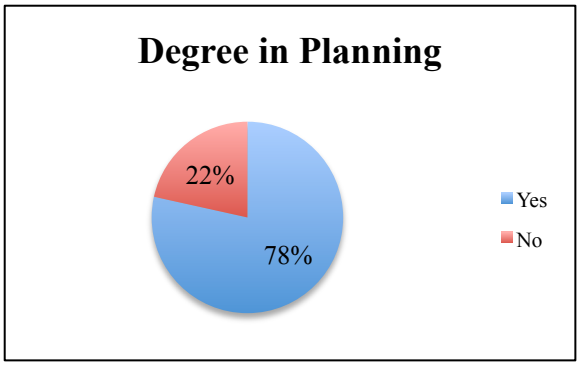


N = 143

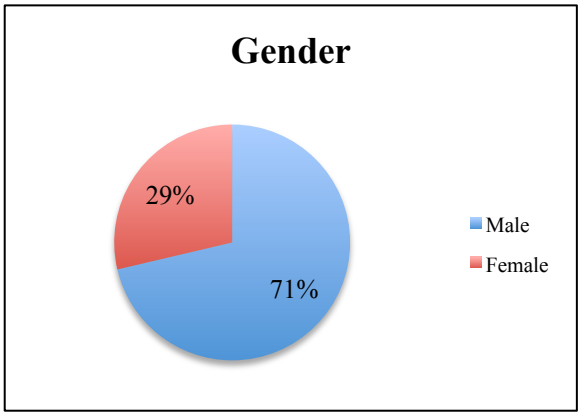


N = 140

78% of respondents have a bachelors, masters, or doctoral degree in planning.
71% of respondents were male.

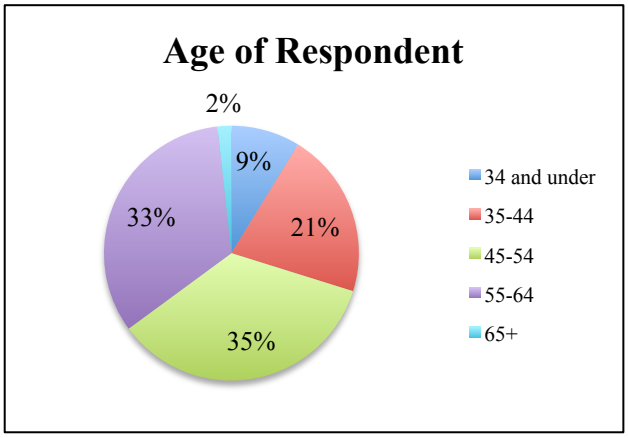


N = 144



N = 136

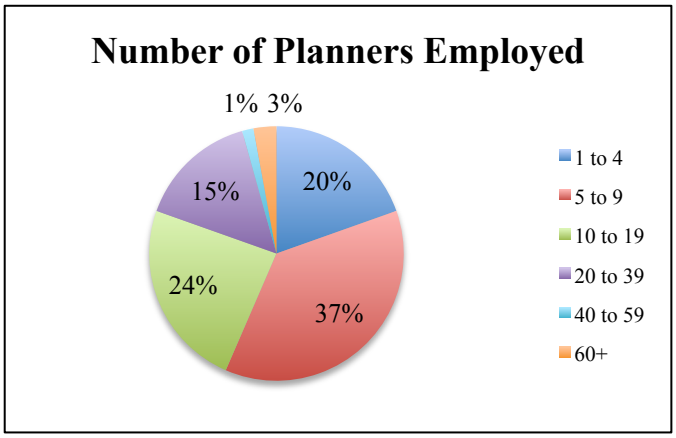
The median age of the respondents who provided this data was 50.5 years.



N = 114

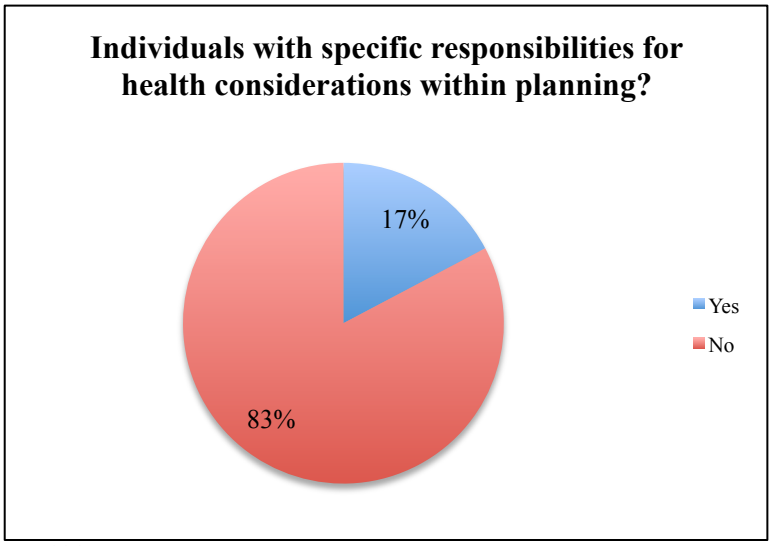
Characteristics of planners, planning departments, and city government structure in responding cities

The median number of planners employed was 8.
60% (N = 139) responded that their planning department is organized by specialization. Of the departments that are organized by specialization, 87% (N = 72) responded that there are certain specializations that are tapped to work with the health department.



N = 138

83% responded that their department does *not* have individuals whose specific responsibilities include considering health within planning.

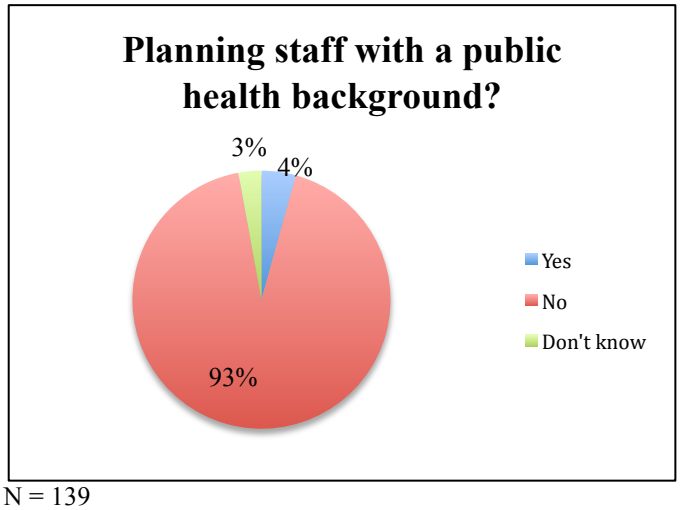


N = 139

# of planners	# of responses
1	10
2	6
3	1
4	2
5 or more	4
No response	1

Of the 24 "yes" responses (17%), nearly 70% indicated that one or two planners in their department have specific responsibilities for considering health.

93% responded that none of their planners on staff have a background in public health.

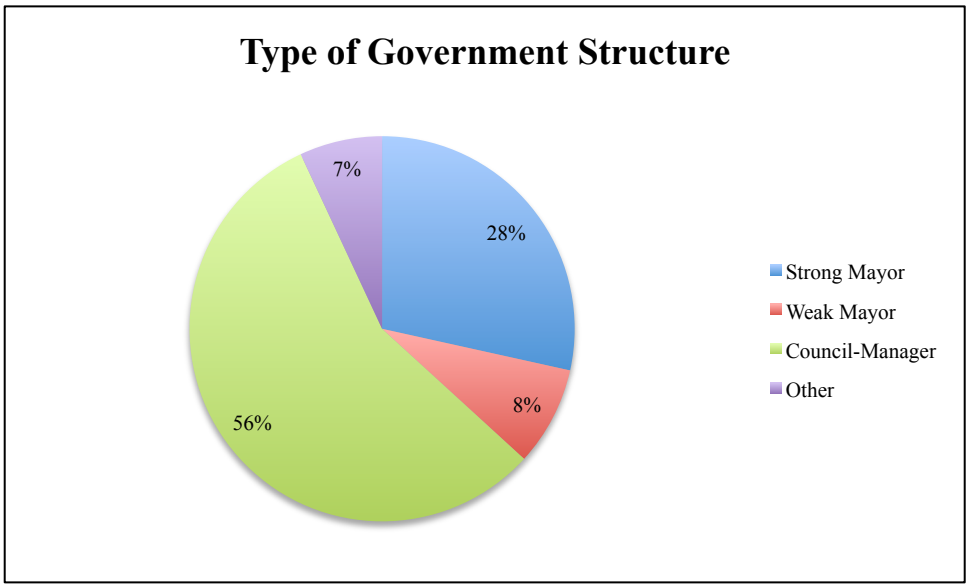


N = 139

Of the 6 "yes" responses (4%), a very small number of planners were reported to have a background in public health.

# of planners	# of responses
1	3
2	1
3	1
No response	1

The majority of respondents (56%) indicated that their city government followed a council-manager structure. Only 8% indicated that their city government followed a weak mayor structure.



N = 144; "Other" responses included Strong Mayor-Strong Council, Strong Mayor-City Manager, and Commissioner forms.

Demographics of Respondent Cities

When looking at the respondents by region (Table 2), they are all within a reasonable range. The Northeast has the lowest rate at 29.5% while the South has the highest at 36.7%.

BY REGION						
Region	Total Cities in Sample	Responses from each region	% from region	Total population (2010)	Population of responding cities (2010)	% population
Northeast	44	13	29.5%	15,529,431	2,541,350	16.4%
Midwest	74	24	32.4%	15,887,415	4,977,039	31.3%
South	139	51	36.7%	30,972,131	14,396,461	46.5%
West	172	57	33.1%	34,907,572	13,867,574	39.7%
Total	429	145	33.8%	97,296,549	35,782,424	36.8%

Table 2. Response rates by region and population

In general, responding cities had higher population (2010 Census), higher population growth, and slightly higher educational attainment (at least high school), while also having slightly lower incomes and higher poverty rates.

COMPARISON OF RESPONDING AND NON-RESPONDING CITIES					
	Population 2010 (average)	Population growth 2000-2010 (average)	Educational attainment (2011 5 year ACS)	Income (2011 5 year ACS)	Poverty Rate (2011 5 year ACS)
Responding	246,775	20.2%	85.1%	52,504	17.2%
Non-Responding	216,599	15.7%	84.1%	54,587	16.1%
Total	226,798	17.2%	84.4%	53,883	16.4%

Table 3. Comparison of responding and non-responding cities (key factors)

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Vita

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