live long and prosper?

Despite the current economic difficulties, we are in a better position to reconnect the work of the planning and health professions than we have been for generations, says Sherman Wong

Most if not all planners appreciate that their profession has its roots in public health. At its most basic, ensuring adequate space and housing standards has been fundamental to enabling people to live cheek by jowl, particularly as our towns and cities grew as a consequence of the Industrial Revolution. Indeed, so explicit was this connection that in attracting new residents and investment new towns such as Letchworth openly set out health statistics in their advertisements. While it is hard to imagine modern housebuilders advertising their developments on the basis of their death and infant mortality rates in the same way, it is true that, more subtly, lifestyle and environment are attractive selling points.

Nowadays, planners are well versed in the need to provide open space and to encourage walking and cycling as ways of getting to the places people need to for work, shopping or leisure – all of which have a role to play in contributing to greater public health. It is also taken as read that new development will meet certain standards. However, it is probably also true that despite the profession’s roots planners do not routinely or systematically consider the impact that their schemes, advice or decisions have on the wider health of the community. Nor, indeed, and somewhat more problematically, do we routinely consider how our actions fit into the wider mosaic of decisions that influence people’s health.

Yet every day, decisions by planners affect people’s ability to live healthy lifestyles, helping to determine where and in what sort of home we can live in and where and what kind of jobs there are. They affect simple things like whether it is possible to go for a walk and sit and feed ducks in the park after a tough day at work, buy fresh food, or enable children to get to school without crossing a major road or running the gauntlet of fast-food shops on the way home. In any one of a myriad ways planning influences the liveability of the places in which we live, and in doing so it can affect either beneficially or detrimentally the mental and physical health of the community.

Despite the current economic difficulties, we are in a better position to reconnect the work of the planning and health professions than we have been for generations, says Sherman Wong.
Although perhaps not an explicit priority for many in recent years, the recognition that the way that our places develop has an intrinsic relationship with people’s health is undergoing something of a quiet renaissance. The TCPA’s ‘Reuniting Health and Planning – Healthier Homes, Healthier Communities’ project and report is but one instance of this. I recently chaired one of the project’s dissemination seminars, which was supported by the West Midlands Learning for Public Health Network. That there is interest was self-evident from the way the event was fully subscribed well in advance. However, it is also fair to say that the number of health professionals significantly outweighed the number of planners.

The number of examples of best practice in the TCPA report shows that there is a great deal of good practice of bringing planning and health together in the West Midlands, yet this is still very much the exception rather than the rule, and the aim must be to bring health and planning work together as a matter of course.

Ironically, while council planning departments and the public sector in general are facing significant losses of staff and expertise and developers are looking ever more carefully at the financial viability of their schemes, we are perhaps in a better position to reconnect the two professions than we have been for generations. Although planners are coming to terms with the changes to the planning system, not least the National Planning Policy Framework’s directions and exhortations on health, there are also big changes happening to the way that public health is being governed – and, despite the tightness of budgets, change can provide opportunity.

In the spirit of localism, councils are being given some public health roles previously undertaken by the doomed NHS Primary Care Trusts (PCTs). As a consequence they will soon be receiving a large chunk of health funding, along with a number of former PCT public health folk. Moreover, with their partners on their Health and Wellbeing Boards, councils will be responsible for using this money to deliver the Health and Wellbeing Strategies that they are currently putting together. It doesn’t need a visionary to see that there are very real opportunities to bring planning and health more closely together. Working for the same organisation should make it easier to make strategies, policies and processes at least compatible and, ideally, on appropriate issues jointly developed.

Financially, too, councils will be pressed into maximising the ‘bangs’ they can deliver ‘per buck’, and while the mantra of ‘doing more with less’ is looking a little bit worn these days, it is untenable for councils not to at least consider how their different activities can provide mutual support. Councils have been this way before through initiatives such as Total Place, Local Area Agreements and currently the Troubled Families approach. All these initiatives were (or are) intended to break down barriers between organisational and departmental silos, to deliver better outcomes rather than institutional targets.

The need for this has perhaps most graphically been illustrated by the London Borough of Barnet. A video on the council’s website shows that in the foreseeable future the current downward trend of council funding and the upward pressures for spending on children and social care will intersect. At least theoretically, at this point there will be no money left to provide any other services. Across the country, all councils will be grappling with their own version of the so-called ‘Barnet graph of doom’.

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Already at national level, House of Commons Select Committees regularly advise of the need to bring health and social care spending together, and are now increasingly recognising the need to bring housing and transport into this equation as well. The inescapable and perhaps obvious conclusion seems to be that prevention is better than cure: it is hardly contestable that it is better for the elderly and their communities to be able to stay in their own homes rather than in expensive residential homes; likewise it must be better (and cheaper in the long run) that people lead healthy lives rather than requiring expensive clinical services in the longer term. But enabling people to do these things needs forethought aplenty and some upfront resourcing.

This sort of thinking underpinned the influential 2010 report by Professor Sir Michael Marmot into health inequalities. While he found that people in the poorest neighbourhoods in England die, on average, seven years earlier than those in the richest, Marmot considered that these inequalities could be avoided by addressing the underlying social determinants of health. This means that public health is more than a matter of immunisation programmes and preventing the spread of infections, vital though that is.

Public health also means tackling, among other things, the complex interaction between housing, income, disability, social isolation and education. All these things happen in particular ways and in specific places, and places are the very stuff of local government and planning. If this starts to look a bit like the notion of spatial planning that was in common currency not so long ago, it should be no surprise that one of Marmot’s six priority health policy areas was to ‘create and develop healthy and sustainable places’.

Needless to say, none of this will bring instant or necessarily easily measurable returns. But if Marmot
is to be believed, benefits will accrue. His report noted that if everyone lived for as long as the most advantaged, then over £31 billion worth of productivity lost due to ill-health would be added to the economy and some £5.5 billion would saved from the NHS’s bill.

Although there are differences from place to place, like all parts of the country the West Midlands has its own particular health issues, including significant disparities in life expectancy and, collectively, the highest rates of obesity and the lowest rates of physical activity in England. Recognising these issues, the defunct Regional Health and Well-Being Strategy explicitly connected health with planning, housing, transport, the environment, skills and the economy. While it is fair to say that limited progress was made in taking the strategy forward, the region is lucky to have bodies such as the West Midlands Learning for Public Health Network and the West Midlands Healthy Urban Development Group continuing to promote these connections, sharing best practice and retaining some of the institutional memory.

As part of the wider work we are doing to assist councils during the public health transition process, West Midlands Councils is currently working with these groups to keep the impetus from the TCPA seminar going. To this end, collectively we will be circulating a short fact sheet on the kinds of initiatives being undertaken in the West Midlands to raise awareness of what can be done.

We will also be asking people for feedback on what else is going on in their areas and what barriers and opportunities they are experiencing. In doing so we aim to build up a good picture of what is occurring in the West Midlands and a simple contact list so that people can get in touch with and learn from people who have made that first step, or are that little bit further down the path than them.

There are no simple answers or ‘big bang’ solution – like so many things, this is a learning process for everyone. One of the biggest messages to come out of our seminar was that it is better to do something than nothing; better to pick up the phone to the public health team than not. Because, of course, all this stuff really matters to people, affecting not only how long they live (possibly the most fundamental indicator there is) but also the quality of that life and the length we live it without pain or discomfort.

Planning can play an important part in tackling these public health issues, but to be most effective it needs to appreciate that it is part of a wider mosaic, for which it can provide some very important pieces. In returning public health to local authorities, we may also have the opportunity to reconnect planning a little bit better to its own roots.

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**Note**