

# urban planners' knowledge of health and wellbeing issues

A survey of urban planners for the  
PUBLIC HEALTH ADVISORY COMMITTEE (PHAC)  
Undertaken by Beca Carter Hollings & Ferner Ltd (Beca)



The Public Health Advisory Committee (PHAC) is a sub-committee of the National Advisory Committee on Health and Disability (National Health Committee, NHC). The PHAC provides independent advice to the Minister of Health on public health issues, including the factors underlying the health of people and communities.

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## Executive Summary

The Public Health Advisory Committee (PHAC) provides independent advice to the Minister of Health. To inform a project on urban environments and health, the PHAC commissioned a survey of urban planners, urban designers and transport engineers that focused on the relationship between health and urban planning in New Zealand.

The PHAC sought to understand how much planners know about the impact of the urban environment on health and wellbeing, as well as what planners think about how urban settings influence health outcomes. The research objectives included identifying the opportunities and barriers to achieving health goals through urban planning, and assessing the extent to which equity and inequality are addressed in planning.

An online survey was made available for an eight-week period to three target populations: urban planners, transport planners and urban designers. The sample was recruited by self-selection, using established electronic mailing lists from New Zealand professional organisations for the target populations. The response rate was just over 30 percent (n=234).

Seventy-four percent of respondents were in the urban planner category. The sample included 12 percent traffic engineers/transport planners, 3 percent urban designers and 10 percent 'other' (policy analysts, advisors, academics, architects and chief executives). The sample was derived from across New Zealand. The distribution of sectors represented was 49 percent private sector, 38 percent local government, 6 percent central government and 6 percent other agencies. Forty-three percent of respondents had been working in the industry for more than ten years, 21 percent between five and ten years and 36 percent less than five years. Fifty-five percent of respondents held senior positions.

Respondents overwhelmingly (90 percent) believed there is a link between planning and health outcomes. In spite of their recognition of the link between urban planning and health outcomes, just over half of respondents said that they either occasionally or never consider health and wellbeing in their planning. Over two-thirds of respondents said health and wellbeing considerations have little or no impact on final planning decisions compared to other considerations. Two-thirds of planners had received no training in how to consider health outcomes and achieve health goals.

Most survey respondents agreed that health inequalities exist in New Zealand. Equity was considered important by over 80 percent of respondents, but 56 percent said that they do not take such issues into account. Respondents identified a number of constraints planners face when taking equity issues into account, namely lack of relevance, lack of mandate and a focus on other priorities.

Respondents highlighted ways to achieve better health considerations in planning were through:

- *legislative changes* incorporating health considerations into planning processes
- *a shift in the planning model* to facilitate more integrated and strategic urban planning
- *increased awareness and knowledge* of how to incorporate health into planning
- *leadership* that ensures that decision makers understand and prioritise links between planning and health
- *collaboration* between the planning and health sectors
- *greater focus on urban design* that creates compact, mixed-use and walkable environments
- *prioritising active transport.*

Barriers to the consideration of health in planning were:

- *a lack of mandate* within legislation and policies
- *low priority* of health compared to other factors
- *a lack of resources* in terms of time and money to incorporate health considerations
- *a lack of knowledge* as to how to incorporate health into planning.

# 1 Introduction

The Public Health Advisory Committee (PHAC) is a ministerial committee that provides independent advice to the Minister of Health. The PHAC is undertaking a project to explore the relationship between the urban environment and health and wellbeing in New Zealand. As part of this effort, the PHAC commissioned a survey of urban and transport planners and urban designers to identify their views on the health and wellbeing consequences of their work. Developing a greater understanding of the ways that these professionals can influence health outcomes through the built environment is important for the future of New Zealand communities.

This report provides a background on the current relationship between health and planning, and outlines the survey's methodology, results and conclusions.

## 1.1 Overview and definitions of health relative to planning

There are a number of theories or 'models' of health, but two key models are commonly referred to in the context of this report.

- **The medical model of health:** In this model, health is defined primarily as the absence of disease. This model is largely driven from a medical or scientific perspective.
- **The social model of health:** This model applies a broader definition of health, considering a range of influences on health such as social behaviours, culture, income, housing and social status – that is, broad environmental, social and economic conditions. The basic premise of this model is that health is determined by a wide range of factors and therefore all influences are to be addressed.

This report applies the social model of health, under which the role of planners<sup>1</sup> is clear. In broad terms, planners have influence over a range of factors affecting the health and wellbeing of communities, such as housing, service accessibility, physical activity, safety and connectedness, among other things.

There is growing evidence of the measurable health benefits that can be achieved through designing environments in a way that facilitates health and wellbeing: by encouraging incidental physical activity, organised physical activity and social cohesion; and by providing open spaces that are safe and support multiple use and accessible public transport. A well-designed built environment fosters community participation and socialisation, which in turn contributes to health and wellbeing.

## 1.2 Role of planners, urban designers and traffic engineers

Planners, urban designers and traffic engineers have significant influence over how cities and towns develop. Whether planners in New Zealand understand their crucial role in influencing health through urban design, or use their influence to maximum effect, is not well known.

Planners also have key roles in developing and implementing policy, engaging with local communities and politicians (as decision makers), and articulating a vision for the future environment. In New Zealand, policy documents that have statutory force under the Resource Management Act 1991 (the RMA) (such as District and Regional Plans) or the Local

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<sup>1</sup> For the purposes of this survey, the term 'planner' includes urban planners, urban designers and traffic engineers.

Government Act 2002 (such as Long-Term Council Community Plans – LTCCPs) are a predominant influence on planners’ responsibilities.

Part of a planner’s role is assessing applications for proposed developments. This process contributes to immediate changes to built environments in a way that can influence health, such as ensuring provision for appropriate forms of public transport. Whether planners are informed, or have the skills, to make the most of these opportunities is unknown. Planners working with development applications require appropriate processes to give them the authority to achieve urban design that considers health impacts.

Local and regional governments play a major role by setting policy, regulating development and providing infrastructure. Because of this, local government takes the lead to ensure that infrastructure, open space and other projects meet best-practice requirements, such as those outlined in the New Zealand Urban Design Protocol.<sup>2</sup>

Many planners, although they show interest, may not be equipped with the skills or knowledge to address ‘healthy planning’ – that is, managing our physical environment to enable communities to effect positive health outcomes – and to integrate it into their planning activities.

Making the links between the urban environment, health and wellbeing through collaboration between the health, local government and environment sectors will improve health and wellbeing outcomes in New Zealand.

### **1.3 Research objectives**

The objectives of the survey were to:

1. assess respondents’ knowledge of the impact of urban planning on health and wellbeing
2. explore opportunities and barriers to addressing health and wellbeing in urban design and planning
3. assess the nature of participants’ perceived capacity to plan for a healthier, more active, socially connected community
4. assess how participants take equity issues into account
5. provide a benchmark for health-related planning issues.

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<sup>2</sup> <http://www.mfe.govt.nz/issues/urban/design-protocol/>

## 2 Methodology

This section outlines the methodological approach used, and describes the research methods employed to collect and analyse the primary data.

### 2.1 Data collection

The PHAC commissioned data collection and analysis of the survey<sup>3</sup> from a company selected for its planning background and understanding of planners. An online survey was developed because of its timeliness, convenience, ability to attract a rich response, ease of wide distribution and cost efficiency, as well as providing surveyors with the ability to send reminders and check on progress. The survey, which is provided in the appendix to this document, used a mixture of closed and open questions. The closed questions restricted participants' responses to predetermined categories related to the research objectives. Eleven open questions provided the opportunity for respondents to clarify ideas, and generated additional data for a more detailed analysis of the issues. The questionnaire was piloted to check for misleading and ambiguous questions, and was reviewed prior to distribution for clarity, adequacy and completeness.

A link to the survey was distributed to the three target populations (urban planners, urban designers and traffic engineers) through the New Zealand Planning Institute (NZPI) and the Institution of Professional Engineers New Zealand (IPENZ) Transportation Group. A secure website hosted the survey (the 'uSuite' survey system), allowing participants to enter and suspend the survey according to personal preference. Completion of the survey was voluntary, and responses were anonymous. An incentive to win one of five \$200 gift vouchers was offered to participants to encourage participation.

### 2.2 Data analysis

Completed surveys were received from 234 individuals (from 774 invited to participate). As the study progressed, results were collated into simple graphic format for each closed question, and a list of responses for the open questions.

Analyses of closed and open questions were undertaken separately. Frequencies were calculated for responses to the closed questions. The open questions were analysed for themes, drawing on the research objectives.

Respondents were not required to answer all questions, so the total number of responses for each question varied. The response rate for closed questions was 100 percent. Response rates for open questions ranged from 74 to 92 percent.

## 3 Survey respondents

To understand 'planners' and their role in planning for health and wellbeing, this section describes the respondents of the survey with respect to their occupation and position, workplace, level of experience, length of time spent in the industry, and locations worked past and present. Results are summarised in Table 1.

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<sup>3</sup> The consultancy service BECA developed and administered the survey and analysed the closed questions. The public health consultancy service Quigley and Watts analysed the open questions.

**Table 1: Overview of survey respondents (n=234)**

Occupation	Percentage of respondents (%)
Planner/urban planner	74
Traffic engineer/transport planner	12
Urban designer	4
Other	10
<b>Workplace</b>	
Private sector	49
Local government	38
Central government	6
Other	6
<b>Industry experience</b>	
More than ten years' experience	43
Five to ten years' experience	21
Less than five years' experience	36
<b>Position</b>	
Senior manager/director	13
Team leader	14
Senior planner/traffic engineer	28
Planner/traffic engineer	32
Other	12
<b>Countries worked</b>	
New Zealand only	63
United Kingdom	21
Australia	9
Asia	6
Europe (other than United Kingdom)	5
United States	2
Other	8
<b>Current work location</b>	
Auckland	23.4
Wellington	18.0
Canterbury	10.8
Waikato	8.6
Northland	5.0
Hawke's Bay	5.0
Manawatu-Wanganui	4.5
Bay of Plenty	3.6
Otago	3.6
Nelson	0.9
Taranaki	0.5
Tasman	0.5
West Coast	0.5
Southland	0.5
Cross-regionally or nationally	14.9

Seventy-four percent of survey respondents described themselves as 'planner/urban planner', 12 percent as 'traffic engineer/transport planner' and 4 percent as 'urban designer'. The 10 percent who described themselves as 'other' were policy analysts, advisors, lecturers, landscape architects and chief executives.

About half of respondents (49%) described their organisation as working for the 'private sector', with 38 percent indicating they worked for 'local government' and 6 percent indicating they worked for 'central government'. The six percent who described their workplace as 'other' were either self-employed, working for tertiary education providers or unemployed.

Forty-three percent of respondents said they had 'more than ten years' experience in their industry. The lowest percentage was for those with an intermediate length of experience (five to ten years). This reflects the Ministry for the Environment and Department of Labour's indication that at present there is a nationwide shortage of planners in the 'intermediate' experience bracket. It may be that at this stage in their career planners choose to work or travel overseas.

Over half of the respondents (55%) described their role as 'senior': specifically as a 'senior manager/director', a 'team leader' or a 'senior planner/traffic engineer'. The remainder of respondents described themselves as 'planner/traffic engineer' (32%) or as 'other' (12%), which includes policy analysts/advisors, university lecturers and researchers.

Although most respondents had worked in New Zealand only, around a fifth had worked in the United Kingdom, and 9 percent in Australia. Several respondents (3%) indicated they had worked in more than one country other than New Zealand. 'Other' countries specified by respondents included the United Arab Emirates, South Africa, Russia, Samoa, Ethiopia and Papua New Guinea. The group with the most overseas work experience were those with 'five to ten years' planning experience.

The majority of respondents were from Auckland, Wellington or Canterbury. Fifteen percent of respondents identified that they did most of their planning work 'cross-regionally or nationally'. The two regions not represented by respondents were Gisborne and Marlborough.

## **4 Results**

### **4.1 Respondents' knowledge of the impact of urban planning on health and wellbeing**

To gain an understanding of respondents' views on health in relation to urban planning, the survey asked respondents to identify the major health issues facing New Zealand. Respondents were asked to state whether there is a link between urban planning and health outcomes, and the features of any such links.

#### **4.1.1 Perception of major health issues facing New Zealand**

Respondents identified a range of health issues for New Zealand. Seventy-six percent (176 respondents) listed obesity as a major health issue, respondents identifying that this was due to both a lack of exercise and poor nutrition. A few respondents expressed particular concerns about childhood obesity, a lack of exercise among children/youth and a lack of balance between eating and exercise. Many respondents also mentioned rising food costs as affecting people's nutritional choices.

Other health issues identified as major included smoking, alcohol and substance abuse (noted by 18% / 42 respondents); access to health care, including waiting lists, a shortage of health professionals and barriers to individual access to care (17% / 38 respondents); cancer (15% / 34 respondents); mental health issues such as depression and stress (14% / 33

respondents); cardiovascular disease (14% / 32 respondents); and diabetes (13% / 29 respondents). Selected open responses are listed in Table 2.

**Table 2: Major health issues facing New Zealand**

Individual health/illness issues
■ <i>'Obesity-related illnesses'</i>
■ <i>'Obesity, heart disease – stemming from a lack of exercise and poor food choices'</i>
■ <i>'Communicable disease thru over crowding/ poor housing conditions'</i>
Social issues
■ <i>'A society that is car dependent where walking is almost extinct'</i>
■ <i>'Affordable housing, might sound a bit left field but I believe it is the cornerstone of a healthy society'</i>
■ <i>'There is a lack of community spirit to organise activities for the whole community'</i>
■ <i>'The binge drinking culture that we have, particularly amongst women'</i>
■ <i>'Mental health and depression in particular ...'</i>
Economic issues
■ <i>'High costs of "staple" food combined with the low costs of unhealthy food'</i>
■ <i>'Lack of funding to deal with health-related consequences'</i>
Equity issues
■ <i>'The growing separation between rich and poor'</i>
■ <i>'Healthy homes for the low-income family'</i>
■ <i>'Poverty – inability to access services and unaffordable housing'</i>

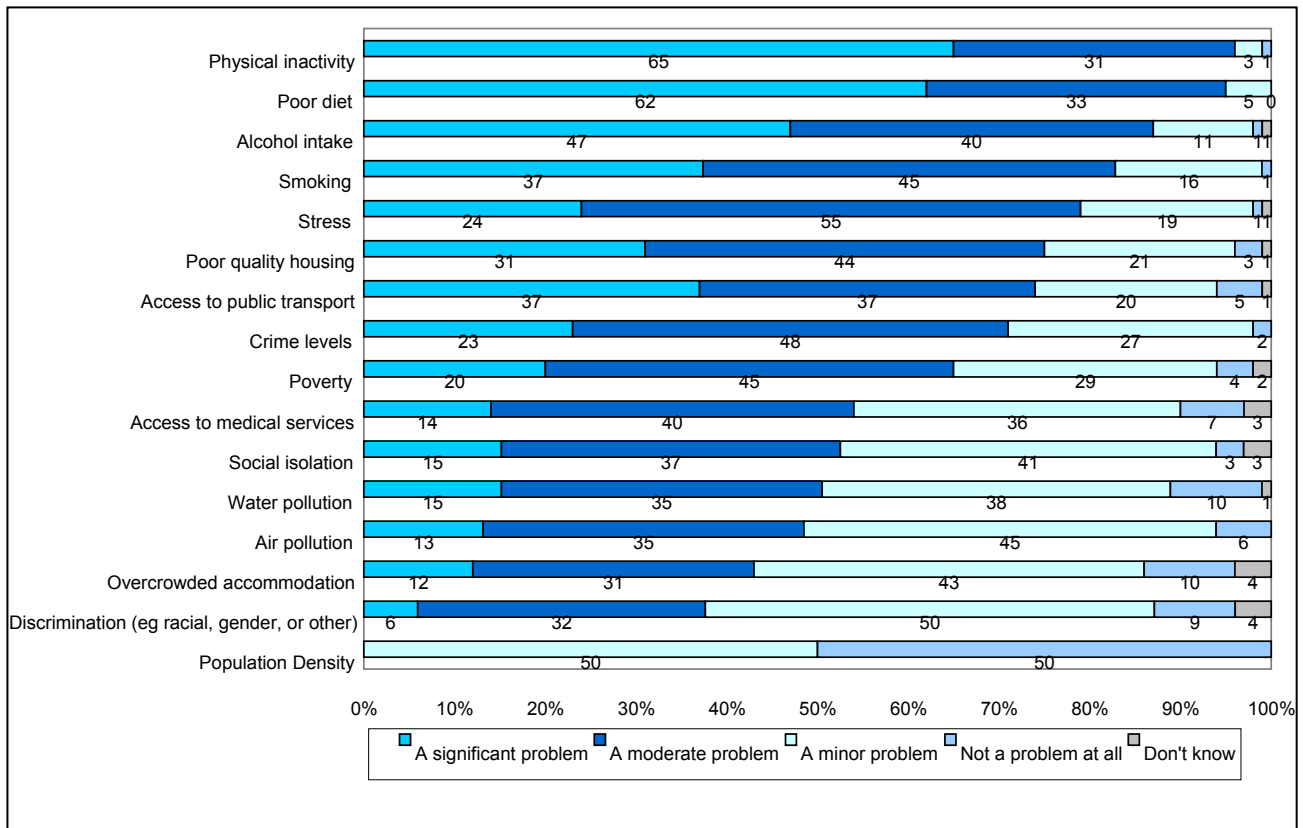
Respondents were then asked to rank how problematic they viewed a series of factors that influence health in New Zealand (potential responses being 'significant', 'moderate', 'minor', 'not a problem at all', or 'don't know'). This question was presented alongside a broad definition of health, and the following factors were listed:

- Air pollution
- Water pollution
- Physical inactivity
- Social isolation
- Overcrowded accommodation
- Access to medical services
- Poverty
- Discrimination (for example racial or gender)
- Poor diet
- Crime levels
- Access to public transport
- Stress
- Population density
- Poor-quality housing
- Smoking
- Alcohol intake

Figure 1 shows that respondents identified physical inactivity and poor diet as the most significant factors affecting health in New Zealand. Alcohol intake was noted by 47 percent of respondents as a significant problem. The eight factors identified as being the relatively least problematic in New Zealand included environmental health factors such as water and air pollution. Discrimination was seen by 59 percent of respondents as 'a minor problem' or 'not a

problem at all'. Population density was ranked as 'a minor problem' by 50 percent of respondents, with the other 50 percent ranking it as 'not a problem at all'.

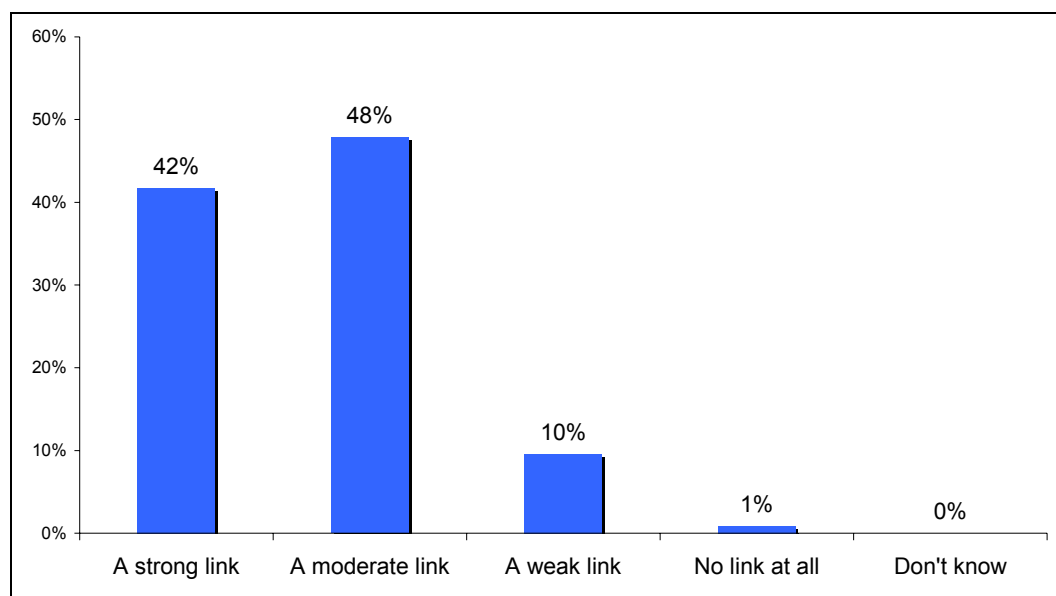
**Figure 1: Health problems as ranked by planners**



#### 4.1.2 Link between planning and health outcomes

Participants were asked about their perception of the link between town planning and health outcomes. As Figure 2 shows, the majority indicated a moderate or strong link.

**Figure 2: Link between planning and health outcomes (n=234)**



A few respondents referred to town planning as having had a fundamental concern with public health historically – as one respondent put it, public health was once a ‘primary driver behind town planning’. In this survey, respondents who stated there were either minimal or no links between planning and health suggested that health was determined more by personal choices than by the actions of planners.

Participants were asked to elaborate on the links between town planning and health outcomes. Five common themes emerged:

1. access to services/facilities
2. opportunities for physical activity
3. environmental quality
4. housing design
5. social networks and connections.

Many respondents referred to more than one of these factors, and emphasised their interrelatedness. Throughout their responses pertaining to each of these themes, many respondents (42% / 96 respondents) made references to the need for good urban design and layout in facilitating positive health outcomes: mixed land use, density controls, management of urban sprawl and provision of public transport. Among other things, good urban design ensures access to services and creates formal and informal opportunities for physical activity.

#### ***Access to services and facilities***

Fifty-seven percent (129) of respondents stressed the importance of planners’ roles in creating access to services and facilities, particularly health services, employment, shops, schools and recreation areas. The role of public and active transport was emphasised; one representative view prioritised ‘Connectivity to town and suburban centres to enable safe walking or cycling routes – accessibility of public transport options to shops/services’.

One respondent highlighted car-dependent town planning as impeding access to services for people without cars: ‘Car-oriented design could make social services inaccessible to people who can’t afford a car, or who don’t drive’.

#### ***Opportunities for physical activity***

Another link between planning and health noted by 114 respondents (50%) was the capacity of urban design and layout to either encourage or discourage physical activity. One respondent noted:

*Designing for active transport modes encourages and supports greater physical activity and social interaction, as does, to a lesser extent, increasing the provision of public transport services. This includes designing ‘living streets’, prioritising the walkability and cycleability of neighbourhoods, and slowing and sometimes discouraging or excluding motor vehicles.*

Respondents frequently referred to creating opportunities for physical activity as the ‘primary link’ or ‘main influence’ of planning on health. They emphasised a need to make walking easier or more practicable, noting that the current design of cities tends to advantage cars, and is a key reason for limited opportunities to walk. Several respondents referred to the need to reduce urban sprawl and to move towards transit-oriented development rather than the ‘typical American suburb’.

Respondents noted that mixed-use environments and compact development provide opportunities to live and work in closer proximity, and increase walking and cycling. As one

respondent noted, 'the way the urban fabric is patched together, either holistically or piecemeal, directly affects people's attitudes towards transport'.

Respondents also identified the link between physical activity and planning's role in facilitating open space and green space for recreation and 'time out'. Some respondents emphasised that parks and recreational areas should be located close to residences, and many mentioned safety issues in relation to open space. Another representative view was that 'Access to good quality open space is important for mental wellbeing too'.

### ***Environmental quality***

Sixty-four respondents (28%) mentioned air, noise and water quality as important areas in which planning could impact health; noting, for example, that 'regulations dealing with environmental pollution are important – because if the air we breathe and water we drink become contaminated, we'll all get sick'. Some respondents highlighted the pollution and congestion that results from car-dependent planning, and emphasised compact development to reduce these: a priority should be to 'Minimise vehicle travel, thereby minimising pollution'.

### ***Housing design***

Housing design and location were noted by 55 respondents (24%) as a link between planning and health. Respondents highlighted the ability of planning to set development standards, which affects the affordability, location and diversity of housing. They also emphasised planners' roles in ensuring a sufficient number of houses and implementing neighbourhood design that promotes healthy housing. One respondent noted that 'planning policy, research and regulation can have obvious impacts on housing quality and availability (i.e. Govt or Council policy on affordable housing)'.

### ***Social networks and connections***

Twenty percent of respondents (46 people) included social cohesion as a link between urban planning and health. This was more commonly noted among those working in local government than among those working in the private sector. Some responses highlighted that planning or transport affects people's social interactions and sense of community. One respondent said that planning provided 'the building blocks on which networks for high-quality social and environmental interactions are constructed'.

Respondents highlighted the connections between urban planning and the development of a sense of place, in terms of identity and cultural and spiritual expression, noting that the design of urban spaces reflects how 'we feel about ourselves and connect with others'.

Twenty-one percent (47 respondents) mentioned safety as a link between planning and health. A sense of safety allows for greater community cohesion, as highlighted by one respondent:

*Creating a pleasant and safe environment is the link. This will encourage people to be active and feel a sense of belonging and pride in where they live. As costs of living increase and our daily lives become more stressful, having safe environments to rest, play, reside and work in will provide some balance to these negative sides of life.*

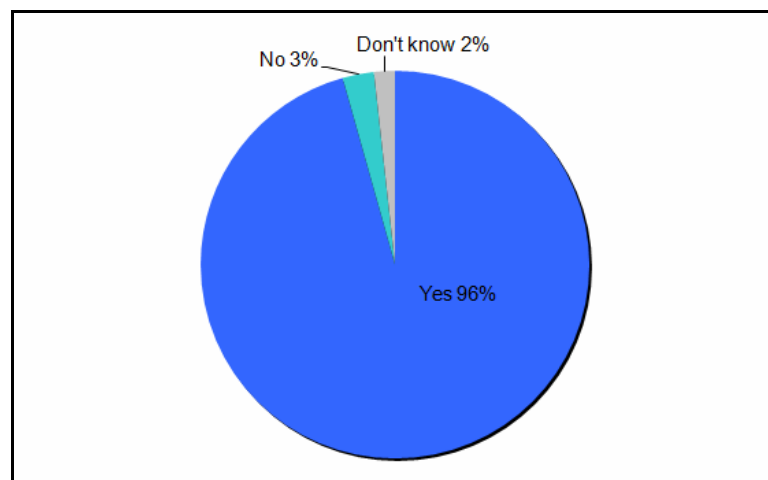
## 4.2 Current consideration of health and wellbeing in urban design and planning

The survey asked respondents a series of questions about the extent to which they considered health and wellbeing in their work. It also asked about the extent to which they thought health was considered in plans, policies and legislation, and whether they knew of information sources on health considerations.

### 4.2.2 Planners' consideration of health and wellbeing in their work

Participants were asked whether they thought planners had a role in creating healthier, more physically active and socially connected communities. Figure 3 shows their responses.

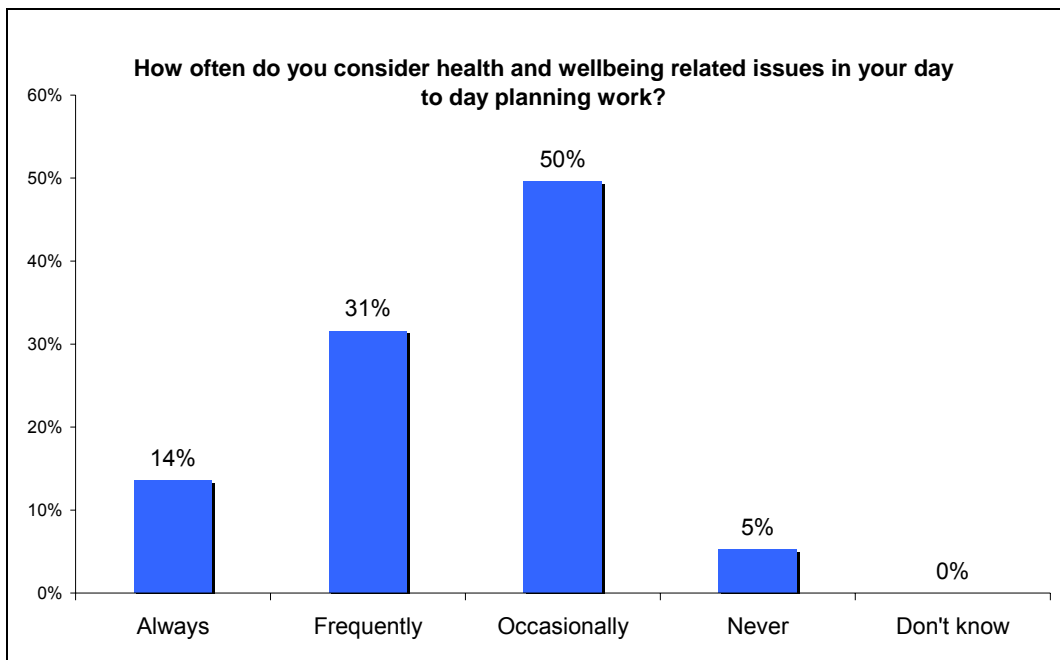
**Figure 3: Do planners play a role in creating a healthier community? (n=234)**



The survey also asked participants how often they considered health- and wellbeing-related issues in their day-to-day work. Fifty-five percent responded that they 'occasionally' or 'never' considered such issues, while 45 percent said that they 'always' or 'frequently' did (see Figure 4).

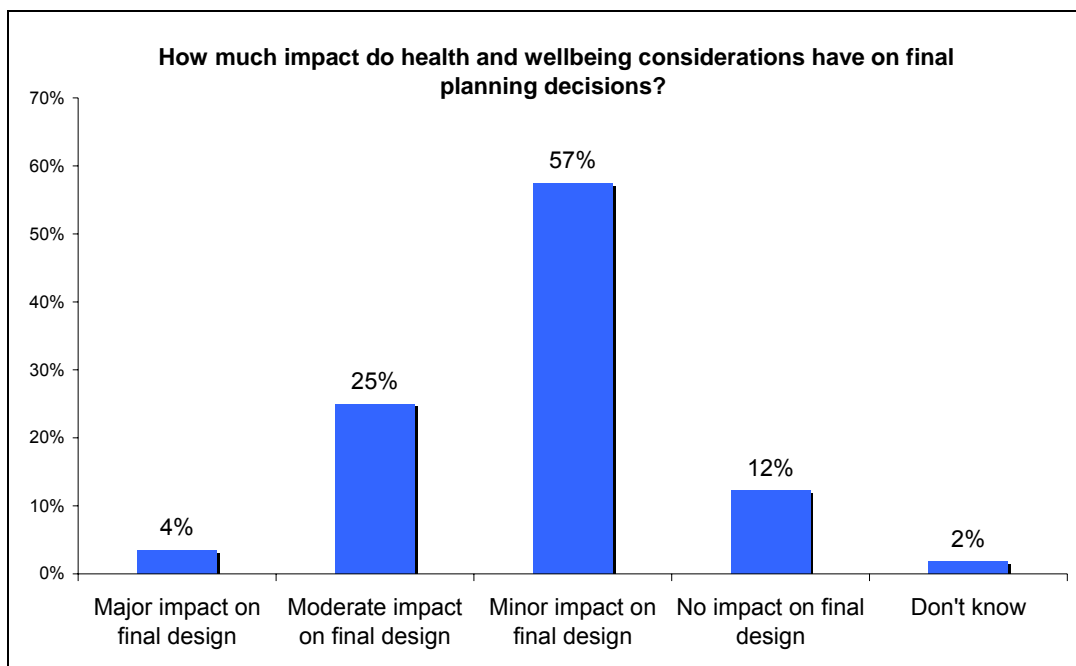
Respondents with 10 or more years' industry experience were more likely to report that they considered health and wellbeing in their daily work. The majority of those who 'never' considered health and wellbeing had less than five years' experience.

**Figure 4: Consideration of health and wellbeing in day-to-day planning (n=234)**



The survey then asked respondents about the extent to which they perceived that consideration was given to health and wellbeing in final planning decisions, relative to other considerations such as budget, design efficiency and aesthetics. Only 29 percent indicated that they thought these considerations had a major or moderate impact on final design. The majority of respondents (69%) said that health and wellbeing considerations had a 'minor impact' or 'no impact' on final design (see Figure 5).

**Figure 5: Impact of consideration of health and wellbeing on planning decisions (n=234)**



### 4.2.3 Health and wellbeing in plans, policies and legislation

Survey respondents were asked a number of questions related to plans, policies and legislation encouraging or requiring planners to consider health. These questions explored whether respondents felt that such documentation existed, and if so, what it was. There were also specific questions about health considerations in the Treaty of Waitangi and District and Regional Plans.

Forty-two percent of respondents said they were aware of plans, policies or legislation that encouraged consideration of health impacts; 58 percent were unaware or did not know. The respondents who answered that they were aware of plans, policies or legislation addressing health impacts were asked to specify these (see Table 3). Forty-eight percent stated that the RMA was a key piece of legislation in this respect. Other plans, policies and legislation identified were the Local Government Act, the New Zealand Transport Strategy and the Land Transport Management Act 2003. Some also referred to specific health-related legislation (including that addressing water and air quality).

**Table 3: Identification of plans, policies or legislation in New Zealand that encourage or require planners to consider health (n=126)**

Plan, policy or legislation	Identified by respondents (%)
Resource Management Act 1991	48
Local Government Act 2002	14
Land Transport Management Act 2003	13
Health-related legislation and programmes (for example SPARC's 'Mission-On' programme)	6
Christchurch City Council's <i>Health Promotion and Sustainability Through Environmental Design</i> guide	4
Hazardous Substances and New Organisms Act 1996	2
Affordable Housing: Enabling Territorial Authorities Act 2008	1

The survey asked participants whether they thought District and Regional Plans address health in their objectives, policies and rules. Forty-eight percent (106 respondents) answered 'yes'. When asked to explain how these plans address health, 36 percent of respondents (39 people) who had answered 'yes' said they addressed health in terms of environmental quality or standards, including air quality, water quality, contamination and noise standards. Representative responses to this question included the following:

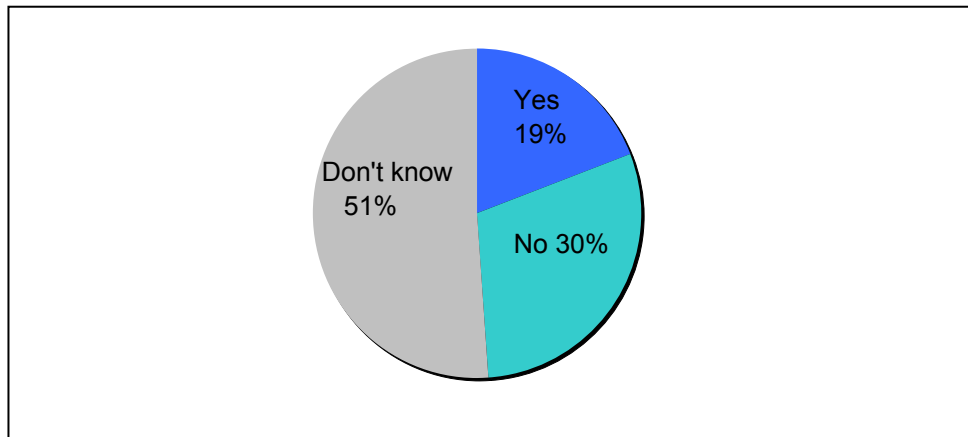
*They include provisions for amenity-related health, such as open space, noise, hours of operation etc.*

*Usually in terms of air quality, odour and water quality.*

Seventeen people (16%) identified transport-related ways in which District and Regional Plans impacted on health, such as through walking and cycling strategies or Regional Land Transport Strategies. Nineteen percent of respondents (20 people) who thought that these Plans did address health considered that they did so broadly, through statements regarding healthy communities, social wellbeing and urban design. About 35 percent (37 people) thought that they did so indirectly, or not as a specific objective. A few respondents felt Regional Plans addressed health to a greater degree than District Plans.

Respondents were asked whether they thought the Treaty of Waitangi imposed any obligations upon planners to address health issues. Figure 6 shows their responses. The survey did not differentiate between Māori and non-Māori respondents.

**Figure 6: Does the Treaty of Waitangi impose obligations upon planners to address health issues?**



Respondents who answered 'yes' were asked to describe how the Treaty provided obligations to address health issues. Forty-seven percent (17 people) commented that health and wellbeing issues were 'inherent' in the Treaty, in its prescription of equity for all New Zealanders and the implied obligation to safeguard and protect all aspects of Māori health. As one respondent put it, the 'concept of self governance and provision for indigenous people, access to ... natural resources ... food, air, sea, earth ... are all a part of health'. Another respondent suggested that 'the Treaty provides a basis for addressing the disparities between Māori and Pakeha health issues'.

#### 4.2.4 Training and information sources on health and planning

The survey asked participants whether they were aware of any sources of information on how to assess the potential health and wellbeing impacts of proposed planning projects. Sixty-nine percent of respondents said 'no'.

Respondents who answered 'yes' identified a range of sources of information for assessing potential health and wellbeing impacts, as Table 4 shows.

**Table 4: Sources of information on how to assess potential health and wellbeing impacts of proposed planning projects identified by respondents (n=69)**

Information sources	Identified by respondents (%)
Health Impact Assessments (HIA) and Social Impact Assessments (SIA)	37
Ministry of Health, including the Ministry of Health website	13
Christchurch City Council's <i>Health Promotion and Sustainability through Environmental Design</i> guide	9
The internet	8
University contacts/specialist consultants	6
United Kingdom guidance documents	4
District Health Board (DHB) material	3

Respondents were also asked to offer examples of good practice in planning for health and wellbeing from other locations that could be useful for New Zealand. The examples they provided mostly came from the United Kingdom, Australia, the United States and Canada (see Table 5).

**Table 5: International good practice examples of planning for health and wellbeing cited by planners**

Country	Good practice example
United Kingdom	<ul style="list-style-type: none"> <li>• Focus on sustainable development and communities, including affordable housing, and 'eco-towns'</li> <li>• Regenerating projects</li> <li>• Use of urban design principles – including design for safety and for health</li> <li>• Enactment of disabilities legislation, publication of accessibility guides and building of relationships with key stakeholders</li> <li>• Use of local development frameworks</li> <li>• Prioritisation of mixed transportation use, walking and cycling initiatives</li> </ul>
Australia	<ul style="list-style-type: none"> <li>• The National Heart Foundation Project in Adelaide</li> <li>• University courses featuring a 'healthy planning' component</li> <li>• Wider spread use of HIAs as part of the planning process</li> <li>• Focus on affordable housing and public transport infrastructure</li> </ul>
United States and Canada	<ul style="list-style-type: none"> <li>• Focus on reducing car dependency through free/low-cost public transport, more bike lanes and fewer new highways</li> <li>• Creation of sustainable communities, with composting, recycling and community garden initiatives</li> <li>• Focus on affordable housing and related legislation</li> </ul>
Other countries	<p>Comments on other countries included the following:</p> <ul style="list-style-type: none"> <li>• 'Look to Scandinavia, particularly Norway'</li> <li>• 'Japan is a good example of urban design working for closely developed communities'</li> <li>• 'South Africa – excellent models on how to address low income housing solutions'</li> </ul>

In answer to this question, one respondent made the comment that 'NZ is in many respects a bit of a transport dodo. That is, we continue to design (i.e. subsidise) our communities around private vehicles (e.g. minimum parking requirements)'.

Respondents were asked about education or training they had received on the topic of health and wellbeing in planning. Sixty-eight percent reported receiving no relevant education or training. The more common types of training that respondents reported attending were on-the-job training or attendance at workshops/short training sessions (38%), and university courses (32%).

In response to a question about their involvement in HIA, the majority of respondents (86%) said that they had never been involved in one (13% said they had been involved, and 1% were not sure). (Health Impact Assessments have been used in New Zealand since 2004 to facilitate the consideration of health in plans and policies in planning and other sectors. These assessments provide a health 'audit' on proposed policies or programmes, and increase awareness about health-related issues during policy and programme development.)

Finally, the survey asked about contact with a health service provider as a potential source of health information. The majority of respondents (85%) did not have regular contact with a

local health service provider. Respondents who answered 'yes' to having regular contact with health service providers were asked to specify these contacts or affiliations: 14 percent said they had contact with the DHB, and a further 11 percent responded that their affiliations were through collaborative work programmes.

Planners who had worked in their industry for more than 10 years were more likely to have contact with DHBs or other health providers. Those who worked for local government had the most regular contact with their local DHB.

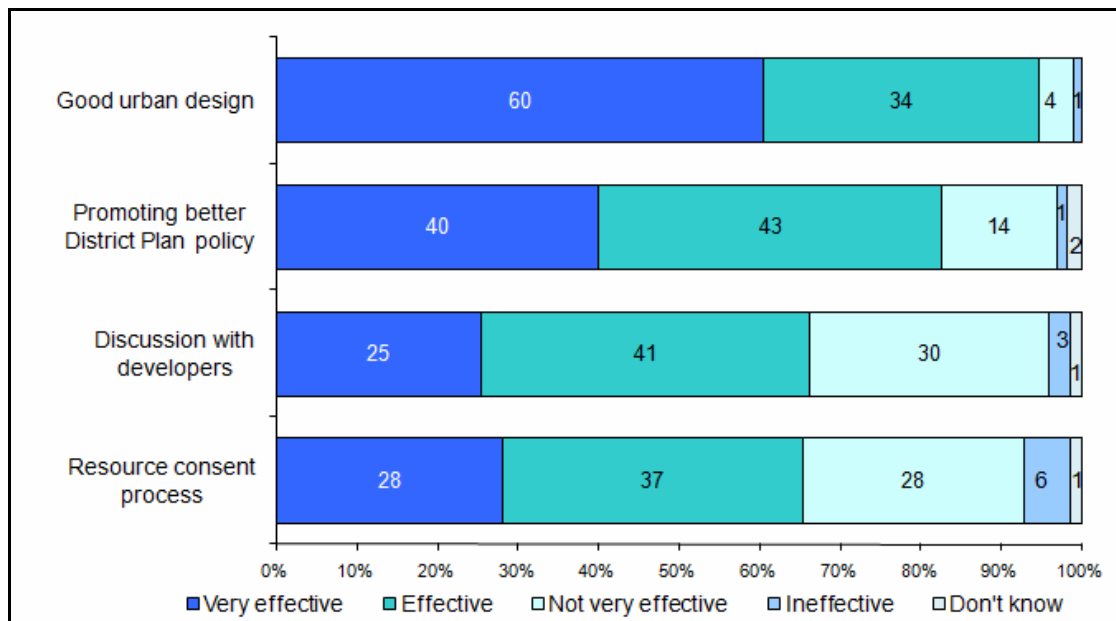
### 4.3 Opportunities for and barriers to addressing health in planning

The survey asked participants about perceived opportunities and barriers to greater consideration of health in urban planning and design.

#### 4.3.1 Opportunities

The survey tried to identify options for greater consideration of health in planning. It asked participants to rank the effectiveness of four planning strategies and activities to influence health outcomes. Figure 7 indicates that all four suggested methods were considered effective. The majority of respondents thought that good urban design was 'very effective' in influencing health outcomes through planning. The resource consent process and discussion with developers were seen as less effective methods.

**Figure 7: Perceived effectiveness of methods for planners to influence health outcomes through planning**



The survey also asked what skills planners would need to be able to take greater consideration of health concerns; what would help planners consider health in planning; and what specific things planners could do in their roles to create healthier communities. Responses to open questions in this area produced a set of overlapping themes:

1. legislative requirements
2. a shift in the planning model
3. increased awareness and understanding
4. leadership
5. collaboration
6. a greater focus on design
7. a greater focus on active transport.

### **Legislative requirements**

Eighty-two (36%) respondents expressed a need for clear legislation addressing health considerations in planning, and/or inclusion of health considerations in District Plans. Other responses focused on the need for greater social responsibility through legislation, for example in affordable housing legislation. One respondent commented that:

*The planning process is very fragmented and inconsistent. If the Government is serious about considering health impacts, I would suggest that HIA are made mandatory for District Plans, Regional Transport Strategies and other spatial plans.*

Respondents who had worked in planning for more than 10 years were slightly less likely to say a legislative requirement to consider health would help (27%), compared with those who had worked in planning for 10 years or fewer (33%). Similarly, respondents who had worked in planning for more than 10 years were less likely to say that such an inclusion in District Plans would help (16%), compared with those who had worked in planning for less than 10 years (24%).

### **A shift in planning model**

Twenty-two respondents (10%) called for a fundamental shift in the current planning model in order to facilitate healthier and more integrated planning. Key points were the need for long-term and holistic planning, better integration between District Plans and LTCCPs, improved strategic planning and a focus on desired community outcomes. One respondent said there was a need to:

*Challenge the way long-term planning for communities is done. Encourage councils and communities to think more about what makes a successful community (see the Urban Design Protocol) and prompt them to take some innovative approaches for enabling this. Encourage LTCCPs to be more than just generic, district-wide documents and provide some more focussed long-term planning for the individual communities within the districts.*

Similarly, another respondent suggested there was a need to 'identify the elements of liveable (high wellbeing) communities, and plan to deliver those through the planning process'. Another suggestion was the implementation of a single set of assessment criteria to help with integration, with the New Zealand Urban Design Protocol as a potential basis.

## **Leadership**

Leadership at both government and senior management levels was mentioned (by 36 respondents / 16%) as a factor likely to help planners address health. Some respondents noted that local and central government should take a legislative and policy lead in addressing health concerns in planning. They emphasised the need to increase decision makers' understanding of the link:

*This would require a greater understanding, by a greater proportion of decision makers and their advisors, that the sustainability principles upon which planning under the RMA is based, are tied inextricably to health and wellbeing, and that urban design, transport and servicing are not just engineering matters, but are part of the larger picture that includes physical and mental health.*

## **Increased awareness and understanding**

Providing training in, and fostering awareness of, links between planning and health was a common response to questions about methods by which to integrate health concerns into planning, identified by 55 percent (127) of respondents. In addition, when asked what skills planners would need to consider health and wellbeing in planning, 81 (44%) said training in assessment tools such as HIA, and 78 (42%) suggested building skills in health and wellbeing as it relates to planning. A few respondents indicated the need for simple, practical measures with which to consider health when writing policy or processing applications. Specific suggestions on training included:

- incorporating training into tertiary or professional development planning courses
- providing guidance or examples of good practice for planners assessing the impacts of planning on health
- incorporating HIA into the assessment of resource management consent applications
- requiring planners to participate in impact assessment alongside health practitioners.

Sixteen respondents (9%) said there was a need for research showing the links between health and planning, and another 12 respondents (7%) said they wanted evidence that HIA makes a difference. One respondent commented on the importance of evidence:

*Evidence! All the right things are being argued for and links made between physical outcomes and health – planning has always been interested in the four wellbeings [sic]. However implementation falls over for a variety of reasons, possibly in part because there is not enough clear evidence that can be used.*

## **Collaboration**

A minority of respondents (19 respondents / 10%) said collaborating to a greater extent with health professionals or community groups, rather than gaining additional skills themselves, would help them to consider health and wellbeing in their role. Respondents' suggestions of ways to strengthen links with the health sector included forums with health practitioners (on links between planning and health); a dedicated health officer who could help with impact assessments; and an external health expert to contact for advice. One respondent said there was a need for advisors on health operating in a similar way to specialist advisors on noise, landscape or acoustics.

A need for general cross-sector collaboration (for example between planners, surveyors, engineers, developers and builders) was a minority view. A few respondents said that building and planning, in particular, should be better integrated. Respondents acknowledged

that specific skills would be needed for this, including the ability to work with others outside their 'silos' and an understanding of a more holistic approach to planning.

### ***A greater focus on design***

Thirty-three respondents (14%) indicated that urban design skills provide a means by which to link health and wellbeing concerns with planning. In addition, when asked what participants could do in their role to contribute towards healthier communities, 37 percent of respondents (87 people) suggested good urban design (for example mixed land use, density of development) as a specific planning approach. Respondents who had spent over 10 years as a planner were more likely to make this recommendation.

Respondents cited problems with current legislation and plans, including the approval they allowed of subdivision developments lacking social infrastructure, and the limited inclusion of building design issues in District Plans. Individuals mentioned public transport availability, cycle paths, streetscapes, access to facilities, access to green space and safety as specific aspects of urban design that influence health outcomes. One respondent noted that planners could positively influence health outcomes 'by making sure there is good public transport, open space for recreational activities, good urban design for walkability'. Another commented that creating a 'better sense of community, rather than sprawl cities' was a good design approach.

### ***A greater focus on active transport***

A large proportion of respondents (40% / 92) highlighted that planners could facilitate active transport modes and infrastructure as a way to improve health and wellbeing; to quote one response, planners could 'promote sustainable modes of transport and encourage modal shift towards cycling and walking'.

Twenty-eight responses (12%) emphasised the need for a shift from car-dependent design and planning. Comments included suggestions that planners could: 'change the mindset of using cars', 'stop building roads' and 'encourage residents to get out of their cars, or leave the cars at home'. There was a related call to reduce the provision of car parks as a way of planning for a healthier community, a typical response noting that: 'planning needs to promote healthy activities such as walking/taking the bus/biking to work, which can be done by having less car parks and more bus stops and bike parks'.

Compared with urban planners, transport planners/traffic engineers were more likely to include the facilitation of active transport modes in their response to questions as to how planners could improve links between planning and health.

#### **4.3.2 Barriers**

The results of this survey suggest that planners understand the connection between planning and health, but face barriers to considering these issues in their work. Respondents were asked to indicate what factors prevent them from placing greater emphasis on health and wellbeing outcomes in their day-to-day planning work. They supplied a range of responses; many of the main barriers relate to themes described in the previous section (4.3.1):

1. lack of a formal mandate to consider health
2. health considerations not seen as a priority
3. lack of resources
4. lack of knowledge

### ***Lack of a formal mandate to consider health***

The most common barrier to addressing health and wellbeing as perceived by respondents (57 people / 25%) was that such concerns are not required to be considered by legislation or District Plans. Respondents said planning work was directed by the content of plans and guidelines – one respondent described the District Plan as the planners' bible. Some said their District Plan did not have any consideration of health in its objectives, rules and policies; in the words of one respondent, the 'Current District Plan does not provide sufficient power'.

Forty-nine respondents (21%) cited the lack of a legislative requirement to address health, described by one respondent as a 'lack of legislative teeth', as a barrier. Some respondents said the current legislation was narrow; for instance, one said it excluded appropriate consideration of the social aspects of health. Others critiqued the RMA for its focus on the physical environment, the length of planning processes it necessitated and the large numbers of RMA practitioners required to be involved.

### ***Health considerations not seen as a priority***

Ten percent (24) of respondents said a barrier to addressing health was its lack of direct relevance to their work. Private sector respondents and urban planners were more likely to identify this as a barrier than local government respondents, urban designers and traffic/transport planners.

A few respondents described health as a central government, rather than a local government, responsibility. One respondent was not sure that health was 'council's core business', and another spoke of the 'reluctance of councils to take on yet another function that in the past has been Central Government responsibility, without any funding'.

A similar proportion (33 respondents) stated that clients had more important concerns, and that health was given a lower priority than other considerations. In particular, many respondents indicated that environmental outcomes or clients' concerns tended to be prioritised over health. Of the 33 respondents who said the demands of clients overrode their ability to consider health, the majority were from the private sector (28 respondents) and had worked in planning for less than 10 years (23 respondents).

### ***Lack of resources***

Other barriers emphasised were cost (17% / 39 respondents), time (15% / 35 respondents) and the demands of multiple assessment requirements. Several respondents said that councils struggled to meet all their policy requirements and competing objectives:

*These are just one more consideration into an already complicated assessment of resource consents. As stated previously, such things need to be fused into the actual planning documents rather than being another consideration at resource consent stage.*

### ***Lack of knowledge***

Lack of awareness, understanding or skills to consider health was raised by a minority of respondents. Fifteen percent (35) of respondents said that a lack of awareness of health considerations or HIA was a barrier, while 9 percent (21) said that they did not know how to address health or did not feel qualified. A few respondents noted that there was no clear directive as to what is meant by 'wellbeing outcomes', with one commenting that there is a 'lack of easy "how to" guidance'.

## 4.4 Respondents' consideration of equity in urban design and planning

Participants were asked questions about both equity and equality, in terms of how strongly they agreed or disagreed with a set of statements about inequalities between and within communities, as well as disparities between individuals.

### 4.4.1 Definitions: equality and equity

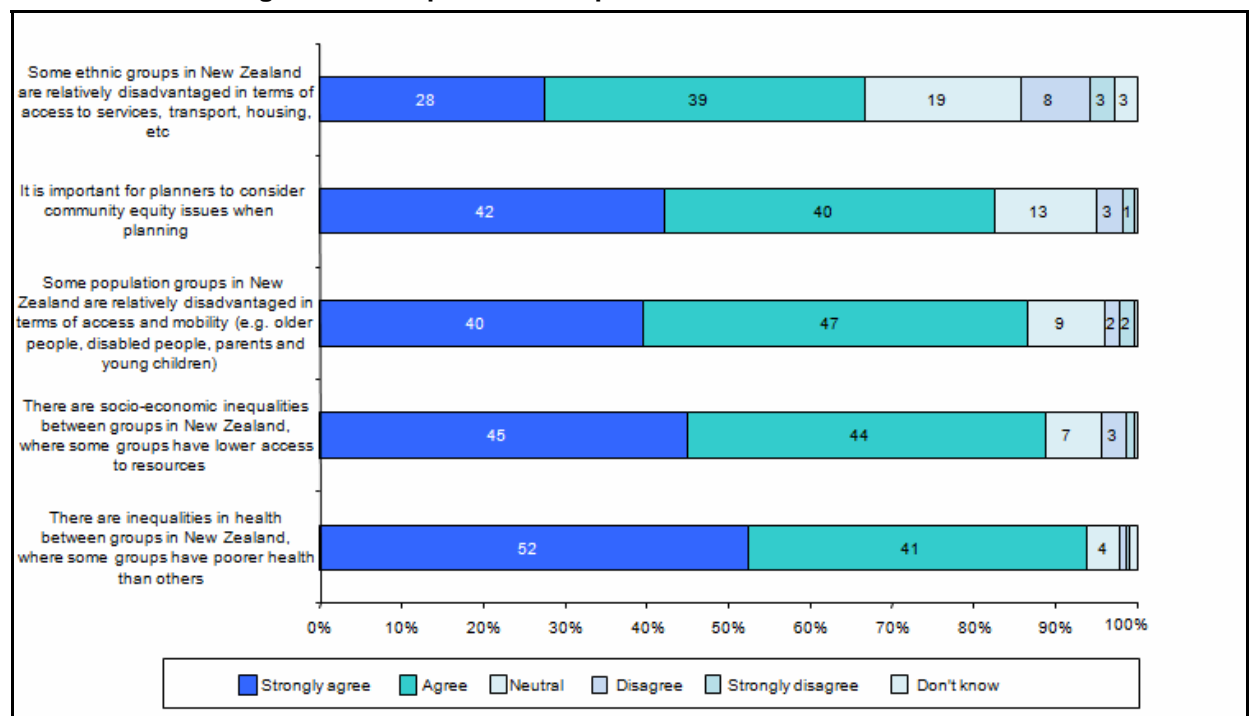
Equality is the state defined as being equal or having the same opportunities and benefits. It is often seen as involving fairness. Equality assumes that everyone has access and receives entitlements in similar ways.

In contrast, equity does not address equal access for all. Rather, equity concerns the removal or absence of systemic and social barriers to fairness. For example, equity attempts to put in place remedies to redress injustices that have prevented or diminished access to goods and services. Equity is defined by its recognition that not all people experience similar access or entitlements because of social conditions (for example income, housing and neighbourhood) that are expressions of structural barriers. Fundamental to this definition is the idea that these barriers are potentially remediable.

### 4.4.2 Inequalities in New Zealand

The majority of respondents (93%) strongly agreed or agreed that there were inequalities in health status between groups in New Zealand, in that some groups have poorer health than others. Further, 89 percent and 87 percent strongly agreed or agreed that there were resource access inequalities and mobility/disability inequalities respectively (see Figure 8).

**Figure 8: Perceptions of inequalities in New Zealand**



#### 4.4.3 Consideration of equity by planners

Eighty-two percent of respondents strongly agreed or agreed that it is important for planners to consider community equity issues, and 46 percent indicated they do take community equity issues into account (40% answered 'no' and 14% 'maybe' to this question). Central government planners were more likely to take equity issues into account than local government and private sector planners.

When asked to clarify their thoughts about community equity, 175 people provided a response. Only six respondents from a mix of sectors and roles said equity was integral or core to their work. One respondent noted:

*Concerns for social issues, community development and the environment are why I got into planning ... For me, it's a mindset ingrained in everything I do in life, but I have a hunch I'm not the norm. I've become this way after studying environmental studies for many years and becoming increasingly aware of the interconnectedness between the environment, health, wellbeing and other social issues, not to mention local economics.*

Respondents identified three specific ways in which equity was considered in routine planning work.

Firstly, 21 percent (36) of respondents said they considered equity issues in terms of access to services, facilities or opportunities. Some respondents said urban planning needed to consider living and working opportunities across a range of social groups. Disability issues were also identified as important for access, such as the importance of mobility-related initiatives for partially sighted and physically impaired people. A need for better public transport planning, especially for people on low incomes, was emphasised.

Secondly, 15 percent (26) of respondents considered equity in terms of planning for diverse populations. Most respondents highlighted the need to plan for people with mobility limitations and who were 'transport disadvantaged'. Planning to support the needs of those in social housing was also identified as a way that respondents planned for diverse populations. A few respondents talked about working with developers to broaden their considerations, encouraging them, in the words of one respondent, to: 'take into account other sectors of the community and consider how the development can respond to those groups and, where possible, benefit them'.

Finally, 11 percent (17) of respondents said they considered equity issues in terms of consulting with the community and meeting the community's needs. This included active consultation and outreach to iwi. One respondent said they addressed equity by appraising whether all people's interests were considered:

*I try to ensure the places I design are able to pass 'the tramp test' (an English term) – i.e. would every person in society feel welcome in this place/space? Would they be able to access it on equal terms?*

#### **4.4.4 Constraints to the consideration of equity in community settings**

Fifty-one respondents (22%) indicated that, although they recognised community equity issues should be taken into account in their role as planners, they were constrained in considering such issues; one noted that planners considered community equity 'As much as possible but [are] constrained by client wishes'. The constraints identified by respondents were:

1. lack of opportunity or relevance
2. lack of mandate
3. equity issues being seen as low priority.

##### ***Lack of opportunity or relevance***

Twenty-six respondents said that limited consideration of equity issues in planning was due to a lack of opportunity and/or relevance. A typical comment was '[Equity] does not often come up in day-to-day work'. Of those who said equity was not relevant to their work, most were from the private sector or local government, and almost all worked in one geographic location only. Only one had been involved in an HIA.

Several respondents said they felt equity issues were outside planners' areas of responsibility; that equity is a national issue, outside statutory planning, or more related to social and economic policies. They argued that community equity is caused by multiple factors outside planning, which need to be addressed before planning can have an influence. There was also a view that equity and mobility issues were dealt with by the Building Code rather than by planners.

##### ***Lack of mandate***

Thirty-two respondents reported the lack of a formal mandate or requirement to incorporate equity concerns as a constraint. Several expressed a view that the current planning system did not allow for consideration of equity; that there was 'limited room' in the present system. Several others gave a stronger response; that they felt the District Plan and legislation *prohibited* them from considering equity.

Some respondents indicated a perception of powerlessness in addressing equity, congruent with the findings of this survey concerning health considerations:

*I don't think it is part of the previously accepted way of operating, and I feel as though I don't have the knowledge or authority to change templates / current Council practice, even though I think it is important and would like to.*

##### ***Equity issues being seen as low priority***

Ten respondents viewed equity issues as a low priority in planning. As in their responses pertaining to health concerns, in this regard several respondents said there were client-related, budget or time constraints to consideration of equity in planning:

*[Equity] issues are important but are not considered due to project scope constraints and at a higher level the direction of clients and their objectives.*

Some respondents talked about taking a universal approach rather than emphasising equity issues or targeting particular groups. One respondent commented 'we cater for everyone' and 'all people have to be treated the same regardless of background, ethnicity, social status etc'.

Several respondents said that some equity issues were viewed as easier to address than others. For instance, accessibility issues (such as access to community reserves) were viewed as relatively simple to deal with, whereas addressing the needs of groups with poorer health was perceived as more difficult. As one respondent said, 'It depends on the merit of each individual case. Sometimes [equity is] more applicable [in some cases] than others'.

## 5 Conclusions

This survey sought to find out how much planners know about the impact of the urban environment on health and wellbeing, what planners think about how urban environments influence health outcomes, and the factors they perceive as opportunities and barriers to achieving better health outcomes through urban planning. In addition, it explored the notions of equity and inequality. The following reflections and conclusions can be made.

### 5.1 Limitations

The survey was developed to collect information from New Zealand 'urban planners', defined as planners, urban designers and traffic engineers. However, many transportation-oriented professionals did not answer questions they felt were only relevant to planners. The intent was that the term 'planner' be used universally throughout the survey, but it may have been more appropriate to differentiate between the three target respondent groups. Further work with these groups may benefit from a distinction being made between planners and urban designers – who traditionally have similar spheres of operation – and transportation-oriented professionals.

The selection strategy did not include planners and traffic engineers who were not members of their respective institutes (NZPI or IPENZ). This limited the range of respondents. A more distributed sample may have been achieved by widening the distribution channels to include local government networks, consulting companies and other companies that employ planners. The 'planning' workforce in New Zealand is estimated at about 2000 people, and the survey link was directly distributed to 774 people. It is also possible that those planners who chose to respond to the survey had a particular interest in health issues. Both of these factors could have led to a selection bias.

Analysis of open questions is useful in providing further information on the initial quantitative findings. However, a survey approach seeking qualitative information does not allow for prompts if a respondent has difficulty understanding a question, or to probe respondents to elaborate on an answer. A limitation of the survey method is that it is not possible to know the reasons for non-response, and there is the potential for differing interpretations of both questions and responses. Examples include possible differing interpretations of the term 'community equity', as well as varying interpretations of what constitutes 'health issues facing people in New Zealand'.

### 5.2 How much do planners know about the impact of the urban environment on health and wellbeing?

Survey responses suggest that, generally, respondents had an understanding of health and wellbeing. They highlighted obesity, poor nutrition, lack of physical activity and alcohol as the most significant health issues in New Zealand. Most respondents said planning influenced health outcomes through multiple links, and made the connection between planning and its ability to influence individual actions: for example levels of physical activity and use of public transport. Access to services and facilities, opportunities for physical activity, environmental quality, housing design, and social networks and connections were areas in which planners

considered that they contribute to the health and wellbeing of communities. One respondent summarised these links as follows:

*The way in which we live, what we live in, how we access services and jobs, how we are able to participate in community life are significantly impacted on by the resource management process and are direct contributors to our physical and mental health.*

Although air and water pollution and population density were not seen as major health problems in New Zealand, these aspects impacting on health also require consideration during planning to manage growth in any city or town.

### **5.3 Do planners think they influence health and wellbeing outcomes?**

Most (90%) of the respondents to this survey overwhelmingly believed there is a link between planning and health outcomes, yet just over half of the surveyed planners said that they either occasionally or never considered health and wellbeing in their planning work. One-third of planners considered health frequently, and one in seven considered it always.

Over two-thirds of respondents stated that health and wellbeing considerations had little or no impact on planning decisions compared to other considerations. One-quarter said that there was a moderate impact, and only 4 percent said that there was a major impact.

Two-thirds of planners had received no training in this area, and most who had received training reported it as being in the form of 'unstructured' short courses. Few planners indicated they had received structured professional training, such as degree-based training, on health and wellbeing considerations. In addition, 85 percent of planners surveyed had no regular contact with health organisations in their professional planning roles.

Respondents indicated that, although planners think they have a role in planning for healthy (and active) communities, there are explicit barriers and constraints to greater consideration of health issues. Respondents provided overseas good practice examples, which may provide case examples for greater consideration of health and wellbeing in planning in New Zealand's future.

### **5.4 What are the opportunities and barriers to achieving better health outcomes through urban planning?**

Respondents highlighted specific opportunities and barriers to achieving better health outcomes, which illustrate where resources can be focused to achieve future benefit.

The opportunities planners identified that would facilitate their ability to consider health in planning were:

- *legislative changes* that incorporate health considerations into planning processes, including *legislative requirements* for health assessments
- *a shift in the planning model* to facilitate more integrated planning and improve strategic planning
- *increased awareness and knowledge* of how to incorporate health into planning, through training in HIA and the provision of practical tools for planners
- *leadership* that ensures that decision makers understand and prioritise links between planning and health
- *collaboration* between the planning and health sectors and within the planning sector (for example between transport planners, builders and planners)
- *greater focus on urban design* that creates compact, mixed-use and walkable environments with sufficient access to public transport

- *prioritising active transport* as an urban design strategy that could have direct health effects.

The barriers to achieving health gains through urban planning identified by respondents fall into four main areas:

- *a lack of mandate* within legislation and policies
- *low priority* of health considerations among planners and their clients in comparison with other factors, including environmental concerns
- *a lack of resources* in terms of time and money to incorporate health considerations, and in the context of the burden of multiple assessment requirements
- *a lack of knowledge* as to how to incorporate health into planning.

## **5.5 How are equity and equality considered in urban planning?**

Most survey respondents agreed that health inequalities exist in New Zealand. Inequalities between groups, based on access to services, mobility issues and health status, were all reported to be of concern to the majority of respondents.

Equity was considered important by over 80 percent of respondents, and particularly among central government planners. Respondents said that they took equity into account in decisions about access to services and facilities, planning for diverse populations and community consultation.

While many said they considered equity where possible, respondents acknowledged they were constrained in their ability to address equity-related concerns, and 56 percent said they did not take such issues into account. Respondents identified a number of constraints planners face when taking equity issues into account, namely lack of relevance, lack of mandate and a focus on other priorities.

## **5.6 Finally**

This survey has indicated that there is some convergence of perspective between the urban/transport planning and public health spheres. The meeting of these perspectives in the past has been predominantly within an understanding of the importance of physical activity and other personal health issues. There now appears to be a growing knowledge base among planners on wider health considerations, including strategies to reduce community inequalities. The survey highlighted good urban design and transport as areas in which planning could make a particular impact on health.

Planners identified two major interventions necessary to facilitate change. Firstly, they require the knowledge and tools to understand when and how to ensure health, wellbeing and equity can be considered in their work; and secondly, they require clear 'signals', through official routes – such as mandates and leadership – that these concerns are important. These signals need to come from the public (including clients), decision makers (including policy advisors) and, finally, from politicians at all levels of government.

This survey has only focused on planners' perspectives and actions regarding consideration of health, wellbeing and equity. This is only half of the picture. The role of public health practitioners and their influence in community planning needs to be explored. The responsibility for change does not lie only with planners. The burden of achieving positive change in urban environments lies equally with public health, urban planning, education, community and public decision makers.

## Appendix 1: Survey Questions

### Section One

1A: What is your role?

- Planner/Urban Planner
- Traffic Engineer/Transport Planner
- Other (please specify)
- Urban Designer

1B: Which of the following best describes your organisation?

- Private Sector
- Local Government
- Central Government
- Other (please specify)

### Section Two

2A: What do you see as the major health issues facing people in New Zealand?

### Section Three

*'In this survey we want to take a broad definition of health. Health is not just about hospitals, illnesses or injuries. The concept of health and wellbeing includes physical, mental, social, and cultural wellbeing. Health outcomes are often influenced by a wide range of factors including air quality, access to transport or affordable adequate housing, opportunities for physical activity, social connectedness, poverty and crime levels.'*

3A: Below are a range of factors that may impact health and wellbeing. Please indicate how much of a problem you think each of these is in New Zealand.

- A significant problem
- A moderate problem
- A minor problem
- Not a problem at all
- Don't know

(i): Air pollution

(ii): Water pollution

(iii): Physical inactivity

(iv): Social isolation

(v): Overcrowded accommodation

(vi): Access to medical services

(vii): Poverty

(viii): Discrimination (e.g. racial, gender, or other)

(ix): Poor diet

(x): Crime levels

(xi): Access to public transport

(xii): Stress

(xiii): Population density

(xiv): Poor quality housing

(xv): Smoking

(xvi): Alcohol intake

3B: Do you think there is a link between town planning (including policy, research and regulatory aspects) and health outcomes?

- A moderate link
- A strong link
- A weak link
- Don't know
- No link at all

## Section Four

4A: What are the links between town planning (including policy, research and regulatory aspects) and health outcomes?

## Section Five

5A: Do you think that planners have a role in creating a healthier, more physically active and socially connected community?

5B: What specific things (if any) could you do in your role to help create a healthier, more physically active and socially connected community?

## Section Six

6A: How often do you consider health and wellbeing related issues in your day-to-day planning work?

6B: How much impact do health and wellbeing considerations have on final planning decisions, compared to other considerations such as budget, design efficiency and aesthetics? Would you say health considerations have a ...

- Minor impact on final design
- Moderate impact on final design
- No impact on final design
- Major impact on final design
- Don't know

6C: Health Impact Assessment (HIA) is a tool used to assess potential health and wellbeing implications of proposed projects or policies. Have you ever been involved in an HIA?

- Maybe
- Yes
- No

6D: How could health and wellbeing considerations have a larger impact on design outcomes?

## Section Seven

7A: Are you aware of any plans, policies or legislation in New Zealand that encourage or require planners to consider potential health impacts?

- Don't know
- No
- Yes (please specify)

7B: Do you think District and Regional Plans address health in their objectives, policies and rules?

Don't know

No

Yes (please describe how)

7C: Do you think the Treaty of Waitangi provides any obligations to address health issues?

Don't know

No

Yes (please describe how)

## Section Eight

8A: Have you ever had any education or training on how to consider health and wellbeing in planning?

No

Yes (please specify what the education or training was)

8B: What additional skills would planners need to help them consider health and wellbeing when planning?

8C: Are you aware of any sources of information on how to assess potential health and wellbeing impacts of proposed planning projects?

No

Yes (please specify)

8D: Do you have regular contact or affiliations with your local District Health Board or other health service providers?

No

Yes (please specify)

8E: What factors prevent you from placing greater emphasis on health and wellbeing outcomes in your day-to-day planning work?

8F: What would help you to give greater consideration to health and wellbeing in your role as a planner?

## Section Nine

9A: Thinking of some of the ways planners could influence health outcomes through planning, how effective do you think each of the following would be:

Very effective

Effective

Not very effective

Ineffective

Don't know

(i): Good urban design

(ii): Promoting better District Plan policy

(iii): Discussion with developers

(iv): Resource consent process

## Section Ten

10A: Please say how much you agree or disagree with the following statements

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree
- Don't know

(i): There are inequalities in health between groups in New Zealand, where some groups have poorer health than others

(ii): I am personally concerned about inequalities in health between groups in New Zealand

(iii): There are socio-economic inequalities between groups in New Zealand, where some groups have lower access to resources

(iv): I am personally concerned about socio-economic inequalities in New Zealand

(v): Some ethnic groups in New Zealand are relatively disadvantaged in terms of access to services, transport, housing, etc

(vi): I am personally concerned about ethnic inequalities in New Zealand

(vii): Some population groups in New Zealand are relatively disadvantaged in terms of access and mobility (e.g. older people, disabled people, parents and young children)

(viii): I am personally concerned about inequalities in access and mobility

(ix): It is important for planners to consider community equity issues when planning

10B: Do you take community equity issues into account in your role as a planner?

- Maybe
- No
- Yes

10C: Please clarify your response above.

## Section Eleven

11A: How long have you worked in your industry?

- More than ten years
- Less than five years
- Five to ten years

11B: Which of these best described your role?

- |                                 |                         |
|---------------------------------|-------------------------|
| Planner/Traffic Engineer        | Senior Manager/Director |
| Senior Planner/Traffic Engineer | Other (please specify)  |
| Team Leader                     |                         |

11C: Where have you worked as a Planner/Traffic Engineer? (Please tick all that apply)

- |                        |                        |
|------------------------|------------------------|
| New Zealand only       | Asia                   |
| United Kingdom         | Europe (other than UK) |
| Other (please specify) | United States          |
| Australia              |                        |

11D: If you have worked or studied overseas, do you have any insights or examples of good practice from other locations that could be useful for New Zealand?

11E: Where do you currently conduct most of your planning work?

Auckland	Otago
Wellington	Nelson
Cross-regionally or nationally	Taranaki
Canterbury	Southland
Waikato	West Coast
Northland	Tasman
Hawke's Bay	Gisborne
Manawatu-Wanganui	Marlborough
Bay of Plenty	

## Section Twelve

12A: Do you have any final comments about this survey or the topics discussed?

12B: If you would like to receive a copy of the final report, and/or go into the prize draw to win one of five \$200 vouchers, please indicate below.

12C: To receive a copy of the report and/or go into the draw to win one of five \$200 vouchers, please enter your email address below.

