NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

03-02

STATEMENT OF POLICY

Healthy Community Design

Policy

The National Association of County and City Health Officials (NACCHO) supports the following:

- Comprehensive, formal, and systemic integration of local public health considerations into community design processes, including community planning, regulations, and design of new development and redevelopment, and design of the public realm to promote and protect the health of communities.
- Dedication of increased federal, state, and local resources to improve the capacity of local health departments (LHDs) to participate effectively in the community design process through training, development of tools, technical assistance, and other support. In addition, federal transportation policy should support LHD involvement in local transportation planning.
- Increased collaboration between local health, planning, transportation, and public works departments from the early stages of community design decision-making.
- Early, sustained, and effective participation by affected community members in all stages of community design decision-making.

Justification

A growing body of research reveals a strong relationship between the built environment[1] and a wide spectrum of public and individual health issues such as asthma, cancer, obesity, mental health, substance abuse, crime exposure, cardiovascular disease, and social and health inequity.

In recent decades, sprawling community design has led to increased use of the automobile and less viability of other transportation options such as public transit, bicycling, and walking. The resulting low level of physical activity contributes to the epidemic of obesity. In addition, as the largest source of manmade urban air pollution, motor vehicles contribute to the development of cardiovascular diseases, such as heart disease, stroke, and chronic obstructive pulmonary disease (COPD).[2,3] Changes in land use regulations and incentives, such as zoning and siting decisions for specific uses, can ensure that new development, redevelopment, and expansion of existing uses contain the needed infrastructure and programs to increase mixed-use communities resulting in reduced single-occupant vehicle trips and overall miles traveled. Transit-oriented development, completed streets, and other mixed-use land policies could reduce the need for single-occupant vehicle trips while increasing transportation modes such as bicycling, walking, and public transit.

Zoning barriers and other regulatory decisions can also make it difficult to open and operate grocery stores that offer a full range of food products, including fruits, vegetables, meats, and other perishable goods. The lack of these options creates "food deserts", where fresh, affordable healthy produce are unavailable. These same

communities often have a high concentration of fast food restaurants and advertisements for unhealthy foods, cigarettes, and alcohol. An increased availability and affordability of processed and fast foods, combined with the lack of access to affordable, high quality fruits and vegetables, means that families in these communities face significant barriers to eating a healthy diet composed of nutritious, low density foods needed to maintain a healthy weight.

Community design decisions can achieve health equity. Community design decisions too often have a disproportionately negative impact on low income, working class, and minority communities.[4] A growing body of evidence documents the impact on community health of psychosocial and built environments shaped by neighborhood deprivation and neglect. According to this research, impoverished community environments are associated with chronic stress and mental fatigue that leads to the release of stress hormones (e.g., corticosteroids) that, over time, can have a deleterious effect on health through their impact on cardiovascular, endocrine, and central nervous systems. For example, researchers from the RAND Corporation find that residents of neighborhoods with many boarded up and abandoned buildings have higher rates of early death from cancer and diabetes compared to those with intact housing but similar rates of poverty and insurance coverage.[5]

Adequate green space can reduce stress and support physical and mental health, but many low income communities lack these areas. Research shows that playing in natural settings can reduce symptoms of attention deficit hypertension disorder in children who already have the disorder[6,7] and generally improves cognitive functioning and coping ability in children.[8,9] For example, children who move to homes with more surrounding greenery, after controlling for a wide variety of confounding variables, have higher levels of cognitive functioning following the move.[10,11]

Greenery is important for adults too. For example, living near green spaces can improve psychological functioning and coping in adults,[12] and adults in greener neighborhoods have lower rates of obesity.[13] Researchers Dr. Kuo and Dr. Sullivan randomized female victims of domestic abuse into housing projects with and without greenery and found a statistically significant higher rate of reporting domestic abuse in the latter group.[14] This research demonstrates the importance of landscaping, gardening, park access, urban forestry, and neighborhood beautification on a number of public health outcomes. *Access* to such greenery and other resources, then, is a public health and social inequity issue.

Public health practitioners are reengaging with planning practitioners. Urban planning was once closely allied to the profession of public health in addressing concerns of public health, safety, and welfare. Over the course of the last century, planning and public health have become separate academic fields with separate administrative units in state and local government and exist with no formal institutional ties between them. Emerging threats to public health arising from community design decisions are revitalizing the ties between the public health practitioner and the planning practitioner, thereby ensuring public health considerations in the community design decision-making process.

LHDs, through their traditional role as brokers[15], are ideal institutions to support a reengagement between public health and planning. The LHD services of assessment, assurance, and policy development are the most effective at ensuring that public health considerations are addressed in community design decisions. LHDs can provide the assessment data to map disease patterns associated with community design. They often work with a wide variety of institutional and community stakeholders to identify and support policies to address the problems associated with community design, including their public health implications. Finally, they can work with local communities to assure that their voice is heard in all arenas in which planning and zoning decisions

are made. More importantly, LHDs could directly engage in the planning process by participating in comprehensive and general planning meetings and by hiring public health staff with planning expertise. These staff could work in planning and health departments; they could participate in design review, sit in planning commission meetings, and bridge the gap between public health and planning.

As LHDs across the country are re-establishing their role in community design, many of them face barriers to effective participation. For example, in a 2004 survey conducted by NACCHO and the members of the American Planning Association, 78 percent of local health officials report that their agencies lacked staff resources to expand their focus to include planning, and 76 percent of them indicated that the lack of funding was a barrier.[16] Recent evidence collected by NACCHO indicates an accelerated LHD staff decline and further funding cuts between 2008 and 2009.[17]

Many free toolkits, online resources, case studies, and model practices are available to support integrating local public health practitioners in the community planning process. However, the lack of LHD staff and systematic training for staff is a major barrier to LHD involvement in planning activities. The ability of LHDs to track and map disease patterns, physical activity levels, travel behavior, and food consumption and overlay these items with aspects of the psychosocial and built environment is critical to improvement in community design and health. This requires sufficient staff trained to collect, process, and analyze the data, so that LHDs can work collaboratively with planning practitioners and the community around a full range of joint activities.

By focusing on healthy community design and working with community partners, LHDs are well-positioned to address health and social inequities. When LHDs have sufficient resources, they can support grassroots community organizations' efforts to bring about a healthier living environment. For example, spatial data showing a concentration of bus depots and asthma attacks in low income neighborhoods can support policies to keep an additional bus depot from opening in the neighborhood or to locate all new bus depots in nonresidential neighborhoods. Mapping food deserts with obesity rates can support rezoning to help bring about a new grocery store within walkable distance of the area. Conducting an inventory and assessment of the quality of local playgrounds can be used to support an increased funding for upkeep. By addressing these issues, LHD could create a noticeable impact on health and social inequities while strengthening their community ties.

Ongoing, proactive leadership by LHDs on community design issues, combined with a strong alliance with community stakeholders, is a powerful model for systems change. LHDs can facilitate community involvement by convening community health coalitions and training community stakeholders in the community design decision-making processes. As a result of these actions, communities can be at the forefront of identifying issues of concern. Working in partnership with LHDs, communities can support policy, environmental, and systems changes that facilitate active living, healthy eating, and wholesome environments, thus improving health *for everybody*.

Record of Action

Proposed by Environmental Health and Prevention Advisory Committee
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References

[1]The built environment consists of the man-made components of an environmental space (in contrast to what nature places in the environment), i.e., streets, highways, houses, apartments, businesses, churches, parks, playgrounds, etc.

[2]American Heart Association. http://www.americanheart.org/presenter.jhtml?identifier=4419 .

[3]Environmental Protection Agency. http://www.epa.gov/ne/healthyhomes/iaq.html .

[4]Anthony, C. *Suburbs Are Making Us Sick: Health Implications of Suburban Sprawl and Inner City Abandonment on Communities of Color. Environmental Justice Health Research Needs report Series*. Atlanta: Environmental Justice Resource Center, 1998.

[5]Epsteine, H. (2003, October 12). Ghetto Miasma; Enough To Make You Sick? New York Times, p 75.

[6]Kuo, FE, & Taylor, AF (2004). A potential natural treatment for attention-deficit/ hyperactivity disorder: Evidence from a national study. *American Journal of Public Health*, 94 (9), 1580-1586.

[7]Taylor, AF, Kuo, FE, & Sullivan, WC (2001). Coping with ADD: The surprising connection to green play settings. *Environment and Behavior*, 33 (1), 54-77.

[8]Wells, NM (2000). At home with nature: Effects of" greenness" on children's cognitive functioning. *Environment and Behavior*, 32 (6), 775-795.

[9]Wells, NM, & Evans, GW (2003). Nearby nature: A buffer of life stress among rural children. *Environment and Behavior*, 35 (3), 311-330.

[10]Wells, NM (2000). At home with nature: Effects of" greenness" on children's cognitive functioning. *Environment and Behavior*, 32 (6), 775-795.

[11]Kaplan, S.(1995). The restorative benefits of nature: Toward an integrative framework. *Journal of Environmental Psychology*, 15 (3), 169-182.

[12]Kuo, FE (2001). Coping with poverty: Impacts of environment and attention in the inner city. *Environment and Behavior*, 33 (1), 5-34.

[13]Ellaway, A., Macintyre, S., & Bonnefoy, X.(2005). Graffiti, greenery, and obesity in adults: secondary analysis of European cross sectional survey. *British Medical Journal*, 331 (7517), 611-612.

[14]Kuo, F. E., & Sullivan,W. C. (2001).Aggression and violence in the inner city: Effects of environment via mental fatigue. *Environment and Behavior*, 33, 543–571.

[15]Health departments' brokering role is a core function of public health. The three core functions of public health—assessment, policy development, and assurance— are articulated in the Institute of Medicine's seminal 1988 report, *The Future of Public Health*. Assurance refers to the responsibility of the public health system to ensure that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services, and evaluation of the effectiveness of that care. Effective assurance requires local health departments to be an unbiased convener, or broker, of multiple stakeholders, including the community and a wide variety of government and private stakeholders.

[16]American Planning Association (Editor Marya Morris) *Integrating Planning and Public Health: Tools and Strategies to Create Healthy Places, Planning Advisory Service Report No*. 539/540, 2006.

[17]The limited funds available for health departments to become involved in the community design process is best illustrated by the estimated 16 percent funding cut for chronic disease prevention programs between July 2008 and June 2009 among the nation's nearly 3000 local health departments. This figure is based on NACCHO Economic Survey, which included a random sample of 990 local health departments.