

## **Building Public Health**

**CABE Policy Seminar in association with UK Public Health Association  
26 July 2005**

### **Opening Presentations<sup>1</sup>**

#### **A Whole Environment for Health**

**Fiona Adshead, Deputy Chief Medical Officer**

Buildings can be potent symbols for regeneration – the Guggenheim in Bilbao is a good example of this.

We have a good public health heritage in this country, and John Sorrell's recent Royal Society for the Promotion of Health annual lecture<sup>2</sup> reminded us just how important improvements to the built environment were to Victorian efforts to improve public health, and in particular combat infectious diseases.

However we've now moved from the need to control infectious diseases such as Cholera to dealing with lifestyle related health issues such as obesity. The quality of the environment is an important aspect in changing behaviour.

Working across Government the sustainable communities agenda should:

- Provide access to person-centred, seamless health and social care
- Promote accessibility, social inclusion and the benefits of diversity
- Promote physical and mental good health

Health improvement factors relating to housing include:

- Materials
- Spatial arrangement
- Market renewal

Maximising the potential impact of the built environment will require a holistic approach to design that takes account of:

- Local involvement: planning & delivery
- Safety
- Physical Activity
- Tackle Anti-Social Behaviour
- Tackle health inequalities

#### **Michael Mehaffey, Prince's Foundation**

**Built Environment and its role in Public Health – evolving implications for practitioners.**

Health effects of the built environment:

- General – toxins and pathogens
- Buildings – health promoting patient environments

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<sup>1</sup> Presentations available to download from [www.cabe.org.uk/policy/reports](http://www.cabe.org.uk/policy/reports)

<sup>2</sup> Available from: <http://www.cabe.org.uk/news/press/showspeech.asp?id=731>

- Urbanism - The structure of neighbourhoods and towns, and in particular connective pedestrian-scale architecture

The US provides an example of what can happen when health is not a central objective in the design of public space.

There is a wealth of evidence that demonstrates how aesthetics and other elements of design can help promote health, for example a view from a window can have a direct impact on patient recovery time and neurologists are increasingly finding that aesthetics define spaces that encourage wellbeing.

Part of the problem that we're now trying to deal with can be traced back to 19<sup>th</sup> Century efforts to deal with the public health issues of the time by segregating uses, followed by the adoption of modernist layouts as proposed by Le Corbusier. These lead to an unravelling of the 'civic tapestry', in addressing this we need to return to more sustainable urban patterns.

New Urbanism provides one solution – it isn't always the right answer, but is trying to address the right problem.

The Princes Foundation is also working with NHS Estates to look at urban models for hospitals.

More research is needed.

### **Angela Mawle, UKPHA**

#### **Words into action**

All of the UKPHA's priorities can be satisfied by the built environment agenda. But although there is so much national synergy it isn't turning into action on the ground.

Sustainable development is a broad political agenda that has to include social justice and the natural environment. The elements of a sustainable community that contribute to public health objectives:

- Good local employment
- Pedestrian bicycle and public transport networks
- A pedestrian dominated public realm
- A rich and diverse natural environment
- Local facilities and resources
- Locally produced good wholesome food
- A rich and diverse cultural heritage
- Vibrantly textured social networks
- Informed and empowered individuals

However, there are still major inequalities in health and life expectancy and inequalities in environmental quality. Acheson highlighted the link between the two and the contribution of the built environment to public health.

Spending on public health can help save money that would have been spent on treatment. For example, exercise is one of the most effective ways of preventing deaths – more so than medical intervention.

The emerging concordat of the Coalition for Public Health Action calls for the need to work in partnership effectively.

What we're doing:

- Learning from grass roots developments
- Representing what is possible to others
- Providing policy recommendations
- Building on presence and work year by year

Most important thing is the need to join up working practices.

## **Discussion (Chatham House)**

### **Research**

Where is the burden of proof? While it is possible to see the direct impact of medication it is difficult to prove the cause and effect of built environment interventions, such as changes to the management of public space.

It may prove impossible to demonstrate the causal link, but regardless there is a need for evidence to show how spending up front on built environment and public health may save money in the long run, identifying the link between short term actions and long term outcomes.

The lack of research shouldn't be used as an excuse for inaction. But delivering may require a leap of faith that is difficult to achieve when a range of organisations and budgets are involved.

It may prove necessary to consider new research methods - for example research by NICE into the impact of a range of complex health interventions on community safety used a community trial method rather than a controlled trial.

There is also a need for further research to identify the necessary policy drivers, what currently prevents professionals from working together and the points at which critical decisions are made.

Public health is very evidence driven. Small voluntary and community organisations beat themselves up about not having enough evidence. Do we really need to prove the health benefits of walking a cycling? A common sense approach is needed.

### **Health, well-being and sustainable communities**

Joining the regeneration agenda and the public health agenda will require a true partnership, but while public health professionals will need to engage with the design agenda in order to meet their own PSA targets they don't currently know how to do so. Within the health sector there is a need to ensure clinical and public health professionals are working together.

There needs to be a public health reality check to join up performance management targets that don't currently co-exist comfortably.

Drivers such as economic regeneration, community cohesion and education are currently seen as higher priorities than health. But the sustainable communities agenda provides an opportunity to consider all elements together with health to focus on wellbeing, creating a desire for public health by creating a society in which people want to live longer.

In some regeneration areas the two agendas are coming together and having a big effect upon public health. This is especially noticeable in cities in the north of England, for example in Manchester health is seen as a fundamental part of city's attempts to create new communities. Healthy living is also being promoted through regeneration schemes' education programmes.

All fits vision of sustainable development, and the UK Sustainable Development Strategy is a promising policy driver.

Sustainability is at the heart of the well-being debate, but there is a need to understand what it really means to be sustainable, including walking and cycling rather than using the car.

Regeneration needs to take a holistic approach to health. Focus on prevention rather than care.

Public health and the quality of the built environment must be used to improve wellbeing and quality of life. Design has an important role to play in producing contentment, and a contented society will be a healthy society.

### **Barriers**

There is a danger of falling into the trap of seeing design from a medical view point, as a way of treating bad health rather than making a broader contribution to a healthier society.

PCT's are either too busy or lack interest.

There is a gap between professional languages; as a result the different professionals involved are often talking at cross purposes. Both sides of the built environment/public health divide produce too much research that is not accessible to the other because of language and jargon.

Health sector needs to own up to being an unformed client and acknowledge that pressure to deliver is hampering the ability of health professionals to see the big picture.

### **Making it happen**

Planners, architects and public health professionals must work together to produce an environment that is conducive to public health.

How people judge risk is relevant. People enjoy taking risks, but the type of risk varies. For example if you build a park people won't necessarily use it, and there is a need to assess and identify 'good risk' to ensure people make use of the facilities provided. Perceptions of risk also vary, for example, walking to school becomes much safer as more people do it, but a perception of risk means that parents continue to drive.

In prisons you can see a 19<sup>th</sup> century model being rethought to get a much more effective way of treating prisoners. Schools are now creating a learning environment as opposed to a teaching environment. There is now a need to rethink health care provision, moving away from hospitals to GP surgeries and elsewhere, starting with people and not buildings – what sort of place and infrastructure do people need to live healthy lives? This won't necessarily be a building; it could even be virtual space.

The challenge is to identify how best to distribute facilities in relation to the home, which may become the main focus for healthcare, and to identify the range of institutions that may become relevant – such as housing associations or football clubs. This may require new institutions rather than remodelled ones.

How can PCTs be encouraged to take on the public health agenda? Many doctors want to rethink their primary role to become health promoters rather than healers, but the traditional role of the surgery is treatment, which keeps them very busy. Some surgeries are being rebuilt to incorporate organic shops and community gardens, but there are cost implications. An alternative may be to use the surgery as the hub for such community facilities.

How can CAGE and built environment professionals demystify themselves so that the PCTs and NHS can work with them, rather than waiting for PCTs to approach them when they have so many other easier routes to advice? One example is CAGE Enabling making use of Enablers from outside specialist professions to breakdown language barriers.

Joining up does happen at the neighbourhood level. Local practices sometimes overtake the policy framework.

Planners, PCTs and local authorities need to work together to identify the health impact of development. Health factors need to be included within LPPs and development plans.

Importance of location of health facilities - often community health facilities are located at the back or on the edge of a hospital development, but if the building is in the wrong place it will never work. But push to deliver means that the Primary Care community don't have time to take anything other than the path of least resistance. PCT's need to recognise the power they have and take a more proactive role, but also want and need practical and active support as well as advice.

Need to recognise cultural differences, policy drivers must address the issues of language and provide practical tools and support.

There is a need for more funding. Creating a healthy community will cost money, but where is it going to come from and how can whole life savings be accounted for.

There is an enormous fertility of ideas, but need to crack the money issue. How do you get the money? There are multiple sources. Is there potential of applying the Carbon Trust's use of hypothecated taxes to encourage behavioural change to public health?

Funding is ultimately linked to policy drivers - ODPM need to recognise that they're already spending money on public health. Don't necessarily need more money but need a better understanding of how to use existing resources across government. Most public health interventions occur outside public health sector.

Can apparent contradictions be avoided by seeking to understand others?  
Contradictions only exist if one side is unable to see other side's perspective. Need to understand the business case from the other's perspective, working together to release more resources.

There is a need to redistribute power - professionals in all sectors need to learn how to give power away and work with communities as well as each other.

### **Best Practice in London**

GLA Act - the Mayor was given cross cutting responsibility with regard to the health of Londoners and charged with including sustainable development and equal opportunities in all policies.

London Plan - existing good connections with public health groups led to an evidence base that provides grounds for planning applications to be supported or for the negative health impacts to be identified.

Best practice guidance for London planners on integrated impact assessment, combining HIA and EIA

The Healthy Urban Development Unit (HUDU) provides a good example of how the interface between healthcare/health promotion and planning and design can be facilitated.

Two main elements to HUDU's work:

1. How to design and build for health
2. What services will new communities need? GPs alongside extended schools, leisure facilities, etc.