Achieving Healthy Urban Planning:
A comparison of three methods

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Executive Summary

With growing recognition of the strong relationship between the urban environment and population health, a diversity of ways of incorporating health and equity into urban planning is emerging. Although health impact assessment (HIA) is the most common and well-researched approach, other promising approaches with similar aims exist, including seconding public health professionals to local government and community-driven planning.

This paper reports on a study undertaken for a Master in Public Health thesis that compares these three approaches. Three case studies, one on each approach, were conducted by analysing recent New Zealand examples. Eleven semi-structured interviews were held with the key informants involved. The case studies were compared using an evaluative framework. The five criteria in this framework were: wellbeing; community participation; equity; collaboration; and common understanding and use of language.

The case study of seconding a public health professional to local government found that this approach can result in successful and sustained integration of broad health frameworks into the organisational culture of a local government agency. However, in the example we looked at, equity considerations had not been fully incorporated into local authority practice.

The community-driven planning case study demonstrated that well-resourced communities can assess local needs and manage projects in partnership with local government. On the other hand, although the financial cost of this process was small, it was very time- and resource-intensive for the community.

The HIA case study showed the potential for HIA to avert significant unforeseen negative health and equity impacts associated with a proposed policy, and to bring an understanding of the social determinants of health to a multidisciplinary setting. Interviewees from across the case studies concluded that HIA is a valuable catalyst for initiating other processes for incorporating wellbeing into urban planning.

This study provides insights on how best to incorporate health and equity considerations into urban planning, and shows that the three approaches have merit as alternative or complementary methods. The context for each case study varied in terms of geographic scope, project duration and population demographics. The results of this study suggest that these contexts contribute to effectiveness of these different methods for incorporating health and equity into urban planning. The insights from this study offer a useful foundation for both broadening the scope of practice and further evaluating diverse approaches to urban planning.

1. Introduction

With the most recent census showing that 85.9% of the New Zealand population live in urban areas (Statistics New Zealand 2009), the urban environment is a logical focal point for public health action, both to improve population health and to reduce inequalities. The importance of urban planning for health and equity has been highlighted in a recent report of the Public Health Advisory Committee. This report provides an overview of the links between urban planning and health, including air quality, injury, physical activity, community resilience and equity (Public Health Advisory Committee 2010). It is therefore important to understand how wellbeing and equity considerations can be included in urban planning.

Recently in New Zealand three different approaches have been used to achieve this:

- health impact assessment (HIA)
- community-driven planning
- seconding public health professionals to local government.

HIA recognises that actions in one sector have widespread impacts throughout other sectors. HIA is a method of policy evaluation in which a proposed policy or project is systematically assessed in terms of its potential beneficial and harmful impacts on population health (Simpson 2005). Likely health impacts are identified to provide recommendations to support decision-making. The intended result is the improvement of policy to support population health (World Health Organization 1999).

By incorporating consideration of health and its determinants into the decision-making processes in non-health areas, HIA aims to provide a catalyst for multidisciplinary collaboration and health promotion (World Health Organization 1999; Bos 2006). Health impact assessments vary in their effectiveness to inform and influence decision making in policy development and implementation. A review of 17 HIA case studies has shown that recommendations are often considered, but seldom acted upon, by policy makers through the amendment of proposals (Wismar, Blau, Ernst, et al 2007).

Another approach to incorporating health and equity into urban planning is through community participation. Community-driven planning makes the assumption that communities hold a body of knowledge about the determinants of their own wellbeing and suggests that the empowerment achieved through meaningful participation can itself improve wellbeing. Urban planning widely acknowledges the importance of involving citizens in planning and the potential of participatory methods to facilitate conflict resolution and information exchange, and to improve planning and design. Other benefits include increased confidence, trust and acceptance of changes, promotion of a sense of community, individual and collective learning, and financial savings (Sanoff 2000).

Community-driven planning is embedded to some degree in New Zealand's planning legislation. Urban land use and community service planning in New Zealand are undertaken under both the Resource Management Act 1991 (RMA) and the Local Government Act 2002 (LGA), with separate legislation (Land Transport Management Act 2003) guiding urban transport planning (Ministry for the Environment 2005). These three pieces of legislation have a variety of consultative requirements. The RMA's focus on the sustainable management of natural resources requires consultation with Māori and the development of regional and district plans. The LGA requires local authorities to develop Long Term Community Plans (LTCCPs) with an emphasis on community participation in setting outcomes and priorities.

Despite participation being legally required under the LGA (Parliamentary Counsel Office 2010), New Zealand's best practice urban design document, *The Urban Design Protocol*, places little emphasis on the role of the community other than in terms of consultation (Ministry for the Environment 2005). There are also few examples in the literature of urban planning professionals of embracing a community-centred approach (Semenza, March, Bontempo, et al 2007; Barton and Grant 2008; Joerin, Desthieux, Beuze, et al 2009). This gap between policy and practice is not unique to urban planning, as shown by recent experience of participation in primary health care (Kearns, Neuwelt 2009).

A third approach to incorporating health and equity into urban planning involves seconding public health professionals to local government. This approach has been used in the United Kingdom (UK), where public health professionals have been jointly employed by health agencies and local governments. In the UK these public health professionals work across organisations, addressing the health and equity impacts of local government activities and also integrating public health concepts into local government functions (Campbell, Marmot, Hunter, et al 2010). There is little experience of this kind of joint employment in New Zealand, possibly reflecting differences in the structure of the public health profession in New Zealand, which is heavily focused on the roles of those with medical training.

There is a great deal of evidence on the theory and practical application of both HIA and community-driven planning. However, reports of seconding public health professionals to local government are scarce. Furthermore, the strengths and weaknesses of these three approaches have not previously been compared. This paper reports on research to address this gap.

We aimed to compare and contrast the three approaches, identify successful methods for incorporating wellbeing and equity considerations in urban planning, and make recommendations for improvements in practice. We considered 'healthy urban planning' to be urban planning that considers human wellbeing outcomes at multiple levels, including both positive and negative influences on wellbeing, consistent with a broad definition of health (Barton, Tsourou 2000).

In New Zealand there is still significant separation between land-use and transport planning processes, with each having very different approaches to consultation. Incorporation of health into transport policies, and planning processes through health impact assessment has been the focus of a recent review (Ball, Ward, Thornley, et al 2009). As a result, this study focuses specifically on land use and the community social planning aspects of urban planning.

2. How the Three Approaches were Compared

Three case studies were conducted by analysing recent New Zealand examples of each approach. Each case study focused on an example of one of the three approaches to incorporating health and equity into urban planning. The contexts for the cases varied widely by geographic scope, case duration and population demographics. These factors are likely to be important in determining the success of different approaches for incorporating wellbeing into urban planning.

Eleven semi-structured interviews were held with the key informants involved. Key informants were chosen according to previously determined criteria that applied to the specific objectives of the study (Patton 2002; Teddlie, Yu 2007). These criteria were that each individual was centrally involved in one of the projects and was able to provide one of three perspectives (of public health, of local government, or as a community representative), and that collectively the participants represented a range of perspectives. The goal was to have a total of three or four participants per case study.

The interviews were conducted between January and March 2010, either face to face or over the phone. The participants were six council employees, three community members and two public health professionals. Participants were invited to review and edit their interview transcripts for clarity, and the researcher carefully examined agreement and disagreement between individuals from the same case study and looked for connections within and between interviews.

The use of qualitative semi-structured interviews allowed interviewees to express their views within a flexible structure, based on topics identified in the literature (Patton 1987; Britten 1995). Interview transcripts were coded using a general inductive approach (Thomas 2006) to explore aspects of each case study, and they were also coded according to the criteria of the evaluative framework developed for this study.

The qualitative methods used facilitated an in-depth comparison of the case studies. Evaluative criteria were developed based on the findings of two narrative reviews of the health, urban planning and policy, and HIA literature. (These reviews are available in the full thesis report.) This evaluative framework was used to consider the effectiveness of various aspects of the process and outcomes of healthy urban planning projects. The evaluative criteria were: wellbeing, community participation, equity, collaboration, and common understanding and use of language. These criteria are described in Table 1.

Table 1: Evaluative criteria used

Evaluative criterion	Description
Wellbeing: concepts and impacts	The wellbeing criterion encompassed both the way participants framed wellbeing, and how actions taken in the case study directly or indirectly influenced community wellbeing. In the HIA case study, this criterion also considered the extent to which recommendations were considered and implemented, as these factors may have an impact on wellbeing as predicted during the HIA process.
Community participation	The term 'community participation' is used widely, with a range of meanings. In this study, 'community' referred to the residents within a particular geographical boundary, due to the spatial nature of urban planning. 'Participation' was taken to mean 'a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services, and in taking action to achieve change' (World Health Organization 2002).
Equity	Reducing population health inequalities is a core value in public health. Equity is concerned with the distribution of differential impacts among population sub-groups to reduce inequalities. Ideally, sub-groups with the greatest need would experience the greatest positive impacts in order to work towards equality. There are a number of ways of defining groups that are at higher risk of inequalities, including geographical, socioeconomic, ethnic, gender and age characteristics. This criterion looked at how those involved considered and acted to reduce inequalities, in addition to attitudes towards inequalities.
Collaboration	In this study, collaboration was defined as multiple stakeholders, representing a range of organisations or the public, working together in order to build consensus, solve problems, or work towards a common goal.
Common understanding and use of language	This criterion was concerned with the way that people from different backgrounds or professions worked together, shared a common understanding and values, and used language. It included the use of jargon or specialised terminology, and the understanding of key concepts such as health. This section investigated whether these differences existed and if they brought about barriers to communication among stakeholders.

Ethics approval for the study was granted by the University of Auckland Human Participants Ethics Committee.

3. Description of the Case Studies

This section describes the background and outcomes of each case study as well as the insights provided by the stakeholders who were interviewed.

Case study 1:
Secondment of a public health professional to a local authority

This case study was of a secondment that emerged from collaboration between the local district health board (DHB) and the city council, which had jointly completed an HIA on the council's urban development strategy. Following this project, the public health professional that had facilitated the HIA continued working with the council through a long-term secondment.

The public health professional was motivated by the idea that the urban environment is a major determinant of health, and by the need for considerations of wellbeing to be better incorporated into local government planning. The focus of the secondment was on education and professional development within the council, and fostering inter-organisational collaboration. To create a foundation of relationship-building, the public health professional arranged workshops about healthy urban planning and did further work on HIA within the organisation. She also helped to coordinate guest speakers, drove the generation of a substantial wellbeing document, and raised awareness among colleagues about how wellbeing relates to local government functions.

The public health professional's work to build capacity for healthy planning relied on the incremental development of individual relationships. The greatest difficulty identified with this relationship development was the high turnover of staff. Another challenge was an initial resistance to the encroachment of health ideas into council work.

> [P]lanners and engineers they do, they do at least justify their, the fact that they don't specifically look at health as being, that it happens implicitly. So yeah, so some people are kind of defensive, if you like either defensive or don't want another level of complication on to something which they're already finding quite complicating. (Participant 2)

The political context was also significant for this case. Participants felt that central government policy was poorly aligned with the holistic approach to improving population health that is advocated for in public health. All participants communicated a need for a whole-of-government, cross-sectoral approach to the development of public policy.

All participants in this case study discussed the learning process that occurred in the council through the public health professional's influence. The most significant area of learning related to the determinants of health and the responsibility of council staff to improve population health. Council staff built their capacity by incorporating wellbeing considerations into their normal processes and integrating HIA as a central element of their projects.

> [T]he more that we can think through those impacts and understand those impacts, the better that we can do our urban planning. And I guess that's an ongoing process for us of really understanding those issues and what, how our planning influences those. (Participant 2)

The public health professional had interesting insights into the barriers that professionals working in the health sector create for themselves. She perceived that the public health workforce as a whole fails to put their teachings into practice and proposed a shift in focus from advising and instructing towards building relationships.

The participants reflected on the value of the secondment and the unique benefits offered by this approach. Having the public health professional inside the organisation made immediate and direct communication possible, and this aided relationship-building. The long-term contact created by this secondment has helped to ensure that plans are implemented. Furthermore, the education focus of this type of role can lead to more sustainable impacts, such as collective learning and capacity building.

> [O]ne of the values of the secondment was actually having someone inside the organisation. I've already said that but I probably can't state that enough, and that continues to be a key thing because staff can have the conversations, information can be exchanged and it's just a more immediate kind of interaction that you get. (Participant 3)

Because the secondment developed out of an urban planning HIA, it was difficult to consider the effect of the secondment in isolation from the earlier HIA. However, our interest was in comparing processes, and the participants in this case study were able to compare the two processes directly.

Case study 2:
Community-driven planning

In the case study of community-driven village planning, the council had previously used fairly standard community consultation processes, such as releasing draft proposals and receiving submissions. The change to community-driven village planning occurred when the community expressed a sense of disenfranchisement and voiced the feeling that their views were being ignored. Not only had the previous consultation processes fostered the development of a negative relationship between the council and residents, but actions taken by the local council were perceived to be misaligned with community priorities. The local residents association saw an opportunity to do things differently with the introduction of the Local Government Act in 2002, which required councils to actively involve communities in the development of their Long Term Council Community Plan (LTCCP).

The residents association desired greater control over the development of their physical environment and so decided to create a way for residents to contribute to their local environment and strengthen their community. The residents association gathered information about the wishes and vision of the community. For this to be credible, they needed this information to be representative of the whole community. The residents held 23 street meetings in their own homes and systematically recorded residents' views. After collating and analysing their data, the residents association presented it to the council.

The priorities identified by the community centred on road safety. Specific aims were to: reduce traffic speed; gain pedestrian access to a disconnected neighbouring suburb; encourage pedestrian transport; and make the town easily and safely accessible for those with disabilities, older residents and families with young children.

Once the residents association overcame initial resistance within the council, it was allocated funding. Not only did the council provide funding for the village to work towards completing its objectives, but the residents also collaborated with external agencies and succeeded in obtaining substantial additional funding.

This particular community is rich in resources, and this was crucial to the successful establishment of the village's planning programme. Many residents brought relevant professional skills, and many were also keen to get involved in projects through providing 'sweat equity', materials, and even financial contributions.

Participants emphasised the importance of having a community liaison person with the right characteristics and skill set, who was truly supportive of a community-driven approach.

> We've learnt from several false starts that liaison with council takes a very particular kind of person ... Community liaison requires the ability to listen, coordinate, connect and communicate. Now they are actually very high level skills and council would have to be very careful, in any other council that is, who they appoint to a role like community liaison because it's the key. (Participant 6)

Participants argued that a process of community change is easier in smaller, more stable communities, as these tend to have greater cohesion than more highly populated areas.

The community-driven village planning had a range of social and physical improvement outcomes. There has been a reduction in graffiti, and road safety has improved as a result of traffic calming. Furthermore, the community is completely wheelchair accessible due to improvements to street kerbs and footpaths, and there is greater social connectivity.

Perhaps the most significant outcomes of this programme have been in social wellbeing, and in particular, strengthened community relationships and the empowerment of residents.

> [I]f you've got people standing talking to each other whilst wielding a paint brush, moving to another part of the fence and meeting somebody else, in terms of the breaking down of community barriers and everybody taking ownership, it was a beginning example of our original goal to build a stronger community. (Participant 6)

The relationship between the council and the community is now substantially more positive than it was prior to this process. The previously combative environment has been replaced by a cooperative relationship and good lines of communication through the council's liaison manager.

The completely community-driven nature of this project brought about a high level of determination and motivation, and the actions taken were appropriate because they were decided upon by the wider community.

> [T]he community themselves, know often what their community wants, what their community would like to see. I mean they talk about it all the time, they live there. Some flash Harry who's got an urban planning degree, who is new to the city may not necessary pick the right way to go. (Participant 4)

From the council's perspective, the community-driven planning project represented enormous value for money, with the small budget bringing about huge changes within the community, increases in resident satisfaction and national recognition of the project's success.

> [T]he programme is extremely small, as I say it's about 1.5% of the rates, but the impact for the community and the impact on the goodwill for the council is much, much larger than 1.5% of the rates. I mean if you spent 1.5% on an advertising budget, you wouldn't get the gearing that we've got now. (Participant 4)

Following the success of the initial community project, the idea has grown and been recreated in other suburbs around the city. Each village is assigned a liaison manager, who assists the community's residents association to reach out to the broader community and determine their overall vision for their local area's future. The liaison manager also helps to access funding and resources for projects, both from within the council and from external agencies. The council's collaboration with a number of other government and private agencies means the communities are able to initiate change in all aspects of their village, such as education, community services, the physical environment and the natural environment.

Case study 3:
Health impact assessment (HIA)

The third case study was a health impact assessment (HIA) of an urban concept plan for a town. Many people at the council felt a sense of responsibility towards this town, which is in a high deprivation area and had historically been neglected. The HIA was considered to be a way for the council and the government agencies to address some of the major physical and social issues facing the town. The HIA followed the approach recommended by the World Health Organization for screening, scoping, identifying and assessing potential health impacts, and reporting on findings and recommendations (World Health Organization 1999).

An HIA facilitator coordinated the scoping meeting and appraisal workshop, conducted a review of the literature, collaborated across agencies to develop the recommendations, and wrote the final HIA report. The main collaborative component of this HIA was a half-day workshop with representatives from the council, community groups, the local public health service, Housing Corporation New Zealand and the district health board.

During the course of this process, the HIA facilitator collaborated with stakeholders remotely. This was described in the interviews as a 'fly-in-fly out' model of HIA.

> [A]t the time [the regional public health service] were more into the model where they contract us in and we do it and write it up and give it [to] them basically ... there wasn't any room in the contract for an ongoing role to work in partnership with the organisations. (Participant 10)

Because the community had been extensively consulted about previous projects, there was a perception among the organisers that the community was experiencing 'participation fatigue'. Those undertaking the HIA therefore opted to rely on representatives from community-based organisations and draw on previous community engagement outcomes.

Individuals from community-based organisations had a great deal of historical knowledge of the local community and provided a deep understanding of how the community functions. This knowledge helped to balance urban design practice with the experience of local people.

> We might design wonderful things that we see are sort of perfect for that community, but really you need to talk to the community about what their view of it is as well cause they may have quite a different perspective ... 'Cause most of the people who work, maybe don't even live [there] or don't understand how it works and ticks, so what you get is a real essence I suppose if you like from those people of what it's really like to be, to live [there], what they think they need. (Participant 8)

Participants felt that the council's documented commitment to a holistic view of wellbeing was an important supportive factor and assisted in effective collaboration with public health personnel.

Of the 46 recommendations developed through the HIA, only two had been carried out by the time this study was undertaken. Participants described a sense of frustration at the slow progress and the difficulty of getting funding to implement the recommended projects.

The most significant outcome of the HIA was considered to be the prevention of unintended negative consequences of the proposed plan. The HIA encouraged reconsideration of the council's initial plans to rezone the caravan park in which many families and young people lived permanently. Stakeholders considered the potential for this rezoning to displace the caravan park residents and therefore decided that a longer-term plan was more appropriate. Government agencies and social services began to work with residents and gradually organise affordable housing for these residents. Also, the proposed development of a central town square would have required the displacement of eight families. In the words of the HIA facilitator, 'from an equity point of view it's not that great that they were all Māori families', and this displacement was also avoided because of the HIA.

One frustration shared by all participants was the hurried nature of the HIA process. Participants perceived that the tight timeframe prevented effective collaboration and restricted the quality of the HIA itself. The organisations involved were viewed as having a poor understanding of each other's roles, restrictions and professional languages. Participants connected the short HIA process with the lack of understanding between organisations.

> [T]he communication post this process was fairly non-existent, so for me it's disappointing that you invest all this time into a process and council did the best it could to incorporate the HIA recommendations into our process, but I don't feel that the other partners did anything to support or reinforce the recommendations we were making. (Participant 9)

Participants spoke extensively of the failure of organisations to follow up on the HIA recommendations. Explanations offered included a perceived lack of accountability among external agencies; changing priorities, both within the council and among external organisations; and stakeholders lacking funding and resources to implement recommended projects. Directly involving those with decision-making power in the HIA process was also difficult.

Because of the difficulties identified in achieving collaboration with external organisations within a short time period, one participant suggested the establishment of a 'town centre manager', who would liaise with stakeholders to facilitate collaboration and follow up on stakeholders' promises.

4. Comparison of the Case Studies

The following section compares the three case studies as they relate to the five criteria in the evaluative framework: wellbeing; community participation; equity; collaboration; and common understanding and use of language.

Wellbeing: concepts and impacts

The three case studies demonstrated diverse understanding and frameworks for health and wellbeing. Although wellbeing outcomes were not measured as part of the case studies, there was much discussion in the interviews about the impacts of the processes being studied on wellbeing. Improving wellbeing was a core objective in the HIA and the secondment cases. Both of these projects were led by public health professionals and were underpinned by an understanding of the determinants of health.

> [W]e learnt that ... a lot of what determines health is stuff that we influence and it's not the health sector's problem, it's our problem in many respects ... [Some staff] have really embraced it and they, there's sort of been a light switching on for them and they're then very keen to ensure that this health thinking is part of the way that they work. (Participant 2)

In comparison, the interviews with participants from the community-driven project indicated possible ways that communities understand and frame wellbeing. In this project, community members focused on improving quality of life, happiness and social connectedness in the community.

> [T]he essence is to build a stronger community. It's actually not about the speed humps and it's not about the visible signs of change, they're just a means to the end. ... When people talked about their feelings about [the town] they had a strong attachment, a strong sense of place and the importance of people being together needing to be enhanced. So if we, in the process, if in what we're doing ... achieve those goals together then that's what it's all about, a community family. (Participant 6)

Community participation

Community participation is a common theme running through all of the cases, but there were contrasting views on the place of community participation and how it could be incorporated into projects. The community-driven case had the most intensive community participation and participation was perceived to be a positive process.

> When a community identifies what it wants to improve and also helps to make the improvement, it is a recipe for success. (Participant 6)

In contrast, those interviewed for the secondment case study cautioned against unconsidered community participation. They expressed the view that there are situations where community participation can be negative and inappropriate. In this case study, the community's voice was incorporated into individual projects. However council representatives were conscious of the potential impacts of participation bias, including over-representation of highly educated and resourced community members, which could lead to inequities in the provision of good planning and infrastructure.

[I]f you look at a lot of the public health agendas, we don't really have a good community support base for them ... if we went with the community voice on quite a lot of the issues that are important to us we would lose. And so we actually need to think very carefully sometimes whether we want to get community engagement in some of those things. Or, you know, how far do you push ahead with proposals that we believe are good for the public health, but we don't actually have support for? (Participant 1)

There was a sense among those interviewed for the HIA case study that community representatives were experiencing 'participation fatigue' from extensive previous community engagement processes. As a result, this project utilised representatives from community-based organisations to provide the community voice and to help represent a wide range of views.

[Community organisations] work with several families in this area so they have got a very broad knowledge around what … the issues are and that means that those voices are being transferred into the urban planning process. (Participant 11)

The tight timeframe for the HIA meant that organisational representatives found the rushed nature of the communication a barrier to meaningful participation.

Equity

The three case studies also identified very different perceptions and approaches to the possibility of inequities existing in their communities. The public health professional seconded to a city council pointed out that there was a lack of focus on equity considerations in the council.

I wouldn't say [structural inequality] was big driver of council, council laws thinking, elected council law thinking ... that structural inequalities stuff is very much a public health perspective ... (Participant 1)

In the community-driven case study, considerations about equity reflected the high socioeconomic status of the town. Discussions on equity in this case study concentrated on universal access for those with disabilities, older residents and parents of young children.

[T]his is a pretty damned expensive area to try and buy a house in, so that automatically gives you a sense of what the community is reflecting financially. (Participant 7)

In comparison, the HIA focused on a community with relatively high social deprivation, and a focus on reducing inequalities underpinned the project. Stakeholders gave particularly strong consideration to the needs of Māori and Pacific residents. As a result, interviewees in the HIA case study had been the most active in addressing inequities.

[T]he un-affordability of housing means that we have lots of Māori and particularly Pacific families that are overcrowded in the houses that they live in, so several families living in one home. There is lack of employment and as a consequence I think that makes, that impacts on their health ... We have very high incidence of diabetes and other similar health-related issues. We have a very, very high youth population, there's very little employment opportunities for our youth. This community also experiences a lack of incentive to stay in education, so there are some loose cannons in our community. (Participant 11)

Collaboration

All case studies showed that participants had been reliant on the input and cooperation of other organisations for the successful completion of their respective projects. However, participants framed and experienced collaboration in different ways. Participants from the secondment case study described the need for support and input from other organisations and individuals. This was because input from many people was required, in addition to leadership from the public health professional. A focus on relationship building laid the foundations for the professional development component of the public health professional's position.

> [Y]ou can't say that one person, ie, me, has been totally responsible for that but certainly being a part of that whole thing in shaping that. And I guess that's the other thing about a role like this, it's never just one person, it's always, there's always lots of other influences. (Participant 1)

Those involved in the community-driven case study spoke of a complete reliance on support and resources from the local council. The residents association engaged in relationship building, both within their community and with the council, to develop a cooperative working environment. Over time, this resulted in a mutually beneficial culture of effective collaboration between the council and the community.

> [T]here's just this general feel that the council is helping them help themselves and that has all sorts of rewards for the council in the sense of brownie points ... I think that it has matured now into, over the last three years, into a win/win. Well, rather than win/win, I think just a partnership, a partnership that is honest. We can't give them everything they want and they understand that, and that's the change ... I've learnt really that communities can look after themselves, and that they will help the council help them. I've learnt that it is quite definitely a two-way thing. (Participant 4)

Those involved in the HIA case study particularly valued the diverse perspectives of multiple stakeholders. This collaboration was considered to generate more creative solutions and a higher-quality HIA. Participants from both the secondment and HIA case studies agreed that HIAs could successfully foster communication between stakeholders in a way that would not otherwise occur.

> [T]he key strength of a health impact assessment is really getting people in a room together to sit around the table and talk. None of it is particularly rocket science, none of it is, you know, there's nothing special about it, but somehow it doesn't happen in the normal course of events. And to provide a process in a facilitatory way that gets people around the table together seems to have enormous outcomes, which I actually don't really understand but it does. (Participant 1)

Common language and use of language

The impact of differences in use of language on communication and relationship building varied widely between the case studies. In the secondment case study, definite differences in professional languages existed, although participants described this situation as more of a capacity-building experience than a barrier. Participants felt that the experience of having a public health professional working in the council had helped council staff understand the values of other sectors, such as health. The participants nevertheless spoke of a disconnection between various organisations.

[The public health professional] helped us gain a sort of understanding that some of the terminology and the jargon that the health sector use and the council sector use are different, but kind of mean the same thing. And I suppose it was a growing understanding that when we talk to each other we might need to change our language. (Participant 2)

Although participants from the community-driven case study identified 'languages' as an initial issue, this was relatively minor and occurred when community members wrote a community needs assessment report, which is traditionally the role of local government. Differences in professional languages were most apparent in the HIA case study, where the short time period and lack of follow-up did little to encourage stakeholders' understanding of each other's roles and restrictions.

I guess it highlighted a lack of understanding for me across all of the groups as to what we all do and how we can work together ... Whilst all the recommendations are valid and things that need to be done, they're not actually often aimed at the right organisation to deliver them ... We need to come to the table having a better understanding of each other's mandates and what control we can exercise over those things. So perhaps if we'd had more time we may have gained a better understanding of each other's areas of expertise and areas of control. (Participant 9)

5. What the Case Studies Highlight about the Three Approaches

We used qualitative case studies to explore three different approaches to incorporating wellbeing into urban planning. We compared the secondment of a public health professional to a local government urban planning team (the secondment case study), a community-driven planning process, and an urban planning HIA. This is the first time these approaches have been compared with each other. All three approaches were found to have merit. The strengths and weaknesses that were identified in the comparison of the case studies are summarised below.

The secondment case study demonstrated that seconding a public health professional to a local authority can lead to the successful integration of broad health frameworks into a wide range of local authority projects and into local government organisational culture. This approach offers the prospect of slow but sustained organisational change in the approaches to urban planning used by a local authority. This cultural shift has the potential to improve the wellbeing of large populations.

Such employment arrangements may to some extent address a recently identified lack of resources and knowledge among urban planners about methods for considering health in planning practice, even when planners realise it is important to do this (Beca Carter Hollings and Ferner Ltd 2010). The secondment also started a process of relationship strengthening between health organisations and local government. However, despite the successful uptake of health frameworks, the case study found that considerations of equity were not being incorporated into practice in this project.

The community-driven planning case study demonstrated a number of advantages. Community understandings of wellbeing were holistic, and the solutions that were developed addressed community priorities, making it highly likely that policies would be supported by the community. This case study showed that well-resourced communities are capable of undertaking needs assessment and managing a planning process in partnership with local government. Those involved in this project succeeded in engaging residents across their whole community, although this particular community was ethnically and socioeconomically homogeneous. Although the cost to the council was very small, the process was time- and resource-intensive for the community. Furthermore, the community had little access to evidence about inequalities and the health consequences of policy choices. Their understanding of inequalities was limited to the experience of disability within their community and did not extend to inequalities associated with poverty or ethnicity.

The secondment and the community owned planning cases were able to start with problems and develop solutions that incorporated wellbeing considerations. Both approaches also identified the critical role played by specific people – the public health professional and the council's liaison manager – in the success of each process.

The urban planning HIA case study demonstrated the ability of health impact assessment to avert some significant unforeseen negative health and equity impacts of a proposed policy. Those providing HIA and public health expertise were able to develop evidence-based recommendations within a short period of time. This case study also showed the potential for HIA to bring an understanding of the social determinants of health inequalities to a multidisciplinary setting. However, there was dissatisfaction among participants about the lack of action on the recommendations of the HIA, and the tight timeframe and hurried nature of the HIA process. Participants across the case studies concluded that HIA can be successful as a catalyst to develop other approaches for incorporating wellbeing into urban planning. For example, the secondment of the public health professional into a local authority grew out of a collaboration established when a district health board and the local authority worked jointly on an HIA.

Participants' opposing views about the place of community participation was striking, but also consistent with debates in the published literature. Wariness about the negative consequences of community participation was expressed by participants from the secondment case study. The risks they identified included the potential for community participation to be manipulative rather than empowering (World Health Organization 2002; Parry, Kemm 2005), inappropriate for complex subjects (Raco 2000; Wismar, Blau, Ernst, et al 2007), and requires a lot of time and resources (Raco 2000; Wright, Parry, Mathers, et al 2005). Other risks mentioned were the difficulties of getting representative participation (World Health Organization 2002; Parry, Kemm 2005; Wismar, Blau, Ernst, et al 2007) and concerns about generating unrealistic expectations (World Health Organization 2002). Concerns about the risks of community participation were also expressed in the HIA case study and reflect the focus on organisational 'expert' participation in the HIA literature (Wright, Parry, Mathers, et al 2005), despite authorities describing community participation as a core HIA value.

In contrast, the views of participants in the community-driven planning case study were closely aligned with authors who argue that community participation in planning is a right (Wismar, Blau, Ernst, et al 2007) and has positive outcomes, including: improved democracy and creative problem-solving (Barton, Grant 2008); ownership of solutions (Wright, Parry, Mathers, et al 2005); and enhanced community skills and knowledge (Wismar, Blau, Ernst, et al 2007). The experience from this case study suggests community participation in planning can lead to positive wellbeing outcomes when a community is well resourced and supported by positive relationships with local government. The community empowerment that results from ownership of the process can itself contribute to wellbeing.

6. Implications for Policy and Practice

This study provides rich material for considering how best to incorporate health and equity considerations into urban planning. The findings from this study are relevant to both urban planning and public health professionals, and complement the suggestions made in the recent report to the Public Health Advisory Committee about urban planners' knowledge of wellbeing and equity (Beca Carter Hollings and Ferner Ltd 2010).

The findings from the current study highlight a variety of ways to diversify approaches for improving consideration of health and equity in urban planning, and these are summarised below.

1. A range of successful approaches can be used to incorporate health and equity into urban planning and policy. There would therefore be value in extending support for HIA to include a wider range of approaches.

2. The public health methods used in HIA could be used to support other approaches for incorporating health and equity into urban planning. These methods include tailored literature reviews, context-dependent communication of public health evidence, and promoting an equity focus.

3. Health impact assessments are most useful when they lead to the use of other processes for incorporating health and equity into urban planning, which is often the case. This effect could be considered a vital component of the HIA process.

4. The community-driven planning process described in this study has been used in other communities in New Zealand. Evaluating the process and outcomes of these other examples would provide more generalisable recommendations for practice.

5. There is potential to develop a best-practice model for incorporating health and equity into small-scale urban planning. The model would include support for communities to develop ownership of their local community planning; resource contributions from local authorities and health sector agencies to reduce the burden on the community's time, skills and finances; and employing individuals with specific skills sets, such as public health professionals in local authorities and liaison managers adept at facilitating council–community relationships.

6. Methods that can successfully 'upscale' successful local planning processes to a regional level should be further explored. This could be initiated through studies of successful participatory processes for healthy regional planning and investigating the longer-term effects of integrating public health expertise into local and regional governance.

References

Ball J, Ward M, Thornley L, et al. 2009. *Applying Health Impact Assessment to Land Transport Planning. NZ Transport Agency Research Report 375.* Wellington: New Zealand Transport Agency.

Barton H, Grant M. 2008. Testing time for sustainability and health: striving for inclusive rationality in project appraisal. *Journal of the Royal Society for the Promotion of Health* 128(3): 130–39.

Barton H, Tsourou C. 2000. *Healthy Urban Planning: A WHO guide to planning for people.* London: Spon Press on behalf of the World Health Organization.

Beca Carter Hollings and Ferner Ltd. 2010. *Urban Planners' Knowledge of Health and Wellbeing Issues.* Wellington: Public Health Advisory Committee.

Bos R. 2006. Health impact assessment and health promotion. *Bulletin of the World Health Organisation* 84(11): 914–15.

Britten N. 1995. Qualitative research: qualitative interviews in medical research. *British Medical Journal* (311): 251–3.

Campbell F, Marmot M, Hunter D, et al. 2010. *The Social Determinants of Health and the Role of Local Government.* London: Improvement and Development Agency.

Joerin F, Desthieux G, Beuze SB, et al. 2009. Participatory diagnosis in urban planning: proposal for a learning process based on geographical information. *Journal of Environmental Management* 90(6): 2002–11.

Kearns RA, Neuwelt PM. 2009. *Within and Beyond Clinics: Primary health care and community participation.* In: Andrews G, Crooks V (eds). *Primary Health Care: People, practice, place.* Aldershot: Ashgate Press.

Ministry for the Environment. 2005. *The New Zealand Urban Design Protocol.* Wellington: Ministry for the Environment.

Parliamentary Counsel Office. 2010. *Local Government Act 2002 No 84 (as at 06 August 2010).* URL: http://www.legislation.govt.nz/act/public/2002/0084/latest/DLM170873.html. Accessed 28 August 2010.

Parry JM, Kemm JR. 2005. Criteria for use in the evaluation of health impact assessments. *Public Health* 119(12): 1122–9.

Patton M. 1987. *Depth Interviewing.* In: Patton MQ (ed). *How to Use Qualitative Methods in Evaluation* (pp. 108-143). London: SAGE.

Patton MQ. 2002. *Qualitative Designs and Data Collection.* In: Patton MQ (ed). *Qualitative Research and Evaluation Methods* (pp. 207–428). Thousand Oaks, California: SAGE.

Public Health Advisory Committee. 2010. *Healthy Places, Healthy Lives: Urban environments and wellbeing.* Wellington: Ministry of Health.

Raco M. 2000. Assessing community participation in local economic development – lessons for the new urban policy. *Political Geography* 19: 573–99.

Sanoff H. 2000. *Participation Purposes.* In: Sanoff H (ed). *Community Participation Methods in Design and Planning* (pp. 1–36). New York: Wiley.

Semenza JC, March TL, Bontempo BD. 2007. Community-initiated urban development: an ecological intervention. *Journal of Urban Health* 84(1): 8–20.

Simpson S. 2005. An introduction to health impact assessment. *New South Wales Public Health Bulletin* 16(7–8): 106–7.

Statistics New Zealand. 2009. *Population Mobility of Urban/Rural Profile Areas.* Wellington: Statistics New Zealand.

Teddlie C, Yu F. 2007. Mixed methods sampling: a typology with examples. *Journal of Mixed Methods Research* 1(1): 77–100.

Thomas DR. 2006. A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation* 27: 237–46.

Wismar M, Blau J, Ernst K, et al. 2007. *The Effectiveness of Health Impact Assessment: Scope and limitations of supporting decision-making in Europe.* Trowbridge: World Health Organization, Europe Observatory on Health Systems and Policies.

World Health Organization. 1999. *Health Impact Assessment: Main concepts and suggested approach. Gothenburg consensus paper.* Sweden: European Centre for Health Policy , World Health Organization.

World Health Organization. 2002. *Community Participation in Local Health and Sustainable Development: Approaches and techniques.* European Sustainable Development and Health Series 4. Copenhagen: World Health Organization Regional Office for Europe.

Wright J, Parry J, Mathers J. 2005. Participation in health impact assessment: objectives, methods and core values. *Bulletin of the World Health Organization* 83(1): 58–63.