

LEVERAGING HEALTH FOR SMART GROWTH

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Urban planning and public health have common historical roots. More than a century ago – in the era of urban reform and the ‘sanitary’ public health movement – professionals and policy makers recognized that the design of cities had direct consequences for public health. The evidence was as apparent as sewage-contaminated drinking water causing epidemics of dysentery. But urban planning and public health diverged for most of the remainder of the 20th century. Effective victory over traditional infectious diseases fueled the belief that science was a more powerful health tool than policy. Professional and economic forces split urban planning and public health apart both as disciplines and as tools for social advancement.

Today, however, we face health dangers dramatically different from those of the early 20th century. High among these are the epidemics of cardiovascular and respiratory disease and related conditions associated with mounting obesity. Leaders in public health and urban planning recognize the contributions their fields can make to this challenge and have rediscovered the synergy between their disciplines.

The key realization contributing to this renewed partnership is that the modern built environment increasingly lends itself to unhealthy physical inactivity. As our suburbs have grown, more and more people in the Region live in low-density environments and are largely reliant on automobiles for their mobility. The use of the automobile requires little physical activity and burns few calories, robbing many drivers of valuable exercise that urban dwellers and transit riders take for granted, walking around a city or from a train station to access goods and services. This problem is now causing planners and health officials to reexamine our suburban centers for ways that compact, mixed-use environments can reconnect the places where we live, work and play.

Regional Plan Association is one of several organizations around the country working to build healthy communities using community design strategies. RPA is developing a typology of built landscapes that will demonstrate how the rationale for greenways, transportation improvements and rational roadway network design is created at the regional and sub-regional levels. RPA has already launched a number of place-based interventions, so called “natural experiments,” to measure the impact on activity levels of changes in community design. For example, a project with NJ TRANSIT will attempt to measure the impact on activity levels of service improvements (the Secaucus Transfer) and relate those outcomes to several different settings for train stations.

In Stamford, in collaboration with our new health partners – the Yale Griffen School of Public Health, the City of Stamford and State of Connecticut Health Departments – we will measure the impact on activity levels of a new Mill River Greenway, which we advocate in the recent Master Plan.

There are also a variety of initiatives across the country that exemplify different aspects of the healthy communities concept. Oakland, California,

shows us that creating compact, mixed-use environments is no longer only an urban designer’s aesthetic preference, but a way of creating an environment that promotes walking and reduces traffic. A community development corporation called the Spanish Speaking Unity Council partnered with Bay Area Rapid Transit (BART) and the City of Oakland to develop a large mixed-use development adjacent to the BART station in Fruitvale, a low-income, minority community. With its groundbreaking in September 1999, this very unusual project was made possible because of the leadership provided by a non-traditional discipline partnering with transportation and planning agencies, banks, local, regional and federal government, nonprofit health and advocacy organizations and a variety of other partners.

Portland, Oregon has shown that promoting transit is not only a congestion-mitigation strategy by traffic planners, but a healthy communities objective for promoting walking at both ends of a transit trip. The city has combined a strong citizens advisory committee, a successful growth management initiative, significant transit development, strong efforts to link transit with bicycling and walking, a strongly stated goal to increase non-motorized travel, maps and pamphlets, rides, races and clinics and significant construction of alternative infrastructure to create one of the most successful efforts in the nation.

In Lake Worth, Florida we learn that neighborhood traffic calming now is not only a traffic management technique but a strategy for making places more “bikeable” and “walkable”. Lake Worth transformed a declining downtown with speeding traffic into a vibrant, pedestrian-friendly center using transportation improvements as the catalyst for broader community revitalization goals. Negotiations between local planners and Florida DOT led to narrower lanes, parallel parking, decorative light fixtures, planters, paved-block sidewalks and crosswalks, benches, trash containers, and other amenities.

In Cabarrus and Henderson counties, North Carolina, creating greenways, bikeways and pedestrian routes is no longer only an urban and suburban amenity, but a resource for an active and healthy lifestyle. The involvement of the Cardiovascular Health Coordinator (CVH) helped bring resources to the “Livable Community Blueprint” initiative and as a result bicycle and pedestrian facilities were made an integral part of the MPO’s transportation plan.

As with all forward-thinking initiatives in tight times, the biggest challenge for the Healthy Communities movement is funding. In addition to the support of leading foundations, notably the Robert Wood Johnson Foundation, the healthy communities agenda has helped directly leverage new capital. Sources of new capital for projects that have a biking/walking component and therefore a mobility or transportation component include Transportation Enhancement Act monies and “Rails to Trails” programs. In addition, when community not-for-profit hospitals become private, they are required to set up so called “local health conversion foundations” to commit some funds to community health promotion projects (not unlike the Community Reinvestment Act obligations private banks must meet).

