Health Inequities and Community Design

Roles, Barriers, and Needs of Local Public Health Agencies

A FOCUS GROUP REPORT

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for the National Association of County
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INTRODUCTION

One of America's persistent and significant public health problems is the disparity in health status that exists among low-income and racial/ethnic communities relative to other populations.

In fact, the Centers for Disease Control and Prevention (CDC) cautions that, "despite great improvements in the overall health of the nation, Americans who are members of racial and ethnic minority groups, including African Americans, American Indians and Alaska Natives, Asian Americans, Hispanics or Latinos, and other Pacific Islanders, are more likely than whites to have poor health and to die prematurely. These disparities are believed to be the results of the complex interaction among "environmental factors and specific health behaviors."[1]

For decades, we've recognized that land use patterns and community design create built environments that impact health and can lead to health disparities, primarily by creating social, economic and environmental inequities.[2] Gentrification, toxic exposure, access to health care, affordable housing and opportunities for gainful employment are examples of the range of (these are not all health related) issues that disadvantaged communities face with regard to land use and the built environment. Public health professionals are increasingly acknowledging that to fully address the problem of health disparities, they need to engage in the community design process. Local public health agencies are beginning to define their role in this process, the strategies they should promote, and how to overcome the challenges they face as they enter into the process.

As part of a cooperative agreement with the CDC's National Center for Environmental Health and National Center for Chronic Disease Prevention and Health Promotion, the National Association of County and City Health Officials (NACCHO) is seeking to assist local public health agencies (LPHAs) integration into the land use and transportation planning process. Through a series of focus groups and other activities, NACCHO is helping to define the role, barriers and needs of LPHAs as they address an array of health impacts related to planning and development. To date, six focus groups have been conducted focusing on environmental health, chronic disease/physical activity, collaboration between health and community design, traffic safety and health disparities. Copies of other focus group reports are available at www.naccho.org/project84.cfm.

This report summarizes findings from the focus group on "Health Disparities and Community Design". The session was held on January 30, 2003 in conjunction with the New Partners for Smart Growth national conference in New Orleans, Louisiana. A total of ten individuals participated representing LPHAs, planning departments, and state and local organizations with particular experience in health disparities and community design.

Four questions were posed to the focus group, including:

- What is your sense or understanding of how land use and transportation planning affects, or is related to, health disparities?
- What do you envision as the role of LPHAs in addressing health disparities via community design?
- What are the barriers to taking on this role?
- What is needed to help LPHAs overcome these barriers?

In terms of a baseline working definition, the consultant provided the following:

"Community design" encompasses:

- All of the policies, processes and decisions made within a community that determine the look and composition of the community, neighborhoods, streets, and environment;
- It includes decisions about whether transportation funding goes towards highway improvements or towards alternative transportation modes (including pedestrian and bicycling facilities);
- It determines whether the community accommodates population growth via more auto-oriented suburban subdivisions or via increased density in existing neighborhoods with compact, mixed-use development; and
- It dictates the siting of industrial and other environmentally impactful facilities within communities and it dictates the relationship of open space to developed land."

The consultant also offered the following as a working definition and understanding of the relationship between health disparities and community design:

- "Land use and transportation planning decisions influence the underlying determinants of health (e.g., income, transport/mobility, housing, employment, air/water quality, access to health care) and can therefore negatively impact/cause the health disparities experienced by low-income and racial/ethnic communities. For example:

- Decisions about the mix of residential and environmentally impactful industrial facilities can disproportionately affect disenfranchised communities;
- Smart Growth and community revitalization efforts have the potential to increase segregation and gentrification; and
- Transportation planning decisions about the siting of off-ramps and transit routes can unequally impact sectors of the community."

Finally, to clarify terminology, participants were informed that throughout the focus group, the terms "community design", "land use planning", and "land use and transportation planning" would be used interchangeably with each other as would the terms "built environment" and "physical environment". "Social inequity", "environmental injustice" and "health disparities" would also be used interchangeably but with the understanding that social inequity and environmental injustice are often contributors to health disparities.

Given these baseline definitions, focus group members provided their own definition and opinions on how community design and the built environment relate to and affect health disparities. The following summary captures these ideas and the group's responses to other posed questions.

FOOTNOTES

[1] Office of Minority Health, Centers for Disease Control and Prevention. Disease Burden & Health Risks. Accessed online at: www.cdc.gov/omh/AMH/dbrf.htm.

[2] PolicyLink. Reducing Health Disparities through a Focus on Communities. November 2002. Accessed online at: www.policylink.org/pdfs/HealthDisparities.pdf.

THE RELATIONSHIP BETWEEN COMMUNITY DESIGN AND HEALTH INEQUITY

> *"It all comes down to land use planning…asthma, air quality, access….they all have the same root causes. It really affects the way the entire community functions."*

Social Equity as an Underlying Factor

Focus group members embraced a broad and socio-ecological understanding of the relationship between health disparities and community design. They noted that while land use patterns and transportation systems affect, to some degree, the health of every member of a community, they can have a particularly burdensome and disparate impact on low-income and otherwise disadvantaged segments of the community. Several focus group members felt that the community design process directly relates to and often exacerbates the root causes of health disparities - namely class, racism, poverty and social isolation. In addition, the focus group noted that using the term "health disparities" in our local and national dialogue on this issue only serves to misdirect our attention towards "symptoms" and away from "underlying causative factors". They felt that the real problems are social and economic inequity and environmental injustice. Working under this definition, focus group members felt that the public health and community design communities can begin to ask:

> "*How does land use planning relate to these root causes? We never want to talk about racism but that is a root cause. How come land use planning does not take class into consideration?*"

Several focus group members asserted that power and class are prominent actors in the local community design process. Decisions about land use and transportation planning perpetuate class distinctions and the imbalance of power, thus maintaining the status quo in our society. They felt that communities and elected officials continue to make land use, housing and transportation policies and decisions that are not in the collective best interest of the entire community but rather for the benefit of a smaller, more affluent sub-section.

> *"All of those people engaged in constructing our environment in all its constellations in this country are wealthy and powerful and there is very little reason to change what they're doing."*

Beyond the Medical Model

The focus group emphasized the need to go beyond the typical medical model view of health and health disparities as they relate to the built environment. Too often, the dialogue on designing for a healthy community narrowly centers on the role of transportation systems in determining access to health care services, particularly by the poor. Consequently, city planners design for health care access but not necessarily for the underlying environmental and socio-ecological determinants of health. Focus group members felt that this perspective reflects a "medicalized" view of health and fails to apply the public health model's more comprehensive definition and prevention-oriented approach to health. Using a public health framework, the discussion could expand to consider how multiple aspects of the built environment contribute to disparities in health. For example:

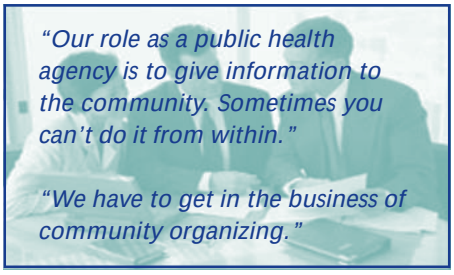
- Is affordable and acceptable housing available to all members of the community?
- Do all members of the community have access to fresh fruits and vegetables?
- Are there gun dealers or an over abundance of alcohol outlets in certain neighborhoods?
- Do lower income neighborhoods have as much access to walking as a safe and convenient form of physical activity?

Lastly, focus group members noted concern that smart growth and similar development strategies have the potential to spur gentrification. While the tenets of smart growth call for a mix of housing types, the experience of focus group members is that these projects often unintentionally decrease affordable housing supplies and increase socio-economic segregation, thereby possibly contributing to social inequity and health disparities.

THE ROLE OF LOCAL PUBLIC HEALTH AGENCIES

According to focus group members, historically and in current times, the public health community has an important role to play in ensuring that the environments in which people live, work and play are safe and healthy, and do not contribute to social, economic or health disparities. Members suggested several specific ways in which LPHAs can fulfill this role including direct advocacy and community organizing, education and awareness raising, participation in the community design process, collaboration, and defining the problem through data.

Community Organizing and Advocacy



"Our role as a public health agency is to give information to the community. Sometimes you can't do it from within."

"We have to get in the business of community organizing."

- LPHAs need to speak out and be more proactive with regard to housing, development projects and other community design decisions that have the potential to perpetuate health disparities. Similarly, public health agencies need to speak out in favor of community efforts that can rectify social inequities.
- However, focus group members acknowledged that, at times, LPHAs will need to take a behind-the-scenes role to avoid political hailstorms. In these situations, they recommended that LPHAs to assume a more passive approach, empowering the residents and community advocates by strategically assisting them with data, information and technical assistance. LPHAs need not be the front-runner to move an agenda and mobilize the community.
- Focus group members felt that LPHAs should also speak to the economics of health care and its link to community economic development. When "job creation" is pushed as a rationale for growth and major development projects, public health professionals should insist that these jobs provide a living wage and include adequate health insurance coverage.

Build Informed and Self-Determining Communities

"There should be nobody asking, 'What are health disparities and are some people in our community worse off than others?' There should be a real clear understanding in the community."

- In addition to mobilizing around specific development issues, LPHAs should increase general awareness about health disparities: that they exist and how they relate to the root social and environmental causes including power, class, poverty, and race/ethnicity. For example, LPHAs should help communities and elected officials understand the links between asthma and inadequate low-income housing and between childhood diabetes and the lack of parks, safe places to walk and school-based physical activity.
- Public health professionals should build support and momentum for the types of housing and community design that minimizes inequities. LPHAs can provide communities with tools, models and a vision of what constitutes an equitable and healthy community and how it would look.
- However, LPHAs should ultimately allow communities to be self-determining. While they may play a key role in educating, mobilizing and catalyzing around an issue, LPHAs need to recognize that their role is in helping the community to self-identify its major concerns and direct its own problem-solving process.

Expanded Role in Development

The public health community needs to become significantly more involved in the actual land use and transportation planning process. Focus group members identified several specific points where public health agencies can intervene in these processes so as to minimize health disparities and other health impacts:

- Expand the role and purview of LPHAs in the development review process.[1] They need to be at the table at the beginning stages of these conversations and their scope needs to expand from water quality and sewage to include other issues including health disparities.
- Expand the role of public health professionals in the local Environmental Impact Report (EIR) process. LPHAs need to be involved in providing input and approval to the EIR process on issues that go beyond wastewater.
- Public health professionals need to have a seat on local planning commissions. The public health community also needs to encourage under-represented groups to get more involved in planning commissions and other community planning efforts.

- Advocate for the consideration of health disparities and their underlying causes in General/Master Plans, Community Plans, Regional Comprehensive Plans and Regional Transportation Plans.[2]

FOOTNOTES

[1] This is the process by which developers seek approval for development projects from their local city or jurisdiction. The process begins with planning departments providing preliminary input to the developer on changes and improvements to be made prior to the proposal entering into the "formal" approval process. This early review stage is a time to provide suggestions that can be integrated before the developer invests so much that changes are economically or politically unfeasible.

[2] A "Master Plan" is an official public document adopted by a quasi-legislative body (e.g. a county or municipal Planning Commission) that sets out how an area should evolve over a specified period of time. A Master Plan contains general policies that direct growth and development. The term used for these plans varies by locality, state, and region where they may be referred to as General Plans, Comprehensive Plans, or Comprehensive Master Plans. Additional Master Plans can be developed to address specific aspects of land use such as transportation, open space, or pedestrian accommodations. "Community Plans" are for defined communities within a city or county. They can also be referred to as Sub-Area Plans or Special Area Plans. At the regional level, the overarching land use plan is typically referred to as the "Regional Comprehensive Plan" (and may be given a special term for the particular region). A "Regional Transportation Plan" (RTP) is the major policy document and process for transportation planning (as opposed to land use). The RTP dictates how federal transportation funding will be spent in a particular region (e.g., on highways vs. transit vs. pedestrian improvements) and how it gets distributed among the various local jurisdictions within a region. As such, the RTP is instrumental in affecting the region's shape, form, and quality of life.

Data, Assessment and Standards

> *"We have to have some arguments in our hands, we need your help. You will have to give us something with very easy parameters that we can count ourselves."*
> *—City Planner*

> *"This is what a healthy community looks like and these are the kinds of things we want to see"*

- Public health advocates need to provide the standard or measure of what constitutes a healthy community and what community design features promote health improvements. Planners and decision-makers will increasingly look to public health professionals to define the community policies or countermeasures needed to achieve a certain level of "health" or well-being. Traffic engineers and developers already have the statistical models and data, allowing them to provide clear and detailed objectives and outcomes; this same level of specificity is expected of the public health community.
- Additionally, LPHAs should conduct Community Health Assessments and expand them to include issues related to the built environment. Focus group members suggested that local programs build on existing local data when possible and use Healthy People 2010 measures to describe and compare their community.

LPHAs can also:

- Assess the assets of the built environment. Shape the discussion around what makes a healthy environment, not just what's wrong with the community. Overlay the land use factors with the health data to identify the built environment assets that contribute to better health.
- Make better use of qualitative data and information, especially for advocacy and with local elected officials.

Collaboration and Forming Bridges

"We have to link with something bigger than we are"

- The Focus group felt that, to move these issues, public health professionals will need to collaborate with other stakeholders that are already working on smart growth and related movements. Obvious allies include bike and pedestrian groups, livable communities advocates and community development advocates. These groups typically welcome the participation of public health professionals, particularly in getting unpopular social equity measures passed (e.g., ordinances to increase the number of single room occupancy units).
- Public health professionals can also ally with residents and other community-based groups such as the faith community and neighborhood planning groups.
- LPHAs can work much more closely with their key governmental partners in community design (i.e., planners, traffic engineers, public works, and parks and recreation). They can start by having cross-disciplinary meetings to share information and identify common goals. Ultimately, they can graduate to a process of coordinated organizational planning in which shared objectives are built into each other's budget and programmatic planning.

EXAMPLE FROM THE FIELD

The state of Pennsylvania provides some examples of cross-disciplinary collaboration at the state level. Recently, three state departments (Health, Conservation and Natural Resources, and Transportation) began meeting to discuss health and the built environment and how they could encourage collaboration at the local level. As a first step, they are adding cross-disciplinary collaboration as a requirement for grant proposals. They are also looking at what criteria local programs can use to demonstrate improvements in health and quality of life as a result of either health or built environment interventions.

CHALLENGES AND BARRIERS

"Public health and health officials have a hard time making that "root cause" connection…they never really know how to branch out to that transportation and land use planning world because it's a stretch, its not in their comfort zone."

The focus group identified several barriers for LPHAs in addressing health disparities and community design. One of the most significant is the general lack of priority for health disparities within the public health community. This may be due in part to the more abstract nature of health disparities as a problem and to the dominance of the medical model in shaping our thinking and approaches to prevention.[1] Relative to other public health issues, "health disparities" encompass many "diseases" and is not solely a disease-specific public health problem. Having more to do with the underlying causes of poor health, health disparities are a complex, global set of issues that are less amenable to typical medical model interventions. All of these factors contribute to making it harder for local public health agencies to know what or how to tackle health disparities, ultimately relegating it to an issue that should be, but is not addressed. The following describes additional barriers identified by the focus group.

- ***Public health's lack of political power.*** In general, LPHAs and the public health community do not have the political cache relative to developers, the business community and other players in community design. This is particularly so when it comes to advancing an agenda that goes against the power status quo and, instead, serves the under-represented.
- ***Lack of clarity on "the issue" and the "how to".*** Compared to other interest groups that are already involved in the process, the public health community's desired outcomes are less defined and not yet easily rendered into measurable objectives with timelines. This lack of clarity puts the public health message at a disadvantage relative to other interests in the community design process.
- ***Categorical programs promote categorical thinking.*** To be effective, local public health agencies need to recognize the ubiquitous nature of health disparities (and the built environment's impact). It is not a categorically defined problem, but instead relates to many public health issues and programs. LPHAs need to rethink their approach so that programmatic planning merges these overlapping issues.

- ***Over-reliance on quantitative data for defining health problems.*** Several focus group members noted that often, environmental health hazards are validated as problems only when they can be measured quantitatively. Toxic exposure and other environmental health issues that are documented through qualitative means typically do not receive the same level of attention or validation. Consequently, the health impacts and disparities of certain communities do not get counted because they are documented through other means (e.g., those communicated through the oral history of Native American populations). The public health community does not yet make effective use of the methodology or practice of capturing and using people's stories. As an advocacy tool, public health professionals should bring in the "living" examples of health disparities and the built environment. The tangible stories about people are often what convince local decision-makers.
- ***Differences in levels of funding reflect the institutionalization of class.*** Federal funding, especially research-based funding streams, flows in greater quantity towards major institutions of research and higher learning (e.g., the Johns Hopkins, Columbia's and Harvard's). This concentrates funding according to the geographic location of research centers as opposed to need and disparity. Consequently, communities with the greatest need, but without research institutions, may be short-changed in accessing federal funds.

MOVING FORWARD: SOLUTIONS AND CAPACITY BUILDING

Focus group members called on NACCHO, CDC and other national organizations to provide training, technical assistance and capacity building to help local public health agencies address health disparities and community design. They also emphasized that national entities should coordinate these efforts so that they make sense when translated to the local level.

Training and Technical Assistance

- Several types of training and capacity building activities were recommended including:
  - Provide the rationale and build momentum around a role for public health professionals in land use and transportation planning.
  - Promote a broader definition of health disparities and community design, one that is not solely based on the medical model.
  - Conduct training for public health professionals on the role of the built environment and the community planning process, including how to strategically intervene.
  - Disseminate the tools, approaches, and models.
  - Provide training to public health professionals in the public health approach, prevention, building alliances, collaboration, and community organizing. The training has to go beyond the medical model.
  - Provide leadership development for public health professionals.
  - Provide assistance in policy and public health advocacy.
  - Include sessions on the impact of the built environment at public health conferences (begin talking about the relationship and the strategies).
- Establish cross-disciplinary training programs between schools of public health, schools of urban planning and schools of traffic engineering.
- Provide cross-disciplinary training and education among working professionals. Model these after other successful cross-disciplinary programs such as the NACCHO Community Revitalization Forums (that involved public health/environmental health and economic development professionals). Out of these programs, develop and disseminate the technical assistance tools and resources.

Additional Recommendations

- Provide the impetus for cross-disciplinary collaboration at the local level. 0For example, funding agencies could require collaboration between health, planning and transportation as a part of grant applications (as per the Robert Wood Johnson Foundation Active Living by Design Call for Proposals).
- Integrate some of these issues into the discussion on emergency preparedness. Much of LPHA resources and capacity are currently dominated by efforts in emergency preparedness and bioterrorism prevention. Local programs should consider ways to leverage these resources by building into the discussion related issues of health and the built environment.

CONCLUSION

The issue of health disparities is a complex and persistent one, that has not yet received the attention or priority it deserves from the public health community or the broader society. In most communities, land use patterns and community design contribute to social and environmental inequities and, consequently, perpetuate disparities in health. While LPHAs have a clear responsibility for eliminating health disparities, their role in doing so is less clear, particularly with regard to the land use planning process. Findings from this focus group illustrate several potential roles for LPHAs. However, several questions need to be explored in greater depth including:

- How do LPHAs most effectively engage in community design in order to eliminate health disparities?
- What is the clear and concise message that they should carry into these efforts?
- What community design strategies should LPHAs promote to mitigate the most pressing health disparities?
- Administratively and programmatically, how can LPHAs integrate their health disparities work with their work related to other built environment issues (e.g., physical activity)?

Clearly, national public health organizations such as NACCHO and CDC should play a strong leadership role in helping to answer these questions. They should also provide the training, technical assistance, coordination and vision that the public health community needs to move forward in eliminating health disparities through community design.

FOOTNOTES

[1] However, focus group members noted that the medical model, when linked with the public health model, form a comprehensive approach to health. Certain aspects of the medical model are critical for defining problems, priorities and directions. For example, the data generated through health care systems is important for describing community health status and targeting interventions.

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