TOWARD THE HEALTHY CITY

People, Places, and the Politics of Urban Planning

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1 Some Challenges for Healthy City Planning

Urban places and the city planning processes that shape them—particularly those processes governing land use, housing, transportation, job opportunities, social services, the quality of the urban environment and opportunities for public participation in local government—are increasingly understood as powerful determinants of population health. Premature death, and unnecessary burdens of disease and suffering, are disproportionately concentrated in city neighborhoods of the poor and people of color, where residential segregation concentrates poverty, liquor stores outnumber supermarkets, toxic sites are adjacent to playgrounds, and public resources go to incarceration rather than education. While urban divestment, redlining and racist neglect were largely to blame for many urban ills and inequities of the twentieth century, city planners in the twenty-first century are increasingly faced with the added challenge of revitalizing neglected urban neighborhoods in ways that improve health and promote greater equity.

How can modern city planning, a profession that emerged in the late nineteenth century with a goal of improving the health of the least-well-off urban residents but lost this focus throughout the twentieth century, return to its health and social justice roots? What are the connections among contemporary city planning processes, not just physical outcomes, and health equity? What new political processes can help reconnect planning and public health with a focus on addressing the social determinants of health inequities in cities?

This book answers these and other questions by highlighting how public health and planning agencies along with community-based coalitions are redefining environmental health politics in cities to improve the health of people and places. Twenty-first century efforts to reconnect the fields in

the United States have, to date, focused on a very limited conception of healthy planning, such as how physical design changes in cities might increase physical activity and thereby improve health. This book highlights that physical changes to places without accompanying political and institutional change will ultimately fail to improve the health of disadvantaged urban populations and move urban politics toward planning more healthy and equitable cities. Further, while much contemporary research documents what's wrong with cities, particularly in poor communities of color, much less work aims to explore what political and administrative changes in municipal government can improve the well-being of people and places. *Toward the Healthy City* explores how government agencies and community coalitions in the San Francisco Bay Area are reconnecting city planning by working to change the social, scientific, and political institutions that make places and populations healthy. The book offers a new decision making framework—called healthy city planning—that address the political conditions and institutional changes that must occur in order for urban planning and public health to reconnect to promote greater health equity. Healthy city planning will require new issue and problem framings, investigative and analytic techniques, and inclusive and deliberative public processes that together can generate new norms, discourses, and practice for greater health equity. As *Toward the Healthy City* argues, healthy city planning must be viewed as healthy urban governance, where both the *substantive content* of what contributes to human well-being—the physical and social qualities that promote urban health—and the decision-making *processes and institutions* that shape the distributions of these qualities across places and populations are improved.

Unhealthy and Inequitable Cities

American cities—or more precisely certain neighborhoods in these cities—are facing a health crisis. While not a new phenomenon, the urban poor, immigrants and people of color die earlier and suffer more, by almost every measure of disease, than any population group in the United States. A sampling of evidence is as staggering as they are disturbing:

▪ In the New York City area, the predominantly poor, minority neighborhoods of the South Bronx, Harlem, and Central Brooklyn have rates of diabetes, asthma, mental illness, and HIV/AIDS that are nearly double that of the rest of the city (Karparti et al. 2004).

- In Boston's predominantly African-American and Latino Roxbury neighborhood, asthma rates between 2003 and 2005 for children under 5 were the highest in the city and more than double the citywide average (The Health of Boston 2007:35).
- The death rates from diabetes among Puerto Ricans in Humboldt Park and West Town neighborhoods of Chicago are more than twice the citywide average and 34 percent of Puerto Rican children in these neighborhoods have asthma, one of the highest rates recorded anywhere in the country (Whitman et al. 2006).
- Infant mortality for African-Americans living in the City of Compton, Los Angeles County, California, in 2004 was 17.3 deaths per 1,000 live births, the highest in the state of California and nearly two-and-a-half times greater than the rate for the United States (McCormick and Holding 2004).
- Deaths from cardiovascular disease in the predominantly African-American east side of Detroit are the highest in the city and over twice the national average (Schulz et al. 2005).
- The Bayview–Hunters Point neighborhood in San Francisco, where Latinos and African-Americans are a majority, has the highest rates of adult and pediatric asthma, adult diabetes, and congestive heart failure in the entire city (BHSF 2007).

What explains these disturbing and, as I will show in subsequent chapters, persistent but avoidable patterns of death and disease? Public health has a history of searching for the one "big cause" or explanation for differences in health outcomes across populations, from nineteenth-century theories of miasma and contagion to medical care and genetic explanations of the twenty-first century. Yet urban health researchers and professionals are increasingly exploring how a combination of place-based physical, economic and social characteristics and the public policies and institutions that shape them—not genetics, lifestyles or health care—are the cause of inequitable distributions of well-being in cities. For example, Adam Karpati, assistant commissioner of the New York City Department of Health and Mental Hygiene, noted in testimony to the New York City Council that the concentration of health disparities in poor, African-American and Latino neighborhoods are not likely due to disparities in access to health care, risky individual lifestyles, or genetic differences, but that:

They are due primarily to differences in the social, economic, and physical conditions in which people live and the health behavior patterns that arise in these

settings. "Health disparities" are more than "health-care disparities" . . . one lesson from the health data is that disparities exist for almost every condition. This observation suggests that, regardless of the specific issue, poor health shares common root causes. It is important to remember, then, that strategies aimed at particular issues need to be complemented by attention to those root causes of poor health: poverty, discrimination, poor housing, and other social inequities. Fundamentally, *eliminating health disparities is about social justice*, which is the underlying philosophy of public health. (Emphasis added; Karpati 2004)

Toward the Healthy City explores how city planning processes can address the "root causes" of health inequities.[1] I reveal how urban governance practices can alter the social determinants of health (SDOH), including the quality of employment and educational opportunities, affordable housing, access to healthy food, transit that serves a range a users, safe spaces for social interaction, and toxic-free environments, all fundamental drivers of health inequities according to the World Health Organization (WHO 2008). This book explores a new political framework that could improve upon and extend in new ways current efforts to address urban health inequities (Barton and Tsourou 2000; Diez-Roux 2001; Duhl and Sanchez 1999; Fitzpatrick and LaGory 2000; Freudenberg et al. 2006; Frumkin et al. 2004; Geronimus 2000; Kawachi and Berkman 2003).

City Planning as Urban Governance

Planning practice as conceived in this book is about the processes, institutions, and discourses that generate the physical plans and interventions that shape cities. While the everyday practice of city planning has some formal rules, such as drafting land use plans and including the public in environmental review processes, planners regularly have to make discretionary decisions that shape the content and direction of these processes. These discretionary decisions include such subjective judgments as how much information to release to the public, the selection of the consultant team that often performs analyses, the standards of acceptable evidence and norms of inquiry in review processes, which interest groups to invite to public processes, and how participatory processes will adjudicate disputes and reach agreement (Friedman 1987; Forester 1999). These decisions have a significant influence over the content and outcomes of planning processes, such as whether they do or do not respond to claims of bias, discrimination and inequality. Importantly, the politics of planning in America is also shaped by "planners"—from the private sector to

community members—that sit outside of governmental planning agencies. Public–private planning partnerships, autonomous public authorities managing ports and airports, quasi-public redevelopment corporations, nonprofit community development corporations, and the privatized traditional public services in cities have all blurred the boundaries between public, private, and community planning and the political alliances and interests of "planners" (Fishman 2000; Graham and Marvin 2001; Harvey 1989). Thus I view urban planning as simultaneously about the micro-politics of cities—or the day-to-day negotiations over development and management decisions (Majone 1989)—and the macro-politics of cities—or conflicts about how different political ideologies ought to shape the place-based goals and outcomes of planning processes (Hajer 2001).

This micro and macro conception of the politics of planning remains controversial among theorists but suggests that planning practice ought to be considered an essential part of urban governance (Fainstein 2000; Yiftachel and Huxley 2000). Just as the spheres of political, economic, and social life overlap in the activities of everyday lives, the term governance as used here emphasizes the interactions, relations, and meaning-making that occurs as organizations attempt to influence collective action (Cars et al. 2002; Young 1996). Governance is not just about government, it is also about the struggles and conflicts between formal institutions and organizations and informal norms and practices, and how actors use both formal and informal processes to shape public decisions.[2] Urban governance includes a complex mix of different contexts, actors, arenas, and issues, where struggles over power are exposed in public discourses or embedded in tacit day-to-day routines. While I expand on the idea of planning as urban governance in later chapters, I use the term here to make explicit the political conditions that can lead planners to use or abuse power, respond to or even resist market forces, work to empower some groups and dis-empower others, promote multi-party consensual decision making or simply rationalize decisions already made (Forester 1999).

Public Health Promotion in the City

By public health I refer to the public policies, practices, and processes that influence the distribution of disease, death, and well-being for populations, or what the field generally calls health promotion. Similar to my view of planning, the work of public health is often framed as occurring in both

formal governmental institutions and informal governance processes. For example, the US Institute of Medicine's (1988:7) definition of public health states that the profession aims to fulfill:

society's interest in assuring the conditions in which people can be healthy . . . It links many disciplines and rests upon the scientific core of epidemiology. . . . [T]he committee defines the organizational framework of public health to encompass both activities undertaken within the formal structure of government and the associated efforts of private and voluntary organizations and individuals.

Also similar to my view of city planning, public health should be viewed as an ongoing practice, not "merely the absence of disease or infirmity," as the World Health Organization so articulately stated over half a century ago (WHO 1948). The 1986 Ottawa Charter for health promotion further clarified that health is a "resource for everyday life, not the objective of living" and "is a positive concept emphasizing social and personal resources, as well as physical capacities" (WHO 1986). Health promotion, the WHO has repeatedly emphasized, cannot be achieved by the health sector alone but also demands coordinated action across non–health policy areas of government, such as social, economic, service, and environmental sectors, along with participation by nongovernmental organizations, industry, and the media (WHO 2008).

Building on the International Healthy City Movement

This book builds on and explores ways to extend the work of the international healthy cities movement that originated in the European offices of the World Health Organization (WHO 1988). Early leaders of the international healthy city movement were Trevor Hancock and Leonard Duhl (1988), who suggested that the healthy city is a place that is continually creating and improving the physical, social, and political environments and expanding the community resources that enable individuals and groups to support each other in performing all the functions of life and in developing themselves to their maximum potential. Hancock and Duhl (1988:23) go on to note:

[W]e must develop and incorporate into our assessment of the health of a city a variety of unconventional, intuitive and holistic measures to supplement the hard data. Indeed, unless data are turned into stories that can be understood by all, they are not effective in any process of change, either political or administrative.

I will highlight how "planners" in the United States are employing new norms, analytic tools, and decision-making processes to capture some of these qualities of the healthy city. Drawing from the analytic criteria of the WHO for healthy cities, I show how contemporary healthy planning work in the United States is extending these international ideas. Despite barriers of earlier practices, opportunities exist for implementing healthy urban environments whose characteristics can exceed the ideal principles outlined by the WHO (as shown in the sidebars below and next page).

This book differs from and extends the work of the international healthy cities movement in some important ways. First, the WHO healthy cities program has not emphasized the combination of policy processes, science norms, and organizational network building that might contribute to healthy urban development and city planning more generally (Tankano 2003:5). Second, after two decades, the World Health Organization's healthy cities program in Europe has only had limited success integrating analyses of problems that might be driving health inequities in cities with developing healthy urban plans and implementing these plans (De Leeuw and Skovgaard 2005). Third, evaluations of the European healthy cities

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WHO Characteristics of a Healthy City

▪ A clean, safe physical environment of a high quality (including housing quality)
▪ An ecosystem that is stable now and sustainable in the long term
▪ A strong mutually supportive and nonexploitative community
▪ A high degree of participation, and control, by the citizens over the decisions affecting their lives, health, and well-being
▪ The meeting of basic needs (food, water, shelter, income, safety, and work) for all the city's people
▪ Access by the people to a wide variety of experiences and resources, with the chance for a wide variety of contact, interaction, and communication
▪ A diverse, vital, and innovative economy
▪ The encouragement of connectedness with the past, with the cultural and biological heritage of city dwellers, and with other groups and individuals
▪ A form that is compatible with and enhances the preceding characteristics
▪ An optimum level of appropriate public health and sickness care services, accessible to all
▪ High health status (high levels of positive health and low levels of disease)

Source: World Health Organization (1995).

WHO Principles for Developing a Healthy Cities Project

▪ **Equity**   All people must have the right and the opportunity to realize their full potential in health.
▪ **Health promotion**   A city health plan should aim to promote health by using the principles outlined in the Ottawa Charter for Health Promotion (Annex 1): build healthy public policy; create supportive environments; strengthen community action and develop personal skills; and reorient health services.
▪ **Intersectoral action**   Health is created in the setting of everyday life and is influenced by the actions and decisions of most sectors of a community.
▪ **Community participation**   Informed, motivated and actively participating communities are key elements for setting priorities and making and implementing decisions.
▪ **Supportive environments**   A city health plan should address the creation of supportive physical and social environments. This includes issues of ecology and sustainability as well as social networks, transportation, housing and other environmental concerns.
▪ **Accountability**   Decisions of politicians, senior executives and managers in all sectors have an impact on the conditions that influence health, and responsibility for such decisions should be made explicit in a clear and understandable manner and in a form that can be measured and assessed after time.
▪ **Right to peace**   Peace is a fundamental prerequisite for health and the attainment of peace is a justifiable aim for those who are seeking to achieve the maximum state of health for their community and citizens.

Source: World Health Organization (1997).

program have not suggested if the growth of cities participating in the movement—from a handful to over 1,500—has altered regional urban management, development, and planning decisions.

Yet, important for the analytic framework offered in this book, the WHO healthy cities program in Europe has developed a set of evaluative categories that recognize the need for political and institutional change in order to move toward the healthy city. The WHO framework, called "Monitoring, Accountability, Reporting, and Impact assessment" or MARI, recognizes that healthy cities must be simultaneously attentive to changes in the underlying principles behind a healthy city, involve new actors, draft new policies, and identify and implement new methods of monitoring and evaluating procedural and health outcome changes (De Leeuw 2001).

A selection of criteria from the MARI framework used by the WHO to
designate healthy cities suggest that the healthy city is not a static condition
nor a limited set of health outcome measures but rather a commitment to
continually improving the well-being of populations, places, and policy-
making processes with an explicit emphasis on reducing health inequities
(see the sidebar above).

Science and the Healthy City

A crucial aspect of healthy city planning, and one often overlooked or
viewed uncritically by both urban planning and public health scholars, is
the appropriate role for science and technology. As my historical review in
chapter 2 considers in more detail, science and technology were often
viewed by urban developers, governments, and researchers as tools to

simultaneously improve the qualities of places and change the unhealthy behaviors of individuals. I show how this view of science, often labeled "moral environmentalism," has not only regularly failed to improve the health of the least well off places and population groups in cities but also acted to further alienate disadvantaged groups from processes of science and how they can influence urban governance.

Toward the Healthy City argues that science has encoded ways of knowing and acting in both urban planning and public health and that these embedded practices are some of the most significant barriers for moving toward more healthy and equitable cities. For example, I will trace the connections between city planners and public health professionals when the city was viewed as a *field site*—where a preexisting reality was discovered by surveyors, ethnographers, and residents who developed a keen personal sensitivity to the uniquely revealing features of their particular place. This was the dominant "science of the city" during the American Sanitary and Progressive eras, and local institutions such as Settlement Houses and neighborhood health centers helped craft policy responses. However, as germ theory, bacteriology, and the biomedical model set in, a new urban health science emerged—*the city as a laboratory*. The laboratory view of the city realigned urban policies to reflect legitimacy in laboratory settings, where findings and interventions could be applied anywhere and to all population groups because they reflected the placeless, standardized, and controlled environment of the ideal laboratory. The context-specific polices during the city as field site era were largely replaced by universal, nonspecific interventions, such as chemical treatment of drinking water and childhood immunizations administered by centralized and specialized bureaucracies. *Toward the Healthy City* offers a critical examination of how scientific views of the city have not only separated planning and public health but have shaped the analytic and political processes that underwrite city governance today. I argue that new orientations toward science are needed to help bridge the "two cultures" of the laboratory and field site views in order to promote greater health equity in cities (Snow 1962).

Moving toward healthy city planning will require a recasting of science and expertise, similar to calls for a new science in order to address the urgent issues of climate change and sustainability (Cash et al. 2003; Lubchenco 1998). This new "paradigm" calls for a shift away from experimental science driven from inside existing disciplines by scientists working alone to a view of scientific practice that is more dispersed, context-dependent, and problem-oriented (Nowotny et al. 2001). I will show that

the science underwriting the healthy city is inherently political; its facts are uncertain, values in dispute, stakes high, and decisions urgent—all contributing to what Funtowicz and Ravetz (1993) have called postnormal science.[3] In postnormal conditions science crosses disciplinary lines, enters into previously unknown investigative territories, requires the deployment of new methods, instruments, protocols, and experimental systems, and involves politically sensitive processes and results. This book highlights that legitimate science for healthy city planning must be co-produced, where researchers, government agencies, and lay publics engage in polycentric, interactive, and multipartite public sharing of information (Jasanoff 2004). *Toward the Healthy City* explores how this view of science might be applied in governance practices, from new research partnerships that redefine environmental health to the development of healthy city indicators for assessing and monitoring urban planning decisions.

Toward a Politics of Healthy Planning: Populations, Places, Processes, and Power

Toward the Healthy City begins by examining the historical connections and disconnects between city planning and public health in order to highlight some of the unaddressed political challenges facing contemporary efforts to reconnect the fields. Addressing the disconnects between the fields of planning and public health is essential not only for improving local governance but also for understanding and addressing global political change. For example, in 2001 the UN Centre on Human Settlements (Habitat) (UNCHS 2001:1) stated in their *State of Cities* report that cities are where they expect the solutions to society's most pressing problems to emerge:

For better or worse, the development of contemporary societies will depend largely on understanding and managing the growth of cities. The city will increasingly become the test bed for the adequacy of political institutions, for the performance of government agencies, and for the effectiveness of programmes to combat social exclusion, to protect and repair the environment and to promote human development.

Once viewed as sites of parochial and even xenophobic policy making, local governments are increasingly being recognized as sites of progressive reform and innovation (Appadurai 2001; Fung 2006).

Table 1.1
Political frames for healthy city planning

Population health	• Emphasizes distribution of health inequities across groups • Targets social determinants of health, not individual behaviors, genetics or health care
Places	• Defined as the combination of physical, social, and material characteristics, the institutions and policies that shape them, and the attributions of meaning to these qualities • A relational view investigates the interactions among the multiple characteristics and the contestations over assigned meaning and their interpretations
Processes	• Governance as the formal and informal organizations and practices that shape collective action • Exploring the mechanisms for how social inequities get "embodied"
Power	• Fundamental to shaping and reshaping of cities • Power over and with are possible, and often expressed in norms of expertise, structural racism, and condoning of white privilege

A new set of political frames are necessary for moving toward a new practice of healthy city planning. As Shon and Rein (1994) note, *how* policy issues are framed from the outset affects the quality of solutions; defined too narrowly or too broadly, public policy solutions will suffer from the same defects. The frames for moving toward healthy city planning include considerations of population health, a relational view of place, processes of governance, and relations of power (see table 1.1).

Population Health

While the term "population" can imply something different in the fields of demography, geography, and urban studies, population health is concerned with assessing and addressing why some social groups are healthier than others while paying attention to how social inequalities determine health inequities (Evans and Stoddart 1990). Two central questions in population health are "what explains the *distribution* of disease and well-being across populations" and "what drives current and changing patterns of inequalities in well-being across population groups?" By emphasizing *distribution* as distinct from *causation*, population health investigates how social, political, and economic forces—from racism, to economic policies,

to neighborhood environments—shape which groups get sick, die earlier, and suffer unnecessarily.

Population health focuses on changing the *social determinants of health* (SDOH) defined by the World Health Organization (Wilkinson and Marmot 2003) as "the causes of the causes." The SDOH include the positive and negative influences that explain population well-being, including the social gradient (or the idea that the further down one sits in the social ladder, the shorter is life expectancy and the greater is incidence of disease); stress; early-life support; educational status; employment, working conditions and unemployment; and access to food, housing transportation, and health services; income; social exclusion and social support (Raphael 2006; WHO 2008). A population health approach is thus not limited to so-called proximal or "downstream" (i.e., closer to the individual and assumed greater causal strength for explaining disease) risk factors such as smoking or physical activity. Nor does a population health approach, as used in this book, focus exclusively on the distal or "upstream" (i.e., father from the body and assumed to be a less potent causal explanation) social structures, processes, and distributions of power that are blamed for perpetuating inequality and health disparities (Yen and Syme 1999).[4] Healthy city planning must embrace a view of population health that treats the proximate/downstream and distal/upstream dichotomy as problematic and instead seeks to identify what combination of forces—political, social, economic, biologic, and so forth—in certain places are likely driving population distributions of death and disease and what policy interventions might alter these forces (Krieger 2008).

Place, in a Relational View

A central feature of population health, and one that differentiates it from other models of public health, is that context and features of the built and social environments are understood as key drivers of well-being, not merely the background for other mechanisms driving morbidity and mortality to take place. The influence of place, neighborhood, or context is increasingly recognized as major, if not the most important, determinant of human well-being (Cummins et al. 2005; Diez-Roux 2001, 2002; Frumkin 2005; Geronimus 2000; Hood 2005; Macintyre et al. 2002). Urban place characteristics, such as affordable housing, access to healthy food, employment opportunities, quality education, public transportation, social networks, and cultural expression, are social determinants of health and so fall within the domain of many urban governance processes (Burris et al. 2007). Yet

the role of place in urban planning and policy remains controversial, particularly in debates over whether place-based policies can address urban and regional inequality (Dreier et al. 2004; Hayden 1997; Harloe et al. 1990; Logan and Molotch 1987; Orfield 1997).

The second policy frame for healthy city planning demands not only taking place seriously, but viewing place characteristics *relationally*. A relational view of place emphasizes that the physical and social characteristics in spaces matter for well-being, but these features cannot be separated from the meanings that people in different places assign to these characteristics. In other words, the interactive processes of assigning meaning to a place, and these meanings themselves, are crucial aspects of thinking and acting relationally about how places engender health or distribute premature morbidity and mortality (Gieryn 2000; Graham and Healey 1999; Jackson 1994; Whyte 1980).

Therefore, as I argue in this book, healthy places ought to be understood as being doubly constructed; physically (the buildings, streets, parks, etc., often termed the "built environment") and socially (through the assigning of meanings, interpretations, and narratives as well as the construction of networks, institutions and process to shape these meanings and outcomes). This relational view highlights the processes that simultaneously connect the material, social, and political and ultimately turn a physical spot in the universe into *a place*. Yet the social and political processes behind the construction of place-based meanings are often contested and almost always contingent. A crucial aspect of healthy place-making is creating forums for ongoing public discourse that allows for debate over existing meanings and the construction of new meanings, particularly as demographics change. By taking a relational view of places, healthy city planning processes can help reveal the often hidden relations of power and inequality that are manifested in the physical, material, and social characteristics of places (Emirbayer 1997; Escobar 2001).[5]

Importantly the relational view of places aims to shift research and practice away from a conceptualization of places as a set of quantitative variables that act as static covariates in regression models (Diez Roux 1998, 2001; Duncan and Jones 1993; Ewing et al. 2003; Frank et al. 2006; Handy et al. 2002). Defining place characteristics as only static variables obscures the subjective meanings people assign to the features in the places where they live, work, pray and play—such as a "relaxing park," "safe street," and "good school." One dangerous result of research that limits analyses of place and health to quantitative methods alone is that the selected variables

must show a statistically significant "place effect" on well-being (usually health outcomes), or the study may wrongly conclude that individual biology, behaviors or genes—not some aspect of place—are to blame for health status. A similar weakness of variable-centered studies of place and health is that a positive finding, such as a statistical correlation between physical characteristics of neighborhoods and health outcomes, may lead to overly physically deterministic conclusions, such as the idea that the presence or absence of a park, bicycle lane, or grocery store is the primary determinant for why nearby populations are or are not physically active or eat healthy foods. A relational view aims to act as an alternative to these framings of place by emphasizing the mutually reinforcing relationships between places, people, and meaning-making, on the one hand, and the political institutions and processes that shape these relationships, on the other (Cummins et al. 2007).

Processes for the Healthy City

A third policy frame for healthy city planning aims to move practice beyond a focus on people and places by emphasizing the processes, here called urban governance, that shape health promoting opportunities for people and place-based characteristics. Urban policy making has long debated whether to focus *either* on improving opportunities for individuals or the qualities of places (Bolton 1992). Implicit within the people-based versus place-based policy debate is the idea that a conflict exists between two possible goals of policy: improving the welfare of people as individuals, *regardless of where they live*, and improving the welfare of groups by improving qualities of their place. Education, job and family assistance, Section 8 housing subsidies, family relocation programs, and certain types of health care assistance form the core of people-based policy approaches, while strategies aimed at improving infrastructure, building affordable housing, and issuing neighborhood block grants are examples of place-based policies. In a world of limited resources, people-based and place-based policies are often pitted against one another.

Toward the Healthy City extends this discourse by emphasizing that not only are policies focused on people and place important for healthy cities, but that greater attention needs to be paid to the institutional processes that shape these policies. Institutions are not just the formal structures or procedures of government but rather an established way of addressing certain social issues, such as norms of practice, that become "taken for granted" and accepted over time (Healey 1999). One process dimension

for healthy city planning is the meaning-making described above. A second process, also mentioned earlier, is that of science. As I will show throughout this book, reconnecting planning and public health will require processes of analysis that are "trans-disciplinary," or a science that opens up the boundaries of existing fields and disciplines, notions of expertise, and the legitimate participants for shaping science policy. The institutionalist view examines when established processes, such environmental impact assessment, or new processes, such as health impact assessment, might best promote the goals of healthy city planning.

A third process aspect of healthy city planning is for practitioners to more clearly articulate the processes through which they think the characteristics of places get "embodied" (Krieger and Davey Smith 2004). The notion of the bodily imprint of social conditions was powerfully expressed in 1844 by Friedrich Engels in *The Condition of the Working Class in England*, where he observed how the sufferings of children working in wretched conditions were "indelibly stamped" on adults. Geronimus (2000) argues that chronic discrimination, stress, and exposure to home, neighborhood, and workplace hazards results in a persistent "weathering" on the bodies of the poor and people of color that denigrates the immune, metabolic, and cardiovascular systems and fuels infectious and chronic disease. Nancy Krieger (2005:350) claims that our "bodies tell stories about—and cannot be studied divorced from—the conditions of our existence." The implication for healthy and equitable city planning is that practitioners will need to critically engage with how history leaves a biologic imprint on populations through processes of embodiment; investigating these mechanisms is crucial, since our bodies can often "tell stories that people cannot or will not tell, either because they are unable, forbidden, or choose not to tell" (Krieger 2005: 350).

Power and Health Equity

The fourth policy frame for moving *Toward the Healthy City* is to address power inequalities in cities and across metropolitan regions more generally. Questions of who has power, where it derives from, how it is deployed, and to what ends are seminal in urban politics (Banfield 1961; Dahl 1961; Domhoff 1986; Dreier et al 2004; Mollenkopf 1983; Stone 2004). Power in healthy city planning includes the ability to affect institutional, disciplinary, and bureaucratic changes. While the elite, pro-growth coalition articulated by Logan and Molotch (1987) has tended to dominate analyses of urban political power, De Leon (1992) and others have highlighted how

organized coalitions have resisted "growth machines" to promote a more progressive urban politics. Power relationships can enable or place constraints on group and individual abilities to resist exposures to material and social health hazards.

Power also operates in urban politics to keep certain issues and interests off the political agenda (Lukes 2005). For instance, scientific knowledge often acts as a powerful discourse of exclusion and to mask the political and social dimensions of policy issues (Hacking 1999; Jasanoff 2004). Claims of expertise act as a form of power, such as when scientists prematurely minimize potential uncertainties surrounding an issue in order to help shape and legitimize political decisions (Wynne 2003). While experts are expected to play an increasing role in shaping science-based policy decisions—including those of healthy city planning—the rules for demarcating who is "expert enough" to participate in these processes are almost entirely unwritten, open to wide bureaucratic judgment, and, as I will show, reveal entrenched power struggles over urban governance.

Any effort to improve the quality of life in American cities must also address the power inequities perpetuated by structural racism and white privilege (Massey and Denton 1993; Greenberg and Schneider 1994; Wacquant 1993). The origins of urban inequality cannot be divorced from structural racism, such as federal housing policies that not only denied home ownership to urban African-Americans but physically destroyed many predominantly black neighborhoods under the guise of urban renewal (Ford 1994; Sugrue 1996; Wallace and Wallace 1998; Williams and Collins 2001). Moving *Toward the Healthy City* requires that practitioners address the combinations of policies, institutional practices, cultural representations, and other norms that perpetuate racial group inequity and allow for privileges associated with "whiteness" (Aspen Institute 2004; Bonilla-Silva 1997; Ford 1994).[6]

Healthy City Planning in the San Francisco Bay Area

Toward the Healthy City explores how these political frames can shape a new practice of healthy city planning through a series of case studies from the San Francisco Bay Area[7], where governmental agencies, community organizations, researchers, and others have experimented with new city and regional land use policies aimed at promoting health equity. The city and county of San Francisco and the entire Bay Area is an ideal site to investigate the politics of healthy city planning because the region is

struggling to address the forces that contribute to social and health inequities in many postindustrial urban areas, including a decline of affordable housing, hyperresidential segregation, loss of low-skilled well-paying jobs, regional land use sprawl, and neighborhood-scale inequalities of access to transit, supermarkets, open space, and other health-promoting amenities. Yet, at the same time, local governments and civic organizations across the region often innovate with environmental health and social policies that act as models for future state, national, and in some cases, international policy action. For example, the cities in the Bay Area spurred the banning of lead in gasoline and legislated the nation's first Sustainability Plan and Precautionary Principle ordinance. The city of San Francisco has banned the sale of cigarettes in retail pharmacies, has the nation's most ambitious urban recycling, composting and "zero–solid waste" programs, and was the first to attempt to provide universal health care to its residents (Knight 2008).

Studying population health in the Bay Area is also important because, perhaps surprisingly, the region is one of the least healthy metropolitan areas in the United States. For example, a study tracking the progress of the 100 largest US cities toward achieving the goals of *Healthy People 2010*, San Francisco, Oakland, and San Jose (three of the Bay Area's largest cities) ranked in the bottom quintile—below New York, Los Angeles, Chicago, Miami, and Atlanta (Duchon, Andruis, and Reid 2004). Health inequities also plague San Francisco's neighborhoods. For example, African-Americans in San Francisco lose more years of life to just about every possible cause of death than city residents of other racial backgrounds (Aragón et al. 2007). The infant mortality rate for African-American San Franciscans is 11.6 per 1,000 live births, compared to 2.8 for whites and 4.1 for the city as a whole (BHSF 2004). Over 16 percent of African-American babies born in San Francisco have low birth weights, compared to 6.2 percent for whites and 7.4 percent for the city as a whole. Nearly 17 percent of the population in the largely African-American and Latino community of Bayview–Hunters Point has been hospitalized for adult diabetes and the Tenderloin neighborhood, where two-thirds of the population are people of color, ranks second behind Bayview for incidence of chronic disease (BHSF 2007). The South of Market area (SoMa), where over half the population is Latino and Asian, has the highest rates of mental illness in the city of San Francisco (BHSF 2007).

Another objective for looking in-depth at urban governance in one region is to provide the "thick description" that can highlight the distinctive needs

and place qualities that can help planning practices promote health equity. While many studies of the connections between land use planning and heath aim to identify "best practices," or the possibility of melioration through imitation, the cases in this book emphasize that practitioners should engage with the cultural specificities of places and not aim for one-size-fits-all interventions. By exploring the political and cultural challenges for healthy city planning in the San Francisco Bay Area, the cases presented in this book offer analysis and comparison within and across a complex metropolitan region, noting the forces that may be unique to the area and those that can contribute to healthy planning in cities everywhere.

The Cases

Toward the Healthy City is structured around three cases detailing how government agencies, community activists, researchers, and others in San Francisco and across the Bay Area have attempted to practice healthy city planning. Each case describes how traditional planning issues, such as housing development, a neighborhood rezoning plan, the environmental impact assessment process, and drafting a general plan, were reframed as health and justice issues, the influence this reframing had on institutional practices, and how the process outcomes are expected to promote health equity. The cases were selected because they each highlight one or more crucial aspects of the politics of healthy city planning, from how urban issues and problems get redefined as health equity issues, to how new institutional practices across disciplines and agencies are organized, to the gathering and public justification of the new evidence base used to support healthy city planning practices. The cases also highlight that healthy city planning is not one but a set of diverse practices that are more likely to emerge from the work of community-based organizations and public health departments than planning agencies. Each case explores why this might be so and highlights the barriers and opportunities for reconnecting city planning and public health in the San Francisco Bay Area. The cases include the reframing of environmental health practice, healthy urban development, and using health impact assessment for urban and regional planning.

Reframing Environmental Health
In the Bayview–Hunters Point neighborhood of San Francisco, where environmental justice activists have worked for decades to get government

agencies to address toxic exposures and health issues in their community, activists were instrumental in helping to reframe environmental health practice in the city. Local activists partnered with the San Francisco Department of Public Health (SFDPH), Environmental Health Section, to explore the relationships between disease and pollution. The partnership conducted a community health survey, and to the surprise of the agency, the survey revealed that the most important environmental health issues for community members were violence, access to healthy food, and affordable housing—not pollution. The partnership lead to new projects and programs within the SFDPH to address community concerns, including a project focused on addressing the multiple determinants of food insecurity in Bayview. This chapter explores why and how this shift occurred within the SFDPH, and investigates how local and international social movements came together to alter health promotion strategies across the entire agency. I detail both the forces that gave rise to the reframing of environmental health and the new practices that embody the new definition. The case also highlights the political conditions that enabled the new definition of environmental health to spread to non–health focused organizations, particularly the city planning department and community-based activist groups.

Healthy Urban Development

The second case explores how the new environmental health orientation of the San Francisco Department of Public Health was applied to urban development projects. In one project, the Trinity Plaza redevelopment, the developer planned to demolish the rent-controlled building and build a market-rate condominium in its place. At the urging of a coalition of community-based organizations called the Mission Anti-displacement Coalition, that had worked for years to stop rapid gentrification and rising property values during the 1990s dotcom boom, the SFDPH analyzed the likely human health impacts of the residential displacement and unaffordable housing from the Trinity Plaza project. The analysis was submitted as part of the project's environmental impact report, and the case follows the debates between the planning and health agencies over whether the health impacts of housing and related social determinants of health fall within the purview of environmental assessment. In a second development project, the Rincon Hill Area Plan, new high-rise condominiums and high-end retail stores were planned in the low-income South of Market area (SoMa) of San Francisco. Activists and the city's Planning Department

again asked the health agency to analyze the "environmental impacts" from the project. The health agency noted the positive and negative social determinants of health that would likely result from the project, including creating new jobs, concentrating residential segregation by building affordable units off-site and straining existing capacity of local schools, transit and parks. While both projects were approved, each included alterations to mitigate likely health impacts, such as guaranteeing that all affordable units in the Trinity Plaza case would be preserved and, in the Rincon Hill project, the developer agreed to pay an impact fee to support a community benefit fund controlled by local organizations. The case study examines how a health agency participated in the planning process for the first time, made the case for the direct and indirect health impacts of urban development and altered the environmental review process to include health analyses. The chapter highlights key political questions for healthy city planning, such as when and how to use existing planning processes to promote health equity, the role for community planning in promoting healthy development, and the institutional challenges for reconnecting the municipal bureaucracies of public health and planning?

Health Impact Assessment for Urban and Regional Planning

The third case explores the first participatory health assessment of a land use planning issue in San Francisco, called the Eastern Neighborhoods Community Health Impact Assessment (ENCHIA), and how this process helped stimulate the institutionalization of health impact assessment in planning practices across the entire San Francisco Bay Area. The ENCHIA involved over twenty-five different public agencies and nongovernmental organizations and was organized by the SFDPH to allow these groups to collaboratively evaluate the positive and negative impacts of a rezoning plan. The process developed a collective vision of the healthy city, selected indicators to attach to the vision, gathered and spatially analyzed new data to measure the indicators, and combined these data into a land use and health screening tool called the Healthy Development Measurement Tool (HDMT). The case study explores the inner workings of the ENCHIA, including how the process was designed and managed, the products it produced, and how conflicts over the content and direction of the process were handled? I also examine how the ENCHIA has influenced healthy planning practices across the Bay Area metropolitan region. The chapter examines the forces that enable healthy city planning to become healthy regional governance, such as new coalitions involving governmental and

nongovernmental organizations and the construction of new networks for monitoring healthy planning activities that can hold governments and the private sector accountable.

Research Methods

The cases offered here draw from four years of research from 2004 to 2008, including interviews, participant observation in public meetings and within city agencies, and reviews of original documents. The San Francisco Department of Public Health, Environmental Health Section, gave me access to scores of documents for each case, including written reports, original data, and confidential emails and meeting notes. The health agency also provided me with the opportunity to follow the work of the ENCHIA from its inception to conclusion, where I attended tens of meetings, regularly interviewed participants, and observed internal agency meetings within the San Francisco Department of Public Health. I also performed three evaluations of the ENCHIA, two during the process and one at its conclusion. These evaluations included confidential face-to-face and telephone interviews with over forty participants and in one case, a written survey instrument. I also audio recorded each ENCHIA meeting and generated transcripts of the dialogues. All these data—the interviews, surveys and meeting transcripts—aided in my reconstruction of all the cases, since many of the ENCHIA participants were also involved in the other cases presented here. The cases also reflect in-depth interviews with staff from many of the community-based organizations involved in each of the cases presented here and staff in the San Francisco Planning Department. Finally, I performed content analyses of media coverage for each of the cases in an effort to understand how outside observers were characterizing the events behind each case.

Outline of the Book

In the next chapter, I offer a critical review of the histories of modern American city planning and public health from the late nineteenth century through the dawn of the twenty-first century. I observe that both fields emerged with similar concerns of improving the health of the least-well-off urban populations, and this helped connect their work as each field aimed to address infectious disease through new sanitary, housing, and social programs. However, work in the fields diverges by the turn of the twentieth

century, and with a few exceptions the professions of city planning and public health continue to move further apart for the next one hundred years. I trace the policies, programs and science behind this disconnect through five eras: (1) 1850s to 1900s, miasma and the sanitary city; (2) 1910s to 1920s, germ theory and the rational city; (3) 1930s to 1950s, the biomedical model and the pathogenic city; (4) 1960s to 1980s, crisis and the activist city; and (5) 1990s to 2000s, social epidemiology and the resilient city. The chapter emphasizes that five interrelated themes acted to separate the fields and move each away from their social justice roots: (1) reaction to health and urban crises by removing and displacing people and physical blight; (2) reliance on technical rationality and biomedical science; (3) moral environmentalism or the belief that rational physical designs could change social conditions for the poor; (4) scientific representations of the city as laboratory rather than a field site; and (5) increased professionalization, bureaucratic fragmentation, and specialized expertise. The chapter concludes by suggesting that these themes remain encoded in the institutions of planning and public health and that contemporary efforts aimed at healthy city planning must find ways to overcome these challenges and reconnect with the social justice roots of the fields.

In chapter 3, I show how contemporary city planning processes typically fail to address the social determinants of health and thus help perpetuate health inequities in cities. Using the example of the environmental impact assessment process, I suggest how planning processes might engage with the social determinants of health and review the range of ways human health is positively and negatively influenced by planning practices. I go beyond the usual focus on the outcomes of planning practice, such as transportation systems, housing, and different land uses, to consider how planning processes contribute to human health outcomes.

In chapter 4, I offer a framework for responding to the political and institutional challenges outlined in chapter 2 and the adverse health outcomes described in chapter 3. I consider a set of alternative issue framings that build on the political conditions for healthy city planning outlined in the introduction—namely population health, the relational view of place, governance processes, and an attention to power. The issue frames include moving from (1) reaction to crises with strategies of removal to promoting health through precaution and prevention; (2) a reliance on scientific rationality to the co-production of scientific and political knowledge; (3) physical determinism to a relational view of places, where physical and social

characteristics, along with the meanings assigned to places are the focus of analysis and policy; (4) views of the city as laboratory to embracing the field site and population health view of cities; and (5) professionalization, bureaucratic fragmentation, and specialization to building new regional policy and health equity monitoring networks. I use these new issue frames to help analyze the case studies of healthy city planning experiments in the San Francisco Bay Area.

In chapter 5, I present the first case study and reveal how environmental health was reframed to embrace the social determinants of health equity. In chapters 6 and 7, I analyze the political conditions that enable or stymie implementation of the healthy city planning framework from the neighborhood to the regional scale.

In the concluding chapter 8, I draw the key lessons for planning and urban policy making from the case studies. I return to the analytic framework outlined in chapter 4 and evaluate the extent to which the cases pursued these political conditions, what additional factors beyond the framework are necessary to promote healthy and equitable planning, and the general policy lessons suggested by the framework and the case studies. I emphasize that the politics of healthy city planning is an ongoing practice that must engage with the emerging science of the social determinants of health while also learning by doing in collaborations among government agencies, community groups, scientists, and others. I end the book with recommendations for urban planners, public health professionals, and community members seeking to plan more healthy and equitable cities.

Toward the Healthy City by Jason Coburn offers an interesting journey through the history of planning and public health in the United States, by examining the common ground of health and social justice, as well as the forces and circumstances responsible for the disconnect between the fields during the 20th century. The book provides concrete evidence for the need to reconnect the fields to address the systemic failure and health crises in today's cities. The author suggests a new decision-making framework and explores how public health and planning agencies along with community-based coalitio Healthy city is a term used in public health and urban design to stress the impact of policy on human health. It is a municipality that continually improves on a physical and a social level until environmental and pathological conditions are reached establishing an acceptable morbidity rate for the population. Its modern form derives from a World Health Organization (WHO) initiative on Healthy Cities and Villages in 1986, but has a history dating back to the mid 19th century. The term was developed in