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Good planning, good health: An interview with Rajiv Bhatia

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Good Planning Good Health

An interview with Rajiv Bhatia

Rajiv Bhatia, MD, MPH, is the Director of Occupational and Environmental Health for the San Francisco Department of Public Health. He is also a faculty member at both the University of California at San Francisco School of Medicine and the University of California Berkeley School of Public Health. He is a founding member of the Health and Social Justice Committee for the National Association of County and City Health Officials. Nationally recognized for leadership in developing the health impact assessment tool, Bhatia thinks poor health resulting from social factors can be combatted by cooperation among health officials, policy makers, and the public. He was recently interviewed in San Francisco by Metroscope's Vivek Shandas.



Shandas: *What do you see as the critical public health challenges faced by local city and county government agencies today?*

Bhatia: To begin with, our health disparities and our health and equities. While some people are able to take advantage of healthy neighborhood conditions and all of the assets of our medical system, others can't. And that shows up in life-expectancy differences of a decade, from neighborhood-to-neighborhood, in a place like San Francisco or Portland. A child born today in one neighborhood has 10 years less life expectancy than a child in another area. That has to be the driving and motivating challenge of public health. That's the beginning, I think, of the challenge.

If that is the fundamental challenge, then one must ask, why? What are the conditions that we have to change? You can go to the public health library and look at public health research and see that the condition that we have to change is social segregation. We separate by race and economic class, meaning that we give children different resources. Some areas have air pollution and noise, and other places don't. Some people have access to living-wage jobs, and others don't. Some people have access to quality education, and others don't. Some people have parks right down the street that have playgrounds and facilities for physical activity, and others don't.

When you add up all of these differences, you get to the explanation; you begin to understand why differences in life expectancy are as much as a decade from neighborhood-to-neighborhood.

What, then, does a public health department do, understanding that huge health inequities exist from neighborhood-to-neighborhood, and that there are specific conditions that need to be changed? First, they have to realize the obstacles they face in changing the conditions. These conditions – parks, land-use – are not in the mandate and the role of public health agencies. This isn't what public health agencies are expected to do by politicians or the public – our roles have become much more narrow. A hundred years ago, when public health started, we were responsible for air quality, sanitation, water quality, and other environmental conditions. But all of these roles have been more or less fragmented or segregated to different institutions, and now public health has a much narrower role.

So public health has to figure out how to interact and engage, and help shape conditions that are the responsibilities of other public sectors. And I think that's one kind of fundamental challenge.

Another challenge is that people don't necessarily recognize the problems. I think if you begin to have this discussion with people, they'll understand what you're saying, and they'll get it, and they'll say, "Oh, yeah, of course having a park nearby is important to public health." But as a society, we don't really talk about health as product of neighborhood and social environmental conditions. We talk about health more often as the product of individual responsibility and what nature endowed us with through our genes.

Public health has an important role in changing the frame. Public health officials are asked,

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“What do we do about this problem of asthma?” their first response shouldn’t be, “We need to get more people to the hospital to take their asthma inhalers.” Their response has to also include that we need to improve housing conditions so there aren’t allergens in the home, that we need to make sure people aren’t living near freeways, where air pollution levels are higher. We need to make sure that moms have paid sick-days so they can take their children to the doctor to get preventative care. That reframing is a second, very action-level challenge for public health.

The third action is to realize that public health doesn’t need to reinvent the wheel. There are community organizations, there are social justice movements, there are people out there who are working to improve environmental conditions. And public health needs to show these social and environmental movements that it can once again be an ally. A particular way to do that is to provide scientific evidence of the linkages between public policy, environmental and social conditions, and health. That should be our role.

The relationship works in a few ways. Public health needs to make people who are already engaged with different policy sectors aware of what public health knows about the public health impacts of different policy decisions. We need to do health-impact assessments to formally bring that evidence to the table in policymaking.

We also have to create a demand for this work. In part, what we need to do is to convince social movements and people that they need to be demanding that public health is involved. There may be innovators and small groups in public health that are willing to be the early adopters of approaches like health-impact assessment. But in order to move the whole institution, you’re likely going to have to create some political pressure on the public health institution to be more engaged in policy outside the sector.

The fourth action is a critical challenge: ensuring accountability. In San Francisco, I see a lot of health policy written into the general plan. It says, “Avoid exposing sensitive populations to air pollution.” But how are we doing that? We weren’t doing that, we weren’t doing that until public health said, “We’re going to fill this gap that our general plan already calls for.”

There are many examples of where we develop a social policy and agree on a policy, but then it’s just not implemented. The most striking example is in school desegregation – we opened up schools to children of all ethnicities and races, but then

what happened? Because racism was still prevalent in our society, people moved away, and we have greater segregation by residence now than probably we did several decades ago, which totally undermines the idea of integrated schools.

Shandas: *You mentioned the challenge that public health agencies face in interacting with other government agencies. Do you admire any regions or cities across the globe for explicitly attempting to address this issue, places where public health actually work with other government agencies in meaningful and effective ways?*

Bhatia: I’m not an expert and haven’t evaluated the healthy-cities movement, which was founded by a group of public health thinkers around the time of the 1986 Ottawa Charter on Health Promotion, which states everything I’m saying in terms of action much more eloquently. And anyone who’s interested in the topic really should go and read that document two or three times, because it created a very clear blueprint.

I would say, just in a cursory scan of the healthy-cities work, while there’s been collaboration, I think the targets of collaboration often have not been very structural; they have been much more downstream. So, while a lot of the collaboration exists, it needs to move upstream to some of the more structural things, like integration. I don’t know of anyone, really, who’s challenged that one.

Shandas: *Can you touch on what health impact assessment is and how it actually fits into this healthy-cities movement, or how it fits into the larger challenges?*

Bhatia: The health impact assessment was called for in the Ottawa Charter in 1986. And it’s very simple. Health impact assessment is a variety of tools and processes, a toolbox of things that really serves a value or assumption. It’s the idea that when we make a public policy – a social decision; when we make choices together, we should consider how those choices affect our health. When an individual or family picks a house, they ask, “Is this going to create a healthy environment for us?” Health is something that we consider very intimately on an individual and family basis. We need to be making the same type of consideration on a social or collected basis.

So, there is no one way to do health-impact assessment. I think the best health impact assessments are answering questions that are politically relevant to a particular place where stakeholders are engaged in the particular public policy. Good

Land use planning is displacing people — that's got to be bad for health.

health impact assessments use the best quantitative and qualitative methods available. And there's a whole bunch of research tools on the shelf right now that just isn't being applied to health policy issues.

Health impact assessments should be comprehensive. If you do a health impact assessment and you focus on one health issue, you're likely to get the wrong answer because, ultimately, choices in social decisions are about tradeoffs; and if you have many health issues related to a public policy, you need a comprehensive analysis in order to understand how to maximize health.

Those are some of the characteristics. Again, there's lots of ways to do it. You can formally integrate health assessment in an environmental impact assessment process as the National Environmental Policy Act calls for. You can do a voluntary health impact assessment as a collaborative process. But the key thing is bringing the best scientific and community evidence to understand policy levels and questions in a place so that health is considered in the decision-making process.

Shandas: *San Francisco has done quite a bit with health impact assessment. What came together in San Francisco that made government agencies consider more seriously the application of health impact assessment on particular projects?*

Bhatia: The first health impact assessment showed how our Health Department was able to recognize some opportunity that already existed. It was a 1999 assessment on the living wage. We had a city that was generally favorable on progressive labor policy, and it proposed a living wage for workers under city contracts. Community advocates and political leaders were trying to promote this, while some economic interests were saying, "Well, businesses can't afford to pay a living wage."

While it's important to weigh economic impacts, health officials advocated also weighing health impacts that could provide a counterweight to any economic decision. We saw a tremendous amount of evidence on the relationship between income and health that could be applied to do a very robust quantitative analysis. And then we realized that nobody knew that this was on the menu of public health. And so we went and talked to our legislators and said, "If we did this analysis, would it be helpful?" And they said, "Yes." And then we said, "Well, why don't you have us do that analysis?"

That experience taught a lot of lessons, foremost that policy makers and legislators don't know what public health can provide and how health impact assessment can bring evidence to bear on their decisions. Health officials can't wait to be asked to do health assessment. We can't do it by ourselves as a research exercise. We need to engage with decision makers who can use the results of our analysis.

The next step was learning more about health impact assessment internationally. We said, "Let's try to introduce community residents in San Francisco to health impact assessment." And over the course of about a year, we had very short workshops in different parts of the city. We found an organization that was willing to host the workshops. And we said, "You give us a policy you're already working on," and people suggested farmers markets, green schoolyards, and housing subsidies. And we said, "You bring together a variety of allies and advocates you work with, and we'll do a very brief participatory health impact assessment — a very different screening kind of assessment — and then we'll see what the next-steps are."

Through these dialogues, we simply helped people to understand that the policies they were advocating were connected to health outcomes in very broad ways. And we had to think about how making those health connections explicit would be helpful to their policy struggles. That effort introduced our communities to the idea and gave them the sense that you had a health department that was willing to do more than they were being asked to do.

Some of these groups came back to us about nine months after these workshops and said, "We want you to do a health impact assessment of land-use planning that's happening in San Francisco." They said, "Look, this land-use planning is displacing people — that's got to be bad for health."

Shandas: *Who was this that came to you and asked?*

Bhatia: It was PODER (People in Defense of Earth and her Resources), an environmental justice organization. They said, "Hey, Health Department, you're talking about health impact assessment, and we've got a struggle going on. We've got people being displaced. We've got people losing living-wage jobs and business displacement, and we've got gentrification happening. And we don't think this is really good for our health. We have an alternative; we have a people's plan for land-use development. Why don't you do a health

impact assessment of our plan, and maybe that's going to help push our plan forward."

Over the course of a year, we facilitated a health impact assessment that this organization did on its own. We went to the Planning Department, and the Planning Department said, "Well, look, we understand health impact assessment. We understand what you're trying to do here, but we don't want it in the environmental impact process." They suggested that we do a health impact assessment as a separate process and run it parallel to the environmental impact assessment. They promised to use the information but not to regulate or require compliance based on the findings. The community wasn't happy about this, but we decided to go forward.

That process went on for a year and a half and produced the Healthy Development Measurement Tool. The outcome of the Eastern Neighborhoods Community Health Impact Assessment process was essentially the policy recommendation that we develop a tool to evaluate land-use projects on health and that we regularly and routinely utilize that tool in the planning process. And that's exactly what we did. We created the Healthy Development Tool, which is a comprehensive metric, with indicators of community wellbeing, targets for healthy development, and policy design strategies. We've begun to apply those measures to the plans that the Planning Department is producing.

Shandas: *So you combined community groups, the Planning Department, and the Department of Public Health?*

Bhatia: Yes. It's an evolution. I can't remember how I imagined health impact assessment going forward six years ago, but we tried something. We got a response from communities. Community members wanted accountability, so it helped us focus. We shifted to using the Environmental Impact Review (EIR) process. While we've been able to use EIR, we also realized some of its limitations, and so we've shifted again, adapting to what's working and what's not working, and where the opportunities are.

Shandas: *Do specific projects lend themselves more directly to health impact assessment than others?*

Bhatia: You're raising a really important point. Am I saying that every single public policy should get a health impact assessment? Absolutely not. The goal really is healthy public policy, and assess-

ment is just a means. If you can get to healthy public policy easier and quicker without an assessment, then you should pursue the alternative. At present, though, public health hasn't had relationships with land-use and transportation planning; we haven't had many comprehensive health analyses of land-use planning. We don't know the issues. So, on major land-use planning efforts, I think it's appropriate to do health impact assessment to identify as many large-scale issues as possible.

However, if you do a few of these assessments, you probably get to the same kind of answers: Don't build housing near busy roadways, or make sure there's a park nearby, or a grocery store nearby. You get to some rules, essentially. And then those rules can get translated into general plans, or into zoning codes, or other planning tools that don't need to be subjects of health impact assessments anymore.

So health impact assessment is a learning tool at this time. Suppose that 30 or 40 years from now, land-use and planning become better integrated with health policy. We may no longer need health impact assessment to make sure that health needs are being put into plans. I'm being optimistic. But there always will be new issues that we must consider, and those then become the subjects of health impact assessments.

I hope that the meaning here is clear. You do health impact assessment where you need to. If the planning director is planning a theater and says, "Look, we know all the health issues; we understand this and we've considered them, and here I can prove to you how we've considered them," then we're fine.

Shandas: *Currently, health impact assessment acts as an additional, voluntary level of analysis. It is not mandated at the moment. Should it be?*

Bhatia: I think that to the greatest extent feasible, health impact assessment needs to be integrated into existing impact assessment processes. First, there are impact assessment processes that are currently mandated under law. So, because they're mandated, they have regulatory strength and teeth. Our community members criticize health impact assessment because it doesn't have any teeth. That's one reason to integrate it into existing processes. Second, you don't want to duplicate existing processes because it's terribly inefficient. Third, health impact assessment is not unrelated to environmental assessment or

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**Don't
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Local initiatives in healthy planning

by Merilee D. Karr

From the corner of NE 78th Street and NE 25th Avenue in Vancouver, Washington, you can look southwest and see a volunteer trundling a wheelbarrow of tomatoes, broccoli, and snap beans toward the modern Clark County Food Bank in front of you. Acres of community gardens, the source of the veggies, stretch behind the volunteer. In the fields and nearby buildings, Master Gardeners teach classes in raising and preparing healthy food.

You can't see that yet. Right now the former Washington State University Agricultural Experiment Station grows dry grass, weeds, and trees, enclosed by chain-link fence. Other ideas for the 80-acre site included recreational greenspace, sports fields, and conventional commercial development. What tipped the balance was a report the planners invited from a new kind of planning partner: the Clark County Health Department.

"When they talked about access to healthy food," says Michael Mabrey, Transportation Planner at Clark County Community Planning, "It was something people had been thinking about but hadn't put in those terms."

The Health Department received this novel but intriguing call in March 2008, says Heather Gramp, MPH, Health Assessment and Evaluation Manager. Health effects of the built environment are widely recognized but seldom pre-empted, so the task attracted a small but dedicated team willing to take on an extra project. A month later when the group presented its Highway 99 Plan Health Impact Assessment (<http://www.clark.wa.gov/hwy99/docs.html>), "Light bulbs went off in the Planning Council," says Jonnie Hyde, PhD, Public Health Services Manager.

Health Impact Assessment (HIA) is a new technique for recognizing health risks and opportunities before they happen, and for communicating across disciplines to foster environments that support healthy outcomes. The methodology is new to the United States, and newer to the Northwest.

Across the river in Portland, another team lays the groundwork for HIA in larger, long-term projects. They have just completed an HIA for the Columbia River Crossing bridge, (www.co.multnomah.or.us/health), and they are involved with early phases of the Regional Transportation Plan and the Portland Comprehensive Plan.

This "work group" of just over a dozen assorted health professionals has been meeting for more than

a year, educating each other and looking for a project to practice on. They represent several types of organizations: advocacy groups, such as the Coalition for a Livable Future and the Community Health Partnership; government agencies, including the Multnomah County Health Department and the Oregon Health Division; two universities, Portland State and Oregon Health & Sciences; and one health care provider, Kaiser Permanente's Northwest Community Health Initiative. Diversity has been a strength, according to Noelle Dobson, MPH, of the Community Health Partnership. "Different organizations play different roles," she says, "and they need to play together to be effective." For the Columbia River bridge, Multnomah County Health Department led the formal response to a Draft Environmental Impact Statement, digging through its technical jargon; the Coalition for a Livable Future pushed to legally extend the public comment period; and the Oregon Health Division located data to support the analysis. Nationally, most HIAs have been produced by municipal health departments, academics, or consultants. The public-private mix of the Portland-area work group is unique.

Collaboration is intrinsic to the HIA process, but among whom? Perhaps because the Northwest originated the movement to re-unite planning and public health—twins conceived at the Broad Street pump in 1854, and mostly separated since—most HIAs here link planning with public health. The new PSU program granting the Master of Public Health and the Master of Urban and Regional Planning will include HIA in coursework, according to Stephanie Farquhar, PhD, Associate Professor of Community Health.

However, elsewhere the methodology has been used to start different conversations—with the members of communities who will, after all, have to live with the results of the planning. HIA has been used as a community-organizing tool, to articulate the needs and values of residents, so that they can communicate effectively with planners and other decision-makers.

The built environment is not the only significant influence on health. The correlation between equality and community health demonstrates the force of the intangible environment on health. HIAs have been done on intangibles—on economic policy, such as living wage ordinances, affordable housing, and the federal Farm Bill—but in this arena the collaboration partners are less obvious. Only one of half a dozen completed HIAs of economic policy—

Health Impact Assessment is a new technique for recognizing health risks and opportunities before they happen.

"You know, you guys as planners have a greater impact on public health than anything I do."

— a Clark County Health Department official

the San Francisco Department of Public Health report on a proposed Living Wage Ordinance—claims any influence on the outcome of policy decisions. In contrast, planners recognize that health is germane to their work, and residents of communities undergoing a planning process have a stake in the outcome. While the social and economic environment probably has more impact on health than the built environment, it is less clear that public health expertise has a place at the economic policy table.

After Environmental Impact Assessment was federally mandated in 1969, the idea of impact assessment for health spun off, and has been used extensively in the developing world. More recently, Europe and other developed countries have made use of HIA.

Partly due to the comparison with environmental assessment, there is hope and worry about the possibility of mandating HIA. Nancy Goff, MPH, of the Multnomah County Health Department, sees two schools of thought on that question. "The benefit of mandatory HIA is that people would actually do it," she says. But she worries that HIA could follow environmental impact assessment into legalistic rigidity, more focused on legally defensible documentation than public health. "HIA has more flexibility and more potential for different situations if it's not mandatory," she believes.

Indeed, a strength of HIA right now may be that there is no one right way to do it. Tools are being built to measure, for example, a neighborhood's access to healthy food, or a road's production of particulates. But interdisciplinary relationships remain the foundation of HIA. "We struggled," says Dobson of the Portland work group, "with questions like, are we trying to become experts in this methodology, or are we trying to advance the movement to reconnect planning and public health?" It turns out that such a diverse work group generates enough expertise and interest for both.

Michael Mabrey, the Vancouver transportation planner, learned more than he expected from the encounter. One of the Health Department team told him, he remembers, "You know, you guys as planners have a greater impact on public health than anything I do." That shocked me. I don't think planners normally frame their work in terms of health outcomes." **M**

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The I-205 freeway, traversing (north/south) the outer east side of Portland, was designed and constructed at a time (the early 1980s) when the impacts of highway development to human health were largely overlooked. As can be seen in the photograph of the Lents neighborhood above, it bisected the neighborhood, displacing hundreds of people, leaving the Lent Elementary School and many of Lents' residents isolated from the historic town center as well as exposed to automobile emissions and highway noise. The children of this neighborhood were left particularly vulnerable (see the location of the Lent Elementary School, the Wattles Boys & Girls Club, and Lents Park).

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social impact assessment. Health impact assessment builds upon those other assessments. When I look at air-quality impacts, from roadways, I am using traffic to predict air quality, and air quality to predict health effects. So if I have traffic analysis and air-quality analysis within an environmental review, why duplicate it? In fact, I need the analysis of environmental conditions in order to do my health impact assessment.

What are health officials really trying to do? We are trying to get planners and other people in other fields to understand and consider, value, and use human health. Public health agencies don't own the planning code or make the planning decisions; the planners do. So, if I really want planners to have ownership of health issues, I need to use their tools. I don't need to call up and say, "I've got a new tool; use it." I need to integrate my work with their tools. We have been integrating our tools into the Planning Department's environmental impact assessment of air quality, noise, and pedestrian safety issues.

Of course, some people have concerns about integrating health assessment with environmental impact assessment that doesn't necessarily provide useful information. But that's an issue of poor practice. We have the ability to do integrated environmental impact assessment right. Perhaps one of the problems – or one of our frustrations – with impact assessment is that it hasn't adequately considered human welfare issues. By doing an integrated analysis, we may have the best of both worlds.

Shandas: *Locally, the draft EIS for the Columbia River Crossing is being rolled out for public comment. It's Oregon's largest transportation project in the history of the state. Given your experience, what advice do you have for the planning agencies and the public health agencies involved?*

Bhatia: Roadway projects are some of the ripest projects for doing health impact assessment in an integrated approach with the environmental impact statements. And they're ripe for a couple of reasons. They're ripe because of the kinds of research being done on the built-environment and health. The research on transportation systems and health is the strongest: the most robust and the most quantitative.

The opportunity is there because the National Environmental Policy Act is very, very clear that when a project affects the human environment, the health effects of changes in the human envi-

ronment need to be analyzed. The esteemed William Rehnquist supported the position I just gave you. And so you've got a legal mandate. Unfortunately, public health agencies have never put this mandate into practice. Nevertheless, I think that the time is right.

Some of the issues that you can analyze with existing tools in a major transportation project like the Columbia River Crossing include local effects on air quality. These transportation projects – roadway projects – generally increase traffic, which means they increase local concentrations of air pollutants along the freeways. You can analyze those effects with dispersion models; we can use those response functions to analyze the indirect health effects.

The existing models look at noise and at sensitive populations. People who might be already living near these roadway corridors are often lower-income, ethnic minorities. So we have guidance for environmental-justice analysis that could be brought in.

We can look at effects on physical activity and pedestrian injuries. When you have these roadway projects, you're not only increasing traffic on the roadway itself, but you're increasing traffic going to the roadway and going from the roadway, increasing arterial traffic. Roadway volumes are one of the most important contributing factors to pedestrian injuries, walk-ability, safety, and the rates of walking in our neighborhoods.

Finally, we can look at social cohesion. This is something that the Federal Highway Administration used to be more attentive to in the 1990s. When you expand these roadways and increase traffic, you create a barrier for getting from one place to another. In a sense, you're therefore creating a barrier between social communities.

For example, what if you double traffic along an arterial? On one side is a household and on the other side is their church. Maybe an elderly person who lives in the household is dependent on walking to church. Maybe the traffic prevents that person from going to church. Whether a church, a community center, or a park, we have to be very attentive to how these transportation projects affect access and to all of the health effects that depend on access.

I really hope that people can get together to articulate the need for health impact assessment for the Columbia River Crossing. The scientific and technical ability exists to do it, and the analysis would not be complete without it. **M**