**Executive Summary.**

The *Planning and Building Healthy Communities* Study explores the ways in which the shape of our built environments impact, positively and negatively, on the potential to contract current contemporary chronic diseases such as diabetes, various respiratory and heart conditions, various cancers, and depression; the so-called "lifestyle diseases". The Study gives explicit attention to:

- four newly-developing "case-study" residential areas in Sydney (Airds Bradbury, Renwick, New Rouse Hill and Victoria Park), via in-depth auditing of the physical environment of each and in-depth conversations (via interviews and a focus group) with participating residents.
- each of the three key "domains" (physical activity, social interaction, and nutrition) where the built environment can be configured for heathy outcomes, and how they interact. Other studies have tended to focus on only one or a limited number of health and built environment factors and relationships.
- the experiences of the actual residents, and thus users, of the case-study residential areas. Here the Study traces the needs, aspirations and behaviours of the participants from each locality from the primary point of view of their own health.

The Study was conducted between 2011 and 2015 by the City Futures Research Centre (University of New South Wales), UrbanGrowth NSW (a key facilitator in the development of each case-study area), the National Heart Foundation, and the South Western Sydney Local Health District, with contributory funding also from the Australian Research Council.

The Study found there is a need for continual attention to health implications in the design, construction and on-going management of our urban areas. Within the four Study localities positive health outcomes were often the result of fortuitous "co-benefits" from actions aimed at other objectives (eg. "green" environmental outcomes, and provision of amenities to assist marketing), and also that some good intentions have been let down by poor implementation and management. In terms of the three healthy built environment domains, increased attention is required to encourage residents to be more active (only about 75% of participants overall meet minimum recommended weekly requirements); although participants were generally satisfied with their levels of interaction with neighbours, there was also a lingering desire for some greater "connection" within their communities, particularly from those living in multi-storey apartment buildings; and while access to healthy foods is not of particular issue there was still a need for community food box programs in two areas, and markets and community gardens although not well-used were seen as providing important points for social interaction and/or physical activity.

**Summary of Conclusions.**

(1) Most healthy built environment features within the four Study areas, except for Renwick, have been as a result of fortuitous "co-benefits" from other built environment actions (relating to reducing ecological footprints, and/or providing residential amenity to improve marketability) rather than any conscious healthy built environment orientation or focus.

(2) This suggests "we are already doing it" to some extent and that we do not need to take on new, extra work. Rather, we need to be more conscious about what we are doing, to ensure healthy outcomes do arise from our existing design and management actions.

(3) Although there has been an explicit intention to include healthy built environment features in Renwick, aspects of both the initial master planning and implementation limit effectiveness.

(4) Of the three "domains" of healthy behaviours the need to achieve minimum levels of physical activity is of most on-going concern, mostly because of personal motivation reasons.

(5) Levels of social interaction vary, however there is a lingering desire for greater "connection", and thus a need to generate incidental social interactions, as well as more formalised group activities within local community spaces.

(6) There is an unresolved issue about how to generate social interactions amongst neighbours in multi-storey, multi-unit buildings as a result of the "transient" nature of existing common areas, internal security arrangements (and the transient nature of some occupiers).

(7) Access to healthy food options has not been an issue, generally because of reasonable accessibility and affordability of supermarkets. Other fresh food sources (farmers markets and community gardens) are not well-used.

(8) Participants in all areas stress a desire for the early provision of a local centre accessible by walking (or cycling) which includes both food shops and social meeting places.

(9) Participants invariably understand the connections between their health and daily activity and are often active in creating their own solutions that range across two or more of the three "domains".

(10) Combined, these points suggest an increased need for attention to detail in how neighbourhoods are designed, constructed and managed; and a need for planners and managers to recognise the knowledge of residents in terms of what they need to be healthy.

.

## Overall lessons for healthy built environments.

---

**(1) Find and create networks beyond the development site.**

There is a need when planning each development precinct to think outside the boundaries of the subject site – to create links and networks to existing facilities in the surrounding locality, and to encourage use by others of facilities to be provided within the new development (to increase their viability, and generate added opportunities for social interaction).

**(2) Master planning to be innovative, but also realistic.**

Master plans need to be innovative in their approach, but also ultimately realistic. If an otherwise imaginative and desirable master plan proposal cannot be achieved in practice there may be negative flow-on effects in terms of behaviour patterns.

**(3) Designers to "put themselves in the shoes" of residents.**

Designers of built environments need to "put themselves in the shoes" of the anticipated residents, and thus users, of the locality to ensure they are designed and managed to ensure up-take.

**(4) On-going management is as important as initial provision.**

The on-going management of facilities and infrastructure is just as important as their initial provision. Facilities will not be used if they are for example poorly maintained, do not have convenient opening hours, do not adequately manage behaviour of users, provide sufficient services at an affordable cost, or lack child care.

**(5) Active recreation facilities for *both* personal and informal users, and formal group activities.**

The provision of facilities for personal or informal active recreation is just as important as facilities for more formal group active recreation. Participants in all areas expressed a desire for hard surfaces (with nets or hoops, etc.) for ball sports, level running and exercise surfaces, and fixed exercise stations.

**(6) An interest in walking for recreation and active transport, and potentially also in cycling for recreation.**

There is a common interest and participation in walking for recreation and active transport, and potentially also in cycling as a recreation activity. Additional attention to the provision of good walking and cycling infrastructure, including routes and destinations, could generate corresponding increases in physical activity.

**(7) However, short walking and cycling routes may not achieve needed levels of activity.**

However, short walking and cycling routes may not result in needed overall levels of activity. This is an issue where walking and cycling infrastructure is limited to the, generally small area, development precinct. A variety of destinations needs to be established, as well as connections to walking and cycling routes in the wider locality.

**(8) Specific attention required to challenge a "default" car culture.**

Specific attention is required to challenge a "default" car culture. It is still common to use the car for short local trips, rather than walk or cycle. Sometimes this is due to inadequate infrastructure, but programs to shift established habits and perceptions is also required.

**(9) Responses need to be place-specific (one size does not fit all).**

Responses need to be place-specific to account for differences in demographics and geography. One size does not fit all. Sometimes for example, there will always be a low level of active transport possible, so other ways to encourage physical activity will be needed. An ageing population will need different facilities to one which is younger.

**(10) Effective local information - knowing what is available.**

Effective ways to advise new residents of local facilities are required. "Welcome" programs with dedicated community development officers appear effective; however an example where this function has been out-sourced to a non-local consultant firm which mainly used electronic communications was less effective.

**(11) Listen to the locals – people do understand the connections, and often create their own.**

A need to "listening to the locals". Local residents do understand the connections between their health and behaviour and their locality, and often create their own activities and solutions. Healthy built environments should facilitate such local actions, and designers and mangers need to be open to hearing what individuals say they need to be healthy.

**(12) A required attention to detail.**

The importance of detail. Although the overall planning of an area may adequately cover and provide for health-supportive behavior, it was found that a high proportion of deficiencies were often due to an apparent lack of attention to detail within these larger plans and in their implementation and on-going management.

**(13) Co-opt contemporary trends.**

Being open to co-opting contemporary social happenings as they come (and possibly go). Personal choices about taking up health-supportive (and other) behaviour is often influenced by current trends and "fashions". The design and management of built environments should recognise and facilitate such trends where likely to support healthy behaviour. Current examples include the café society, "pop-up" facilities, dog-friendly parks and other facilities, mens' sheds, community gardens, group exercise classes and personal trainers.

*****