Planning Theory & Practice


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ABSTRACT  This article addresses the state of urban planning for health in Norway. The country has a long planning tradition, and a constant focus on public health work, so if an integration of health promotion and planning were to succeed, it would most likely be in Norway. This article focuses on the current state of affairs by addressing the following questions: What are the national ambitions concerning health in planning, and how is planning thought to promote health? How are national ambitions translated into local planning in Norwegian municipalities? What are the prospects for further integration between health and urban planning? The intersection between national ambitions and local practices is studied by analysing core national policy documents, survey data from a lateral section of Norwegian municipalities, and qualitative interviews with core actors at the local level. This paper fills a gap in urban planning research, where broad studies of the integration of public health issues at the local level are rare. Its analysis reveals that healthy urban planning has not yet been achieved, even in Norway. There is little knowledge transfer and interaction between planners and public health coordinators, and it has proven difficult to incorporate public health themes that are out of rhythm with planning’s traditional focus. However, the activities of thirty municipalities at the forefront of healthy planning show promising signs and there are elements in current planning that may help build towards a healthy urban planning in future.

Keywords: Healthy urban planning; health promotion; urban planning; wicked problems

Introduction

This article addresses a new ambition on the planning agenda, namely the aim of creating healthy urban planning (Crawford et al., 2010; Frank et al., 2003; Frumkin, 2003). As the health implications of urban planning have been recognized, health objectives are increasingly pursued as a central part of planning work (Barton & Tsourou, 2000, p. 1). Potentially, healthy urban planning will widen the scope of planning by introducing new concerns, groups, and disciplines into the planning process, as well as strengthening sensitivity to elements in the physical environment that impact people’s health. This article studies the integrative potential of public health and urban planning by identifying national ambitions and their translation into local planning practices. It draws on core Norwegian policy documents, nationwide surveys distributed to Norwegian planners and public health coordinators, and qualitative interviews with the same two groups. As a
result, the article contributes new knowledge to an important, emerging theme in planning. Due to the immense pressure on national health systems and the coming “elderly wave”, the need for preventive steps to encourage public health from outside the health sector is likely to grow in the years to come.

**Research Focus**

Scandinavian countries are often described as a “laboratory” for new policy initiatives, because new trends and ambitions are quickly integrated into policy (Barton *et al.*, 2009, p. 95). Over the last 25 years, Norwegian public health policy has focused constantly on disease prevention and health promotion through different means (Helgesen & Hofstad, forthcoming), while urban planning has developed a long and solid tradition of spatial intervention (Kalbro *et al.*, 2010). In both of these areas, local government is a core agent, playing a huge role in both the Scandinavian welfare state and urban planning (Baldersheim & Ståhlberg, 2002; Kalbro *et al.*, 2010). Additionally, in Norway, the promotion of public health is stated as a guiding principle for planning (MoE, 2008). Despite these links, however, knowledge about planning’s specific role in promoting health is patchy, partly because the question of how local authorities and communities should encourage health remains largely unanswered. This article endeavours to identify the measures offered to local planning authorities and study the integrative status of, and prospects for, public health and planning at the local level. As such, the article focuses on three related questions:

- What are the national ambitions concerning health in planning, and how is planning thought to promote health?
- How are national ambitions translated into local planning in Norwegian municipalities?
- What are the prospects for further integration between health and urban planning?

It is important to see how this research focus is placed within current discourse on healthy urban planning. Scholars studying healthy planning argue that there is substantial potential for health improvement through conscious governance of the built environment (Barton *et al.*, 2009; Frank & Engelke, 2001; Frumkin, 2003; Hancock, 1993; Kearns *et al.*, 2009; Northridge *et al.*, 2003). Yet despite the increased attention to the links between health in planning, it is feared that neither the practice of planning, nor the policy of government, have fully recognized the intimacy of the connection between space and wellbeing (Crawford *et al.*, 2010, p. 95). Barton *et al.* (2003) studied six municipalities taking part in the World Health Organization’s healthy cities project, concluding that the participating cities strove to translate health-related planning objectives and goals into concrete action, but did not always succeed in this objective. Hoehner *et al.* (2003) have argued that there is a methodological division between planners and public health workers that needs to be mended in order to improve community environments and quality of life. Research shows that public health practitioners find it hard to shift focus from their core activities to engage in planning processes, and that successful cooperation between planning and health departments is rare (Barton *et al.*, 2009, p. 94; Crawford *et al.*, 2010, p. 102). Studies have also been conducted on the output side of planning, at the community or neighbourhood scale, investigating the link between the built environment and health problems by combining datasets relating to each (Dannenberg *et al.*, 2003; Frank & Engelke, 2001; Frank *et al.*, 2003; Frumkin, 2002, 2003; Kearns *et al.*, 2009; Northridge *et al.*, 2003; Saelens *et al.*, 2003; Shiediac-Rizkallah & Bone, 1998). The built environment is found to have significant health effects on those inhabiting it, but at the
same time it is acknowledged that there is a need for more in depth studies to identify the core mechanisms influencing human health and wellbeing.

Three partially overlapping themes are traceable in the above-mentioned literature: a normative discourse on the need for reintegration of public health and planning, a focus on efforts to integrate planning and public health work, and a research emphasis on concrete integration effects on the community level, an area where there have been significant developments in recent years. Policy integration studies, though, have been few and far between, and have either drawn on a limited number of municipal case studies from the same country (Hoeijmakers et al., 2007; Jansson & Tillgren, 2010) or concentrated on the experiences of participants in the European Healthy Cities Network (Barton et al., 2003, 2009; Barton & Tsourou, 2000; Green et al., 2009; Hall et al., 2009). This article serves to follow up on current research by relating local experiences to broader arguments about the need to integrate health and planning. It widens the current agenda by studying efforts to bridge between health and planning across a lateral section of Norwegian municipalities; and thereby gives a broader picture of institutional ambitions and efforts towards integration between health promotion and urban planning.

The article proceeds as follows: it starts by outlining the data and methods used, then discusses connections between the fields of planning and public health while presenting theories supporting the analysis of the empirical material. It then turns attention to the detail of the empirical material, where national ambitions are identified and related to planning efforts at the local level. Finally, the empirical findings are summarized, and future prospects for healthy urban planning are raised.

**Empirical Data and Methods**

The study of integrative ambitions, efforts and potentials in relation to public health and planning draws on several data sources:


2. The results of a survey of local civil servants responsible for health promotion and urban planning, conducted in the spring of 2008 in all 430 Norwegian municipalities regarding the integration of public health into planning (the Health in Planning survey). This asked a series of structured questions, mainly on the nominal level. The response rate was 70% for civil servants responsible for public health, and 75% for civil servants responsible for municipal planning.

3. The results of a survey conducted in the spring of 2008 sent to local civil servants responsible for health promotion and urban planning in all 430 Norwegian municipalities about their knowledge and use of Internet-based information tools known as “municipal health profiles” (the Municipal Health Profile survey) containing structured questions, mainly on the ordinal level. The response rate was 64% for civil servants responsible for municipal planning and 56% for civil servants responsible for public health.

4. The findings of qualitative interviews complementing the survey material. In relation to the municipal health profile survey, 20 qualitative telephone interviews with planners and public health coordinators in ten municipalities were conducted (Helgesen et al., 2008). The Health in Planning material was supplemented with 60
interviews with 84 actors (32 on the county level and 52 on the local/municipal level) (Bergem et al., 2009; Ouff et al., 2010).

Together, these data sources give a solid basis for studying the ambitions, efforts and prospects for healthy urban planning. The document analysis is based on what is considered to be the core sources of national policy concerning urban planning and health promotion. National ambitions on the integration of urban planning and health promotion have been identified by searching on the concepts “urban planning” (kommuneplan) and “planning” (planlegging) in the public health documents, and “public health” (folkehelse) and “health” (helse) in the planning documents. In addition, the content of the documents have been double checked to make sure that no references were missed. The survey and interview data rests on a concurrent design where there was one mutual phase of data collection (Creswell, 2009, p. 103). As such, two different research methods, quantitative surveys and qualitative interviews, measure local integrative efforts. Ideally, this methodological triangulation enhances validity, gives richer data, and reveals paradoxes that spur further investigation (Peters, 1998; Johnson et al., 2007). In our case, the general patterns found in the survey material may be compared to interview data, providing contextual and in-depth knowledge of local practices and resulting in a more complete picture of integrative efforts at the local level. The study also includes investigator triangulation as the survey and interview data have been collected according to two different research themes (Denzin, 1978, cited in Johnson et al., 2007, p. 114). I took part in the research theme responsible for the survey data, so when using material from the interview data, I will refer to this as “research reports”, using them to add detail to the more general study (Bergem et al., 2009; Helgesen et al., 2008; Ouff et al., 2010).

The study has methodological challenges that deserve attention. The surveys were addressed to actors responsible for planning and health promotion. In the Health in Planning survey, participants were asked to consider the composition of cross-sectoral working groups in relation to both public health objectives and the integration of public health themes into planning. This methodology risks falling into the individualistic fallacy, where researchers make inferences from individual considerations to collective phenomena (Peters, 1998, p. 204). This danger was recognized and tackled in different ways by the study: firstly, the respondents picked as responsible for health promotion and planning in the municipality were considered to be the most informed actors in relation to local integrative efforts. Secondly, questions were adjusted to the respondent to secure reliability, so that people were asked questions about their personal area of responsibility. For example, specific questions about the use of different planning formats were directed to planners, while both respondent groups received questions about more general integrative measures. Thirdly, in relation to the composition of working groups, the respondents in the survey were asked if their municipality had such groups, and those that did not were guided past these questions. In this way, only municipalities that reported the existence of such groups were included on this specific question. Fourthly, the selection of public health themes to be measured in the Health in Planning survey was informed by governmental reports, the Norwegian Health Directorate (the financier of the project), and a brief study of the themes in local plans. Fifthly, the survey data was supplemented by qualitative data that provides contextual information. Together, these five steps enhance the data’s accuracy, though it must be recognized that the dependence on individual considerations is inescapable while other local data sources (e.g. local planning documents) are not included in the empirical material.
The Links Between Public Health and Urban Planning

Urban planning and public health had a mutual starting point; they were both born as a response to overcrowding and lack of adequate sewerage and water infrastructure in industrializing cities during the nineteenth century (Crawford et al., 2010, p. 91, Frumkin, 2003). The links between them have been revitalized through the current attention to health challenges and the “new public health” era promoted by the World Health Organization (WHO), which argues that “all systems and structures which govern social and economic conditions and the physical environment should take account of the implications of their activities in relation to their impact on individual and collective health and well-being” (WHO, 1998, p. 1; see also Awofeso, 2003). As health is repaired by the health sector, but created in people’s living environments (i.e. in people’s homes, schools, and work places, as well as the physical environment surrounding them), planning’s aptitude for cross-sectoral coordination and spatial allocation is increasingly seen as a core instrument for securing a healthy future (Barton et al., 2003, 2009; Duhl & Sanchez, 1999; WHO, 2010). Planning is therefore highly present in the European WHO initiative, Healthy Cities, launched in 1986 to promote healthy environments and lifestyles by encouraging inter-sectoral approaches to health, and the introduction of health aspects into all new policy (Ashton et al., 1986; Hancock, 1993). Over time, national governments have followed suit, moving towards a position where health promotion is seen as a topic for spatial planning (Barton & Tsourou, 2000; Barton et al., 2009).

Analytical Perspective

The efforts to tie urban planning and health promotion closer together in order to enhance health and wellbeing will be analysed by drawing on an institutional discourse perspective. This perspective does not simply focus on how the current institutionalization of planning constrains integration, but also explores the discursive elements of these integrative efforts. Viven A. Schmidt (2008, 2010) labels discursive institutionalism the “fourth new institutionalism”. As such, it aims to develop rational, historical, and sociological institutionalism by adding a focus on the role of ideas and discourse. Schmidt argues that action in institutional settings is explained by the other institutionalisms, either as an interest-based logic of calculation (rational institutionalism), a norm-based logic of appropriateness (sociological institutionalism), or a history-based logic of path dependence (historical institutionalism) (Schmidt, 2008, p. 314, see also Scott, 1995). Since discourses have a force independent of, and possibly prior to, social structure, Schmidt and others argue that a communicative logic that incorporates discourse into the analysis of policy offers a framework that better captures the dynamics of institutional change (Dryzek & Niemeyer, 2008, p. 483; Schmidt, 2010).

A discourse may be defined as “a specific ensemble of ideas, concepts, and categorizations that are produced, reproduced, and transformed in a particular set of practices and through which meaning is given to physical and social realities” (Hajer, 1995, p. 44). The “reality” is, in this instance, seen as socially constructed. A phenomenon is not important in and of itself and does not carry the means to represent itself as a meaningful object, but it attains its meaning and value through the way that society makes sense of this phenomenon (Hajer & Versteeg, 2005, p. 176). Hence, discourse analysis pushes meaning and constructed understanding to the forefront of analysis, studying how it governs the way people think and act (Hajer & Versteeg, 2005). So, a discourse contains specific assumptions, judgements, dispositions and capabilities that enable categories,
ideas and concepts to be shared in an intersubjectively meaningful fashion (Dryzek & Niemeyer 2008, p. 481).

According to discourse institutionalism, discourses and ideas coexist and interact to create dynamic institutions that produce, reproduce, modify, and transform meaning. Both continuity and change are addressed not only by identifying ideas and discourses, but also by focusing on the context in which they operate, in other words, the institutional features that enable and constrain change. In this article this involves analysing the core ideas and discourses guiding the planning and health fields, and studying how the meeting between them unfolds in the institutionalized planning arena. This is done by identifying national ambitions related to healthy urban planning and analysing how they are interpreted and translated into local planning practices. Dryzek and Niemeyer (2008, p. 483) argue that “persons are not simply bundles of discourses; autonomous individuals can reflect across the discourses they engage, even as they can never fully escape their constraints.” Translated to our context, this means that planning may contain multiple discourses and that these different discourses are, to a certain extent, adjusted to each other in order to create a meaningful planning agenda. Hence, it can be anticipated that public health will be adjusted to fit into the institutionalized practices of planning and the hegemonic discourses governing its activity. It can also be anticipated that the reverse is true: planning’s form and content will be adjusted over time when approached to the ideals of the health promotion discourse.

Such changes are dependent on what Schmidt calls “background” and “foreground ideational abilities” (Schmidt, 2008, pp. 314–315, 2010, p. 14). Background ideational abilities are defined as a “logic of practice” that underpins agents’ ability to make sense of a given context’s meaning on the basis of tacit ideational rules or rationalities of a given discursive institutional setting. In our context, it denotes norms and rules that constitute planners’ interpretation of how planning should be pursued. Foreground ideational abilities, on the other hand, serve to add a discursive element to institutions and denote agents’ ability to change or maintain their institutions following what is called a “logic of communication” (Schmidt, 2010, p. 15). Such abilities enable agents “to think and speak outside the institutions in which they continue to act... to communicate and deliberate about them, to persuade themselves as well as others... to take action to change them” (Schmidt, 2010, p. 16). So, foreground and background ideational abilities aim to capture the dynamic relationship between norms and rules on one side, as well as new ideas and discourses on the other side. Hence, this will not only serve to highlight the institutionalized practices of planning, but also to illustrate how prevailing and emerging modes of meaning influence planning practices. So, in order to enhance the integrative potential of urban planning and public health, the foreground ideational abilities of core actors will have to be developed by promoting mutual goals and arenas, and by cultivating a common understanding of the challenges of planning (conveyed via a common language).

Quantitative surveys combined with qualitative interviews are used to illuminate local practices. Large samples are a rarity in studies that employ discourse theory, and constitute an underdeveloped empirical resource (Howarth, 2004). Such data delivers knowledge that case studies are less able to identify about the broad construction of the meanings that constrain institutional change. In our setting, the survey material aggregates local actors’ understanding and judges the position of health promotion within planning. It contributes a nuanced picture of the ways in which public health goals are constructed and conveyed in urban planning by focusing on the elements that are in rhythm with planning’s logic of practice, as well as to the extent that new “logics of
communication”, i.e. emerging discourses in line with the ideal of healthy planning, are seen. The weakness of quantitative data, namely its inability to convey a sense of situated knowledge (i.e. historical context and concrete specificity), is also mitigated by the use of qualitative data in order to shed light on specific agents’ ideas and arguments.

Healthy Urban Planning in Norway

National Ambitions

The Norwegian Planning and Building Act (PBA) states that the law will: “promote population health, counteract social inequalities in health, and also contribute to prevent crime” (PBA, 2008, ss. 3.1 f). It is further stated that “good planning strengthens public health by contributing to protect against risks and promote factors that have a positive influence on health and life quality, not least by the contribution to a more socially just and equal distribution of factors influencing health” (MoE, 2008, p. 180). Further specifications of measures or instruments are not given in relation to these statements, but through an analysis of central policy documents, three measures anticipated to strengthen health focus in urban planning have been identified.

Systematic knowledge. Accessible statistical material on central health indicators and an introduction of health impact assessments are thought to raise awareness and inspire more informed political decisions (MHCS, 2003, 2007, pp. 85–86). By combining statistical material from different sources, local authorities may create their municipal health profile, using a tool that is already available on the Internet. This tool consists of statistical information on risks; supporting factors for health; as well as information about health status; health services; and the demographic composition of the population (Helgesen et al., 2008, pp. 31–32). In addition, the Internet site includes good examples of local public health efforts, knowledge about documented effects of health measures and fact sheets (Helgesen et al., 2008).

Moreover, impact assessments, in which the health consequences of particular decisions are judged, are supposed to enhance knowledge about the spatial dimensions of health. The impact of (among others) land use plans and more detailed area and development plans is assessed using specific criteria (IAR, 2009). Several of the topics that are judged and described in impact assessments are relevant for health, for example evaluations of population health and its distribution, crime prevention statistics, information about childhood environments and pollution data. Both the statistical material and the impact assessments are thought to feed into planning processes, and the resulting ambition is to raise awareness, support prioritization and, as a consequence, enhance health.

Policy integration. Planning takes place across sectors and levels, and thus enables coordination of measures and impacts from different socio-political areas. A master plan influences the specification of policies, budgets, detailed planning, adaptations within given sectors, and even individual decisions, but it also forms a basis for decisions in the private sector (MoE, 2008, p. 210). An important purpose is to raise consciousness and spur activities horizontally: by making health promotion an objective for urban planning, the burden may be lifted from the shoulders of the health sector and shared by other social sectors through the planning process (MHCS, 2003). This is seen as important as health risks are prevented and good health is promoted in wider society: in schools, at workplaces, in the families, through economic policy and the social security system, etc. However, policy integration also has a vertical component. Priorities set in the master plan
are meant to trickle down the planning hierarchy and eventually influence land use planning, developmental plans, and other thematic plans so that the planning becomes vertically consistent (MoE, 2008, pp. 209, 211). The ambition is that these integrative mechanisms will force public health to be more explicitly addressed across sectors, administrative levels, and finally, in society at large.

Experimentation and best practice. The national project, Health in Plan, was launched in 2005 by the national planning and health authorities, with the aim of strengthening the public health perspective in urban planning (MHCS, 2003; Norwegian Health Directorate, 2007). Approximately 30 municipalities took part in the initiative, which ran until 2010. The objective was to spur innovation and methodological development by anchoring public health measures in regular planning and steering documents, and to build planning and process competence among public health workers in the municipalities (MHCS, 2003; Norwegian Health Directorate, 2007). The primary mechanism was, again, the urban planning system and its processes. The development of new methods focused on how a wide range of public health goals may be realized by inclusion in urban plans and closer cooperation between public health workers and planners. The main instruments were the master plan and concrete action plans. The aim of the national planning and health authorities was that the experiences and solutions created by the participating municipalities would serve as an inspiration for other municipalities, and, over time, strengthen the focus on health in Norwegian urban planning.

All of these measures (systematic knowledge, policy integration, and experimentation/development of best practice) are thought to heighten attention to public health in local planning. However, the question is to what extent this focus is translated into planning practice in Norwegian municipalities.

Local Planning in Norway

The Norwegian Planning and Building Act of 2008 uses different plan formats at the local level to address and act on national goals and policy signals. Urban planning consists of four internally integrated parts: a Planning Strategy (Planstrategi), where local planning needs and strategic decisions are considered, the long-term Master Plan (Samfunnsdel), a

![Figure 1. The Norwegian planning system](image-url)
short-term Action Programme (Handlingsdel), and a Land Use Plan (Arealdel). The four parts have different legal status, time horizons, content, and degree of binding commitment. Figure 1 shows the relationship between them.

The Planning Strategy involves choices concerning long-term land use, environmental challenges, activities in the administrative sectors, and planning needs over a specific period (PBA, 2008, ss. 10.1). The Master Plan reveals long-term challenges, needs, and strategies for the community in general, and for the municipal organization in particular (PBA, 2008, ss. 11.2). It also discusses alternative strategies for development. The Action Programme is basically a plan for the allocation and commitment of the local authority’s financial resources, revised on an annual basis (PBA, 2008, ss. 11.1). The Land Use Plan is the legally binding steering tool to control land use, protect nature and the environment, and provide technical infrastructure (PBA, 2008, § 11.5). The Action Plan may be, and often is, merged with the compulsory Finance Plan, regulated by the Local Government Act (LGA) (1992). The latter gives a realistic overview of income, expected expenses, and a prioritization of tasks (LGA, 1992, ss. 44). In addition to the plan formats demanded by PBA and the Local Government Act, local authorities will make a number of thematic or strategic plans on topics that are either required by national authorities, or are the centre of local attention. Because of the big variation in thematic plans, this planning format is not integrated in Figure 1. The Planning Strategy is a new planning format not yet anchored in Norwegian municipalities and is, therefore, not included in the survey. So, our data covers four planning types, namely master plans, land use plans, thematic plans, and financial plans.

A pertinent question is: what can we expect to find in terms of focus on health promotion when our data was collected the same year the new Planning and Building Act was adopted? However, it is important to bear in mind that the revision of the PBA was a long-term process, with its content discussed for many years (NOU, 2001, 2003; MoE, 2008). Moreover, processes at the international level have influenced specific Norwegian municipalities. In Norway, one municipality participated in the WHO’s healthy cities project, and a healthy cities network, consisting of 19 municipalities, has existed since 1998 (Norwegian Healthy Cities Network, 2010). In addition, health promotion as an urban planning goal has been an official focus since 2001 (NOU, 2001, 2003). Also, with the public health report from 2003, the Norwegian Health Directorate started a number of initiatives related to healthy urban planning (MHCS, 2003; Norwegian Health Directorate, 2009, p. 3). So, concrete activities aimed at enhancing focus on health in planning have existed for some time in certain Norwegian municipalities, though there are reasons to believe that the PBA represents a new endeavour for most. The article will not, therefore, present a fully fledged evaluation, but will instead show integrative efforts and the future potential for integration at the local level.

Local Translation in Practice

We will look at concrete translation practices related to the three governmental measures that have already been identified: namely systematic knowledge, policy integration, and experimentation. In relation to the translation of knowledge, the main focus is on data showing planners’ and public health coordinators’ knowledge and use of municipal health profiles. This is because there is a lack of data on local health impact assessments (Helgesen et al., 2008); therefore, the discussion of local policy integration efforts is based mainly on the Health in Planning survey sent to administrative personnel responsible for planning and health promotion (Ouff et al., 2010). Concrete collaborative practices will be
stressed, and the position of public health themes in urban planning will be assessed. Together, this allows the mainstreaming of public health in the local administrative apparatus to be assessed. Finally, the data will single out municipalities participating in the Health in Planning survey in order to highlight the effect of experimentation on the use of systematic knowledge and policy integration.

Dissemination and Use of Health Knowledge

The flow of health knowledge into plans and planning activities is weakly supported in the survey material. Only 31% of the planners had knowledge of the municipal health profiles, and only 37% of those had used the profiles in relation to planning. Still, the planners that had used the health profiles had used them several times, and when planners who were unaware of the tool were asked to consult the website, they generally got a positive impression of the opportunities for health promotion in planning. On the other hand, public health coordinators made use of the health profiles, but were unable to translate them into planning processes. A total of 70% of this group knew of the profiles, but only 17% had incorporated the knowledge into urban plans. When asked about their involvement in urban planning, a clear majority (87%) reported that they had not been very engaged in the formulation of urban plans. In sum, planners lack health knowledge, and the coordinators that possess such knowledge are not involved in planning. Why is that so? In the qualitative interviews, both planners and public health coordinators pointed to a lack of time and resources to make full use of the municipal health profiles (Helgesen et al., 2008, p. 29). In addition, they highlighted that they had not yet been in need of such knowledge. Still, a common response was “we are about to... start a regulation, planning process, etc., where such knowledge will be of use and give relevant information” (p. 29).

Mainstreaming Health Horizontally

The impression that there is a limited flow of health knowledge between public health and planning is affirmed when looking at the frequency and composition of participants in local cross-professional working groups in the public health arena. Planners participate in such administrative cross-professional working groups in only 30% of the municipalities, whereas the Department for Health is a member of cross-professional groups dealing with public health in almost all municipalities in the survey (over 90%). Also, the department for school and the department for culture are among the prominent participants in such groups (about 70%). However, the qualitative study shows that formal participation in these two sectors does not necessarily imply stable and active contribution (Bergem et al., 2009, p. 60). Hence, in most municipalities, planners and public health coordinators seem to have a hard time bridging the gap between their activities. This conclusion is strengthened by the qualitative interviews where respondents express that the cross-sectoral perspective is lacking in their daily work and that they are fumbling to find mutual arenas where planners and public health coordinators can meet (Bergem et al., 2009) since the established arenas within the two sectors have proved to be unsuitable. According to local actors, there is a need for new arenas to be developed where they can be more acquainted with each other’s language and culture, develop a mutual understanding of how the two fields intersect, and, over time, develop a mutual knowledge base that can form the basis for closer collaboration (Bergem et al., 2009, pp. 68–69).
Mainstreaming Health Vertically

Public health is a broad concept, so when investigating the integration of public health into urban plans, the concept was operationalized into 16 different themes each with its own links to health promotion work and urban planning. This is illustrated in Table 1.

<table>
<thead>
<tr>
<th>Position in public health policy</th>
<th>Public health theme</th>
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<tbody>
<tr>
<td>The core of Norwegian public health policy</td>
<td>Tobacco, Diet, Physical activity, Social inequality, Mental health, Prevention of alcohol/drug abuse</td>
</tr>
<tr>
<td>Routinized activities</td>
<td>Environmental health, Dental health, Infection protection</td>
</tr>
<tr>
<td>Physical themes</td>
<td>Universal design, Green/recreational areas, Coordinated land use and transport</td>
</tr>
<tr>
<td>Community development</td>
<td>Culture and health, Social and physical meeting places, Safety/crime prevention, Prevention of injuries and accidents</td>
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The format of the article does not allow a detailed description of the different themes shown in Table 1, but it is important to underline the fact that they diverge in terms of their position in public health policy. The first category—“the core”—shows themes that have been especially focused on in current Norwegian public health policy (MHCS, 2003, 2007). Success in handling these challenges will have positive repercussions, not only for individual health status, but also for the health sector’s budget. It is therefore interesting to see whether these questions manage to influence goals and priorities in urban planning.

“Routinized activities” includes topics that have a solid anchorage in the local public apparatus, e.g. acts that prescribe the right of the population to receive services (regulated by local and regional obligations) (MHSA, 1982; CDA, 1994; DHSA, 1983). “Physical themes” include themes that are not solely attached to public health; most notably, those central to environmental work that have a long history of integration with urban planning. In “community development”, health promotion and urban planning share a joint need to create local communities with good living conditions.

In the survey, local planners were asked to mark which of these 16 themes were focused on in the master plan, the land use plan, the financial plan, and the various thematic plans. Table 2 shows the average number of planning anchorages of public health themes (anchorage means that respondents report the health themes, as presented in Table 1, as present in a plan). An additive index is constructed for each public health theme so that each municipality is given a value between zero and four, where zero means no anchorage in any of the four planning types, and four means that the specific theme is anchored in all four plans.

Table 2 gives a general impression of a low level of vertical integration between the four local plans. That being said, green or recreational areas have the highest average score, being integrated in 1.7 out of four possible plans. Also, physical activity, coordinated land use and transport, universal design, and social and physical meeting places are integrated in more than one plan. On the other side of the spectrum, themes like tobacco, diet, and social inequality in health and dental health are seldom emphasized in urban plans. Thus, it is themes of “physical relevance” that are most topical for urban planning: green or recreational areas, physical activity, coordinated land use and transport, universal design, social and physical meeting places, and prevention of alcohol and drug abuse. Core
elements to prevent the galloping trend of lifestyle diseases, namely tobacco, diet, and social inequality in health have a hard time entering the planning agenda. Some of the low-scoring themes such as tobacco and dental health can be said to have low relevance for urban planning. However, regional actors indicate in interviews that the absence of attention paid to more complex and challenging themes as social inequality in health or mental health can originate in a reluctance or “cowardice” to work with the most difficult themes (Bergem et al., 2009, p. 72). Unfortunately, the qualitative study did not dig deeper into this question when interviewing local actors.

So, according to public health coordinators and planners in a lateral section of Norwegian municipalities, systematic knowledge and policy integration, highlighted as core measures in central policy documents, have been put in use at the local level only to a minor degree. The flow of health knowledge into planning is generally low. Moreover, public health coordinators and planners seem to have a hard time bridging the gap between their activities, resulting in low horizontal integration. There is also a low level of vertical integration of public health themes into the planning hierarchy. The highest integration score is obtained by themes that have a physical relevance: green/recreational areas, physical activity, coordinated land and transport, universal design and social and physical meeting places.

Our attention will now turn to the third tool provided in national policy, namely experimentation and development of best practice. The question is whether experiments to integrate public health and planning have created new patterns in relation to the use of systematic public health knowledge, or influenced horizontal and vertical integration of public health and planning.

**Health in Planning Municipalities as Forerunners?**

The 30 municipalities that took part in the Health in Planning (HIP) project may give a more nuanced picture of healthy planning practices. Do these municipalities differ from other Norwegian municipalities in some way? A study of important structural variables shows that HIP municipalities do not differ significantly from other municipalities, except in the fact that they are somewhat larger, with their public health coordinators placed

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**Table 2. Average number of anchorages in local plans. Public health themes. Additive index.**

<table>
<thead>
<tr>
<th>Public health theme</th>
<th>Average planning anchorage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green/recreational areas</td>
<td>1.7</td>
</tr>
<tr>
<td>Physical activity</td>
<td>1.3</td>
</tr>
<tr>
<td>Coordinated land use and transport</td>
<td>1.2</td>
</tr>
<tr>
<td>Universal design</td>
<td>1.1</td>
</tr>
<tr>
<td>Social and physical meeting places</td>
<td>1.1</td>
</tr>
<tr>
<td>Prevention of injuries and accidents</td>
<td>0.9</td>
</tr>
<tr>
<td>Culture and health</td>
<td>0.9</td>
</tr>
<tr>
<td>Prevention of alcohol/drug abuse</td>
<td>0.9</td>
</tr>
<tr>
<td>Environmental health</td>
<td>0.9</td>
</tr>
<tr>
<td>Mental health</td>
<td>0.8</td>
</tr>
<tr>
<td>Safety/crime prevention</td>
<td>0.6</td>
</tr>
<tr>
<td>Infection protection</td>
<td>0.6</td>
</tr>
<tr>
<td>Social inequality</td>
<td>0.4</td>
</tr>
<tr>
<td>Diet</td>
<td>0.4</td>
</tr>
<tr>
<td>Tobacco</td>
<td>0.3</td>
</tr>
<tr>
<td>Dental health</td>
<td>0.2</td>
</tr>
</tbody>
</table>

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higher up in the administrative hierarchy. They also have slightly more time to spend on public health work (Ouff et al., 2010). Together, these differences may influence their capacity to prioritize public health work, and thereby lead to a stronger focus on healthy planning.

If we look at the proportion of the 30 HIP municipalities that have anchored public health themes in their planning, we see that they generally have higher scores on all the 16 themes. However, because the sample is small, minor changes can therefore have large effects, so operating with percentages is methodologically challenging. Therefore, an isolated focus will be put on these municipalities while looking for significant factors influencing their integration of public health and planning. The municipalities’ knowledge about the status of public health will be examined alongside the ways in which health goals are focused in urban plans. Unfortunately, it is not possible to single out HIP municipalities in the survey on public health profiles; therefore, the ability to receive and anchor health knowledge will be monitored indirectly, through the involvement of public health coordinators in planning processes.

Half of the HIP municipalities involve their public health coordinators in planning processes to a large or very large extent. A total of 77% of the coordinators are involved in master plans and thematic plans; moreover, 65% of the HIP municipalities engage the planning department and the chief administrative officer in their cross professional working groups for public health. Hence, many HIP municipalities seem to have breached the wall between planning and public health activities in the administration.

HIP municipalities’ vertical integration of public health themes into urban planning generally follows the same pattern as other municipalities. A clear majority of HIP municipalities focus on green/recreational areas, coordinated land use and transport, physical activity, and social and physical meeting places in more than one of the four local plans. In addition, a majority focus on universal design, mental health, environmental health, prevention of alcohol and drug abuse, culture and health, safety/crime prevention and prevention of injuries and accidents in at least one plan. It is interesting, however, that the core themes of social inequality in health and diet are anchored in one plan or more in a majority of the HIP municipalities. So while the physically relevant themes dominate in HIP municipalities, an emerging tendency to focus on issues outside the traditional agenda of planning has also been found in these areas.

To find that HIP municipalities are ahead of other municipalities in their pursuit of public health via planning is hardly surprising since the aim of the programme was precisely to achieve this goal. However, since the programme was developed with scant public funding, the closer integration of public health and planning work, and the emerging focus on core topics in public health policy, may signal lasting changes. Interviewees from the qualitative part of the study thought that public health had been made more present in plans and that both planners and public health coordinators had gained new insights and come closer during the process. One planner expresses it in this way: “The communication between the administrative personnel within planning and public health are better now” (Bergem et al., 2009, p. 74). Still, the qualitative data shows that while these municipalities have succeeded in formally anchoring public health in plans, concrete activities with an impact on public health status has not yet been pursued (Bergem et al., 2009). Moreover, cross-professional working groups had trouble communicating their work to relevant administrative sectors. So while new interactive patterns between planners and public health coordinators have been established, the realization of healthy urban planning in the form of altered routines and new activities is harder to find.
Integration of Public Health and Planning

The level of integration found at the local level does not correspond to the high expectations at the national level. The instruments of systematic knowledge, policy integration, and experimentation are supposed to support the creation of healthy urban planning, signifying an adoption of public health as a guiding principle. At the local level, however, Norwegian municipalities have a hard time creating the desired links between public health and planning, both in plans and in planning work. Integration of planning and health has not been achieved in most municipalities, although HIP municipalities have taken a step further in terms of development of mutual arenas and integration of core themes into municipal plans. It may be that local planning is out of step with national ambitions because of the inability or unwillingness of national authorities to assert priorities among different planning goals and support local healthy urban planning initiatives. Alternatively, implementation research has showed that clear national expectations do not always lead to the desired local result (Pressman & Wildawsky, 1973). Established world views and routines founded in the practices of public health and planning may also have a significant impact on the development of healthy urban planning at a local level. Discursive institutionalism directs attention to institutionalized practices: specifically, the role of ideas and discourse in various institutions and in the framing of practice. By analysing the presented material through the lenses of discursive institutionalism, public health and planning’s rationalities, their integrative potential, and the prospects for synergy effects between aspects of public health and planning are discussed.

Healthy Urban Planning: The Meeting Between Two Different Rationalities

Health is a slow policy field where changes are, at best, seen after long term efforts to change lifestyles and socio-economic determinants of health (Merzel & D’Affitti, 2003). Correspondingly, concrete outcomes such as the effect of a particular intervention in terms of changes to the health of an individual or group are hard to measure (Glouberman & Millar, 2003; Nutbeam, 1998). Tackling health challenges through health promotion comes close to what has been labelled as a “wicked problem”, in that it is difficult to demarcate, define and frame, and has no simple, commonly accepted, agreed solution (Innes & Booher, 2010; Jansson & Tillgren, 2010; Rittel & Webber, 1973).

When approached with the task of preventing, for example, social inequality in health, one is confronted with a theme that is highly complex. Solutions to such problems are composite and found only partly on the local level. The basic elements of social and economic policy, for example, are formulated on the national level, through the social security system and tax and financial policies. Still, the idea that planning has a contribution to make in improving physical conditions in residential and public environments to improve quality of life in an area is persuasive (Barton & Tsourou, 2000, p. 14). The question therefore becomes: how can municipalities combat social inequalities in health in practice? National health policy offers few recommendations (MHCS, 2003, 2008; Norwegian Health Directorate, 2007, 2008, 2009), instead trusting the HIP municipalities to develop best practice despite the findings of this research, that such municipalities struggle to operationalize composite public health qualities into measurable guidelines and indicators. In addition, the qualitative research conducted for this study found a degree of uncertainty amongst practitioners about the extent to which the Planning and Building Act authorizes public health claims in land use plans and regulations (Bergem et al., 2009, p. 78). Public health seems to operate at the border of
planning’s traditional focus, challenging its institutionalised practices and stretching the limits of its activities.

When related to planning, public health meets a practice that has, as its core focus, economic development and evidence-based methodologies (Davoudi, 2006; Kleven, 2010; Tewdwr-Jones, 2008). Success in planning is still measured by reading the economic fine print; economic growth and competition continues to be the language of planning (Tewdwr-Jones, 2008, p. 675. Although statistical health data is provided, quick and ready-made answers cannot be found within the language of health promotion. Can the difference between the rationalities and institutional practices of health and planning shed light on possible reasons for the discrepancy between national ambitions and local practices?

In relation to systematic knowledge, our data shows that municipalities make use of municipal health profiles to only a minor degree. There may be many complex reasons for this. From the point of view of discourse institutionalism, our data suggests that health knowledge is regarded as lying outside of planning’s background ideational abilities. When they were made aware of the profiles and asked to review them, planners generally approved their value and thought that they would be important in coming planning projects. This may signify an unreleased potential for the integration of public health into planning. So far, though, it is the limitations that prevail, both in terms of planners’ capacity to make use of health knowledge in terms of their unawareness of health issues.

When it comes to policy integration, planners have a hard time prioritizing cross-sectoral working groups in the public health field. The linkages between the two fields and potential gains by closer collaboration are not obvious to local actors. For the time being, most municipalities seem content to stick to the well-known topics of planning. This is interesting in view of a traditional discourse in planning literature in which the breadth of planning, i.e. the number of goals and fields managed through planning is addressed. Wildawsky’s (1973) famous statement “if planning is everything maybe it’s nothing” may point to a fear of thematic overload that threatens to paralyse the field, which is currently tackled by focusing on the traditional areas of coordinated land use and transport, green/recreational areas and universal design.

Public health coordinators’ efforts may therefore be key to making progress. Their ability to argue for the importance and topicality of public health in planning processes can raise awareness. However, our data suggests that public health coordinators have had a hard time using such foreground ideational abilities in planning processes. Their involvement in the planning process is low, and their ability to engage in such processes is generally also low.

In sum, public health is a premature goal for urban planning, partly because of the challenge it presents to established planning practice. The topicality of public health in planning is acknowledged by planners, but this insight has not yet materialized into clearer indicators and institutionalized practices. Planners and public health coordinators in HIP municipalities, however, have started to develop a common ground by engaging in each other’s arenas. This may be seen as a first step towards integration of public health goals in urban planning.

**Integrative Abilities**

Discourse institutionalism anticipates that health promotion will be adjusted to fit into the institutionalized practices of planning and the hegemonic discourses governing its activity. In other words, planning’s form and content will be adjusted over time as it incorporates the ideals of the health promotion discourse. Does the data material show
signs of such mutual adjustment? It is natural to look at the practices of HIP municipalities since they have proved to be forerunners in integrating health and planning. The most significant result is that health has been integrated on the planning agenda, while planning has reached an impasse on the health agenda. Mutual interaction between the fields has increased, but not at the expense of these fields’ core topics and activities. So healthy urban planning represents an addition to the original agenda of each field, but has not yet resulted in deeper changes of institutionalized practices.

**Potential Synergy Effects**

There are elements here that may act as building blocks for a more holistic and comprehensive form of planning that goes beyond planning’s physical and economic starting point and thus drives the development of a common agenda.

Physical public health themes are also central elements in environmental work, making possible a synergy between these often separated activities within the local administrative apparatus. For example, over the last couple of years there has been an increased attention to the health impact of exposure to nature (Frumkin, 2003), with the result that core activities of environmental work, such as the preservation of biodiversity and natural habitats, create positive synergy effects in terms of health and well-being. Closer collaboration between environmental and public health workers may release unforeseen benefits for both humans and the natural environment. The physical environment may also be designed to enhance walking and cycling which benefits environmental health through better air quality and lower noise levels as well as reducing CO₂ emissions (Frank & Engelke, 2001; Saelens et al., 2003). In addition, such sustainable mobility patterns enhance the core goal of increasing physical activity, the only health theme that is, to a certain degree, present in municipal plans. To a larger extent than other core themes, physical activity is vertically integrated into the planning hierarchy and this may enhance the probability of implementation. Through coordinated spatial and transport planning, localization and shaping of residential areas, adaptation of existing areas, and creation of accessible nature and recreational areas, urban planning may contribute to physical activity among citizens.

Community development themes such as culture and health, prevention of injuries and accidents, safety and crime prevention, and social and physical meeting places, are also frequently reported, especially in HIP municipalities. Physical and community development themes are both closely related to urban design. Therefore, the material supports the notion of planning as an instrument for forming surroundings that enhance activity and create living communities. To succeed, planners need public health colleagues that manage to use their foreground ideational abilities to go beyond initiatives on the individual level by gearing health promotion measures towards the social environment and broader community level (Merzel & D’Affitti, 2003). Over time, such initiatives can create living communities where people feel comfortable, thus contributing to a central planning goal: to create attractive communities.

**Summary and Concluding Remarks**

Our first research question was: what are the national ambitions concerning health in planning and how is planning thought to contribute to promote health? This paper has identified three measures that can help ensure links between the planning and health agendas:
1. To integrate systematic health knowledge into planning to support priorities and draw attention to health challenges;

2. To integrate health promotion as a goal horizontally across sectors and vertically in the local planning hierarchy;

3. To develop best practice through experimentation by a limited number of forerunning municipalities.

These integrative measures served as a starting point for our study of local planning practices, building on two different survey materials and data from qualitative interviews. This material was used to answer the question: how are national health ambitions translated into local planning practices in Norwegian municipalities? It shows that local spaces are shaped by planners who lack health knowledge, despite the existence of public health coordinators who possess such knowledge but are not involved in planning processes. Moreover, planners are seldom involved in cross-sectoral working groups in the public health field, leading to low horizontal integration between public health and planning. When it comes to vertical integration in the local planning hierarchy, it is themes of physical relevance that are most topical for, and easily adopted by, urban planning: green/recreational areas, physical activity, coordinated land use and transport, universal design, social and physical meeting places, but also prevention of alcohol and drug abuse. However, core elements to prevent the galloping trend of lifestyle diseases, namely tobacco, diet and social inequality in health, have a hard time entering the planning agenda.

The Health in Planning municipalities who were supposed to serve as leaders in integrating public health concerns into planning have breached the wall between planning and public health activities in the administration, and have therefore succeeded to a larger extent in integrating health and planning horizontally, and in ensuring knowledge flow between the two sectors. When it came to vertical integration, though, the physically relevant themes tend to dominate in HIP municipalities, as well as in ordinary municipalities. As such, the Norwegian case confirms the results of earlier studies that have argued that integration between public health and urban planning is a new and somewhat premature goal that needs more time to find its form.

Based on these results, what are the prospects for further integration between health and urban planning (research question 3)? Although our data shows some promising signs, immediate results should not be expected. To couple two different sectors with diverging norms, world views and goals is challenging. Moreover, health in urban planning is more about managing a problem than solving it, and health promotion requires continuous, stepwise efforts towards this enduring goal. However, HIP municipalities seem to have taken the first steps towards a closer integration of health promotion and planning. Over time, this may result in increased knowledge and understanding of the other’s norms and activities, to the point that a mutual agenda can be developed to promote healthy urban planning. Planning’s traditional physical focus and health promotion’s core goal of enhanced physical activity constitute the first building blocks of such an agenda. In addition, an emerging trend to focus on the core themes of social inequality in health and diet has been found among HIP municipalities. Environmental work, which is more integrated into planning than health promotion, can be another bridge between the two fields. Often, environmental measures have a positive health effect and vice versa. As such, a closer integration of health and environmental work may create positive synergy effects for both humans and the natural environment.
The focus on public health in society in general and in planning will last. National health budgets in Norway continue to swell, and attention to measures outside the health sector that prevent the need for resource-intensive medical care has been raised (MHCS, 2009; WHO, 2009). This need will only become greater due to the coming demographic shift, which will see the number of elderly individuals in western populations rise, placing larger drains on health resources. Therefore, both local municipalities and national governments will have to continue the development of healthy planning efforts. Here the focus has been on integrative ambitions and efforts in a national context. In the years to come, national comparisons will be needed in order to strengthen knowledge and theories on how health and well-being may receive greater attention when municipalities’ and communities’ future development are planned.

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Notes

1. This is not a problem in relation to the municipal health profile survey. Here respondents are asked about their own knowledge and actions, i.e. both respondents and the phenomenon studied are at the same level.
3. The percentage is based on a combination of the categories “to some extent”, “to a little extent”, “not at all” and “do not know”.
4. This question was not posed to public health coordinators as it was anticipated that they were less familiar with the content in the different plans.
5. A total of 26 HIP-municipalities answered the survey sent to urban planners; 37 HIP-municipalities answered the survey sent to public health coordinators.
6. The Health in Plan programme had been operating for two and a half years when the survey was conducted.
7. Thirty-five municipalities taking part in HIP answered this question.

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