



Health and the Built Environment

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The 4 articles that follow summarize the consequences for the health of populations, especially in cities and their metropolitan regions, of public- and private-sector decisions about characteristics of the built environment. The Milbank Memorial Fund commissioned these articles, in collaboration with the Centers for Disease Control and Prevention and the New York Academy of Medicine, to help in the process by which the findings of research in this area inform the judgments of decision makers.

We also asked the authors to participate in panels at a conference in March 2003, convened to stimulate communication between experts on health policy and research and persons who study, plan for, and regulate the built environment. The Academy and the Centers for Disease Control took the lead in planning and convening this conference. Colleagues at the Regional Plan Association and the Project for Public Space joined in devising the conference agenda and selecting panelists and invitees. These organizations have earned respect and visibility among persons in the public and private sectors across the country who are professionally involved with the built environment.

At the conference, panelists discussed the practical implications of the research findings presented by the authors of these articles. They explained why it is difficult, but feasible, to use public and private investment in the built environment to improve health.

An apparent obstacle to the use of these resources is that the builders' and developers' and governments' costs for creating such environments can appear to compete with other important goals—such as creating jobs and increasing corporate earnings, meeting citizens' aspirations for housing, shopping, and recreation, and facilitating the movement of people and goods in densely populated areas.

The desired benefit is that improving health often can complement, and sometimes enhance, achieving other goals. Panelists offered examples of redesigned public spaces that promote both commercial and physical activity and of investments in mass transportation that reduce air pollution from automobiles and commuting time and also create incentives for commercial construction and housing.

Each of the four articles addresses a different aspect of the complicated analytical and political relationships between the built environment and health status. In "Residential Environments and Cardiovascular Risk," Ana V. Diez Roux arrays and assesses evidence about the effects of the varying characteristics of different neighborhoods on the current epidemic of cardiovascular disease. She emphasizes environmental determinants of such risk factors for cardiovascular disease as physical activity and diet. Similarly, Gary W. Evans, in "The Built Environment and Mental Health," describes the effects on mental health of housing quality, crowding, noise, indoor air, and daylight exposure. Both authors document their findings from a rich literature to which each of them has contributed.

Two other articles discuss the people and organizations that plan, make policy for, finance, and build our environment. In "How Urban Sprawl Shapes Human Well-Being," Harold V. Savitch summarizes an extensive literature on the relevant politics of policymaking and public financing. Savitch describes how the tax policies of the states create strong incentives for officials of local government to accord the highest priority to local economic development. These policies cause local governments to become, in his metaphor, "growth machines" in order to generate money to pay for the services that voters demand. However, he also finds examples in the research literature, including studies he conducted, of political action to create policies that resulted in a better balance between accelerating economic growth and maintaining and improving health.

Mary Northridge, Elliot Sclar, and Padmini Biswas propose a conceptual framework for planning healthy cities. In "Sorting Out the Connections Between the Built Environment and Health," they propose ways to integrate research findings from the literatures of planning, the policy sciences, and the sciences of public health with a commitment to policy that improves the quality of life for vulnerable people. They ground their framework in research they have done as well as their collaborative teaching. The authors also call attention to current impediments to conducting research on the built environment. These challenges include the complexity and abundance of the variables that link health and the built environment and the lack of valid and reliable indicators of the health effects of many planning and policy decisions.

These articles augment other publications that are expanding both the research and action agendas on the environmental determinants of health status. People cannot be healthy in unhealthy environments. What and how societies build, using which materials, and how governments regulate the uses of land and the quality of air and water obviously affect the health of populations. But the health status of populations and subgroups of them also determines capacity for economic growth, social peace, and political stability within societies and their jurisdictions. The linkage of health and the built environment is a familiar subject to many who practice urban and regional planning and the disciplines of both policy sciences and health sciences. For that reason, the development of clear, linked research agendas at the clinical, public health, and environmental levels is essential. This linkage has recently become a matter of concern to persons who work in foreign and international affairs. The importance of research and policy for the built environment is simultaneously local, regional, national, and global.

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