Published in *A Love of Ideas* in 2014 by Future Leaders (www.futureleaders.com.au)

Using soft and smart power to create a healthy, liveable and sustainable city

Billie Giles-Corti

In September 2011, a high-level UN meeting brought together leaders from across the globe to discuss the prevention and control of chronic diseases. This meeting acknowledged that the global burden of preventable health conditions such as cardiovascular disease and type 2 diabetes was so immense that if uncurbed, it will cripple global health systems and undermine social and economic development.[1]

Globally, the prevalence of chronic diseases is increasing. Currently, some 36 million deaths annually are caused by chronic disease,[2] and notably this is in both the developed and developing world. This is particularly disturbing because most chronic diseases are caused by preventable lifestyle-related risk factors: physical inactivity, sedentariness, unhealthy diets and smoking.

While many may trivialise these behaviours as something that individuals can and should fix themselves, in public health circles[3] and increasingly beyond[4] it is now recognised that global trends in chronic diseases and their major risk factors are thought to be caused by 'system' failure: a system that discourages healthy, and encourages unhealthy, lifestyle choices; and as a result creates poor health outcomes and health inequity.[5]

UN leaders have agreed that combatting chronic disease is not something that could be handled by the health sector alone. Rather, they concluded that many of the solutions to combating chronic diseases would be found in sectors outside of health: in planning, transport, economics, food production, agriculture, and recreation sectors, to name a few. Decisions made by professionals working in sectors outside of health create the *conditions* for good (or bad) health.

Australians enjoy considerable health and wellbeing, although there is considerable inequity, with the less wealthy more at risk than others. While the prevalence of cardiovascular disease continues to fall, according to the Australian Institute of Health and Welfare, the prevalence of preventable cancers continues to rise, the prevalence of diabetes has more than doubled in recent decades, and mental health problems accounts for 24% of total years lost due to disability.[6] In addition, there is little room for complacency: two thirds of Australian adults and around one quarter of Australian children are either overweight or obese. Notably, disease patterns are also spatially distributed, with those in less wealthy suburbs, particularly those on the urban fringe, more at risk than others.[7]

The idea that where we live might affect our health is not new. However, in the 21st century, it is increasingly being recognised that many health and wellbeing outcomes are affected by the way we build and plan cities. For example, the way we plan cities affects whether people can walk or cycle to local shops or services; whether jobs are co-located near housing; whether people have access to public transport; whether housing is exposed to transport-related pollution; whether children are able to walk safely alone or with their friends to and from school; whether food available locally is fresh and healthy, or whether the only food available is fast food and unhealthy; and whether local recreational opportuni-

ties are health-enhancing or health-damaging, focused mainly on gambling or alcohol.

All of these outcomes directly or indirectly impact the health and wellbeing of citizens and hence, their chronic disease profiles. Moreover, we are beginning to see that city plans are either equitable, or not. In the same way that in the late 19th century that the poor were profoundly affected by crowded conditions and pollution in urban slums, in the 21st century we are beginning to see the social patterning of the access to social infrastructure, public transport and services, along with the social patterning of the distribution of major chronic diseases: where you live matters. Hence, from a health perspective, decisions about the way we plan our cities definitely matters.

The importance of city planning is becoming even more acute globally as cities grow. For example, for the first time in human history, 50% of the world's population live in cities and this will leap to 70% by 2050.[8] This problem is amplified because of rapid global population growth, with the world's population tipped to reach nine billion people around the same time. Governments across the globe are grappling with how to house, mobilise and feed a rapidly growing population. This is also true for Australia: the Australian Bureau of Statistics' upper estimate for population growth in Australia by 2050 suggests our population could almost double.[9] The exponential growth being experienced in Melbourne's growth corridors and on the peri-urban fringe sharpens the focus of this issue from a local perspective.

Communities are struggling to cope with the growth: the influx of new residents and the lifestyle changes required of existing residents, the demands on existing infrastructure and the lack of new infrastructure, and a rapidly changing environment that puts pressure on agricultural land and on industries where there are conflicts with their proximity to suburban development. The changes to communities and thus for some,

the sense of isolation they experience during these periods of rapid growth, is significant.

Solving these 'wicked' problems requires a new way of thinking and working: sectors working together in an integrated way, to optimise societal outcomes. The term 'wicked problem' is used in social planning to describe complex problems that are difficult to solve, often because of complex interdependencies, which means solving one aspect of the problem may create another problem: the notion of unintended consequences. Hence, solving these problems is not an easy task: the problems are complex and interrelated, priorities and language of each sector are different, and the threads that bind sectors together are not always clear. They require new ways of thinking and the potential to being open to the possibility, rather than locking into concrete ideas driven by a commitment to concrete ideologies. Opening questions need to be: how can we deliver the best possible city for our residents, and how can we create a more equitable city?

Thus, the starting point must be the use of 'soft power'. The term 'soft power' was coined by Joseph Nye, and comes from the field of international relations.[10] Soft power is the ability to persuade by attracting and co-opting, rather than coercing or forcing. In a world that largely values market forces within a free market, the notion that we need to build cities differently to create the conditions for good health has great potential to be met with resistance.

So, what is the solution for the health sector to creating better cities? The first response of the health sector has been to use 'soft power' by creating guidance — for example, the World Health Organization's guidance to member states in 1986 focused on the need for 'healthy public policy': no regulation or force, just guidance of what is important to create health, and to use policy to promote health and wellbeing. Second, there has been recognition about the need to create alliances — for

example, the WHO's Healthy Cities Movement sought to encourage local government engagement to promote comprehensive and systematic policy and planning approaches for health, and also to involve the public through participatory planning. Third, and most recently, public health has moved towards creating policy-relevant evidence that it hopes 'speaks' to sectors outside of health. In so doing, the public health research community is trying to use evidence to engage and raise awareness of the unintended health impacts of decisions made in city planning; but to work constructively by helping to come up with solutions that might ameliorate these problems.

Yet, providing guidance, seeking engagement and creating evidence appears not to be enough. There is now a growing body of evidence about what's required to create health-enhancing neighbourhoods and optimise health outcomes, and this is simply not being translated into policy and practice. We continue to build low density single-use residential developments on the urban fringe, with poor access to public transport, local jobs, shops, service and essential social infrastructure.

As fuel prices will inevitably rise, what will happen to the 'affordable' housing developments on the fringe? These neighbourhoods are not walkable because there is nowhere to walk to; and they are poorly served by public transport. Moreover, as Dodson and Sipe demonstrated with their now famous 'vampire' maps, people living in these areas are vulnerable to both oil and mortgage stress.[11] Hence, it is quite likely that these developments are not healthy.

There a number of issues that need to be addressed from a health perspective. The evidence suggests that in these areas there will be:

- lower levels of walking;
- fewer people using active modes of transport (walking, cycling and public transport);

- more sedentary behaviour;
- increased levels of obesity;
- more vehicle miles driven;
- more motor vehicle accidents with more VMD associated with crash outcomes; and thus
- more greenhouse emissions.

There is also some evidence that urban sprawl may also be 'depressogenic'. For people with long commute times and time disconnected from their communities, these are contributors to poor mental health outcomes.

However, if the impacts on cardiovascular disease, diabetes and other chronic diseases, mental health outcomes and the long-term impact on the health budget are insufficiently compelling, a more hard-nosed economic perspective might be to ask whether building on the urban fringe is cost-effective? Are we getting the most out the resources and social infrastructure in middle- and inner-suburban areas? Are we using our resources efficiently, and can we afford to continue to build on the urban fringe, particularly into the long term?

Whichever perspective one uses, clearly we need a new way of thinking and working. From a health perspective, what we are doing has the potential to produce harm. Thus, to create health, wellbeing and prosperity in cities we need a combination of what Nye refers to as 'smart power': the appropriate use of both soft and hard power, with hard power in city planning being legislative and regulatory reform. In international relations, it now recognised that neither soft nor hard power alone is enough to bring about change. We need both.

As the evidence mounts and coalitions are built between health, environment, transport and health sectors, 'soft power' must therefore shift to 'smart power', with the aim of transforming cities and bringing about widespread reform. In the context of city planning, hard power involves the use of regula-

tion so that some things are mandated: density, connectivity, mixed planning and the timely delivery of infrastructure. However, critically, smart power requires leadership — across all levels of government and across organisations responsible for the built environment. It also requires leadership for a long-term commitment to city planning and to support reform.

'Soft power' is needed to engage, persuade and attract a multitude of stakeholders: the public, local business, and professional groups. However, there is also the need for 'hard power': for example, a commitment to an urban growth boundary in Melbourne, a commitment to density, and a commitment to the timely delivery of social infrastructure. In the same way that it is now unimaginable that we would build cities without water and sanitation, we need to get to a point where it is unimaginable to build neighbourhoods without public transport and appropriate social infrastructure.

To create health, wellbeing and prosperity for citizens requires leadership and a long-term commitment to the city's plan. Not the plan of one government, but the long-term plan of the city. Thus, good city planning requires smart power: the appropriate mix of 'soft' and 'hard' power to optimise outcomes, and an unflinching commitment to the long term. Wisdom and self-insight are critical for the type of leadership required for the city planning that is required to create health, wellbeing and prosperity.

So, to finish where we began: globally, we are facing a crisis in the health sector. While not as extreme in the Australian context, I have argued there is little room for complacency. In many ways the trends seen overseas are being played out in Australia, and in Melbourne. The cost of preventable chronic diseases and their risk factors will not only cripple health systems, but will jeopardise social and economic growth unless it can be curbed. Globally, there is growing recognition that while the health sector carries the burden of these costs, the

solutions to combating preventable chronic disease lie in sectors outside of health: transport, land-use planning, agricultural, and recreational planning, to name but a few.

While some are beginning to be persuaded by the arguments, there is a large gap between what we know, and what we act upon. Critically, what we need is bipartisanship: a long-term commitment to a city plan that makes the best use of existing infrastructure and ensures timely delivery of essential services in new areas. We need city plans with a focus on the health, wellbeing and prosperity of its residents. In this sense, we need 'soft' power used by city and state leaders of all political persuasions, to commit to 'smart' power; the appropriate use of persuasion and negotiation, as well as a commitment to regulation about the things that matter most. At the heart of using 'smart power' should be the aim of a long-term commitment to optimising health and wellbeing outcomes, and thus creating healthy and sustainable future for our citizens, our cities, and ultimately our nation.

Endnotes

1 United Nations, *Political Declaration of the High Level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases* (Sixty-sixth session, Resolution 66/2). Retrieved from http://www.who.int/nmh/events/un_ncd_summit2011/political_declaration_en.pdf

2. R Lozano et al., 'Global and regional mortality from 235 causes of death for 20 age groups in 1990 and 2010: a systematic analysis for the Global Burden of Disease Study 2010', *Lancet,* vol. 380, 2012, pp. 2095–2128.

3 M Marmot, *Fair society, healthy lives. Strategic review of health inequalities in England post-2010*, UCL Institute for Health Equity, London, 2011.

4 United Nations, op. cit.

5 Marmot, op. cit.

6 Australian Institute of Health and Welfare (AIHW), *Australia's health 2012*, AIHW, Canberra, 2012.

7 Heart Foundation, 'Victorian Heart Maps'. Retrieved from http://www.heartfoundation.org.au/information-for-professionals/data-and-statistics/Pages/interactive-map-victoria.aspx
8 United Nations Population Fund (UNPF), *State of world population 2010*, UNFP, 2011.
9 Australian Bureau of Statistics (ABS), *Regional Population Growth, Australia, 2012* (Fact Sheet No. 3218.0), ABS, Canberra, 2012.
10 J Nye, *Bound to lead: The changing nature of American power,* New York, Basic Books, 1990.
11 J Dodson & N Sipe, 'Planned household risk: mortgage and oil vulnerability in Australian cities', *Australian Planner*, vol. 45, no. 1, 2008, pp. 38–47.