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Public Health Representation on Active Transportation Bodies Across US Municipalities

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Abstract

Context: Municipal bodies such as planning or zoning commissions and active transportation advisory committees can influence decisions made by local governments that support physical activity through active transportation. Public health professionals are encouraged to participate in and inform these processes. However, the extent of such collaboration among US municipalities is currently unknown.

Objective: To estimate the prevalence of active transportation bodies among US municipalities and the proportion with a designated public health representative.

Design: A cross-sectional survey administered from May through September 2014.

Setting: Nationally representative sample of US municipalities with populations ≥1,000 people.

Participants: Respondents were the city or town manager, planner, or person with similar responsibilities (N=2018).

Main Outcome Measures: The prevalence of planning or zoning commissions and active transportation advisory committees among municipalities, and whether there was a designated public health representative on them.

Results: Approximately 90.9% of US municipalities have a planning or zoning commission, while only 6.5% of these commissions have a designated public health representative. In contrast, while 16.5% of US municipalities have an active transportation advisory committee, 22.4% of them have a designated public health representative. These active transportation bodies are less common among municipalities that are smaller, rural, located in the South, and where population educational attainment is lower. Overall, few US municipalities have a planning or zoning commission (5.9%) or an active transportation advisory committee (3.7%) that also has a designated public health representative.

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Conclusions: Approximately 9 in 10 US municipalities have a planning or zoning commission, while only 1 in 6 have an active transportation advisory committee. Public health representation on active transportation bodies across US municipalities is low. Increasing the adoption of active transportation advisory committees and ensuring a designated public health representative on active transportation bodies may help promote the development of activity-friendly communities across the United States.

Keywords

Public Health; Urban Planning; Built Environment; Physical Activity

Introduction

Regular physical activity is one of the most important things people can do to improve their health.[1] Community design is known to influence participation in physical activity, particularly through active transportation.[1–4] Municipal governing bodies (e.g., city councils) can adopt policies, plans, and zoning regulations, such as Complete Streets policies and form-based codes, to encourage and support activity-friendly community design.[5–8]

Several types of municipal bodies can play an important role in community decision-making processes related to active transportation, such as adopting land use and transportation policies and conducting community planning. These active transportation bodies can include planning or zoning commissions and pedestrian, bicycle, or alternative transportation advisory committees (active transportation advisory committees). In general, planning or zoning commissions act as an advisory group to a municipal governing body on matters related to planning, land use, development, public improvements, and zoning regulations.[9] Alternative transportation advisory committees (often called bicycle/pedestrian advisory committees) advise a municipal governing body on bicycle and pedestrian projects, plans, programs, and policies.[10] Both of these active transportation bodies often include representatives from the transportation, land use, and community design sectors; however, they can also include public health professionals.[11, 12] The American Public Health Association supports local public health officials in their efforts to engage in local and regional transportation and land use planning and policy-making processes and calls for improving public health participation in transportation and land-use decisions.[11] Local health departments offer unique contributions to this decision-making process, including their expertise in physical activity and health, data analysis and assessment, and knowledge of the public health evidence base and best practices, among others. As such, collaboration between public health and the other sectors can help promote activity-friendly community design.[1, 3, 13]

To date, no study has examined the prevalence of active transportation bodies or the extent to which public health representation exists within them in US municipalities. As such, the objectives of this study were twofold. First, to estimate the prevalence of planning or zoning commissions and active transportation advisory committees among US municipalities. Second, among municipalities with an active transportation body, to

determine the proportion that have a designated public health representative on it. Findings from this study can help practitioners identify characteristics of communities in the United States where there are opportunities to increase the adoption of active transportation bodies and public health representation on them to help promote activity-friendly community design.

Methods

Sample

The National Survey of Community-Based Policy and Environmental Supports for Healthy Eating and Active Living (CBS HEAL) was conducted by the Centers for Disease Control and Prevention (CDC) to gather information on the existence of certain policies, standard, and practices enacted or implemented by local government that promote more healthful eating and physical activity for residents. It was conducted from May through September 2014 and the sample pool of potential respondents was based on the 2007 Census of Governments (COG) files which list municipalities by state.[14] Municipalities with populations of <1,000 people were excluded from the survey because small communities were less likely to have policies and practices that support healthy eating and active living.[15] Sampling was stratified to create a nationally representative sample of municipalities (4,484 municipalities from all 50 states) and participating municipalities were each assigned sample weights. Additional information regarding the sample design and weighting has been previously published.[15–19]

The primary respondent for the survey was the city or town manager, planner, or person with similar responsibilities. Respondents were encouraged to ask for assistance in completing the survey if needed from other municipal officials such as a tax office or procurement department representative, a parks and recreational department representative, or a human resources representative. This data collection was deemed exempt from institutional review because of the public nature of the data being collected. Respondents were given a unique identifier to enable them to complete the survey through a secure website. They also had the option of completing a paper based version of the survey. A total of 2,029 surveys were returned, with a response rate of 45%. Municipalities with missing data on measures of interest were excluded (n=11), resulting in a final study sample of 2,018.

Measures

To assess the presence of planning or zoning commissions, local officials were asked: “Does your local government have a planning and/or zoning commission?” Response options included yes; no; or don’t know. Those who responded yes were then asked: “Is there a designated health/public health representative on the planning and/or zoning commission?” Response options to this question were yes; no; or don’t know. To assess the presence of active transportation advisory committees, local officials were asked: “Does your local government have a pedestrian, bicycle, or alternative transportation advisory committee?” Response options included yes; no; or don’t know. Those who responded yes were then asked a similar question about a designated public health representative on the committee. All four outcome variables (i.e. having a planning and/or zoning commission,

having an active transportation advisory committee, and having a designated public health representative on each body) were defined as yes or no. Respondents who selected “don’t know” for each question were categorized as a no response.

Municipality characteristics were obtained from Census data and merged using each municipality’s unique Federal Information Processing Standards place code. According to the 2010 U.S. Census, urban areas included both urbanized areas (areas with 50,000 or more people) and urban clusters (areas with at least 2,500 but fewer than 50,000 people), and areas outside urban areas are considered rural.[20] The 2010 US Census Urban Area to Place Relationship File provides relationships between the 2010 urban areas and places.[21, 22] Based on this, we defined municipalities as urban if the majority (>50%) of the population in the municipality lived in an urbanized area; those with 50% or less were defined as rural. Median education level, poverty level, and race/ethnicity of the population of each municipality were estimated from the 2009–2013 American Community Survey.[23] Education was categorized according to whether more than 50% of the population were either high school graduates or lower or had some college education or greater. The poverty level was categorized as ≥20% or <20% below poverty level (calculated by comparing family income to thresholds based on family size and composition)[24] and the race/ethnicity category was designated by majority (>50%) non-Hispanic white or ≤50% non-Hispanic white.

Statistical Analyses

Prevalence and 95% confidence intervals (CI) of having a planning or zoning commission or active transportation advisory committee were estimated overall and by municipality characteristics (i.e., population size, rural/urban status, census region, median education level, poverty prevalence, and racial/ethnic composition). Among municipalities with a commission or committee, prevalence of having a designated public health representative on the body was estimated overall and by municipality characteristics. Finally, among all municipalities, prevalence of having a commission or committee with a designated public health representative was estimated overall and by municipality characteristics. The large sample size allowed us to use the normal approximation for the binomial distributed main outcome measures. Pairwise t-tests were used to identify significant differences. *P*-values <0.05 were considered statistically significant. Analyses were conducted using SUDAAN Version 11.0 (Research Triangle Institute, Research Triangle Park, NC) to account for survey design and weights.

Results

The majority of municipalities in our study sample had a population size between 2500 and 49,999, were urban, had a median education level of some college or higher, had <20% of the population below the poverty level and had >50% non-Hispanic white (Table 1).

Planning or Zoning Commissions

Overall, 90.9% of US municipalities had a planning or zoning commission (Table 2). Such commissions were less common among municipalities with populations of <2,500 persons

compared to those with 2,500 – 49,999 ($p<0.001$) and ≥50,000 persons ($p<0.001$). They were also less common among municipalities that were rural ($p<0.001$), located in the South ($p<0.001$ for comparisons to the Northeast, Midwest, and West), and where educational attainment was lower ($p<0.001$) and poverty prevalence was higher ($p=0.005$). Among municipalities with a planning or zoning commission, 6.5% had a designated public health representative on it. This proportion was lower in the West compared to the Northeast ($p=0.02$) and among municipalities where educational attainment was higher ($p=0.004$). Overall, 5.9% of US municipalities had a planning or zoning commission with a designated public health representative. This proportion was also lower in the West compared to the Northeast ($p=0.02$) and among municipalities where educational attainment was higher ($p=0.02$).

Active Transportation Advisory Committees

Overall, 16.5% of US municipalities had an active transportation advisory committee (Table 3). Such committees were less common among municipalities with populations of <2,500 persons compared to those with 2,500 – 49,999 ($p<0.001$) and ≥50,000 persons ($p<0.001$) and among municipalities with populations of 2,500 – 49,999 compared to those with ≥50,000 persons ($p<0.001$). They were also less common among municipalities that were rural ($p<0.001$) and where educational attainment was lower ($p<0.001$). Such committees were also less common in municipalities located in the Northeast, Midwest, and South compared to the West ($p<0.001$ for each), and in the South compared to the Midwest ($p=0.03$). Among municipalities with an active transportation advisory committee, 22.4% had a designated public health representative on it. This proportion was lower in the West compared to the Northeast ($p=0.01$) and among municipalities where poverty prevalence was lower ($p=0.02$). Overall, 3.7% of US municipalities had an active transportation advisory committee with a designated public health representative. This proportion was lower among municipalities with populations of <2,500 persons compared to those with 2,500 – 49,999 ($p=0.005$) and ≥50,000 persons ($p<0.001$) and among municipalities with populations of 2,500 – 49,999 compared to those with ≥50,000 persons ($p<0.001$). It was also lower among municipalities that were rural ($p<0.001$) and where educational attainment was lower ($p=0.004$).

Discussion

Public health representation on both planning or zoning commissions and active transportation advisory committees across US municipalities is low. Approximately 1 in 16 municipalities with a commission and 1 in 4 municipalities with an advisory committee has a designated public health representative on the respective body. In addition, while 9 in 10 US municipalities have a planning or zoning commission, only 1 in 6 has an active transportation advisory committee. Opportunities exist to help increase the adoption of active transportation advisory committees and ensure the presence of a designated public health representative on active transportation bodies. Increasing adoption of these committees and public health representation may help promote the development of activity-friendly communities across US municipalities.

We observed that most US municipalities have a planning or zoning commission, although far fewer have an active transportation advisory committee. In addition, both types of active transportation bodies were less common among municipalities that were smaller, rural, located in the South, and where educational attainment was lower. For example, the proportion of municipalities with an active transportation advisory committee was greater among municipalities with larger populations, with nearly half (49.2%) of municipalities in the largest population size category (i.e., population size ≥50,000) having an advisory committee. By comparison, the *2018 Bicycling and Walking Benchmarking Report (Benchmarking Report)* from the League of American Bicyclists indicates that 41 of the 50 most populous US cities have a bicyclist and/or pedestrian advisory committee.[25] While this proportion appears greater than our finding even amongst the largest municipality size group in our study sample, the 50 most populous cities are represented by a small subset of municipalities in our sample on the upper end of those with a population size of ≥50,000. Given our observed differences by population size, municipalities with populations well beyond 50,000 would potentially be even more likely to have an advisory committee, consistent with the *Benchmarking Report*'s finding. In general, our findings highlight opportunities to expand the adoption of active transportation advisory committees across US municipalities overall, and of both types of active transportation bodies among municipalities with identified characteristics (e.g., those that have smaller population sizes, are rural, and where educational attainment was lower). Future research examining the underlying factors influencing these patterns may help inform the development of effective strategies to overcome barriers and increase the adoption of active transportation bodies.

Public health officials are encouraged to engage in local and regional transportation and land-use planning and policy-making processes.[11, 12] We found that public health representation on active transportation bodies is low, particularly for planning or zoning commissions. This may be related to differences in mechanisms for how representatives come to serve on commissions compared to active transportation advisory committees. Overall, our findings of low public health representation on active transportation bodies demonstrates that an opportunity for engagement is being missed. Previous research has shown that local health department officials are less likely than other municipal officials to engage in transportation and land-use decision making, even though zoning and land use decisions were historically based on public health protection.[26, 27] Local health departments can offer unique contributions to this process, including: a physical activity and health perspective, data analysis and assessment, partnerships, public education, knowledge of the evidence base and best practices, resource support, and their ability to focus a health-equity lens on the transportation and land-use policy process.[28] Collaboration between the public health and transportation, land use, and community design sectors can help promote activity-friendly community design, and our findings highlight a significant opportunity for enabling the collaboration.

The underlying reasons why public health officials are not well represented on transportation bodies is currently unknown. However, barriers to cross-sector collaboration in transportation and land-use planning and policy-making processes may be contributing factors. Previous research has identified several barriers, including lack of staff,[26] lack of contacts at relevant agencies,[26, 29] challenges in communication given differences in

technical language and terminology,[29] and lack of political and public support.[26, 29, 30] Presently, published tools can help public health practitioners overcome these barriers to increase their participation on active transportation bodies. For example, investigators from the Physical Activity Policy Research Network+ (PAPRN+) developed a research-based tool to help public health entities strategically plan their engagement in local processes to improve opportunities for walking and biking.[12] Future research may wish to further explore the varying impact of barriers to including public health representation on different types of active transportation bodies and how barriers may differ by characteristics of the municipality. For example, we found that public health representation on active transportation bodies was greater among municipalities with certain sociodemographic characteristics. A further understanding of how barriers vary across different municipalities can provide insight on local efforts to overcome barriers and increase cross-sector collaboration. In addition, to our knowledge studies examining the impact of public health representation on active transportation bodies on policy and practice outcomes are lacking. Future evaluation efforts and research in this area may help local public health agencies better make their case for ensuring that such representation exists.

Our study is subject to several limitations. First, the CBS HEAL survey was designed to exclude unincorporated areas from the initial sample selection, as well as municipalities with populations of <1000 people. This limits the generalizability of our findings to incorporated municipalities with populations ≥1000 people. Second, the CBS HEAL survey data are self-reported by a target respondent, such as the city manager or an individual of similar title, who may not be as familiar with policies or standards that support the physical activity as they are with other policies. Although respondents were instructed to consult with a representative if they could not answer a question, it is unknown how many respondents did this and for what type of information. Third, the meaning of a “designated health/public health representative” was left to the interpretation of individual respondents which could potentially vary. Fourth, it is unknown whether municipalities had a local health department from which a representative could be drawn to sit on active transportation bodies. However, since included municipalities were incorporated and had populations ≥1000 people, we think this would be unlikely. Fifth, a large number of respondents reported “don’t know” to the questions examined in this study. However, repeat analyses excluding those who responded “don’t know” showed similar patterns by municipality characteristics. Finally, the response rate could have resulted in response bias. However, our study is based on a large, nationally representative sample of US municipalities. Despite these limitations, to our knowledge this is the first study to examine the prevalence of active transportation bodies or the extent to which public health representation exists within them across US municipalities.

Conclusions

Public health representation on planning or zoning commissions and active transportation advisory committees across US municipalities is low. Approximately 1 in 16 municipalities with a commission and 1 in 4 municipalities with an advisory committee has a designated public health representative on the respective body. In addition, while 9 in 10 US municipalities have a planning or zoning commission, only 1 in 6 have an active transportation advisory committee. Efforts to increase the adoption of active transportation

advisory committees and ensure public health representation on active transportation bodies may help promote activity-friendly community design and ultimately increase physical activity levels across the United States.

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Implications for Policy & Practice

- Public health professionals are encouraged to participate in community design decision-making processes to promote activity-friendly community design.
- One mechanism to achieve this is to designate public health representation on municipal planning or zoning commissions and active transportation advisory committees.
- Resources and tools can help public health professionals increase their participation on these active transportation bodies.
- Promoting cross-sector collaboration in transportation and land-use planning and policy-making processes may help promote activity-friendly community design.

TABLE 1.

Municipality Characteristics, CBS HEAL 2014

Municipality Characteristics	Sample Size	%
All Municipalities	2018	100.0
Population Size		
<2,500 persons	718	34.8
2,500 – 49,999 persons	1158	58.3
≥50,000 persons	142	6.9
Rural / Urban Status		
Urban (>50% urban)	1481	74.9
Rural (≤50% urban)	537	25.1
Census Region		
Northeast	232	14.4
Midwest	747	35.2
South	706	36.1
West	333	14.3
Median Education Level		
High school graduate or lower	890	44.4
Some college or higher	1128	55.6
Poverty Prevalence		
≥20% below poverty level	611	30.3
<20% below poverty level	1407	69.7
Race/Ethnicity		
≤50% Non-Hispanic White	269	13.4
>50% Non-Hispanic White	1749	86.6

Abbreviations: CBS HEAL = National Survey of Community-Based Policy and Environmental Supports for Healthy Eating and Active Living.

TABLE 2.

Proportion of U.S. Municipalities with a Planning or Zoning Commission and a Designated Public Health Representative, by Municipality Characteristics, CBS HEAL 2014*

	Have a Planning or Zoning Commission (N=2018)		Among those with a Commission, Have a Designated Public Health Representative (n=1832)		Have a Commission with a Designated Public Health Representative (N=2018)	
	%	95% CI	%	95% CI	%	95% CI
All Municipalities	90.9	(89.6–92.0)	6.5	(5.5–7.8)	5.9	(5.0–7.1)
Population Size						
<2,500 persons	80.1	(77.1–82.8)	7.6	(5.6–10.1)	6.1	(4.5–8.1)
2,500 – 49,999 persons	96.4	(95.2–97.4)	6.1	(4.8–7.6)	5.8	(4.6–7.4)
≥50,000 persons	98.6	(94.6–99.6)	5.8	(2.9–11.3)	5.7	(2.9–11.1)
Rural / Urban Status						
Urban (>50% urban)	95.3	(94.1–96.3)	6.3	(5.1–7.7)	6.0	(4.9–7.4)
Rural (≤50% urban)	77.6	(73.9–80.9)	7.3	(5.1–10.2)	5.6	(4.0–8.0)
Census Region						
Northeast	95.0	(91.5–97.1)	9.9	(6.6–14.6)	9.4	(6.2–13.9)
Midwest	92.8	(90.8–94.4)	6.1	(4.5–8.1)	5.6	(4.2–7.5)
South	85.5	(82.9–87.8)	6.4	(4.7–8.7)	5.5	(4.1–7.5)
West	95.6	(92.8–97.3)	4.4	(2.6–7.3)	4.2	(2.5–7.0)
Median Education Level						
High school graduate or lower	85.8	(83.4–87.9)	8.6	(6.8–10.8)	7.3	(5.8–9.3)
Some college or higher	94.9	(93.5–96.1)	5.0	(3.8–6.6)	4.8	(3.7–6.2)
Poverty Prevalence						
≥20% below poverty level	87.9	(85.2–90.2)	7.5	(5.6–10.1)	6.6	(4.9–8.9)
<20% below poverty level	92.2	(90.7–93.4)	6.1	(4.9–7.6)	5.6	(4.5–7.0)
Race/Ethnicity						
≤50% Non-Hispanic White	90.0	(85.9–93.1)	8.2	(5.3–12.5)	7.4	(4.7–11.3)
>50% Non-Hispanic White	91.0	(89.6–92.2)	6.3	(5.2–7.6)	5.7	(4.7–6.9)

Abbreviations: CBS HEAL = National Survey of Community-Based Policy and Environmental Supports for Healthy Eating and Active Living; CI = confidence interval.

*Participants who responded “No” (n=174) or “Don’t Know” (n=12) to the question “Does your local government have a planning and/or zoning commission?” were considered not having a commission. Participants who responded “No” (n=1558) or “Don’t Know” (n=157) to the question “Is there a designated health/public health representative on the planning and/or zoning commission” were considered not having a designated public health representative on the commission.

TABLE 3.

Proportion of U.S. Municipalities with an Active Transportation Advisory Committee and a Designated Public Health Representative, by Municipality Characteristics, CBS HEAL 2014*

	Have an Active Transportation Advisory Committee (N=2018)		Among those with a Committee, Have a Designated Public Health Representative (n=337)		Have a Committee with a Designated Public Health Representative (N=2018)	
	%	95% CI	%	95% CI	%	95% CI
All Municipalities	16.5	(15.0–18.2)	22.4	(18.2–27.2)	3.7	(2.9–4.6)
Population Size						
<2,500 persons	7.5	(5.8– 9.7)	21.0	(12.0–34.2)	1.6	(0.9–2.8)
2,500 – 49,999 persons	18.1	(16.0–20.4)	20.1	(15.2–26.1)	3.6	(2.7–4.9)
≥50,000 persons	49.2	(41.0–57.5)	30.6	(20.7–42.7)	15.1	(9.9–22.2)
Rural / Urban Status						
Urban (>50% urban)	19.9	(18.0–22.0)	23.0	(18.5–28.1)	4.6	(3.6–5.8)
Rural (≤50% urban)	6.4	(4.7– 8.9)	17.0	(7.8–33.0)	1.1	(0.5–2.4)
Census Region						
Northeast	14.3	(10.3–19.4)	37.0	(22.4–54.4)	5.3	(3.0–9.1)
Midwest	17.0	(14.5–19.9)	23.0	(16.5–31.2)	3.9	(2.7–5.6)
South	13.1	(10.8–15.7)	22.0	(14.6–31.7)	2.9	(1.9–4.4)
West	26.3	(21.9–31.2)	13.8	(8.0–22.8)	3.6	(2.1–6.3)
Median Education Level						
High school graduate or lower	9.1	(7.3–11.1)	26.3	(17.8–37.1)	2.4	(1.6–3.6)
Some college or higher	22.5	(20.2–25.0)	21.1	(16.5–26.7)	4.8	(3.6–6.2)
Poverty Prevalence						
≥20% below poverty level	16.0	(13.3–19.1)	31.1	(22.6–41.0)	5.0	(3.5–7.0)
<20% below poverty level	16.8	(14.9–18.8)	18.8	(14.2–24.4)	3.1	(2.3–4.2)
Race/Ethnicity						
≤50% Non-Hispanic White	15.2	(11.3–20.0)	36.3	(22.8–52.4)	5.5	(3.3–9.1)
>50% Non-Hispanic White	16.8	(15.1–18.5)	20.4	(16.2–25.5)	3.4	(2.7–4.4)

Abbreviations: CBS HEAL = National Survey of Community-Based Policy and Environmental Supports for Healthy Eating and Active Living; CI = confidence interval.

*Participants who responded “No” (n=1618) or “Don’t Know” (n=63) to the question “Does your local government have a pedestrian, bicycle, or alternative transportation advisory committee?” were considered not having a commission. Participants who responded “No” (n=210) or “Don’t Know” (n=54) to the question “Is there a designated health/public health representative on the bicycle and/or pedestrian advisory committee” were considered not having a designated public health representative on the commission.