



An introduction to transport planning for health and happiness

Part 3: Health considerations for transport planning

About this document

Intended audience: Public health professionals, transport planners, spatial planning and highways teams working in public bodies with a role in transport planning and active travel.

After reviewing this document, we hope you will:

- Feel confident talking about how and why transport is a health issue. (Part 1)
- Know where to look for health and transport related data. (Part 2)
- Have some ideas about key public health considerations relevant to transport planning (Part 3). Specifically,
 - Active travel / walking wheeling and cycling plans and strategies, and
 - Local Transport Plans / Integrated transport plans and strategies.

Overview

PART 1: Transport as a Health & Happiness Issue (Separate guide)

PART 2: Measuring transport-related health and health inequalities (Separate guide)

PART 3: Health considerations for transport planning

a. Local Transport Plans (Slides 5-17)

b. Active Travel / Walking, Wheeling & Cycling Strategies (Slides 18 – 27)

How to use this resource

- Public Health teams should be invited to engage in local transport plan / integrated transport strategy development, either during the formative stages, or as a consultee during strategy finalisation or adoption. Where possible, **early and sustained engagement using a health-in-all policies approach is preferable.**
- The following slides outline considerations that Public Health and Transport teams may find useful in developing health-focused transport plans. This is not an exhaustive list! Each slide has three key elements....

Summary statement, explaining the relevance of this issue to health. This may be useful when explaining your inputs to other teams.

Questions you may like to consider when reviewing or inputting to the strategy

9. There are valuable opportunities to address commercial determinants of health within our transport systems.

Transport infrastructure forms a large part of the built environment and can be used effectively to support good health. For example, some locally managed public transport networks have banned the advertising of unhealthy products (e.g. high fat, sugar and salt foods; cars; gambling products; alcohol). The Transport for London advertising policy, which prohibits advertisements for high fat, sugar and salt foods, was found it to positively affect behaviour, especially for those living in more deprived areas [1].

Public Health Considerations

- Will advertising of harmful commercial products be banned on local networks?
- Do local plans for a branded local transport network? If so, will the brand values focus on health and happiness?
- Does the strategy include reference to whether vaping / smoking / drinking will be allowed in transport hubs or on the network?



Additional Resources

[1]. Yau et al. (2022) [Changes in household food and drink purchases following restrictions on advertisement of high fat, salt and sugar products across the TfL network: A controlled interrupted time series analysis](#). Plos Medicine.

References and further reading if you want to learn more, or evidence your inputs.

Local Transport Plans & Integrated Transport Strategies



A. Local Transport Plans – what are they?

What are they	Local Transport Plans (LTPs) are strategic documents outlining the transport policies and priorities for a specific geographical area. They typically cover a 15–20yr period and are reviewed every 5 years. LTPs address all transport modes (including road, public transport, and active travel) and set out plans for improving connectivity, reducing congestion, and promoting sustainable transport.
Legal duty	Under the <i>Transport Act 2000</i> all LTAs in England (outside London) have a statutory duty to develop Local Transport Plans
Purpose	To set out the authority's long-term strategy and short-to-medium-term plans for managing and improving transport in their area.
Potential impact on transport related health and health inequalities	HIGH. The extent to which LTPs acknowledge and seek to address transport related health and health inequalities sets the tone and direction for all 'daughter documents' plans, and policies pursued in an area. Some LTAs use their LTPs to set a bold vision of reduced car dependency, prioritising investment in public transport, walking and cycling.

1. There are many links between transport and health (see part 1 of this resource).

Accessible, affordable and sustainable transport systems have the potential to considerably improve population level health and happiness.



Access to health care and other essential, health generating services



Physical activity



Access to employment & opportunity



Access to community networks, and by shaping the physical environment

Key Health Considerations

- **Does the strategy include a focus on health and wellbeing?** Is improved population health an explicit objective of the strategy?
- **Are a wide range of direct, and indirect health benefits associated with transport referenced?** Or is there a narrow focus – e.g. on air-quality and physical activity?
- **Does the plan refer to the health profile of the population** (as set out in the JSNA or equivalent) and consider how these health needs may be impacted by transport systems?
- **Does the strategy explicitly support the sustainable transport hierarchy** (i.e. subscribe to the general principal that we should prioritise walking and wheeling> public transport > shared use cars > private cars.

Additional Resources

- [1] Public Health Scotland (2024) [Place and Wellbeing: Movement Theme – Evidence informed links from transport to Health](#)
- [2] DfT (2019) [Transport, health and Wellbeing: Evidence review](#)

2. Tackling car-dependency is central to achieving transport-related population health gains (see Part 1 of the guide).

Many of the harms associated with our transport systems are caused by high rates of driving, and a car-centric built environment. Reducing population-level driving, as measured through vehicle miles (or kilometres) travelled per capita, is essential to improving transport-related health.



Air & noise pollution



Road collisions



Access to green space



Sedentary behaviour



Social exclusion & poverty



Climate change

Key Health Considerations

- **Does the plan include explicit targets to reduce population level driving** as measured by vehicle miles / kilometres travelled per capita (VMT / VKT) or a similar metric?
- **Are targets for reduced car-use / driving sufficiently ambitious to improve health?** Consider reviewing proposed targets in relation to local Vision Zero strategies; targets set by neighbouring authorities, or nations (e.g. Wales, and Scotland, which have both committed to a reduction in overall rates of car use).
- **Does the plan articulate the population health benefits that can be achieved through reduced levels of car use?**

3. Links with spatial development and housing plans are essential if we are to improve travel-related health and reduce car dependency.

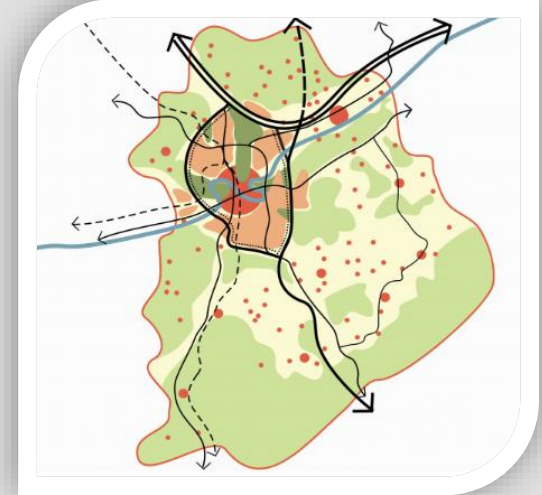
The way cities and communities are designed—such as the location of housing, workplaces, schools, and amenities—determines how people move around and what transport options are available or practical.

Compact, mixed-use developments encourage walking, cycling, and public transport use – supporting physical activity and reducing air pollution, noise, and traffic injuries. In contrast, car-dependent urban sprawl promotes sedentary lifestyles, increases exposure to vehicle emissions, and contributes to road traffic collisions.

Effective spatial planning that prioritizes accessibility, connectivity, and sustainable transport modes can therefore play a crucial role in improving population health. [1]

Key Health Considerations

- **Does the strategy refer to links with local spatial development plans** as a means of delivering modal shift targets and / or health objectives?
- **Does the strategy include accessibility-based targets for any new housing developments** (e.g. % of households able to reach a GP, school, or employment centre within X mins by walking / cycling, or Y mins by public transport? Or with a score above Z as measured by the DfT Connectivity Tool [2])
- **Does the strategy explicitly refer to land use and spatial planning measures which will reduce car dependency?** e.g. pursuing high-density, mixed-use developments; avoiding dispersed, edge of town retail and business parks which lock in car dependence; encouraging transit-oriented development around rail stations, bus interchanges etc [3].



Additional Resources

[1] Faculty of Public Health (2024) [Transport Special Interest Group: Policy Brief – Transport, spatial planning and health](#)

[2] DfT (2025) Connectivity Tool [Connectivity Tool - GOV.UK](#)

[3] New Economics Forum (2024) [Trapped behind the wheel](#)

4. Improving accessibility within neighbourhoods is essential for reduced car dependency and improved transport-related health.

Accessible neighbourhoods - that feel safe - can support good health by increasing opportunities for active travel and reducing car dependency. They can also enable social connections and improve access to essential services [1]. In accessibility-based planning, what matters is how many useful destinations people can reach, how convenient and inclusive access is. This contrasts with traditional planning which focuses on mobility (speed, minimal congestion etc) [2].

Small changes (such as improved pavement quality, dropped curbs, and crossings) can improve accessibility, especially if there is a focus on inclusive design [3]. Tackling pavement parking, installing play areas, planters and benches can make streets feel welcoming, inclusive, and safe.



Key Health Considerations

- Does the plan include a focus on creating attractive, connected, safe neighbourhoods?
- Has the plan been developed with the meaningful involvement of disabled people and other underserved communities? For example, to identify 'access deserts', areas that feel unsafe, or inaccessible infrastructure? Ideally this would involve the working with "access panels" from an early stage [3].
- Does the plan include targets relating to improved accessibility [3]?
- Does the plan include measures that can improve accessibility of pavements? e.g. removing street clutter, and tackling pavement parking installing dropped curbs, creating frequent crossings, pedestrianising areas, creating children's play areas.

Additional Resources

- [1] [Lge-Elegbede, J. \(2022\) Designing healthier neighbourhoods. A systematic review of the impact of the neighbourhood design on health and wellbeing](#)
- [2] [Litman, T. \(2025\) Evaluating Accessibility for Transport Planning: Measuring people's ability to reach desired services and Activities](#)
- [3] [Sustrans \(2025\) Transforming mobility: Ensuring disabled people are represented as places seek to transform how people get around](#)

5. Supporting walking, wheeling and cycling; and improving access to affordable, reliable public transport will generate health and wellbeing benefits.

People love having the freedom to choose between transport modes; deeply value access to public transport; and want the opportunity to walk, wheel, and cycle.

Active travel not only feels great, it can also increase overall activity levels - which has well evidenced health benefits[1], particularly for inactive individuals [2]. Increased rates of public transport use also has the potential to improve population health by reducing harmful emissions from private vehicles, and by contributing to higher activity rates.

Creating physical infrastructure, and projects that support the use of public transport and create opportunities to use public and active travel helps achieve these health benefits.

Key Health Considerations

(See Part B for a more detailed set considerations around active travel)

- Does the strategy focus on supporting under-served and inactive communities to walk, wheel cycle and use public transport?
- Does the strategy commit to reallocate road space to create efficient public transport links, and safe walking, wheeling and cycling routes?
- Does the strategy include a major focus on improving perceived safety (known to be a major barrier to active travel and public transport use).
- Does the strategy focus on supporting whole journeys?



Additional Resources

[1] PHE 2018 rapid evidence review on [Cycling and Walking for Individual and Population Health Benefits](#)

[2] Geidl et al (2020) *Dose-response relationship between physical activity and mortality in adults with noncommunicable diseases: a systematic review and meta-analysis of prospective observational studies*. International Journal of Behavioural Nutrition and Physical Activity.

6. A focus on equality, inclusion and accessibility can reduce health inequalities.

Transport systems can influence health inequalities by shaping access to essential resources, exposure to environmental risks, and opportunities for healthy living. Highly car-dependent transport systems can limit access to employment, education, healthcare, and social activities—particularly for low-income households, of which 40% do not own a private car. More disadvantaged and marginalised communities are more likely to rely on walking, cycling, or public transport, yet often face unsafe routes, unreliable services, or longer travel times.

Additionally, disadvantaged populations are disproportionately exposed to traffic-related air pollution, noise, and road danger, as major roads and transport corridors are frequently located in lower-income areas. Without meaningful engagement, the voices of these groups risk being overlooked when policies are developed.

Addressing these inequities by reducing transport poverty is therefore essential for promoting health equity and reducing the social gradient in health [1,2,3].

Key Health Considerations

- **Does the strategy identify and target areas / populations with poor access to public transport and high levels of car dependency?** This may include rural populations, and more deprived communities The DfT connectivity Tool, or the Transport Related Social Exclusion data tool may be useful..
- **Does the strategy have a major focus on affordability** – e.g. through measures to ensure ticketing / fare structures that are simple and affordable?
- **Has the strategy been developed with the meaningful engagement of communities** who are poorly served by existing systems and will have insights into barriers (such as perceived safety) which may prevent use of public transport and active travel opportunities which already exist? Have “seldom heard” groups been actively engaged and involved in shaping the policy or programme?
- **Does the strategy include equity indicators?** (e.g. % of households without cars within x minutes of essential services; transport spend as a % of household income).
- **Will all targets and evaluation metrics be disaggregated** to enable an evaluation of impact between groups as well as across an entire area?
- **In addition to an Equity Impact Assessment (EQIA) required by law, has a health impact assessment (HIA) been conducted** to identify health impacts and how they are distributed among different populations?
- Does the strategy seek to address [transport poverty](#)[3] by improving availability, reliability, affordability, accessibility and safety.

Additional Resources

[1] Mindell et al (2024) [Transport, health and inequality. An overview of current evidence - ScienceDirect](#)

[2] NatCen Social Research (2019) [Transport and inequality: An evidence review for the Department for Transport](#)

[3] Public Health Scotland (2024) [Transport poverty: a public health issue](#)

7. Taking bold action to remove some of the existing incentives to drive (along side interventions to promote other transport modes) is necessary to help achieve modal shift - with associated health and equity benefits.

Existing systems subsidize private car ownership by under-pricing the infrastructure that cars use, and by publicly absorbing the negative externalities which arise from car-use [1]. The full costs of car ownership and use aren't borne by car owners and as such we are incentivised to own and use cars. These incentives are invisible to most of us, because of the highly motor-normative context we live in [2].

Removing incentives to drive by introducing fiscal measures (such as permits for parking, or air quality charges) whilst using funds generated to explicitly and visibly improve access to affordable alternatives to car use can impact on car use, on air quality, and on health [3]. There is evidence that measures which encourage active travel (carrots), for example active travel schemes, are most effective when implemented alongside measures which discourage car use (sticks) [4].



Examples of fiscal measures found to impact on modal share [1, 5]

- On street parking pricing.
- Removing income tax exemption for employer-paid parking or introducing employer parking levies.
- Low emission zones and congestion charging.

Key Health Considerations

- Does the strategy consider and balance both carrots (interventions designed to encourage people to use active travel and public transport options) and sticks (interventions that address existing car-centric financial and infrastructural incentives by discouraging car-use)?
- Have measures to reduce car-dependency been targeted to reduce inequalities or is there a risk that they could further entrench differences?
- Are there ways of directing funds generated from any fiscal interventions visibly and meaningfully towards alternative travel options?
- Has there been careful consideration and testing of framing strategies that will be used to communicate planned changes and maximise acceptability?

Additional Resources

- [1] International Transport Forum: (2021) [Reversing Car Dependence, Summary and Conclusions](#)
- [2] Walker (2025) [Why do cars get a free ride? The social-ecological roots of motornormativity](#), Global Environmental Change
- [3] Chanberlain et al (2023) [Health effects of low emission and congestion charging zones: a systematic review](#) The Lancet Public Health
- [4] Xiao et al (2022) [Shifting towards healthier transport: carrots or sticks? Systematic review and meta-analysis of population-level interventions](#) The Lancet Planetary Health
- [5] Rye et al (2023) [Reducing car use through parking policies: an evidence review](#) ClimateXChange

7. Taking bold action to remove some of the existing incentives to drive (along side interventions to promote other transport modes) is necessary to help achieve modal shift - with associated health and equity benefits. **What does this look like in action??**

Case study: Nottingham City's Workplace Levy

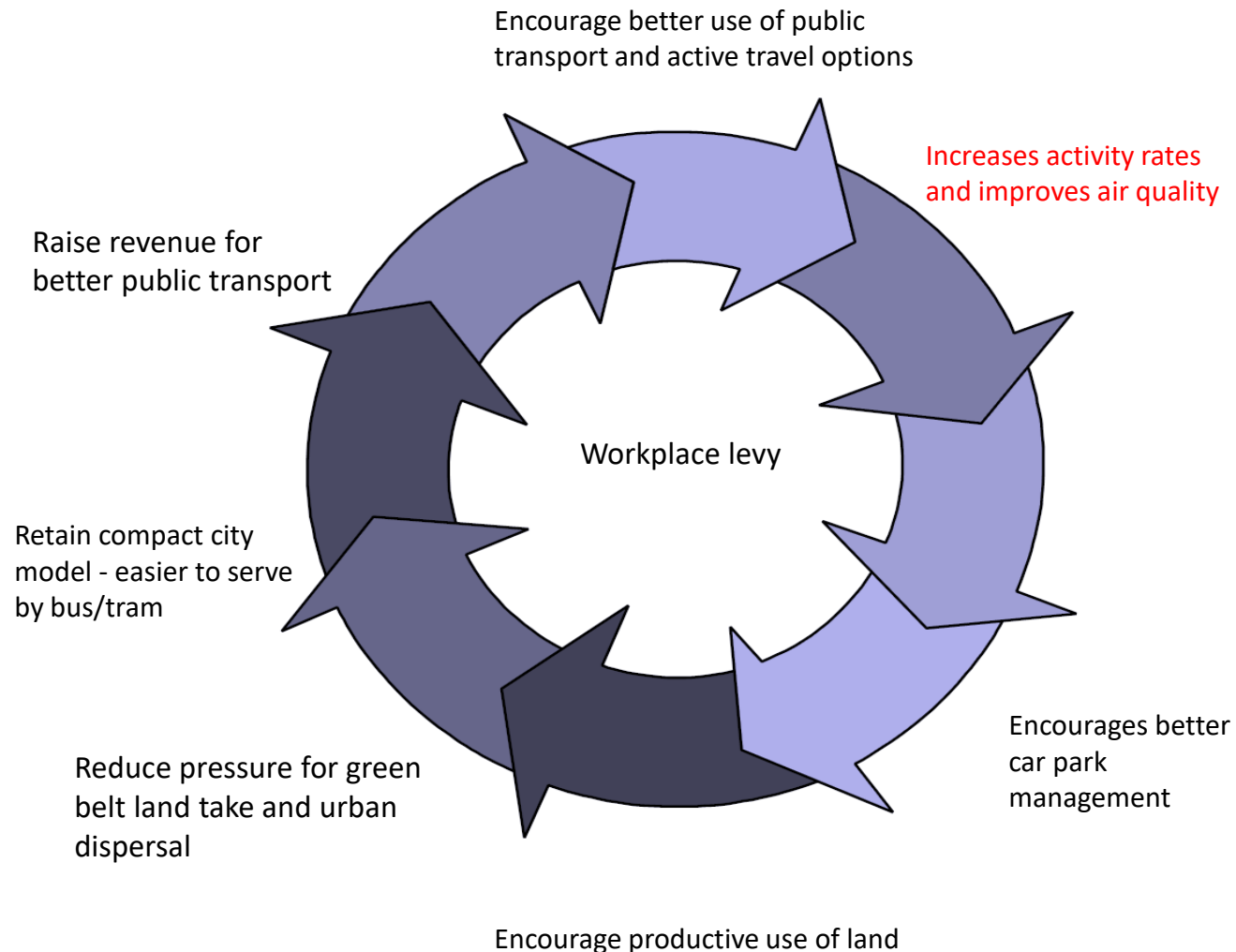
In 2012, Nottingham City Council introduced [Europe's first Workplace Parking Levy](#) paid by employers in the city with eleven or more parking spaces.

The scheme was introduced to tackle congestion growth by offering high quality, affordable and reliable alternatives to driving into the city and acting as an incentive for employers to manage their workplace parking.

Since its introduction, the scheme has raised over **£118m** in revenue. Money raised by the scheme, which has enjoyed **100% compliance** from day one, is **ring-fenced for public transport or active travel improvements**. The scheme has enabled a doubling of the tram network and has sustained bus routes that are not otherwise financially viable.

There has been a 58% reduction in carbon emissions, and **26% growth in new businesses** since its implementation.

Growth in congestion has slowed and public transport/cycle mode share and bus patronage has increased. Nottingham has one of the highest levels of public transport use outside London, with over 40% of journeys into the city centre made by public transport pre-pandemic.



8. Beware of a piecemeal focus on individual health issues, without a broader focus on reducing car-dependency and driving.

Some gains can be made by mitigating separately against the individual negative externalities associated with high rates of driving (emissions, greenhouse gasses, traffic collision). But these initiatives are only part of the picture; do little to reduce car dependency; and often reinforce existing car normativity.

Treat with caution!

- **Fleet electrification** – important in terms of reducing carbon emissions and air pollution, but EVs are not carbon neutral, still generate particulate matter, still kill people in collisions, and do nothing to address transport poverty or improve access for people who can't afford a car (nb – [22% of UK households in 2024 didn't own a private car](#). In the lowest income quintile, this figure is 40%).
- **Use of A.I to reduce congestion and improve traffic flow** – can contribute to reduced levels of congestion and build up of air pollutants in a local area, but don't reduce overall greenhouse gas emissions and can encourage longer journeys.
- **School's programmes which educate children on road safety** – important in terms of developing the skills of individuals, but shift responsibility for road safety onto (young) non-car users, and victims without doing anything to improve systems-level safety.
- **Behaviour change programmes which encourage less car use** – shift responsibility for car harms onto drivers without creating the conditions in which people can meaningfully choose not to drive.

Key Health Considerations

- Do measures included in the plan focus on reducing 'high risk' driving behaviours (such as speeding) without aiming to reduce driving levels overall?
- Does measures included in the plan rely on individual behaviour change without addressing systemic factors affecting car dependency?
- Does the strategy overly rely on technological adaptations to vehicles / roads etc without addressing transport policies or systems?
- Does the strategy reinforce motornormativity? i.e. the default position that cars are the best / preferable way to travel.



9. There are valuable opportunities to address commercial determinants of health within our transport systems.... And we shouldn't overlook the motor industry within our CDOH work more widely.

The motor-industry is often overlooked in discussions around the commercial determinants of health (CDOH), but many industry tactics familiar in other sectors are also evident in relation to transport. There's growing evidence that the activities of commercial actors strongly influence transport systems [1].

In addition, transport infrastructure forms a large part of the built environment and can be used effectively to support good health. For example, some locally managed public transport networks have banned the advertising of unhealthy products (e.g. high fat, sugar and salt foods; cars; gambling products; alcohol). The Transport for London advertising policy, which prohibits advertisements for high fat, sugar and salt foods, was found it to positively affect behaviour, especially for those living in more deprived areas [2].

Key Health Considerations

- Is the motor-industry included within existing work focusing on commercial determinants of health?
- Will advertising of harmful commercial products be banned on local networks?
- Are there plans to develop a branded local transport network? If so, will the brand values focus on health and happiness?
- Does the strategy include reference to whether vaping / smoking / drinking will be allowed in transport hubs or on the network?



Additional Resources

[1] Jochem et al (2025) [Commercial determinants of active travel: a crucial but overlooked barrier to health and sustainability - The Lancet Planetary Health](#)

[2]. Yau et al, (2022) [Changes in household food and drink purchases following restrictions on advertisement of high fat, salt and sugar products across the TfL network: A controlled interrupted time series analysis](#). Plos Medicine.

10. Don't forget community engagement!

Involving communities in planning ensures that transport systems reflect diverse needs, particularly those of vulnerable or marginalized groups (including people living with disabilities) who are often most affected by poor transport access or unsafe environments.

Meaningful engagement builds trust, fosters shared ownership of decisions, and can lead to more equitable, acceptable, and sustainable solutions. By incorporating lived experience into transport design and policy, planners can create systems that promote physical activity, reduce pollution and injury risks, and enhance social connectedness.



Key Health Considerations

- Has there been community engagement in the development of plans and strategies, including with vulnerable and marginalised groups?
- Have the specific needs and experiences of different groups been considered when planning and delivering community engagement?
- Have stakeholders who represent underserved populations been included in the design, development, and decision-making process from an early stage and kept involved throughout so they can provide insights and expertise based on lived experience?

Additional Resources

- [1] Active Travel England (2024) [A best practice guide to community consultation and engagement](#)
- [2] Sustrans (2025) [Transforming mobility: Ensuring disabled people are represented as places seek to transform how people get around](#)
- [3] Community Centred Approaches for Public Health (2015) [A guide to community-centred approaches for health and wellbeing](#)

Summary of Key PH considerations for Local Transport Plans

1. **There are many links between transport and health.**
2. **Tackling car-dependency** is central to achieving transport-related population health gains.
3. **Links with spatial development and housing plans** are essential if we are to improve travel-related health and reduce car dependency.
4. **Improving accessibility** within neighbourhoods is essential for reduced car dependency and improved transport-related health.
5. **Supporting walking, wheeling and cycling; and improving access to affordable, reliable public transport** will generate health and wellbeing benefits.
6. **A focus on equality, inclusion and accessibility can reduce health inequalities.**
7. **Taking bold action to remove some of the existing incentives to drive will help achieve modal shift** (i.e. less driving, and more active travel and use of public transport) with associated health and equity benefits.
8. **Beware of a piecemeal focus on individual health issues, without a broader focus on reducing car-dependency and driving.**
9. **There are valuable opportunities to address commercial determinants of health within our transport systems.... And we shouldn't overlook the motor industry within our CDOH work more widely.**
10. **Don't forget community engagement!**

Walking, wheeling
and cycling strategies



B. Active Travel Strategies – What are they?

What are they?	Active Travel (or Walking, Wheeling and Cycling) Strategies are policy documents produced by local authorities or combined authorities that outline plans, policies, and infrastructure investments to promote walking, cycling, and wheeling as everyday modes of transport. They are part of the wider UK Government's goal to encourage healthier, more sustainable transport and reduce car dependency. They are often developed alongside or integrated with Local Transport Plans (LTPs), though they can also stand alone.
Legal duty	Active Travel Strategies are not a statutory requirement in themselves but are strongly encouraged by central government. The Department for Transport (DfT) and Active Travel England (ATE) , expect authorities to produce these strategies to access certain streams of funding (e.g., Active Travel Fund).
Purpose	To set out a long-term vision for increasing walking, cycling, and wheeling.
What do they cover?	• A clear vision and goals (e.g., % modal shift targets). • A network plan of routes for walking, cycling, and wheeling. • Policies for inclusive access, especially disabled people or people with mobility issues. • Proposals for safe infrastructure (e.g., protected bike lanes, low-traffic neighbourhoods). • Links to schools, workplaces, and key amenities. • Plans for behaviour change programmes (e.g., school travel planning, campaigns). • Monitoring and evaluation framework. • Integration with wider transport strategies (e.g., buses, rail). • Reference to LCWIPs (Local Cycling and Walking Infrastructure Plans), if developed.

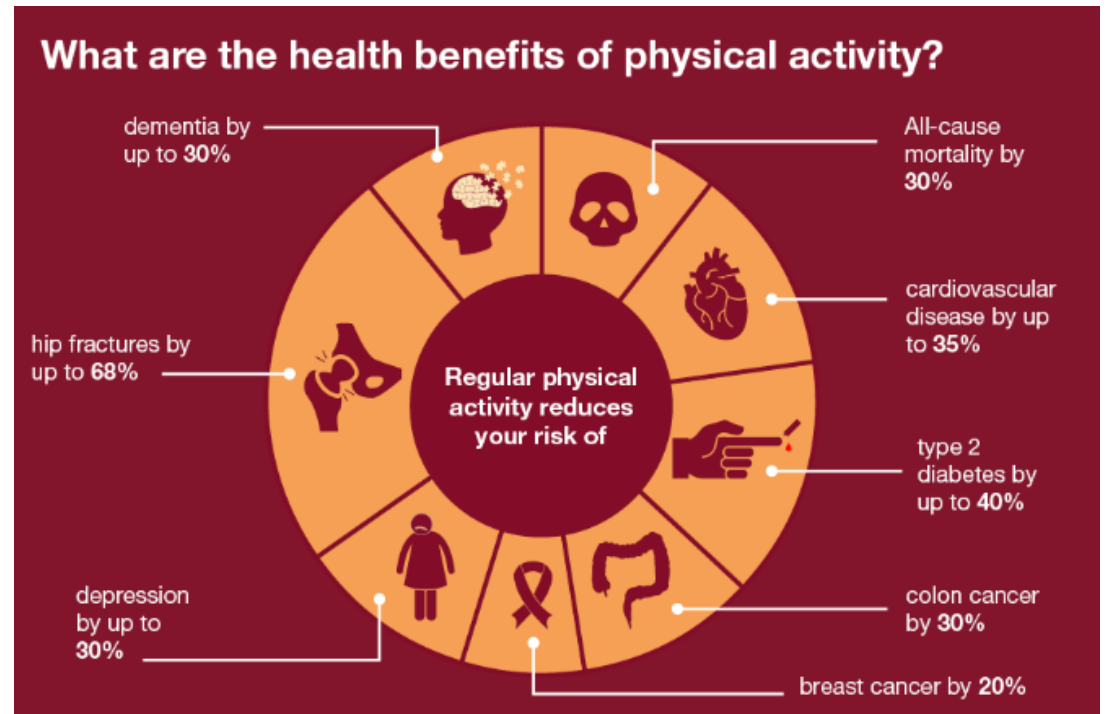
1. There is good evidence that increasing walking and cycling can positively contribute to overall activity levels, which can improve population level health.

Regular physical activity is associated with a 30% reduction in all cause mortality. It is also associated with a reduced risk of several cancers, some cardiovascular diseases, muscular skeletal conditions, and some neurological illnesses. The UK Chief Medical Officers' guidance for adults includes 150 minutes of moderate intensity activity a week, and that the easiest way to achieve this is through daily activity such as walking and cycling [1].

The evidence is that the health benefits of walking and cycling outweigh any potential health risks and harms – for example from injury or pollution.

Key Health Considerations

- Does the strategy reflect the physical and mental health outcomes that can be achieved at population level from increased levels of physical activity?
- Does the strategy reflect and reference the health needs and priorities of the local population as detailed in JSNAs, Health and Wellbeing strategies etc?



[Physical activity: Applying all our health](#)

Additional Resources

- [1] The PHE 2018 rapid evidence review on [Cycling and Walking for Individual and Population Health Benefits](#) includes a good overview of evidence on health benefits associated with increased rates of walking and cycling.
- [2] Fingertips profile on [Obesity, Physical Activity, and Nutrition](#)
- [3] [Department of Health, 2011 Stay Active: A report on physical activity from the four home countries](#)
- [4] [The role of Active Travel in Improving Health](#) (Sustrans, 2017)

2. There are also considerable co-benefits associated with increased rates of walking wheeling and cycling beyond physical activity – many are derived from reduced rates of car-use.

Active travel offers a range of health benefits beyond increasing physical activity. By reducing reliance on motor vehicles, it lowers air and noise pollution, leading to improved respiratory and cardiovascular health.

Fewer vehicles on the road mean that actual safety is improved, and that streets *feel* safer, even if collision rates were low / non-existent before. Active travel can enhance mental wellbeing through greater social interaction, connection with the local environment, and reduced stress associated with driving or congestion.

Furthermore, promoting active travel supports more equitable access to employment, education, and services—key social determinants of health—helping to foster healthier, more resilient communities.



Source: Taken from [Community Health Partnerships](#) 2024

Key Health Considerations

- Does the strategy reflect the full range of health co-benefits associated with active travel?
- Does the strategy include plans to measure the impact of interventions on outcomes such as air quality, noise level, connectivity?

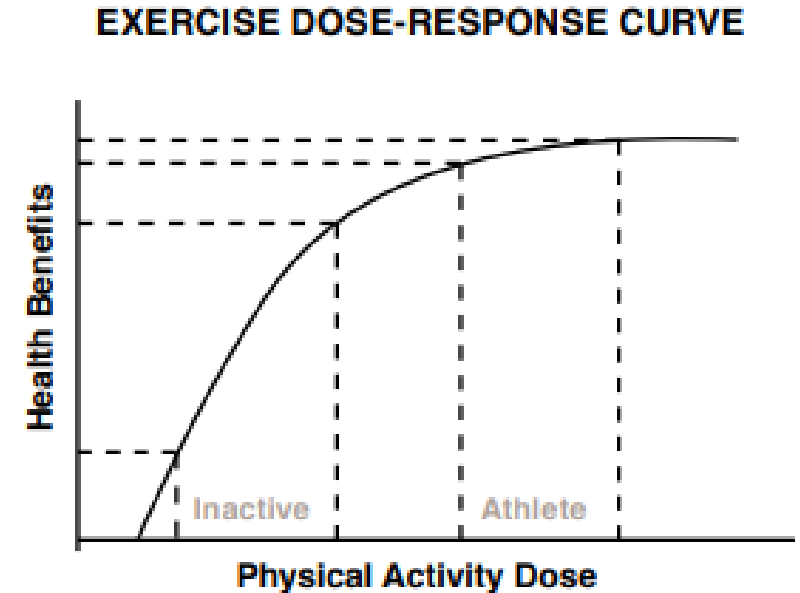
Additional Resources

- [1] Lancet article (2024) on [The co-benefits of active travel interventions beyond physical activity: a systematic review](#)
- [2] [Working Together to Promote Active Travel A briefing for local authorities](#) Public Health England (2016)
- [3] Chief Medical Officer's Annual Report: [2022 \(Air Pollution\)](#) and [2024 \(Health in Cities\)](#)

3. The greatest health benefits come from increasing activity levels amongst the least active populations.

There is non-linear dose-response relationship between physical activity levels and health benefits (see graph) [1]. This means that small increases in activity levels amongst inactive groups, will achieve greater marginal health gains across the population, than increased activity levels amongst already / highly active groups. Nationally, some groups have significantly higher rates of inactivity, although this may vary locally:

- Men are more likely to report being active at the recommended level than women [3].
- People tend to get less active with age, especially in older years [3].
- People with disabilities or long-term conditions are 2x as likely not to be inactive.
- People from Asian, Black, and Other ethnic groups are more likely to be physically inactive than those from the White British, White other and Mixed ethnic groups



Key Health Considerations

- Does the strategy identify and focus on groups, locally, that are currently inactive and therefore likely to derive the greatest benefits?
- Does the strategy aim to reach the least active population subgroups – who have the most to gain from increased rates of activity?
- Has the strategy been developed with the involvement of typically less active groups to understand their perspective?

Additional Resources:

- [1] Geidl et al (2020) [Dose-response relationship between physical activity and mortality in adults with noncommunicable diseases: a systematic review and meta-analysis of prospective observational studies](#) | [International Journal of Behavioral Nutrition and Physical Activity](#)
- [2] [Physical Activity: Applying All our Health \(2022\) OHID](#)
- [3] [Fingertips](#)
- [4] [Physical inactivity - GOV.UK Ethnicity facts and figures](#)

4. There are major transport-related health (and social) inequalities, which walking, wheeling and cycling plans can potentially impact on – positively or negatively.

Walking, wheeling and cycling plans have the potential to reduce health inequalities by ensuring that everyone has access to employment opportunities, to education, to essential services, and to community – regardless of whether they can afford to own a car. Conversely, if active travel schemes fail to account for the barriers to walking, wheeling and cycling that disadvantaged communities face, they have the potential to further entrench health inequalities by continuing to privilege wealthier communities who experience less transport related social exclusion [4], and experience better health.

Key Health Considerations

- **Have plans been developed with reference to which areas face the highest levels of transport poverty [3] and transport related social exclusion [4]?** These areas may have the most to gain from increased active travel rates (deprivation strongly associated with poor health) but may face the biggest barriers to active travel (including lack of infrastructure, capability or opportunity).
- **Has a Health Impact Assessment been conducted to review the strategy's potential impact on health and how these impacts are distributed among different population groups?**
- **Do plans consider the different barriers to active travel faced by different populations?** There is evidence that some ethnic groups and people living in deprived areas face specific barriers to cycling [6].
- **Will all monitoring and evaluation data be disaggregated** by age, sex, ethnicity, and deprivation to enable subgroup analysis?
- **Does the strategy include SMART targets relating to transport related social exclusion**, or connectivity in areas of high deprivation been included? (The DfT Connectivity tool may be useful here)

Additional Resources:

- [1] [Transport and inequality](#): An evidence review for the DfT (2019) National Centre for Social Research
- [2] [Car or van ownership - GOV.UK Ethnicity facts and figures](#) (2019) DfT
- [3] Transport poverty index <https://www.smf.co.uk/publications/transport-poverty-hidden-crisis/>
- [4] Transport related social exclusion index <https://www.transportforthenorth.com/social-inclusion/>
- [5] Ethnicity facts and figures, DfT [National Transport Survey results 2019](#)
- [6] TfL Policy Analysis (2011): [What are the barriers to cycling amongst ethnic minority groups and people from deprived backgrounds](#)

5. Walking and cycling are both beneficial from a health perspective, but may not be equally accessible to all. They require distinct strategic focus and set of inputs.

Both cycling and walking contribute to a range of positive outcomes (as per slide 42). However, there are differences, too. Walking is far more common - contributing between 26-42% of total physical activity across all age groups [3], and is more accessible for many people. Cycling is generally a more intense form of exercise, but is far less prevalent – especially for females who made an average of just 9 trips by bike per year [2]. A strategic focus on walking is important in terms of increasing activity levels amongst the least active – who have the most to gain from active travel in terms of health and happiness.

Different interventions will support different active travel modes. Don't assume that the same infrastructure will be safely or happily shared by people walking and people cycling. It is likely that different behaviour change approaches will also be needed.

Key Health Considerations

- Does the strategy recognise the central importance of walking (and wheeling)? Or is there a dominant focus on cycling?
- Does the strategy include measures that can address barriers to walking (e.g. eliminating pavement parking; increasing crossings; dropped kerbs; ensuring more separation from traffic, separation between walkers and cyclists, wide pavements etc).
- Do monitoring and evaluation frameworks include separate targets and measures for walking and wheeling; vs cycling?



Additional Resources:

[1] [Cycling and walking for individual and population health benefits: a rapid evidence review](#)

[2] DfT (2024) [Walking and cycling statistics, England](#)

6. Strategies should focus on creating safe, accessible neighbourhoods as well as supporting travel *between* ‘destinations’.

Accessible neighbourhoods - that feel safe - can improve health by increasing opportunities for active travel and reducing car dependency. They can also enable social connections and improve access to essential services. In accessibility-based planning, what matters is how many useful destinations people can reach, how convenient and inclusive that access is. This contrasts with traditional planning which focuses on mobility (speed, minimal congestion etc).

Small changes (such as improving pavement quality, including dropped kerbs, creating crossings) can improve accessibility, especially if there is a focus on inclusive design. Tackling pavement parking, installing play areas, planters and benches can make streets feel welcoming, inclusive, and safe.



Key Health Considerations

- Does the strategy include a focus on creating safe, accessible neighbourhoods? Or is the focus primarily on getting people away from where they live into centres of commerce / places of employment?
- Has the plan been developed with the involvement of communities? For example, to identify ‘access deserts’, and with reference to the needs of disabled people or other groups with access needs experience the current system.
- Does the plan include measures that can improve accessibility of pavements? e.g. removing street clutter, and tackling pavement parking installing dropped curbs, creating frequent crossings, pedestrianising areas, creating children’s play areas.
- Is there a local Play Strategy that the plan could link with?

7. Achieving a step change in active travel also requires action to reduce car dependency.

Interventions which aim to improve the attractiveness of active travel (for example, e-bike hire programmes, new walking routes or behaviour change interventions) are most effective when applied **alongside** interventions which discourage driving (e.g., congestion charging, or removal of parking spaces) [1]. **Using a combination of 'carrots' and 'sticks' therefore has the potential to generate modal shift at a scale that will generate public health benefits.**

There is good evidence in favour of policy approaches that discourage car use (see resources) - including reallocation of road space; traffic demand management approaches [3]; fiscal measures (such as congestion charging) [4]; and parking reform [5].

Key Health Considerations

- Does the strategy include measures that both encourage walking, wheeling and cycling (carrots), and discourage driving (Sticks)?
- Does the strategy consider links with local spatial development and planning strategies? The location and nature of future housing developments, as well as their travel infrastructure, will have a major impact on car dependency rates for future generations (see slide X).



Additional Resources:

- [1] [Shifting towards healthier transport: carrots or sticks? Systematic review and meta-analysis of population-level interventions - The Lancet Planetary Health](#)
- [Strategies for local traffic demand management \(Local Government Association\)](#). Overview of traffic demand management approaches used by LAs, including reflections from LA experience. Includes mapping on public acceptance of different approaches
- [2] [Local Transport Plans guide \(Low Traffic Future\)](#) – guide to addressing car dependency through LTPs
- [3] [Clean Mobility \(Transport for the North\)](#) – guide to demand management and mode shift policies which are evidenced for different settings (major urban conurbations, rural villages).
- [4] [Reversing Car Dependency](#) (International Transport Forum). Overview of evidence on different approaches.
- [5] [Reducing car use through parking policies: an evidence review](#) (Evidence review by Scottish Government on parking).

8. Framing and communications are important.

How we share ideas shapes how people see the world, so it's important to choose our words carefully. When talking about walking, wheeling and cycling projects, it helps to connect with what people already want (like healthy, connected neighbourhoods); to build on their positive feelings about walking, wheeling and cycling; and to reinforce the frame that '*streets are for all*', avoiding the dominant frame that '*roads are for cars*'.

There is evidence that people respond positively to messaging about the individual health benefits of active travel, and that 'happiness' is the most compelling way to talk about health in relation to walking, wheeling and cycling [1]. Conversely, people respond poorly to 'big heroic statistics' about the wider benefits of active travel (e.g. economic growth, climate change, or even population level health benefits. There are resources outlining effective communications techniques around walking wheeling and cycling [1,2,3], which can be used to improve acceptability of interventions designed to increase active travel rates.



Key Health Considerations

- Does messaging focus on happiness and individual health benefits associated with walking, wheeling and cycling?
- Have strategies and plans been developed with reference to evidence about what techniques can reinforce support for walking, wheeling and cycling?
- Do images, showing local people using infrastructure and enjoying walking, wheeling and cycling (no pictures of beautiful, empty pavements please!)
- Has language been reviewed to ensure that it is consistent with best practice? (e.g. avoid referring to 'traffic accidents'.

Additional Resources

- [\[1\] ATE Engagement Webinar: Spotlight on Active Travel Communications](#) includes insights into the type of messaging that builds support for walking, wheeling and cycling schemes
- [\[2\] Common Cause Australia](#) explores framing techniques which are effective in relation to active travel.
- [\[3\] Frameworks UK](#)

Summary of key public health considerations for active travel strategies

1. **There is good evidence that increasing walking and cycling can positively contribute to overall activity levels – which can improve population level health.**
2. **There are also considerable co-benefits associated with increased rates of walking wheeling and cycling beyond physical activity – many are derived from reduced rates of car-use.**
3. **The greatest health benefits come from increasing activity levels amongst the least active populations.**
4. **There are major transport-related health (and social) inequalities, which walking, wheeling and cycling plans can potentially impact on – positively or negatively.**
5. **Walking and cycling are both beneficial from a health perspective, but may not be equally accessible to all. They require distinct strategic focus and set of inputs.**
6. **Strategies should focus on creating safe, accessible neighbourhoods as well as supporting travel *between* ‘destinations’**
7. **Achieving a step change in active travel also requires action to reduce car dependency.**
8. **Framing and communications are important.**

Good luck!

Acknowledgements

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