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Demand response to improved walking infrastructure:

A study into the economics of walking and health behaviour change

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Abstract
Walking is the most common form of moderate-intensity physical activity among adults, is widely accessible and especially appealing to obese people. Most often policy makers are interested in valuing the effect on walking of changes in some characteristics of a neighbourhood, the demand response for walking, of infrastructure changes. A positive demand response to improvements in the walking environment could help meet the public health target of 150 minutes of at least moderate-intensity physical activity per week. We model walking in an individual’s local neighbourhood as a ‘weak complement’ to the characteristics of the neighbourhood itself. Walking is affected by neighbourhood characteristics, substitutes, and individual’s characteristics, including their opportunity cost of time. Using compensating variation, we assess the economic benefits of walking and how walking behaviour is affected by improvements to the neighbourhood. Using a sample of 1,209 respondents surveyed over a 12 month period (Feb 2010-Jan 2011) in East Belfast, United Kingdom, we find that a policy that increased walkability and people’s perception of access to shops and facilities would lead to an increase in walking of about 36 minutes/person/week, valued at £13.65/person/week. When focusing on inactive residents, a policy that improved the walkability of the area would lead to guidelines for physical activity being reached by only 12.8% of the population who are currently inactive. Additional interventions would therefore be needed to encourage inactive residents to achieve the recommended levels of physical activity, as it appears that interventions that
improve the walkability of an area are particularly effective in increasing walking among already active citizens, and, among the inactive ones, the best response is found among healthier, younger and wealthier citizens.

Highlights

- First paper to model the demand response for walking using weak complementarity
- First paper to model effects of investment in walking infrastructure on walking behaviour
- Maximizing walkability increases walking on average by 36 minutes/person/week
- Urban renewal programs can be designed to improve the health of inactive residents
- Through walkability upgrades guidelines for physical activity are met by 12.8% of inactive people

Keywords: United Kingdom, revealed preferences, demand response, walking, weak complementarity; valuation
1. Introduction

An increasing proportion of the population being overweight or obese in most Western societies is leading to a significant burden on society and contributing to the rise of conditions such as diabetes, cardiovascular disease and cancer (James et al., 2004; WHO, 2011). Physical activity levels are on the decline in Northern Ireland, as in other countries, including England, (Farrell et al., 2013, SportNI, 2010), with 60% of the local adult population not meeting the recommended levels of activity (DHSSPS, 2011). Physical inactivity, in addition to unhealthy diet, has fuelled the rising level of obesity within the population, with 59% of adults in Northern Ireland either overweight or obese (DHSSPS, 2011). Obesity has become an economic burden as well as a major health problem (Müller-Riemenschneider et al., 2007) and, as a result, governments and public health agencies are diverting considerable resources to prevent obesity and promote healthy lifestyles (Fit Futures, 2006; Butland et al., 2007; DHSSPS, 2010). The UK Department of Health recommends that adults should aim to be physically active on a daily basis and over the period of a week should aim to achieve at least 150 minutes of moderate intensity physical activity in bouts of 10 minutes or more (DoH, 2011a). Significant health consequences arise from not meeting the recommended levels of activity, including higher relative risk (adjusted for known confounders) of coronary heart disease, type 2 diabetes, breast cancer, colon cancer and all-cause mortality (Lee et al., 2012). However if the recommended guidelines for physical activity are met, then the population can expect a lower average Body Mass Index (BMI), a reduced incidence of lifestyle diseases related to obesity, such as type 2 diabetes mellitus and high blood pressure, and lower associated healthcare costs (Frank et al., 2009, Auchincloss et al., 2009, Ogilvie et al., 2007).
Walking is the most common form of moderate-intensity physical activity among adults (Siegel et al, 1995; Eyler et al, 2003; Ogilvie et al, 2007; Sport NI, 2010), is widely accessible and especially appealing to obese people, who are less likely to perform vigorous-intensity physical activity (Erlichman et al, 2002). It is an aerobic exercise that confers the diverse health benefits of physical activity with few adverse effects (Morris and Hardman, 1997).

Several studies have confirmed that walking reduces the development of cardiovascular diseases (Jones and Eaton, 1994; Albright and Thompson, 2006; Boone-Heinonen et al., 2010), even though the health improvements are smaller for obese people (Boone-Heinonen et al., 2010).

Many factors influence or facilitate the choice to walk for either travel or recreational purposes, including the availability of footpaths, the attractiveness of the route (e.g. interesting facades, a variety of architecture, the absence of long, blank walls), route choices for variety and safety, the number of destinations within a walkable distance (e.g. work places or nearby shops), and the opportunity cost of walking. Walking interventions include education and encouragement, as well as infrastructure investments, such as better street lighting, improved footpaths, and the creation of attractive green open spaces. Behavioural changes can arise from the increases in access, attractiveness, safety, comfort and security that these improvements offer (Krizek et al, 2009).

Interventions aimed at increasing walking have been shown to be effective (Ogilvie et al, 2007), but policy makers making investment decisions aimed at improving the infrastructure for walking may wish to consider the costs and the benefits of such interventions (Dallat et al, 2014). Whilst their costs can relatively easily be quantified using market data, the monetary benefits of such interventions, in terms of increased walking, are more difficult to assess and estimate (Litman, 2003). One notable exception is the World Health
Organization’s Health Economic Assessment Tool (HEAT) for estimating the monetary health benefits from reduced mortality from interventions aimed at increasing walking and cycling (Kahlmeier, 2010; WHO, 2014). This paper aims to quantify such benefits in monetary terms and to answer the following questions. What is the monetary value and the demand for walking in an individual’s neighbourhood? How are these monetary benefits and demand affected by the characteristics of the neighbourhood, and by its improvements? What is the value of the health benefits that might accrue from the additional walking associated with the demand response to neighbourhood improvements? How do these benefits vary for respondents with different health levels?

We address these questions by proposing an economic model of walking, based on the assumption that walking in a neighbourhood is affected by the characteristics of the neighbourhood itself, substitutes for walking in the neighbourhood and that walking is a function of the value of time.

In the next section, we review previous studies on the economics of walking. Section three describes our economic model for walking. Section four presents the case study of walking in East Belfast, Northern Ireland. The results of the econometric analysis are reported in section five, with section six presenting forecasts of demand response (resulting behaviour change) and welfare calculations. Section seven concludes with a discussion of the results and suggestions for further research.

2. The economics of walking

Several studies have successfully modelled the economics of walking, spanning the well developed disciplines of outdoor recreation (see Burt and Brewer, 1971, McConnell and Strand, 1981, Herriges and Kling, 1999), active transportation (see Button, 2010), and health
related physical activity (Humphreys and Ruseski, 2007 and 2011). Jones and Eaton (1994), investigating how walking affects the relative risk of developing coronary heart disease, found that if all inactive people began walking regularly, the US would save US$4.3bn annually. Other studies have focussed on both cycling and walking. Saelensminde (2004) conducted a cost–benefit analysis of walking and cycling track networks in three Norwegian cities taking into account insecurity, health effects and external costs of motorized traffic. The health-economic benefits from both walking and cycling varied considerably between the three cities and ranged between US$16million and US$258million. Wang et al (2005) compared direct medical costs between active and inactive people to assess costs and benefits of building and maintaining new bike/pedestrian trails, finding a benefit cost ratio of 2.94. Sustrans (2006), in a cost-benefit analysis of three walking and cycling routes, found benefit cost ratios ranging between 14.9 and 32.5. The HEAT for walking and cycling (Rojas-Rueda et al, 2011; De Hartog et al, 2010; Kahlmeier, 2010; WHO, 2014) addressed the question “If x people cycle or walk for y minutes on most days, what is the economic value of the health benefits that occur as a result of the reduction in mortality due to their physical activity?” (WHO, 2014, page 14). It is based on the value of a statistical life and provides a tool to estimate the health benefits in terms of mortality reduction from walking or cycling interventions. Using the HEAT method, Rabl and de Nazelle (2012) found that for a driver who switches to cycling or walking for a commute of 5 km (one way) 5 days/week 46 weeks/year the health benefit from the physical activity is worth about 1,200 €/year, even though it may be questionable whether a person would actually walk 10km/day for commuting purposes. Other studies have used the hedonic price method, focussing on “walkability” – the quality of walking conditions, including safety, comfort and convenience – and how this is affected
by development density, land use mix, provision of public open space and pedestrian infrastructure (Cortright, 2009; Sohn et al., 2012). Such studies have found that house prices in more walkable neighbourhoods are about US$4,000 - US$34,000 higher than houses located in areas with average levels of walkability.

Although the economics of walking may have been relatively overlooked by health economists, it has been extensively investigated in transportation economics and the economics of outdoor recreation. The transportation literature has most commonly used a value of time trade-off method to compare different transportation modes including walking (see Beesley, 1965; Wardman, 1998; Small and Verhoef, 2007). Walking is not a popular transportation mode, unless for very short journeys, and is often only considered in conjunction with a second transportation mode – walking and driving, walking and travelling by bus, or walking and travelling by train – as walking alone is impracticable for longer journeys (Litman, 2003).

The economic value of outdoor recreation sites, including walking facilities has been extensively studied, first using a revealed preference method, the travel cost method, (McConnell and Strand, 1981, Bockstael et al, 1987, Herriges and Kling 1999, Abidoye et al, 2012) and then using stated preference methods, such as contingent valuation (Bishop and Heberlein, 1979, Hutchinson et al 1999), contingent behaviour (Alberini and Longo, 2006) and choice experiments (Hanley et al, 1998, Adamowicz et al, 1998,). The travel cost model, originally conceived by Hotelling (1949) and developed by Clawson (1959) and Clawson and Knetsch (1976), treats the cost of travel to a site as a proxy for the value of the trip. In the United Kingdom, Christie and Matthews (2003) applied the travel cost model to assess the economic value of outdoor recreation in England and found that walkers in the English countryside spend around £6.14 billion a year, generating a profit in excess of £2 billion and
supporting up to 245,000 full time jobs. This literature does not consider health benefits which could have been gauged by the average distance walked and frequency of trips. The contingent valuation method and choice experiments have also been extensively used in the UK to assess the monetary value of hypothetical improvements to walking paths, recreation infrastructure and access to the countryside (Bateman et al, 1996; Christie, 1999; Scarpa et al, 2000a, 2000b; Angus et al, 2006; Morris et al, 2009). This is a well developed literature which has ignored health benefits but often includes information on distance walked and trip frequency.

In summary, previous studies have found that walking is affected by land use and built environment infrastructure, and that the walking infrastructure of neighbourhoods is reflected in real estate prices. The non-market value of walking has been studied extensively in both transportation and outdoor recreation studies, including the effect on demand of walking infrastructure (Scarpa et al, 2000a, 2000b), but provides no estimates of the health benefits. So extensive and well developed is this literature in outdoor recreation that there are many meta-analyses intended for benefit transfer purposes which investigate the stability of the relationship between site infrastructure and walking demand across large numbers of sites. For example, Matthews et al (2009) uses data for walking at 42 major recreation sites in Ireland and Scotland. Economists of outdoor recreation have also used detailed focus group discussions among walkers and other forest users as pilot studies to determine which attributes of forests users value and while recreation use is often mentioned health benefits have been largely overlooked (Chilton and Hutchinson 1999a 1999b and 1999c). In spite of a common interest in modeling walking demand, there is little meeting of minds between this area of environmental economics, where demand analysis is mostly conducted in willingness to pay space, and health economics, which is
interested in the demand quantity response for walking, which is directly related to health behavior change. In the next section we present a novel economic model of demand quantity response to improvements in walking infrastructure in a residential neighbourhood, using a revealed preference method that builds on the weak complementary approach of the travel cost model. The travel cost model has been used in very few studies for valuing health benefits, and never for valuing walking (Clarke, 1998; 2002; Jeuland et al, 2009). When discussing the application of non-market valuation methods in health economics, Hanley et al (2003) mostly consider stated preferences methods.

3. A model for the demand for walking in the neighbourhood

In this paper we are interested in valuing the demand for walking in the neighbourhood, with neighbourhood walking defined as walking in the area of a city where a person also lives. Walking in a neighbourhood is a good not traded in any market. To assess both the demand response and the monetary benefits of transport walking and recreational walking in the local neighbourhood, we rely on a non-market valuation technique, where the quality of a neighbourhood is a non-market or public good (Freeman, 2003.) We assume that people receive private utility from walking in a residential neighbourhood. We further assume ‘weak complementarity’ between walking and a neighbourhood’s pedestrian characteristics: as a neighbourhood becomes more walkable, walking in the neighbourhood increases (Saelens and Handy, 2008; Wilson et al, 2011). This latter assumption allows us to build a utility function that permits us to model changes in a public good – improvement in neighbourhood pedestrian characteristics – and to trace these changes to changes in
consumption of a complementary private good – individual walking activity in the
neighbourhood. Consider an individual’s utility function,

\[ u_i(w_i, N_i, Z), \]

where \( u_i \) is utility of individual \( i \), \( w_i \) is the number of minutes that individual \( i \) walks in
his/her neighbourhood in a seven day period, \( N_i \) is a vector of quality attributes of individual
\( i \)’s neighbourhood, and \( Z \) is a vector of all other goods. Even though walking may be
considered a daily activity, we model the amount of walking in a neighbourhood on a
weekly basis, to accommodate for the fact that the amount of walking may vary between
weekdays and weekends. Individual \( i \)’s budget constraint is given by

\[ y_i + a_i = Z + p_i w_i, \]

where \( y_i \) is income, \( a_i \) is individual \( i \)’s wealth, and \( p_i \) is the opportunity cost of time,
expressed in terms of hourly wage, i.e. the price of walking. Maximization of utility subject
to the budget constraint yields a system of Marshallian demand functions for walking in the
neighbourhood,

\[ w_i = w_i(N_i, X_i, p_i, a_i, s_i), \]

where \( X_i \) is a vector of individual \( i \)’s characteristics, such as gender, age, BMI, and \( s_i \) is the
season when individual \( i \) is surveyed. We assume that the demand response for walking is
affected by neighbourhood characteristics, hourly wage, and wealth. All else being equal,
an improvement in neighbourhood walking characteristics will produce a positive demand
response for walking in the neighbourhood, \( \frac{dw}{dN} \geq 0 \); the more expensive walking in the
neighbourhood is, the less people walk in their neighbourhood, \( \frac{dw}{dp} \leq 0 \); as an individual
becomes wealthier, we assume that he/she walks less in his/her neighbourhood, as other
more expensive alternatives become available, \( \frac{dw}{da} \leq 0 \). Walking in the neighbourhood is an
inferior good: as an individual becomes wealthier, walking in the neighbourhood should be
substituted by more expensive activities, such as cycling, driving, going for a walk at
substitutes sites, such as more pleasant and more distant area, or going to a golf course or
a gym.

To assess the non-market value of walking in the neighbourhood, we recall that the concept
of weak complementarity implies that the value of, or the willingness to pay (WTP) for a
public good equals the value of access to the private good (Freeman, 2003). The value of
walking in a neighbourhood can then be calculated by estimating the Hicksian demand
function for walking and then calculating the compensating variation under a hypothetical
scenario where no pedestrian access to the neighbourhood is allowed. The compensating
variation measures the amount of income paid or received to compensate for an exogenous
change in the provision of a good that leaves an individual at the initial level of utility.

Equation (3) is the Marshallian demand function, and not the Hicksian demand function. To
use the Marshallian demand function, preferences must satisfy the weak complementarity
assumption and the “Willig condition” (Willig, 1976), which requires, as described by
Bockstael and McConnell (1993), that, at the equilibrium, the effect of a good’s price change
on the marginal price of quality equals the effect of a quality change on the quantity
demanded of the good. In our case, the Willig condition requires that the change in the
value of walking given a change in the opportunity cost of time equals the effect of a change in the demand for walking given a change in neighbourhood characteristics. Given these assumptions, we can use the demand function (3) to estimate the quantity and value effects of a quality change in neighbourhood walking characteristics. Equation (3) can be used to calculate two types of monetary values for walking: the access value of all pedestrian use of the neighbourhood and the effect on walking value and distance walked of a change in a characteristic of the neighbourhood. It is this demand response or effect on distance walked which is the primary focus of this paper. The access value is calculated as the area under the demand curve for walking from the current opportunity cost of time \( p \) to the minimum level of the opportunity cost of time that induces zero consumption of walking, the so called ‘choke price’ \( p^* \):

\[
(4) \quad WTP(\text{all access}) = \int_{p_0}^{p^*} w_i(N_i, X_i, p, a_i, s_i) dp_i
\]

\[
= m(N_i, X_i, p^*_i, a_i, s_i) - m(N_i, X_i, p_i, a_i, s_i),
\]

where \( m \) is the expenditure function and \( p_0 \) is the current opportunity cost of walking for individual \( i \). Equation (4) is of particular interest to policy makers who want to assess the total economic value of walking in a neighbourhood. This measure is of interest when policy makers have to consider a drastic policy change that could result in a closure of an area for all walking activities, such as the complete removal of pedestrian access.

Most often policy makers are interested in valuing the effect on walking of changes in some characteristics of a neighbourhood, the demand response for walking, of infrastructure changes. To value a change in one or several characteristics of a neighbourhood, we estimate the demand curve (3) under current and changed neighbourhood characteristics,
and then calculate the compensating variation and change in walking demand for the proposed policy change. For an improvement in a neighbourhood quality to the level $N_i^*$, the demand for walking described by equation (3) shifts to the right. The improved welfare, the compensating variation, or the WTP, brought about by the policy change is the area between the two demand curves above $p_0$:

$$\text{(5) } WTP(\Delta \text{ in quality}) = \int_{p_0}^{p_0^*} w_i(N_i, X_i, p_i, a_i, s_i) dp_i - \int_{p_0}^{p_0^*} w_i(N_i, X_i, p_i, a_i, s_i) dp_i$$

Equation (5) is useful when policy makers want to assess the monetary value of and the demand response to improvements that will affect walking in a neighbourhood by, for example, providing improved walking facilities, making green open spaces more attractive, or making an area safer from crime. Once welfare measures and demand response have been calculated, it is possible to estimate the health benefits associated with additional walking produced by the walking demand response to neighbourhood renewal programs offering improved walking infrastructure. From the point of view of health economics it is the demand response or behaviour change in walking which is of most interest. The welfare measures or WTP may be of primary interest to local government officials who may insist that projects of this type be seen to pass the benefit cost test before infrastructure investments are made.

4. Data

The area chosen in this study is the site of a proposed major urban regeneration public sector investment - the Connswater Community Greenway in East Belfast, Northern Ireland, United Kingdom - the development of a 9 km linear park, including the provision of new
cycle paths and walkways. The data were collected through in-person interviews over a 12 month period (Feb 2010-Jan 2011), using a random sample of addresses stratified by electoral ward within a 1-mile radius of the Greenway for a total population of 73,378 (Tully et al, 2013). Ethical approval for the study was provided by OREC, Northern Ireland, (Reference, 09/NIR02/66). (See the supplementary material for the survey instrument). In each household, using the last birthday rule, an adult (16 years or older) was interviewed for a final sample of 1,209 respondents. To reduce sample selection bias, interviewers would make at least 3 calls to each address at varying times of the day and evening, and days of the week. Our analysis, after deleting 7 respondents who were unable to walk, is characterized by the following descriptive statistics: 40.6% are male, 30% own a car, 51% are employed and almost 33% are graduates. On average, our respondents are about 50 years old, and earn a gross weekly income of £465.73 (At the time of the survey, the exchange rate was about 1GBP(£) = 1.60US$). Our sample mirrors reasonably well the characteristics of the population of the area, which has a lower proportion of females than our sample. The corresponding statistics for the population of the residents in the wards we surveyed are: female 53%; full time or part time employed 55,9%; average age 39 years (this is computed for the whole population, whilst our sample surveyed individuals older than 16 only) (2011 Census).

The survey queried respondents about their perceptions of the characteristics of their local neighbourhood, their health status, and the amount of walking they habitually do.

Respondents were asked to rate three characteristics of their neighbourhood as either ‘poor’, ‘fair’ or ‘good’: 1) safety of the area from crime; 2) availability of walking paths and attractive open spaces; 3) availability of local shops and facilities within walking distance. Results show that neighbourhoods in East Belfast are considered to be relatively safe from
crime, as approximately 45% of respondents rate their neighbourhood to have a good level of safety, 43% consider their neighbourhoods’ safety to be fair and only about 11% of participants deem their area ‘poor’ in terms of safety from crime. Our participants also consider their neighbourhood to score quite well in terms of availability of walking paths and attractive open spaces, with almost 80% of respondents judging their neighbourhoods’ availability of walking facilities to be either ‘good’ or ‘fair’. Finally, most respondents (72.3%) say that there is a good availability of local shops and facilities within walking distance.

Next, we assigned each respondent to an objectively measured walkability index ranging from 1 to 4 (1=Low walkability; 2=low-med; 3=med-high; 4=high). This index is calculated for the neighbourhood where respondents live, based on residential density, street sidewalk intersection density, land use mix, and retail floor area ratio following methods outlined in Leslie et al, 2007 and Frank et al, 2010. The median value for this variable is equal to 2, suggesting that East Belfast is equally split between areas characterized by good walkability and areas with poor walkability.

To measure health outcome, we used the EQ-5D-5L standardised instrument, available at www.euroqol.org. Most respondents consider that they enjoy good health, as, on average, they report their health status to be equal to 73, on a 1 to 100 scale, where 1 means very poor, and 100 excellent. Despite this data, our sample confirms the prevalence of obesity in Northern Ireland, as most of our respondents are either overweight (36%) or obese (20%), and the median (self reported) BMI is equal to 25.84.

Respondents were instructed to consider the amount of time they spend walking to and from places such as work, shops and places of worships and for recreational purposes. They were first asked about how much time they spent walking in a typical week at this time of the year. Next, they were asked about how much of that time they spent walking in their
neighbourhood. The first question on walking aims at making the respondent think about all
the walking he/she usually does, and at assessing any substitutes for walking in a
respondent’s neighbourhood. The second question is the one of interest to us, as this
question allows us to assess the amount of walking in a person’s neighbourhood. Thus over
a seven day period, the median respondent reports walking 150 minutes. Of these, 100
minutes are spent walking in his/her local neighbourhood. From these answers we notice
that half of our sample currently does less than the recommended amount of physical
activity. To account for any substitutes for walking, respondents reported the amount of
moderate intensity physical activity per day, which on average is about 28 minutes per
respondent. Descriptive statistics for our sample are reported in Table 1.
Table 1. Descriptive statistics

<table>
<thead>
<tr>
<th>Variables</th>
<th>N</th>
<th>Mean</th>
<th>Std Dev</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walkab (objective measure of walkability: 1=Low walkability; 2=low-med; 3=med-high; 4=high)</td>
<td>1192</td>
<td>2.42</td>
<td>1.12</td>
<td>1</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>BMI</td>
<td>1137</td>
<td>26.52</td>
<td>5.53</td>
<td>15.06</td>
<td>57.47</td>
<td>25.84</td>
</tr>
<tr>
<td>age</td>
<td>1185</td>
<td>50.29</td>
<td>18.94</td>
<td>16</td>
<td>94</td>
<td>49</td>
</tr>
<tr>
<td>income</td>
<td>1038</td>
<td>465.73</td>
<td>388.90</td>
<td>90</td>
<td>1500</td>
<td>340</td>
</tr>
<tr>
<td>health (1=very poor; 100=excellent)</td>
<td>1198</td>
<td>73.77</td>
<td>19.65</td>
<td>3</td>
<td>100</td>
<td>80</td>
</tr>
</tbody>
</table>

In a typical day, how many minutes do you spend doing moderate-intensity physical activity?

G1 In a typical week at this time of year how much time do you spend walking? (MINUTES)

G2 And how much of that time do you spend walking in your local neighbourhood? (MINUTES)

<table>
<thead>
<tr>
<th>Dummy variables (N=1202)</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>walkab_miss (dummy variable for missing ‘walkability’)</td>
<td>0.0083</td>
</tr>
<tr>
<td>BMI_miss (dummy variable for missing ‘BMI’)</td>
<td>0.0541</td>
</tr>
<tr>
<td>age_miss (dummy variable for missing ‘age’)</td>
<td>0.0141</td>
</tr>
<tr>
<td>income_miss (dummy variable for missing ‘income’)</td>
<td>0.1364</td>
</tr>
<tr>
<td>health_miss (dummy variable for missing ‘health’)</td>
<td>0.0033</td>
</tr>
<tr>
<td>crime_good (equals to 1 when safety of the area from crime is good)</td>
<td>0.4509</td>
</tr>
<tr>
<td>walk_good (equals to 1 when availability of walking paths and attractive open spaces is good)</td>
<td>0.4318</td>
</tr>
<tr>
<td>shop_good (equals to 1 when availability of local shops and facilities within walking distance is good)</td>
<td>0.7230</td>
</tr>
<tr>
<td>Male (equals to 1 when a respondent is male)</td>
<td>0.4060</td>
</tr>
<tr>
<td>Degree (equals to 1 if a respondent has at least a graduate degree)</td>
<td>0.3278</td>
</tr>
<tr>
<td>Couple (equals 1 if a respondent is married or living with a partner)</td>
<td>0.4991</td>
</tr>
<tr>
<td>Car (equals to 1 if a respondent has at least one car in the household)</td>
<td>0.2920</td>
</tr>
<tr>
<td>Spring (equals to 1 if a respondent was surveyed in Spring)</td>
<td>0.1963</td>
</tr>
<tr>
<td>Summer (equals to 1 if a respondent was surveyed in Summer)</td>
<td>0.1988</td>
</tr>
<tr>
<td>Autumn (equals to 1 if a respondent was surveyed in Autumn)</td>
<td>0.2471</td>
</tr>
<tr>
<td>Winter (equals to 1 if a respondent was surveyed in Winter)</td>
<td>0.3577</td>
</tr>
</tbody>
</table>

5. Econometric Analysis

To model the demand for walking, we use a tobit model (Tobin, 1958) to account for the fact that time spent walking is either positive or zero. We estimate the following regression model based on equation (3):
where $w_i$ is the number of minutes walked in the neighbourhood in a seven day period by respondent $i$; $Y$ is a vector comprising an intercept, neighbourhood characteristics, respondent’s $i$ characteristics, including a variable that captures the value of time, calculated as 15% of the net weekly income, divided by the number of minutes worked; $\beta_y$ is a vector of coefficients to be estimated; $\varepsilon_i$ is an error term assumed to be independently and normally distributed with mean zero and variance $\sigma^2$. Table 2 reports the output of three specifications for the tobit model. We favour the use of a tobit model because the data for time spent walking conform to a ‘corner solution model’, being either zero or positive, as indicated by Wooldridge (2002). Using ordinary least squares would result in inconsistent parameter estimates. An alternative model would be to apply a Cragg model, a two stage model where first a dichotomous choice model estimates the decision to participate in walking and then a truncated model is estimated on the assumption that when an individual decides to participate, the quantity of walking is positive. One of the difficulties in using a two-step model, like the Cragg model, would be in deciding which variables to use to explain the decision to participate. In addition, a Cragg model would underestimate the demand responsiveness, as much of this would be captured by the decision to participate.

In Table 2, Model (1), we use only an intercept, walkability (walkab), that ranges from 1 to 4 (1=Low walkability; 4=high walkability) and a dummy variable (walkab_miss) as explanatory variables. To circumvent the problem of missing values in some of our independent variables, we recode an independent variable to zero when missing and create a dummy variable, that takes on a value of one when the independent variable is missing and zero.
otherwise, and entering both the recoded independent variable and the indicator of a missing value in the right-hand side of the equation (Longo and Alberini, 2006). Variables for which we have missing observations are: walkab, BMI, age, income and health. We find that walkability is positive and significant, suggesting that the more objectively ‘walkable’ an area is, the more time people spend walking. The variable ‘walkab_miss’ is not statistically significant, indicating that respondents for whom we have no information about the walkability of their area are not different in terms of amount of walking from respondents for whom we do have information on the walkability of their area. We look at the effects of other variables in the next specification.

The second specification, Table 2, Model (2), investigates the effects on walking of respondents’ subjective perceptions of the walkability of the area, in addition to the objective walkability measure, by studying the effect of (a) safety of the area from crime, (b) availability of walking paths and attractive open spaces, and (c) availability of local shops and facilities within walking distance, as perceived by the respondents. The results show that walking is positively affected by the presence of shops and facilities at walking distance, whilst the safety of the area and the availability of walking paths and attractive open space, as perceived by respondents do not affect time spent walking.
Table 2. Tobit model. Dependent variable is minutes walked in the neighbourhood in a seven day period.

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coeff.</td>
<td>t-ratio</td>
<td>Coeff.</td>
<td>t-ratio</td>
</tr>
<tr>
<td>Constant</td>
<td>60.84</td>
<td>2.98</td>
<td>17.56</td>
<td>0.68</td>
</tr>
<tr>
<td>Crime_good</td>
<td>-23.31</td>
<td>-1.26</td>
<td>-19.19</td>
<td>-1.05</td>
</tr>
<tr>
<td>Walk_good</td>
<td>19.98</td>
<td>1.02</td>
<td>16.97</td>
<td>0.87</td>
</tr>
<tr>
<td>Shop_good</td>
<td>66.81</td>
<td>3.21</td>
<td>52.40</td>
<td>2.50</td>
</tr>
<tr>
<td>Walkab</td>
<td>32.46</td>
<td>4.28</td>
<td>31.04</td>
<td>3.96</td>
</tr>
<tr>
<td>Walkab_miss</td>
<td>58.09</td>
<td>0.69</td>
<td>53.59</td>
<td>0.56</td>
</tr>
<tr>
<td>BMI</td>
<td>-2.84</td>
<td>-1.74</td>
<td>-2.70</td>
<td>-1.66</td>
</tr>
<tr>
<td>BMI_miss</td>
<td>-1.32</td>
<td>-0.02</td>
<td>-1.85</td>
<td>-0.03</td>
</tr>
<tr>
<td>Male</td>
<td>15.07</td>
<td>0.87</td>
<td>18.86</td>
<td>1.10</td>
</tr>
<tr>
<td>Age</td>
<td>0.11</td>
<td>0.04</td>
<td>1.77</td>
<td>0.66</td>
</tr>
<tr>
<td>Age_squared</td>
<td>-0.01</td>
<td>-0.55</td>
<td>-0.03</td>
<td>-1.32</td>
</tr>
<tr>
<td>AGE_miss</td>
<td>-35.24</td>
<td>-0.37</td>
<td>-9.85</td>
<td>-0.10</td>
</tr>
<tr>
<td>Spring</td>
<td>73.49</td>
<td>3.11</td>
<td>68.28</td>
<td>2.88</td>
</tr>
<tr>
<td>Summer</td>
<td>104.13</td>
<td>4.43</td>
<td>96.08</td>
<td>4.08</td>
</tr>
<tr>
<td>Autumn</td>
<td>56.27</td>
<td>2.55</td>
<td>54.81</td>
<td>2.50</td>
</tr>
<tr>
<td>Health</td>
<td>1.86</td>
<td>4.14</td>
<td>2.06</td>
<td>4.56</td>
</tr>
<tr>
<td>Health_miss</td>
<td>105.94</td>
<td>0.67</td>
<td>107.35</td>
<td>0.68</td>
</tr>
<tr>
<td>Substitute</td>
<td>0.02</td>
<td>0.41</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Car</td>
<td>-50.17</td>
<td>-2.46</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>-0.03</td>
<td>-1.65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income_miss</td>
<td>-59.50</td>
<td>-0.30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sigma</td>
<td>286.44</td>
<td>42.69</td>
<td>284.95</td>
<td>42.73</td>
</tr>
<tr>
<td>Observations</td>
<td>1202</td>
<td>1202</td>
<td>1202</td>
<td>1202</td>
</tr>
<tr>
<td>Log-likelihood</td>
<td>-7062.37</td>
<td>-7054.781</td>
<td>-7022.60</td>
<td>-7016.94</td>
</tr>
<tr>
<td>AIC</td>
<td>11.75</td>
<td>11.75</td>
<td>11.71</td>
<td>11.71</td>
</tr>
<tr>
<td>BIC</td>
<td>11.77</td>
<td>11.78</td>
<td>11.79</td>
<td>11.80</td>
</tr>
</tbody>
</table>
The third specification in Table 2, Model (3), adds respondents’ socio economic characteristics, in addition to the ‘walkability’ index of the area and respondents’ perceptions about the quality of their neighbourhood. We find that the higher the BMI and the poorer the health, the less a respondent walks. Walking does not appear to differ with age and gender. Walking is lowest in winter (reference dummy), increases in spring, peaks in summer, and declines in autumn.

In the fourth specification, Table 2, Model 4, we add variables for respondents’ income, car ownership and minutes of walking in a different area to a respondent’s neighbourhood, calculated as the total amount of walking minus the amount of walking in a respondent’s neighbourhood, which aims to capture the effect of substitute opportunities for walking. Similarly, the variable ‘car’, captures both a measure of wealth, as well as a substitution possibility for walking as a mode of transport. A log-likelihood ratio test shows that model 4 outperforms model 3 at the 5% level (Chi-squared is equal to 11.32, with 4 degrees of freedom). This specification confirms the findings of previous specifications: walking increases with an increase in the objective walkability of an area, with the increased supply of shops and facilities at walking distance, with the good health of a respondent and decreases with an increase in BMI. In addition, we find that whilst walking in a neighbourhood is not affected by how much a person walks elsewhere, owning a car reduces the amount of walking. We also find a negative and significant coefficient for income, suggesting that walking in a person’s neighbourhood is an inferior good: the higher the salary, the less a person walks in her/his neighbourhood. In specifications not reported here, we investigated any spatial effects by running cluster regression models (Wooldridge, 2001), using dummy variables for the wards where residents live, but found the coefficients of the cluster dummy variables to be not statistically significant.
6. Demand Response and welfare analysis for improved walking infrastructure

We use the results of Model 4 to calculate the marginal effects on walking, reported in Table 3:

\[
(7) \frac{\partial E[w_i|y_i]}{\partial y_i} = \beta \Phi \left( \frac{y_i \beta}{\sigma} \right)
\]

Table 3. Marginal effects (minutes of walking per week)

<table>
<thead>
<tr>
<th></th>
<th>Marginal effect</th>
<th>Std.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shop_good</td>
<td>36.48</td>
<td>14.40</td>
</tr>
<tr>
<td>Walkab</td>
<td>15.51</td>
<td>5.58</td>
</tr>
<tr>
<td>BMI</td>
<td>-1.86</td>
<td>1.12</td>
</tr>
<tr>
<td>Spring</td>
<td>47.18</td>
<td>16.37</td>
</tr>
<tr>
<td>Summer</td>
<td>66.38</td>
<td>16.28</td>
</tr>
<tr>
<td>Autumn</td>
<td>37.87</td>
<td>15.17</td>
</tr>
<tr>
<td>Health</td>
<td>1.42</td>
<td>0.31</td>
</tr>
<tr>
<td>Car</td>
<td>-34.67</td>
<td>14.08</td>
</tr>
<tr>
<td>Income</td>
<td>-0.02</td>
<td>0.01</td>
</tr>
</tbody>
</table>

Respondents rating their area as having ‘good’ availability of shops and facilities in their neighbourhood walk on average 36.48 minutes (std. err. 14.40) more per week compared to people who live in areas rated as having poor or fair availability of shops and facilities at walking distance. This also means that improving an area’s availability of shops and facilities improves walking by more than half an hour per week. Car ownership decreases the walking in an area by 34.7 minutes (std. err. 14.08) per week, suggesting that policies that increase the cost of car ownership or car usage may have an important effect on the amount of physical activity that people do. Interventions that improve the objective walkability of an area lead to an increase in walking of about a quarter of an hour per week. The table also
shows strong seasonality in walking patterns: in summer people walk about one hour and 6 minutes more than in winter, a result that is consistent with previous literature (Tucker and Gilliland, 2007). We use model (4) and equations (4) and (5) to calculate the demand response and monetary value of improved walking infrastructure in the neighbourhood. Using equation (6), considering that the ‘choke price’, p*, is the price that sets the demand for neighbourhood walking to zero, equation (4) becomes:

\[
WTP(\text{access}) = \int_{p_0}^{p^*} Y_i \beta_y dp_i = -\frac{\bar{w}^2}{\beta_p},
\]

where \(\bar{w}\) is the predicted number of minutes walked per week from equation (4) and model (3). Using equation (8), the access value to walking in the neighbourhood is equal to £33.27 (std. err. 20.21, calculated with the delta method) per week. This is the monetary value that, on average, a person living in East Belfast values the right of access to walking in the neighbourhood.

The access value is, however, of limited interest, as it is unlikely that a neighbourhood becomes unavailable for walking. More interesting is an assessment of the monetary value and especially the supply response to interventions aimed at improving the walkability of the area. To value a change in one or several characteristics of a neighbourhood, we use model (4) and equations (5) and (8) under current and changed neighbourhood characteristics:

\[
WTP(\Delta \text{in quality}) = \int_{p_0}^{p^*} Y_i \beta_y dp_i - \int_{p_0}^{p^*} Y_i \beta_y dp_i = -\frac{\bar{w}_x^2}{\beta_p} + \frac{\bar{w}^2}{\beta_p},
\]
Where $Y_i^n$ is the demand for walking under improved neighbourhood characteristics, and $\bar{w}^*$ is the predicted number of minutes spent walking – the demand response for walking – in a seven day period estimated from model (3) and (6) under improved neighbourhood characteristics. For example, a policy that improved East Belfast walkability from the current levels to the ‘high’ level of walkability throughout the district and that also improved people’s perceptions of their areas from the current levels to ‘good’ levels in terms of availability of local shops and facilities within walking distance would result in an increase of walking for the average respondent of 36.18 minutes (std. err. 9.93) per week. Such a policy is valued at £13.65 (std. err. 9.49) per week. Table 4 reports a set of demand responses for walking and related monetary values for selected scenarios.

Table 4. Increased minutes of walking per week and monetary value of (WTP) in GBP (£) for selected scenarios. Standard errors calculated with the Delta Method.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>WTP (std. err.)</th>
<th>Increased minutes of walking (std. err.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving East Belfast to high walkability; good availability of local shops and facilities within walking distance; all other variables at their mean value</td>
<td>13.65 (9.49)</td>
<td>36.18 (9.93)</td>
</tr>
<tr>
<td>Improving East Belfast's availability of local shops and facilities within walking distance to ‘good’; all other variables been at the average value</td>
<td>3.62 (2.63)</td>
<td>10.24 (4.09)</td>
</tr>
<tr>
<td>Improving East Belfast's walkability to ‘high’; all other variables been at the average value</td>
<td>9.30 (6.98)</td>
<td>25.31 (9.38)</td>
</tr>
<tr>
<td>Respondent interviewed in spring with BMI=23, gross weekly income=500, health status=85, no car for improving East Belfast to ‘high’ walkability and ‘high’ availability of local shops and facilities within walking distance</td>
<td>18.13 (13.00)</td>
<td>39.96 (10.89)</td>
</tr>
<tr>
<td>Respondent interviewed in spring, BMI=32, gross weekly income=500, health status=55, no car; improving East Belfast to ‘high’ walkability and ‘high’ availability of local shops and facilities within walking distance</td>
<td>12.12 (8.74)</td>
<td>34.94 (8.74)</td>
</tr>
</tbody>
</table>
We notice the differences between normal weight and obese respondents, with the latter having a considerably lower value for improvements in their neighbourhood and also a lower increase in expected walking. For example, a policy that improves the walkability to ‘high’ and also improves people’s appreciation of the availability of shops and facilities at walking distance to ‘good’, leads to an increase of almost 40 minutes per week of walking for a respondent with a health status of 85 and BMI of 23, and of only 35 minutes for a less healthy respondent with a health status of 55 and a BMI of 32. Although obese people walk at a slower speed (Browning and Kram, 2005), they would accumulate a similar amount of energy expenditure from 35 minutes of walking - 170 kcals if walking at 3.0 Metabolic Equivalent of Task (METs) - compared to the normal weight individual walking for 40 minutes - 164 kcals if walking at 3.5 METs - assuming they were both of similar height (1.7m in this example) (Bushman, 2011).

7. Discussion and conclusion
Walking in the area where a person lives is a widely accessible form of moderate-intensity physical activity, suitable for overweight and obese people, as well as for older people with limited mobility or limited transport opportunities, who are less likely to perform vigorous-intensity physical activity. Walking has been found to improve human health by reducing the development of cardiovascular diseases and cancer. Given its importance, it is surprising that there has been little health economic research into modelling the demand response which is linked to behaviour change. In this paper we have introduced a novel revealed preference model of the demand response for walking and the enhanced value of neighbourhood walking which results from improvements in neighbourhood walkability and
walking infrastructure. The model assumes that walking in a neighbourhood depends on the characteristics of the neighbourhood, as well as residents’ characteristics. We have found that walking in the area where a person lives is an “inferior” good: as an individual becomes wealthier, walking in the neighbourhood will be substituted with more expensive activities, such as cycling, driving, walking in a different area outside the neighbourhood, or going to the golf course and the gym. To our knowledge, this is the first time that such a model has been proposed for estimating the demand response, the potential health benefits and consumer’s value of walking. We have applied the model to walking in East Belfast, Northern Ireland, UK, and find that our empirical data supports our theoretical model: minutes walked are negatively affected by the value of time and by a person’s wealth. We further find that people living in more walkable areas and in areas which have a good availability of local shops and facilities within walking distance, tend to report walking more than other people.

Considering the monetary value of walking, a public programme that would enhance to a ‘high’ level the walkability of all of East Belfast and improve to ‘good’ all resident’s perception of the availability of local shops and facilities within walking distance is valued at £13.65 (std. err. 9.49) per person per week. Assuming that estimated levels would correspond to actual behaviours, the corresponding increase in minutes walked per week from such a policy should result in 36.18 (std. err. 9.93) extra minutes walked per person on average. These results show that a policy that would produce an increase of about one quarter of the recommended amount of moderate-intensity physical activity has an average annual value per resident of about £710. When we apply the WHO’s HEAT methodology (WHO, 2014) to our data, using a value of a statistical life for the UK of £3.2M, and a mortality rate of 432.1 deaths per 100,000 people per year, we find that the same policy
would be worth about £34 per resident per year. This is a much lower estimate than the one arising from our model, suggesting that the WHO’s HEAT methodology underestimates the total value of walking, as it only focuses on the health benefits of walking from mortality risk reduction.

One may wonder whether individuals who like walking may decide to live in more walkable areas. To address this point, we investigate any difference in walking outside an individual’s neighbourhood. Using a t-test, we find no difference (p-value=0.93279) in mean values for walking outside an individual’s neighbourhood for people living in high walkability areas (walkab = 3 or 4) and for people living in low walkability areas (walkab = 1 or 2). From this result, it appears that people walk more in more walkable areas because they live in those areas, and not because they walk more in general. Future longitudinal studies should cast more light on this issue.

From a policy perspective, it may be interesting to investigate the effects on inactive residents, to gauge the impact on the numbers becoming active and reaching the recommended guidelines of 150 minutes per week of moderate-intensity physical activity.

When we focus our attention on inactive participants, respondents who currently do not engage in at least 30 minutes of moderate-intensity physical activity per day, and walk less than 150 minutes per week, we find that this group of 567 respondents (about 44% of our survey sample) only walks a total of 105 minutes per week on average. These are respondents with an average BMI of 25.40, are on average 53 years old, predominantly female (62%), with a self-reported health value of 68.5, and a weekly income of £373. Our demand response model shows that if the government implemented a public program to maximize the walkability of East Belfast and to improve residents’ perceptions of the attractiveness of the area, then these inactive respondents would, on average, increase
their amount of walking by 38.49 minutes (std. err. 10.25) per week. Such a program would therefore increase, on average, the total amount of moderate-intensity physical activity for this group of inactive residents to about 142 minutes per week, an increase of about 35%, an important amount, though still short of the recommended 150 minutes per week. Put another way, this policy would help an additional 12.8% of the inactive sample (73 people) - who do not currently meet the recommended guidelines for physical activity – achieve the recommended target of 150 minutes per week of physical activity. Interestingly, when we look at the average characteristics of these 73 respondents, we find that this is a relatively young group, about 47 years old, with a large proportion of men, 44%, with a BMI of 24.7, a self-reported health status value of 75, and a weekly income of £421, a healthier (and wealthier) group compared to those not achieving the recommended targets for physical activity after the implementation of the walkability improvements.

Additional interventions would therefore be needed to encourage inactive residents to achieve the recommended levels of physical activity, as it appears that interventions that improve the walkability of an area are particularly effective in increasing walking among already active citizens, and, among the inactive ones, the best response is found among those healthier, younger and wealthier citizens. Sattelmair et al. (2011) have shown that compared to taking no physical activity, people who are physically active at half the recommended level (75 minutes per week), are at a 14% lower risk of coronary heart disease. Our findings of a possible increase of nearly 30 minutes on average per week of activity from infrastructure and walkability changes to the neighbourhood may therefore be associated with widespread health benefits. Compared with completely inactive adults, Wen et al (2011) have demonstrated that those who undertake low levels of activity (90 minutes per week), had a 14% reduced risk of all-cause mortality, and had a 3 year longer
life expectancy. After that, every additional 15 minutes of activity (half the level we have

demonstrated) further reduced all-cause mortality by 4% and all-cancer mortality by 1%.

These benefits were applicable to all age groups and both sexes. Considering the results of
these studies in conjunction with our findings, we conclude that a policy that improved the
walkability in East Belfast to a high level and also improved to ‘good’ residents’ perceptions
of the availability of local shops and facilities within walking distance, would contribute to
an increase in moderate-intensity physical activity of about 36 minutes on average per
week, which could result in a reduced all-cause mortality by about 8% and all-cancer
mortality by about 2%.

Capewell and Graham (2010) and the recent guidelines from the National Institute for
Health and Care Excellence (NICE, 2010) have highlighted how population level measures
are generally more effective at narrowing inequalities than interventions targeted at
individuals, which may widen inequalities. Our findings demonstrated that for poorer
respondents it is relatively less costly to do physical activity in their neighbourhood than
elsewhere. However, we also found that an intervention that improves the walkability and
the subjective perceptions of the walkable environment where people live is more effective
in increasing physical activity levels of already healthy (and wealthier) people. It is therefore
vital that we are never seduced by our assumptions (about whole population approaches)
and that all public health programmes are evaluated appropriately to mitigate any potential
for intervention generated inequalities (Frohlich and Potvin, 2008). One must also be
mindful that there are likely to be synergies between physical and social infrastructure (Diez
Roux and Mair, 2010) and that changes in social norms (around walking) may also change
individual’s utility functions (Prior et al 2014) and that even this might have a differential
effect across socioeconomic groups.
Our conclusions must be guarded, as the analysis is obviously subject to assumptions concerning the relationship between revealed and actual behaviour which can be tested more robustly by natural field observations after an urban regeneration has taken place. In addition, our WTP perspective might be thought of as providing a lower bound to the monetary benefits to the public sector of such walking infrastructure improvements. It does not include indirect benefits that might arise from improved business and tourism in areas with improved infrastructure, and reduced pollution.

Information on the monetary health benefits of walking may also be useful to policymakers since there has been considerable debate about the use of incentives for behavioural change. We found that individuals with a greater BMI have lower values for walking in their neighbourhood and, when compared to people with lower BMI, are likely to change their physical activity levels less under the various improvement scenarios. Therefore, it could be that differential incentives may be required to improve physical activity levels. Larger incentives may be needed to modify the behaviour of individuals with higher BMI values, a suggestion that accords with previous research (Ogilvie, 2007), but which needs to be empirically tested.

Our research finds that in Belfast, at least, people do not seem to be walking for health reasons alone, they walk "opportunistically", that is, to reach a destination to undertake regular daily activities such as shopping, eating out, going to places of worship etc., while other physical activities seem to be associated with more moderate-intensity and vigorous-intensity activities such as going to the gym, playing sports etc. This is entirely borne out by the findings of our recent qualitative work with stakeholders of the Connswater Community Greenway (Prior et al, 2014). From these findings we derive two messages for policy makers: 1) walkability is increased by the placing of typical urban structures and functions
such as shops, restaurants, libraries and playgrounds within walking distance of as many
people as possible, and 2) ordinary walking is a healthy activity and this includes all walking-
not just walking for long periods, at a very fast pace or hiking.

As a methodological contribution to the literature, this paper has used a novel revealed
preferences method to model the demand and value of neighbourhood walking in the event
of interventions to improve pedestrian infrastructure in the district. Further research should
explore the use of stated preferences, also in conjunction with revealed preferences, to
investigate the benefits of walking and other forms of physical activity. Stated preferences
may be used to further validate the findings from revealed preferences, and/or to explore
scenarios that cannot be studied with revealed preferences alone.
References


Urban greenways have the potential to increase physical activity levels cost-effectively. *Eur J Public Health*, 24(2), 190-5.


