Impact on Urban Health

Global perspectives on urban health

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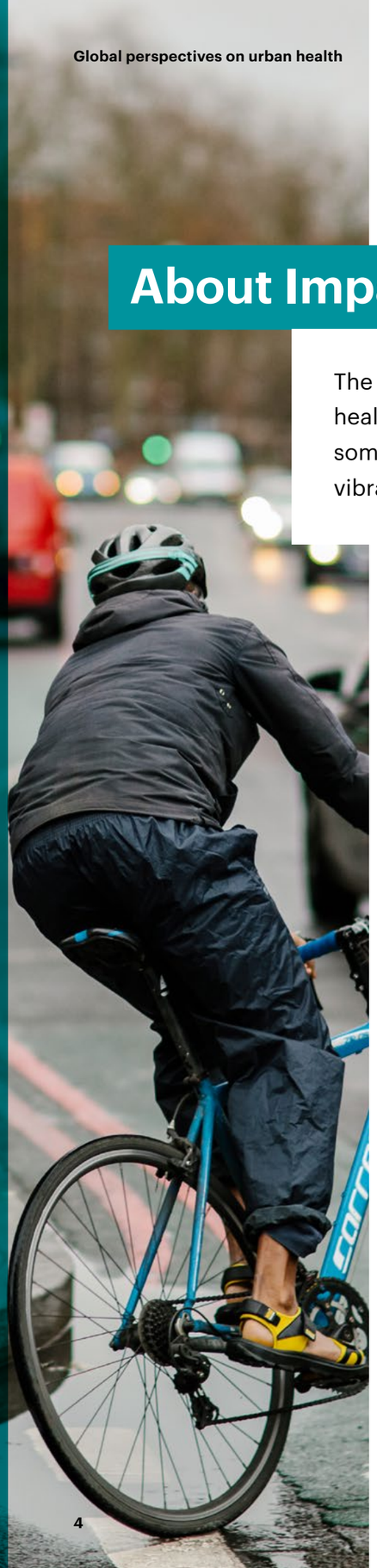


About Impact on Urban Health

The places where we grow up, live and work impact how healthy we are. Urban areas, like inner-city London, have some of the most extreme health outcomes. Alongside their vibrancy and diversity sit stark health inequalities.

The London boroughs of Lambeth and Southwark are our home. They are densely populated, with a rich and diverse mix of cultures and ethnicities and a wide variation in household income, with areas of affluence and poverty side by side. Compared to London averages, our boroughs have close to twice the amount of social housing, half the amount of green space and a much wider range of income and health outcomes.

It is here that we invest, test, and build our understanding of how cities can be shaped to support better health. We focus on a few complex health issues that disproportionately impact people living in cities, and we work with local, national and international organisations, groups and individuals to tackle these.

At Impact on Urban Health, we believe that we can remove obstacles to good health, by making urban areas healthier places for everyone to live. Our place is like so many others, so we share our insight, evidence and practical learning to improve health in cities around the world.

Our boroughs have:

~2x

the London average of social housing

1/2

the London average amount of green space

Our approach

At Impact on Urban Health, we take a place-based approach to tackling urban health issues. We pay particular attention to the context in which people live and the wider determinants of their health, from finance and employment to social connections. Partnering with individuals, groups and organisations, we learn what works to improve health in inner cities and share lessons with others across the world.

We are rooted in place - this helps us understand how the local environment affects people's health and to find solutions that work in practice. From our place in Lambeth and Southwark we support those committed to achieving health equity in inner-city areas, locally, nationally and internationally.

We combine data, evidence and lived experience - our approach is underpinned by curiosity and an eagerness to learn and share. We combine rich data from a variety of sources, including our own, with robust evidence on what works to improve health in cities and people's lived experiences.

We focus on a few complex health issues that disproportionately impact people living in urban areas. We're currently working on reducing childhood obesity, slowing people's progression to multiple long-term health conditions and finding innovative solutions to the health effects of air pollution. In 2021, we will launch a new programme exploring adolescent mental health.

We share lessons - we believe we can have an even wider impact by sharing what we learn with others working on similar issues in other global cities. Learning rooted in practice is our contribution to the growing body of evidence around urban health.

We partner - We believe we can improve health in urban areas but know we cannot do this alone. We work with organisations and people from all sectors, from community groups to large commercial enterprises, to research issues, test ideas on the ground, share knowledge and evaluate the effectiveness of projects. While some of our joint projects focus on a handful of streets, others are global initiatives.

Foreword

For the past 50 years, urban centres have been great engines for prosperity, yet this has always masked huge health inequalities. Cities are responsible for both the best health and the worst health outcomes in ways that are predictable, entrenched but also amenable to change.

Take for example the impact of the COVID-19 pandemic, which has not been experienced equally. If you live in an overcrowded house, travel on busy public transport, and have little say over your working conditions, your threat from the virus will be much higher. It goes deeper than that. Your risk of serious illness from COVID-19 is higher if you live in polluted areas or on streets with limited access to affordable healthy eating options. It is also higher if you already have other long-term health conditions, which is more likely if you live in poorer neighbourhoods.

These health inequalities are not new. What the pandemic has done is to fast-forward a clock on urban health patterns that were there all along. They were less visible, perhaps, but with just as great a human and economic cost. How to improve urban health, then, is an urgent question that needs practical answers.

This report looks at exactly that. It explores how cities around the world are addressing health inequalities. It finds real-world solutions in how they are shaping the built environment, devolving power, building cross-sector collaborations, centring the voice of urban communities, using new data and technologies, and tackling systemic issues of racial and economic segregation.

Through these examples, the report paints a clear picture of how to unlock the potential for cities to be healthier. We need to take a broad view of what drives all our health. We need to work in wide partnerships that bring a range of perspectives. And, crucially, we need to ensure that the process of building health equity is equitable itself.

These global insights are shaping our own work. We hope they are interest to yours too.

Kieron Boyle, Chief Executive
Impact on Urban Health

Executive summary

Cities are the places where we see the starkest health inequalities, with the worst and best health outcomes often sitting side by side. From our place in inner-city London this is only too evident. If we compare two adjoining neighbourhoods of Clapham in South London, men in one area live in good health for an average of 12 years longer than those a few streets away. For women, the gap is seven years. We believe that the reasons why the best health outcomes exist alongside the worst in cities are complex and sit at the intersection of diversity in urban areas, the built environment and income inequalities.

These health inequalities are not unique to London, so we began to look at similar cities and neighbourhoods to ours across the world. We started by identifying those comparable cities with a view to understanding what urban health equity (or lack thereof) looked like globally. Even in different cultural and political contexts, we wanted to know if there were any commonalities between health and the places people grow up, live and work. that would help deepen our understanding of what drives positive health outcomes for all.

Work on this report, which explores the important role cities can play in improving global health outcomes, started before the COVID-19 pandemic began. Over the last year, the pandemic has further highlighted the deep, complex link between poor health and social and environmental factors, such as where we live, our ethnicity, our jobs and our income. The heavy toll the pandemic has had on urban communities, here in the UK and globally, cannot be ignored.

Health challenges associated with density of population, overcrowded housing, poor air quality, social isolation, ethnic and cultural diversity, precarious employment and income inequality are present in the majority of urban communities. This shared context means we believe there is huge potential for cities across the world to learn from each other.

By focusing our attention on understanding health in urban areas, looking at what works and creative ideas to tackle what doesn't, we gain valuable insight which can then be applied in other places. By sharing our knowledge, expertise and vision with others, nationally and internationally, we can begin to remove the barriers to achieving health equity.

We believe collective action is needed, and urgently. This report highlights a variety of urban health approaches that are being tried and tested around the world, with early indicators suggesting that change is possible. We have been inspired by work in cities in South America, Europe, Asia, Australia and North America. From Paris's approach to sharing power and decision making with residents to Mexico City's creativity in bringing together experts from vastly different disciplines to solve some of the city's health-related issues. Through exploring initiatives driving positive change in health across the world, it's become clear that to address health inequalities in cities we need to collaborate – both across sectors, and with local communities and organisations.

Cities are constantly changing which presents a powerful opportunity to reshape urban areas and services to support health. However, health challenges cannot be tackled in isolation; we must take collective responsibility, across sectors and disciplines. For example, we can learn from São Paulo's Better Hearts Better Cities initiative which built a network of partners, reaching beyond the health sector, and co-created solutions with communities which drove tangible improvements in control of high blood pressure. Alongside addressing inequalities present now, we must tackle structural inequalities that lead to poor health, including putting health and wellbeing at the heart of the design and redesign of cities.

Decision making on health must involve those whose lives are disproportionately impacted by poor health outcomes. For a city to be healthy it needs to centre on the voices of all communities in urban areas and commit to rebalancing the power dynamic that exists in decisions around health. Grassroots organisations and shared spaces deeply rooted in urban communities offer real opportunities to drive health equity. Building trusted relationships with communities, through these places, is a key route to engaging people with health initiatives. For example, Queens Community House and Harlem Children's Zone in New York City demonstrate the reach and influence of anchor organisations and the impact they have on health at every stage of people's lives. Together, we can build an understanding of the barriers to living healthier lives and how to collectively remove them, reducing health inequalities. What is most important though is that health equity cannot be achieved by one organisation or sector alone. Solutions must be multifaceted and, though improved health may be the end goal, they do not always need to start with healthcare.

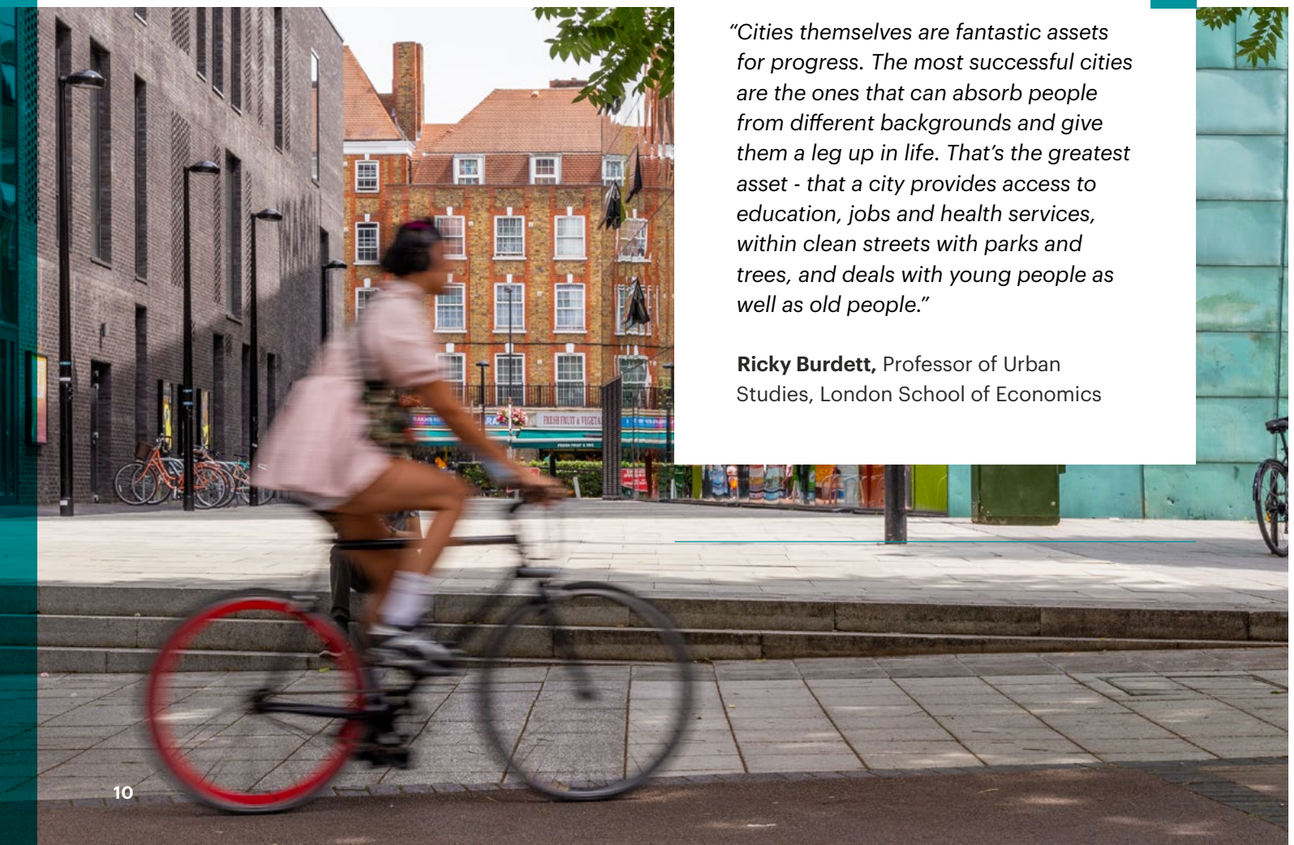
An introduction to health equity in cities

The importance of cities

According to the United Nations, by 2050 nearly 70% of the world's population will live in cities. In the UK, over four in five people already live in urban areas.

Cities sit at the centre of modern life, acting as engines driving wider society, and their ability to generate wealth and opportunity shapes our health. They have potential and resources to provide positive benefits to people of all ages, such as access to education, jobs, health services, supportive communities and transport. However, not all city residents experience or can access these benefits equally and the many positive attributes of cities mask the inequalities that exist within them.

Living in urban areas, like inner-city London, carries distinct health challenges, many of which start early in life and are influenced by the wider determinants of health and wellbeing. The unequal distribution of assets - human, financial and environmental – can be considerable, leading to vastly different health outcomes for residents depending on income, gender and cultural and ethnic background. For example, if you live in an inner-city area in the UK, you are more likely to have low paid employment or be unemployed, be exposed to high levels of air pollution and live with multiple long-term health conditions from an earlier age.



> *"Cities themselves are fantastic assets for progress. The most successful cities are the ones that can absorb people from different backgrounds and give them a leg up in life. That's the greatest asset - that a city provides access to education, jobs and health services, within clean streets with parks and trees, and deals with young people as well as old people."*
>
> **Ricky Burdett,** Professor of Urban Studies, London School of Economics

Understanding health equity

At Impact on Urban Health, when we speak about *health equity* in the context of cities – the places across the world where the greatest health inequities are found - we mean *fair and equal access to the opportunities a city has to offer and protecting the city's most disadvantaged residents from its harmful health impacts*.

Poorer health outcomes are often driven and exacerbated by structural inequalities and track closely to income, race and class.[1] Research into the causes of these health inequalities tends to focus on drivers like class and individual behaviours, with limited research and therefore recognition of the impact of structural racism[2].

People rarely have a single identity or are part of one community. People may be part of different and sometimes overlapping groups, for example based on geography, identity or interests. Yet current data and common narratives often group people into binary groups which do not fully reflect the richness of their lived experience. This limits our understanding of how these differences contribute to health outcomes, creates a unique set of challenges and risks exacerbating inequalities. Seeking to understand the assets and barriers that different intersections bring – for example, class and race or poverty and gender - can reduce the risk that blanket local, city-wide or national policy can have on equitable health outcomes.

Cities are constantly changing. Over time, a city's physical, social and economic environments adapt in response to changing populations. This has the potential to strengthen a city's economic and social resilience and contribute to a country's wider prosperity, but the benefits are not always experienced equally. This ability to respond and change as required presents ideal opportunities to build health equity into the design and redesign of cities over time. However, until recently, the design of modern cities has focused primarily on building infrastructure to house residents and support economic activity. In most cases, these changes have not considered people's health, the importance of place and the complex relationship between them. To have the greatest positive health impact, the design of cities and urban infrastructure needs to start from the perspective of what people and communities need to be healthy and equal.

Emerging lessons from the COVID-19 pandemic

Around the world, the pandemic highlighted the disproportionate impact poor health had on minoritised communities. It reinforced and accelerated the underlying factors driving poor health - particularly systemic inequalities - and intensified the challenges of urban health. If you live in an overcrowded house, travel to multiple jobs on crowded public transport and have little say over your working conditions, the threat of the virus will be much higher. It is also higher if you already have other long-term health conditions. And you are more likely to have one, and at a younger age, if you are Black or from a minoritised community in an urban environment.

Despite being centres of prosperity, culture and opportunity, cities across the world are experiencing a disproportionate share of deaths due to COVID-19. During the first wave of the pandemic in the UK, London was particularly hard hit in comparison to the rest of the country, as were many of the places listed as comparable cities to London within this report. The pandemic has prompted an essential national and international conversation about the inextricable link between health and inequalities.

1 Inequality.org. 'Inequality and Health'. www.inequality.org/facts/inequality-and-health, **2** Saffron Karlsen. Ethnic Inequalities in Health: the impact of racism. Race Equality Foundation. 2007. raceequalityfoundation.org.uk/wp-content/uploads/2018/03/health-brief3.pdf

Methodology

This report focuses on what we can learn across cities, both in the UK and internationally, about how to remove barriers to health equity and improve health on a global scale.

Recognising the potential for cross-city learning, this report set out to explore how different cities across the world are approaching urban health, learning from what is working well and sharing key observations that can be applied in other places.

While historical and social context is important to how inequalities play out in each place, this research identified common themes in some of the solution-focused approaches the world's leading cities are taking to achieve health equity.

Using data

The UN Habitat's City Prosperity Initiative (CPI); a composite index that measures a city's overall achievements in key areas, including prosperity, infrastructure development and quality of life, was used to identify urban places across the globe with similar characteristics to London in the UK, in terms of population density, diversity and income. This provided a consistent and carefully constructed sample of cities and their characteristics. To find cities around the world that might have comparable neighbourhoods to Lambeth and Southwark, Euclidean distance analysis[3] was then applied to the UN's open cities dataset. Based on this CPI data, cities were ranked for closest comparison to London, the boroughs of Lambeth and Southwark and the specific neighbourhoods Impact on Urban Health works in.

However, the CPI data did not allow us to compare and measure diversity and cultural mix at a global level. What is considered diversity in London and the UK, may not look the same elsewhere in the world. We focused on ethnic and cultural diversity and proxies that looked at the percentage of foreign-born populations and number of non-native languages spoken[4].

Our final cities

This data analysis gave us a list of ten cities from across the world, each undertaking interesting urban health initiatives.

Those that are the closest comparators to London:

- Melbourne, Australia
- Mexico City, Mexico
- New York, USA
- Paris, France
- São Paulo, Brazil
- Shanghai, China
- Toronto, Canada

Those that are the closest comparators to Lambeth and Southwark, in terms of similar sized populations and poor health outcomes:

- Detroit, USA
- Glasgow, Scotland

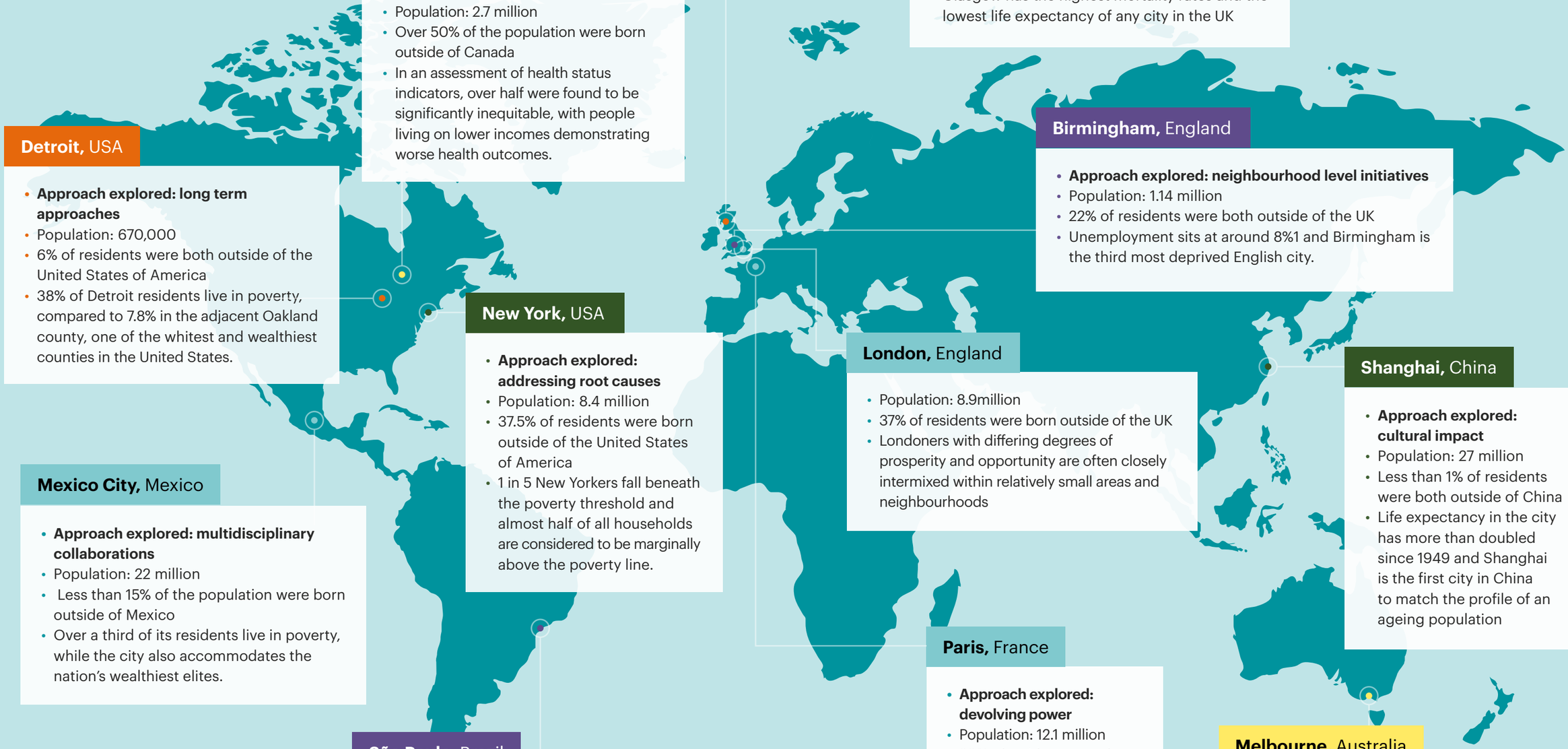
One city that contains the most similar neighbourhoods to Lambeth and Southwark:

- Birmingham, England

Though not an exhaustive list, we identified innovative initiatives designed to have a positive impact on urban health in each of these cities.

3 In general terms, distance metrics used in both supervised and unsupervised machine learning, generally to calculate the similarity between data points. Euclidean Distance represents the shortest distance between two points. **4** We looked at the differences between migrant and indigenous populations or in the case of countries like America and Australia, difference between the migrant white-European populations (ethnic majority) and the migrant and indigenous non-white populations (ethnic minorities).

City Profiles



Toronto, Canada

- **Approach explored: data led initiatives**
- Population: 2.7 million
- Over 50% of the population were born outside of Canada
- In an assessment of health status indicators, over half were found to be significantly inequitable, with people living on lower incomes demonstrating worse health outcomes.

Glasgow, Scotland

- **Approach explored: community health**
- Population: 633,000
- 15% of residents were born outside of Scotland
- Glasgow has the highest mortality rates and the lowest life expectancy of any city in the UK

Detroit, USA

- **Approach explored: long term approaches**
- Population: 670,000
- 6% of residents were both outside of the United States of America
- 38% of Detroit residents live in poverty, compared to 7.8% in the adjacent Oakland county, one of the whitest and wealthiest counties in the United States.

Birmingham, England

- **Approach explored: neighbourhood level initiatives**
- Population: 1.14 million
- 22% of residents were both outside of the UK
- Unemployment sits at around 8%1 and Birmingham is the third most deprived English city.

New York, USA

- **Approach explored: addressing root causes**
- Population: 8.4 million
- 37.5% of residents were born outside of the United States of America
- 1 in 5 New Yorkers fall beneath the poverty threshold and almost half of all households are considered to be marginally above the poverty line.

London, England

- Population: 8.9million
- 37% of residents were born outside of the UK
- Londoners with differing degrees of prosperity and opportunity are often closely intermixed within relatively small areas and neighbourhoods

Shanghai, China

- **Approach explored: cultural impact**
- Population: 27 million
- Less than 1% of residents were both outside of China
- Life expectancy in the city has more than doubled since 1949 and Shanghai is the first city in China to match the profile of an ageing population

Mexico City, Mexico

- **Approach explored: multidisciplinary collaborations**
- Population: 22 million
- Less than 15% of the population were born outside of Mexico
- Over a third of its residents live in poverty, while the city also accommodates the nation's wealthiest elites.

São Paulo, Brazil

- **Approach explored: cross sector partnerships**
- Population: 12 million
- 30% of residents identifying as multiracial and 6.5% as Black
- Nearly a third of São Paulo's population, around 3 million people, live in urban favelas.

Paris, France

- **Approach explored: devolving power**
- Population: 12.1 million
- 20% of residents were born outside of France
- The city is highly segregated by both race and income.

Melbourne, Australia

- **Approach explored: reshaping the built environment**
- Population: 4.8 million
- 41% of residents were born outside of Australia
- Melbourne has the greatest wealth gap of any city in Australia

Global perspectives on approaches to health inequality in cities

The central London boroughs of Lambeth and Southwark are our home. We take a place-based approach to improving urban health, working in partnership to tackle the complex health issues that impact on people and communities in our place. Throughout this report, we will explore how ten cities around the world are tackling similar health challenges and share examples of action we are taking to drive better health where we work.

London, England

Comprised of 33 local boroughs, London is home to 8.9 million people[5]. In 2000, the city's political organisation was restructured with the Greater London Authority (GLA) and a directly elected Mayor. Over the last 20 years, London has experienced significant economic and population growth, fuelled by migration and natural birth rate increases. One of the most multicultural cities of the Global North, 37% of London residents were born outside the UK[6] and minority ethnic populations are projected to grow significantly within the next decades.

Covering around 1,500 square kilometres, London is significantly less dense than otherwise comparable global cities at 5,701 people per square kilometre[7], reflecting a generous provision of parks and gardens, and the low-rise nature of its terraced housing stock. It has a relatively organic and unplanned urban structure, organised around a number of urban villages which define London's residential communities. Denser central business districts with a new generation of taller towers have been established in well-connected areas including the City of London (Square Mile), the West End and Canary Wharf. Public housing estates from different generations are interspersed in the city's urban fabric, defined by linear high streets with local shops and amenities.

5 Office for National Statistics. 'Population estimates for UK, England, Wales, Scotland, and Northern Ireland' 2020. www.ons.gov.uk/datasets/mid-year-pop-est/editions/mid-2019-april-2020-geography/versions/1 **6** Office for National Statistics. 'Population of the UK by country of birth and nationality'. 2020. www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/internationalmigration/datasets/populationoftheunitedkingdombycountryofbirthandnationality **7** Office for National Statistics. 'Population estimates for the UK, England and Wales, Scotland and Northern Ireland: mid 2019.' www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2019

Neighbourhood snapshot: **Lambeth and Southwark**

- **Population density:** the boroughs are around twice as densely populated as the London average (estimated 12,000 people per square km in Lambeth, and 9,988 people per square km in Southwark)[13]
- **Diversity:** 3 in 5 people in Lambeth describe their ethnicity as other than white British;[14] almost 1 in 3 of the population of Southwark are from a minority ethnic background[15]
- **Poverty:** Around 1 in 3 people in Lambeth and Southwark live in poverty

London ranks as one of the most expensive cities in the world, yet it also houses highly deprived communities. While deprivation is mostly concentrated in parts of East and South London, with more affluent residents to the West and around the periphery, there is no direct spatial correlation between race, class and deprivation as can be found in many large cities today. Despite significant levels of wealth inequality within the population - 62% of total wealth ownership in London is owned by the wealthiest 10% - Londoners with differing degrees of prosperity and opportunity are often closely intermixed within relatively small areas and neighbourhoods.

The socioeconomic and cultural diversity of London's population, coupled with reverberations of Great Britain's history as a strong welfare state, have produced a complex, and at times contradictory, set of public health outcomes in the current urban health landscape. London has a strong history of public health provision, beginning in the nineteenth century with the creation of a state-of-the-art sanitation system and defined by the introduction in 1948 of the National Health Service (NHS) and universal healthcare provision[8].

These overarching characterisations of health and health provision in the UK mask highly variated and unequal health outcomes between London's neighbourhoods. Life expectancy varies widely across the city, with residents of wealthier London boroughs living up to five years longer than their counterparts in less affluent areas. This difference becomes even more pronounced when considering healthy life expectancy, or the average number of years a person would expect to live in good health. This increases to an expectancy difference of 16 years between those in higher and lower income boroughs[9]. Health disparities are also stark between ethnic and cultural groups, with Black and South Asian residents (who make up a third of the city's overall population[10]) having demonstrably worse health outcomes on nearly all key measures[11]. While these outcomes can be linked to higher levels of economic and overall deprivation for ethnic minorities, COVID-19 research suggests that a health system that does not adapt and respond to cultural differences, creates barriers and disincentivises marginalised groups from accessing essential health services[12].

Lambeth and Southwark are inner-city boroughs that are vibrant places to live, work, age and grow. The physical landscape, infrastructure and population of both boroughs are changing all the time. Around 600,000 people live here; roughly the same population size as Glasgow in Scotland or Boston in the US. Both boroughs are densely populated and have a rich and complex social and ethnic mix with over 100 different languages spoken and large Black and LGBT+ communities. Like much of London, areas of affluence and poverty are in close proximity.[16]

There are a range of local health challenges including a prevalence of respiratory problems and cardiovascular disease linked to poor air quality[17], of childhood obesity and of people living with multiple long-term conditions, often with a shorter and very poor quality of life.[18]

100
different languages spoken in Lambeth and Southwark

600k
people living in Lambeth and Southwark

37%
of London residents were born outside the UK

5,701
people living per square kilometre in London

8 Adam Oliver. Reflection on the Development of Health Inequalities Policy in the United Kingdom. LSE Health. October 2008. www.lse.ac.uk/lse-health/assets/documents/working-paper-series/LSEHWP11.pdf **9** Public Health England. Health inequalities in London. 2015. assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/467805/Health_inequalities_in_London_Oct_15.pdf **10** Office for National Statistics. 2011. www.nomisweb.co.uk/census/2011/QS201EW/view/2013265927?cols=measures **11** Mohammed Razai. 'Mitigating ethnic disparities in covid-19 and beyond.' BMJ. January 2021. www.bmj.com/content/372/bmj.m4921 **12** Mohammed Razai. 'Mitigating ethnic disparities in covid-19 and beyond.' BMJ. January 2021. www.bmj.com/content/372/bmj.m4921 **13** Southwark Council. 'Census 2011 briefing'. www.southwark.gov.uk/council-and-democracy/statistics-and-census/census-2011-briefing **14** Lambeth Council. Demography factsheet. May 2017. www.lambeth.gov.uk/sites/default/files/ssh-demography-factsheet-2017.pdf **15** Overview of Southwark, Southwark Giving **16** Guy's and St Thomas' Charity. Personal perspectives on urban health and wellbeing. 2017. urbanhealth.org.uk/insights/reports/personal-perspectives-on-urban-health-and-wellbeing **17** World Health Organisation. 'Ambient air pollution.' www.who.int/teams/environment-climate-change-and-health/air-quality-and-health/ambient-air-pollution **18** Dr Maria Kordowicz. Understanding Multiple Long-Term Conditions & Community Assets in Lambeth & Southwark. School of Population Health and Environmental Sciences, King's College London. 2018.

Devolving power: Paris, France

One of Paris's approaches to addressing urban health is devolving power. The city does this by enabling people across the city to make decisions about how public money is spent, this resulted in the the city choosing to support projects focused on health improvements, not only in their own neighbourhoods, but city-wide.

Between 2014 and 2020, the City of Paris committed 500 million euros of public money (about 5% of the city's capital fund) to be spent on projects chosen by the city's residents. Participatory budgeting is open to everybody in Paris, regardless of age, nationality or documentation. It enables people to make decisions on how public money is spent, to develop proposals for their city and to communicate with the administration and municipal service experts.

Each of Paris's twenty Districts decide on local projects, as well as one city-wide initiative. There is also a commitment to direct 30 million euros into working-class neighbourhoods in the city. Analysis of the projects shows that they are spread over the entire territory of the city, with a high concentration in the lower income areas of central Paris and fewer projects in affluent neighbourhoods of the West. Successful health-related projects include:

- 3,000 survival and health kits distributed to the homeless
- Establishing a refuge shelter for migrants
- New public gardens and pedestrian areas
- More co-working spaces and sports facilities.

20%

of the population born outside of France

150+

nationalities are represented within the wider city

> *"We worked with a community-based organisation who became our ambassadors in the field. They ran workshops for people to build ideas for improving their urban environment. We were committed to answering everybody: if a project was rejected, we would give an explanation as to why the project was not possible. This was very important for the education of the people; they need to understand how the system works. It's something that works and it's important that you let people know that new things in the city are thanks to them."*
>
> **Julien Antelin**, Director of Innovation at the Department of Neighbourhood Empowerment for the City of Los Angeles and formerly chief of staff for the Deputy Mayor of Paris, France.

Political leadership was key to this initiative's success. The Mayor of Paris was a strong advocate of the approach, throwing weight behind it and enabling those delivering it to push the boundaries. The City realised it was important not only to inform people about the initiative, but to engage them at every stage, so they used existing community networks to provide clear feedback about the chosen projects.

A key reflection of this project was that, when given the choice, people often direct resources to neighbourhoods with the greatest levels of need. People voted for projects even if they didn't live there. They didn't want to just improve their own street; they want to improve the whole city.

About Paris

The Greater Paris Region accommodates a population of 12.1 million, making it the most populous metropolitan region in Europe, even though the Ville de Paris (the City of Paris) had just under 2.2 million residents, roughly a quarter of London's population in 2019. Inner Paris, which makes up 19% of the overall region, has a high population density, nearly four times as high as London[19].

The capital has long been the central point of immigration in France, initially due to the historic concentration of industrial work. Today, Paris is the second most multicultural city in Europe, with 20% of the population born outside France and more than 150 nationalities represented within the wider city[20]. Paris's racial diversity is more challenging to quantify due to French law, which prohibits distinguishing between people on the basis of race or religion. This 'colour-blind' model of public policy largely limits policies targeted at racial or ethnic groups, as well as research into population differences and disparities[21].

Paris differs from London's more organic spatial organisation with a formally planned inner-city core (defined by Haussmann's mid-19th century interventions) and mid-late 20th century more fragmented outer core beyond the city's ring road Boulevard Périphérique. The city is highly segregated by both race and income. The western neighbourhoods are inhabited by affluent French-Parisians or international elites, while the southern and north-eastern suburbs (banlieues) are home to a high proportion of residents of foreign origin, and also have high levels of crime, unemployment and social deprivation.[22] Seine-Saint-Denis, the 'department' which encompasses a number of north-eastern suburbs, illustrates the challenges faced by communities and residents in the banlieues.

In 2016, 30% of the department's residents were immigrants and an additional 28% of adult residents were descendants of immigrants[23]. Seine-Saint-Denis has twice the national unemployment rate and more than a quarter of its population live beneath the poverty line[24]. Overcrowded social housing, cultural and language barriers and limited access to public transport to other parts of the city with higher paying jobs, contribute to lower overall health outcomes in the banlieues like Seine-Saint-Denis compared to less deprived Parisian neighbourhoods[25]. Seine-Saint-Denis, for example, has the highest rate of diabetes in mainland France[26] and life expectancy in western Paris is greater than in the poorer northern departments[27].

In 2016, 30% of the department's residents were immigrants and an additional 28% of adult residents were descendants of immigrants. Seine-Saint-Denis has twice the national unemployment rate and more than a quarter of its population live beneath the poverty line.

Healthcare in France is well-regarded and designed to provide accessible medical treatment to all through scaled government reimbursements for healthcare costs[28]. Nevertheless, state bureaucracy and the system of co-payments can ostracise the more deprived residents and recent immigrants. Additionally, healthcare providers have increasingly concentrated in more affluent sections of the city, requiring poorer residents to travel greater distances to receive specialised care. The impacts of these structural inequalities have become particularly clear during the COVID-19 pandemic, with lower-income neighbourhoods experiencing significantly higher overall mortality rates compared to previous years[29].

19 Le Grand Paris. 'The Greater Paris Region Demography.' www.grand-paris.jll.fr/en/paris/demography **20** OECD "Migration Snap-shot of the city of Paris", in Working Together for Local Integration of Migrants and Refugees in Paris, OECD Publishing, Paris. 2018. https://doi.org/10.1787/9789264305861-6-en. **21** Erik Bleich. 'Race Policy in France.' Brookings. May 2001. www.brookings.edu/articles/race-policy-in-france/ **22** 'Paris: A Model of Economic Inequality'. Borgen magazine. 4 August 2014. www.borgenmagazine.com/paris-model-economic-inequality/ **23** INED. 'Excess COVID-19-related mortality in France's Seine-Saint-Denis department.' July 2020. www.ined.fr/en/everything_about_population/demographic-facts-sheets/focus-on/excess-mortality-due-to-covid-19-seine-saint-denis-invisibility-of-minorities-in-the-figures/ **24** Julia Dumont and Sam Ball. 'Saint-Seine-Denis: France launches plan to rescue its poorest suburb.' France 24. 31 October 2019. www.france24.com/en/20191031-seine-saint-denis-france-launches-plan-to-rescue-its-poorest-suburb **25** INED. 'Excess COVID-19-related mortality in France's Seine-Saint-Denis department.' July 2020. www.ined.fr/en/everything_about_population/demographic-facts-sheets/focus-on/excess-mortality-due-to-covid-19-seine-saint-denis-invisibility-of-minorities-in-the-figures/ **26** Arno Pedram. 'Virus exposes economic, racial divide in French healthcare.' AP News. 13 August 2020. apnews.com/article/ap-top-news-race-and-ethnicity-understanding-the-outbreak-paris-immigration-0c3f1ae72ca05f66f4916d28f0962a87 **27** Magali Barbieri. Mortality in France by department. INED. 2013. www.ined.fr/fichier/s_rubrique/22051/2013_3_france_mortality_by_departement.en.pdf **28** Jean-Francois Briere. 'The French Health Care System.' PNHP. pnhp.org/news/the-french-health-care-system/ **29** Arno Pedram. 'Virus exposes economic, racial divide in French healthcare.' AP News. 13 August 2020. apnews.com/article/ap-top-news-race-and-ethnicity-understanding-the-outbreak-paris-immigration-0c3f1ae72ca05f66f4916d28f0962a87

Cross sector partnerships: São Paulo, Brazil

In São Paulo, we researched how cross-sector partnerships and collaboration are at the heart of successful initiatives to address global health concerns like hypertension. Learning first from local intelligence, solutions are developed, and partners involved to expand reach and impact.

Facilitating public collaboration and community ownership was a key component in engagement at every level, from policy makers to communities and local people. Dealing with complex health issues, such as hypertension and cardiovascular disease, requires collaboration across the system. Connecting stakeholders in urban communities can help them to collectively own solutions and carry them forward in the long term. Non-government organisations can act as active facilitators, helping to broker effective relationships across the system to improve health outcomes.

> *"Belonging is a key condition – health service teams users need to buy into the project and see it as an advantage for the citizens. If managers or decision makers are not convinced they could hinder or block the project. It is important to keep re-engaging and designing with them, and practice active listening to understand political priorities. One of the main learnings was that we have to understand how they can own the solutions developed without dependency, by connecting different stakeholders and governance models to ensure their sustainability and replicability become more independent."*
>
> **Germano Guimarães**, Co-Founder and CEO of Tellus Group

Initiatives explored: Better Hearts Better Cities

Working with local authorities and partners from different sectors, the Novartis Foundation's Better Hearts Better Cities initiative addressed hypertension – the leading risk factor for cardiovascular diseases – by testing pioneering models and initiatives that achieved impact at scale. In each participating city, it built networks of partners that reached beyond the health sector and focused on prevention, engaging the community through co-creation and improving quality of care delivery in the healthcare system, summarized in the Foundation's CARDIO-approach. Solutions are designed based on insight gathered from users and public employees at workshops, unlocking local intelligence, before expanding on a larger scale. Partners included city governments, healthcare providers, but also digital and telecommunication organisations, food suppliers, employers, insurance funds, social enterprises and civil societies.

> *"The Novartis Foundation is an accelerator for public health interventions, particularly in areas where governments are without human, financial and time resources to initiate change and look into change components. The foundation wanted to be a spark in these multidisciplinary partnerships and support networks to continue engaging governments in multidisciplinary activities."*
>
> **Johannes Boch,** Director of Access and Urban Health at the Novartis Foundation

The Novartis Foundation selected the São Paulo-based Tellus Group as their implementation partner on the ground. Grupo Tellus aims to generate social impact through innovation and design of public services. They work directly with different stakeholders from street level to government.

Better Hearts Better Cities worked. In São Paulo, preliminary data showed that blood pressure control nearly tripled after just 18 months of implementation. This is important given that uncontrolled high blood pressure is a leading risk factor for stroke, heart attacks and heart failure and directly impacts mortality and morbidity.

Led by the Municipal Health Secretariat of São Paulo, the initiative has achieved this by engaging and building a common focus of multi-sector partners towards health, impacting primary health delivery and management and engaging communities in the care process, prevention, healthy living and well-being. This cross-sector approach has brought more and different people into primary care to monitor their blood pressure through engaging activities which appeal to wider groups. Overall, the improvements in management of NCDs at primary care level, guided by the newly developed, official treatment protocol "Caring For All", have led to better prevention, monitoring of patients and disease as well as data-based measuring of progress.

> *"Co-creating helped us to understand that we could reach people through culture and arts. We've been having really good results with young people and adults. We promoted a samba contest with a local samba school, [who are] important influencers in the region to attract men who aren't regular users of primary clinics.. We invited young poets to write about heart health and blood pressure, in a way that engages other young people in the importance of self-care."*
>
> **Mariana Silveira,** Better Hearts Better Cities Coordinator at Tellus Group

Impact on Urban Health's cross sector, scalable approach

13%

more fruit and vegetables sold

22%

fewer packets of confectionary sold

Food and drink retailers and manufacturers collaborated on 34 trial interventions in over 200 grocery stores in Lambeth and Southwark, designed to improve the healthiness of consumer baskets for families living on low incomes. The trials included changes to pricing and promotions, availability, choice architecture, shelf and nutritional labelling, as well as social feedback techniques.

A University of Oxford evaluation of the trials found that companies were able to influence the healthiness of consumer shopping baskets, achieving impact through simple and commercially sustainable actions. The most successful trials used pricing and promotional tactics and increased the availability of healthier options, though some choice architecture trials have also shown a significant and positive impact.

It concluded that we need to both increase the purchase of healthier foods and decrease the purchase of less healthy foods are required to support healthier diets. Results from successful trials included 13% more fruit and vegetables sold and 22% fewer packets of confectionary sold.

About São Paulo

Home to 12 million residents[30], São Paulo is the most populous city in Brazil and one of the biggest metropolitan areas in the world with over 20 million inhabitants. Larger than London in both size and population, São Paulo has the highest GDP in Latin America and is an influential centre of commerce, finance, arts and entertainment, both regionally and globally. It is Brazil's most multicultural city, with a history of immigration and large communities of Arab, Italian, Japanese, and Portuguese residents. One survey[31] estimates that São Paulo is a majority white city (60%), but still quite diverse with 30% of residents identifying as multiracial and 6.5% as Black. Brazil's system of racial classification is controversial: many Brazilians do not identify with any of the[32] categories, resulting in a variety of sometimes contradictory measures to identify and understand differences between racial and ethnic groups[33].

São Paulo is characterised by the extreme polarisation between its ultra-low and ultra-high-income populations. While rates of poverty are actually lower in relative terms compared to London (19%[34] in São Paulo compared to 28%[35] in London[36]), what poverty looks like in São Paulo is very different. Nearly a third of São Paulo's population, around 3 million people, live in slum-like conditions[35]. These favelas, or informal settlements, appeared in the 1990s as housing became too expensive for many of the city's residents and have rapidly expanded out from the city centre. While these informal settlements have access to some municipal systems,[37] rates pose significant health risks to a large portion of the city's population.[38]

Health inequality, particularly between different socioeconomic groups, has been a long-standing challenge in Brazil and S ã o Paulo, but concerted efforts to address these disparities have improved access to healthcare[39]. Nearly half of Paulistanos access healthcare primarily through universal government coverage and between 2001 and 2012 the city saw a significant level of expansion of public health services specifically in marginalised areas. Although concerns remain regarding the quality of service received compared to private health providers. Clinical and environmental factors still limit the access and quality of health services and overall opportunity for wellbeing for S ã o Paulo's most deprived residents.[40] Living in less well-off areas outside the city core have higher relative risks of mortality from circulatory system diseases, are less likely to have[41] stores[42] and have higher rates of exposure to vehicle-related air pollution[43].

Brazil's government-run health system has been severely overburdened during the pandemic. This is due to a combination of insufficient funding and disproportionately serving those populations which are most vulnerable to COVID-19. This overburdening may threaten future access to consistent and high-quality care for those who rely on it[44].

20m

inhabitants in São Paulo, Brazils most populous city

80%

of the population is descended from foreign immigrants

30%

of residents identify themselves as multiracial

~3m

of the population live in slum-like conditions

30 World Population Review 'SãoSão Paulo population 2021'. worldpopulationreview.com/world-cities/São-paulo-population **31** https://worldpopulationreview.com/world-cities/São-paulo-population **33** Mara Loveman, Jeronimo O. Muniz & Stanley R. Bailey. Brazil in black and white? Race categories, the census, and the study of inequality, Ethnic and Racial Studies, 35:8, 1466-1483. 2012. DOI: 10.1080/01419870.2011.607503 **34** The Borgen Project. '10 facts about living conditions in Brazil. September 2016. borgenproject.org/tag/poverty-in-brazil/#:~:text=São%20Paulo%20is%20known%20as,the%20rich%20and%20the%20poor. **35** Trust for London. 'London's Poverty Profile 2020.' www.trustforlondon.org.uk/publications/lpp2020 **36** Fernando Serpone Bueno and Veridiana Sedeh. 'Improving Slums: Stories from SãoSão Paulo.' World Bank Blogs. 29 June 2011. **38** Francesco Chiodelli. 'SãoSão Paulo, the Challenge of the Favelas.' Planum Magazine. www.planum.net/francesco-chiodelli-São-paulo-the-challenge-of-the-favelas **39** Monteiro, Camila Nascimento, Beenackers, Mariëlle A., Goldbaum, Moisés, Barros, Marilisa Berti de Azevedo, Gianini, Reinaldo José, Cesar, Chester Luiz Galvão, & Mackenbach, Johan P. 'Use, access, and equity in health care services in São Paulo, Brazil'. Cadernos de Saúde Pública. Epub May 18, 2017.https://doi.org/10.1590/0102-311x00078015 **40** Ligia Vizeu Barrozo, Michel Fornaciali, Carmen Diva Saldiva de André, Guilherme Augusto, Zimeo Morais, Giselle Mansur, William Cabral-Miranda, Marina Jorge de Miranda, João Ricardo Sato, Edson Amaro Júnio. 'GeoSES: A socioeconomic index for health and social research in Brazil.' Plos One. 2020. https://doi.org/10.1371/journal.pone.0232074 **41** Duran AC, Diez Roux AV, Latorre Mdo R, Jaime PC. 'Neighbourhood socioeconomic characteristics and differences in the availability of healthy food stores and restaurants in São Paulo, Brazil.' Health Place. 2013. pubmed.ncbi.nlm.nih.gov/23747923/ **42** Habermann, Mateus, Souza, Míriam, Prado, Rogério, & Gouveia, Nelson. 'Socioeconomic inequalities and exposure to traffic-related air pollution in the city of São Paulo, Brazil.' Cadernos de Saúde Pública, 2014. https://doi.org/10.1590/0102-311X00168412 **43** Monica Malta, Laura Murray, Cosme Marcelo Furtado Passos da Silva, Steffanie A Strathdee. 'Coronavirus in Brazil: the heavy weight of inequality and unsound leadership.' The Lancet. 24 July 2020. www.thelancet.com/journals/eclinm/article/PIIS2589-5370(20)30216-9/fulltext

Multidisciplinary collaborations: Mexico City

Mexico City is committed to taking a multidisciplinary approach to urban health. By bringing together experts from many different sectors with activists, academics, local communities, politicians and businesses, they together devised creative and sustainable solutions to the city's health challenges.

While political will and leadership is important, bringing activists, communities and civil society into the design and development of solutions can help the city survive political cycles. Dispersing leadership by bringing together a diverse ecosystem of people from across organisational boundaries, disciplines and sectors can help to embed change and build creative solutions that can be carried forward in the long term.

Initiatives explored: Laboratorio para la Ciudad

Laboratorio para la Ciudad was an experimental and creative area of the government of Mexico City that ran from 2013 to 2018. It provided a space in which local people, civil society, academia, private initiatives and government met to tackle urban challenges. The Lab explored urban creativity with the aim of generating participation, collaboration and co-creation with people and communities.

The Lab's methodology was to design, disseminate and promote the adoption of creative solutions to urban challenges. It formed six teams, composed of non-governmental organisations, activists and universities. It then created a portfolio of experiments, each focused on an urban challenge, that a multidisciplinary community worked together to tackle. These experiments included:

- Pedestrian City which dealt with issues around mobility
- Open City which looked at democracy and governance
- Playful City which asked how can you use play as a city making tool and bring in a children's perspective?
- Participatory City which focused on revamping participatory budgeting in Mexico City
- Creative City which invited groups from the arts and humanities to share their creative perspective on how to build bonds in the urban landscape.

"Mexico City affords a lot of variety because every neighbourhood changes drastically from one to the other; so many different types of societies are there. This is very much a melting pot of all of Mexico. We have indigenous communities represented from almost every state.

"I had a team of 20 people, half of them came from the urban political science realm and half from arts, culture and humanities. We had urban geographers, political scientists, AI experts, civic tech experts and sociologists working hand in hand with writers, historians, philosophers, artists, designers, filmmakers, architects, urbanists and futurists. The reason we sat in between these two spaces was, though we definitely need to understand the objective realities of cities, we have to layer our stable built environment and this objective data with the messiness of the human heart. There is so much that happens in the meeting space between both."

Gabriella Gomez-Mont, Laboratorio Para la Ciudad, Mexico City

How has this approach supported improvements in health?

This multidisciplinary approach gave sustainability and stability to initiatives. While the Lab did not survive a change in government, many of its projects were continued and scaled by activists, communities and partner organisations. One of the many health-related projects identified where public space was needed in the city. The Lab came up with a framework for how to work with communities to create public space out of nothing and that work continues to be carried forward. The road safety plan has had a huge impact on the number of road-related deaths in the city and is being scaled nationally by local activists in partnership with the Senate. Similarly, the constitution that the Lab helped to develop is still the most important document in the city.

> *"A benefit of working with other organisations is that, even with a change of government, civil society is still there. So much of the unspoken bridge of policy from one government to another, is in having robust communities. Bringing in the activists was actually a benefit to the road safety policy. In hindsight, they have been the ones who have preserved and pushed for the continuation of the policies we created together and also taking them to scale."*
>
> **Gabriella Gomez-Mont**, Laboratorio Para la Ciudad, Mexico City

About Mexico City

Mexico City accommodates nearly 22 million people, representing close to 20% of Mexico's national population[45]. For many years it was the largest metro region in the world, even though its administrative jurisdiction straddles different political boundaries of the State of Mexico and the former Distrito Federal. Known officially as Ciudad de México (or CDMX), the city has a similar population size to London who live at higher, though relatively low-rise, density (at 15,600 people per square kilometre[46]).

The city is described as a 'melting pot of all of Mexico' with 18.7% of the population representing resident indigenous communities from nearly every Mexican state[47]. A 2015 study undertaken by the National Institute of Statistics and Geography estimated that the population was 47% white, 30% unclassified/Mestizo, 21% indigenous and 1% Black. However, it is worth noting that Mexico does not collect official census data on ethnicity and shifting definitional categories produce highly variable estimates depending on the source[48]. Mexico City also has a high population of foreign-born residents, primarily from South and North America, and is home to the highest number of Americans outside of the United States[49].

Mexico City is a highly unequal city, both socially and spatially. Over a third of its residents live in poverty, while the city also accommodates the nation's wealthiest elites[50]. This difference is visible in the fabric of the city itself, where upscale Spanish-influenced residential neighbourhoods and modern financial districts contrast with quasi-informal settlements often located on the fringes of the vast city[51]. A 2019 study found that residents in wealthier districts had 113 times better access to public hospital beds, 21 times better access to public transport and 1.5 times better access to food supply facilities, as compared to residents in poorer districts[52].

Environmental factors also affect the health and wellbeing of Mexico City residents in unequal ways. It has more rainy days per year than London, and an old, inadequate sewer and water processing system results in regular flooding of some of the lowest-income neighbourhoods. That same system then generates shortages of drinkable water which drive up the price per litre to one of the highest in the world, thus making it unaffordable to many people living in low-income communities.

Currently, the Mexican health sector is implementing public policies that tackle the social determinants of health, mainly to reduce health inequities. However, only a few of these policies involve other sectors and barriers such as government effectiveness and leadership, as well as limited research and data for decision making, remain significant challenges.

20%
of the national population live in the city

18.7%
of the population represent indigenous communities

>1/3
of residents live in poverty

113x
better access to hospital beds in wealthier areas

45 World Population Review. 'Mexico City Population 2021.' worldpopulationreview.com/world-cities/mexico-city-population **46** World's capital Cities. 'Capital facts for Mexico City, Mexico.' www.worldscapitalcities.com/capital-facts-for-mexico-city-mexico/ **47** Indigenous Mexico. 'The Indigenous People of Mexico City:1895-2010.' 2019. indigenousmexico.org/mexico-city/the-indigenous-people-of-mexico-city-1895-2010/ **48** INEGI. 'Principales resultados de la Encuesta Intercensal 2015.' www.inegi.org.mx/app/biblioteca/ficha.html?upc=702825079246 **49** World Population Review. 'Mexico City Population 2021.' worldpopulationreview.com/world-cities/mexico-city-population **50** Alicia Ziccardi.' Poverty and urban inequality: the case of Mexico City metropolitan region.' International Social Science Journal. 2016. igop.uab.cat/wp-content/uploads/2018/05/4_Ziccardi-2014-International_Social_Science_Journal.pdf **51** Alejandra Maria Leal Martinez. 'Mexico City'. Oxford Bibliographies. 2020. www.oxfordbibliographies.com/view/document/obo-9780190922481/obo-9780190922481-0010.xml **52** Mauricio Brito, Lorelei Ramirez Reyes, Jorge Macias and Eric Mackres. 'From Jobs to Education, Inequality in Mexico City is About Access.' The City Fix. 7 June 2019. thecityfix.com/blog/map-month-mobility-health-education-inequality-mexico-city-spatial-problem-mauricio-brito-lorelei-ramirez-reyes-jorge-macias-eric-mackres/

Cultural impact: Shanghai, China

In Shanghai we saw how the city's approach to urban health recognises the significance of social and cultural factors on health. By considering the importance of culture, the city is learning how to break down barriers to good health and create solutions tailored to the needs of specific groups.

Understanding the influence of social and cultural factors on health in cities is vitally important. This initiative made the clear distinction between culture and ethnicity; a finding that has clear implications for cities with high levels of ethnic and cultural diversity. Many of the barriers to good health encountered in this initiative related to culture - generational differences, habit and conventions that changed as people move and migrate within countries. A finding that has clear implications for cities with high levels of ethnic and cultural diversity.

As with any collaboration, reflective practice was key and even more important when exploring the nuances and unspoken rules of culture. By developing a shared framework and a willingness to reflect on emerging lessons, the team were able to adapt practices.

> *"There are cultural paradigms that encourage withdrawal in a lot of people in Shanghai. You have a city already that's incredibly populated, it isn't easy to make connections. Bear in mind all of these transitions and changes and add to it a stigma around a condition which gets people to withdraw or not talk about it, and that of course stigmatises the condition even more."*
>
> **Anna-Maria Volkmann,** UCL Research Lead, Cities Changing Diabetes, Shanghai and Mexico City

Initiatives explored: Cities Changing Diabetes

Cities Changing Diabetes is a partnership programme launched by Novo Nordisk, University College London (UCL) and the Steno Diabetes Center. It explores the cultural and social factors driving type 2 diabetes in urban contexts and creates solutions according to local needs. Research by the University and local academic teams inform interventions locally. A distinctive feature of their approach is its engagement with culture and how cultural paradigms affect the way that people interact with spaces and services.

> *"It's really shifted the conversation. By pushing the word culture into mainstream discussions about diabetes, there is more conversation about social and cultural determinants than there ever has been."*
>
> **Anna-Maria Volkmann,** UCL Research Lead, Cities Changing Diabetes, Shanghai and Mexico City

How has this approach supported improvements in health?

11.3% of the adult population (aged 20-79) in Shanghai has diabetes and the prevalence is projected to reach 18.2% in 2045 if action is not taken[53]. The National Office for Diabetes Primary Care in Shanghai has created a network of directors of community health centres and primary care physicians. They meet regularly to improve the prevention and control of diabetes in community health centres.

Standard diabetes treatment and referral guidelines have been created and shared, while more than 2,000 healthcare professionals, including primary care physicians and nurses, have received training at over 240 community health centres in Shanghai. The programme has helped to create a unified approach to caring for people with diabetes and has also improved communication between policy makers and healthcare services in the city.

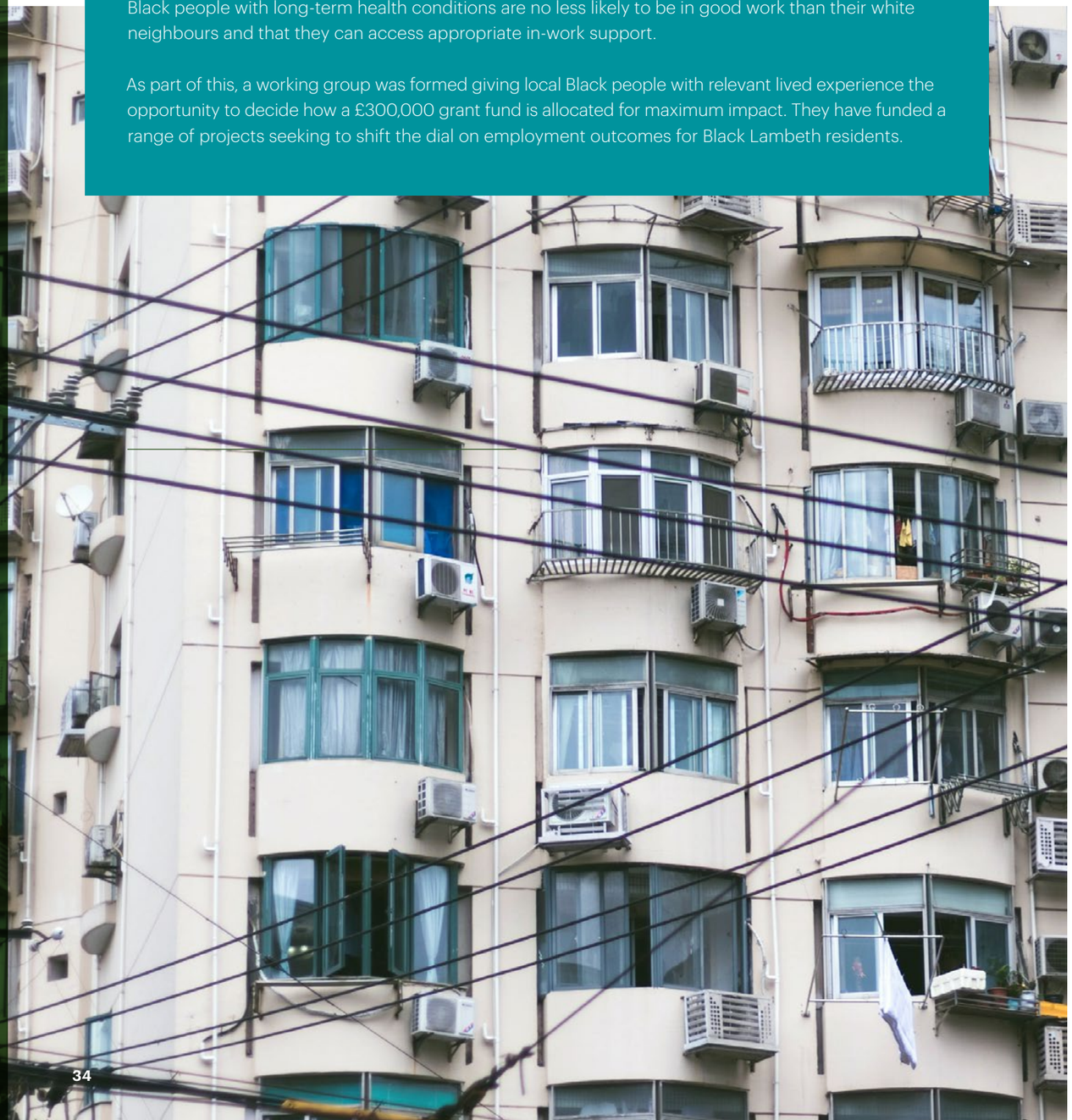
53 Cities Changing Diabetes. Bending the Curve on Urban Diabetes. 2017. www.citieschangingdiabetes.com/content/dam/cities-changing-diabetes/magazines/CCD-BriefingBook-2017-BendTheCurveOnUrbanDiabetes.pdf

Impact on Urban Health:
Black-led investment in mental health and work

Black people in the London borough of Lambeth often experience multiple disadvantages that negatively impact on physical and mental health. To begin to address this, Impact on Urban Health has invested in Black Thrive, a Black wellbeing partnership.

Black Thrive collaborates with employers, statutory and community partners to pilot solutions to tackle health inequalities. One of these pilots is an employment initiative working to ensure local Black people with long-term health conditions are no less likely to be in good work than their white neighbours and that they can access appropriate in-work support.

As part of this, a working group was formed giving local Black people with relevant lived experience the opportunity to decide how a £300,000 grant fund is allocated for maximum impact. They have funded a range of projects seeking to shift the dial on employment outcomes for Black Lambeth residents.



About Shanghai

Shanghai is China's economic engine and most populous city. It is one of the largest cities in the world with more than 27 million residents ([54]three times the population of London). Shanghai is a hub for international trade and finance and the city's economy has been described as the 'showpiece' of China's economy. It is one of four municipalities that have an independent government structure and report directly to Chinese central government[55].

Defined by continuous development of high-rise, high-density residential and office buildings in central districts, Shanghai's administrative area is extensive, covering the Yangtze estuary, several islands and industrial districts. It has an overall population density of 3,823 people per square kilometre[56] compared to London's 5,701.

Shanghai has seen explosive growth following economic reforms in the 1990s which encouraged greater flows of foreign investment[57]. Shanghai's downtown is densely built around its historic core along the Pudong River and has expanded outwards in former farmland areas now covered with medium to high-density residential complexes accommodating the emerging Chinese middle-class. Over the last decades the city has invested in an efficient public transport infrastructure, with over 400 stations and 700 km of subway lines, which serves some of the world's densest residential urban neighbourhoods.

Shanghai is considered to be a domestic immigration city[58]; the majority of residents are Chinese, but more than 40%, or close to ten million people, are from other regions of China. It is estimated that only 1.2% of the Chinese population in Shanghai are from minority groups, but that small portion of the population has nevertheless grown by a notable 165% since 2000, a rate faster than the overall population growth. An estimated 150,000 foreign residents are officially registered in the city, primarily from Japan, America and Korea, although unofficial counts may be higher.

Life expectancy in the city has more than doubled since 1949 and Shanghai is the first city in China to match the profile of an ageing population, with 35% of the population 60 years or older. This 'greying' of Shanghai's population[59] also reflects changes in disease patterns, which have shifted from infectious diseases and infant health problems to non-communicable diseases such as diabetes, heart disease and stroke. This is largely driven by population-level increases in high blood pressure and BMIs, and decreased rates of physical activity since the 1980s[60].

This shift in health patterns was likely both spurred by, and has continued to influence, health policy and public health approaches in Shanghai. In 1998, the Shanghai Municipal Bureau, using the US Centers for Disease Control and Prevention (CDC) as a model, reorganised Shanghai's public health structures to consolidate seven previous institutions into a single agency. The Shanghai CDC was established to facilitate coordination in programme planning, emergency response and public communication[61]. The State Council has set out to limit the population of Shanghai to 25 million people by 2035 in an attempt to manage 'big city disease' associated with environmental pollution, traffic congestion and a shortage of public services[62]. China also has an overarching national domestic population health policy – The Healthy China 2030 plan. It contains 15 goals to be achieved between 2020-30 with specific targets, which include decreasing the health effects of second-hand smoking, reducing obesity, increasing overall physical activity and preventing chronic diseases[63].

150k
foreign residents are officially registered in the city

25m
population limit by 2035

54 World Population Review. 'Shanghai Population 2021.' worldpopulationreview.com/world-cities/shanghai-population **55** Jing Peng, Sheng Nian Zhang, Wei Lu and Andrew T L Chen. 'Public Health in China: The Shanghai CDC Perspective.' American Journal of Public Health. 2003. www.ncbi.nlm.nih.gov/pmc/articles/PMC1448136/ **56** World Population Review. 'Shanghai Population 2021.' worldpopulationreview.com/world-cities/shanghai-population **57** Earth Observatory. 'World of Change: Sprawling Shanghai.' earthobservatory.nasa.gov/world-of-change/Shanghai **58** World Population Review. 'Shanghai Population 2021.' worldpopulationreview.com/world-cities/shanghai-population **59** https://urbanage.lsecities.net/search?city=9&keyword=shanghai **60** Harvard T H Chan School of Public Health. 'China facing epidemic of heart disease, stroke.' 2016. www.hsph.harvard.edu/news/press-releases/china-heart-disease-stroke-epidemic-hu-li/ **61** Jing Peng, Sheng Nian Zhang, Wei Lu and Andrew T L Chen. 'Public Health in China: The Shanghai CDC Perspective. American Journal of Public Health. 2003. www.ncbi.nlm.nih.gov/pmc/articles/PMC1448136/ **62** Cities Changing Diabetes. www.citieschangingdiabetes.com/ **63** Xiaodong Tan, Xiangxiang Liu, Haiyan Shao. 'Healthy China 2030: A Vision for Health Care.' Elsevier. 2017. www.ispor.org/docs/default-source/publications/newsletter/commentary_health-care_china_2030.pdf

Data led initiatives: Toronto, Canada

Toronto's approach to urban health includes an exploration of how data and technology can be used to identify and build an accurate picture of health issues, and then to target interventions where they are most needed.

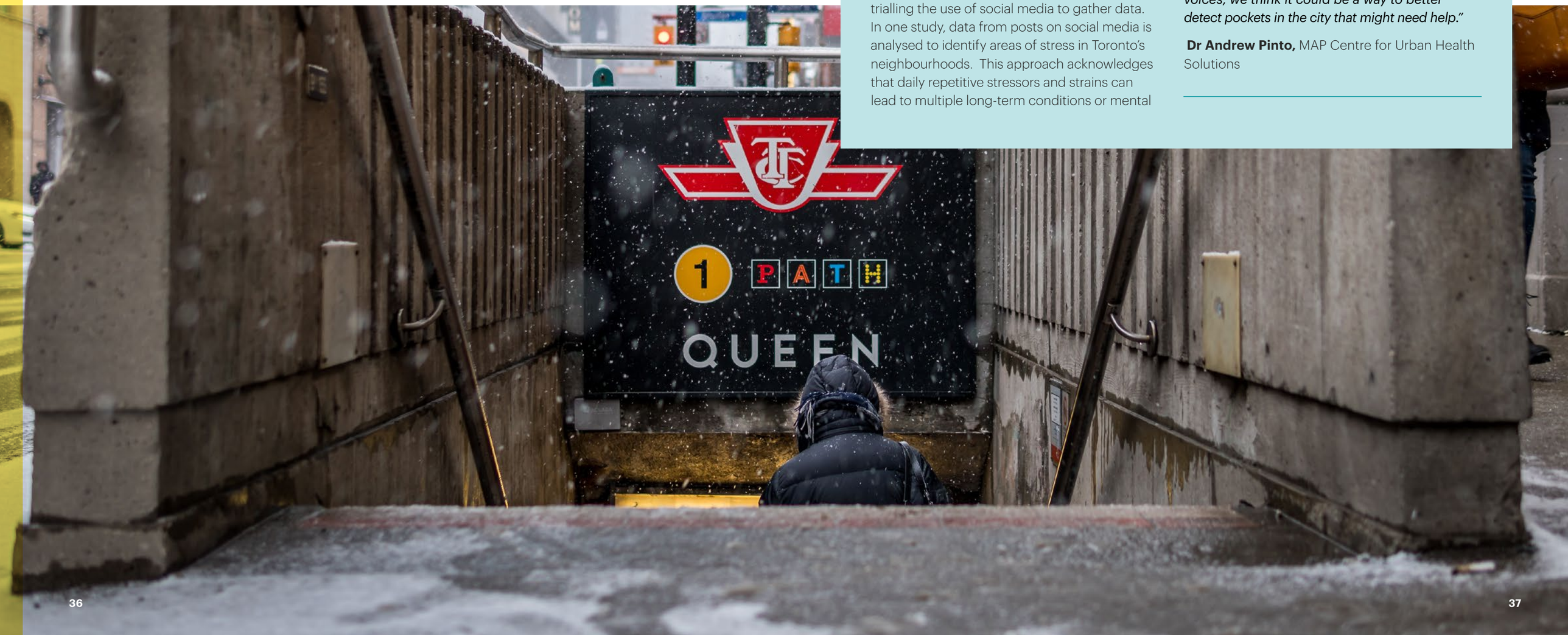
Urban health problems are often political and economic in nature and can exist at the intersection of multiple forms of disadvantage. It is important to understand those intersections and where value is derived from different sectors working together. Incorporating many different data types and methods into a programme enables it to be flexible enough to identify need and to build a fuller picture of an area or issue. This allows idea generation that is informed by stakeholders in real time. New technology and data can support this process in innovative ways.

Initiatives explored: Sidewalk Labs & MAP Centre for Urban Health Solutions

Sidewalk Labs in Toronto used technology to enable more personalised responses to health, so that populations can live well and thrive day to day. Data collected provides insight into people's health needs and experiences of daily life. The anonymised health data of communities is then linked to other systems that impact on health, such as waste, transport, food and housing. The aggregation of big data, as well as in-person community engagement work, endeavours to create healthier, more equitable communities.

MAP Centre for Urban Health Solutions uses big-picture research and street-level solutions to tackle complex urban health issues. It is trialling the use of social media to gather data. In one study, data from posts on social media is analysed to identify areas of stress in Toronto's neighbourhoods. This approach acknowledges that daily repetitive stressors and strains can lead to multiple long-term conditions or mental health struggles at a neighbourhood level. MAP will use social media to inform the city of Toronto on improvements that need to be made to address these areas of stress in communities. They're focused on building long term embedded relationships with communities are using novel as well as traditional routes to develop these relationships and insight.

> *"We see social media as a way to feed into the existing processes of neighbourhood planning that are happening in cities. We don't see social media being a replacement for community voices, we think it could be a way to better detect pockets in the city that might need help."*
>
> **Dr Andrew Pinto,** MAP Centre for Urban Health Solutions



About Toronto

While only a third the size of London, with 2.7 million total residents and 4,334 people per square kilometre[64] Toronto is the most populous city in Canada. Despite its smaller size, it resembles London in that it is highly multicultural, with 51.5% of residents belonging to a minority ethnic group[65] and flourishing ethnic neighbourhoods including multiple Chinatowns, Little India, Little Portugal and Little Jamaica. This ethnic diversity is largely owed to Toronto's enduring role as an important destination for immigrants to Canada. The 2016 census found that 47% of Toronto residents were immigrants[66].

Spread across 630 square kilometres[67], Toronto has a central downtown district of dense skyscrapers ringed by medium density neighbourhoods featuring extensive green space and local commercial corridors. Toronto has the largest public transport system in the country and third largest in North America[68], but it does not provide consistent coverage across the city, leaving many lower income and minority communities with poor access to transport[69]. COVID-19 has further limited access to transport for the communities that need it most: despite significant service cuts, 41% of households earning less than $40,000 a year report still rely primarily on public transport[70].

Canada uses a national system of universal healthcare, which overall has produced positive health outcomes for Canadian people, particularly in comparison to the United States. Studies have demonstrated that Canadians are more likely to have a regular doctor and less likely to have unmet health needs or forgo necessary medication in contrast to their American counterpart[71]. While Canadian healthcare provision is shown to reduce many health disparities, significant gaps still exist in urban centres such as Toronto. Studies by Toronto Public Health found that in an assessment of 34 health status indicators, 20 are significantly inequitable, with low-income groups demonstrating worse health outcomes. Notably, these inequities are not improving over time. Over a ten-year period, health inequities persisted for 16 indicators and worsened for four indicators. Only one indicator showed any improvement in equity during the same period[72].

Canada uses a national system of universal healthcare, which overall has produced positive health outcomes for Canadian people, particularly in comparison to the United States.

Toronto's position as the financial capital of Canada and the most culturally cosmopolitan city has produced a potentially contradictory social context which both threatens and presents opportunities for equitable urban health. On the one hand, a focus on knowledge-sector industries has led to demographic change within the city and spurred on spatial development which favours market-rate development at the expense of more affordable options. On the other, projects such as the now-defunct Quayside development by Sidewalk Labs represent opportunities to weave individual and public health interests directly into the creation and functioning of new developments and districts[73], enrolling spatial practices directly in the promotion of positive health outcomes.

47%

of residents are immigrants

51.5%

of residents belong to a minority ethnic group

64 Statistics Canada. 'Census Profile 2016: Toronto.' www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/Page.cfm?Lang=E&Geo1=CSD&Code1=3520005&Geo2=PR&Data=Count&B1=All **65** Statistics Canada. 'Immigration and ethnocultural diversity: Toronto.' www12.statcan.gc.ca/census-recensement/2016/as-sa/fogs-spg/Facts-CSD-eng.cfm?TOPIC=7&LANG=eng&GK=CSD&GC=3520005 **66** Statistics Canada. 'Immigration and ethnocultural diversity: Toronto.' www12.statcan.gc.ca/census-recensement/2016/as-sa/fogs-spg/Facts-CSD-eng.cfm?TOPIC=7&LANG=eng&GK=CSD&GC=3520005 **67** Statistics Canada. 'Census Profile 2016: Toronto.' www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/Page.cfm?Lang=E&Geo1=CSD&Code1=3520005&Geo2=PR&Data=Count&B1=All **68** en.wikipedia.org/wiki/Toronto_Transit_Commission#cite_note-TTCstats-3 **69** Dr Steven Farber and Jeff Allen. Planning for Transit Equity in the GTHA. 2019. uttri.utoronto.ca/files/2019/06/Planning-for-Transit-Equity-in-the-GTHA-Report-May-29-2019.pdf **70** Toronto Foundation. The Toronto Fallout Report: key insights for an equitable recovery. 2020. torontofoundation.ca/wp-content/uploads/2020/11/Toronto-Fallout-Report-2020.pdf **71** Karen E Lasser, David U Himmelstein and Steffie Woolhandler. 'Access to care, health status and health disparities in the United States and Canada: results of a cross-national population-based survey.' American Journal of Public Health. 2006. www.ncbi.nlm.nih.gov/pmc/articles/PMC1483879/ **72** Trevor Van Ingen, Erika Khandour, Paul Fleiszer. The Unequal City 2015: Income and Health Inequities in Toronto. Toronto Public Health. April 2015. www.toronto.ca/legdocs/mmis/2015/hl/bgrd/backgroundfile-79096.pdf **73** Aaron Orkin. 'Sidewalk Labs project is a public health opportunity.' Toronto Star. 30 June 2019. www.thestar.com/opinion/contributors/2019/06/30/sidewalk-labs-project-is-a-public-health-opportunity.html

Addressing root causes: New York, USA

New York City gave us evidence of the vital role anchor organisations - those with deep roots in local communities - play in tackling drivers of poor health in urban neighbourhoods. These organisations support local people throughout their lives, recognising how related issues like precarious housing and lack of access to nutritional food must be addressed to improve health outcomes.

Initiatives explored:
Queens Community House & Harlem Children's Zone

Queens Community House (QCH) is a multi-site, multi-service settlement house that serves residents of all ages, races, faiths and ethnicities in the neighbourhoods of Queens. It promotes neighbourhood stability in the face of increasing gentrification. Queens is the most racially and ethnically diverse borough in New York and the most diverse county in the US[74].

QCH recognises the relationship between health, housing, employment, education, self-esteem and financial wellbeing and works to ensure people in Queens have access to a full range of resources to help them achieve wellness and life-long security. For example, it addresses the security needs of individual households and support recently evicted families to find new homes, while also advocating for more affordable housing and stronger tenant protection for the borough of Queens.

Harlem Children's Zone (HCZ) focuses on one area – some 100 blocks of Harlem – marked by high levels of disadvantage. In 2018, the poverty rate in Central Harlem was 25.1%, compared to 17.3% citywide. A lack of affordable housing is shifting the demographics and creating changes within the city over time.

HCZ seeks to create a pipeline of support for children by linking high quality school and early years provision with personal, social and health support for children and their families, alongside community development initiatives.

Having identified that a lack of access to affordable fresh produce was contributing to the community's overreliance on fast food, QCH worked in partnership with residents to introduce an affordable farmers market selling fresh produce which has been running for over nine years. Queens Community House has also trained three community chefs to run cooking classes on how to prepare and make healthy food.

Both approaches work to tackle the systemic drivers of poor health. They do this primarily by taking an equitable approach to supporting individuals and communities to access fundamental services. By providing support throughout people's lives, QCH and HCZ focus on root causes of inequality that significantly impact the health outcomes of communities but are not automatically seen as health issues. Improving health and wellbeing often means supporting people and whole communities across the different contexts of their life. However, for community-led organisations like QCH and HCZ, this presents challenges around funding. Siloed funding streams can make it difficult to work holistically on cross-sector issues in a community or place.

Through their work, these two anchor organisations have upskilled and nurtured talent from within the community. This not only builds additional capacity within programmes and develops transferable skills in communities facing high levels of employment, but importantly, it also reinvests knowledge and builds community leadership that can continue to advocate on behalf of residents and their needs.

> *"The city became much more diversified than it was back in the 70s. We really see that here in Queens. Queens is considered the most diverse county in NYC but is probably the most diverse county in the country in terms of the number of countries where people are coming from."*
>
> **Dennis Redmond**, Queen's Community House, New York City

74 Lazaro Gamio. 'Where America's diversity is increasing the fastest.' Axios. July 3, 2019. www.axios.com/where-americas-diversity-is-increasing-the-fastest-ae06eea7-e031-46a2-bb64-c74de85eca77.html

> *"We take a holistic approach to supporting the Harlem community. Our Community Centres strive to provide children - and adults - with something very important: a safe place to learn, play, and grow."*
>
> **Yacine Dialo,** Harlem Children's Zone, New York City

> *"Our challenge, given these siloed funding streams and sometimes siloed populations, is how do we connect it all together? How do we do something more holistic and comprehensive that tries to really deepen our work in that community and have a greater impact?"*
>
> **Dennis Redmond,** Queen's Community House, New York City

About New York

New York City is the largest and most populous city in the United States. While New York's population of 8.4 million is comparable to London, its five boroughs cover half the land area (487 square kilometres) and are considerably denser with 38,242 people per square mile[75]. The borough of Manhattan combines high-density with high levels of affluence, centred on Central Park which acts as a green lung for the entire city. In 2015, the average annual income of the wealthiest 1% of New Yorkers was $2.2 million, compared to an annual average of $49,600 for the other 99% of residents[76]. One in five New Yorkers fall beneath the poverty threshold and almost half of all households are considered to be marginally above the poverty line.

The historic 'gateway to America', New York City today remains highly diverse and international. As of 2016 it had the largest foreign-born population of any city with 3.1 million residents born outside of the United States[77]. New York is the most linguistically diverse city in the world, with as many as 800 languages spoken[78], and one of the most racially diverse cities in the United States. While the majority racial group is white (42%), Hispanic/Latino (29%), Black (24%) and Asian (14%) residents make up large pluralities of the population[79]. Race-based planning legacies, foreign investment and a corporate-growth city agenda have led to high rates of income inequality in the city. Unlike London, ethnic diversity and economic deprivation are often concentrated, especially in the outer boroughs of the Bronx and Queens.

Given New York's size and density, individual and public health have long been concerns, but social, structural and political factors have led to highly inequitable health outcomes across the city. Much of this inequality is spatially driven. As a result of decades of development policies, such as redlining, up-zoning and neglecting public housing, New York City today is the fourth most segregated city in the country[80]. This has concentrated ethnic minorities and low-income residents into specific neighbourhoods which are simultaneously underserved by health services[81] and more likely to be located closer to environmental health hazards, such as heavy industry, waste and sewage treatment and other polluting infrastructure[82]. While non-white New Yorkers are more than six times as likely to be hospitalised for asthma complications and three times more likely to be hospitalised for diabetes-related complications[83], the neighbourhoods in which they predominantly live have lost thousands of hospital beds in recent years due to state healthcare funding priorities[84].

At the same time, national policies disproportionately exclude immigrants in New York, and unauthorised immigrants in particular, from equitable access to healthcare. Due to their immigration status, immigrants not authorised to live long-term in the United States are both unable to receive health benefits through their employer and ineligible for healthcare coverage through the federal government. With an estimated 643,000 unauthorised immigrants in New York City as of 2016, this represents a significant gap in access to quality healthcare which primarily falls upon ethnic and/or racial minority groups.

800

languages spoken in New York

1/5

people fall beneath the poverty threshold

75 United States Census Bureau. 'QuickFacts; New York City, New York; Detroit City, Michigan; Michigan.' www.census.gov/quickfacts/fact/table/newyorkcitynewyork,detroitcitymichigan,MI/PST045219 **76** John Cropley. 'Study finds N.Y. income disparity widest in nation.' The Daily Gazette. 19 July 2018. dailygazette.com/2018/07/19/study-finds-n-y-income-disparity-greatest-in-nation/ **77** United States Census Bureau. 'Place of birth by year of entry by citizenship status for the foreign-born population.' data.census.gov/cedsci/table?q=B05007&g=1600000US3651000&tid=ACSDT5Y2019.B05007&hidePreview=true **78** Untapped Cities. 'Fun map - NYC is most linguistically diverse urban area in the world.' untappedcities.com/2019/12/06/fun-maps-nyc-is-most-linguistically-diverse-urban-area-in-the-world/ **79** United States Census Bureau. 'QuickFacts; New York City, New York; Detroit City, Michigan; Michigan.' www.census.gov/quickfacts/fact/table/newyorkcitynewyork,detroitcitymichigan,MI/PST045219 **80** Churches United for Fair Housing. Zoning and Racialized Displacement in NYC. static1.squarespace.com/static/5dc0429de5717c7ff1caead0/t/5de6c0e683bec649d37ab0cc/1575403753814/Zoning+and+Racialized+Displacement+in+NYC.pdf **81** Amanda Dunker and Elisabeth Ryden Benjamin. 'How Structural Inequalities in New York's Health Care System Exacerbate Health Disparities during the COVID-19 Pandemic: A Call for Equitable Reform.' Community Service Society New York. 4 June 2020. www.cssny.org/news/entry/structural-inequalities-in-new-yorks-health-care-system **82** Rachel Ramirez. 'A threat multiplier: The hidden factors contributing to New York City's coronavirus disparities.' Grist. 21 April 2020. grist.org/justice/a-threat-multiplier-the-hidden-factors-contributing-to-new-york-citys-coronavirus-disparities/ **83** New York State Department of Health. New York State Health Equity Report. 2019. health.ny.gov/community/minority/docs/health_equity_report_2019.pdf **84** Lena Afridi and Chris Walters. 'Land Use Decisions have Life and Death Consequences.' Association for Neighbourhood and Housing Development. 10 April 2020. anhd.org/blog/land-use-decisions-have-life-and-death-consequences

Long term approaches: Detroit, USA

In Detroit, we learnt about the role philanthropic foundations can play in driving health improvements across the city. As independent, established organisations they can take a long-term view of health and place substantial value on listening to and empowering communities to tackle health inequalities.

Initiatives explored: The Kresge Foundation, The Michigan Health Endowment Fund, The Skillman Foundation

Foundations hold a unique space in the urban health system. They are independent and able to take a long-term view, as well as to respond to change and emergent needs. This ability to take a long-term view means foundations can focus resource on issues where the desired change or impact is often only seen over a generation, providing opportunities to measure impact beyond two to three-year projects.

The work of three foundations exploring opportunities to drive health improvements in Detroit demonstrates the impact these philanthropic organisations can have:

The Kresge Foundation is a private, national foundation located in Detroit that works to expand opportunities in America's cities through grant making and social investing in arts and culture, education, environment, health, human services and community development.

The Michigan Health Endowment Fund is a philanthropic foundation that works to improve the health and wellness of Michigan residents, while reducing healthcare costs. It considers the context in which health outcomes arise, including social and cultural drivers, and goes beyond qualitative data and short-term funding cycles. The Fund supports organisations across Michigan, from grassroots groups addressing local health challenges to large agencies working in every county.

The Skillman Foundation is a private philanthropic foundation that serves as a champion of Detroit children. The Foundation works to ensure Detroit youth achieve their highest aspirations by strengthening primary and secondary public education, after-school learning opportunities and college and career pathways.

The strength of foundations and trusts to bear risk, bypass political cycles and set their own boundaries gives them a pivotal role in galvanising and initiating the conversation on addressing inequalities. Communities hold an understanding of what that community needs. Foundations are well placed to convene, galvanise and act as a central cohesive source of support and stability on addressing systemic drivers of health outcomes.

> *"Foundations don't have the answer - communities do. We have moved into more of a listening mode with communities recognising their assets, riches and intelligence and listening to their needs. We realised that communities don't work in a silo - they're intersected. People are worried about housing, food access, making sure they're healthy e.g. flu jabs - all those things really intersect. Over the next few years we probably won't have the siloed teams but an intersection of teams."*
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> **Stacey Barbas,** Senior Programme Officer, Health, Kresge Foundation

The Kresge Foundation realised that much of the work it does across its programmes has an impact on health outcomes. It now anticipates a move toward including health outcomes within all their work to respond to the intersected nature of communities. It also focuses on equitable financing to empower communities that have been historically excluded. Viewing practices, processes and resources through an equity lens enables funders to focus resources on those disproportionately impacted by poor health outcomes, thereby avoiding widening health inequality gaps.

> *"Many people are doing great work, but they aren't necessarily talking to each other. We try to analyse gaps and identify what work is already underway. Ideally, we really want to know where work isn't happening."*
>
> **Laurie Solotorow,** Director, Nutrition & Healthy Lifestyles, Michigan Health Endowment Fund
>
> *"Communities of colour have been left out of traditional capital growth for forever. For example, Black farmers, indigenous farmers, they could never get loans or capital. We're trying to work with equitable finance folks, so our community financial development institutions were actually created to give capital to communities."*
>
> **Stacey Barbas**, Senior Programme Officer, Health, Kresge Foundation

Detroit, US

About Detroit

Birthplace of the modern motorcar and one of the most important centres of American industry in the early to mid-1900s, Detroit has come to exemplify post-industrial urban decline. From its peak population of 1.8 million in 1950, Detroit experienced dramatic population decline, shrinking to 670,000 in 2019[85]: a 63% decrease. Detroit today is a majority Black city (78%)[86] burdened with significant levels of deprivation- 38% of Detroit residents live in poverty[87], compared to 7.8% in the adjacent Oakland county, one of the whitest and wealthiest counties in the United States.

Spread across 222 square kilometres, Detroit's urban environment is low-density, with 1,865 residents per square kilometre and primarily single-family housing throughout[88]. Although Detroit has become notorious for empty housing, Detroit nevertheless is home to a central downtown and a number of historic, well-maintained residential neighbourhoods.

Detroit's population decline was driven by twin forces of deindustrialisation and racial unrest; forces which continue to shape the outcomes for Detroit residents today. As early as 1950, car manufacturing began to leave Detroit, first for the surrounding suburbs and then overseas. This led to a 50% reduction in vehicle manufacturing jobs[89] and hollowed out the industry, drying up the taxes that largely funded the city's budget. At the same time the 1967 Detroit Rebellion, a five-day uprising of Black Detroiters in the face of police misconduct, triggered significant migration of white residents and wealthier Black residents to the surrounding suburbs, leaving a concentration of many of the region's most vulnerable people within the city itself.

These twin crises have, over time, shaped a legacy of municipal insolvency and generational poverty which has greatly impacted the health and wellbeing of Detroit residents. While Detroit is home to some of Michigan's top hospitals, 12% of Detroiters have no health insurance coverage, rendering most health services inaccessible. Perhaps as a result, 28% of Detroit's population are considered to be in 'fair or poor' general health and a significant portion of the population suffers from preventable diseases like diabetes (13%), asthma (21%) and cardiovascular disease (11.4%)[90]. Detroit has a maternal mortality rate three times the national average with 32 pregnancy-related mother mortalities per 100,000 births[91], coming in last in State county health rankings[92].

Aside from clinical measures of health, the city's often precarious financial status has also posed health risks for the city's residents. Beginning in 2013, tens of thousands of Detroiters[93] lost access to drinking water when their services were cut off due to non-payment and ongoing tax foreclosures have created precarious housing environments which, especially in the context of the spread of Covid-19, pose significant obstacles to individual and community health[94].

Detroit's legacy has also shaped the current culture of non-governmental civic development in the City's absence. In the past ten years, private developers have put significant effort into revitalising the city, including large-scale redevelopment of the downtown area and the relocation of large corporate headquarters from surrounding suburbs to the city. These changes have led to some early but encouraging environmental and social improvements, but are also driving demographic shifts as younger, wealthier and white residents move into the city, potentially setting up an emerging crisis of inequality between 'New' and 'Old' Detroit.

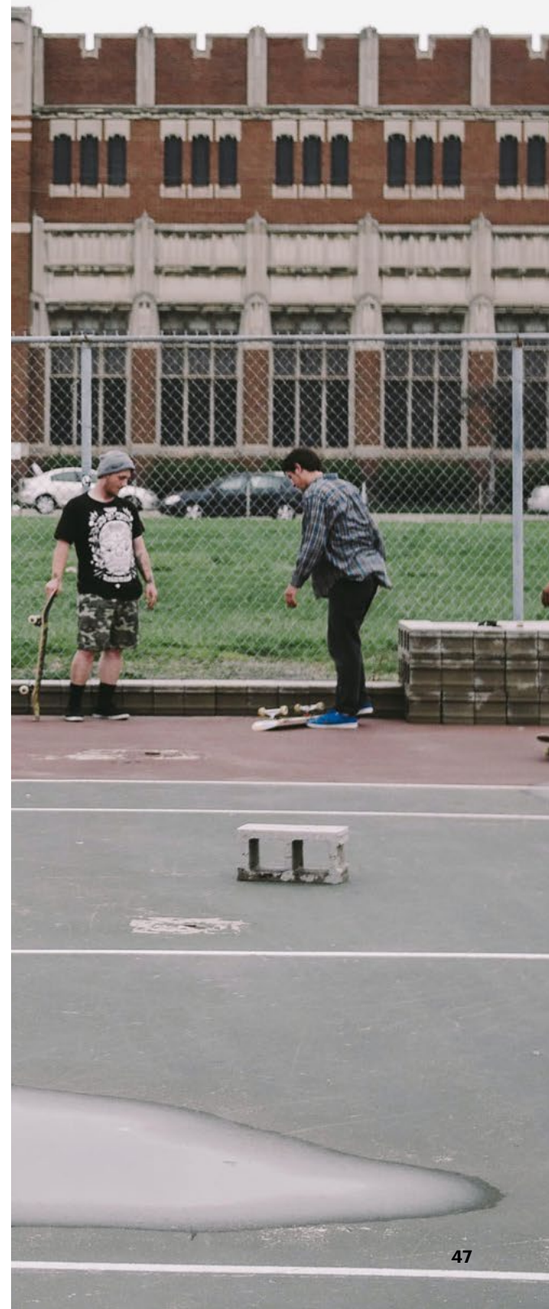
63%

decrease in the general population from 1950 to 2019

28%

of the population are considered to be in 'fair to poor' health

85 Bridge Michigan, 2020 https://www.bridgemi.com/urban-affairs/detroit-population-continues-decline-according-census-estimate **86** United States Census Bureau. 'QuickFacts: Detroit City Michigan; Michigan.' www.census.gov/quickfacts/fact/table/detroitcitymichigan,MI/PST045219#qf-headnote-a **87** City of Detroit District Health Department. 2018 Detroit Community Health Assessment. detroitmi.gov/sites/detroitmi.localhost/files/2019-04/4pm_April11_DHD_report.pdf **88** United States Census Bureau. 'QuickFacts: Detroit City Michigan; Michigan.' www.census.gov/quickfacts/fact/table/detroitcitymichigan,MI/PST045219#qf-headnote-a **89** Thomas J Sugrue. 'From Motor City to Motor Metropolis' How the Automobile Industry Reshaped Urban America.' Automobile in American Life and Society. www.autolife.umd.umich.edu/Race/R_Overview/R_Overview5.html **90** Data snapshot on health in Detroit 2018. research.wayne.edu/docs/a_data_snapshot_on_health_in_detroit_2018_all_figures_and_tables_website_10312018-1.pdf **91** City of Detroit District Health Department. 2018 Detroit Community Health Assessment. detroitmi.gov/sites/detroitmi.localhost/files/2019-04/4pm_April11_DHD_report.pdf **92** County Health Rankings and Roadmaps. 'Michigan 2020'. www.countyhealthrankings.org/app/michigan/2020/rankings/wayne/county/outcomes/overall/snapshot **93** We the people of Detroit, Mapping the Water Crisis https://www.wethepeopleofdetroit.com/product-page/mapping-the-water-crisis-ebook **94** Nancy Kaffer.'It took a global pandemic for Detroit to find solutions for water shutoffs, foreclosures.' Detroit Free Press. eu.freep.com/story/opinion/columnists/nancy-kaffer/2020/03/25/detroit-water-shutoffs-foreclosures-coronavirus/5024525002/



Reshaping the built environment: Melbourne, Australia

Melbourne shares similar demographics with London. It has implemented a number of city-wide initiatives that showed us how changes in infrastructure, from housing to transport to public landscaping, can help to embed health outcomes in the development of cities.

We explored several of these city-wide initiatives, including transport design hubs, health foundations, innovation hubs, new housing developments, academic research institutes and internationally backed city-wide renewal projects. Each initiative is taking on a different systemic lever, sector or environment to counteract imbalances across the city and ensure that, wherever possible, it evolves to allow all residents to access its positive aspects. The number of different stakeholders involved can be vast and varied, as can their measures and goals for what a successfully developed city would look like.

Much of the city-wide initiatives focused on the development and impact of changes to the built environment, in contrast to neighbourhood initiatives we saw elsewhere which took people's interaction with place as a starting point. We observed that changes in infrastructure, for example housing, transport and urban forestry, provide opportunities for interdisciplinary research and planning to embed and measure health outcomes in future city development. In a constantly evolving city, putting health as a core outcome of success is possible. Melbourne's 20-Minute Neighbourhood Programme is a good example of how expanding cities can accommodate the needs of residents by actively considering the health objectives of changes to the built environment. However, the challenge is how best this can be done while managing and meeting the needs of its current populations.

Where space in cities is a limiting factor, there is a need to plan high density environments that enable access to appropriate services. However, in Port Philip, new developments increased the cost of housing and rents, and led to loss of public housing, encouraging high-income residents into the area, along with associated services and facilities. This in turn was seen to price out existing residents and their services and facilities, creating a divide between 'old' and 'new' residents.

As can be observed in many cities, displacement and disenfranchisement of established communities as a city expands and evolves can create a tension in terms of resource allocation and in perceptions of whose voice is or is not heard. There is a growing tension and debate on whether city-wide initiatives that attract high earners into declining urban neighbourhoods with improved built environment is indeed regeneration or gentrification. While there is no clear evidence on whether gentrification is positive or negative for existing residents and communities, gentrification of previously underinvested urban neighbourhoods can undoubtedly amplify feelings of disenfranchisement and social segregation.

Fishermans Bend

Fishermans Bend is an urban renewal project covering approximately 480 hectares connecting the city's central business district to the bay. By 2050, it's planned that it will be home to approximately 80,000 residents and provide employment for up to 80,000 people.

The vision is to create liveable and vibrant neighbourhoods that are world-leading examples of urban renewal. Working to a framework with robust evaluation, the project is focused on creating parks, schools, roads, transport and community facilities and services to ensure liveability as the precinct grows over the next 30 years. The framework is supported by a suite of evidence-based research reports, strategies and plans and its development benefited from more than 12 months of engagement with community and other stakeholders.

Resilient Melbourne, the Rockefeller Foundation and City of Melbourne

Melbourne is made up of 32 local government authorities (councils), comprising hundreds of diverse local neighbourhoods, each with its own character, cultural mix and set of advantages and disadvantages. The city is growing, and by 2051 is expected to be home to approximately 7.7 million people. The shared administration means city-wide challenges cannot be dealt with independently. Resilient Melbourne offers a rare opportunity to tackle these challenges in new collaborative ways.

Melbourne's first resilience strategy was endorsed by the City of Melbourne's Future Melbourne Committee in 2016. It is the first resilience strategy produced by any Australian city; and is the result of the work of more than 1,000 individuals from 230 organisations, Melbourne's 32 local councils, and many Victorian Government (state) departments. The strategy is the first metropolitan plan that has been led by local government in Melbourne's 180-year history. Developed with the support of 100 Resilient Cities – Pioneered by the Rockefeller Foundation – the strategy sets out a series of distinct, yet connected, actions that will help make Melbourne a viable, liveable and prosperous city, long into the future. The city has put in place another plan of initiatives as part of the strategy, including the development of a metropolitan urban forest, and early research suggests the strategy has led to increased knowledge exchange across sectors and urban innovation.

Neighbourhood snapshot:
Central Business District and Port Phillip

Population: Melbourne's central business district is the most densely populated area in Australia, with a population density of just over 19,100 people per square kilometre and median age of 26 years. In contrast, Port Phillip is one of the smallest municipalities in Victoria, only 21 square kilometres, and the most densely populated with more than twice the population density of the metropolitan Melbourne average. They are the two most visited places in metropolitan Melbourne, attracting 2.8 million visitors each year.

Diversity: In the CBD, 66% of people born were overseas and 55% of people speak a language at home other than English. In Port Philip, 31% of its population is born overseas and 21% speak a language other than English.

Poverty: In the CBD, 87% of the population live in high-rise apartments with four or more storeys and 50% of the population rent their property. .

Impact on Urban Health:
London's Child Obesity Taskforce

London's Child Obesity Taskforce is an initiative driven by the Greater London Authority in collaboration with Public Health England and the Association of Directors of Public Health. Impact on Urban Health are a lead partner in the Taskforce, which was established in 2018, contributing strategic support and funding for work to ensure every London child has every opportunity to enjoy a healthy weight.

Through the Taskforce, we can leverage London-wide influence to make changes in the environments where children eat, play and live. The Taskforce has created an action plan to significantly reduce childhood obesity across the city, focusing on the unfairness in prevalence of childhood obesity in poorer communities and taking a whole-systems approach to solutions.

About Melbourne

Melbourne is the fastest growing city in Australia with 4.8 million residents and population growth averaging 3.8% a year between 2011 and 2020[95]. It also has the tenth largest immigrant population among global metropolitan areas, with most new arrivals coming from India, China, UK, Vietnam and New Zealand[96].

Capital of the Australian State of Victoria, Melbourne's urban development pattern reflects the national trend towards car-dependent sprawl. Covering an area much larger than London, it has a much lower population density: around 453 people per square kilometre[97]. Compared to its suburban neighbourhood, the city's central district has a greater intensity and variety of development and character, with active street frontages organised along a traditional urban grid. This approach has been promoted by proactive municipal leadership that has prioritised public transport, walkability and mixed-use development.

This spatial distribution combined with significant population growth has produced a socially and economically polarised neighbourhood distribution. As the business district and central neighbourhoods, such as Yarra and Port Phillip, become increasingly wealthy, peripheral suburbs such as Cardinia to the southeast, continue to concentrate lower-income households and recently arrived immigrants due to a relative abundance of lower-cost housing[98]. As a result these suburbs are continuously expanding to accommodate Melbourne's growing population, leaving many areas with available housing but little other urban infrastructure like public transport or health services[99]. Income inequality has also followed Melbourne's explosive population growth. With incomes of the top 20% of earners 8.3 times as high as the bottom 20% of earners, Melbourne has the greatest wealth gap of any city in Australia[100].

Melbourne is ranked eleventh on the 2021 Healthy Lifestyle Cities Report and residents generally have high rates of access to healthcare and important factors of wellbeing[101]. Social variations, however, drive inequitable outcomes between different populations. While overall life expectancy is high, averaging 84.4 years, Aboriginal people are expected to live on average seven years less than their non-Aboriginal counterparts. Self-reported measures of wellbeing are also highly differentiated, with lower-income respondents rating their wellbeing more than ten points lower than those in higher income brackets[102]. These variations can also be mapped to Melbourne's urban geography. A 2019 study found that social indicators tend to deteriorate with distance from central Melbourne, including essential health determinants such as obesity rates, reports of heart disease, on-track child developmental milestones and levels of social cohesion[103].

Private and civic institutions are conducting interdisciplinary research and planning for how the city will inevitably need to change and adapt in response to an ever-growing population and climate change. In Port Phillip, wage increases in professional households have caused property prices and rents in the private sector to soar. In public housing, areas have been sold or remodelled in ways that have led to the introduction of more high-income residents. In addition, services and shops have followed suit to accommodate for higher earning populations. This has led to either the displacement of residents on a lower income to further out of the city, or the removal of affordable shops and services that once served these residents.

A growing city population is increasing the demand for more areas, outside of the expensive, congested city centre, to be within walking distance of shops, services and public transport. Melbourne's 20-minute Neighbourhood Pilot Programme is an example of this, testing the practicalities of 'living locally' by giving people the ability to meet most of their daily needs within a 20-minute walk from home, with safe cycling and local transport options. With space at a premium, rapid high-rise development are favoured, often delivering small and low-quality apartments. Such rapid responses to fast growing cities rarely consider health equity in spatial development and so risk negative implications on health and wellbeing.

95 Population Australia. 'Melbourne Population 2021'. www.population.net.au/melbourne-population/ **96** Australian Bureau of Statistics. '2016 Census Quickstats: Greater Melbourne.' quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/2GMEL?opendocument **97** Population Australia. 'Melbourne Population 2021'. www.population.net.au/melbourne-population/ **98** Charting Transport. 'Visualising the changing socio-economic landscape of Melbourne.' 2013. chartingtransport.com/2013/09/29/visualising-the-changing-socio-economic-landscape-of-melbourne/ **99** Rebecca Madill. Comparing Health Services Access Across Regions of Melbourne: A Case Study of Diabetes Services. 2017. minerva-access.unimelb.edu.au/handle/11343/214059 **100** Nicholas Biddle and Francis Markham. 'What income inequality looks like across Australia.' The Conversation. 5 July 2017. theconversation.com/what-income-inequality-looks-like-across-australia-80069 **101** 'Sydney and Melbourne listed among world's healthiest cities.' Australasian Leisure Management. 7 February 2021. www.ausleisure.com.au/news/sydney-and-melbourne-listed-among-worlds-healthiest-cities/ **102** City of Melbourne. Health and Wellbeing Profile 2020. www.melbourne.vic.gov.au/SiteCollectionDocuments/health-wellbeing-profile-2020.pdf **103** Brain, P., Stanley, J. and Stanley, J. Melbourne: How big, how fast and at what cost?. Melbourne Sustainable Society Institute, The University of Melbourne. 2019. sustainable.unimelb.edu.au/__data/assets/pdf_file/0006/3065334/MSSI-Research-Paper-2019_Stanley_et_al.pdf

Community health: Glasgow, Scotland

Glasgow is a city with similar health outcomes and population size to Lambeth and Southwark. We visited the city to explore its population level interventions on urban health, which demonstrate the importance of better understanding the social issues affecting health in order to spot trends and tailor support to key groups.

In Glasgow we saw clearly the importance of local welcoming spaces, enabling people to be together, and allowing trusted relationships to be built. People who run these spaces – including community centres, GP surgeries and youth clubs - can help to identify those in need of support, as well as creating opportunities to meet those needs in ways that are appropriate and sustainable. Having built a relationship based on trust, staff may spot issues linked to subjects that people may not be comfortable speaking about, but which have tangible impact on health outcomes, such as food poverty, debt, financial difficulty or abuse.

Building an understanding of these issues and their prevalence at a population level, allows trends to be identified which supports better development and targeting of solutions. The environment in which people live, work and grow is vitally important to health outcomes. In the Gorbals neighbourhood, historic moves to improve housing have unintentionally led to the breakdown of established communities, eroding social connections. A bid to improve health through improving housing addressed one issue but created others, as it didn't involve efforts to understand the social context and what was important to local people. Social connections are now being re-established through community initiatives such as Bridging the Gap.

Urban areas are often characterised by longstanding communities living side by side with more transient populations. Existing communities may have different health needs and priorities to newer populations. Because of this, initiatives to improve health need to be tailored and offer access to culturally appropriate services. The ever-changing nature of cities makes evaluating and measuring the impact of such initiatives difficult and undertaking longitudinal studies complex. Evidencing impact on wider health outcomes is especially difficult, as they often vary and are dependent on wider context. Additionally, there's often a tension between the short-term need for health initiatives to track impact for funders and to be reactive to immediate population needs, and the desire for interventions to be a catalyst for longer-term change and health impact.

Neighbourhood snapshot: Gorbals and Govanhill

Population: Both neighbourhoods in the South of Glasgow, Gorbals has a population of 8,530 and Govanhill of 14,412.

Diversity: In Govanhill, 28% of local people were born in a country other than the UK (compared to 12% of people city-wide).

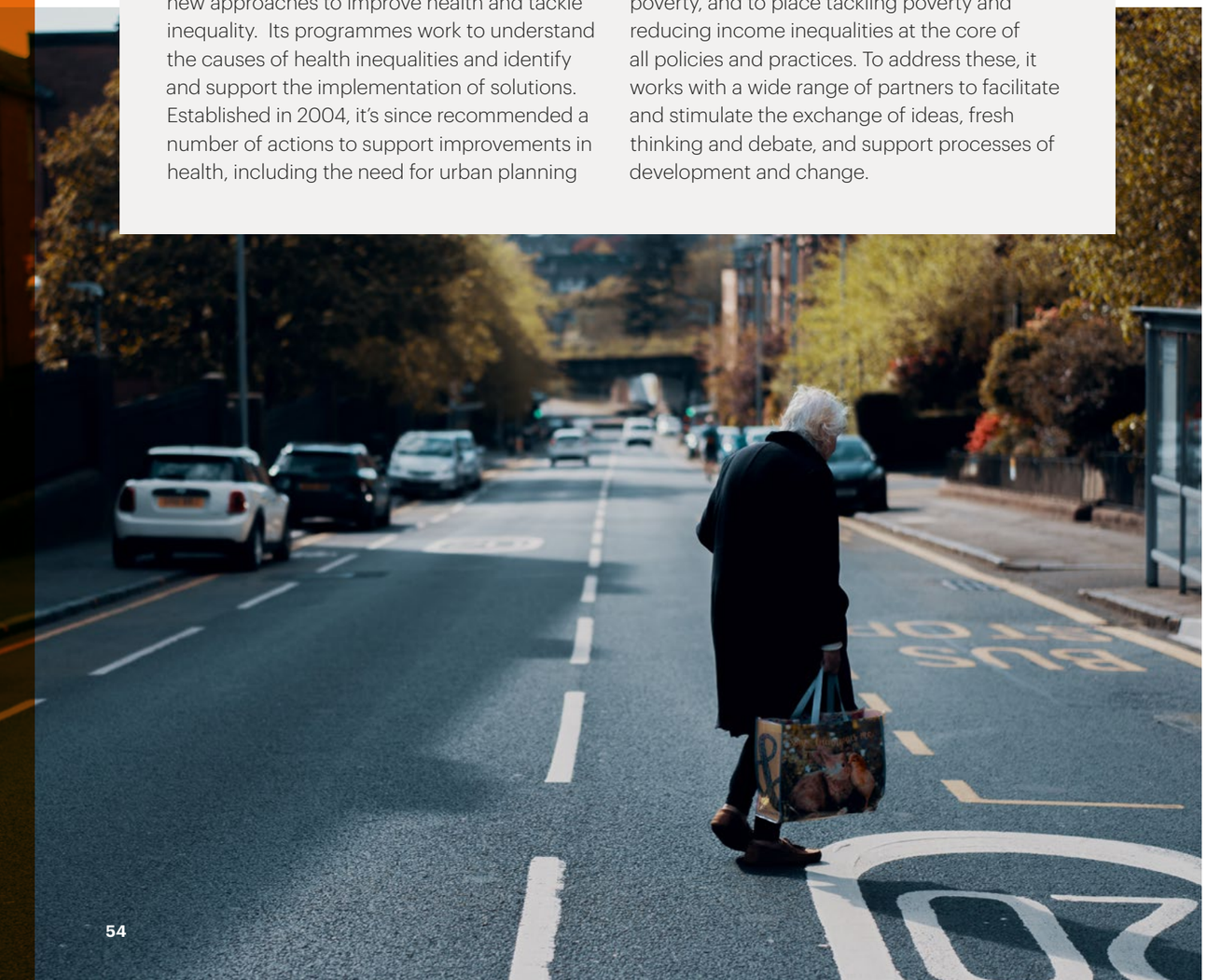
Poverty: Gorbals has high levels of poverty, including child poverty, unemployment and obesity compared with the Glasgow average. Govanhill is one of the most densely populated areas in Scotland, which has placed strain on local infrastructure and services.

The Deep End Group: ‘holistic approaches to health.’

Deep End group is a network of GP surgeries in Scotland. They cover the 100 most deprived patient populations in the country. GPs share experiences of the challenges they face in supporting people with complex needs. A joined-up, holistic approach to healthcare helps support those with multiple long-term conditions, drug and alcohol problems and social isolation. Deep End GPs have also pioneered working more closely with non-medical experts, for example community Link Practitioners and financial advisors, recognising the importance of social determinants as both risks and benefits to health.

The Glasgow Centre of Population Health

The Glasgow Centre for Population Health generates insights and evidence and supports new approaches to improve health and tackle inequality. Its programmes work to understand the causes of health inequalities and identify and support the implementation of solutions. Established in 2004, it’s since recommended a number of actions to support improvements in health, including the need for urban planning to consider health impact, initiatives to improve early life experience with a focus on tackling poverty, and to place tackling poverty and reducing income inequalities at the core of all policies and practices. To address these, it works with a wide range of partners to facilitate and stimulate the exchange of ideas, fresh thinking and debate, and support processes of development and change.



About Glasgow

With a population of 633,000, Glasgow is Scotland’s most populous city, although significantly smaller than London in both population size and density[104]. Typical of many post-industrial cities, Glasgow experienced significant growth in the early to mid-twentieth century during its time as a manufacturing and shipping hub, followed by population decline and economic stagnation through the latter half of the 1900s. This period of managed decline was accompanied by urban renewal programmes, which included the demolition of low-income housing and neighbourhoods and the relocation of primarily lower-income residents to peripheral tower estates and new towns[105].

Recent decades have seen some reversal of these trends, with Glasgow increasing in population by 7.8% since 1998. As the population has grown it has also become older, with a 25% increase in the 64 plus age group, and more ethnically diverse[106], with a 400% increase in residents from non-white ethnic groups[107]. Glasgow is more spatially segregated than London, with ethnic minorities tending to concentrate in more northern and southern districts, while white residents generally occupy the central districts bordering the River Clyde.[108] While this segregation largely conforms to the distribution of deprived areas in Glasgow, with ethnic minorities more likely to live in a deprived area[109], Glasgow overall has a high degree of deprivation.

The link between socioeconomic deprivation and health is well established, but Glasgow’s particularly poor health outcomes have come to be described as the ‘Glasgow Effect’. Glasgow has the highest mortality rates and the lowest life expectancy of any city in the UK or western Europe, but research has shown Scotland’s overall morbidity and mortality rates to be above what would normally be attributable to deprivation. Compared to UK cities with similar deprivation profiles, Glasgow has a 30% higher rate of deaths under the age of 65. Deaths among Glaswegians are also 27% higher for lung cancer, 70% higher for suicide and nearly 2.5 times higher for alcohol and drug-related poisonings[110].

Speculation as to the cause of the ‘Glasgow Effect’ includes the legacy of urban renewal projects which concentrated marginalised groups and a culture of limited social mobility and risk-taking behaviours. In the absence of a single explanation, Glasgow has adopted a holistic approach to health and social determinants of health to address the city’s poor health outcomes. One approach, the Glasgow Community Plan, outlines a focus on economic growth, resilient communities, equity, childcare and transport as strategies to improve overall community health.

30%
higher rates of deaths under the age of 65

400%
increase in non-white ethnic groups since 1998

24%
increase in residents over the age of 64

2.5x
higher death rate for alcohol and drug-related poisonings

104 National Records of Scotland. ‘Glasgow City Council profile’. 2020. www.nrscotland.gov.uk/files/statistics/council-area-data-sheets/glasgow-city-council-profile.html#migration **105** Kirsty Mackay. ‘The Glasgow Effect: examining the city’s life expectancy gap’. The Guardian. 26 February 2021. www.theguardian.com/artanddesign/2021/feb/26/the-glasgow-effect-examining-the-citys-life-expectancy-gap-a-photo-essay **106** National Records of Scotland. ‘Glasgow City Council profile’. 2020. www.nrscotland.gov.uk/files/statistics/council-area-data-sheets/glasgow-city-council-profile.html#migration **107** Walsh, D., Buchanan, D., Douglas, A. et al. ‘Increasingly Diverse: The Changing Ethnic Profiles of Scotland and Glasgow and the Implications for Population Health.’ Appl. Spatial Analysis 12, 983–1009 (2019). doi.org/10.1007/s12061-018-9281-7 **108** Brian Kelly and Stephen Ashe. Geographies of deprivation and diversity in Glasgow. Centre on Dynamics of Ethnicity, University of Manchester. 2014. hummedia.manchester.ac.uk/institutes/code/briefings/localdynamicsofdiversity/geographies-of-deprivation-and-diversity-in-glasgow.pdf **109** Jack Aitchison. ‘Glasgow’s most and least deprived areas revealed in new SIMD figures.’ Glasgow Times. 28 January 2020. www.glasgowtimes.co.uk/news/18193458.glasgows-least-deprived-areas-revealed-new-simd-figures/ **110** Glasgow Centre for Population Health. Investigating a ‘Glasgow Effect’: why do equally deprived cities experience different health outcomes?. 2010. www.gcph.co.uk/assets/0000/0801/GCPH_Briefing_Paper_25_for_web.pdf

Neighbourhood level initiatives: Birmingham, England

Birmingham, a city with similar neighbourhoods to Lambeth and Southwark, offered an opportunity for us to explore neighbourhood level interventions. We found that physical spaces and the people running them can provide strong foundations for healthy neighbourhoods.

We visited a number of neighbourhood projects, each of which relied heavily on the provision of physical and accessible space, underpinned by social support and a well networked community.

Space for people to interact and build neighbourhood-based networks and activities supports mental and physical wellbeing in different ways. Organisations and projects across the board at the neighbourhood level were mindful of tailoring the provision to the specific needs of the community to ensure not only physical access, in terms of location and affordability, but also social accessibility, so people felt the service was welcoming and relevant to them.

These spaces, and the people who bring them to life, are critical foundations for healthy neighbourhoods. Many of the projects were run by a few passionate individuals with a strong commitment to the city and/or local area. These people are the cornerstones of this work. We saw examples of staff going without pay or working outside of their remit to keep services going to ensure the wellbeing of individuals or protect service delivery.

Many of these initiatives drove positive outcomes across sectors. However, in some cases limitedresource, lack of recognition of their work and lack of a voice on the issues they dealt with, often created a disconnect with other sectors whose services or priorities impacted on neighbourhoods or communities. Despite the willingness of community leaders to build valuable relationships with others outside of their sector, they found collaboration difficult when decision makers did not appear to be acting in the best interests of their communities.

Civic Square

Civic Square built on a previous initiative in Birmingham – Impact Hub. At its heart it is a community focused on unlocking the extraordinary capability of every single local resident, and what sits behind it is a deep mission of pursuing systemic change.

Civic Square takes a bold and visionary approach to building and investing in civic infrastructure for neighbourhoods of the future, working with a range of partners. The physical space is situated in the Port Loop housing development and consists of flexible shared spaces as well as an experimental lab, focused on testing new approaches to five key areas, including buildings, business models and circulation of capital.

> *"We know that places, cities, systems are never static. Just when you think you have an understanding, a map, a plan, it changes again, meaning it can never be the responsibility of a single organisation, a single approach, a single sector, a single way of doing or thinking alone in order to understand, nor to act."* – CIVIC

Impact on Urban Health: Neighbourhood schemes

Through our Faraday Neighbourhood Scheme, we're working with a group of local and national organisations to encourage children and families to eat well and move more in Southwark's Faraday ward. Faraday has the highest rates of childhood obesity in the two London boroughs we work in, as well as some of the greatest levels of deprivation. Almost a quarter (23%) of children under five living in Faraday are an unhealthy weight.

Our five-year programme has funded a range of activities designed to reduce childhood obesity. For example, we are helping social support project Parents and Communities Together (PACT) to pilot a weekly community cooking club for local parents, while our partner, the Alexandra Rose charity provides vouchers for local families to buy fresh produce from their local market. 95% of families reported eating more fruit and vegetables after receiving the Rose vouchers.

Neighbourhood snapshot: Ladywood and Aston

Population: Ladywood and Aston are two of the most populous wards in the city (Ladywood: 20,250, Aston: 22, 636)

Diversity: Ladywood is one of the most multicultural neighbourhoods in Birmingham and has a very high proportion of residents aged 18-44. Aston has a higher Black and South Asian population, with over 50% being of Pakistani or Bangladeshi heritage and with 44% of the population born outside the United Kingdom. 15.6% do not speak English as their main language, well above the national average of 1.9%[124].

Poverty: In Ladywood, average income levels are above the average for the city. Aston has one of the highest rates of unemployment in the city;just44.5% of residents are employed compared to the city average of 60% and national average of 71.2%. The average income in Aston (£12,033) is 35% less than the average income (£18,788) in England as a whole[125].

About Birmingham

Birmingham is the UK's second largest city, but only a fifth of London's size with 1.14 million residents[111]. Despite its small size, it has similar density rates to London, with 4,200 people per square kilometre[112]. Like London, Birmingham had a major influx of immigrants from the Commonwealth following World War II, with particularly large communities from South Asia and the Caribbean. In the 1950s and 1980s further waves of economic immigration came from Ireland, followed by further immigration from Eastern Europe with the expansion of the EU, making the city one of the UK's leading multicultural cities.

At the time of the 2011 census, 22% of Birmingham's residents were born overseas and nearly half of those were recent migrants to the UK[113]. While the city has long been a destination for immigrants, international immigration has been declining in recent years and in 2019 was down 38%, the lowest estimate since 2013[114]. Birmingham is also racially diverse and projected to become a majority-minority city within the next decade[115]. 58% of the population is white, 27% Asian, and 9% Black[116]. Overall, there is a young age structure with 64% of the population of working age and only 13% aged 65 and older.

Birmingham is a quintessential post-industrial city. Once called "the first manufacturing town in the world", its industrial economy boomed from the late 18th century through the post-war years but ultimately collapsed in the 1970s[117]. The city lost as many as 200,000 jobs between 1971 and 1981 and plummeted from having the highest GDP of any UK city to the lowest in just five years[118]. The legacy of this economic collapse is still visible today: unemployment sits at around 8%[119] and Birmingham is the third most deprived English city, with 43% of the population living in areas with high rates of deprivation. In some areas of Birmingham, it is estimated over 50% of children live in poverty[120]. Growing wealth inequality in the city is further exacerbating existing social disparities. The highest-paid full-time workers earn 6.5 times as much as the lowest-paid, compared to 3.5 as much nationally (2020 figures). The distribution of personal wealth is even more unequal, with the wealthiest 10% having 850 times the wealth of the bottom 10%[120].

Like London, Birmingham benefits from a comparatively high level of healthcare provision compared to similar cities in other countries, but equitable access to healthcare and the determinants of health and wellbeing remain a challenge. Compared to Birmingham's most affluent residents, those living in the most deprived communities have lower life expectancies[122], are three times more likely to be admitted to hospital for treatable conditions and three times more likely to have a long-term health condition. These disparities are compounded when race is factored in: Black Caribbean residents make up 17% of all in-patients, four times more than expected based on population proportions.

Birmingham Public Health has developed a policy framework[123] and implementation strategy to improve and protect health and wellbeing in the city by reducing health inequalities. The plan prioritises addressing key health concerns at different life stages, in addition to a focus on a healthy environment, including strategies around social deprivation, air quality, nutrition and housing conditions.

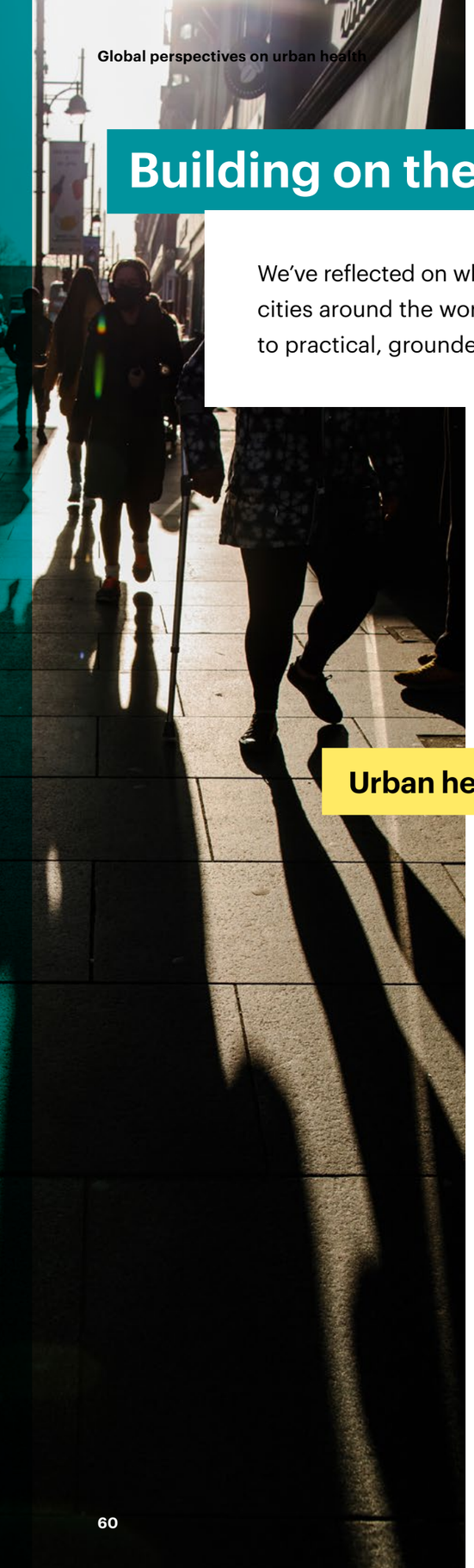
22%

of residents were born overseas

50%

of children in certain areas live in poverty

113 Birmingham City Council. '2011 Birmingham population and Migration Topic report'. www.birmingham.gov.uk/downloads/file/9742/2011_birmingham_population_and_migration_topic_report **114** Birmingham City Council. '2018 to 2019 International Migration Birmingham.' www.birmingham.gov.uk/downloads/file/11280/2018_to_2019_international_migration_birmingham **115** Birmingham City Council. Community Cohesion Strategy for Birmingham Green Paper. 2018. www.belongnetwork.co.uk/resources/community-cohesion-strategy-for-birmingham-green-paper-forward-together-to-build-a-fair-and-inclusive-city-for-everyone/ **116** Office for National Statistics. 2011. www.nomisweb.co.uk/census/2011/QS201EW/view/1946157186?cols=measures **117** URBACT. urbact.eu/birmingham **118** Ivan Turok and Nicola Edge. The jobs gap in Britain's cities: employment loss and labour market consequences. The Joseph Rowntree Foundation. 1999. www.jrf.org.uk/sites/default/files/jrf/migrated/files/1861347685.pdf **119** Office for National Statistics. 'Labour Market Profile – Birmingham. 2020. www.nomisweb.co.uk/reports/lmp/la/1946157186/report.aspx?#ls **120** Birmingham City Council. 'Index of Deprivation 2019'. www.birmingham.gov.uk/downloads/file/2533/index_of_deprivation_2019 **121** Birmingham Policy Commission on the Distribution of Wealth. Sharing Our Good Fortune: Understanding and Responding to Wealth Inequality. 2013. www.birmingham.ac.uk/Documents/research/policycommission/BPCIV-Distribution-of-wealthfull-report.pdf **122** Birmingham City Council. Birmingham health profile 2019 **123** https://www.birmingham.gov.uk/downloads/file/11845/birmingham_health_profile_2019 **124** Birmingham City Council. 'Aston Ward factsheet'. www.birmingham.gov.uk/download/downloads/id/15446/aston_profile.pdf **125** Birmingham City Council. 'Aston Ward factsheet'. www.birmingham.gov.uk/download/downloads/id/15446/aston_profile.pdf



Building on these findings

We've reflected on what we have learnt from approaches to urban health in cities around the world; from inspiring ideas and alternative perspectives to practical, grounded advice on how to drive positive health impact.

Despite very different cultural, social, political and economic contexts, consistent themes emerged as we explored each city:

- Our health is shaped widely, and unequally, by the places in which we live. Urban environments both create and enforce health inequalities.
- Tackling health inequalities will depend on cross-sector collaboration and bringing a range of perspectives.
- The process of building health equity must be equitable. Deep rooted community has an essential role in building trust, resilience and collective voice.

Urban health is about far more than healthcare

Complex health issues rarely have a single cause, often driven by many interconnected factors. Through different cultural and political contexts, we've explored the commonalities between health and the places people grow up, live and work. This has helped deepen our understanding of what drives positive health outcomes for all.

For the past 50 years, cities have been great engines for prosperity, yet this has always masked huge health inequalities. They are responsible for both the best health and the worst health outcomes in ways that are predictable, entrenched but also amenable to change.

COVID-19 has brought into sharp focus the dramatic impact living in a city and underlying inequalities has on health and has also shown the fragile circumstances of so many people living in urban areas. In the UK, food insecurity for families on lower incomes was exacerbated by the absence of free school meals early in the pandemic, we saw higher mortality rates because of high pollution levels in densely populated areas and low paid employees were at greater risk of contracting the virus through their day-to-day work.

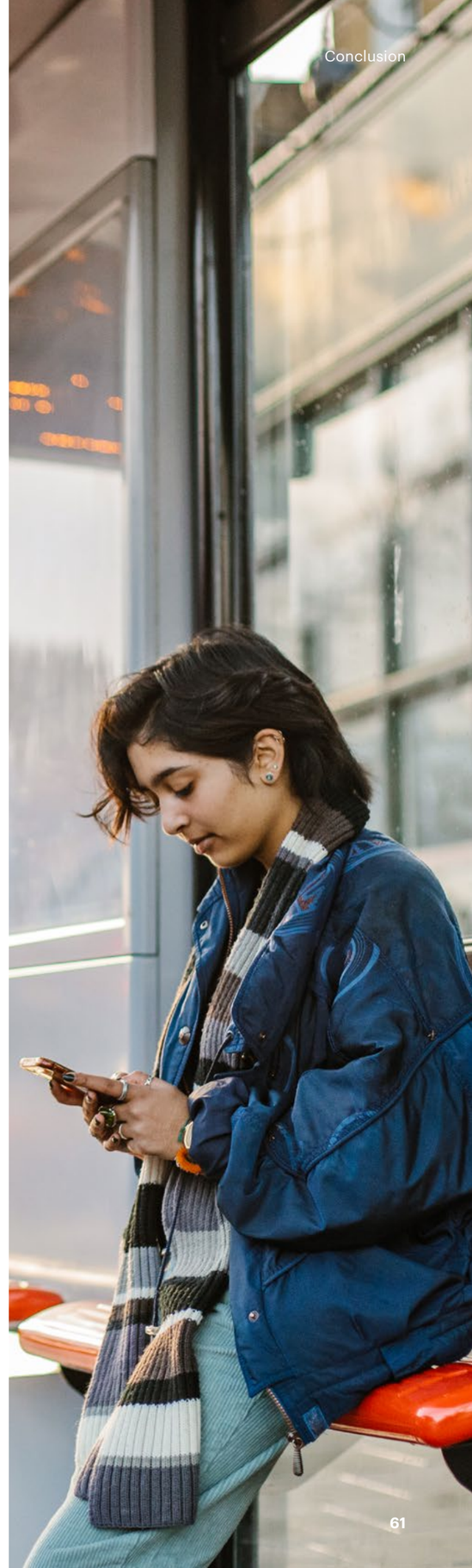
While the social and economic drivers of health are recognised by some, more work is needed to engage those who own the environments that impact on our health that are outside of the healthcare system. We must clarify their role in shaping health environments, push an agenda of collective responsibility for health and bring to the fore the work they are already doing that promotes health, even when health outcomes are not an explicit goal.

Shaping our cities to improve urban health requires a collective effort which goes much wider than the healthcare system, clinical interventions and public health authorities, and includes urban planners, civic institutions, investors, employers and residents. The health disparities we find in urban areas around the world are the outcome of wider systemic inequalities, and these inequalities are woven into the fabric of our societies. Shifting the dial for those disproportionally impacted by poor health outcomes starts with acknowledging that these inequalities exist, but that change is possible.

To achieve health equity, we must prioritise urban areas where the gap between the best and worst health outcomes is widest.

Our commitment: a dedicated taskforce
In 2021, we are creating an urban health taskforce. This two-year project will convene a broad spectrum of voices from urban communities, academia, business, statutory and third sector organisations to drive the urban health debate in the UK. The taskforce will focus on evidence gathering and consultation to establish the key challenges around urban health and to develop recommendations that can be implemented to improve health in our cities. We will also use this platform to help to raise the profile of urban health in the UK and to influence key thinkers working in this space.

> *"An important evolution has been things we did not consider to be part of urban health - the design of our cities, spatial justice, community bonds - all end up fitting into urban health. A city or neighbourhood that looks healthy would be one that had a very good allotment of green spaces, a city that is designed on a human scale, a city that knows not only the very visible and palpable factors that are influencing health - such as air quality - but also the social factors, such as loneliness, which have a huge impact on health."*
>
> **Gabriella Gomez-Mont,** Laboratorio Para la Ciudad, Mexico City



Tackling health inequalities will depend on cross sector collaboration and collective responsibility

Whilst collaborative working is happening in many places it is seldom cross-sector. We need to look at how to encourage and incentivise different sectors to recognise their own influence on health and measure the health impacts of their work. This is particularly important now as we see the impact COVID-19 has had on economies all over the world.

We know that it can be difficult to engage other sectors in the health agenda when health is not their primary business. In our research, we found little mention of work that businesses, investors, ventures, SMEs or private landlords are doing to improve health, and links to housing and transport were also limited. Even when these sectors are having a positive impact on health outcomes it can be difficult to identify and learn from their successes because they are not labelled as 'health'.

Engagement with those outside of healthcare may mean meeting people where they are. On housing this could mean engaging with private landlords on the commercial benefits of reducing void properties rather than starting with the health benefits of providing secure housing tenure. For the commercial sector this could be establishing multi-sector partnerships like Collaboration for Healthier Lives UK where leading food retailers and manufacturers are taking action to improve the healthiness of the shopping baskets of low-income families, meeting the needs of customers while helping to reduce childhood obesity.

The most impactful collective health initiatives connect local community leaders with decision makers, all of whom need to be willing to commit time to building trusted relationships and to be open to experimenting with new ways of working together. For example, in Detroit, the Michigan Health Endowment Fund recognises that many parts of the system are doing great work, but poor communication can lead to duplication and unhelpful competition. To address this, the Fund takes a whole-system view, producing a services map which they analyse for gaps. Once identified, it seeks out grant partners who can fill those gaps, usually drawn from the community level. It is also beginning to bring together leaders from different sectors to leverage the work each are doing and address urban health issues, such as food insecurity, at a systemic level.

This collective approach needs political support at both local and national level to be most effective. Politicians may be reluctant to engage, as systemic change requires sustained commitment and a long-term view, which cannot be measured within a political cycle and does not always neatly align with political priorities. However, cross-sector collaborations can present a strong prospect for politicians if they demonstrate long-term commitment and influence, involve clear and measurable goals and offer resource to implement action, as demonstrated in the multidisciplinary approach seen in Mexico City.

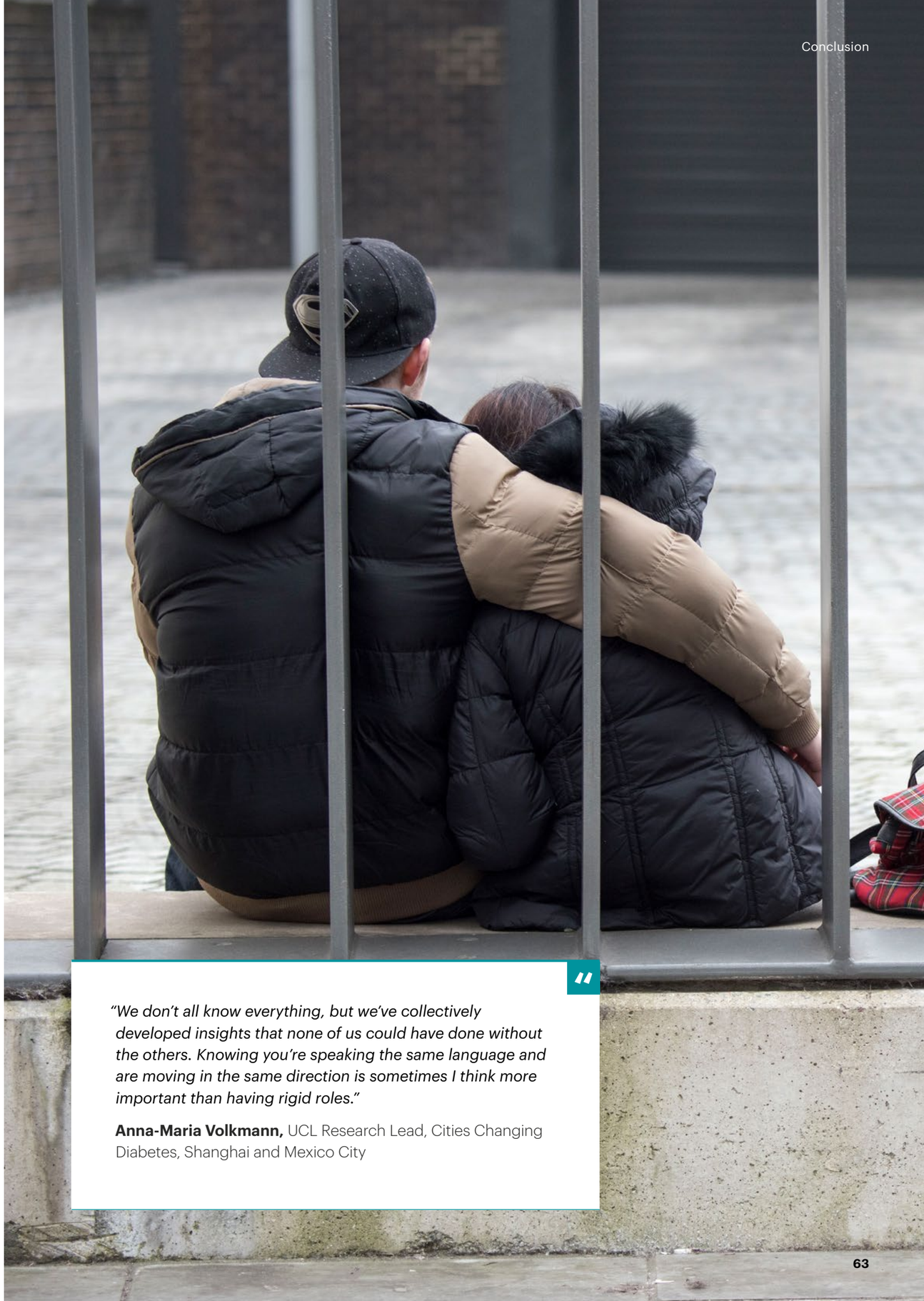
Our commitment: sharing what we learn

The COVID-19 pandemic has taught us now, more than ever, that we live in a globally connected community; that there is much we can learn and achieve from working together.

Truly understanding what works in improving health in inner cities is key to achieving impact. Learning rooted in practice is our contribution to the growing body of evidence around urban health, and we're committed to sharing what we learn about what works and what doesn't with other global cities.

We'll continue to work with decision makers, community leaders, businesses, investors, and others – both here in the UK, and internationally – to build on this research and take practical action towards building health equity.

We'll also continue to work with organisations and people from all sectors, from community groups to large commercial enterprises. Our collaborations with anchor organisations allow us to research issues, develop new methods, test ideas on the ground, share knowledge and evaluate the effectiveness of projects. We will continue to support anchor organisations in Lambeth and Southwark, working with them to test solutions to some of the biggest urban health challenges we face.



> *"We don't all know everything, but we've collectively developed insights that none of us could have done without the others. Knowing you're speaking the same language and are moving in the same direction is sometimes I think more important than having rigid roles."*
>
> **Anna-Maria Volkmann,** UCL Research Lead, Cities Changing Diabetes, Shanghai and Mexico City

The process of building health equity must be equitable

We can only achieve health equity through an equitable process that invests time, rebalances power and builds trust. This is critical in ensuring that a genuinely collective voice advocates for better health.

Taking the time to fully understand the experiences of people living and working in cities, will keep the process of engagement, involvement and delivering action centred on the perspectives of urban communities.

The common narrative suggests poor engagement of marginalised communities is due to their lack of trust of those in power. This may be true, but it is often the case that those in power also lack trust in these communities and therefore fail to recognise their value in such processes. Often the real barrier to including such voices is the imbalance of power. Those with the capacity or ability to direct or influence decisions can be reluctant to share this power. This often manifests itself through limiting access to, and removing opportunities be involved in, the decision-making process.

Acknowledging and placing equal value on the different perspectives of stakeholders and addressing them accordingly builds trust and is necessary to enable a true collective effort and fullest participation. Redressing power imbalances creates a firm foundation on which to develop health equity goals for cities. It also prevents building inequity into systems and solutions. Our research highlighted how this approach worked in São São Paulo and in Shanghai, with both the Better Hearts, Better Cities and Cities Changing Diabetes initiatives building trust, taking time to explore cultural differences and engaging in genuine co-creation to successfully tackle big urban health issues like hypertension and diabetes.

In our experience, decision makers in cities are often working with limited resources and facing the challenge of meeting the often-conflicting needs of highly divergent and transient populations. This can mean deciding between retaining community organisations and assets, or using their funding to deal with immediate needs. The social value of these organisations, that often translate into tangible health benefits, is rarely understood or acknowledged. This is because their impact is not easy to measure or immediate, with positive changes often realised over the long term.

We believe that community organisations can play a pivotal role in driving positive change in health. They can act as anchor organisations, offering stability and a trusted reference point for community knowledge. Our research also showed that they were best placed to build personal and collective resilience in neighbourhoods, offering trusted support for residents most at risk from poor health outcomes. But they are also flexible and willing to adapt, exploring opportunities to support communities to grow and thrive in response to changing needs. One example of this is the way Queens Community House in New York City improved local people's access to fresh, nutritious produce by establishing a farmers' market with and for the community.

Our commitment: Strengthening our approach to community research and engagement

We recognise that for too long, communities experiencing the negative consequences of inequality have been the subjects of research programmes. As demonstrated by numerous examples in this report, improvements in health which have been driven from the ground up rely on communities instead becoming partners in the design and implementation of research and active agents in developing solutions.

That's why Impact on Urban Health has invested in developing a Community Research approach, with our strategic partner, The Social Innovation Partnership, built upon principles of community leadership and co-ownership. It ensures that people who are living in a place and are experiencing the challenges that organisations are trying to solve are more involved in local research, and the projects and interventions that come out of that research. The Community Research team leverage their knowledge, awareness and relationships in their communities in Lambeth and Southwark to deliver nuanced insight that would be inaccessible through traditional research methods.

We believe this mutually beneficial approach will not only enable us to learn and to build our understanding of urban health, but will also build new networks and connections, creating opportunities for local voices to have greater influence on what matters in urban health.

> *"It is important that you don't tear down things that are important to people and communities: new developments must be based on what local people value and what they need."*
>
> **Sadie Morgan,** de Rijke Marsh Morgan Architects (dRMM)

We believe cities around the world can and must learn from each other if we are to achieve health equity in urban areas. Collectively we need to rethink approaches to health to consider the reality of people's lives; to drive positive change to health in cities; to think differently, try new things and bring others with us on the journey.

It is essential that we ask the questions and build the relationships that will allow us to understand the day-to-day experience of living and working in a city, rather than focusing our efforts via existing structures and professional specialisms. Listening, collaborating and adapting will give us all the best chance of tackling health inequalities.

We are committed to playing our part. With individuals and organisations across the world, we want to continue to learn from other cities and share what we discover to inform urban health approaches across the UK and globally. Like other organisations we have the potential to galvanise different sectors within our own nation and, internationally, to work towards our goal of urban health equity. We believe that reshaping cities so they are healthier places for everyone is not just about improving urban health, but a critical route to improving global health.

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