THE STATE OF URBAN HEALTH

LIVING SIDE BY SIDE,
BUT WORLDS APART

Impact
on **Urban**
Health

ACKNOWLEDGEMENTS

We are grateful to the residents and our partners in Lambeth and Southwark who shared their time, experiences, and insights with us. Their contributions have been central to shaping this research, ensuring that the findings reflect not only patterns in the quantitative data, but the realities of people's everyday lives and the systems they navigate.

Participants described the research process as energising and valuable, highlighting the importance of creating space for shared reflection, learning, and connection. At the same time, some residents expressed frustration at the lack of visible progress on issues affecting their communities, and a clear desire for these conversations to lead to meaningful and sustained change. The insights shared through this work offer a rich and important perspective on urban health, and the importance of driving actual change. While this report draws on these contributions throughout, we recognise their value in their own right and will publish a dedicated piece to explore these insights in more depth.

We are also grateful to members of our advisory group for their thoughtful challenge, guidance, and expertise throughout the development of this work. Their feedback helped strengthen the work, sharpen the framing, and ensure the findings are relevant and useful for decision-makers.

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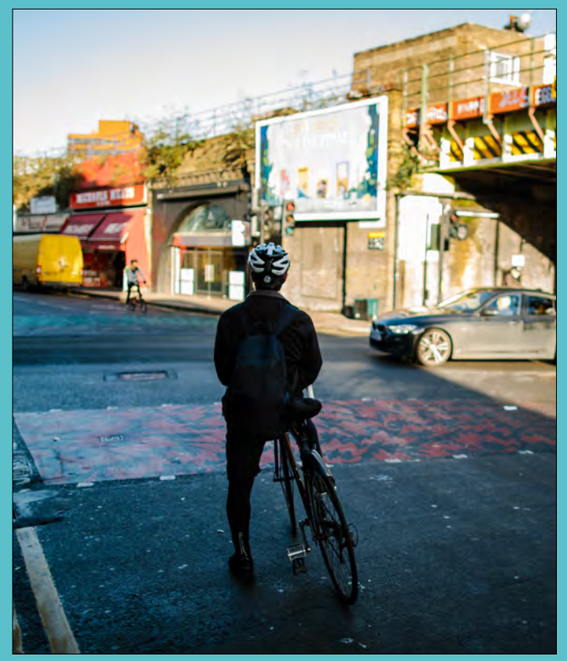
EXECUTIVE SUMMARY

FOR MOST PEOPLE IN ENGLAND, URBAN HEALTH IS HEALTH.
URBAN LIFE IS WHERE SOME OF THE STARKEST HEALTH INEQUALITIES ARE FOUND. BUT THESE INEQUALITIES ARE NOT INEVITABLE, THEY ARE PREVENTABLE. THE STATE OF URBAN HEALTH REVEALS HOW PLACE AND SYSTEMS SHAPE HEALTH, AND WHERE ACTION CAN CHANGE OUTCOMES.

Urban areas are home to more than eight in ten people in England. They are centres of diversity, opportunity, and growth. But they are also where health inequalities are most concentrated, complex, and persistent.

The State of Urban Health provides one of the most comprehensive pictures of urban health in England to date. It combines analysis of over 120 national indicators with lived experience from residents and our partners in Lambeth and Southwark, alongside wider evidence. This research enables us to understand not only where there are inequalities, but how they are shaped by systems and experiences in daily life.

This report sits alongside a suite of data dashboards and resources, designed to make urban health visible, navigable, and actionable. Together, they provide a shared evidence base to explore inequalities in more depth and support more informed decision-making.



The most striking findings from this analysis are:

1. **Urban life expectancy is shorter — and urban areas contain some of England's starkest health inequalities.**

2. **Living in deprived urban areas can more than double your risk of poor health.**

3. **Poverty in urban areas is widespread — and for many children, it is the norm.**

4. **Health inequalities are structurally driven and shaped by racism and discrimination.**

5. **Everyday environments and systems are undermining health.**

6. **Communities are clear on what needs to change.**

7. **Urban health inequalities are not inevitable — they are systemic and preventable.**

URBAN LIFE EXPECTANCY IS SHORTER — AND URBAN AREAS CONTAIN SOME OF ENGLAND'S STARKEST HEALTH INEQUALITIES

People living in urban areas can expect to live on average **two years less** than those in rural areas. And in urban areas the range of average life expectancy is much wider.

Urban areas include both some of the best and worst health outcomes nationally, with stark differences often found between neighbouring communities.

Preventable mortality [1] is also around **10% higher** than the national average — indicating a greater burden of deaths that could be avoided through effective public health and healthcare.

Serious illness is also more common. Emergency hospital admissions for conditions such as chronic obstructive pulmonary disease (COPD) are on average around **twice as high** in urban areas.

[1] **Preventable mortality:** "...deaths are considered preventable if, in the light of the understanding of the determinants of health at the time of death, all or most deaths from the underlying cause (subject to age limits if appropriate) could mainly be avoided through effective public health and primary prevention interventions." (Department of Health and Social Care (DHSC)).

LIVING IN DEPRIVED URBAN AREAS CAN MORE THAN DOUBLE YOUR RISK OF POOR HEALTH

People living in the most deprived urban neighbourhoods experience preventable mortality rates more than **two and a half times** higher than those in the least deprived.

Across multiple indicators, urban areas contain both the highest and lowest outcomes in the country. This means that people living just streets apart can experience entirely different realities of health.

POVERTY IN URBAN AREAS IS WIDESPREAD — AND FOR MANY CHILDREN, IT IS THE NORM

Poverty is one of the most powerful drivers of these inequalities — and it is more prevalent, more extreme, and more concentrated in urban areas.

In England's urban areas, an average of **around one in five children** come from families living on low incomes, but in some areas, this rises to as many as **nine in ten.**

"Ultimately, people haven't got money to buy food. They can't cover the cost of living. We thought COVID was bad, but the state of it now [...] it's worse [...] and people just not being able to make their money stretch."

Funded partner, Impact on Urban Health
Children's health and food programme

HEALTH INEQUALITIES ARE STRUCTURALLY DRIVEN AND SHAPED BY RACISM AND DISCRIMINATION

Inequalities for people who experience racism persist across multiple outcomes related to health, including child mortality, housing, and employment, where people from minoritised ethnic groups experience worse outcomes.

These findings point to structural drivers of inequity, including systemic racism and discrimination more broadly, which shape access to resources, services, and opportunity.

”

“...a lot of Black women [are] saying they’re not listened to and they’re not respected when they discuss their children’s housing needs, as simple as that.”

Funded partner, Impact on Urban Health
Children’s mental health programme

EVERYDAY ENVIRONMENTS AND SYSTEMS ARE UNDERMINING HEALTH

Health in urban areas is shaped by the environments people live in and the systems they rely on every day.

Many people are living in conditions that actively harm their health.

For example:

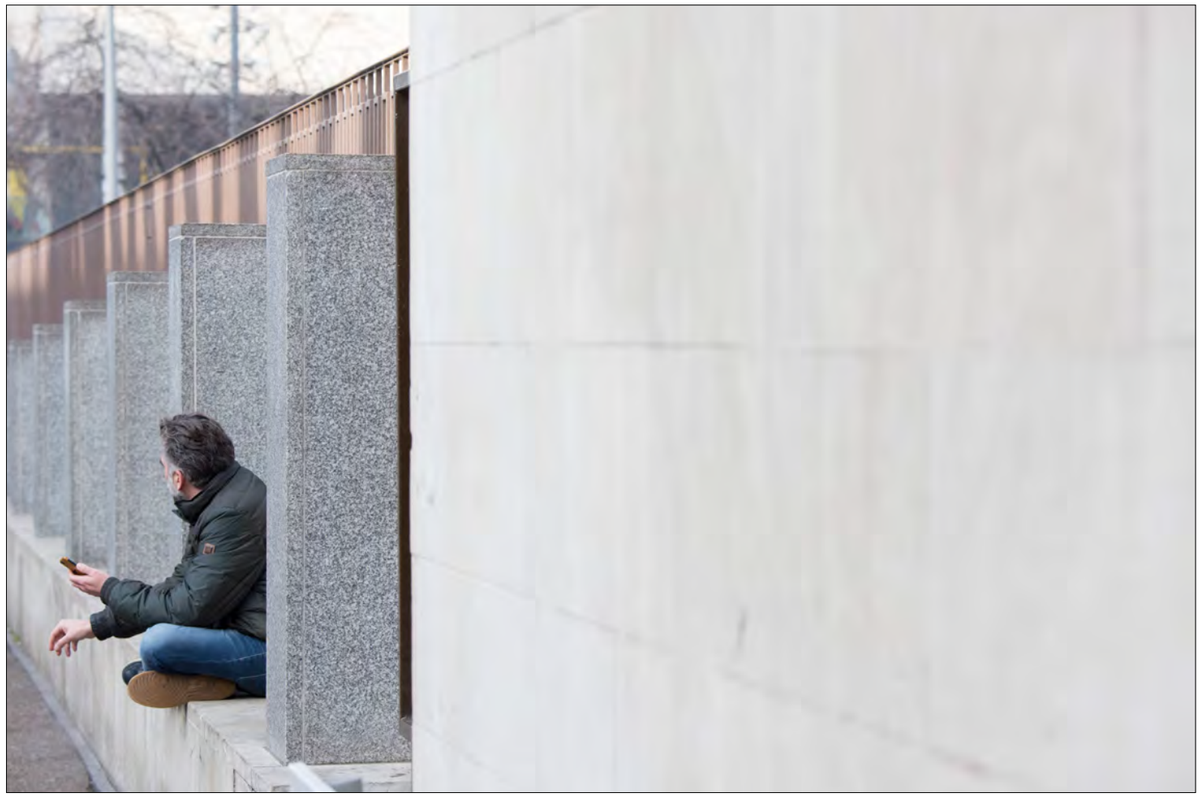
Overcrowding is higher in urban areas.

Homelessness rates in the urban areas we reviewed are far above the national average.

Healthy food is often inaccessible or unaffordable.

Air pollution remains a major health risk.

People in Lambeth and Southwark described systems that are difficult to access, slow to respond, and not designed around their lives – with gaps in mental health, domestic abuse, and other essential support.



”

“The people I work with [...] can’t be healthy if they’re living in bad situations. [...] they’re still going home to a damp and mouldy flat, and they can’t do anything about that.”

35-39; Male; white British

COMMUNITIES ARE CLEAR ON WHAT NEEDS TO CHANGE

People in Lambeth and Southwark we spoke to described similar conditions needed for good health: **trusted local relationships, accessible services, and stable community spaces.**

People were clear that communities already understand what shapes health locally. The challenge is how consistently this insight is reflected in the systems around them.

”

“One thing I’d love to see happen in the next few years is increased investment in community-led health initiatives. I’d like to see more funding and resources allocated to community-led health initiatives, just like developing culturally sensitive means of health support services. That would be very helpful.”

25-29; Female; white British

URBAN HEALTH INEQUALITIES ARE NOT INEVITABLE — THEY ARE SYSTEMIC AND PREVENTABLE

Urban health inequalities are not random or inevitable. **They are deeply concentrated within places and shaped by the conditions people live in every day.**

The concentration of inequality, where disadvantage is not spread evenly but clustered in specific communities, is what makes urban health both more urgent and more solvable.

RECOMMENDATIONS

Based on the insights from this extensive research, we have two key recommendations for policymakers to improve the health and lives of people living in urban areas and increase health equity.

RECOMMENDATION 1

Make prevention count in neighbourhood health design

To maximise the potential of the Government's 10 Year Health Plan and Neighbourhood Health agenda, and ensure concerted action on the wider determinants of health to make urban places healthier for everyone to live and work in, we recommend:

1. Centring prevention by requiring Health and Wellbeing Boards to set locally–determined targets and metrics for primary prevention as part of neighbourhood health plans.

2. That these targets, and subsequent action, should be determined in partnership and consultation with local communities, to ensure plans reflect need and reach those people furthest from health equity.

RECOMMENDATION 2

Involve the people most affected by urban health issues in policymaking

We recommend that policymakers across government departments:

1. Actively involve people and communities most impacted by urban health challenges in policy development — starting with the Government's flagship Neighbourhood Health approach. 'Seldom heard' communities should be included by:

   A. Proactively reaching out to these groups, for example via community research organisations which can act as a trusted broker between policymakers and communities.

   B. Ensuring pre-read materials are accessible, by avoiding jargon and making them available in different languages.

   C. Fairly compensating people for their time and expertise.

2. As an enabling step, NHS England should develop "best practice guidance" for local authorities and Health and Wellbeing Boards on involving local communities in Neighbourhood Health policy.

3. To ensure neighbourhood health plans take full account of equity considerations, they should include a specific Equality and Health Inequalities Impact Assessment (EHIA), following the standard format set out by NHS England.

Implications for decision-makers

Urban health is not a niche issue and yet, historically, it has not formed a specific focus in policy and practice efforts to improve health.

More than eight in ten people in England live in urban areas. Making those places health-enabling holds enormous potential to unlock health and equity for the population as a whole, and particularly for those who have faced significant barriers to good health.

While our recommendations are directed to government and to the emerging Neighbourhood Health agenda, this report is relevant to anyone shaping the conditions for health in urban areas. Local authorities, health systems, funders, employers, housing providers, planners, service providers, researchers, and community organisations all make decisions that influence whether urban areas protect health or deepen inequality.

The findings show that urban areas can create opportunities for health, connection, and support, but these benefits are not shared equally. Neighbourhood-level data, lived experience, and a clear focus on the people and places facing the greatest barriers to good health are essential for making better decisions.

EXPLORE

THE DATA

EXPLORE THE DATA

Our interactive **Dashboards** allow users to explore the datasets used in this report in more detail:

- **Urban & Rural Differences**
- **Demographics in Major Urban Areas**
- **Outcomes in Major Urban Areas**
- **Avoidable Mortality**
- **Child Mortality**
- **Housing Conditions**
- **Homelessness**
- **Temporary Accommodation**

Dashboard **User Guides** are available to help users navigate and interpret the dashboards.

Our **Directory of Themes** also provides a detailed bank of quotes from the qualitative research grouped by themes as set out in this report.

THE RESEARCH

THE CONTEXT, METHODOLOGY, AND HOW TO USE THE INSIGHTS

For the purposes of this research, an ‘urban area’ is defined as a built-up area with a population of 10,000 or more. We use the term ‘towns and cities’ interchangeably throughout.

CONTEXT FOR THE RESEARCH

At Impact on Urban Health, we understand that 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.

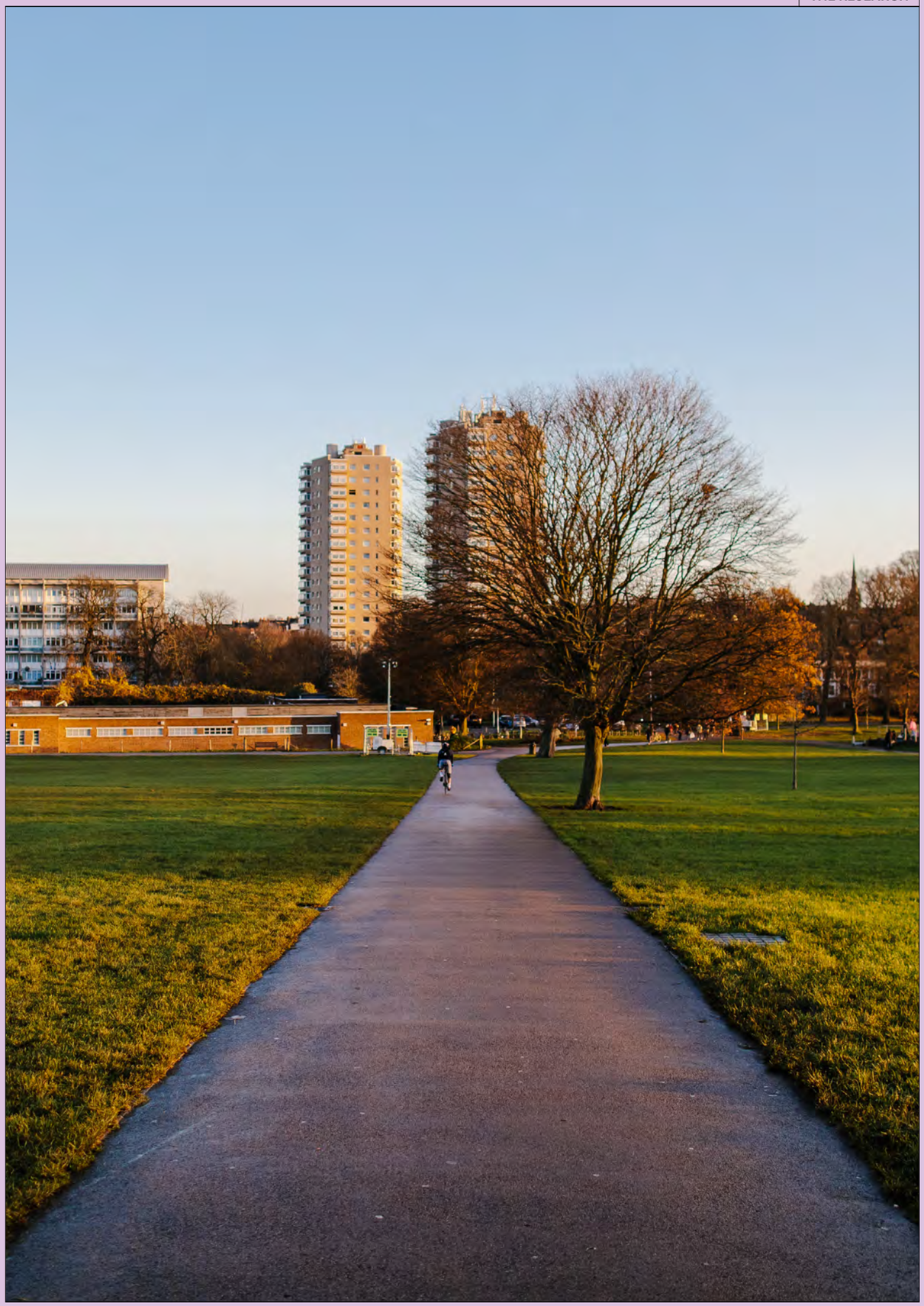
THE LONDON BOROUGHS OF LAMBETH AND SOUTHWARK ARE OUR HOME.

They are some of the most diverse areas in the world. It is here that we invest, test, and build our understanding of how cities can be shaped to support better health.

Living in a town or a city, you could experience some of the best and the worst health outcomes in the UK. Individual health outcomes are shaped by complex systems and interconnected factors at multiple levels — individual, family, neighbourhood, societal, political, and environmental. To reduce health inequalities, we need to understand what inequalities exist and which factors may be driving them.

This work explores where urban-rural differences are most pronounced, what factors may drive inequities in health outcomes, and how urban health systems can evolve to be more equitable and effective.

HOW WE DID THE RESEARCH



QUANTITATIVE ANALYSIS

Descriptive quantitative analysis [2] of 67 publicly available indicators to understand the difference between outcomes in urban and rural areas. In addition, a review of 69 publicly available indicators to understand trends over time, and how selected urban areas (Lambeth, Southwark, Birmingham, Leicester, Manchester, and Southampton) compare with England overall and, where available, inequalities by deprivation, ethnicity, and other key characteristics. Indicators were organised across key thematic domains: demographics, family structures & experiences, health outcomes, housing, money & resources, education, community & neighbourhood, and environment.

QUALITATIVE RESEARCH

Seven focus groups with 26 residents and 21 sector partners in Lambeth and Southwark, exploring lived experience, local contexts, and system influences on health. Our qualitative research was grounded in epistemic justice and co-creation, with participants setting the agenda, ensuring the analysis reflects their priorities rather than a predefined hypothesis.

[2] Our analysis of urban and rural differences focused on differences ('the size of the gap') between urban and rural area averages. We have not assessed whether these are statistically significant.

See **Technical Appendix** for more detail on the specific research methods, sample, and technical notes.

HOW WE BROUGHT THE DATA TOGETHER

We have examined urban health from multiple perspectives, from a big-picture view of England to a zoomed-in look at life in our home boroughs of Lambeth and Southwark. This reflects our belief that any action to improve health and reduce inequalities in urban areas requires both local and national solutions.

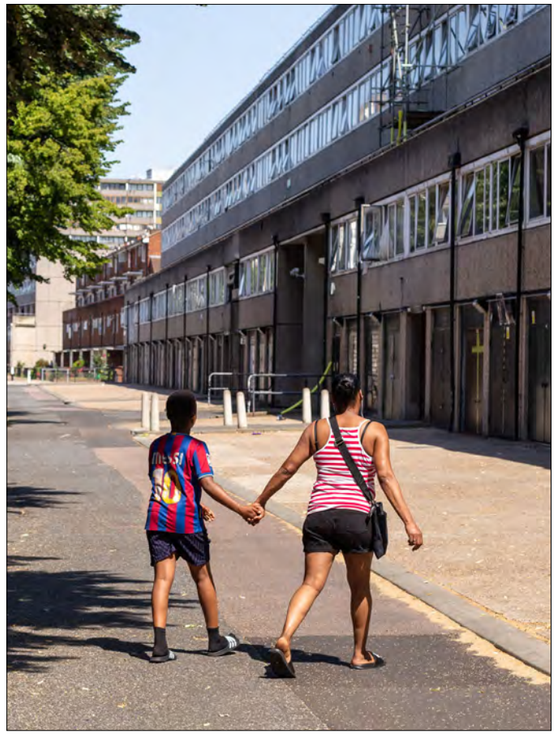
The report is structured around the insights and themes that emerged from this qualitative work. Quantitative indicators sit alongside lived experience to **triangulate, contextualise, and strengthen** what residents and partners told us.

Where helpful, we also drew on existing external evidence. This was not a full or systematic evidence review; instead, we used relevant studies and datasets to deepen and clarify emerging insights.

LIMITATIONS OF THE RESEARCH

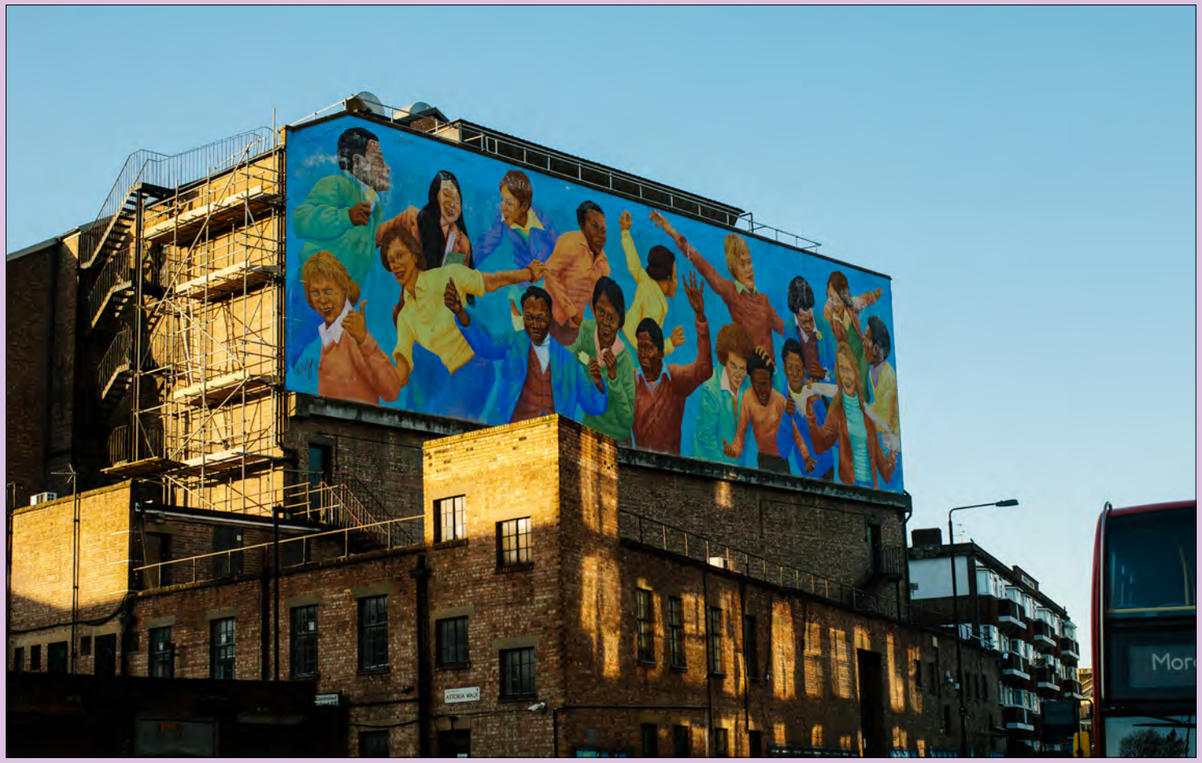
This research combines descriptive analysis of publicly available quantitative data with qualitative insights from residents and partners in Lambeth and Southwark. The quantitative analysis identifies patterns and differences across urban and rural areas but does not test for statistical significance or establish causality.

The qualitative findings provide rich local insight but are not representative of all residents in Lambeth and Southwark or all urban areas in England. Instead, they help interpret how wider systems and conditions are experienced in everyday life. Findings are likely to be most relevant to urban areas with similar patterns of deprivation, diversity, density, and inequality, but should be interpreted alongside local data and community insight.



HOW TO USE THE STATE OF URBAN HEALTH

THE ANALYSIS BEHIND THIS PIECE OF WORK IS EXTENSIVE, AND ONLY A SELECTION OF THE MOST DISTINCTIVE AND MEANINGFUL INSIGHTS APPEARS IN THIS REPORT.



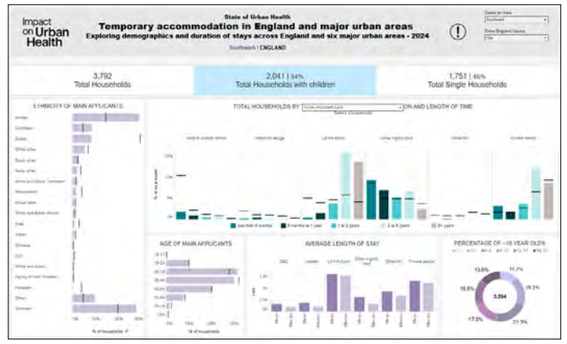
The State of Urban Health is designed as a suite of products:

THIS REPORT

This report summarises the most pressing insights emerging based on analysis of the urban and rural difference and what we heard through the qualitative research.

THE INTERACTIVE DASHBOARDS

The interactive **dashboards** provide further access to the data we analysed allowing anyone to explore the full dataset, compare indicators across places, and look deeper into what interests them.



THE DIRECTORY OF THEMES

The **Directory of Themes** provides a detailed bank of quotes from the qualitative research that shows the breadth and depth of the insights and lived experience emerging from this work.

Together, they offer a rich, multi-layered view of urban health. They provide a wide range of analysis and insights, as well as ready to use data, that give a picture of the current State of Urban Health based on what matters most to people in Lambeth and Southwark.

Definitions:

URBAN AREA

For the purposes of this research, an ‘urban area’ is defined as a built-up area with a population of 10,000 or more. We use the term ‘towns and cities’ interchangeably throughout.

HEALTH EQUITY

Health equity means everyone having the chance to be as healthy as possible, no matter who they are or where they live. Improving health equity means tackling the unfair and avoidable differences that stop some people and communities from living healthy lives.

MIDDLE LAYER SUPER OUTPUT AREA (MSOA)

A geographic hierarchy used in England and Wales for reporting small-area statistics. They are designed by the Office for National Statistics (ONS) to have a population of 5,000–15,000 residents and 2,000–6,000 households.

LOWER LAYER SUPER OUTPUT AREAS (LSOA)

A small, consistent geographic unit used for collecting and publishing statistics in England and Wales, designed by the Office for National Statistics (ONS). They provide a stable, standard unit (typically 1,000–3,000 residents) for analysing small-area data.

DECILE

Deciles break up a set of data into tenths.

QUINTILE

Quintiles break up a set of data into fifths.

HOW TO READ THE CHAPTERS THAT FOLLOW

EACH CHAPTER IS DESIGNED TO GIVE A SPECIFIC VIEW OF THE COMPLEX PICTURE OF URBAN HEALTH. EACH CHAPTER CAN BE TAKEN AS A STANDALONE SET OF INSIGHTS ON A TOPIC. TOGETHER, THEY PROVIDE A MULTIFACETED VIEW OF **THE STATE OF URBAN HEALTH.**

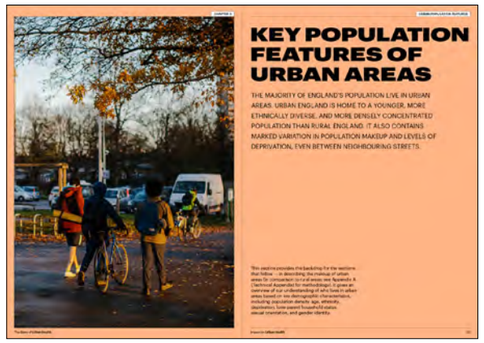
CHAPTERS AND THEIR ASSOCIATED COLOURS

CHAPTER 3	KEY POPULATION FEATURES OF URBAN AREAS
CHAPTER 4	HOW LIVING IN AN URBAN AREA AFFECTS HEALTH AND LIVING CONDITIONS
CHAPTER 5	DRIVERS OF HEALTH INEQUITY
CHAPTER 6	THE SYSTEMS THAT AFFECT HEALTH IN URBAN AREAS
CHAPTER 7	WHAT PEOPLE TOLD US WOULD MAKE A DIFFERENCE

The chapters within this report follow a consistent structure to make the evidence easy to navigate:

HEADLINE INSIGHT

The key story emerging from the data.

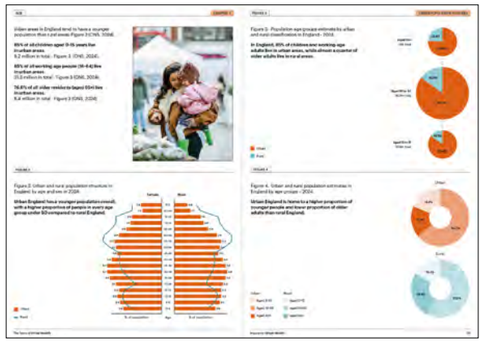


KEY FINDINGS

Summarising key findings from the analyses.

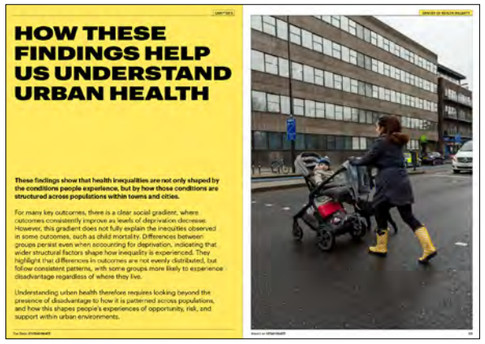
DATA AND ANALYSIS

Figures, charts, indicators, analysis, and lived experience that underpin the findings.



HOW THIS HELPS US UNDERSTAND URBAN HEALTH

How to interpret the findings.



KEY POPULATION FEATURES OF URBAN AREAS

THE MAJORITY OF ENGLAND'S POPULATION LIVE IN URBAN AREAS. URBAN ENGLAND IS HOME TO A YOUNGER, MORE ETHNICALLY DIVERSE, AND MORE DENSELY CONCENTRATED POPULATION THAN RURAL ENGLAND. IT ALSO CONTAINS MARKED VARIATION IN POPULATION MAKEUP AND LEVELS OF DEPRIVATION, EVEN BETWEEN NEIGHBOURING STREETS.

This section provides the backdrop for the sections that follow — in describing the makeup of urban areas (in comparison to rural areas; see **Technical Appendix** for methodology). It gives an overview of our understanding of who lives in urban areas based on key demographic characteristics, including population density, age, ethnicity, deprivation, lone-parent household status, sexual orientation, and gender identity.

EXPLORE THE DATA

- **Urban & Rural Differences Dashboard**

Most data in this chapter come from our dashboards, which you can explore for more detail, so they are not individually referenced. Where we use an inline citation, the data has been analysed or presented specifically for this report, with references provided.

KEY FINDINGS

The majority of people in England — **more than eight in ten** — live in urban areas, across both towns and cities.

Urban England is home to a higher proportion of younger people and a lower proportion of older adults than rural England.

Urban areas are on average more ethnically diverse than rural ones — and in urban areas diversity increases with deprivation.

Urban areas tend to have a higher proportion of residents with an LGBTQIA+ identity than rural areas.

Urban areas tend to have a higher proportion of lone-parent households with dependent children, and this proportion increases with the level of deprivation.

THE DATA AND ANALYSIS

POPULATION DENSITY

Population density [3] is one of the key demographic factors that differentiates urban areas from rural areas, with urban areas much more densely populated.

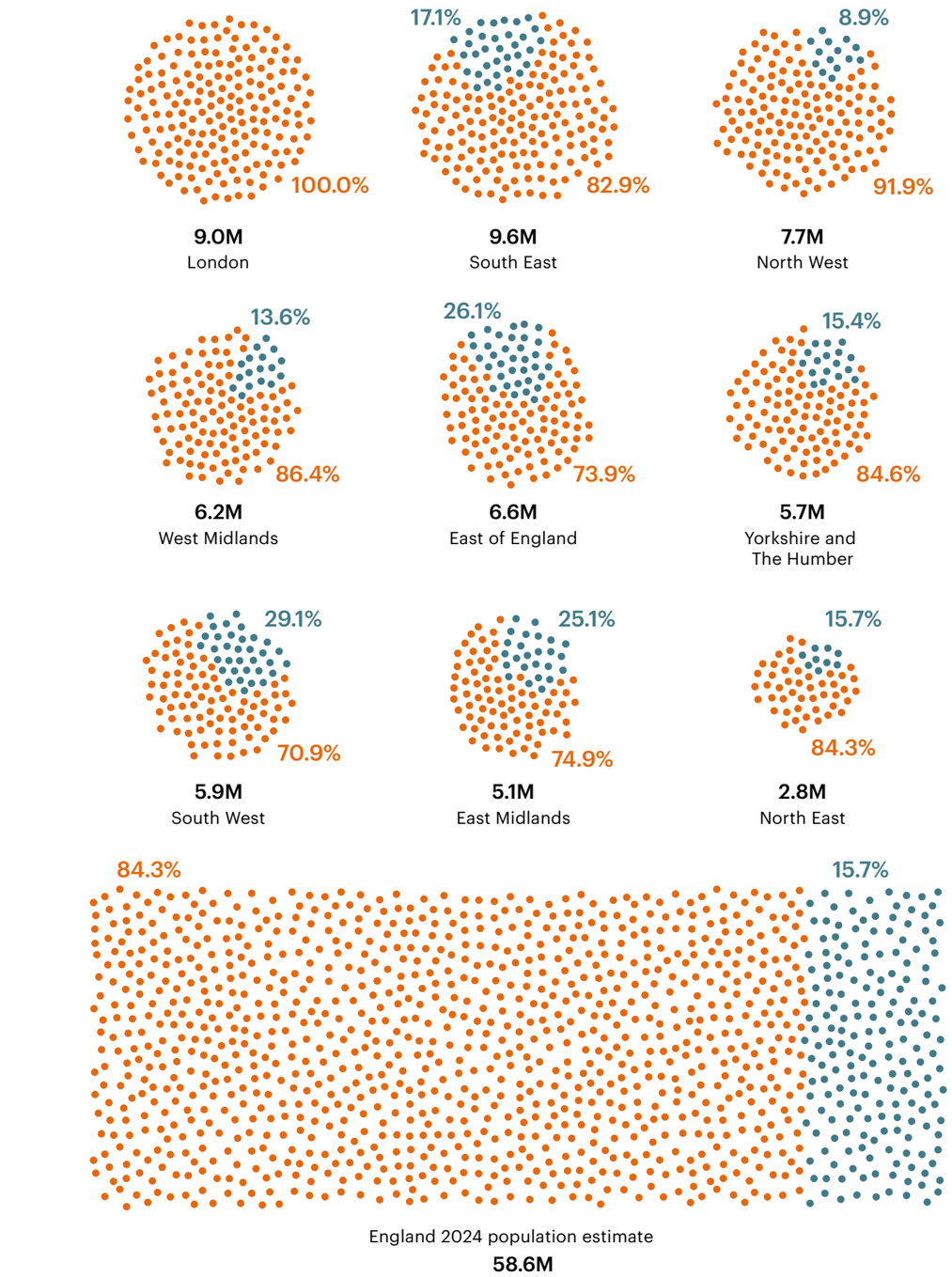
According to the Office for National Statistics (ONS), **84% of the population in England lives in urban areas** and London alone accounts for around 16% of the national population; Figure 1 (ONS, 2024).

On average, the population density of urban neighbourhoods (4,228 people per sq/km) is **18 times higher** than rural neighbourhoods (230 people per sq/km). And on average, the **most deprived neighbourhoods** — whether urban or rural — have more than **double the average population density** of the least deprived areas.

[3] The number of people living in a specific unit of area e.g. square kilometre (sq/km).

Figure 1. 2024 population estimates for each region in England — urban and rural breakdown.

The majority of England's population lives in urban areas, with London alone accounting for around 16% of its residents.



Urban areas in England tend to have a younger population than rural areas; Figure 2 (ONS, 2024).

85% of all children (0-15) live in urban areas.
9.2 million in total — Figure 3 (ONS, 2024).

85% of all working age people (16-64) live in urban areas.
31.3 million in total — Figure 3 (ONS, 2024).

76.6% of all older residents (65+) live in urban areas.
8.4 million in total — Figure 3 (ONS, 2024).

FIGURE 2

Figure 2. Urban and rural population structure in England by age and sex in 2024.

Urban England has a younger population overall, with a higher proportion of people in every age group under 50 compared to rural England.

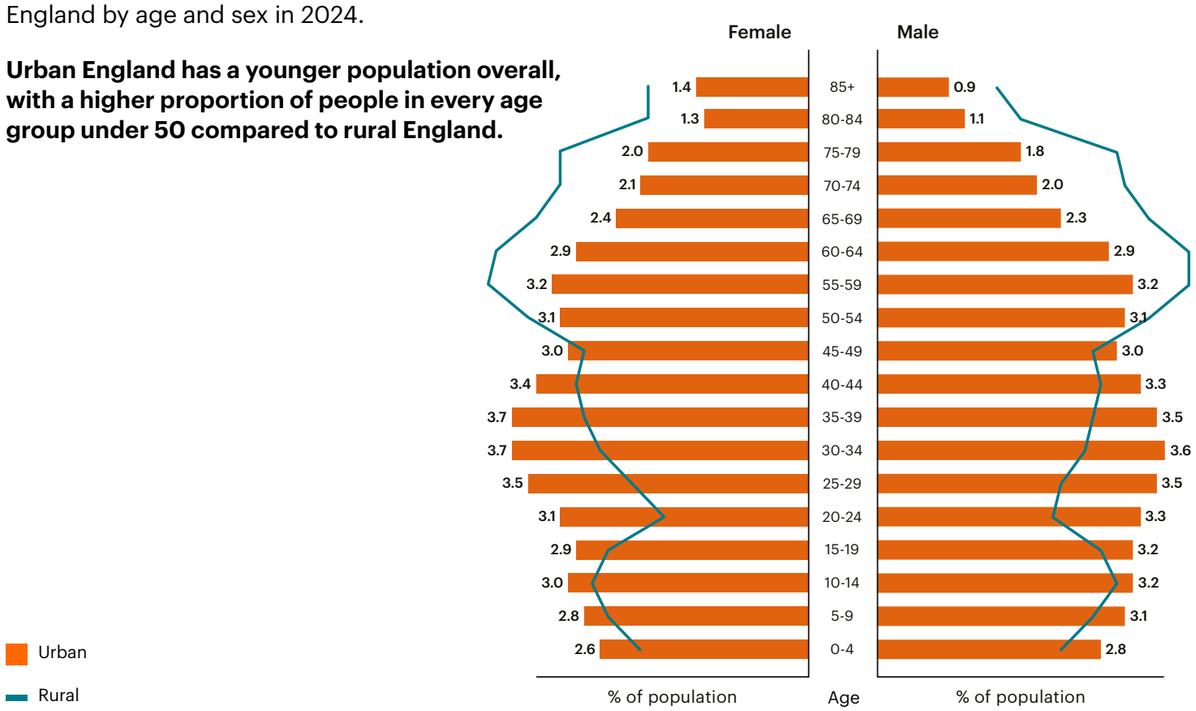


Figure 3. Population age groups estimate by urban and rural classification in England — 2024.

In England, 85% of children and working-age adults live in urban areas, while almost a quarter of older adults live in rural areas.

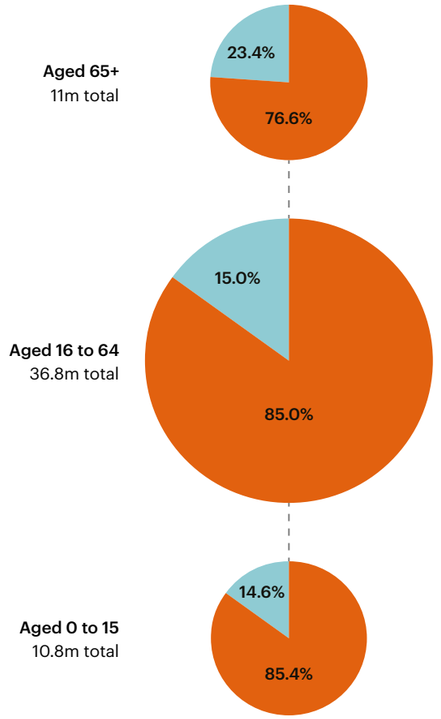
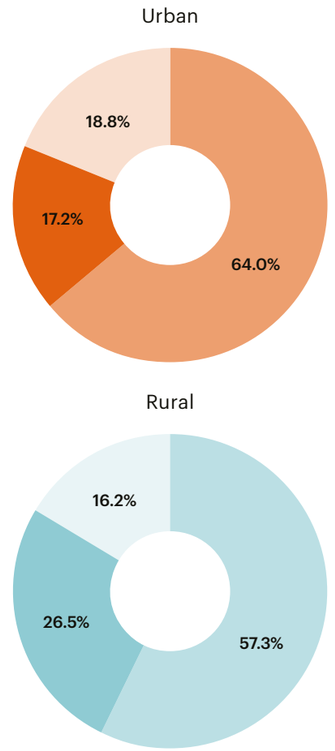


FIGURE 4

Figure 4. Urban and rural population estimates in England by age groups — 2024.

Urban England is home to a higher proportion of younger people and lower proportion of older adults than rural England.



Urban areas are more ethnically diverse than rural areas, on average.

On average, urban neighbourhoods have 7.5 times the proportion of Asian residents and 8.4 times the proportion of Black residents compared to rural areas.

On average, urban areas have a higher proportion of residents from minoritised ethnic groups than rural areas, particularly in the most deprived urban areas; Figure 5 (ONS, 2021).

In some neighbourhoods, one minoritised ethnic group can make up more than 80% of the population, while others are highly mixed.

On average, people in urban areas have a 3 times higher chance of randomly meeting a person from a different ethnic background than their own, than people in rural areas.

Explore further:
- **Urban & Rural Differences Dashboard**

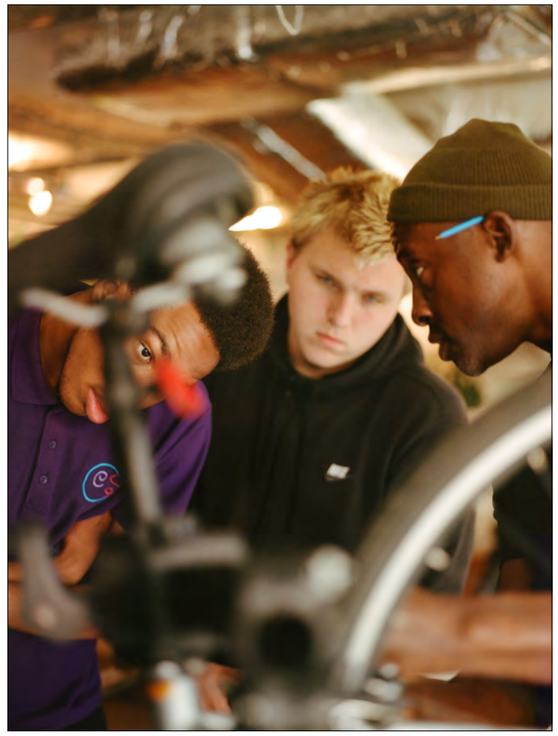
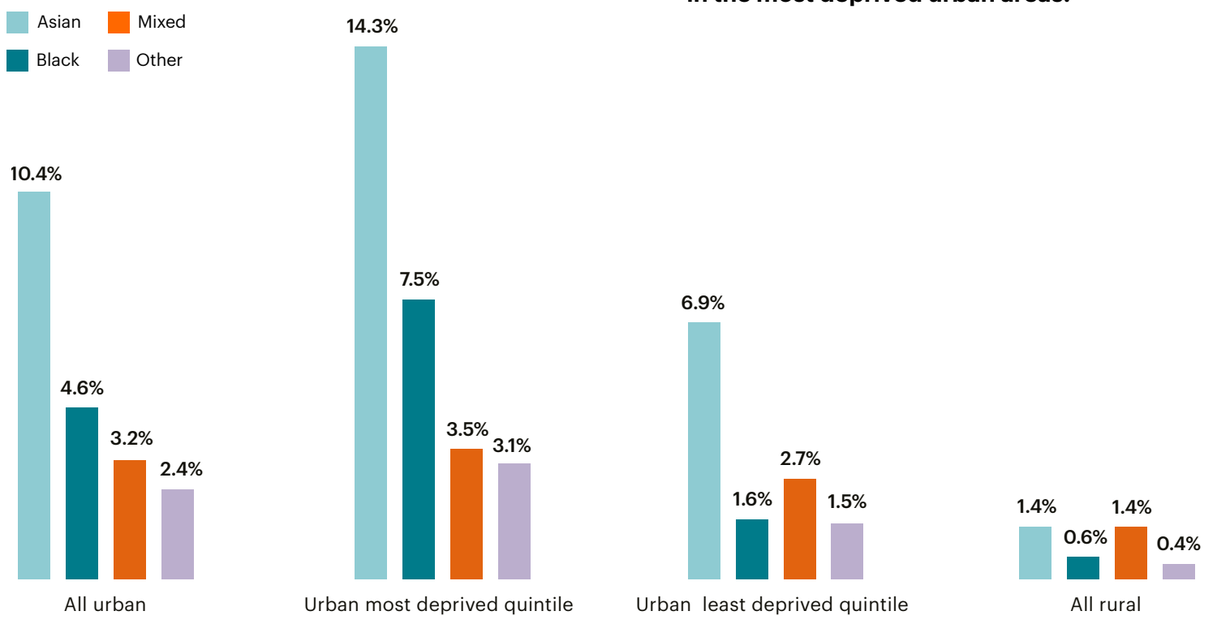


FIGURE 5

Figure 5. Average proportion of residents from minoritised ethnic groups for MSOAs in each area type.

On average, urban areas have a higher proportion of residents from minoritised ethnic groups than rural areas, particularly in the most deprived urban areas.



Overall, urban areas tend to have higher levels of deprivation. Urban areas are overrepresented in both the most and least deprived areas (deciles), meaning urban areas are more likely than rural areas to be very deprived or relatively affluent. Rural areas on the other hand are more likely to have moderate levels of deprivation.

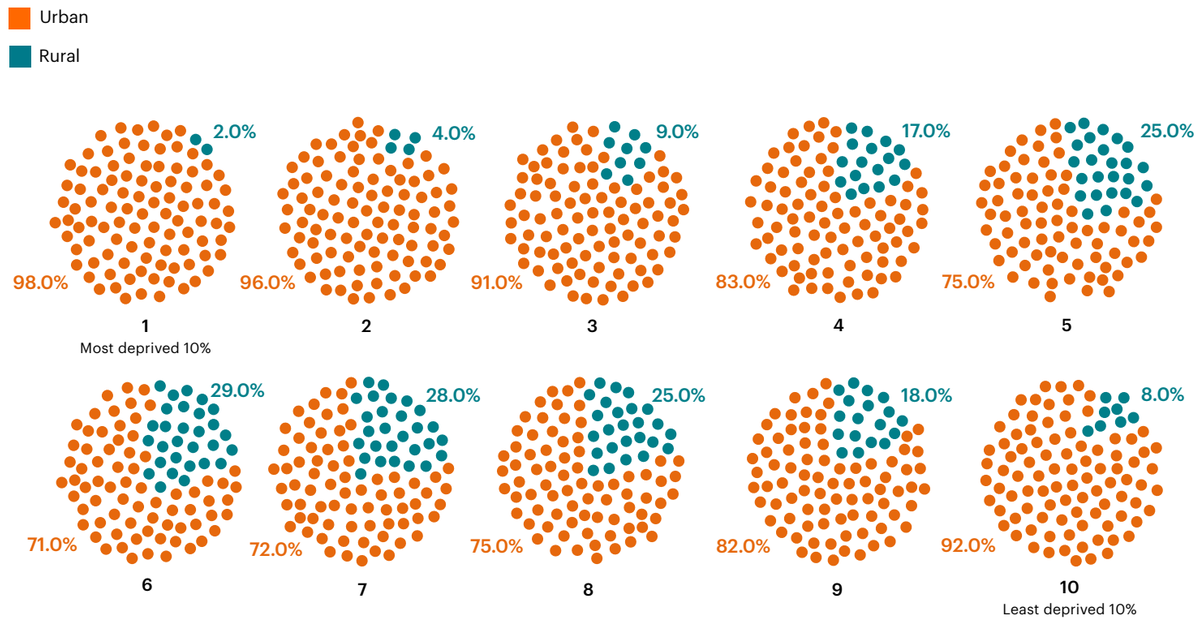
98% of the most deprived neighbourhoods in England are classified as urban; Figure 6 (MHCLG, 2019).

In many deprived neighbourhoods in Manchester, Birmingham and Leicester over a third of residents are 0-19 years old.

FIGURE 6

Figure 6. Proportion of urban and rural LSOAs in each deprivation decile.

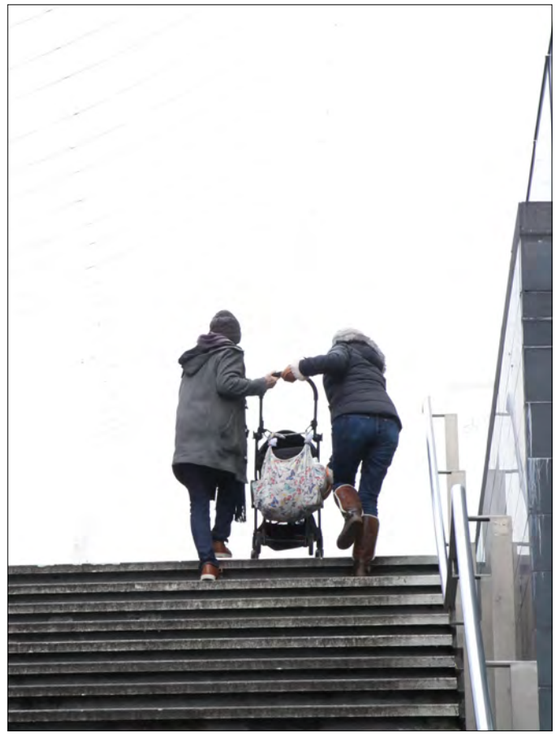
98% of the most deprived areas (LSOAs) nationally are urban.



Urban areas tend to have a greater proportion of households that are made up of lone parents with dependent children.

In urban areas, on average **7.3% of households are made up of lone parents** with dependent children, compared to 4.7% in rural areas. This rises to **11% in the most deprived urban** neighbourhoods; Figure 7 (ONS, 2021).

On average, in the most deprived urban neighbourhoods, one in ten households are households with dependent children headed by a lone parent. In some areas this rises to **one in five.**

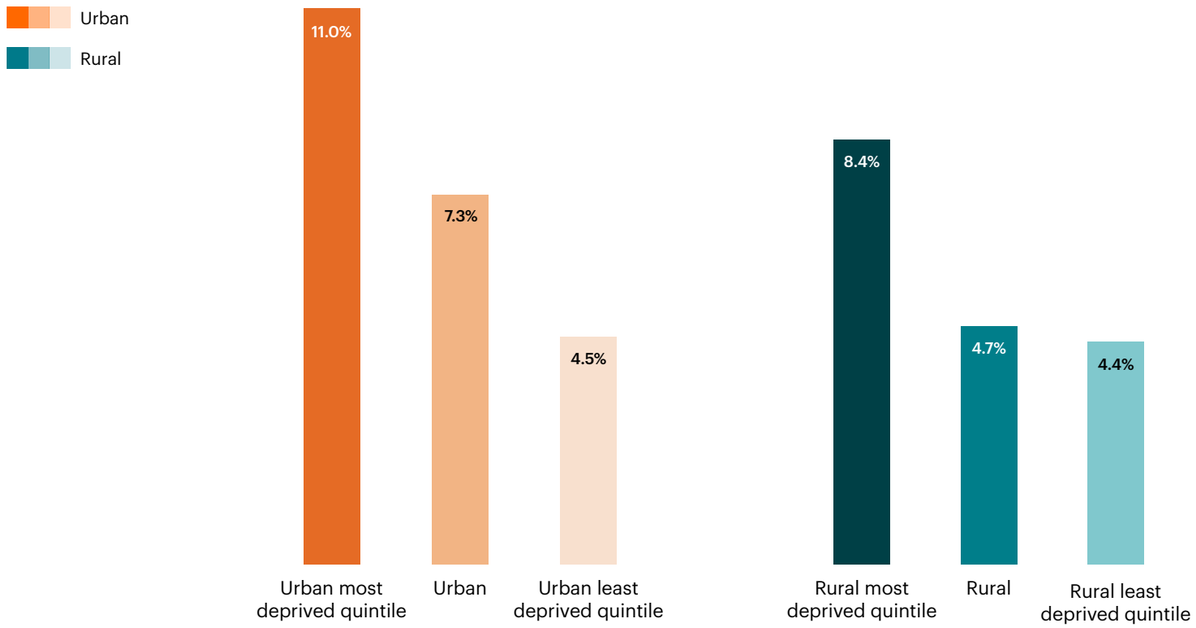


Explore further:
- **Urban & Rural Differences Dashboard**

FIGURE 7

Figure 7. Average proportion of households classified as 'lone-parent households with children' for MSOAs in each area type.

On average, urban areas have a higher proportion of lone-parent households than rural areas.



On average, urban areas have a higher proportion of residents with an LGBTQIA+ identity.

Urban areas have a higher average proportion of residents identifying as gay, lesbian or bisexual, with levels increasing in areas of greater deprivation; Figure 8 (ONS, 2021).

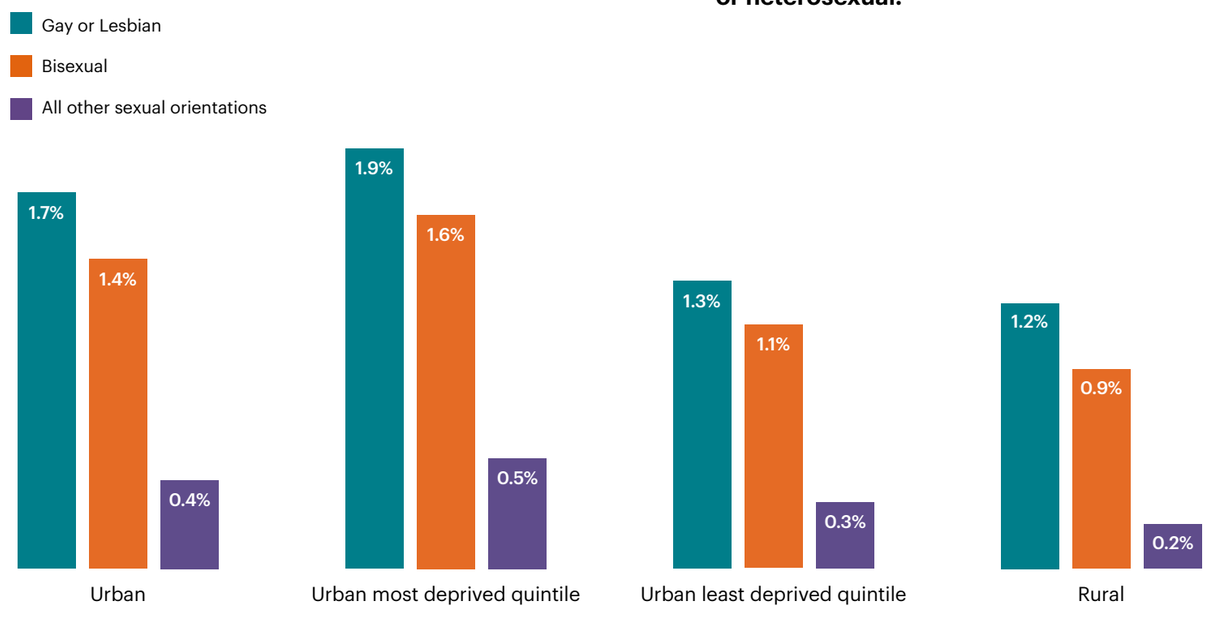
Some London boroughs have neighbourhoods where more than 5% of residents identify as lesbian or gay.

Explore further:
- **Urban & Rural Differences Dashboard**

FIGURE 8

Figure 8. Average proportion of residents by sexual orientation other than straight or heterosexual for MSOAs in each area type.

On average, urban areas have a higher proportion of residents identifying with a sexual orientation other than straight or heterosexual.



On average, urban areas have a higher proportion of residents identifying with a gender different from the sex registered at birth.

In urban areas, the average proportion of residents who identify with a gender different from the sex registered at birth is **0.6%**, twice the rural average of **0.3%**.

The proportion of people identifying with a gender different from their sex at birth is highest in the most deprived urban neighbourhoods (at around 0.9%). This is three times the urban average in the least deprived neighbourhoods (0.3%).

In one urban neighbourhood in Southwark (Burgess Park), 9% of residents identify with a gender different from the sex registered at birth.

A NOTE ON DATA RELIABILITY

The ONS notes that data estimates related to gender identity from Census 2021 can be used to provide broad insights. However, it also flags a high level of uncertainty around this data, likely related to English language proficiency. The Census 2021 estimates showed that respondents with lower levels of English language proficiency were more likely than the general population to say their gender identity was different to their sex registered at birth. This could suggest some have unintentionally given an answer suggesting that they were trans.

Explore further:
- **Urban & Rural Differences Dashboard**

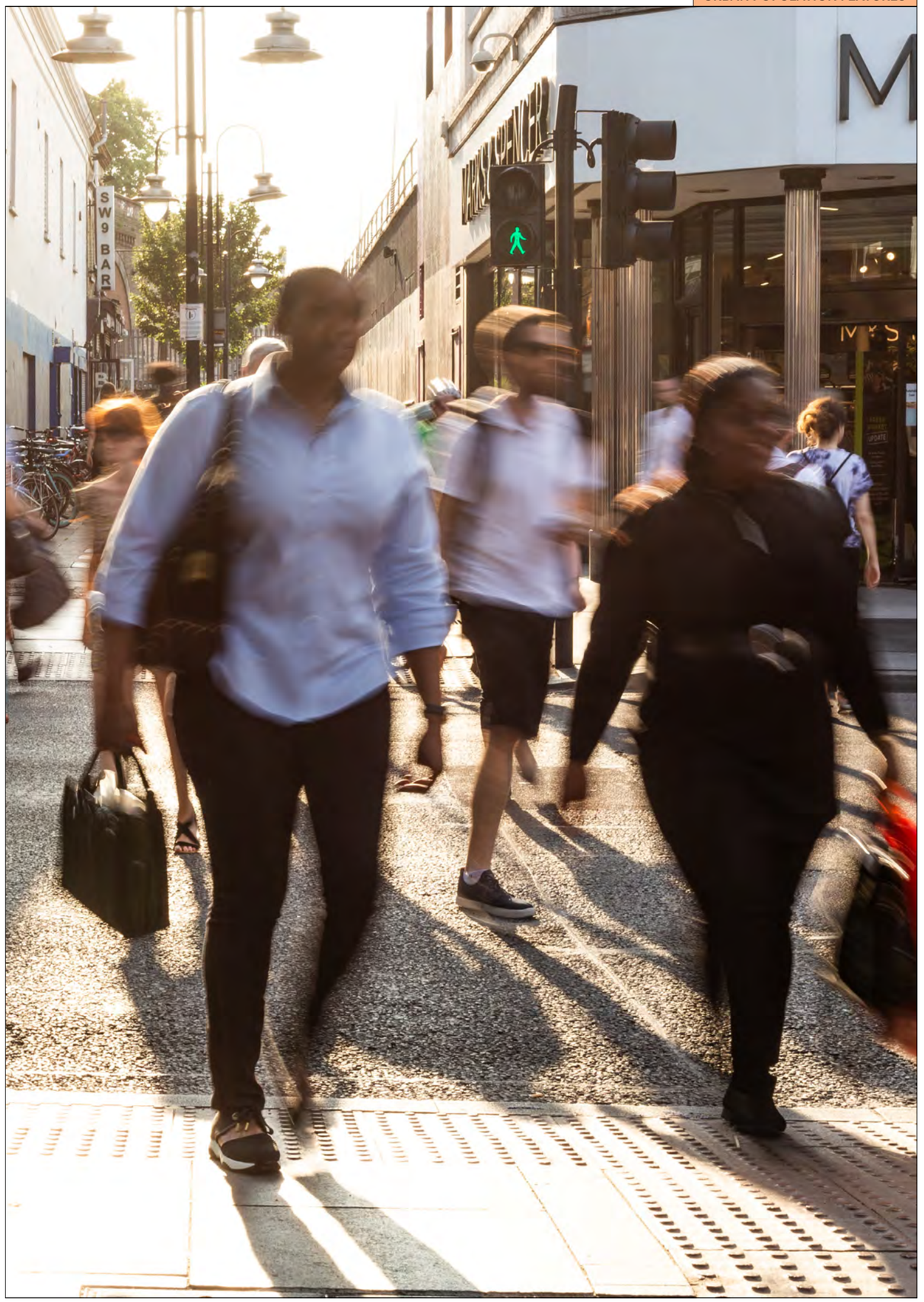
HOW THESE FINDINGS HELP US UNDERSTAND URBAN HEALTH

Urban health is shaped not just by place, but by **the concentration and mix of people within it.**

The distribution of **population characteristics within urban areas** helps explain why health outcomes vary so widely within and between places. The **demographic makeup of our towns and cities** influences everything from the types of services that are needed, to experiences of **discrimination, inclusion, and access to culturally appropriate care.**

This means that urban health cannot be understood through averages alone. Patterns of inequality are closely tied to how **populations are distributed within cities**, with different groups experiencing very different conditions and opportunities for health.

Without this **demographic lens**, it is harder to design fair systems, measure inequality or **understand who benefits — and who doesn't**. Understanding these underlying population patterns is therefore critical to making sense of the inequalities observed throughout **The State of Urban Health.**



HOW LIVING IN AN URBAN AREA AFFECTS HEALTH AND LIVING CONDITIONS

URBAN AREAS SHOW GREATER INEQUALITY IN HEALTH AND LIVING CONDITIONS THAN RURAL AREAS.

This section explores how health outcomes, and the conditions for good health, differ between England's urban and rural areas. It presents key findings from our quantitative analysis. This was based on data from a range of sources including national datasets e.g. ONS, NHS England, Department for Work and Pensions (DWP), and Office for Health Improvement and Disparities (OHID). It provides the insights from four sub-themes where there were notable differences between urban and rural areas (Health differences, Poverty, Employment, Housing & Neighbourhoods).

Our analysis included 68 indicators for which we were able to explore the differences between urban and rural areas as well as across urban areas, looking at averages and ranges. It also considered 58 additional indicators, for which we could not compare all urban and all rural areas — instead, we compared selected urban area rates with the England average.

This analysis focused on Lambeth and Southwark, our base, as well as four major urban areas (Manchester, Leicester, Birmingham, and Southampton) that were selected based on their ethnic makeup and level of deprivation, and to provide snapshots from various regions across England. See **Technical Appendix** for data sources and more detailed methodology.

EXPLORE THE DATA

- **Urban & Rural Differences Dashboard**
- **Outcomes in Major Urban Areas Dashboard**
- **Housing Conditions Dashboard**
- **Directory of Themes**

Most data in this chapter come from our dashboards, which you can explore for more detail, so they are not individually referenced. Where we use an inline citation, the data has been analysed or presented specifically for this report, with references provided.

Implications for decision-makers

These findings matter for anyone shaping policies, services, places, investment or support in urban areas. They show that drivers of ill health are highly concentrated, with poverty, poor housing, unemployment, and worse health outcomes clustering in particular neighbourhoods.

For local authorities, health systems, funders, employers, housing providers, planners, and community organisations, this means looking below urban or borough averages which might mask deep inequalities within place. Neighbourhood-level data and community insight can help identify where need is greatest, target resources more fairly, and focus efforts to prevent poor health before it develops.

How living in an urban area affects health and living conditions:

HEALTH DIFFERENCES

WHILE MANY HEALTH OUTCOMES IN URBAN AREAS ARE, ON AVERAGE, WORSE THAN IN RURAL AREAS, THE BIGGEST HEALTH GAPS ARE FOUND WITHIN URBAN AREAS THEMSELVES, WHERE THE BEST AND WORST OUTCOMES SIT SIDE BY SIDE.

KEY FINDINGS

Urban areas include both the best and worst health outcomes nationally. People living in close proximity in urban areas can experience stark inequalities in health outcomes.

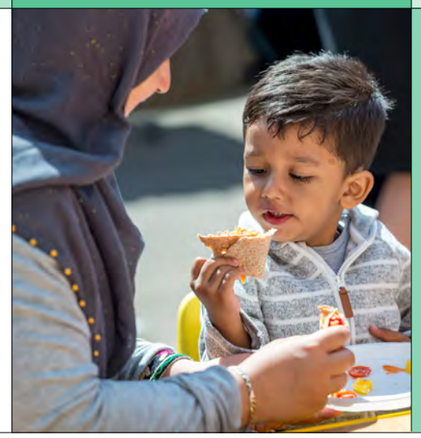
Across the life course, from child health and prevention to hospitalisation and mortality, the most deprived urban neighbourhoods face far worse health outcomes than the least deprived, with inequalities often greater than those in rural areas.

Life expectancy is two years lower in urban areas, on average, than rural areas for both men and women — and life expectancy varies even more widely by deprivation.

On average, urban areas have a higher-than-expected number of emergency hospital admissions compared to the national rate for conditions such as chronic obstructive pulmonary disease (COPD), stroke, and coronary heart disease (CHD).

The biggest difference in emergency hospital admissions between urban and rural areas is on emergency admissions for COPD, with urban neighbourhoods having an average ratio **twice that of rural neighbourhoods.**

On average, the preventable mortality rate is **10% higher** than the national average in urban areas, and **25% lower** in rural areas.



Average obesity rates for children in Year 6 are higher in urban areas than rural areas.

THE DATA AND ANALYSIS

HEALTH DIFFERENCES INDICATORS COMPARED

Life expectancy

Preventable mortality

Premature mortality

Chronic obstructive pulmonary disease (COPD)

Stroke

Coronary heart disease (CHD)

Obesity rates

On average, health outcomes are worse in urban areas than in rural areas.

Average life expectancy is lower in urban areas. On average, men in urban areas can expect to live two years less than men in rural areas, and women in urban areas can expect to live almost two years less than women in rural areas; Figure 9 (OHID, 2016-2021).

The range in average life expectancy is much bigger in urban areas, (28 years in males in urban areas); Figure 9.

There is a gap in average life expectancy between the least and most deprived urban areas, which is wider that the urban and rural gap. The difference in life expectancy for both urban and rural areas is more than six years for men and more than five years for women.

Emergency hospital admissions for COPD, CHD and stroke are, on average, higher in urban areas than rural. And emergency hospital admissions for COPD are almost twice as high on average in urban areas compared to rural areas; Figure 10 (OHID, 2016-2021).

On average, premature mortality [4] and preventable mortality [5] are higher in urban areas compared to rural areas. Average preventable mortality in most deprived urban areas (quintile) is 2.7 times higher than the least deprived; Figure 11 (OHID, 2016-2021).

Child obesity in year 6 is higher in urban areas than rural areas; the average urban area obesity rate in year 6 is five percentage-points higher than the average rural area obesity rate (23% vs 18%).

[4] **Premature mortality:** deaths in those aged under 75.

[5] **Preventable mortality:** "...deaths are considered preventable if, in the light of the understanding of the determinants of health at the time of death, all or most deaths from the underlying cause (subject to age limits if appropriate) could mainly be avoided through effective public health and primary prevention interventions." (DHSC)

Explore further:
- **Urban & Rural Differences Dashboard**

Figure 9. Average life expectancy at birth for urban and rural MSOAs in England (2016-21).

Average life expectancy is approximately two years higher in rural areas than urban, with almost a 28 year range in male life expectancy across urban areas.

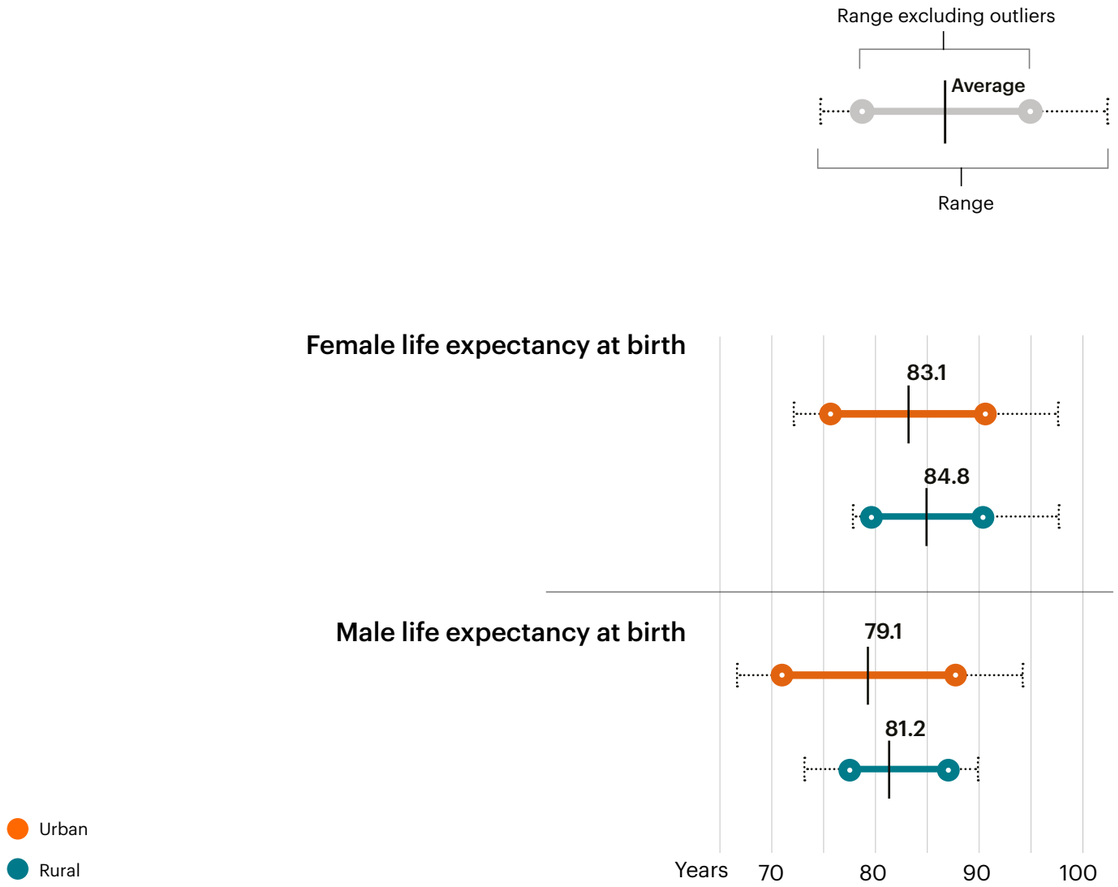


Figure 10. Average emergency hospital admissions ratios (SAR*) for urban and rural MSOAs in England.

On average, the emergency hospital admissions ratio for COPD is almost twice as high in urban areas than rural.

*Standardised admission ratios (SAR) shows whether more or fewer people are being admitted to hospital than would be expected for an area, taking into account the age of the population; SAR = Number of Observed Admissions/ Adjusted Expected admissions (national average). Values below 100 suggest relatively low emergency admissions, whereas numbers above 100 suggest higher than expected emergency admissions.

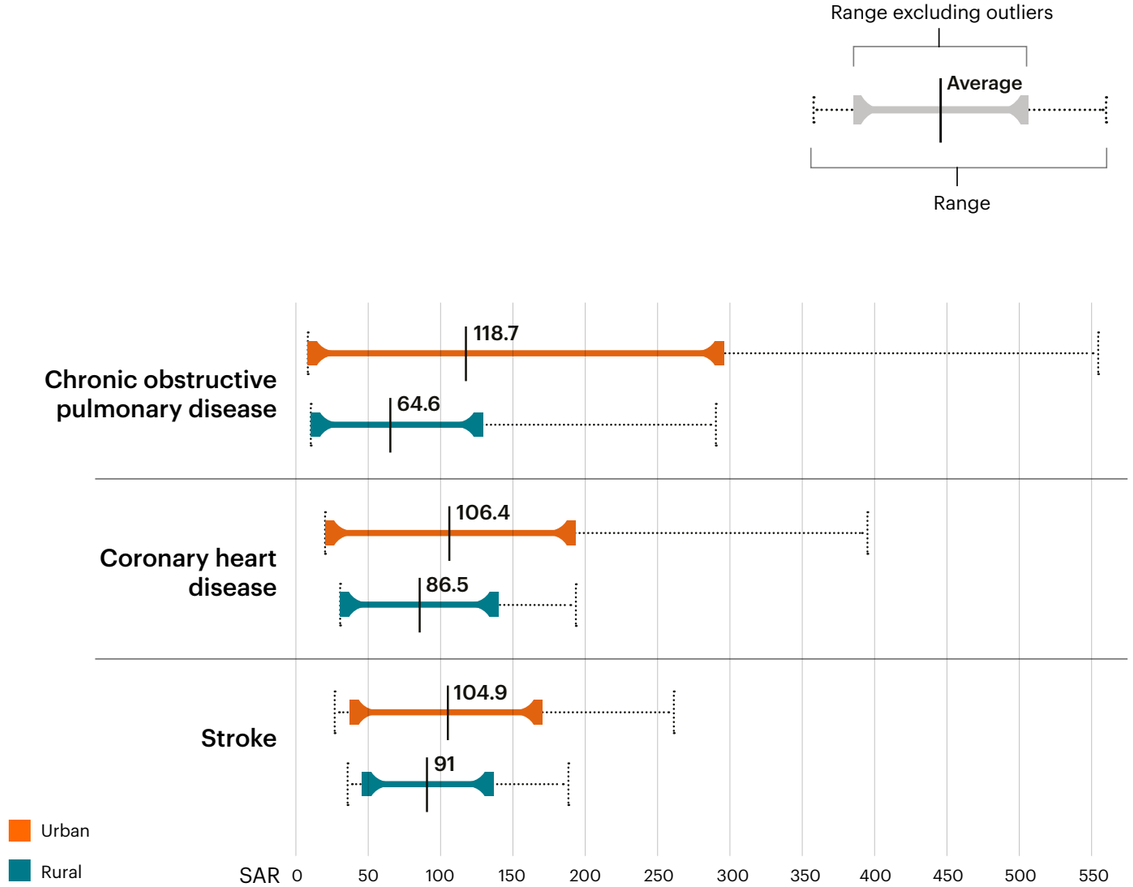
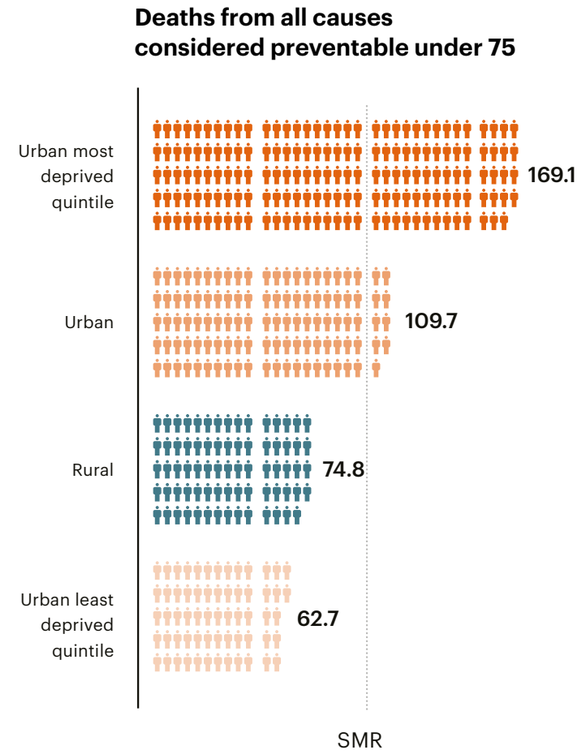
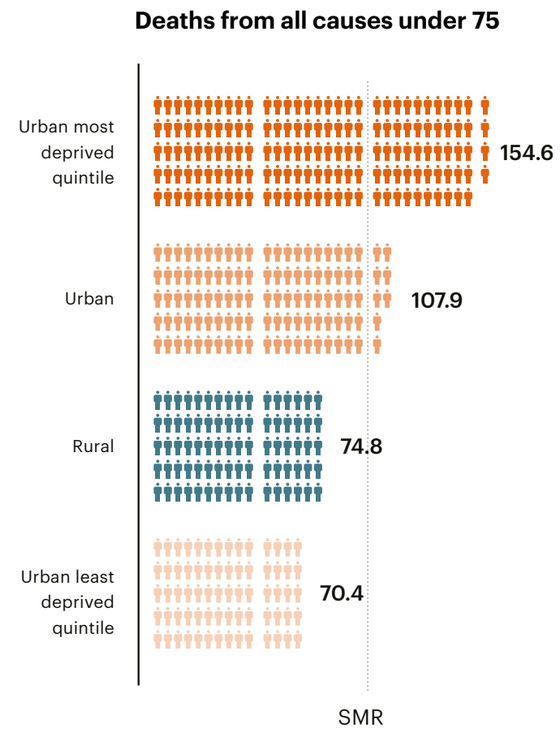


Figure 11. Average deaths under 75, standardised mortality ratio (SMR*) for MSOAs in each area type (2016-21).

On average, premature mortality from all causes, and from causes considered preventable, is higher in urban areas than rural areas.





Urban
Rural

*Standardised mortality ratio (SMR) = shows whether more or fewer people are dying in an area than would be expected, taking into account the age and gender of the population. SMR = Observed total deaths in the area (by five-year age and gender band) / Expected deaths (applying age-specific death rates for England) x 100.

Values below 100 suggest lower than expected mortality (better than England), whereas numbers above 100 suggest higher than expected mortality (worse than England)

Urban areas include the best and worst outcomes nationally. The highest and lowest rates for many different health measures often sit side by side geographically. For example, **in Kensington and Chelsea**, females in Notting Dale can expect to live around 74 years, while those in Holland Park can expect to live up to 93 years — **a striking 19 year difference between two neighbourhoods within the same borough**. While these are not the absolute highest and lowest figures nationally, they still represent some of the most extreme contrasts, highlighting the scale of inequality within urban areas.

Average data show that urban areas tend to have worse outcomes than rural areas — but what averages do not show is the extreme variation within urban areas.

The data shared above show that urban areas often have slightly worse outcomes than rural areas. However, these average figures mask the extreme differences in health outcomes seen across urban and rural areas. There are substantial gaps between the most and least deprived areas.

Another example relates to COPD admissions — on average, urban areas have a higher emergency hospital admissions ratio than rural areas; Figure 10 (OHID, 2016-2021). But some of the lowest admissions ratios are seen in selected urban areas and, excluding outliers, range between **9.3 and 295.1** SAR, compared to 11.8 and 132.2 SAR in rural areas. The urban range (excluding outliers) is 2.4 times that of rural areas.

In more deprived areas (based on quintiles), the patterns are even sharper:

In the most deprived urban areas, the average preventable death rate in under 75s is 2.7 times higher than in the least deprived.

The average COPD admissions rate in the most deprived urban areas is four times higher than in the least deprived.

The average child obesity rate in the most deprived urban areas is almost twice as high as in the least deprived urban areas.

Explore further:
- **Urban & Rural Differences Dashboard**

How does this show up in the lives of people living in Lambeth and Southwark?

We did not talk to people in focus groups directly about health differences. But we did hear that people are aware that the places where they live and spend their time affect their health. The rest of this report seeks to understand the drivers and reasons for this.

"There was something that I saw around Southwark having one of the highest rates of childhood obesity in London. I'm not sure if that's still the case, and that obviously, of course, wasn't because families, like don't care about their children's health or anything like that, but it was because the most affordable food options are often like unhealthy, ultra processed and cheap takeaways."

Funded partner, Impact on Urban Health
Children's health and food programme

Explore further:
- **Directory of Themes**

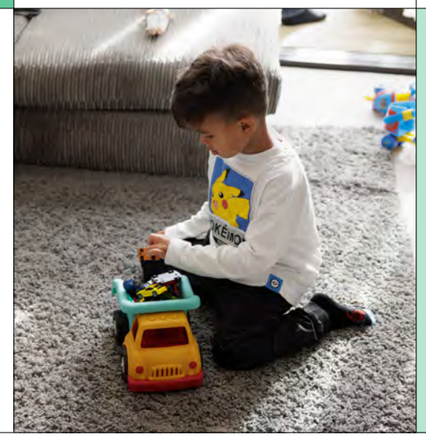
Additional quotes from our qualitative research related to this topic.

POVERTY

POVERTY IS SLIGHTLY MORE PREVALENT ON AVERAGE IN URBAN THAN IN RURAL AREAS. BUT THE GREATEST INEQUALITIES ARE WITHIN URBAN AREAS THEMSELVES, WHERE SOME NEIGHBOURHOODS EXPERIENCE EXCEPTIONALLY HIGH LEVELS OF POVERTY WHILE OTHERS EXPERIENCE FAR LOWER RATES.

In this analysis, poverty refers to income-based measures of financial hardship — such as households receiving Universal Credit, children in relative low-income families, pensioners in poverty, and lone-parent households receiving Universal Credit. These indicators reflect not just low income, but the material disadvantage that limits access to essentials like food, housing, and care.

KEY FINDINGS

Poverty is more concentrated and more unequal in urban areas than rural areas and tends to cluster in specific neighbourhoods.	There are stark inequalities within urban areas, with neighbourhoods ranging from very low to extremely high levels of poverty across all indicators.	In some urban neighbourhoods, poverty reaches very high levels, with the majority of children, pensioners or households experiencing financial hardship.
Child poverty is both widespread and increasing, with around **one in five** children in urban areas living in low-income families.		Poverty is not evenly distributed, with higher rates of free school meals (FSM) eligibility among some ethnic groups, highlighting how poverty intersects with ethnicity to shape health and wellbeing.

THE DATA AND ANALYSIS

POVERTY INDICATORS COMPARED

Children in relative low-income families

Households receiving Universal Credit

Lone-parent households with dependent children receiving Universal Credit

Pensioners in poverty

Free school meal (FSM) eligibility

Poverty is more concentrated in urban areas, and the range in poverty indicators is much wider in urban areas than rural areas, from very low to extremely high, highlighting stark inequalities.

Urban areas, on average, have over twice the proportion of pensioners in poverty than rural areas (Figure 12). There is large variation between urban neighbourhoods; in the neighbourhood with the highest proportion, more than four in five pensioners live in poverty.

In urban areas, on average, one in five children live in a relative low-income family. There is large variation between urban neighbourhoods; in the neighbourhood with the highest proportion, nine in ten children live in relative low-income families.

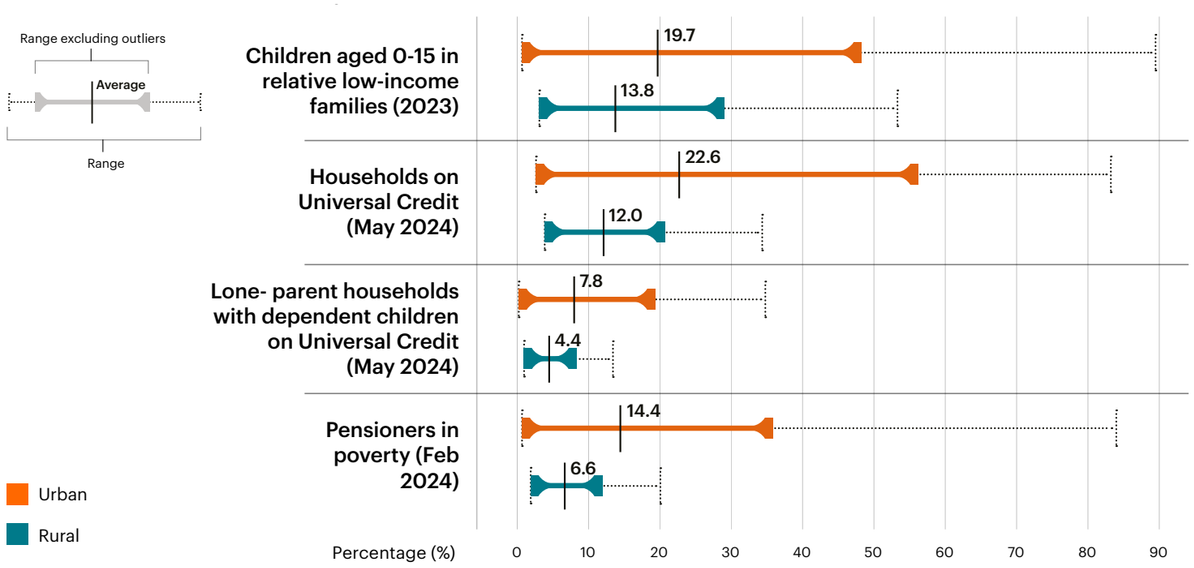
The average proportion of households receiving Universal Credit in urban areas is twice the rural (Figure 12). There is large variation between urban neighbourhoods; in the neighbourhood with the highest proportion, more than four in five households are receiving Universal Credit.

There is a higher average proportion of lone-parent households with dependent children receiving Universal Credit in urban areas (Figure 12). In the urban neighbourhood with the highest proportion, a third of lone-parent households receive Universal Credit.

Explore further:
- **Urban & Rural Differences Dashboard**

Figure 12. Average proportion of children, households, and pensioners experiencing financial hardship for urban and rural MSOAs.

Poverty is more concentrated in urban areas. In particular, urban areas on average have over twice the proportion of pensioners in poverty than rural areas.



FSM eligibility [6] has often been used as a proxy for child poverty. These figures underline the concentration of poverty in large cities and its impact on families with children:

Around one in four pupils (25%) are eligible for FSM in England, on average. But rates are much higher in many urban areas — reaching 44% in Manchester, 40% in Birmingham, 38% in Lambeth, and 37% in Southwark; Figure 13 (DfE, 2024).

Nationally, the proportion of pupils eligible for FSM is significantly higher among Black, Mixed, and other minoritised ethnic groups compared with the national average, highlighting how financial disadvantage intersects with ethnicity in shaping children's health and wellbeing; Figure 14 (DfE, 2024).

[6] Nationally FSM eligibility is used as a proxy for child poverty as it is means tested, but since 2023 in London there have been free school meals for all children in state primary schools, and from September 2026 for all children in England from families in receipt of Universal Credit. The eligibility criteria used here is that which pre-dates these initiatives.

Explore further:
- **Outcomes In Major Urban Areas Dashboard**

Figure 13. The proportion of school pupils eligible for FSM — 2023/24.

The proportion of school pupils eligible for FSM is much higher in many urban areas than the national average.

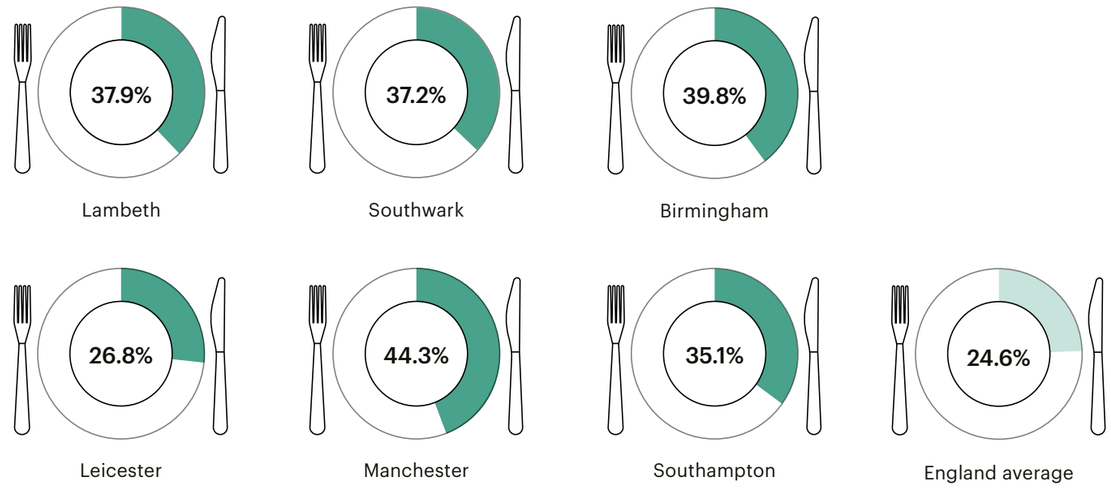
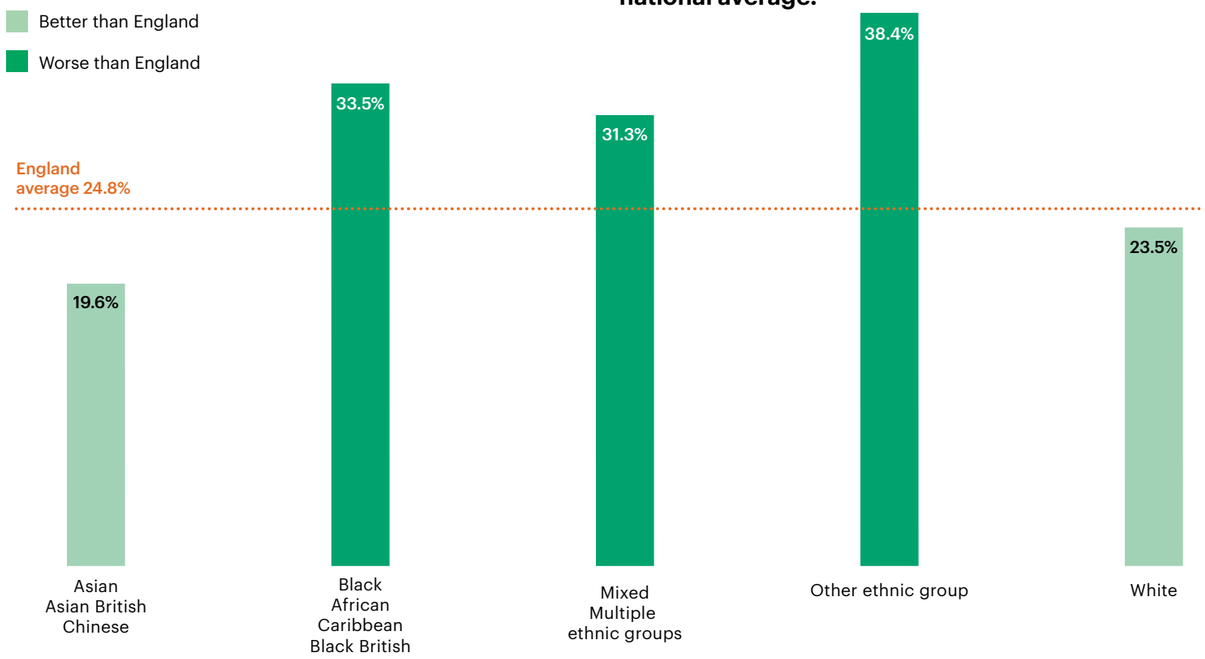


Figure 14. Proportion of school pupils eligible for FSM by ethnic group in England — 2023/24.

In England, the proportion of pupils eligible for FSM is significantly higher among Black, Mixed, and "Other ethnic group" compared with the national average.



How does this show up in the lives of people in Lambeth and Southwark?

We heard from people in Lambeth and Southwark that they are aware poverty can limit every opportunity to live well. At the most fundamental level, this can look like not having the means to even buy food.

"Ultimately, people haven't got money to buy food. They can't cover the cost of living. We thought COVID was bad, but the state of it now [...] it's worse [...] and people just not being able to make their money stretch"

Funded partner, Impact on Urban Health
Children's health and food programme

Explore further:
- **Directory of Themes**

Additional quotes from our qualitative research related to this topic.

EMPLOYMENT

UNEMPLOYMENT REMAINS HIGHER AND MORE VARIABLE IN URBAN AREAS. ACROSS ENGLAND, PEOPLE WITH DISABILITIES, LONG-TERM HEALTH CONDITIONS OR THOSE ACCESSING MENTAL HEALTH SERVICES FACE SOME OF THE LARGEST EMPLOYMENT GAPS.

KEY FINDINGS

Unemployment is **twice as high in urban areas**, with extreme variation between neighbourhoods.

In England, people with disabilities, long-term health conditions or those in contact with mental health services face the largest employment gaps.

Young people are almost **twice as likely to be unemployed** in urban than rural areas and face the sharpest urban employment disadvantage.

THE DATA AND ANALYSIS

EMPLOYMENT INDICATORS COMPARED

Unemployment benefits

Youth unemployment

Unemployment and youth unemployment rates are nearly twice as high in urban areas as in rural areas (Figure 15).

There is also far wider variation between urban neighbourhoods than rural ones; many urban neighbourhoods' rates are over ten times higher than the rural average — ranging from almost 0% unemployment claimants to double-digit rates for unemployment (up to 11%) and for youth unemployment (up to 16%).

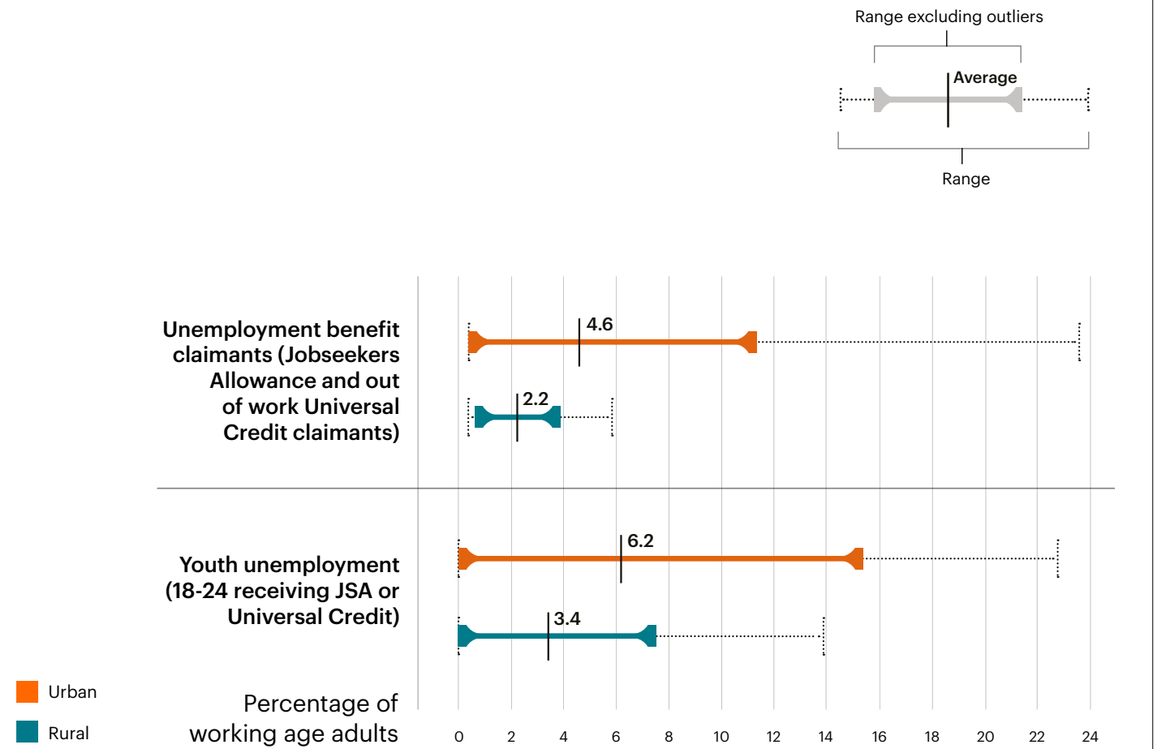
Overall in England, employment rates are significantly lower for people with disabilities, long-term conditions, and those in contact with secondary mental health services, compared with the general population. In particular, the employment rate for people receiving long-term support for learning disabilities is around 71 percentage points lower than the overall rate, while for those in contact with mental health services it is approximately 69 percentage points lower.

Explore further:

- **Urban & Rural Differences Dashboard**
- **Outcomes In Major Urban Areas Dashboard**

Figure 15. Average percentage of working age adults, and adults aged 18-24, receiving Jobseeker's Allowance (JSA) or Universal Credit for unemployment for urban and rural MSOAs – Oct 2024.

The average proportion of working age adults claiming unemployment benefits in urban areas is more than double that in rural areas, with many urban neighbourhoods recording rates over ten times higher than the rural average.

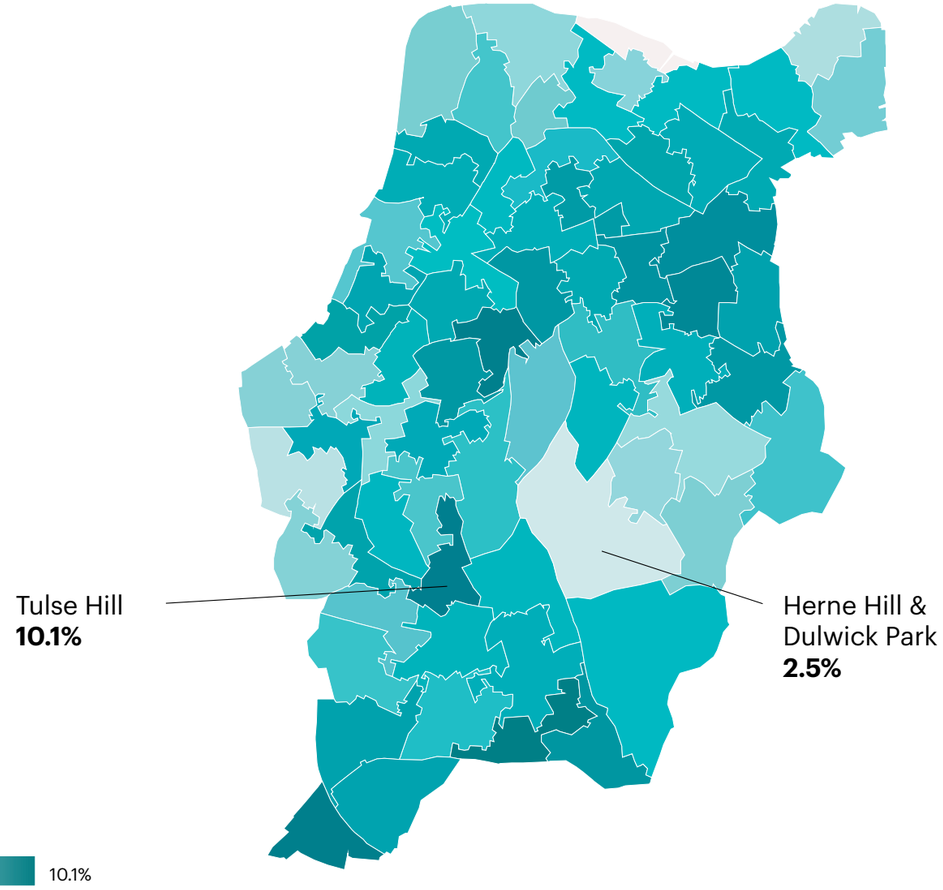


How does this show up in the lives of people in Lambeth and Southwark?

In some urban neighbourhoods in Lambeth and Southwark, unemployment is extremely low, while in others it is persistently high — meaning that people living just a few streets apart can face very different prospects (Figure 16).

Figure 16. Percentage of all working age adults receiving Jobseeker's Allowance (JSA) or Universal Credit for unemployment — October 2024

Despite their close proximity, Tulse Hill has a rate of working age adults receiving Jobseeker's Allowance or Universal Credit for unemployment (10.1%) that is four times higher than in Herne Hill & Dulwich Park (2.5%).



We heard from people in Lambeth and Southwark about the impact of insecure work and low wages, and what this means for day-to-day living, and ultimately their health.

"

"I guess, if you're in a more secure job, you have, like, rights, including the right to sick pay."

Funded partner, Impact on Urban Health
Health effects of air pollution programme

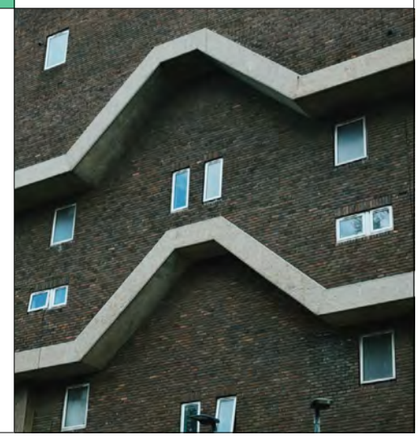
Explore further:
- **Directory of Themes**

Additional quotes from our qualitative research related to this topic.

HOUSING & NEIGHBOUR-HOODS

URBAN HOUSING PRESSURES, SUCH AS OVERCROWDING, HOMELESSNESS, AND DAMP AND MOULD, ARE SEVERE AND ARE MUCH HIGHER IN SOME NEIGHBOURHOODS THAN OTHERS.

KEY FINDINGS

Overcrowding affects a much larger proportion of households in urban areas than in rural areas, with the **highest rates in more deprived neighbourhoods.**	Homelessness rates are consistently higher in major cities than the national average, particularly for households with children.	Damp and mould are more common in urban, deprived, and privately rented homes.
Housing challenges are not evenly distributed, with higher exposure among more deprived communities and some minoritised ethnic groups.	Crime rates are higher in urban areas than rural areas, including violent crime, and vary widely between neighbourhoods.	

THE DATA AND ANALYSIS

HOUSING & NEIGHBOURHOODS INDICATORS COMPARED

Overcrowding

Homelessness

Damp & Mould

Crime

Overcrowding is over three times more common in urban than rural areas, with an average of 5% of urban households living in overcrowded homes compared to 1.4% of rural households.

Average overcrowding rates are higher in more deprived urban neighbourhoods — 7.7% of households in most deprived areas compared to 1.6% in the least deprived areas. In many urban neighbourhoods, **more than one in five households live in overcrowded homes.**

Across our selected cities, homelessness rates [7] are consistently higher than the average for England; from 16 per 1,000 households in Birmingham to 27 per 1,000 in Manchester. The latter is twice the national average.

Households with dependent children are particularly affected; 33 per 1,000 households with children are homeless in Lambeth and 36 per 1,000 in Manchester, compared to 16 per 1,000 nationally.

We also know damp and mould are more common in urban areas than in rural areas (7.1% vs 6.3%). They are considerably more prevalent in deprived areas compared to the least deprived (9.3% vs 1.5%) and in private rented homes (9.2%) compared to other tenures (owner-occupied 3.6%, social rented 6.9%). National data also shows higher rates among Black (10.5%), Asian (8.0%), and other minoritised households (7.3%) than among white households (4.8%).

[7] People who have been legally recognised as homeless or at risk of homelessness; defined by people owed a homelessness duty.

See environments section for further exploration of this topic and explore data further in our:

- Urban & Rural Differences Dashboard
- Outcomes In Major Urban Areas Dashboard
- Housing Conditions Dashboard

On average, crime rates are almost double in urban areas (101.3 per 1,000 population) compared to rural areas (52.7 per 1,000 population) — including violent crime (1.7 times higher) — and vary widely within cities.

Explore further:
- **Urban & Rural Differences Dashboard**

How does this show up in the lives of people in Lambeth and Southwark?

People in Lambeth and Southwark talked about how they experience their environments, including housing, homelessness, temporary accommodation, and many other aspects of their local areas. Their insights demonstrate how routinely and profoundly environments affect people in Lambeth and Southwark, and how this affects their health.

"The people I work with [...] can't be healthy if they're living in bad situations. [...] they're still going home to a damp and mouldy flat, and they can't do anything about that."

35-39; Male; white British

Explore further:
- **Directory of Themes**

Additional quotes from our qualitative research related to this topic.

HOW THESE FINDINGS HELP US UNDERSTAND URBAN HEALTH

Comparing urban and rural areas helps identify broad differences in key outcomes and establish why **urban health matters as a distinct issue.**

However, our analyses also show that understanding urban health is not just about differences in average rates between urban and rural areas. It is the **wide range of outcomes within towns and cities themselves** that makes urban areas especially important to focus on if we want to improve health and reduce inequalities.

Across health outcomes, poverty, unemployment, and housing, the same pattern emerges: conditions that affect health are **not evenly distributed, but rates are elevated in more deprived areas.**

The result is not only worse average outcomes in some cases, but a **much wider range of experiences across urban areas** — with urban areas having some of the best and some of the worst outcomes.

Understanding urban health therefore requires **more than broad comparisons.** It also needs a focus on how **disadvantage is concentrated and compounded within places**, and how this shapes people's exposure to risk, access to resources, and overall opportunities for good health.

STRUCTURAL DRIVERS OF HEALTH INEQUITY

HEALTH INEQUITY IS STRUCTURAL — DRIVEN BY OVERLAPPING SYSTEMS OF DEPRIVATION, RACISM, AND DISCRIMINATION.

This section explores one of the core themes from our qualitative research (see **Technical Appendix** for methodology). It provides the insights from three sub-themes (**deprivation, racism, and discrimination**), alongside selected quantitative evidence, to understand what drives inequity in urban health.

Structural discrimination makes it harder for people living in poverty, and those subjected to racism or other forms of discrimination, like ableism or ageism, to live a healthy and happy life (Marmot, Allen, Goldblatt, Willis, & Noferini, 2024).

EXPLORE THE DATA

- **Outcomes in Major Urban Areas Dashboard**
- **Directory of Themes**

Most data in this chapter come from our dashboards, which you can explore for more detail, so they are not individually referenced. Where we use an inline citation, the data has been analysed or presented specifically for this report, with references provided.

Implications for decision-makers

These findings matter for anyone designing, funding, delivering or evaluating work to improve health equity. They show that deprivation, racism, and discrimination are not separate issues, but central drivers of unequal health outcomes.

For local authorities, health systems, funders, employers, housing providers, schools, researchers, and community organisations, this means equity needs to be built into decisions from the start. Data and lived experience should be used to understand who benefits, who is missed, and where services, policies or investments may be reinforcing inequality.

Drivers of health inequity

SECTION 5.1

Deprivation

SECTION 5.2

Racism

SECTION 5.3

Discrimination

DEPRIVATION

DEPRIVATION IS A MAJOR DRIVER OF HEALTH INEQUITY, SHAPING LARGE DIFFERENCES IN HEALTH OUTCOMES ACROSS ENGLAND. IN URBAN AREAS, DEPRIVATION IS OFTEN MORE CONCENTRATED AND MORE UNEQUAL BETWEEN NEIGHBOURHOODS.

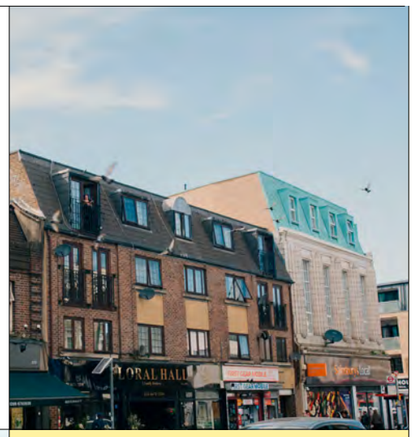
In this analysis, deprivation refers to area-based measures of disadvantage, captured through the Index of Multiple Deprivation (IMD). [8] This combines indicators across several domains, including income, employment, education, health, crime, housing, and the living environment. These measures reflect the wider conditions in a neighbourhood that shape people's opportunities, wellbeing, and access to services.

[8] The Indices of Deprivation 2025 are a relative measure of deprivation for small areas (LSOAs) across England. The overall IMD 2025 combines indicators under seven different domains of deprivation: Income Deprivation; Employment Deprivation; Education, Skills and Training Deprivation; Health Deprivation and Disability; Crime; Barriers to Housing and Services; and Living Environment Deprivation. A higher score indicates that an area is experiencing higher levels of deprivation.

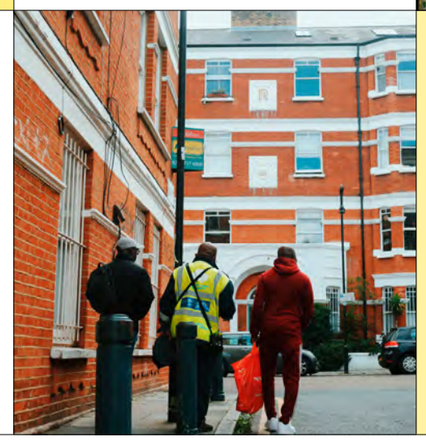
KEY FINDINGS

Health outcomes consistently worsen as deprivation increases across a wide range of indicators.

People in the most deprived areas can expect to live over **15 fewer years** in good health than in the least deprived areas, alongside much higher rates of preventable mortality.



Higher deprivation is associated with worse outcomes across many areas, including chronic disease, child health, and hospital admissions.



Deprivation is higher on average in urban areas than rural areas and varies widely between neighbourhoods.

THE DATA AND ANALYSIS

Deprivation levels are higher on average in urban areas than in rural areas and vary much more widely between urban neighbourhoods (IMD, 2019; MHCLG, 2019).

Looking at England, across 43 indicators from life expectancy to access to care [9], there was a consistent trend, with those living in the more deprived areas (deciles) of the IMD faring worse than those in less deprived areas. Most starkly, people in the least deprived areas can expect to live more than 15 years longer disability-free than those in the most deprived areas.

[9] Impact on Urban Health analysis of selected publicly available national indicators, including OHID Fingertips / DHSC. Data years vary by indicator.

Figure 17 shows the rate of comparison between the most deprived and least deprived areas, from a subset of those 43 indicators, and demonstrates that:

Preventable mortality in the most deprived areas (decile) is more than twice as high (2.1) as in the least deprived areas.

All-cause mortality in people aged under 75 in the most deprived decile is 1.8 times as high as in the least deprived decile.

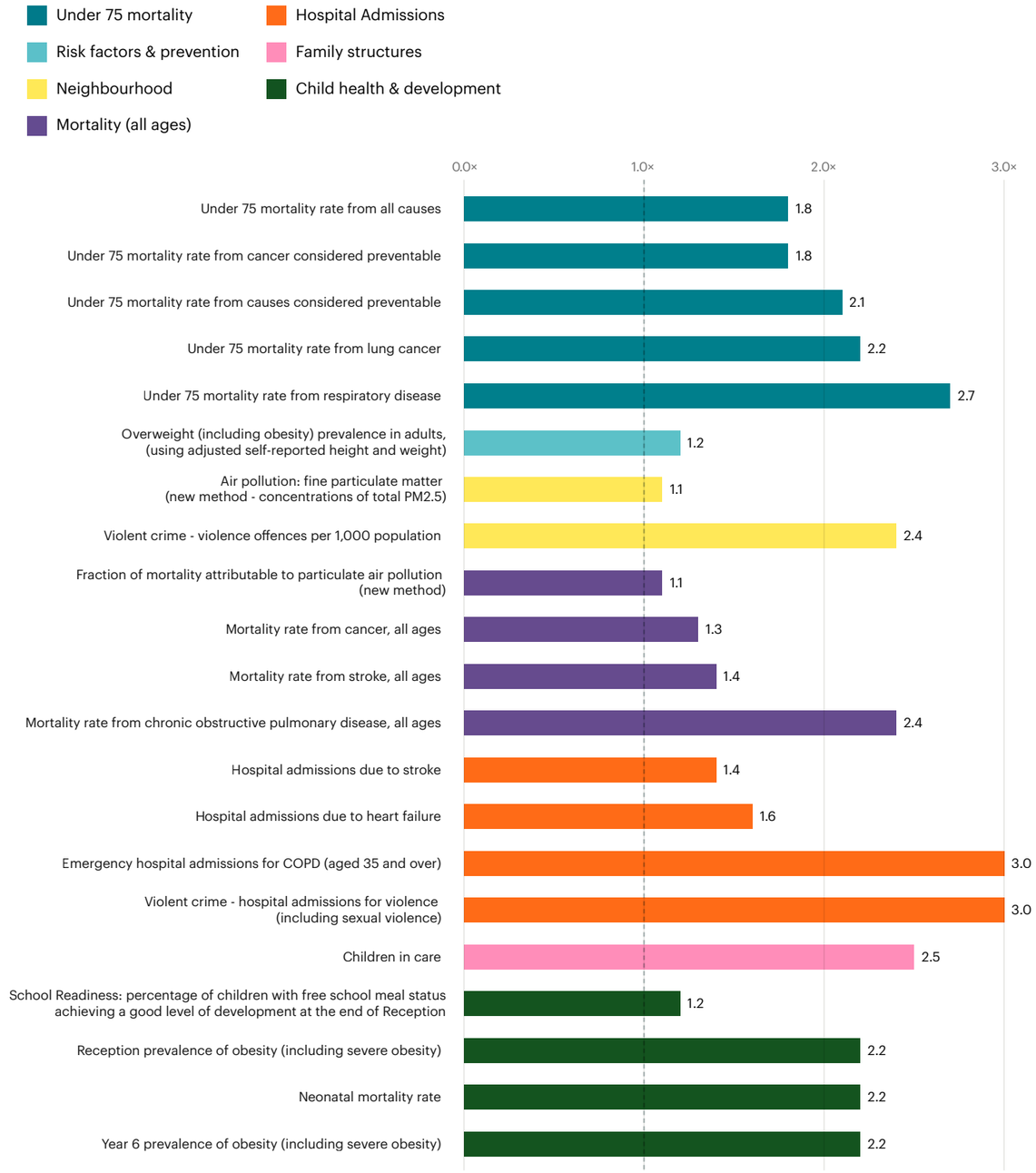
Mortality from respiratory diseases is 2.7 times higher in the most deprived decile than in the least deprived decile.

COPD emergency admissions, and hospital admissions for violent crime, are three times as high in the most deprived decile than in the least deprived decile. Emergency admissions for stroke and heart failure are 1.4 and 1.6 times higher in the most deprived areas.

Obesity in children at reception age and in year 6, as well as neonatal mortality, are more than twice as high in the most deprived compared to the least deprived decile.

Figure 17. Ratio of selected indicators in the most deprived IMD decile compared with the least deprived IMD decile, England.

Values show the ratio of the rate or prevalence in the most deprived IMD decile compared with the least deprived IMD decile. A value above 1 indicates that the outcome is higher in the most deprived areas. Indicators cover different time periods depending on data availability.



How does this show up in the lives of people in Lambeth and Southwark?

People in Lambeth and Southwark describe the constant pressure of trying to meet basic needs on a low or unstable income — and how this leads to stress and can affect mental health.

“So many people in Lambeth, many residents in Lambeth, are on low wages or have insecure work, meaning that they can’t afford nutritious food, or things like gym memberships or even time off work when they’re sick.”

Funded partner, Impact on Urban Health
Financial foundations for adult health programme

Explore further:
- **Directory of Themes**

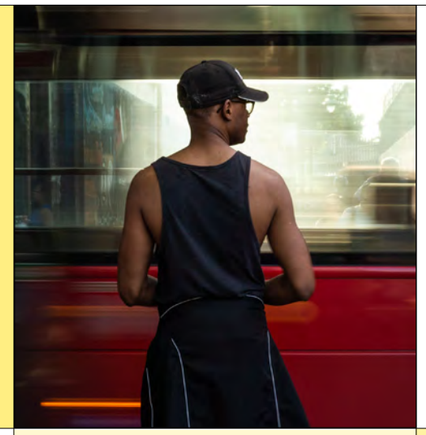
Additional quotes from our qualitative research related to this topic.

RACISM

RACISM — BOTH OVERT AND SYSTEMIC — REMAINS A BARRIER TO HEALTH EQUITY. IT AFFECTS HOW PEOPLE ARE TREATED WITHIN SERVICES, THEIR ACCESS TO SUPPORT, AND THEIR OPPORTUNITIES ACROSS EDUCATION, WORK, AND HOUSING. THESE PATTERNS CONTRIBUTE TO UNEQUAL HEALTH OUTCOMES.

KEY FINDINGS

Health and social outcomes vary by ethnicity across multiple areas, including child mortality, obesity, housing, and employment.



Some of the starkest differences are seen in early life, with **child mortality rates around twice as high for Black and Asian children** compared to white children.

These inequalities persist even when accounting for deprivation, indicating that factors beyond income and area-level disadvantage are driving differences in outcomes.

People from some racially minoritised communities are more likely to experience poorer housing conditions, higher risk of homelessness, and lower employment rates.

Racism and discrimination in services affect trust, access to support, and overall wellbeing.

THE DATA AND ANALYSIS

Urban areas are more ethnically diverse than rural areas. Looking at England, ethnic inequalities appear across several indicators, including child mortality, school readiness, obesity, housing quality, and employment:

Asian and Black children have mortality rates around two times higher than white children; child mortality rates also increase with higher levels of deprivation across all ethnic groups, except for Black and Other groups (Figure 18), meaning that large, persistent ethnic inequalities are not explained by deprivation (National Child Mortality Database, 2024).

62.3% of Black children achieve a good level of development at the end of Reception; a lower percentage compared to Asian (66.9%), Mixed (69.5%) and white (69.2%) children.

Prevalence of obesity at Reception age is up to 1.5 times higher in children from Black African (14.2%) and certain Mixed ethnic groups than white British (9.6%) children.

Prevalence of obesity in Year 6 is higher in children from Black (Black African 31.3%) and certain Mixed (white and Black Caribbean 28.4%) and Asian (Bangladeshi 29.3%) ethnic groups than white (white British 20.5%) children.

Asian (8%) and Black (10.5%) households have higher proportions of damp and mouldy homes than white (4.8%) households.

Employment rates are lower among certain communities, including Pakistani (61.1%) and Black (67.4%) communities, compared to white (77.2%) residents.

There is a higher percentage of overweight adults (including obesity) in Black (73.4%) and white British (65.7%) ethnic groups compared to Asian (60.5%), Mixed (58.4%) and Other white (60.2%) ethnic groups.

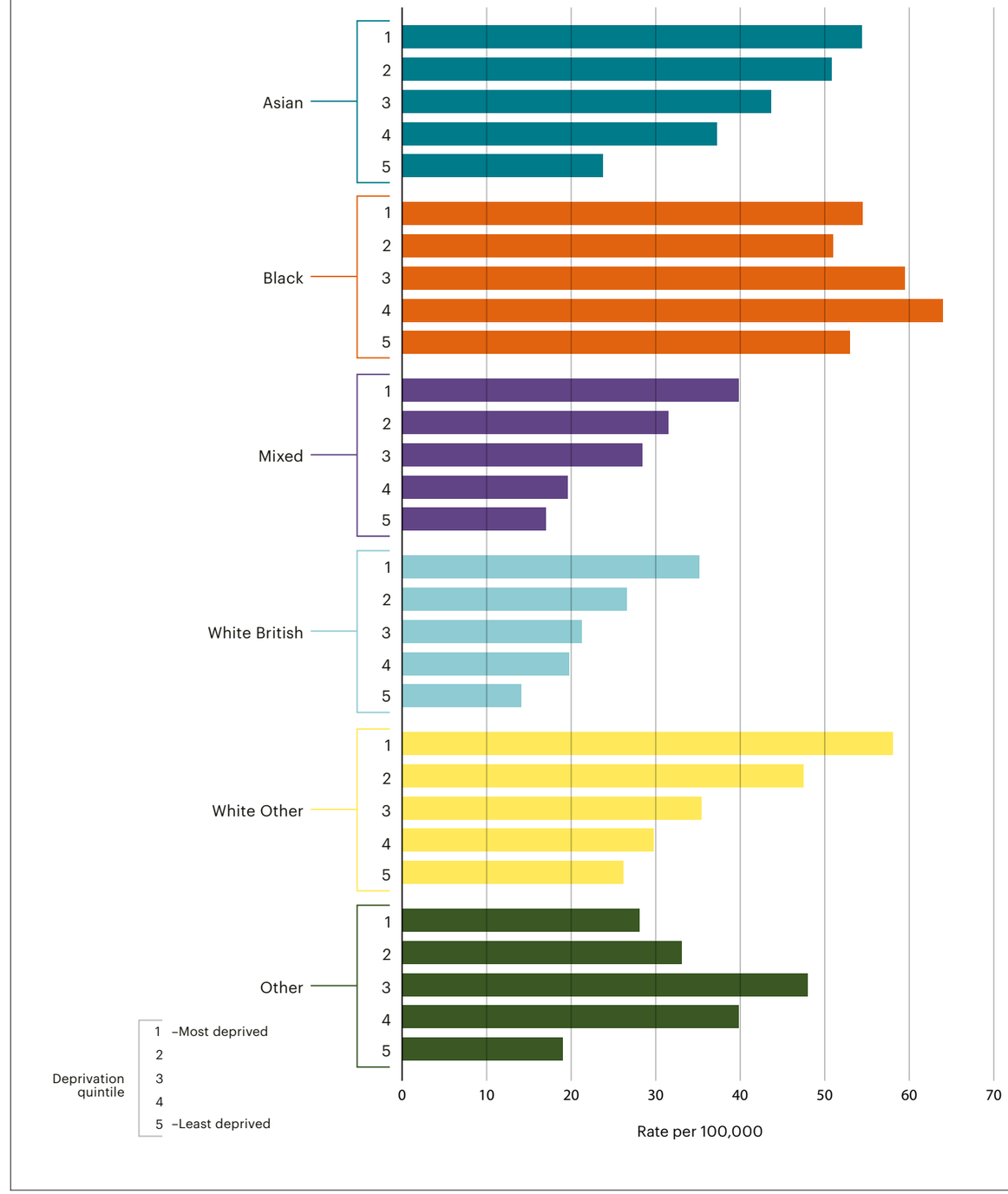
Early access to maternity care is worse than the England average across all ethnic groups apart from white (67.6%) ethnic groups.

Explore further:
- **Outcomes In Major Urban Areas Dashboard**

Note: Differences in health outcomes and other indicators in relation to ethnicity are also explored in other sections of this report.

Figure 18. Estimated death rate per 100,000 population of children aged 0-17 years by social deprivation quintile and ethnicity 2024.

In England, child death rates increase with higher deprivation levels for all ethnic groups, except Black and Other ethnic groups.



How does this show up in the lives of people in Lambeth and Southwark?

People in Lambeth and Southwark described how racism affects people's health through day-to-day interactions with services and the systems they rely on. Some residents described not being listened to or respected when seeking help, particularly when raising concerns about their children or housing needs. These experiences left people feeling dismissed and unsure whether their needs would be taken seriously. And some of the starkest examples related to poor maternity care, leading to stillbirths in some instances.

"

"It got so bad that we were so worried. We said, you have to go back because you can't even walk. When she did go back, she was told that her son – so she was 38 weeks – his heartbeat had stopped and she had to deliver. She had to wait, so she went into natural labour and had to deliver a stillborn son."

45-49; Non-binary; Mixed or multiple ethnic groups

"

"My son's got a white wife, and when they were giving birth, she automatically said 'I'll have a caesarean, no problem.' You wouldn't get a Black woman say that, because your chances of coming out of it, well, it's limited."

Funded partner, Impact on Urban Health
Children's health and food programme

Explore further:
Directory of Themes
Additional quotes from our qualitative research related to this topic.

DISCRIMINATION

DISCRIMINATION BASED ON DISABILITY, AGE, GENDER OR LGBTQIA+ IDENTITY LIMITS ACCESS TO CARE, SUPPORT, AND OPPORTUNITY, CREATING BARRIERS TO ACHIEVING AND MAINTAINING GOOD HEALTH.

Some forms of discrimination are not consistently captured in national datasets, and the available data varies across characteristics. This means that lived experience and wider research play an important role in understanding how discrimination affects health.

KEY FINDINGS

Experiences of discrimination across multiple characteristics are associated with poorer health and wellbeing, affecting how people access services, are treated within systems, and experience everyday life.

People facing multiple forms of discrimination (for example disabled women or LGBTQIA+ migrants) experience compounded disadvantage.

THE DATA AND ANALYSIS

EXISTING EVIDENCE SHOWS US THAT DISCRIMINATION — WHETHER BASED ON DISABILITY, GENDER, SEXUALITY, AGE OR OTHER PROTECTED CHARACTERISTICS — SITS ALONGSIDE AND OVERLAPS WITH DEPRIVATION AND RACISM TO PRODUCE DEEPER AND MORE PERSISTENT HEALTH GAPS IN URBAN AREAS.

Data on experiences of discrimination is less consistently available than other indicators, but existing evidence highlights clear and persistent impacts on health and wellbeing.

DISABILITY AND ABLEISM	Perceived disability-related discrimination is associated with poorer wellbeing, with evidence that some people face barriers to participating fully in health and social care systems (Hackett R. A., 2020).
AGE-RELATED EXPERIENCES	Older people using healthcare services may perceive negative attitudes, with feelings of exclusion particularly reported among those with complex needs (Jackson, 2019).
WOMEN'S EXPERIENCES	Women carry a disproportionate share of unpaid work and emotional labour (ONS, 2016), and there is some evidence that women aged 52 or above who perceive gender discrimination are more likely to report poorer mental wellbeing (Hackett R. A., 2024).
MEN'S HEALTH AND GENDER NORMS	Men are often disadvantaged in aspects of their health and wellbeing, for reasons including sexism, expectations on men, and male attitudes to self-care, health, and wellbeing (Narasimhan, 2021).
HEALTHCARE EXPERIENCES FOR LGBTQIA+ PEOPLE	LGBTQIA+ people may experience micro-insults, micro-assaults, and micro-invalidations when engaging with health professionals and clinical services. Research suggests that some LGBTQIA+ people feel better supported by specialist organisations, underscoring the need for safe spaces and affirmative models of care. Lesbian, gay, and bisexual people also report worse general health and greater dissatisfaction with services compared to heterosexual people, with mental health services most commonly perceived as discriminatory (Mitchell, 2023).

"

“She spent all her life suffering because [...] she was a deaf person. She’s not part of the norm. How does that thought process damage us as a society?”

Funded partner, Impact on Urban Health
Children’s health and food programme

How does this show up in the lives of people in Lambeth and Southwark?

People in Lambeth and Southwark discussed how they experience discrimination. They highlighted experiences of exclusion based on ableism and ageism, as well as the environments and infrastructures that they come up against.

"

“I get the idea that in terms of healthcare, older people are treated as less important than other people, and that annoys me. But it also annoys me that older people accept that. I’m wondering, do they treat us as less important because they think, ‘Oh, well, end of life, about to pop their clogs’. It just makes me angry.”

65-69; Female; white British

Explore further:
- **Directory of Themes**
Additional quotes from our qualitative research related to this topic.

HOW THESE FINDINGS HELP US UNDERSTAND URBAN HEALTH

These findings show that health inequalities are not only shaped by the conditions people experience, but by how those conditions are structured across populations within towns and cities.

For many key outcomes, there is a clear social gradient, where outcomes consistently improve as levels of deprivation decrease. However, this gradient does not fully explain the inequities observed in some outcomes, such as child mortality. Differences between groups persist even when accounting for deprivation, indicating that wider structural factors shape how inequality is experienced. They highlight that differences in outcomes are not evenly distributed, but follow consistent patterns, with some groups more likely to experience disadvantage regardless of where they live.

Understanding urban health therefore requires looking beyond the presence of disadvantage to how it is patterned across populations, and how this shapes people's experiences of opportunity, risk, and support within urban environments.

THE SYSTEMS THAT AFFECT HEALTH IN URBAN AREAS

URBAN SYSTEMS ARE NOT NEUTRAL — THEY CAN EITHER BUFFER OR REINFORCE INEQUALITY, AND OFTEN DO BOTH SIMULTANEOUSLY.

This section covers one of the core themes from our qualitative research (see **Technical Appendix** for methodology). It provides the insights from four sub-themes **(Environments, Better services, Crucial service gaps, Workforce)** alongside selected quantitative evidence, to understand how different systems affect health in urban areas.

The health system is complex and is not just about healthcare. What surrounds us, shapes us. The places we live, work, and spend our time have a huge impact on our health and wellbeing. They can lead to drastically different health outcomes for people living just a few streets apart in urban areas.

Everyday things like the air we breathe, the food we have access to, the homes we live in, our employment opportunities, and our experiences of and access to health and related services are all affected by the overlapping drivers of deprivation, racism, and discrimination.

EXPLORE THE DATA

- **Directory of Themes**

Most of the data in the chapter comes from our qualitative research, but some quantitative data is also presented. Where data comes from our dashboards, you can explore for more detail and these are not individually referenced. Where we use an inline citation, the data has been analysed or presented specifically for this report, with references provided.

Implications for decision-makers

These findings matter for anyone designing, funding, delivering or improving the systems that shape health in urban areas. They show that environments, services, and support can protect health, but can also deepen inequality when they are hard to access, poorly joined up or not designed around people's lives.

For local authorities, health systems, funders, housing providers, service providers, employers, and community organisations, this means looking beyond whether provision exists. Decisions should consider who can access support, who trusts it, who is excluded, and where gaps or pressures are causing harm.

The systems that affect health in urban areas:

SECTION 6.1

Environments

SECTION 6.2

Better services

SECTION 6.3

Crucial service gaps

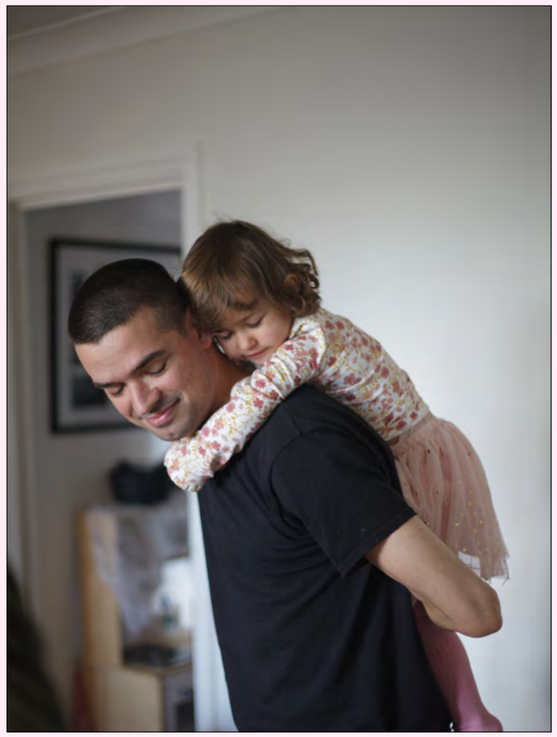
SECTION 6.4

Workforce

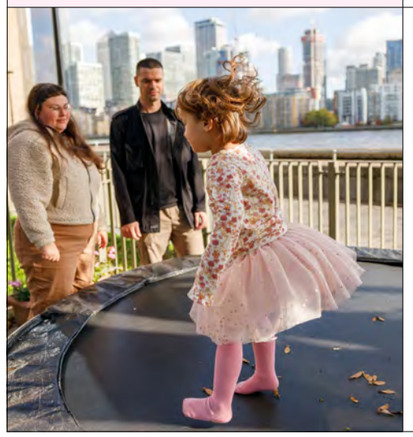
ENVIRONMENTS

THE PLACES, OR ENVIRONMENTS, WHERE PEOPLE SPEND THEIR TIME OFTEN HARM RATHER THAN SUPPORT THEIR HEALTH. UNSTABLE HOMES, POLLUTED AIR, LACK OF ACCESS TO HEALTHY, AFFORDABLE FOOD, AND INACCESSIBLE SPACES ALL CREATE CONSTANT PRESSURES ON PEOPLE'S WELLBEING.

The physical and social environments people live in can affect people's health directly and indirectly. For example, indoor air pollution, caused by damp and mould in people's homes, can have direct negative effects on respiratory health (Raju, Siddharthan, & McCormack, 2020). Access to parks and green spaces gives people opportunities to exercise or relax in nature, which in turn may positively affect people's physical and mental health (Wood, Hooper, Foster, & Bull, 2017; Eadson, Harris, Gore, & Dobson, 2019).



KEY FINDINGS

Housing quality, affordability, and stability are fundamental to health, yet many people are living in conditions that undermine wellbeing. This is particularly true for people who experience poverty and racism.	**Homelessness and use of temporary accommodation** are rising and are deeply destabilising for health, particularly for families with children, with urban rates far exceeding the national average.	**Food environments** can make healthy eating difficult, with healthy food often inaccessible or unaffordable while fast food dominates in deprived urban areas.
	**Air pollution remains a major urban health risk.** In Lambeth and Southwark, people identify traffic as the main source of pollution, with children and people living near busy roads facing the greatest exposure and health impacts.	**Green spaces, safe infrastructure, and inclusive public environments** have strong potential to support wellbeing. But accessibility, regeneration-driven displacement, unsafe neighbourhoods, and exclusionary design (especially for disabled residents) limit these benefits.

THE DATA AND ANALYSIS

The data and analysis within **Environments** relate to nine subthemes, as found below.

ENVIRONMENTS

Housing

Homelessness & temporary accommodation

Food environments

Air pollution & traffic

Green spaces

Infrastructure & regeneration

Work

Safety

Social media & media

People in Lambeth and Southwark view housing as a human right, with good quality and stable housing enabling better access to a healthy life.

But this is not the reality for many. People raised concerns related to damp and mould, issues with heating, hot water and gas leaks, and pest infestations; conditions which negatively affect families' wellbeing and contribute to poor health outcomes.

> **"I frequently have parents complaining to me about how their baby / child has a cough / asthma, etc., and how their home is full of damp and mould, despite constantly reporting / complaining to the council."**
>
> **Funded partner, Impact on Urban Health**
> Children's mental health programme

Affordability was also a key concern. High rents can mean residents have little money left for other expenses needed to protect and maintain their health. Rent is often the biggest outgoing in many household budgets.

Stability was viewed as essential for health and wellbeing. And a lack of stability, for example when people are frequently moved or displaced, leads to uncertainty and disruption. It affects things such as registration with GPs, schools, access to preferred food and shops, and the loss of established connections.

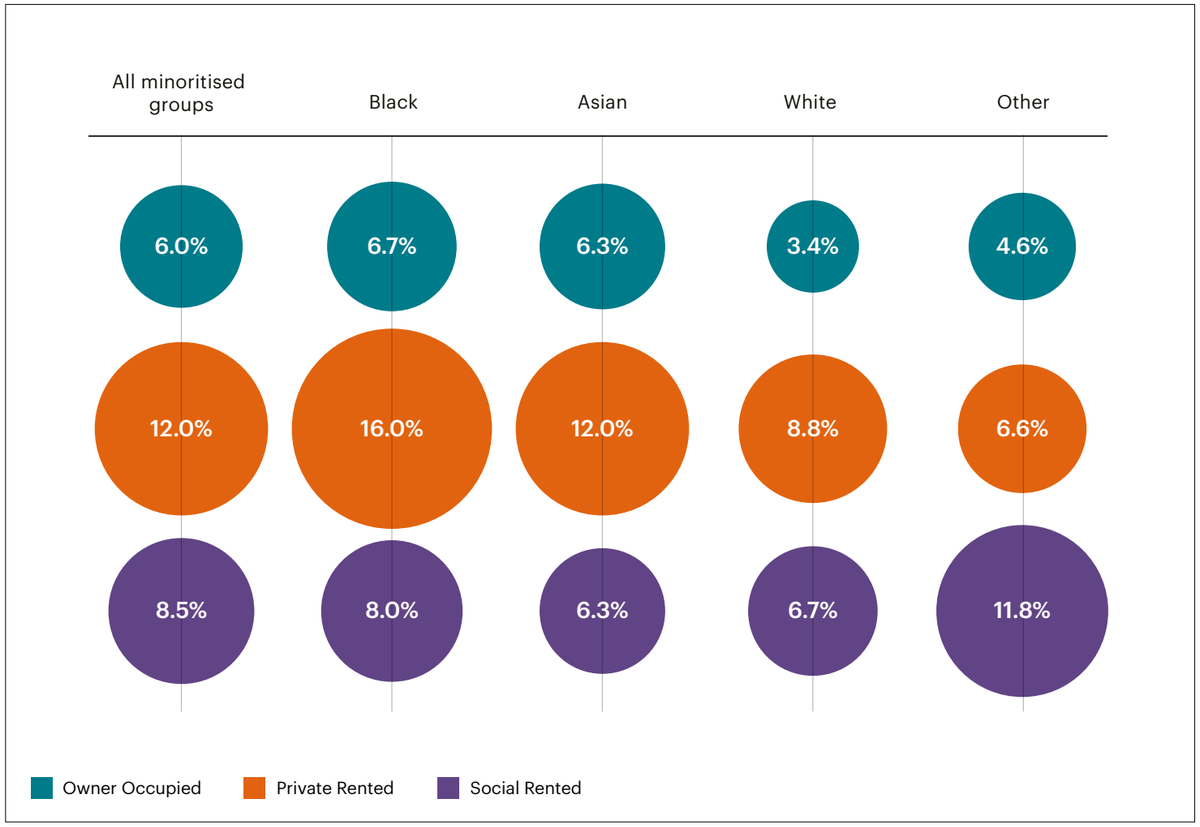
In England, damp and mould were almost six times more likely in the most deprived areas (9.3% of dwellings with any damp) than the least (1.5%) (English Housing Survey, 2023).

In private renting, Black households are almost two times as likely as white households to live with damp and mould (Figure 19).

Figure 19. Proportion of dwellings with any damp by tenure and ethnic group of Household Reference Person — 2023.

Damp is more prevalent in the private rented sector, in particular among Black households.

Explore further in our
Housing Conditions Dashboard



Homelessness and temporary accommodation have a significant impact on people's health and stability (OHID, 2022).

People in Lambeth and Southwark described homelessness and temporary accommodation as destabilising for health, especially for children and people already managing complex needs.

People stressed that homelessness is not only a housing issue but one that cuts across safety, health, mental health, schooling, and access to care. People who are homeless or at risk of homelessness [10] often face multiple challenges at once, with many having additional support needs. Domestic abuse, family or friends no longer being able to accommodate someone, and the end of private tenancies are common reasons for homelessness.

[10] People who have been legally recognised as homeless or at risk of homelessness; defined by people owed a homelessness duty.

In England, 324,990 households were owed a homelessness duty (a 9% increase from the previous year) (2023/24).

In Southwark, Black African residents were strongly overrepresented in homelessness applications; this group makes up 16% of the population but 29% of applicants (2023/24).

Explore further:
- Homelessness Dashboard

Temporary accommodation is often unsuitable for families and does not provide the safety, stability or conditions that people need to maintain their health and wellbeing (Shelter, 2017).

"It's a Black woman with two children, living on an estate that's been earmarked for demolition, which is now being used for temporary accommodation, which isn't being maintained. One of the lady's children is neurodiverse by the way. And [...] the fact that the accommodation is rat infested, and not on the ground floor, makes it sort of doubly unsafe and unsuitable in ways that it would be for any household. She's been given therapeutic activities to do with her child, which she can't do in the space."

Funded partner, Impact on Urban Health
Children's mental health programme

Families with children make up a large proportion of households in temporary accommodation, and the numbers have risen in recent years. In some local authorities, temporary accommodation rates are far higher than the national average.

In England, as of March 2024, 117,430 households were in temporary accommodation (an increase of 12% from the same period in the previous year); 63% of these were households with children (an increase of 14.6% from the previous year).

In Southwark, 26.8 households per 1,000 were living in temporary accommodation (compared to 4.6 per 1,000 in England) (2024).

Explore further:
- Temporary Accommodation Dashboard

People in Lambeth and Southwark described that healthy food is often inaccessible as it is unaffordable.

They discussed the fact that there are limited food options, as many convenient and affordable options are unhealthy; they want access to fresh produce and healthy, culturally appropriate, and affordable food.

“The only options you could [...] go down is the unhealthy route, because that would be the cheaper route.”

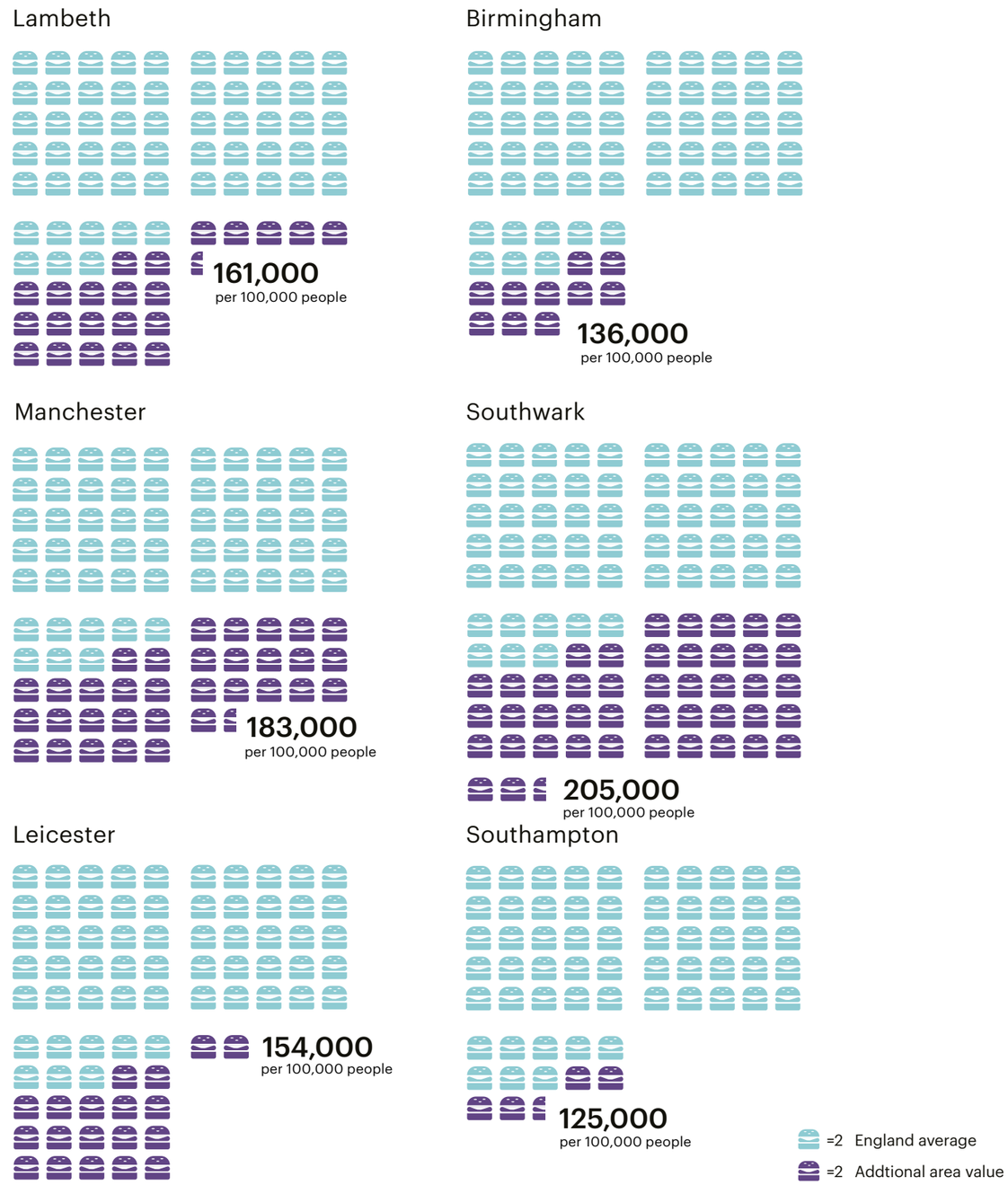
25-29; Male; Mixed or multiple ethnic groups

In many urban areas, the number of fast-food outlets per 100,000 people is significantly higher than the rate for England (116 per 100,000) (OHID, 2024). In Southwark, the rate is almost double the rate for England (Figure 20).

In England, the rate is twice as high in the most deprived areas (146.6 per 100,000) compared to the least (73.1 per 100,000) (OHID, 2024).

Figure 20. Number of fast food outlets per 100,000 population.

In many urban areas, the number of fast food outlets per 100,000 population is significantly higher than the national rate.



Air pollution is a public health crisis, particularly in urban areas like London. Every year, air pollution contributes to up to 43,000 deaths per year and is linked to a range of serious conditions, from asthma and lung disease to heart attacks, dementia, cancer, and strokes. [11]

People in Lambeth and Southwark see air pollution, especially from traffic, as a major health risk, particularly for people with asthma and other respiratory conditions.

They discussed how air pollution contributes to serious health problems, including hospital admissions and premature deaths. They also highlighted that children, especially around schools, and residents near busy roads are disproportionately affected. People thought that heavy traffic, especially diesel vehicles and HGVs, increase air and noise pollution. They want initiatives and transport and environmental policies that prioritise health. For example, reducing car dominance, expanding eco-friendly transport, such as e-bikes and e-scooters, and improving access to free or discounted public transport, particularly for older adults.

"In Lambeth and Southwark, the cars, the traffic, all these things are making us like ill in the area, [...] traffic around schools is terrible. When you've got all the cars dropping off, and traffic, and kids with asthma at school and things like that. I think that's really damaging."

35-39; Male; white British

[11] https://urbanhealth.org.uk/insights/data/data-air-pollution-laei

Data from the London Atmospheric Emissions Inventory (LAEI) [12] provides information on the sources of key pollutants in London (2022):

Road transport contributes **42% of NOx emissions** and **29% of PM2.5** emissions.

Industrial and commercial heat and power generation sources contribute **25.5% of NOx** and construction **8.7% of PM2.5.**

Domestic wood-burning accounts for **15.4%** of PM2.5.

[12] The LAEI is the most detailed air pollution dataset of its kind in the UK, and one of the most comprehensive globally. It tracks emissions of key pollutants like nitrogen oxides (NOx) and particulate matter (PM2.5 and PM10) and breaks them down by source.

Read our blog on **What the latest data reveals about air pollution** in London

People in Lambeth and Southwark felt that access to green spaces and affordable leisure is a major priority for community health.

They emphasised that green spaces and parks enable:

Improved mental health and wellbeing, through interacting with the outdoors and nature, recreation, relaxation, and socialisation.

Community connection, especially for families, elderly residents, and individuals living in flats.

Physical activity, including for children and those with predominantly sedentary lifestyles.

Access to cleaner air, especially compared to polluted main roads.

"

"I realised that the park, Ruskin Park, is actually about the green therapy."

55-59; Female; white Other

People noted that these spaces must be equitable, well-maintained, and close to home. They should also be designed to serve a diverse range of needs, from improving mental health to social connection to offering opportunities for physical activity and youth engagement. Specifically, people suggested focusing on:

Creating community gardens and pocket parks.

Improving accessibility and maintenance of existing parks.

Promoting activities in green spaces, like nature drawing or group walks.

Offering community-based exercise programmes.

Offering free or low-cost exercise opportunities, such as in gyms and swimming pools or through exercise equipment in parks.

Ensuring young people of all ages, including teenagers, can benefit from outdoor spaces and activities.

People in Lambeth and Southwark talked about how regeneration efforts often displace marginalised communities, causing harm, rather than upgrading neighbourhoods equitably.

They also discussed a shortage of schools and medical centres, sometimes linked to new housing, which increases demand for services.

"In terms of infrastructure, when we're walking on a pavement [...] being uneven is inaccessible for anyone in a wheelchair, [...] So when I'm pushing my auntie, there's been times where she's nearly fallen out, and we're just trying to do fun things. I'm just trying to go get a posh ice cream down in Clapham old town and trying to do the simple things. It [..] affects my auntie's mental health and how she feels about herself, so she doesn't leave the house often enough. Everything is a little bit too difficult, and I think that [is] because of simple things that could be fixed."

35-39; Female; Black, Black British, Caribbean or African

People in Lambeth and Southwark viewed secure employment as a protective factor for health and wellbeing.

They describe how secure jobs provide income stability and come with certain rights (e.g., sick pay) that may help people to stay healthy. Economic equality and job security are seen as foundational for access to basic needs, including food and shelter, and for activities that enable positive wellbeing. And insecure work makes it difficult to prioritise health due to constant financial stress.

However, while work can be a way to secure money and resources, unhealthy work environments and cultures can also affect people's health directly. Examples of this include gig and informal economies where people often work multiple low paid jobs with no time off or sick leave, facing health risks from demanding work, inability to rest, and living with ongoing pain or injury without adequate support. People also recognised systemic inequalities affecting racially minoritised communities, who often work long hours in lowly paid, physically demanding jobs. Some people, for example those who have newly migrated from abroad, might be particularly vulnerable to exploitative work conditions.

"I mean, surely the people [who] struggle the most are the people who have to work multiple jobs and don't have time to go and access healthcare. And then the other thing is they can't, they feel pressurised to not take time off."

Funded partner, Impact on Urban Health,
Health effects of air pollution programme

People in Lambeth and Southwark were concerned about people being safe at home and outside, citing concerns around domestic violence, as well as public safety and violence.

They also emphasised that safety should be created equitably, ensuring people are safe from discriminatory practices (e.g. racial profiling, stereotyping, and discriminatory practice within police and institutions) that could affect communities' trust and sense of belonging.

"And if we're talking about health, these are the things that impact your mental health, how you walk through society, because you're constantly being victimised."

35-39; Female; Black, Black British, Caribbean or African

People in Lambeth and Southwark shared reflections on the potential effects of media and social media, and how they can affect everyday stress, behaviour, and wellbeing.

This included the role social media might play in normalising knife carrying among young people, how global news might impact the wellbeing of young people, how the climate crisis might increase anxiety, and how framing in the media can reinforce stereotypes andperpetuate inequities.

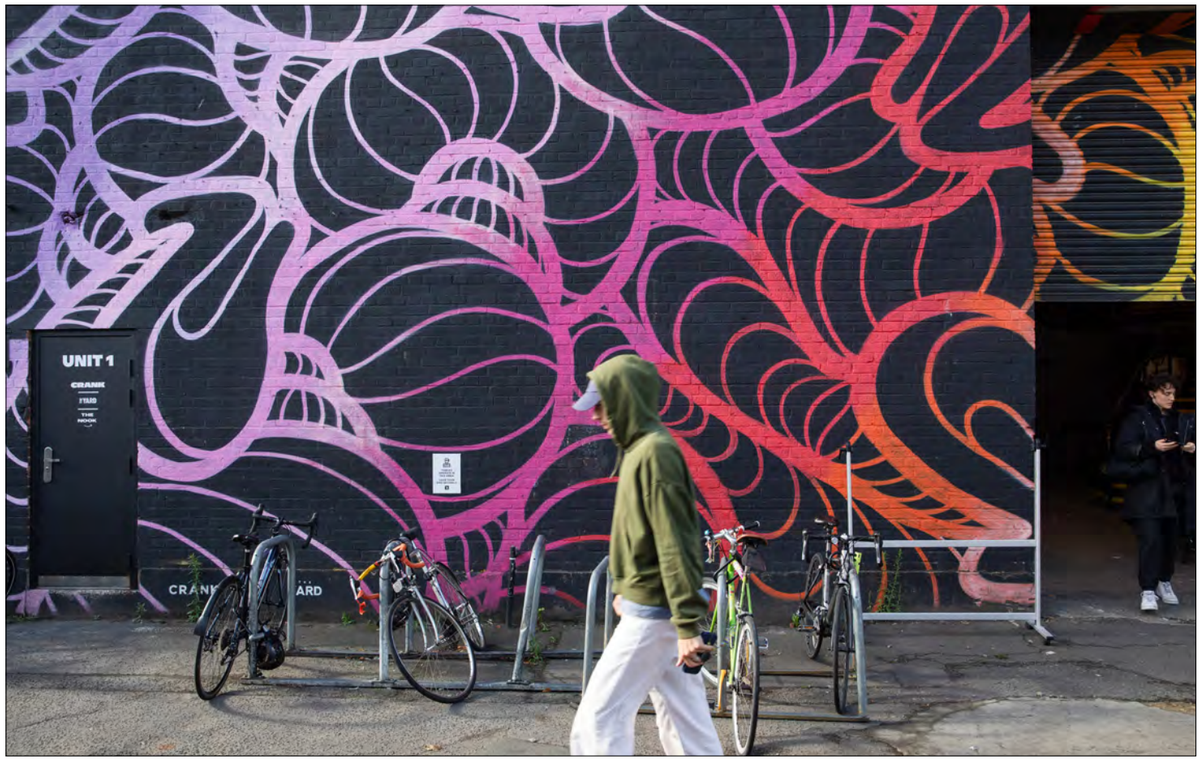
"I think the like, wider effects of that in the news, [...] really changes people's mental health [...]. I just think that young people are stressed and worried about the future. And I think some of it is like really immediate stuff, and then some of it is like wider stuff in the news as well. And I think that can, it can feel really kind of hard to talk about."

Funded partner, Impact on Urban Health,
Health effects of air pollution programme

"How are you supposed to look after yourself if you're not, like, safe and secure in where you live? Or if your housing is covered in mould, air pollution, pests. How are you supposed to look after yourself if you've got all of those drains on your mental and physical health? And yeah, I guess I think just the state of housing is shocking in London. I just think that should be a really big priority."

Funded partner, Impact on Urban Health
Health effects of air pollution programme

Explore further:
Directory of Themes
Additional quotes from our qualitative research related to this topic.



BETTER SERVICES

HEALTHCARE AND COMMUNITY SERVICES PLAY A VITAL ROLE IN SHAPING HEALTH, BUT SIGNIFICANT BARRIERS EXIST, WITH CLEAR ROOM FOR IMPROVEMENT IN SERVICE DESIGN AND EXECUTION.

KEY FINDINGS

People in Lambeth and Southwark described barriers to accessing care that is timely, preventative, responsive, and equitable.

Access: Long waits and complex systems make it difficult to secure healthcare appointments.

Prevention: People want more early support to prevent health problems escalating.

Trauma-informed care: Services do not always respond appropriately to people who have experienced trauma.

Equity: People highlighted the need for culturally sensitive and accessible care.

THE DATA AND ANALYSIS

The data and analysis within **Better Services** relate to four subthemes, as found below.

BETTER SERVICES

Difficulty accessing healthcare appointments

Preventative care

Trauma-informed and responsive care

Culturally sensitive and equitable care

People in Lambeth and Southwark expressed major concern around securing healthcare appointments and the associated waiting times, both for GP appointments and specialist care.

In addition, processes which involve triaging and having to make multiple appointments or follow-up calls add to frustration and delays. People would like more informal spaces and walk-in services that could help people get timely access to health and preventative care.

"You finally get somewhere, then they say they don't have any appointments for either an adult or a child for like, six months. Well, in six months, what am I supposed to do with my child waking up screaming that I'm going to die in the middle of the night?"

45-49; Female; Black, Black British, Caribbean or African

People in Lambeth and Southwark felt there was a need for more preventative care and early support to stop more complex health issues developing.

They emphasised that this should be fairly and equitably available. People want a more holistic approach to health, considering wider support needs as well as acute health needs.

> **“ [...] Pre-emptive kind of stuff to help people stop getting to a point where they’re in a crisis. I think that it’s all really important.”**

Funded partner, Impact on Urban Health
Health effects of air pollution programme

People in Lambeth and Southwark recognised that people who engage with support services have often had deeply traumatic experiences.

They explained how essential it is that services take a trauma-informed approach, identify specific support needs, and provide trauma-responsive care. Instead, however, people shared experiences of receiving generic letters or leaflets with no-longer-active phone numbers, even after experiences such as being a victim of violence, e.g. stabbing or sexual abuse.

"There's something so offensive when you've been through such a highly traumatic event to then find yourself in a service that can't respond to you. Or sends you a telephone number that doesn't work, or doesn't reply to an email, or maybe even lies and says 'we did refer you to an agency, we did send you that email'. When you've been through that sort of trauma, you can't accept an email. You need one-to-one, face-to-face support and nourishment and holding."

65-69; Female; white Other

People in Lambeth and Southwark also stressed that it is essential for support to be inclusive and cater to the needs of all residents; considering language requirements, special educational needs, cultural expectations, and the health experiences of people from racially minoritised communities.

"

"For a lot of Spanish people, Colombian people, African people, there's a language barrier. I've seen it for myself, like people who've got learning difficulties and people are getting frustrated with them on the phone because they don't understand. Yeah, like they should learn how to talk to people better, especially people with learning difficulties who just can't understand."

40-44; Female; Black, Black British, Caribbean or African

"

"I was looking for some sort of assistance for myself, or maybe even my son with maybe seeking like a counsellor's help for a bereavement. And I went to the school and they say, 'call this place'. I go to my GP, they say, 'call this place'. I call this place. They say, 'call this place'."

Funded partner, Impact on Urban Health,
Health effects of air pollution programme

People described the systems that affect health as a “failing system” and recognised that this is affecting some people more than others.

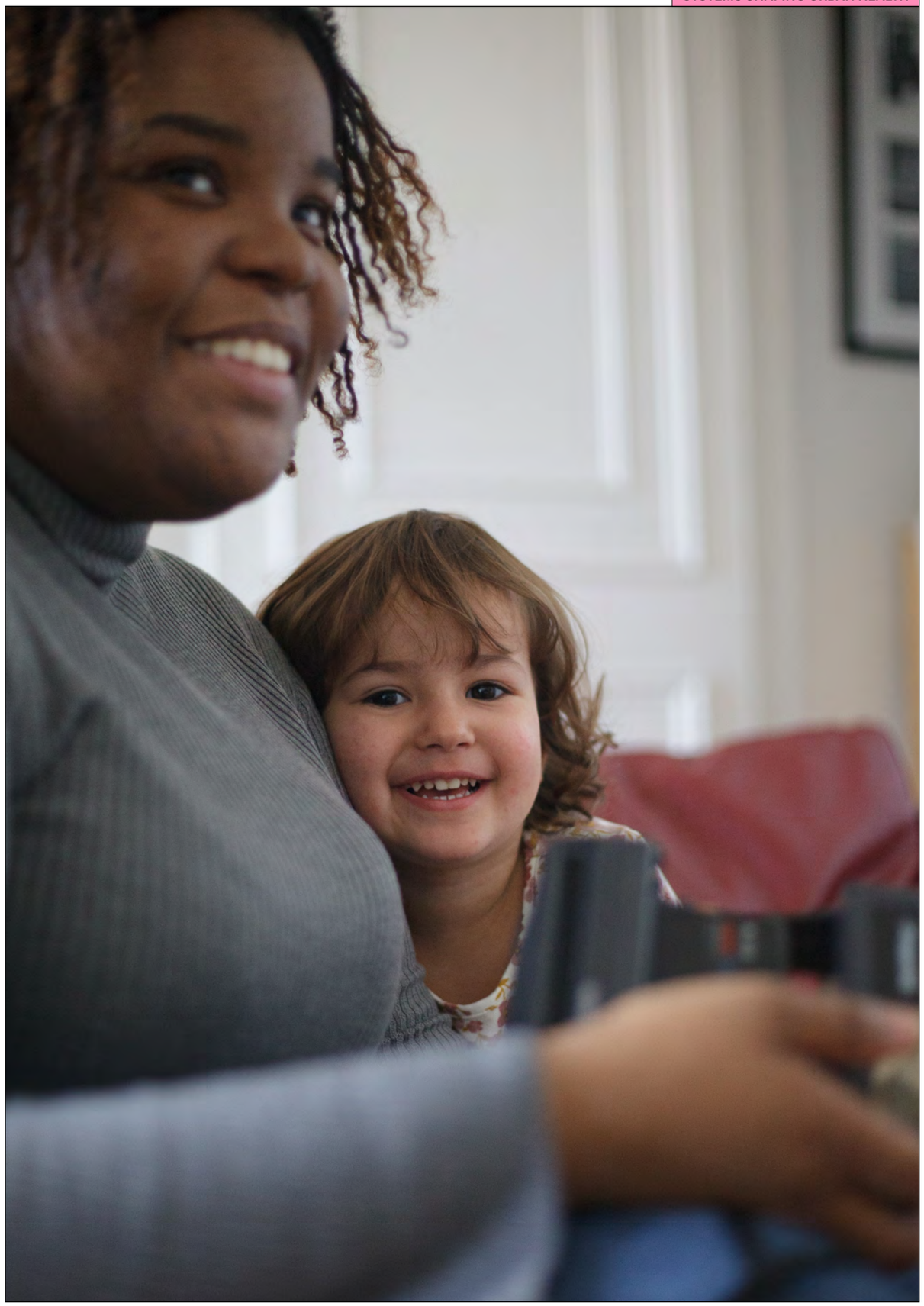
> **“People that struggled most with their health were ones that have been like, typically, quote, unquote, like, failed by the system. So it was, it tended to be, groups like low-income families [...] people that had disabilities, people that lived in overcrowded or poor-quality housing, and people of colour in particular.”**

40-44; Female; Black, Black British, Caribbean or African

Discussions indicated there is a need for focused efforts to create health-enabling environments and better services. They should ensure local provision meets local needs, the workforce is well supported, people have agency in their own health and wellbeing, and that services are accountable.

Explore further:
- **Directory of Themes**

Additional quotes from our qualitative research related to this topic.



CRUCIAL SERVICE GAPS

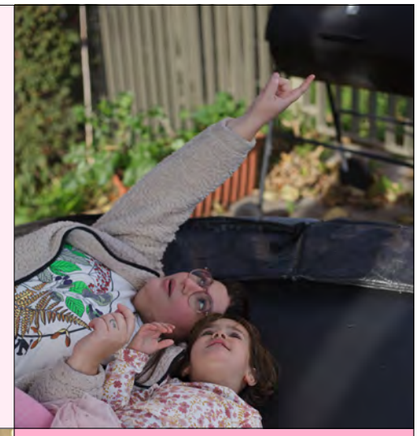
ESSENTIAL SERVICES THAT PEOPLE RELY ON ARE SEEN AS MISSING, OVERSTRETCHED OR HARD TO REACH, LEAVING PEOPLE WITHOUT HELP AT THE MOMENTS THEY NEED IT MOST.

KEY FINDINGS

People in Lambeth and Southwark described significant gaps and capacity pressures across essential support services, including:

Domestic abuse support: Services for victims of domestic abuse and sexual violence were described as overstretched and difficult to access, leaving some survivors without timely help.

Mental health and special educational needs and disabilities (SEND) support: Long waiting times and limited availability mean many residents struggle to access support when they need it, particularly young people, men, and racially minoritised communities.



Sexual health services: Access has worsened following clinic closures, increasing pressure on remaining services despite very high sexually transmitted infection (STI) rates in urban areas including Lambeth and Southwark.

Other essential services: Residents also highlighted shortages in dentistry, menopause support, and physiotherapy.

THE DATA AND ANALYSIS

The data and analysis within **Crucial Service Gaps** relate to five subthemes, as below.

CRUCIAL SERVICE GAPS

Domestic abuse support

Mental health support

Send support

Sexual health services

Other gaps

People in Lambeth and Southwark felt available support for victims of domestic violence, sexual abuse, and rape falls short, with serious consequences for people's lives.

They spoke about reduced service availability and overworked staff, including within social services. Funding cuts were seen as a reason why services cannot meet the demand for help.

"I work with a lot of women and children who've been victims of rape, domestic violence, and sexual abuse, and there is absolutely no refuge, no sanctuary, no support groups. I mean, yes, there are — [but they're] completely inaccessible. You phone [service provider A] now and say 'So I've got a young woman who's been raped. She's in a terrible state. She's a minor. I need counselling.' and they say 'We've got a six-month waiting list'. Like, we could lose her. Yes, there's [service provider B]. You know, you refer everything to [service provider B]. [service provider B] can't cope. It's no point in referring them to [service provider B] anymore, because they just can't cope."

65-69; Female; white Other

People see a great need for sanctuaries for those struggling with mental health difficulties, those escaping violence, and those who are homeless. Data from the MHCLG (2023/24), gives a clear indication of the scale of the need and the resulting problem.

In Southwark, 10% of all households defined as homeless or at risk of homelessness are experiencing domestic abuse — meaning one in ten families or individuals turning to councils for help were fleeing violence or living in unsafe homes (MHCLG, 2024).

Explore further:
- **Homelessness Dashboard**

People in Lambeth and Southwark discussed that many people face long waiting times for mental health services.

They highlighted the importance of providing easy-to-access early support for mental health. They stressed that delays in support may come with a direct risk to people's lives, as unaddressed mental health difficulties may lead to risk of suicide.

Moreover, participants felt that there is a need for more mental health support for young people, with concerns raised that young people who cannot access relevant support early on may become involved in crime.

They also highlighted the importance of meeting identified needs, such as neurodiversity or psychosis, and how lack of support might lead to worsening mental health among affected young people.

Participants also discussed that there is a gap in support for men when it comes to mental health services, including for fathers, especially single dads.

One in four households in England defined as homeless or at risk of homelessness [13] (26.4%) had a history of mental health problems.

[13] People who have been legally recognised as homeless or at risk of homelessness; defined by people owed a homelessness duty.

Explore further in our
Homelessness Dashboard

> **"I remember thinking, all right, cool, I wouldn't mind getting some therapy, but there wasn't really any access to therapy. It was something I had to do myself, and if I wanted to get therapy [through the NHS], the actual wait list — I felt like I really felt suicidal. I would have probably killed myself by the time they would have seen me."**

40-44; Male; Black, Black British, Caribbean or African

People in Lambeth and Southwark talked about the difficulty of getting neurodiversity diagnoses.

They described this as a battle, highlighting long waiting times, and diagnosis being extremely hard to access. This leaves many children and families to fend for themselves, with late or limited support having a potentially lifelong effect.

> **"[...]It's an ongoing battle, especially with special needs. Every special needs parent I come across, battle is the word that is said."**

45-49; Female; Black, Black British, Caribbean or African

People in Lambeth and Southwark discussed how the closure of a sexual health clinic made it more difficult to access sexual health care.

They highlighted how, while some testing services could be done through the mail, a smaller number of clinics means more pressure on availability of in-person appointments and care.

“Recently, [...] the sexual health clinic in Streatham was closed. [...] There is now one less sexual health clinic available, a whole physical space unavailable, which is putting pressure on other clinics. [...] And now, when we’re seeing rising levels of chlamydia and gonorrhoea all across London, I think it’s a real issue that needs to be addressed.”

45-49; Female; white Other

In some urban areas, the rate of STI diagnoses are higher than the national average (520 per 100,000 in England). Southwark has a rate of 2,633 per 100,000, and Lambeth 3,304 per 100,000 — more than five to six times the England average (Figure 21).

FIGURE 21

Figure 21. New STI diagnoses (excluding Chlamydia in under-25s) per 100,000 - 2023.

Across many urban areas, STI diagnosis rates are significantly higher than the national rate, in particular in Lambeth and Southwark, where rates are more than six and five times higher respectively.

People in Lambeth and Southwark described further essential gaps across dentistry, menopause support, and physiotherapy.

Limited capacity, long waits, and restricted availability meant many people felt like they were left without support.

“All I can say is DENTIST in capital letters.”

45-49; Non-binary; Mixed or multiple ethnic groups

Explore further:
Directory of Themes
Additional quotes from our qualitative research related to this topic.

WORKFORCE

FRONTLINE STAFF ARE DOING THEIR BEST UNDER IMMENSE PRESSURE, BUT HEAVY WORKLOADS, LIMITED CAPACITY, AND SKILL GAPS ARE UNDERMINING PEOPLE'S EXPERIENCES OF CARE AND DEEPENING INEQUITIES.

KEY FINDINGS

People in Lambeth and Southwark recognised the essential role of the workforce within services that affect health, while also highlighting pressures and support needs:

Appreciation for staff: There is strong appreciation for the care, dedication, and professionalism of many frontline staff.

Workforce pressures: High demand and limited capacity mean many staff are carrying heavy workloads, with concerns about burnout and the impact this can have on service delivery.

Training and skills: There is a need for improved training, particularly in active listening, cultural awareness, and responding to the diverse and intersectional needs of urban communities.

Differences across sectors: Community and voluntary sector organisations are often felt to provide more responsive and compassionate support than statutory services.

THE DATA AND ANALYSIS

The data and analysis within **Workforce** relate to three subthemes, as below.

WORKFORCE

Appreciation

Workload

Training

People in Lambeth and Southwark see that the workforce plays an essential role in the systems that affect people's health.

There was recognition and praise for the work, passion, and care of staff.

"

"The people at the child maintenance service, and I don't know who they're being trained by, but whoever it is, the way they're dealing with customers is beyond good, even if they can't give you the answer you want."

45-49; Female; white Other

People in Lambeth and Southwark acknowledged the high workload frontline staff carry; and that services often need to respond to high demand with limited capacity.

They recognised that placed a heavy burden on the staff's own wellbeing, with burnout being a very real risk. Some participants highlighted the need for more capacity and resources. People also felt that the health system required a lot of paperwork and bureaucracy, making it harder for frontline staff to care for service users.

"

"I think the work that people in health have to do is too much for their capacity, because I actually work in mental health, and we get so many referrals, and we have ladies that are on our waiting list for months, but we're trying. There's only so many patients that I can see in a day. But then what about the others?"

30-34; Female; Black, Black British, Caribbean or African

People in Lambeth and Southwark spoke of the need for better professional skills training, regarding active listening and ways of working.

They also highlighted the need for training on intersectionality and diversity, equity and inclusion to enable the workforce to respond to people's diverse needs. People also emphasised the need for improved cultural awareness and competency among practitioners.

People spoke positively about the care provided by both the community and voluntary sector and statutory services. However, experiences were mixed, with some feeling that the level of care was not always consistent.

> **"[We need] primary care staff to be trained on different intersectional needs of vulnerable groups."**

Funded partner, Impact on Urban Health,
Children's mental health programme

Explore further:
- **Directory of Themes**

Additional quotes from our qualitative research related to this topic.

HOW THESE FINDINGS HELP US UNDERSTAND URBAN HEALTH

These findings show that health in urban areas is shaped not only by individual circumstances or population characteristics, but by how systems are designed, accessed, and experienced.

Urban systems — including environments, the service landscape and where there are gaps, and how the workforce providing frontline services is trained and supported — do not affect all people equally. Instead, they interact with existing patterns of disadvantage, shaping who is exposed to risk, who can access support, and how effectively needs are met.

This helps explain why inequalities persist even where services and resources are present. Proximity to services does not guarantee access, and availability does not ensure that systems work in ways that are responsive, equitable or trusted. As a result, the same systems can offer protection for some groups while reinforcing disadvantage for others.

Understanding urban health therefore requires us to pay attention not only to what systems exist, but to how they operate in practice. This must include how they are experienced by different communities, and how they interact with existing patterns of inequality.

WHAT PEOPLE TOLD US WOULD MAKE A DIFFERENCE

BETTER HEALTH STARTS WITH FAIRNESS, BELONGING, AND COMMUNITIES HAVING THE POWER, RESOURCES, AND RELATIONSHIPS TO SHAPE THEIR OWN FUTURES.

Implications for decision-makers

These findings matter for anyone seeking to improve health in urban areas with communities, not just for them. People described the importance of trusted relationships, accessible services, community spaces, long-term investment, and decision-making that reflects lived experience.

For local authorities, health systems, funders, service providers, researchers, and community organisations, this means treating community insight as essential evidence. Engagement should lead to meaningful participation in decision-making and visible action to ensure communities have real influence over decisions which affect their health.

One of our key recommendations highlights the opportunity the emerging Neighbourhood Health agenda provides to embed community voice and participation from the outset.

EXPLORE THE DATA

- **Directory of Themes**

All data and insights in this chapter are from our qualitative research. You can explore this further and find more quotes related to this in our **Directory of Themes**.

KEY TAKEAWAYS

Local connection and shared spaces build trust, reduce isolation, and allow collaboration to take root.

Accessible, empathetic services that work with people are central to restoring confidence.

Trust, representation, and partnership are needed for decisions to reflect lived experience.

Long-term, joined-up approaches, not short-term projects, create the continuity required for lasting change.

WHAT PEOPLE SAID WOULD MAKE A DIFFERENCE LOCALLY

Connection and community spaces

Access and empathy in services

Trust and representation

Time and long-term commitment

Connection and community spaces

Participants said that health improves when communities have safe, welcoming places to connect in person, as well as online. Community centres, parks, schools, faith venues, and small charities were seen as anchors of wellbeing — places where relationships form and information is shared.

Many described the loss of these local spaces and wanted to see them protected and rebuilt, not as services but as community infrastructure that enables mutual support.

“I worked very hard as a community advocate to start things like street parties during COVID, we moved our neighbourhood watch into a WhatsApp chat, which has created a huge network from my community.”

45-49; Female; white other

Access and empathy in services

People talked about the need for services that are easy to reach, joined up, and delivered with empathy. They valued staff who listen, understand, and treat them as partners, not problems to be managed.

Participants wanted consistency and collaboration between services, so people do not have to repeat their stories or navigate complex systems alone.

"Closer collaboration with well-established community spaces (churches, local business, dance groups) and organisations to reach and increase trust in services from community members. Increasing information and access to services."

Funded partner, Impact on Urban Health,
Children's mental health programme

Trust and representation

Participants emphasised that trust is built through visibility and follow-through. They want to see leaders and decision-makers who reflect the diversity of their communities and who communicate honestly about what can and cannot change. People discussed the importance of connecting people with similar experiences and advocating for change together. By drawing on diverse perspectives and focusing on the solutions, they can drive inclusive change.

People described fatigue with engagement processes that feel tokenistic; trust grows when relationships are sustained and feedback leads to action.

“More spaces for these types of stories to show up, because I think there’s real importance for communities to see that their voices are heard and to see that there are positive outcomes as well.”

Funded partner, Impact on Urban Health
Health effects of air pollution programme

Time and long-term commitment

Participants consistently said that short-term funding and pilot projects undermine progress.

They wanted long-term investment that gives organisations and residents time to build relationships and confidence. Sustained presence and continuity were viewed as proof that institutions are serious about change.

"One thing I'd love to see happen in the next few years, is increased investment in community-led health initiatives. I'd like to see more funding and resources allocated to community-led health initiatives, just like developing culturally sensitive means of health support services. That would be very helpful."

25-29; Female; white British

HOW PEOPLE SEE CHANGE HAPPENING

Collaboration and integration

Working with communities

Using data and evidence

Policy, leadership, and influence

Funding and investment

Collaboration and integration

Participants described change as something that happens when organisations work together with communities, not in parallel.

They emphasised the importance of shared goals across sectors and clear accountability.

Collaborative approaches were seen to reduce duplication, build trust, and make the most of limited resources. When people and organisations work side-by-side, participants said, local energy can translate into wider system change.

“Effective collaboration between organisations in the community, groups and individuals is like a reoccurring theme in these stories.”

35-39, Female, Black, Black British, Caribbean or African

Working with communities

People repeatedly highlighted the value of community-led work. They said communities already have the knowledge, relationships, and solutions that can improve health; systems need to create the conditions for that leadership to flourish.

Participants wanted decision-makers to recognise local expertise and to invest in community capacity, not just in service delivery.

“You know, the community can come with inventive solutions [...] communities actually have a lot of the solutions, all of the knowledge, because they experience it in their own bodies.”

Funded partner, Impact on Urban Healt
Health effects of air pollution programme

Using data and evidence

Participants saw data as a tool to improve visibility and accountability. They wanted evidence to be shared openly and used to demonstrate both need and progress.

Accessible, transparent data was seen as a way to strengthen collaboration, helping people understand what works and where effort should focus.

"Better sharing of patient records from primary and secondary care. So, without being asked the same things again, it's just better sharing of information."

40–44; Male; Asian or Asian British

But not only was sharing of evidence important – striving for better data that represents our communities well was also a key issue.

"So this is going back to the previous census, 2011 I think, 9.8% of the population were of Latin American heritage. Unfortunately, the Office of National Statistics does not include Latin American as an option when it comes to equalities monitoring, and that has an impact in terms of maybe assessing the needs of the community, responding to the needs of the community, etc."

Funded partner, Impact on Urban Health, Financial foundations for adult health programme

Policy, leadership, and influence

People thought that Government should commit to working across departments on issues affecting people's health. For example, improving the healthcare system and prioritising a race equality strategy. But they also wanted to see progress made on housing, employment, and children and family policies that affect people's health experiences.

"I think that would be fantastic to see [...] the new Labour Government enforcing their new race equality strategy [...] and seeing how that trickles down to affect local councils."

Funded partner, Impact on Urban Health
Innovation team

Funding and investment

Across discussions, people pointed to funding as both a mechanism and a barrier to change, highlighting how philanthropic funding can enable community-based organisations to get established and mature.

They called for flexible, longer-term funding that allows organisations to plan and adapt. Short-term or competitive models were seen as undermining collaboration and trust.

“Flexible funding programmes are amazing.”

Funded partner, Impact on Urban Health
Health effects of air pollution programme

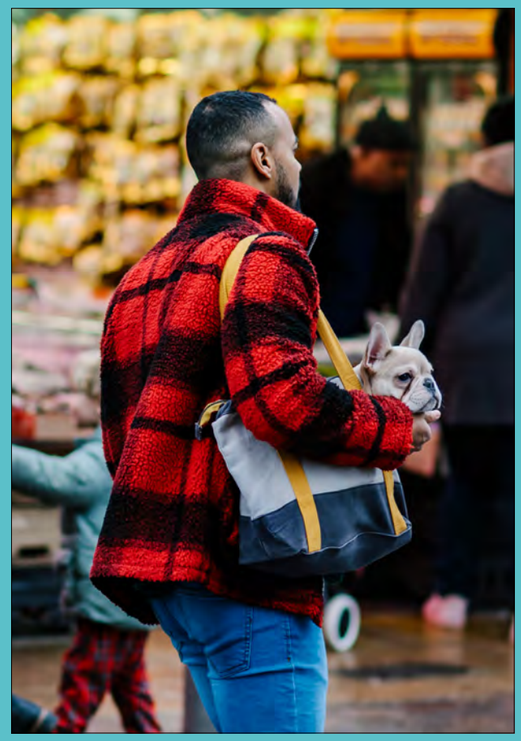
WHAT THIS MEANS FOR URBAN HEALTH

The residents and partners who took part in the focus groups reflected on what they believed could be done locally and nationally to tackle the health inequalities they see playing out in their communities. Participants described both the changes they want to see, and how those changes can happen. Together, these insights build a picture, grounded in local experiences, of how to create the conditions for better urban health.

Explore further:
- **Directory of Themes**

Additional quotes from our qualitative research related to this topic.

OUR RECOMMENDATIONS



THESE RECOMMENDATIONS IDENTIFY WHERE CONSISTENT NATIONAL ACTION CAN HELP IMPROVE HEALTH AND REDUCE INEQUITY IN URBAN AREAS. THEY FOCUS ON STRENGTHENING PREVENTION, IMPROVING ACCOUNTABILITY, AND ENSURING THAT PEOPLE MOST AFFECTED BY URBAN HEALTH INEQUITIES HAVE A MEANINGFUL ROLE IN SHAPING THE DECISIONS THAT AFFECT THEIR LIVES.

MAKE PREVENTION COUNT IN NEIGHBOUR-HOOD HEALTH DESIGN

Living in urban areas carries many distinct challenges, which often start early in life and are strongly influenced by the places people live, work, and socialise. Centring primary prevention — preventing ill-health before it develops — and seeking to create health-enabling urban places is central to ambitions to ensure people from all communities have equitable opportunities to live healthy lives.

The Government's Neighbourhood Health proposals are at the heart of the new NHS 10 Year Health Plan. They recognise the importance of place-based approaches to driving effective prevention and improving health outcomes.

But while the emerging strategy recognises the importance of a shift to prevention, there is a risk that proposals focus too heavily on access to services and miss the opportunity to act upstream. Addressing the social, commercial, and environmental drivers of health could, in turn, reduce the risk of ill-health developing in the first place.

As we know from our work, any approach to improving health and wellbeing in communities, and consequently reducing pressure on local services, must start with concerted action to make the places we live and work health-enabling. It will take time to embed the Neighbourhood Health agenda, but there is an opportunity now to focus on primary prevention from the outset.

We recommend:

01

Centring prevention by requiring Health and Wellbeing Boards to set locally determined targets and metrics for primary prevention as part of neighbourhood health plans.

02

That these targets, and subsequent action, should be determined in partnership and consultation with local communities, to ensure plans reflect need and reach those people furthest from health equity.

Alongside clear targets on access to care and admissions, equally rigorous primary prevention metrics at the neighbourhood level should be set, such as specific targets for reducing food-related ill-health, local air quality improvements or ensuring access to effective financial and debt advice. As Health and Wellbeing Boards take on responsibility for developing neighbourhood health plans from 2027-28, these plans should include a specific, measurable focus on prevention.

INVOLVE THE PEOPLE MOST AFFECTED BY URBAN HEALTH ISSUES IN POLICYMAKING

Cities and towns provide a range of health challenges and opportunities. This research consistently shows that people in urban communities do not experience these equally. People from low-income communities, from racialised communities or those experiencing discrimination are often most acutely impacted by the intersection of urban health issues.

At the same time, the voices of those people who are disproportionately affected are rarely heard by policy and system actors. Solutions will only be genuinely equitable and effective if they are developed with communities that have the most at stake.

Communities that are currently underrepresented in policy debates may also be at higher risk of being harmed by unintended consequences of policy change. Proactively and meaningfully involving communities in policymaking is vital to ensure policies are well designed and have a positive impact on health and equity.

In particular, the proposed abolition of Healthwatch, which champions local voices and feedback in health and care decision-making, brings risk for ambitions to ensure neighbourhood health plans reflect local and community needs. Healthwatch has played a significant role in shaping early thinking on the agenda. It is essential that this voice and momentum is not now lost if its functions are absorbed into government and the NHS.

We recommend that policymakers across government departments, and policymakers developing neighbourhood health plans:

01

Actively involve people and communities most impacted by urban health challenges in policy development — starting with the Government's flagship Neighbourhood Health approach. 'Seldom heard' communities should be included by:

- Proactively reaching out to these groups, for example via community research organisations which can act as a trusted broker between policymakers and communities.
- Ensuring pre-read materials are accessible, by avoiding jargon and making them available in different languages.
- Fairly compensating people for their time and expertise.

02

As an enabling step, NHS England should develop best practice guidance for local authorities and Health and Wellbeing Boards on involving local communities in Neighbourhood Health policy. This should draw on broader work on community involvement in policymaking, for example, the approaches set out in the **Demos and Involve Citizens' White Paper.** (Levin, Curtis, Castell, & Kapetanovic, 2024).

03

To ensure neighbourhood health plans take full account of equity considerations, they should include a specific Equality and Health Inequalities Impact Assessment (EHIA), following the standard format set out by NHS England.

OUR APPROACH TO PARTICIPATION

At Impact on Urban Health, we believe the people most affected by health inequalities should have a real say in the decisions that affect their lives. Too often, decisions about services, funding and programmes are made without the voices of the communities they're meant to support. We want to change that. Participation for us means listening, learning and sharing power.

This is already part of how we work. Community members sit alongside trustees on our Impact on Urban Health Committee and on our Executive Investment Committee, where major funding decisions are made. Across our programmes, teams design and deliver work with participation at the centre, working closely with residents through community led research, long term place based relationships, and testing new ideas together to see what works in real life. We support this with practical tools to help teams design participatory approaches, and we're strengthening how learning from communities feeds into our strategy design, data, evaluation and learning work, and our decision making.

We aim to involve people early, be clear about what power and influence they have, and make participation fair, respectful and worthwhile. By building skills, confidence and connections in communities and grounding our work and decisions in lived experience we think participation leads to better choices, stronger relationships and healthier, more equal futures in Lambeth and Southwark.

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EXPLORE

THE DATA

EXPLORE THE DATA

Our interactive **Dashboards** allow users to explore the datasets used in this report in more detail:

- **Urban & Rural Differences**
- **Demographics in Major Urban Areas**
- **Outcomes in Major Urban Areas**
- **Avoidable Mortality**
- **Child Mortality**
- **Housing Conditions**
- **Homelessness**
- **Temporary Accommodation**

Dashboard **User Guides** are available to help users navigate and interpret the dashboards.

Our **Directory of Themes** also provides a detailed bank of quotes from the qualitative research grouped by themes as set out in this report.

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