Spatial inequalities in health and wellbeing
Placemaking to improve health outcomes

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Local health inequality in the north of England

Professor of Public Health at Newcastle University, Clare Bambra’s research Health Divides: Where you live can kill you, discusses the spatial pattern of health outcomes in the UK and its causes, including compositional factors (attributes and behaviour of the population) and contextual (economic, political, access to services, place stigma, physical environment etc). Bambra’s study, Local health inequalities in an age of austerity, took place in Stockton on Tees which has the largest health inequality in England. A boy born in the town centre can expect to live 15 years less than one born two miles away in Hartburn.5

There have been recent improvements in Stockton town centre to try to help combat this, including Stockton Central Garden, and the Hub, the UK’s first active travel and cycle parking centre, funded by Stockton Borough Council and Sustrans, a UK walking and cycling charity.

Local health inequality is also illustrated in a study conducted by Newcastle Initiative on Changing Age. It showed the difference in the average healthy life expectancies for adults aged 55, along the stations on the Tyne and Wear Metro system.6 For example, those living in South Gosforth over the age of 55 will have over twice the number of healthy years ahead of them than those living in Byker.
Regional health inequality

Bambra also explored regional disparities in health, and the very real north / south health divide illustrated in Figure 1. This shows the average life expectancy at birth for both men and women for the stops along some of the major railways in England. Although there are exceptions, this clearly shows the health divides within England. This is most pronounced for the north east and south east regions, which have the lowest and highest life expectancies respectively for both men and women (gaps of four to five years).¹

Public Health England commissioned the Due North Inquiry into health equity for the north in 2014 which found that people in northern cities and towns are almost twice as likely to die early (before age 75) as their counterparts in the south.²

“There are deep rooted and persistent regional inequalities in health across England, with people in the north consistently found to be less healthy than those in the south – across all social groups and amongst both men and women … Over the last 50 years, this is equivalent to over 1.5 million northerners dying earlier than if they had experienced the same lifetime health chances as those in the rest of England.”³

Figure 1: An English Journey – life expectancy for men and women along the East Coast, Great Western and West Coast Mainlines⁴
Changing economies and the historical growth and decline of industry in the north have resulted in entrenched concentrations of poverty (the north includes 50 percent of the poorest neighbourhoods, whilst accounting for only 30 percent of the population), which is partly responsible for the health inequalities we see today. However, as the Due North Report states, even neighbourhoods in the south with similar poverty levels benefit from better health than those in the north. It also reports that, despite a narrowing of the gap in the latter half of the twentieth century, recently this trend has reversed, in part due to the disproportionate impact of austerity measures on the north.

To compound this evidence The Marmot Indicators (originating from the Marmot Review’s Fair Society, Healthy Lives report in 2010 and updated every two years) have found that increases in life expectancy have slowed since 2010.

“... The Marmot Indicators (2015) demonstrate that men in Blackpool (classified as the most deprived ward in England) can expect to live 16.5 more years in poor health and 7.4 fewer years overall than men in Wokingham (classified as the least deprived ward in England). For women, the differences are 11.6 and 4.6 years respectively ... Poor and disadvantaged communities are more likely to live in areas that have poor quality built environments.”

The Marmot Review ‘10 Years On’ confirms an increase in the north / south health gap, where the largest decreases were seen in the most deprived 10% of neighbourhoods in the north east and the largest increases in the least deprived 10% of neighbourhoods in London.

What can the built environment industry do to tackle this injustice and ensure that we are creating places which meet the needs of the communities who will use them, and improving their health and wellbeing rather than worsening it?
Factors influencing health and wellbeing

The spatial disparities in health described in this article are the product of individual, socio-economic and political factors, as illustrated in Figure 2, with advantage and disadvantage accumulating across the life course. However, the physical environment – natural and built environment, and the activities which take place within it – also plays a role in influencing people’s behaviour and choices.¹³

There are complex, and sometimes contradictory, interactions between these which impact health outcomes. For instance, poorer neighbourhoods, which generally have lower levels of car ownership (although a 2018 study in Glasgow also found some instances of ‘forced car ownership’¹⁴), might be expected to report better health but this is not usually the case.

There are other elements at play: whether healthy food is available within easy walking distance, the quality and accessibility of green space, how safe and attractive walking and cycling routes and public spaces are, and whether neighbourhoods are alienated by impenetrable highways infrastructure. Related to this are local health inequalities where “the richest areas own the most cars but people in the most deprived areas have the worst air quality – and the lowest car ownership figures”.¹⁵ High streets are often an indicator of health inequalities. For instance, does the high street have a healthy retail offer, is it inclusive, safe, clean, walkable and cycle friendly?

In many instances, tackling health inequality will also help to tackle climate change.

Figure 2: The determinants of health and wellbeing¹⁶
Clearly, there have been huge advances in public health since the Victorian era. The healthy nation was a cornerstone of twentieth century planning, including the 1909 Housing and Town Planning Act which outlawed the notoriously unsanitary back to back housing, the Garden Cities movement and the Town and Country Planning Act 1947.

However, “in the process of modernisation, we may have created less visible, but more insidious life threatening syndromes.”17 This has taken the form of low density sprawl along with high rise housing set in large areas of poor quality open space, the dominance of the private car and therefore car orientated streets which discourage walking, cycling and play, mono functional rather than mixed use places, lack of availability of healthy food and a reliance on security features.

It is true that these factors also affect better off neighbourhoods, but the impact is felt more acutely in deprived communities with a legacy of interlinked poverty and poor health. With the wealth of evidence now available to inform decisions about the places we are creating, shouldn’t the industry be stepping up to this challenge?

A ‘new normal in placemaking’ to reduce inequality and improve health
Rachel Toms, programme manager at Housing and Health at Public Health England, states

“The NHS budget won’t stretch to treating multiple, long term preventable diseases en masse and people really don’t want to suffer from those diseases. We understand a lot about the role of the physical environment in shaping people’s behaviours, wellbeing and health. We need a new normal in placemaking.”18

Given the statistics highlighted earlier, at the very least we should take care not to exacerbate inequalities by creating places which are bad for people’s health. To play our part in improving the situation, opportunities for enhancing health and wellbeing must always be at the forefront of our minds when designing all places, particularly in areas which suffer from health inequality.

As an industry our starting point must be understanding people and place, including what health and wellbeing needs exist within the community. Armed with this and the wealth of evidence and best practice available, we can create places which improve health and wellbeing for all.
At Ryder we are increasingly designing places informed by the growing evidence base on health and wellbeing and recommend the following guiding principles.

Engage with people and place to understand health and wellbeing

Not only does this draw on local knowledge and increase a sense of ownership, research suggests that increased community control and democratic engagement have a positive impact on social capital, and consequently on health and wellbeing.¹⁹

This can include collaborative workshops, ‘place checks’ and utilising community engagement technology. Urban data collection, for instance using sensors to measure air quality or identify patterns of movement, can be used alongside qualitative surveys and engagement. Utilising local data, for example Public Health England’s freely available local health online tool, can highlight health inequalities facing specific areas.

Consider health and wellbeing factors in site location and uses

Development should take place in sustainable locations, with good public transport and active travel provision, increasing accessibility for everyone and encouraging physical activity. A good mix of local amenities should be within easy walking distance to reduce car dependence and isolation found in mono functional developments.

Provide high quality, well managed and affordable housing in well connected neighbourhoods with a sense of place

High quality, well managed and truly affordable housing with good access to green space, public transport, safe and attractive walking and cycling routes is associated with numerous positive health outcomes.

These include increased physical activity, reduced injury and improved social engagement and general wellbeing. It can also help to reduce the impact of economic disparities on the mental health of residents in poorer areas.

A solid evidence base can demonstrate not only the predicted health benefits of a design but also interlinked economic, environmental and social benefits, useful for communicating value to different audiences.

Be aware of research, guidance and best practice on health and wellbeing

Potential impact on health and wellbeing should be considered early in the design process. Once the challenges are understood, guidance and best practice can help address these and identify opportunities, for example through neighbourhood design, housing, food, natural and sustainable environments, and transport. Public Health England’s evidence review resource²⁰ recommends design interventions and clearly links these to evidence.
Providing a diverse mix of housing type and tenure is important in improving health and wellbeing for all. Flexibility and future proofing is also important, demonstrated by Ryder’s work in the Future Homes Alliance.21

Design for active travel and physical activity

Proposals should ensure that travelling on foot or by bike is a more attractive option than driving. This can also help to reduce air pollution. Measures include introducing safe cycling and walking routes, bicycle parking (and showers, lockers etc for offices), high quality public spaces, reduced vehicle speeds, mixed uses so that amenities are easily accessible, good public transport and a permeable street network with convenient connections between different areas.

Feelings of safety and security can encourage physical activity and improve mental health. This can be facilitated by creating legible places and increasing natural surveillance through active frontages and a mix of uses at different times of day and night.

Include opportunities for social interaction

Compact, walkable places with a mix of uses also provide increased opportunities for social interaction which helps to mitigate feelings of loneliness and builds our self esteem and resilience. Cultural opportunities and interventions in public space such as seating, games, pop up uses and multi use events spaces can also be beneficial in this respect.

A recent Joseph Rowntree Study22 highlights the role of strong social networks in forming place attachment and the importance of this, particularly in deprived neighbourhoods.

Provide access to green space and nature

This is crucial in improving both physical and mental health as it promotes exercise, provides a setting for social interaction, and reduces stress, as well as improving air quality. Well maintained green space should be integrated into all designs, with a focus on ensuring people have consistent, regular exposure to urban nature in their daily routines. This could include incorporating street trees and planting into commutes, green walls, views of nature from office windows and gardens for lunch, and networks of parks and public spaces for recreation.

Ensure there is access to healthy food

The places we design should provide a range of affordable, healthy food options. Food growing has also been found to be associated with improved attitudes towards healthy eating, increased opportunities for social connectivity and physical activity.23

Research indicates that increased access to unhealthier food retail outlets is associated with increased weight status in the general population, and increased obesity and unhealthy eating behaviours among children residing in low income areas.24
Embed health and wellbeing in the design process

Use existing toolkits such as Healthy Streets\(^{25}\) and Place Standard\(^{26}\).

Ryder has developed a placemaking toolkit which assists with place analysis and identifying opportunities to improve health and wellbeing in the design. This is also included in our design review process. Our projects are drawing on research in the early stages to identify the evidence and set objectives for health and wellbeing.

The recent TCPA report The State of the Union\(^{27}\) identifies several planning mechanisms which should be implemented to embed health and wellbeing in the process, including local plans and health impact assessments. Design and access statements should also include health and wellbeing.

Influence policy and guidance

Set indicators early on in projects, evaluate the effects of interventions over time (such as levels of cycling and walking, or over the longer term healthy life years) and feed this back into the evidence base.

As an industry we should help to shape effective policies where we can. One of the key recommendations in the Due North report is to increase investment in place based public health in Northern Powerhouse local authorities.\(^{28}\) As the Health for Wealth study finds, improving health in the Northern Powerhouse is also a route to increased productivity.\(^{29}\)

Cross discipline working and joined up services

Work more closely across disciplines, and involve health professionals and academics if necessary, to enable a better understanding of interlinked health determinants. For instance, the ambition to increase people’s activity levels by providing improved walking and cycling routes is linked to the need to also reduce exposure to air pollution through discouraging private car use, improving public transport and increasing areas of vegetation and trees. It can also achieve other benefits such as supporting local businesses. Working together in this way means that as an industry we are better placed to demonstrate the value of healthy placemaking.

Along with encouraging healthier behaviours through the built environment, we should also aim to provide health and social care services to communities in a joined up way, one of the key objectives of the NHS Healthy New Towns programme.

We would love to hear from you if you are interested in collaborating.

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References


10. Ibid


24 Ibid.


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