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Health equity from the start - and the role of 'built environment'

What is health equity?

Health inequalities are commonly understood as "the systematic and avoidable differences in health outcomes between social groups such that poorer and/ or more disadvantaged people are more likely to have illnesses and disabilities and shorter lives than those who are more affluent"[1].

Health inequalities are observed in all European countries and they are substantial[2]. For example, the difference in life expectancy between high and low socio-economic groups amounts to several years. In other words, many people who are dying prematurely each year as a result of health inequalities would otherwise have enjoyed a longer life.

Health inequalities that could be avoided by reasonable means are in general perceived as **unnecessary, avoidable, unfair** and **unjust**. Society must therefore invest to promote **health equity**.

How do we achieve health equity?

To a large part, health results from **social determinants**. These are the conditions in which people are born, grow, live, work and age. They include social and community networks, living and working conditions, and the health system. These conditions are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices.

Obviously, the health system alone cannot promote health equity. Action is needed across different sectors at different levels. Health ministries have a vital role to play both in ensuring the contribution of the health system, and in advocating for health equity in the development plans, policies and actions of players in other sectors.

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Why health equity from the start?

The **early years are a key determinant of health**. Giving every child the best start in life is crucial to reducing health inequalities across the life course, and other social and economic inequalities throughout life. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood.

What happens during these early years has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health, to educational achievement and economic status[3].

In order to promote health equity from the start, the EC **Joint Action on Health Inequalities** project aims to initiate and strengthen cooperation of stakeholders from sectors such as health, education, social welfare and the built environment.

This paper highlights some key findings and makes recommendations for the area of the built environment.

Why is the built environment important for health equity?

The **direct physical environment** may have an impact on health outcomes through air pollution, traffic, noise, space, housing, and safety behaviour. Also, neighbourhood conditions and lack of opportunities might create serious disadvantages in people's lives. For example, there is a significant lack of play areas and green space for children in disadvantaged areas. Parents' fears about safety lead them to constrain their children, and fear generates withdrawal from streets and public spaces, particularly by families and elderly people. Ethnic minorities have, on average, poorer health and are concentrated in poorer areas[4].

Evidence

Road injuries are among the leading causes of loss of life and disability worldwide, and they are projected to make an increasingly important contribution to public health burdens over the coming decades, especially in low- and middle-income settings.

The introduction of 20 mile per hour (32 kilometre per hour) speed zones in London neighbourhoods was associated with a 41.9% reduction in road casualties. The percentage reduction was greatest among younger children[5].

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How can the built environment sector contribute to health equity?

This sector can contribute in many ways to promoting health equity from the start. The following suggestions are not exhaustive, but can be used to stimulate discussion[3].

- **Traffic-calmed residential streets, and safe cycle and pedestrian routes** are much safer for families, children, young people and the elderly.
- **Green infrastructure** makes for healthier urban living and encourages physical activity. There should be a park or small supervised/overlooked play area within a 4-minute walk of every family home. These should be well designed and family-friendly.
- Public transport and green infrastructure are complementary in promoting **active travel** and less reliance on cars. Planners and urban designers have a vital part to play in promoting public health by providing environments where physical activity is encouraged through active travel. An integrated public transport policy should help shape urban planning.
- Targeting **crime prevention** and street security would reduce stress and increase children's ability to play freely and safely. It is difficult to police unstable, fast-changing communities which house many newcomers, and such policing requires sensitivity, particularly with regard to inter-ethnic relations. Local authorities need to work with local communities to plan for and provide regular policing of streets and parks.
- Improving physical environments, including empty derelict buildings and spaces, reduces the opportunity for crime and gives positive behaviour signals to young people. It leads to an increased density of people and activity and therefore a greater **sense of security** and natural surveillance. Making streets and areas more attractive and better cared for encourages social contact, helps prevent disorder and enhances people's well-being.
- **Home upgrading** in poorer areas brings many benefits, including community energy savings programmes and community strategy consultations.
- Special efforts are needed to **include minorities** in community activities. They need community meeting places and community development inputs.
- The planning system plays a very important role in enabling (or hindering) these recommendations. Public health should be involved to ensure that the interventions recommended above are built into new area plans and into existing plans that are being upgraded.

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The EC-funded Equity Action project

Joint Action on Health Inequalities (Equity Action) is the EC joint action project on health inequalities. It is designed to help turn the ambitions of *Solidarity in Health*, the EC communication on reducing health inequalities, into reality, by raising awareness, promoting the exchange of information and knowledge, identifying and sharing good practice, and facilitating the design of tailor-made policies. There are four main work packages (WPs):

- **Tools (WP4)** - building capability and improving policy at member-state and EU level, focusing on health impact assessment and health inequality strategies
- **Regions (WP5)** - identifying and supporting regional approaches to address health inequalities, including influencing EU structural fund programmes that start in 2014
- **Knowledge (WP6)** - engaging scientific experts to develop a European research agenda on the effectiveness of inter-sectoral action to support policymakers
- **Stakeholders (WP7)** - developing lessons for building alliances and networks with key stakeholders at member-state and EU level, to promote and embed the social determinants of health agenda.

The project runs from 2011 to 2014 and involves 24 partners from 16 member states.

To find out more about us, visit the Equity Action website www.equityaction-project.eu.

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