

The role of cities in improving population health

International insights

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Key messages

- Cities are playing a growing role in national and international politics, and are increasingly exercising leadership on complex social and economic issues. Population health improvement is one such issue to which some city leaders are turning.
- Cities have enormous potential to be health-generating places, but some of the same characteristics that make them engines of growth, innovation and creativity can also result in wide inequalities in health. One of the major challenges for cities is how to reconcile and manage these tensions.
- Although there is considerable variation in governance arrangements, powers and leadership capacity, all cities have resources at their disposal that can be used to improve population health. Some cities have made extensive use of regulatory and other levers to drive health improvements.
- Elected mayors and other city leaders have soft powers beyond their formal responsibilities that they can use to drive pro-health policies. Significant improvements in population health are possible when city leaders are willing to invest their own political capital to advocate for change.
- Improving population health depends on co-ordinated action at multiple levels in the system and ensuring that decisions in areas such as housing, employment and education have a positive impact on the wider determinants of health. This requires effective leadership, robust governance and accountability, and adequate investment in central programme management.
- In England, debates about the role of cities are closely connected with the devolution agenda. Seven new combined authorities and 'metropolitan mayors' now cover one-fifth of the country's population, creating significant opportunities to develop the kind of large-scale approach to population health currently being implemented in Greater Manchester.
- Compared with other countries, the fiscal regime in the UK is highly centralised, with more than 90 per cent of tax revenue being raised at the national level. Policy-makers should explore the case for giving cities further fiscal and regulatory freedoms to enable them to tackle population health challenges more effectively.



- London has many assets to draw on in improving population health and has the potential to become a world leader in areas such as healthy transport strategy, but it also faces significant challenges. Chief among these is its complex and fragmented governance arrangements, which can create problems for co-ordinating activities across the city and for accountability.
- Priorities for London should include strengthening public health capacity at city level, ensuring that the new pan-London structures for health and care function effectively, and making it easier for boroughs to collaborate. The recent devolution agreement provides a platform to build on and should be used to press for further devolution of powers.
- The Mayor's forthcoming health inequalities strategy is also a significant opportunity for London's partners to work together around a common set of goals. It will provide a key test of whether they are able to demonstrate the kind of leadership needed to deliver positive change in such a complex system.



1 Introduction

Improving population health involves thinking beyond the health care system itself. All aspects of our lives and communities affect our health, including employment, education, housing, leisure opportunities, social relationships and public infrastructure. Evidence from around the world shows that these factors – collectively known as the social or wider determinants of health – play a bigger role than health care services in influencing the health of the population. Although exact numbers vary, estimates suggest that wider social determinants account for more than half of the variation in overall population health outcomes ([McGovern et al 2014](#); [The King's Fund 2013](#)).

To address these factors, place-based approaches to health are needed that join up efforts from across different sectors, deploying all the resources available within a given place in the most co-ordinated way possible, with the aim of improving the health of the local population ([Alderwick et al 2015](#); [Ham and Alderwick 2015](#)). In England, this will require a more significant role for local governments, working closely with NHS organisations and other local partners. This is one reason why the reforms introduced by the Health and Social Care Act 2012 gave local government a renewed role in public health.

In this report we examine what a place-based approach to population health might look like in a city context. Drawing on international examples, we explore the range of roles that city governments can play in improving population health (directly and indirectly), and the underlying conditions needed for effective urban health governance.

The rise of cities

The role of cities has risen up the policy agenda internationally. Political scientists have pointed to various reasons for thinking that cities might play an increasingly significant role in the world. Benjamin Barber and others have suggested that in various areas of public life, cities could succeed where nation states have struggled to make progress (Barber 2013). Their argument is that city governments are close



enough to the people they serve to be directly accountable, sufficiently grounded in practical issues to avoid the risk of ideological paralysis, while being large enough to mobilise a range of resources and have an impact on wider systems beyond the city.

The challenge of democracy in the modern world has been how to join participation, which is local, with power, which is central. The nation state once did the job, but recently it has become too large to allow meaningful participation even as it remains too small to address centralised global power... The solution stands before us... Let cities, the most networked and interconnected of all our political associations, defined above all by collaboration and pragmatism, by creativity and multi-culture, do what states cannot.

Benjamin Barber, political scientist (Barber 2013, page 5)

These arguments are given some credence by various signs of cities playing a more prominent role in domestic and international politics. For example, city leaders in many countries have become highly influential advocates for robust action on climate change (see box below). In England, the recent introduction of elected mayors in some of the country's biggest cities appears to have been associated with cities taking a more assertive stance, as exemplified by the recent visit of the mayors of Birmingham, Bristol, Nottingham, Manchester, Leeds and Newcastle to the European Union's Brexit negotiator to discuss future relationships with Europe (Walker 2018).

Debates about the role of cities and city regions are often closely connected with the issue of devolution of political power. In terms of taxation, the UK is one of the most centralised states in the developed world, with more than 90 per cent of its tax revenue raised at the national level (Miller and Roantree 2017; Organisation for Economic Co-operation and Development 2016). It is in part as a response to this that there has, in recent years, been experimentation with various forms of devolution to local areas in England. The most well known are the changes in the Greater Manchester region, which include delegated powers over the organisation of health and social care, and give the region greater control over the use of multiple funding streams from Westminster. Among other things, this has resulted in a Greater Manchester Population Health Plan (Greater Manchester Health and Social Care Partnership 2017b), which includes co-ordinated, region-wide action on the wider determinants of health (see page 18).



Cities are becoming increasingly well connected globally, with a growing array of networks supporting city-to-city communication, bypassing traditional relationships between national-level actors. In section 2 we describe how cities from across the world are collaborating to share learning on population health and other policy challenges. A long-established example is the European Healthy Cities Network, supported by the World Health Organization (WHO), which includes nearly 100 cities across 30 countries, including eight cities in the United Kingdom (see page 28).

Cities are also often seen as important settings for innovation (Florida 2017). As discussed further in section 3, it is sometimes argued that cities provide an environment in which new policy approaches can be tested more quickly and nimbly than can be done by national governments. This potentially includes introducing innovations aiming to develop new responses to the wider determinants of health. For example, in some countries cities have developed new regulatory measures designed to reduce smoking or obesity, which have only later been taken up by national governments.

Cities as global leaders: the example of climate change

The increasingly prominent role played by cities in the field of environmental sustainability illustrates the scope for city governments to exercise leadership locally, while also wielding influence on the national and international stages. Cities such as New York, London, Copenhagen, Paris, Barcelona, Oslo, Stockholm and Vancouver have committed themselves to carbon reduction targets that surpass those signed up to by national governments through the Paris climate accord. And while the federal government of the United States has signalled its intention to pull out of the Paris agreement, almost 250 US cities have pledged to continue to honour their share of the country's climate commitments (Bliss 2017). Cities are increasingly working together through national and global networks such as C40 Cities and the Carbon Neutral Cities Alliance to increase their impact on climate change policy and practice.

There is a considerable overlap between the sustainable cities and healthy cities agendas, not least because some of the actions that cities might take to reduce greenhouse gas emissions also confer health benefits (for example, promoting active travel or reducing car use), and also because climate change poses significant direct and indirect risks to health (Watts *et al* 2018). Examples from around the world

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Cities as global leaders: the example of climate change *continued*

illustrate how cities can improve environmental sustainability at the same time as creating liveable, healthy environments for their citizens. Freiburg in southern Germany has become a global exemplar of a city that has created people-friendly neighbourhoods, strengthened public transport systems, and protected the environment while boosting economic growth, with its district of Vauban being seen as a leading example of sustainable urban planning (Hall 2014). Similarly, cities such as Curitiba in Brazil and Bogotá in Colombia have sought to build healthy environments, strengthen social capital and improve environmental sustainability through a variety of highly participatory social movements around community, physical activity, green space, air quality and other issues, as well as through investment in public transport (del Castillo *et al* 2011).

Why cities matter for health

We know very much about good habitats for Siberian tigers and mountain gorillas, but only very little about a good urban habitat for Homo sapiens.

Enrique Peñalosa, Mayor of Bogotá 1998–2000 and 2016–present day

The relationship between cities and health is an important and longstanding one. The growing political prominence of cities means that it is important to understand how cities influence our health, and to learn from others about how to shape this impact.

City leaders are increasingly aware that the policies they pursue and the choices they make matter for health. By concentrating people and resources in one place, the urban environment creates hazards for health as well as opportunities for health improvement. For many health conditions, concentrations are highest and inequalities are greatest in cities. This challenge led to the creation of the modern public health discipline in UK cities in the 19th century.

In the UK more than eight out of every ten people now live in cities or towns ([Population Reference Bureau 2017](#)) and most of the remainder live in surrounding regions within the economic, social and cultural influence of nearby cities. The premise underpinning this report is not that the health of urban populations is



more important than those living in rural areas, but that the pervasive influence of cities means that we all stand to benefit from stronger and more effective action on population health in cities.

City and local governments are in a prime position to tackle the social determinants of health because of the breadth of their responsibilities over a defined geographical area, with powers cutting across different areas of public policy. This ability to take a place-based approach is important because of the way that health needs and outcomes are distributed spatially. In most cities, the greatest levels of need are concentrated in neighbourhoods where poverty levels are highest and social outcomes are poorest. Improving health outcomes in these areas requires multi-sectoral action and leadership from those with an overarching responsibility for place.

Most of the actions taken by city governments have an impact on the health of citizens, and most of that is not about health care per se but about transport systems, urban design, planning and all the other functions and tools that city governments have at their disposal. This, and the willingness to learn from others' experience, gives cities an enormous potential to be health-generating places. But making the most of the opportunities and co-ordinating all of this activity in the context of a complex city system represents a significant governance challenge.

Diversity, inequality, complexity

While cities are, in some ways, fertile environments for health improvement, they also present considerable challenges. Large cities in particular are often highly diverse and highly inequitable places. Some of the same characteristics that make them engines of growth, innovation and creativity can also cause or contribute to economic inequality and ultimately health inequalities. London illustrates this point all too well. As we discuss in section 4, the capital has some of the healthiest areas and populations in England and also some of the unhealthiest. One of the major challenges for cities in the 21st century is how to reconcile and manage these tensions to ensure that cities can be health-creating places for all their citizens while also promoting economic growth. For example, there is evidence that in some cases, efforts to make cities greener have led to gentrification and population changes that have reinforced rather than reduced health inequalities (Cole *et al* 2017). This illustrates how action to promote population health can have unintended consequences if not managed and monitored carefully.



A related challenge is complexity. City systems consist of networks of formal and informal interests, organisations and groups, each with their own objectives. Moreover, these operate at neighbourhood, sub-city and pan-city levels and beyond into city regions, and also have a relationship with the nation state. Recognising this, the UCL–Lancet Commission on Healthy Cities argued that improving health in urban settings requires understanding cities as complex adaptive systems, in which population health is shaped by multiple interacting factors in ways that cannot be wholly anticipated in advance (Rydin *et al* 2012). This has implications for how efforts to improve population health are designed, organised and governed (see box below).

Cities are complex systems, with urban health outcomes dependent on many interactions and feedback loops, so that prediction within the planning process is fraught with difficulties and unintended consequences are common.

(Rydin *et al* 2012, page 1)

Cities as complex adaptive systems: implications for population health improvement

The UCL–Lancet Commission on Healthy Cities argued that several practical implications follow from applying complexity science to urban health. First, that there needs to be an emphasis on incremental change, including ‘promotion of experimentation through diverse projects and the use of trial and error to increase the understanding of how best to improve urban health outcomes in specific contexts’. Second, that alongside formal evaluation of these efforts there needs to be learning based on ‘dialogue, deliberation, and discussion between key stakeholders’ including practitioners and communities.

Similarly, Glouberman and colleagues (2006) argue that the complexity of cities means that to be effective, attempts to improve the health of residents should emphasise continuous learning and fine-tuning of processes; promoting variation in the approaches taken; appreciation of local history, assets and context; and encouraging self-organisation and grassroots mobilisation.

Complexity theory leads to a focus on the wider systems that influence health outcomes in cities as well as the proximal, visible causes. For example, as a result of

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Cities as complex adaptive systems: implications for population health improvement *continued*

considering the social systems and networks that individuals live their lives in, greater weight might be placed on designing interventions to change social group attitudes and norms, as well as targeted individual behaviour. It also has implications for timeframes, leading to a focus on longer-term outcomes across the whole system rather than short-term impact on the immediate targets.

About this report

This report explores key learning and insights for England's cities on how to govern more effectively for health, drawing on the experience of a number of international cities, and including specific examples of how these cities have approached issues such as obesity, air pollution, HIV and mental health .

We look first at how cities make decisions on issues that affect health, examining the governance arrangements needed for cities to fulfil their potential role in population health improvement (section 2). We then describe some of the specific functions that city governments and their partners can perform (section 3). The conceptual framework developed in sections 2 and 3 is then applied to London, as an extended case study illustrating the complex array of organisations and structures that have a role in improving health in a major city (section 4).

We chose to focus section 4 of the report on London because the city's scale and complexity creates a distinctive set of challenges and opportunities for improving population health. London also has some of the UK's widest and most persistent inequalities in health. However, we also recognise that many other cities and city regions in England provide compelling examples of how cities can take a leadership role on population health. For example, elsewhere in the report we describe work being done in Greater Manchester as part of its devolution programme.

The material presented in the report is based on three methodological components:

- 50 in-depth qualitative interviews, including 25 focusing on London and 25 focusing on other international cities (selected as described below)



- a literature review of relevant evidence and data (including analyses from previous international comparative work conducted as part of the London Health Commission)
- an expert roundtable discussion with London system leaders and other invited experts to test emerging findings, held in January 2018.

Our approach included a ‘deep dive’ on four major public health issues, selected to represent a range of challenges that may require different responses from city governments: obesity, HIV, air quality and public mental health. These issues share two characteristics: they are complex problems requiring multiple and sustained intervention through a wide range of actions; and they are particularly prevalent or problematic in the context of cities. For example, more than half of all people diagnosed with HIV in the UK live or work in London, and air quality in many major cities is compromised by heavy traffic flows and congestion.

We used these four areas to help focus our research activities – for example, we interviewed people in cities known to be doing successful or innovative city-wide work on one of these four areas. We also targeted large, global cities sharing some characteristics with London. Other international interviewees were selected through a snowballing process, based on recommendations from previous interviewees. The cities covered by our interviews were Paris, Berlin, Barcelona, Madrid, Copenhagen, Amsterdam, New York, San Francisco, Mexico City, Seoul, Tokyo, Curitiba and Auckland.

London interviewees were selected to give a cross-section of the system, ensuring that we included perspectives from different levels of government and from a wide range of organisations responsible for leading improvements in the health of London’s population. The 25 interviewees included representatives from local government, clinical commissioning groups, the Greater London Authority (GLA), Public Health England, Healthy London Partnership, the voluntary sector, think tanks and academia.



2 Conditions for successful health governance in cities

City governance has an important impact on health and wellbeing. The health of urban residents is influenced by how decisions are made within public authorities, and the powers and responsibilities that sit at various levels. These include decisions about urban planning, the built environment, transport, economic development, housing, policing and many other factors, in addition to decisions about public health and the health care system itself. Through our research we identified a number of underlying characteristics that shape the ability of a city to take effective action to improve population health. We have grouped these characteristics into five areas:

- governance structures
- leadership
- powers
- expertise
- connectivity.

Governance structures

No two cities in the world have the same governance system.

Professor Tony Travers, LSE London (research interview)

Cities vary hugely in terms of the structures through which they are governed. A review of urban governance arrangements conducted for the UK government's Foresight programme distinguished between several main models, including the following ([Slack and Côté 2014](#)):

- **'one-tier fragmented'** – where governance is provided by multiple local governments, with no formal structures sitting above them to cover a wider geography (eg, Paris, Los Angeles)



- **‘one-tier consolidated’** – where governance is provided largely through a single city- or region-wide structure (eg, Toronto)
- **‘two-tier’** – in which responsibilities are split across lower- and upper-tier governing authorities (eg, London, Brussels).

In practice, arrangements are more complex and more varied than this framework suggests. For example, cities with two-tier structures vary widely in terms of how powers and responsibilities are distributed across the lower and upper tiers. City governments are also affected by regional and national governments sitting above them, and this dynamic is very different from one city or country to the next.

Several arguments have been put forward in favour of more centralised models of city governance, including those listed below ([Slack and Côté 2014](#)):

- more efficient provision of public services through greater economies of scale
- better co-ordination of services across the wider geographical area
- opportunities to address ‘spill-over’ effects that cross local government boundaries (health-related examples include air pollution or infectious diseases)
- greater opportunities to promote redistribution between rich and poor areas (for example, to address health inequalities)
- a wider tax base allowing costs to be shared more equitably.

However, this may come at the expense of creating large bureaucracies and reducing accessibility, accountability and responsiveness to local citizens, creating a democratic deficit. Two-tier systems potentially offer the best of both worlds, but risk creating inefficient decision-making processes, higher costs through waste and duplication, and reduced transparency as residents struggle to understand who is responsible for what ([Slack and Côté 2014](#)).

The tension between centralising decision-making (primarily on efficiency grounds) versus maintaining local democratic legitimacy has been an ongoing issue for many years in the study of urban governance. It is closely linked to the ‘metropolitan reform debate’ associated with Ostrom (1972) and others. This debate takes place between those who argue for rationalisation of decision-making bodies and a clear division of responsibilities between different levels of government, and



those who see a benefit in ‘polycentric’ decision-making involving multiple bodies with overlapping jurisdictions, capable of forming ad hoc partnerships and flexing decision-making processes to fit a given issue.

In many (if not all) cities, debates about the relative merits of centralisation and decentralisation are a live and ongoing issue, with one or the other tending to dominate political discourse at a given moment in time. For example, in 1998 Toronto underwent a major amalgamation (despite significant public opposition), merging six local authorities into a single metropolitan government with a directly elected mayor. This was intended in part to reduce costs, but there is little evidence that it did so, and there have been some concerns that the reforms reduced opportunities for citizen involvement (Slack and Bird 2013). Conversely, in Madrid and several other Spanish cities there is currently a trend for decentralising powers to districts, with city governments seeking to see a bigger percentage of the overall city budget controlled at a more local level.

Given the pros and cons, the Foresight review on urban governance concluded that ‘no one model of governance stands above the rest’ (Slack and Côté 2014, page 5). However, while the overall structural arrangements might not be the main determinant of successful governance, what is important is that there is a clear and well-reasoned distribution of decision-making powers across these structures. Form needs to follow function – some decisions are better taken on a bigger geographical footprint than others, depending on the types of considerations listed above. There also needs to be clarity regarding the relative roles and responsibilities of different decision-making bodies and committees, how decisions are made and who needs to be involved, and who is accountable to the public for what. Having clear decision-making processes is particularly important in more complex systems where powers are split across multiple levels, and where there is most potential for confusion and inertia.

Another important condition for successful health governance in cities is that those working in a given system (including public health professionals) understand the governance structures they are operating within, and how to navigate these structures to greatest effect. The importance of this was identified as a key lesson in research on obesity prevention in New York City during the Bloomberg administration (Kelly *et al* 2016). This line of argument shifts the focus from structure to leadership behaviours, something we explore further in the following section.



A final consideration in relation to governance arrangements is the question of how city governments engage with other governments or agencies in their wider metropolitan area or sphere of influence. Many aspects of city life (including population health) are shaped by decisions made well beyond the political boundaries of city governments. This is an inevitable consequence of the economic growth of successful cities and city regions, and creates a new set of governance challenges.

Economically dynamic regions, by their nature, eventually outgrow their local political boundaries.

(Slack and Côté 2014, page 12)

In England, recognition of the increasing need for formal governance arrangements over extended metropolitan regions has led to the creation of seven new combined authorities with directly elected mayors (see box page 17). Taken together, the areas covered by these new mayors include one-fifth of England's population (Harkness *et al* 2017). The opportunities for improving population health through enhanced collaboration at this level are illustrated by the Greater Manchester Population Health Plan (see box page 18).

London already has a metropolitan tier of government – the GLA – covering a population of almost 9 million people, but the city's economic or 'functional' area is bigger still, extending to much of the south-east and east of England. Given that the economies of these areas are highly interdependent, there have been calls for closer collaboration and more robust governance mechanisms across this wider region (Centre for London 2018).

Outside the UK, Paris and Barcelona are two cities currently developing new metropolitan governance arrangements (see box page 17). These emerging structures present both opportunities and challenges for population health improvement – opportunities to co-ordinate work across a larger footprint and to address region-wide determinants of health, but challenges relating to building effective relationships across different administrations (in both Paris and Barcelona, tensions have arisen as a result of differing political priorities in inner city and outer suburban areas). As the economic importance of city regions continues to grow, developing governance arrangements capable of resolving these tensions will become increasingly important.



Developing governance arrangements across wider metropolitan regions

Grand Paris

The *Métropole du Grand Paris* is an emerging administrative structure supporting voluntary co-operation between the City of Paris (with a population of 2.2 million) and the surrounding inner-suburban departments, covering a combined population of around 7 million. It consists of a Metropolitan Council of 210 members, not directly elected, but chosen by the councils of the member communes. It is intended to create a structure for regional decision-making on matters including transport planning, urban planning, housing, and protection of the environment. The primary driving force for its creation was the need to co-ordinate transport planning in the city and surrounding suburbs, which is an issue where there have been major problems and where there are also significant public health implications. The Metropolitan Council is intended to have legal powers in future, but the details of this are still under discussion.

Greater Barcelona

In 2010, a new tier of government was developed covering the Barcelona Metropolitan area, sometimes referred to as Greater Barcelona. This includes the City of Barcelona (population 1.6 million) and 35 other municipalities around the city (combined population 3.5 million). The new Metropolitan Council consists of 90 elected metropolitan councillors. The metropolitan government has a role in a number of policy areas, including urban planning, transport planning, environment and sustainability, housing and economic development – but formal powers in these areas are still poorly defined. It was created in response to the need to plan more efficiently over a larger geography, eg, on transport issues.

England's new metropolitan mayors

As part of the devolution agenda in England, seven combined authorities have negotiated devolution deals with national government, giving them increased powers over areas such as housing, transport and skills ([Centre for Cities 2016](#)). These cover metropolitan regions in Greater Manchester; Liverpool City Region; Sheffield City Region; Tees Valley; Cambridgeshire and Peterborough; the West of England; and the

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Developing governance arrangements across wider metropolitan regions *continued*

West Midlands. As part of the agreement with national government, elections for new mayors to cover these regions took place in 2017 and 2018. The powers granted to the new 'metro mayors' and the authorities they preside over vary, depending on the deal negotiated. Each is backed by a 30-year investment fund from national government. To illustrate some of the work being done at this level to improve population health, we have included a separate box on the Greater Manchester Population Health Plan.

Population health in Greater Manchester

The Greater Manchester Population Health Plan aims to build a single population health system across the 10 localities that make up the Greater Manchester metropolitan region. This includes creating a unified leadership and governance system for population health and a common approach to commissioning. As part of the region's devolution agreement, public health resources previously controlled by NHS England are being delegated to the Greater Manchester Combined Authority, and there is an intention to explore extending public health commissioning at Greater Manchester level where this 'achieves additional impact and is complementary to that at locality level' ([Greater Manchester Health and Social Care Partnership 2017b](#)).

By building a collaborative approach to population health across the region, the plan aims to achieve the following outcomes:

- more Greater Manchester children will reach a good level of development cognitively, socially and emotionally
- fewer Greater Manchester babies will have a low birth weight, resulting in better outcomes for the baby and less cost to the health system
- more Greater Manchester families will be economically active and family incomes will increase
- fewer people will die early from cardiovascular disease, cancer or respiratory disease
- more older people will be supported to stay well and live at home for as long as possible.

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Population health in Greater Manchester *continued*

The plan makes an explicit connection between population health outcomes and the economic performance of the region, arguing that health inequalities have ‘acted as a drag on our economy’.

Greater Manchester has also produced a separate tobacco reduction plan, ‘Making smoking history’, which sets an ambition to reduce smoking prevalence ‘at a pace and scale greater than any other major global city’ ([Greater Manchester Health and Social Care Partnership 2017a](#)).

Plans at the Greater Manchester level are intended to complement work on population health being led by the 10 local authorities involved in the regional partnership. For example, Wigan Council has developed a ‘Deal for Health and Wellness’, part of its wider attempts to strike a new relationship with local people resting on a shared understanding of how the council and citizens must both play a part in creating a thriving, healthy city. The Deal for Health and Wellness frames health as a civic responsibility to be enacted in various ways, including ‘getting involved in your local community’; ‘supporting older relatives, friends and neighbours to be independent for as long as possible’; and ‘taking charge of your own health and wellbeing’.

Further resources:

Greater Manchester Population Health Plan: www.gmhsc.org.uk/assets/GM-Population-Health-Plan-Full-Plan.pdf

The Wigan Deal for Health and Wellness: www.wigan.gov.uk/Council/The-Deal/Our-Deals/The-Deal-for-Health-and-Wellness.aspx

Leadership

The importance of effective leadership cannot be overstated. While the formal governance structures and powers found in the case studies included in our research were highly diverse, leadership was seen to be a key issue in all. A common thread was bold **political** leadership, particularly from elected mayors (or their equivalents), whose visibility and ‘soft’ powers were seen as far exceeding the limits of their formal authority.

Political leadership is essential because elected politicians are in a position to lead a debate and secure public consent in a way that it can be difficult for technical



experts and specialists to match. Politicians can use their public profile to convey a vision to a wide audience, and to have traction with groups of all kinds. By being representatives of the public rather than technical experts, politicians can mediate between different city agencies and departments, and between wider stakeholder groups with conflicting interests. Political leadership can be particularly important in relation to measures that involve prohibition or restriction, where there often needs to be some form of mandate from the public to proceed.

Elected city mayors can play a uniquely important role due to the prominent public profile granted by their position. Harkness and colleagues (2017) argue that ‘the need to lead beyond the limits of formal powers is a defining condition of mayoral reality’ (page 17), not least because ‘mayors get blamed and praised for things well beyond their formal spheres of control’ (page 10). Their research raises the question of whether changing the formal powers of mayors is the best way to improve city governance, or whether a focus on the ‘functional capacities’ possessed by mayors might be more productive. These capacities include the ability to build cross-sector networks and to partner with intermediaries, and to support innovation, learning and improvement (see table below).

Table 1 Where a mayor’s power comes from

Formal power	Functional capacities
<ul style="list-style-type: none"> • Executive powers • Legislative powers • Fiscal powers • Powers over specific sectors 	<ul style="list-style-type: none"> • Building, maintaining and activating cross-sector networks • Partnering with intermediaries • Learning, innovating, continually improving

Source: adapted from Harkness *et al* 2017

Several examples of bold political leadership stand out from our research. Since 2014, the Mayor of Paris, Anne Hidalgo, has been highly vocal about her ambition to reduce air pollution and improve the urban environment by ‘reconquering the public space’ from vehicles. This has included changes aimed at cutting the amount of traffic in the city (see box page 22). The current Mayor of Seoul, Park Won-soon, has been similarly proactive in his city, including through a comprehensive strategy to turn Seoul into a walking- and cycling-friendly city. And in Amsterdam, the



leadership of Alderperson Eric van der Burg has been instrumental in securing broad-based support for the Amsterdam Healthy Weight Programme, including collaboration with the food and retail industry. Van der Burg is responsible for a number of policy areas including health, sports and spatial planning, and is able to use this mixed portfolio to hold the necessary people to account across the city administration (eg, ensuring that planners give due regard to guidelines on active travel).

The power of political leadership is greatest when a high-profile politician is willing to risk investing some of their personal political capital in championing health improvement measures. One of the most striking examples of this is how Michael Bloomberg used the New York City mayoralty as a platform for public health advocacy. Bloomberg made himself directly accountable for improvements in population health outcomes by stating that the metric by which his mayoralty should be judged was whether the life expectancy of New Yorkers had increased by the end of his term in office (Isett *et al* 2015). Another notable feature of leadership under Bloomberg was the stability and length of tenure of people in key leadership positions in the city administration during this period, including the Health Commissioner and other city commissioners. This stability allowed a long-term vision to develop and to be implemented progressively through a series of measures over time. Effective leadership from key figures such as these can be as important as political leadership.

City leaders need to be able to draw on leadership skills and styles appropriate to the model of governance in their system. In Copenhagen and Amsterdam, interviewees attributed some of the progress made over the past few decades to the existence of a consensual style of decision-making in city politics – ‘a preparedness to co-operate with each other’ even when there are differences of opinion. A report published by the Brookings Institution argued that one of the main reasons for Copenhagen’s perceived success as a city was a willingness to collaborate across political parties, levels of government, and sectors of society (including through innovative public–private partnerships) (Katz and Noring 2016). This culture of collaboration may in part be the consequence of political systems that tend to generate coalition governments at city and national level, necessitating compromise and finding common ground.



Improving air quality in major European cities: key measures

Paris

- Paris Breathes – a major car-free scheme launched in 2016 in which cars are banned from large areas of the city centre on Sundays, creating new spaces for cyclists and pedestrians.
- Air quality strategy – including action to promote cleaner and more fuel-efficient vehicles, eg, providing charging sockets for electric cars, and a proposal to ban diesel vehicles from the city centre.
- Paris Pedestrian Strategy – includes more shared road space, redesign of public squares and promenades, promoting diverse use of public space, and installing more street furniture and signage for pedestrians.
- Other measures to restrict traffic – cars manufactured before 1997 are banned from the city on weekdays; and the Mayor aims to limit access to the Champs-Élysées and other major thoroughfares to hybrids and electric cars by 2020.

Berlin

- Each year the city incrementally and deliberately reduces the availability of car parking spaces and the number of lanes available for traffic. This is intended to deter people from driving and to ‘nudge’ them towards choosing other forms of transport. The goal is that by 2025 only 20 per cent of journeys will be by private car (down from 31 per cent currently).
- Ambitious planned expansion of the cycling network – Berlin will have 100km of cycling lanes within four years, 100,000 bicycle parking places, and mandatory cycle lanes on all major roads. Supported by €50 million per year earmarked for infrastructure investment.
- Low Emission Zone restricting the most polluting vehicles from entering the city.
- Buses retrofitted with particulate filters.
- Future measures may include a complete ban on diesel vehicles in the city centre, following a landmark legal ruling in February 2018 empowering German cities to introduce these restrictions as part of clean air plans.

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Improving air quality in major European cities: key measures *continued*

London

- Congestion charging in central London since 2003. In 2017, a new Toxicity Charge was added to this, increasing the costs for driving older vehicles that fail to meet emission standards, and from 2019 an Ultra Low Emission Zone will cover the same footprint, making requirements still more demanding.
- Retrofitted buses with particulate filters and selective catalytic reduction systems to reduce nitrogen oxide emissions.
- Low Emission Zone implemented in 2008 limiting the most polluting diesel-powered commercial vehicles from entering most of Greater London.
- Ambitious procurement standards for the construction sector.
- Air quality policies appear to have had some effect between 2005 and 2014, although in some areas (particularly in outer London) the benefits have been partly offset by increased volumes of buses, coaches and heavy goods vehicles (Font and Fuller 2016).

Powers

The formal powers available to a city shape the kinds of actions it can take to improve population health. These include regulatory and legislative powers, revenue-raising powers, commissioning powers and the ability to use other financial levers such as subsidies. In choosing how to use these powers, cities have much more autonomy from higher levels of government in some countries than others. Devolved powers are often particularly extensive in countries with a federal political structure such as Germany or the US, where there are constitutional limits on the jurisdiction of federal government over policy-making in states and cities.

Regulation has been a powerful tool enabling city governments to tackle risk factors for poor health, as described further in section 3. For example, New York's success in using measures such as these is explained in part by the wide-ranging regulatory powers available to the city administration. The role of the Board of Health has been particularly critical. The board, created as part of the 1866 Health



Code, consists of health experts appointed by the Mayor, and has extensive powers to introduce new regulations without going through the normal legislative process. Several of the city's high-profile public health interventions were introduced using these powers, including the ban on using trans-fats in restaurant food and mandatory calorie labelling (see section 3). During the mayoralty of Michael Bloomberg there was a particular willingness to push the boundaries of the board's mandate – at times resulting in legal challenge at state level. Bloomberg and other New York City mayors have also used executive orders to introduce new regulations, again by-passing city council and the need to secure wider political support (Kelly *et al* 2016; Isett *et al* 2015). New York City officials involved in our research were clear that the city health department would have fewer options and be less effective without this independent regulatory authority for public health at city level.

The wider political context is also relevant to the New York story. The US constitution ensures that if federal and state governments have not assumed regulatory powers in relation to a given issue, then the city has jurisdiction by default, but that once passed, federal/state regulations supersede any pre-existing city ones.

Although the powers available in New York City appear to have been very helpful for efforts to improve population health, it is important not to overstate the significance of this. Studies comparing public health measures taken in New York and London observe that each city has a unique set of powers at its disposal (Freudenberg and Atkinson 2015; Freudenberg *et al* 2010). While the New York City government has the Health Code, direct control over schools, and can also exert influence through municipal contracts for a wide range of public services funded by the city government, London mayors have some powers not available to their New York counterparts, including much greater control over the transport system and regulatory powers over buses and taxis (see section 4).

An important conclusion from this comparison is that city leaders need to understand and make use of the regulatory powers available to them. Recent efforts to reduce childhood obesity in Amsterdam reinforce this point, with those involved observing that they did not realise how many powers they could draw on until they started asking the right questions. It seems unlikely that Amsterdam is the only city to have been in this position.



The question we have asked ourselves throughout the programme is: ‘What can we do as a city government?’ ... We realised that there are so many things we can do. We can really make a difference if we put healthy environments as the starting point in all government policies and regulations.

Karen den Hertog, Amsterdam Healthy Weight Programme (research interview)

Along with regulatory powers, revenue-raising powers may also be an important enabler by giving cities greater autonomy and scope to finance health improvement measures through local taxation and other locally controlled income. Research published by the Brookings Institution argued that Copenhagen’s success in creating a healthy, liveable urban environment is in part due to the high level of fiscal autonomy that the city government enjoys from the Danish national government. Local governments are responsible for more than 60 per cent of all government spending in Denmark – the highest proportion in any advanced OECD country ([Katz and Noring 2016](#)).

The UK is an outlier in terms of the distribution of fiscal powers, with a far higher proportion of tax receipts being raised by central government than seen in other European Union countries ([Slack and Côté 2014](#)). Travers has argued that localism ‘will come to nothing unless Britain can transfer a significant proportion of tax-raising power away from the Exchequer’ ([Travers 2011](#), quoted in [Slack and Côté 2014](#), page 33). The current government’s plans to devolve business rates to local authorities may represent a small step in this direction, but the effect of this is likely to vary between cities and the implications for public health budgets remain unclear ([Centre for Cities 2017](#); [Buck 2016](#)).

Expertise

Building a place-based approach to population health involves influencing decision-making across all tiers of government – often referred to as a ‘health in all policies’ approach. As public health expertise in any city is a finite resource, and the potential opportunities to influence are effectively limitless, a critical question is how and where this expertise should be deployed to ensure that a health perspective is included in the decision-making processes that are likely to have the greatest impact on population health. Cities need to have sufficient public health expertise at the right levels in the system, but where these points of influence lie will be unique to each city. In a given city, the pertinent questions to ask are where



are the key decisions being made, and what access do public health professionals and other health experts have to those decision-making processes?

In cities with more centralised governance arrangements, public health teams are often based at city rather than borough or district level. For example, many of the decisions affecting the lives of New Yorkers are made at city level rather than in the five boroughs, and mirroring this, public health expertise is concentrated within the city government's Department of Health and Mental Hygiene (although there are also structures supporting a more distributed approach, including four Neighborhood Health Action Centers targeted at communities with the greatest health inequalities). Similarly, in Barcelona, all public health officers are concentrated in a single organisation, the Agència de Salut Pública de Barcelona (ASPB), which has a staff of around 300 people covering a population of 1.7 million. This reflects the balance of power in the city, with the City of Barcelona municipality having significantly more power and resources than the 10 district governments within the city.

In both cities, public health officials saw some advantages to being concentrated within a single team. These included:

- a more coherent and co-ordinated response to public health challenges facing the whole city
- easier to access a range of specialist expertise, eg, epidemiological analysis, legal advice
- quicker to scale up and spread innovation
- fewer overheads, less resource intensive than running multiple offices
- greater opportunities to influence other major players or systems beyond the city's boundaries, for example the food industry
- easier to attract and train high-calibre staff, including through opportunities to be involved in prestigious research activities (in Barcelona the ASPB has a partnership agreement with Johns Hopkins University dating back to 1985 that supports collaborative research and training).

However, there are also some potential advantages to more decentralised models, most importantly the opportunity to be responsive to local needs and to tailor



approaches to specific populations. Many of our interviewees argued that for some issues, work at neighbourhood or locality level needs to be the starting point for efforts to improve population health, and that this should not be lost in attempts to strengthen city-wide action.

Crucially, the distribution of public health expertise needs to match the wider governance arrangements in a city. Where city government is the dominant tier of decision-making, this may lend itself to a centralised model for public health. In a two-tier structure like London, where there are important systems to influence at both borough and city level, there needs to be sufficient public health resource available at both levels (see section 4).

Contextual differences between cities make it difficult to compare the level of public health expertise or funding available in a meaningful way. For example, while the per capita budget of the public health department in New York City significantly exceeds the combined budget of public health teams in London's 33 local authority districts, this partly reflects the different nature of the task being faced – as observed in a study comparing public health governance arrangements in New York, London and Paris, the resources available to the public health department in New York City are needed in part to provide primary care services to populations with poor access to care in the absence of universal health care coverage (Doyle *et al* 2017).

Connectivity

Cities are becoming ever more connected nationally and internationally, with a growing number of formal and informal networks linking city leaders in different locations (see box page 28). Making the most of this connectivity allows city leaders to seize new opportunities to improve population health. Equally important is internal connectivity, linking up the different parts of the system within a city.

Building connections between cities creates important opportunities for mutual learning and exchange. Interviewees in our research stressed the value of this, particularly when there are opportunities to meet person to person with your opposite number in another city. This applies both at the political level (eg, between mayors) and the technical level (eg, between public health experts). Some cities have made learning from other cities part of their standard way of working. For example, in Vienna the Mayor travels with a team of around 30 people (including



senior government staff, professional experts and members of the community) for a week twice a year to another city to learn in detail about what they are doing well, and what they are struggling with. This same commitment to learning from elsewhere is not evident in all cities.

As well as supporting learning, connectivity between cities gives leaders a means of addressing determinants of health that lie outside the control of any given city. For example, New York City worked with a coalition of other US cities and states to introduce common salt reduction regulations, on the basis that food companies had argued they were unable to reformulate their products for New York City alone. By advocating collectively for the common needs of their citizens, city leaders can magnify the impact of work within their own jurisdiction.

The issue of internal connectivity is also crucial. Overcoming silos between different agencies and sectors is a key challenge highlighted by our work and previous research on cities and health. One approach taken to this in New York City has been to create individuals or offices that play a co-ordinating role across agencies. New umbrella structures have been created in recent years to co-ordinate policies across administrative boundaries and ensure that a consistent approach is taken. For example, a Food Policy Co-ordinator role has helped to introduce consistent nutritional standards for all foods purchased by government agencies across the city. The role of these boundary-crossing groups has been identified as being a key enabler of success in an evaluation of public health reforms in New York City (Isett *et al* 2015).

International city networks

- **Healthy cities** – The Healthy Cities movement, supported by the WHO, originated in Toronto in 1984. In the years since, the concept has been taken up most enthusiastically in Europe through the WHO European Healthy Cities Network. Nearly 100 cities across 30 European countries are formal members of the Europe-wide network (including eight cities in the United Kingdom – Belfast; Carlisle; Derry City and Strabane; Liverpool; Newcastle; Stoke-on-Trent; Sunderland; and Swansea). In addition to this, around 1,400 cities and towns participate in national healthy city networks across the WHO European region.

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International city networks *continued*

Member cities in the European network are encouraged to implement a 'health in all policies' approach, strengthen cross-sectoral partnership working, and develop specific tools such as health impact assessment and 'city health development plans'.

- **Age-friendly cities** – The concept of age-friendly cities has gained currency since 2010, when the WHO established a global network of cities attempting to adapt to the needs of an ageing population. The emphasis has shifted from an initial focus on improving the physical infrastructure to one which also includes building stronger community networks and enhancing intergenerational links. A core principle is the argument that a city designed to meet the needs of older people will also support better, healthier lives for people of all ages.
- **Child-friendly cities** – A child-friendly city is one in which children are safe, nurtured and able to participate in decision-making as part of inclusive civic governance. As with age-friendly cities, a core part of the concept is the idea that children's wellbeing can be taken as an indicator of the wider wellbeing of a city and the strength of its governance arrangements. The Child Friendly Cities Initiative was launched by UNICEF in 1996.
- **C40 cities** – Bringing together 90 major cities, the C40 Cities Climate Leadership Group describes itself as 'a network of the world's megacities committed to addressing climate change'. The group has a rotating chair elected from city mayors participating in the network.
- **Smart cities** – The Smart Cities concept emphasises the role of innovative digital technologies in supporting high quality of life, economic development and sustainable use of resources in cities. The use of artificial intelligence, machine learning and the 'internet of things' have all formed part of this idea. There are a number of potential applications to population health – for example, digitally enabled cities could support improved population-level data analytics or help to create an infrastructure for telehealth systems.



3 Roles for city governments in population health

City governments and their partners are well placed to play a number of important roles in relation to population health. Our research focused on five roles, which were highlighted by interviewees as areas where city governments can perform a particularly valuable function. The following sections discuss each of these in turn.

- Co-ordinating system-wide action.
- Promoting innovation.
- Using regulatory and legislative levers.
- Mobilising the population.
- Using planning powers to create healthy places.

Co-ordinating system-wide action

Complex public health challenges require a co-ordinated response from across the system – public, private and voluntary sector organisations all have important roles to play, as do local people and communities. City governments are well placed to bring together this wide range of partners and to play a central co-ordinating role.

Cities involved in our research highlighted two key lessons around how city governments can use their convening and co-ordinating powers to greatest effect. First, performing this role successfully requires adequate investment in programme management, with a central team responsible for co-ordinating activities across partner organisations. In Amsterdam, this has been a critical component of work on childhood obesity and on HIV. The city's apparent success in reducing childhood obesity rates has been attributed to the co-ordinated, whole-system approach it has taken since 2013, supported by a dedicated programme management team based in the city government's public health service (see box page 31). The central team's primary focus is on managing the programme as a whole and maintaining coherence, with a range of other bodies leading the delivery of specific interventions and activities.



Because obesity is a complex systems problem, it needs a complex adaptive systems approach, and you can only deliver that approach if there is central co-ordination. That doesn't mean that part of the programme can't be delivered by different municipality or private organisations, but it is all within one set framework.

Karen den Hertog, Amsterdam Healthy Weight Programme (research interview)

The Amsterdam Healthy Weight Programme

The Amsterdam Healthy Weight Programme is a whole-system approach to reducing childhood obesity founded on the premise that a healthy life for children is the responsibility not just of parents but also of schools, neighbourhoods, health professionals, city planners, legislators, the food industry and others. The programme was launched in 2013 with the aim that within 20 years, there should be no overweight or obese children in the city.

One of the notable features of the programme is its long-term vision. It is framed around a 20-year plan divided into three main phases. The City Council has supported this by awarding the programme an indicative budget extending to 2033 (currently worth €5.2 million annually). It is anticipated that the interventions deployed in the programme will evolve over time as information on their impact becomes available. Measures currently being used include the following:

- new policies in schools, for example, only tap water is drunk in primary schools, packed lunches must be healthy, and more time is allotted for physical activity
- regulatory measures, including a ban on advertisements for unhealthy foods targeting children in subway stations, and a ban on unhealthy sponsorship at sporting events aimed at children
- targeted interventions in neighbourhoods with the highest obesity levels, co-created with local residents and community organisations
- a number of interventions focused on the first 1,000 days of a child's life, from conception to the second birthday, including support for women to live healthily during pregnancy and to offer their baby a healthy lifestyle from birth
- training for health and other professionals in talking sensitively to parents about healthy choices
- a network of food businesses, including a major supermarket chain, exploring their role in supporting healthy eating in childhood.

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The Amsterdam Healthy Weight Programme *continued*

Crucially, the components of the programme are co-ordinated through strong programme management and a continuous adaptive learning process that uses output and outcome monitoring and ongoing formative evaluation.

Early results have been encouraging. Rates of childhood overweight and obesity fell from 21 to 18.5 per cent over the first years of the programme, although it is not clear what this reduction can be attributed to. This is a reversal of the trend for rising rates of childhood obesity seen in many cities internationally.

We are starting to see a real change happening at grassroots level, with neighbourhoods, communities, groups of mums or dads making healthier choices for their children and actively going to their schools and asking for more healthy choices, or organising activities to keep their children in contact with healthy messaging.

Karen den Hertog, Amsterdam Healthy Weight Programme (research interview)

A similar message emerges from Amsterdam's work on HIV. Since 2012, Amsterdam has built a consortium of all the stakeholders involved in HIV prevention or treatment across the city to devise a shared programme of work. Partner organisations pool funding, and receive additional money from the city government, pharmaceutical industry and fundraising events. The consortium – known as the 'H Team' – is held together by a centralised body responsible for co-ordinating activities across partners and overseeing how each contributes to the overall programme objectives. Interviewees stressed that allocating adequate funding for performing this co-ordination function was a critical part of the programme's success.

The second lesson about co-ordination identified by our research was that when city agencies use their convening power to bring together partners from across the system, this can be particularly impactful if done in the context of an explicit approach for collaborating and achieving change. Many US cities have used formalised methodologies to provide a structure for partnership working. One example is the Collective Impact framework developed by Kania and Kramer (2011). This has been used in a number of cities, including in San Francisco as part of the influential 'Getting to Zero' HIV prevention programme (see box below). Similarly,



in New York City the major mental health programme, Thrive (see page 43), has used a modified version of the Collective Impact framework, and has also used a learning collaborative approach to support programme implementation in selected neighbourhoods, adapted from quality improvement methodologies developed by the Institute for Healthcare Improvement. An important lesson from the Thrive programme is that bringing people together is often insufficient by itself to achieve change – you also need to have an agreed method to guide effective partnership working.

If you convene with a method, it's actually very powerful.

Gary Belkin, Executive Deputy Commissioner for Mental Health, New York City
(research interview)

Accepting that a co-ordinated approach is indispensable for tackling many public health challenges, one question that arises is what level this co-ordination should take place at – city level, nationally, or more locally? The answer to this will vary depending on the issue in question. Many of those we interviewed argued that it had proven significantly easier to build an effective collaboration at city level rather than attempting to do so nationally, in part because the necessary relationships already existed within the city or were easier to build. More local levels of government also played a critical role, for example, in tailoring interventions to specific local populations, but there was seen to be significant value in having a consistent, unifying framework across a city (see page 34).



Using the Collective Impact framework in San Francisco

The Collective Impact framework developed by Kania and Kramer (2011) has been used increasingly widely in social programmes in the US to provide an explicit methodology for collaboration. Structured approaches like Collective Impact may be particularly helpful for tackling complex problems in the context of major cities where there are large numbers of stakeholders and where organic relationships may not be sufficient.

The framework is based on five conditions underpinning successful collective endeavours:

- ensuring that there is a common agenda shared by all partners
- agreeing the metrics through which success will be measured
- selecting a set of mutually reinforcing activities that play to the different strengths of partner organisations
- continuous communication between partners
- a central 'backbone organisation' that co-ordinates activities and provides a supporting infrastructure.

Since 2014, the public health department in San Francisco has used the Collective Impact framework in a number of programmes, including a major HIV prevention programme (Getting to Zero), and in work on hepatitis C and other chronic diseases. Having used it successfully in the Getting to Zero programme, the team reports that it is now part of its default way of working and that it would use it for any major public health programme that required substantial stakeholder involvement. In the team's experience, the framework adds value in a number of ways, including by ensuring that early in the process, all of the stakeholders and potential partners are mapped out systematically; helping to flush out differences of perspective and work towards a common agenda; and providing a set of prompts and checklists to return to throughout the process.



Promoting innovation

Cities are often seen as engines of innovation, their density making it easier for people, organisations and ideas to come together in new and diverse combinations (Florida 2017). While much of the commentary on this focuses on the role of cities as drivers of innovation in business, technology and the arts, city governments can also play an important role in promoting **social** innovation as part of efforts to tackle the social determinants of health. Some cities have deliberately invested in building an innovation infrastructure with the aim of encouraging the development of novel solutions to social policy challenges. Approaches taken to this include:

- developing 'innovation labs' to work alongside city administrations
- using challenge prizes and innovation funds to catalyse innovation in other organisations
- developing close links between city governments and universities.

Urban innovation labs have been developed in several major cities in recent years. The term is used to describe a range of approaches, with common features including a focus on supporting government agencies to work in different ways and explore novel policy solutions, often by bringing in skills and knowledge not always found in the administration's traditional workforce; co-designing new approaches in partnership with communities; and joining up data from across different parts of government and using this in new ways to support evidence-based policy-making. Innovation labs typically consist of multidisciplinary teams drawn from a mixture of sectors and professional backgrounds, including people with scientific or technical skills working alongside designers and other creative professionals. Their role tends not to be to run innovation programmes themselves, but to help other agencies increase their capacity and capability to do so. Examples of innovation labs with an urban focus include NYC Opportunity, Laboratorio para la Ciudad (Laboratory for the City) in Mexico City, and a co-design lab established as part of the Southern Initiative in Auckland. In all three cases, the labs are seen as having played an important role in supporting city governments to tackle social determinants of health in more innovative, people-centred ways (see box below for more details).



Innovation labs addressing urban health challenges: three case studies

NYC Opportunity

NYC Opportunity works in partnership with city agencies to develop and test new programmes, largely with a focus on low-income populations and poverty reduction. It conducts this work in various ways, including:

- providing city agencies with expertise in programme design, implementation, performance monitoring and evaluation
- conducting evidence reviews to identify interventions that have worked well in other cities
- championing human-centred design to improve public services, for example using process mapping to ensure that pathways are as client-friendly as possible
- supporting participatory research projects involving local communities
- connecting city agencies with external research and evaluation partners
- developing data-sharing strategies to help different city agencies share data more easily, and to use this to inform policy-making.

Projects with an explicit focus on health include a Shop Healthy programme aiming to improve access to healthy food in areas with high levels of poverty. NYC Opportunity is based in the Mayor's Office and has around 50 to 60 members of staff. It receives a core budget of around \$35 million from the city government plus a similar amount of additional funding from philanthropic foundations, federal government and other private sources.

Laboratorio para la Ciudad, Mexico City

The Laboratorio was established in 2013 with a mandate to encourage fresh thinking around public participation and innovation in Mexico City. Its objectives are to fill the gap between civil society and government, bridge different government departments and agencies, help the government to understand the city's population (particularly younger generations), and support data-driven policy-making and better use of technology. There are several health-related work programmes, including a programme on mobility (focusing on cycling, walking and public transport), work on

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Innovation labs addressing urban health challenges: three case studies *continued*

children and public space (promoting access to open space for children in deprived areas), and various projects exploring creative use of data, for example on air quality or road safety. The Laboratorio has an annual budget of around \$1 million and roughly 25 members of staff. The team is multidisciplinary, with half its members coming from technical or scientific backgrounds (eg, urban geographers, data analysts, social scientists, digital experts) and half coming from creative fields and humanities (eg, artists, designers, filmmakers, historians). The Laboratorio's founder, Gabriella Gómez-Mont, reports directly to the Mayor of Mexico City.

The Southern Initiative, Auckland

The Southern Initiative was established in 2012 to create a prosperous, resilient place where children and families thrive. The initiative focuses on supporting community and social innovation in South Auckland – a highly diverse population with many strengths but poor health and educational outcomes. It is based in Auckland Council and works in collaboration with various parts of government, including through a co-design lab that is jointly funded by the council and eight government agencies. The co-design lab aims to put people and communities at the centre of policy-making and implementation by helping city government agencies to use participatory methodologies more effectively.

As part of the Southern Initiative, a broad range of approaches have been developed and tested, with a particular emphasis on early years, families, employment and skills. Specific activities include co-delivering the national Healthy Families NZ programme, which aims to prevent chronic illness through locally driven action, and a 'Healthy Homes' programme, which seeks to improve health outcomes by improving the quality and warmth of rental properties.

The Southern Initiative has a staff of around 25 people, with a mixture of skills including legal expertise, community development, design and cultural expertise. It reports to the Auckland City Council executive and governing body.



Some cities use challenge prizes and innovation funds to give businesses and other non-governmental organisations a financial incentive to develop innovative solutions to public policy challenges. Michael Bloomberg was a notable enthusiast for these kinds of approaches when Mayor of New York City. One large-scale example was the Applied Sciences NYC initiative, an open international competition to develop three new campuses devoted to applied sciences research, including a new Center for Urban Science and Progress focusing on applying big data to urban problems. The focus of challenge prizes and innovation funds is often on science and technology. For example, in 2017 the UK government launched a new Industrial Strategy Challenge Fund to strengthen science and business innovation, including £300 million for an Ageing Society Grand Challenge intended to support the development of new technologies to meet the needs of older people. However, the same approaches can also be used to address social policy issues that have an impact on population health in cities.

Cities can also promote innovation by actively harnessing the expertise found in universities. In our research, the relationship between city governments and local universities appeared to be much more collaborative in some cities than others. The leading architect Jan Gehl argued that in Copenhagen, close interaction between city agencies and academics is one of the principal reasons there has been such a sustained emphasis on using planning powers to promote health and wellbeing in the city, most famously through investment in cycling infrastructure over many years (see 'Using planning powers to create healthy places', page 44). Research teams in the University of Copenhagen have studied the city closely, publishing data and evidence about the needs of the local population and using the city as a test bed for new ideas.

There has been a close collaboration between town and gown. We did the research and they laid the stones... They used every bit and scrap of research we made.

Jan Gehl, Architect, Copenhagen (research interview)

City governments can create incentives and opportunities to influence universities and encourage the production of knowledge, evidence and skills that serve the needs of the city. For example, the health department in New York City has worked with universities to develop new training programmes for peer and community health workers, to ensure that the city has the kind of workforce it needs for the future. There may also be value in exploring mechanisms to



make interactions between academics and city officials easier and less reliant on individual relationships.

A consistent message from people involved in our research was that it is often easier to innovate at city level than at regional or national level. In some cases, new approaches developed in cities have served as a proof of principle and have subsequently been scaled up to the national level. For example, the introduction of mandatory calorie labelling in New York City in 2008 helped pave the way for later inclusion in federal legislation. There may be a particular role for large cities here, as innovations of the kind that national governments can learn from often need to be tested at sufficient scale for findings to be generalisable.

Large cities act as laboratories for learning in public health.

Sonia Angell, Deputy Commissioner, New York City Department of Health and Mental Hygiene
(research interview)

Using regulatory and legislative levers

Some city governments have become highly adept at using regulatory and legislative levers to improve population health. The options available depend on the specific powers that exist in each city, as discussed earlier, but the case studies examined below provide some generalisable lessons about how to take this kind of approach successfully.

Cities have a long history of using regulatory and other powers to limit exposure to harmful substances and control the spread of infectious diseases. More recently, city governments have started to extend this role from communicable to non-communicable diseases, assuming responsibility for tackling the behavioural risk factors most closely associated with ill health in today's populations, including tobacco and diet. New York City has been particularly proactive in this, with sustained attempts from 2002 onwards to use regulations and legislation to reduce smoking rates and reshape the food environment in the city. Specific measures have included the following.

- A ban on smoking in public places (introduced in 2003 and extended in 2011 to include outdoor public spaces such as parks, beaches and pedestrianised squares).



- A ban on the use of trans-fats in restaurants (due to their association with cardiovascular disease).
- Compulsory calorie labelling in chain restaurants.
- An attempt to regulate portion size for sugary drinks (this was later challenged and overturned in the New York State Court of Appeals – but consumption levels declined nonetheless).
- Mandatory nutritional standards in schools and other city-run institutions.

Another example is Amsterdam. As part of the Amsterdam Healthy Weight Programme (see page 31), advertising unhealthy foods has been banned on trams and in metro stations since January 2018, and the city will not grant permission for sporting events aimed at children that have an unhealthy food company as the main sponsor.

Tackling public health issues through legislation and regulation has a number of advantages – when it works, it can have a significant population-wide impact within a relatively short period of time, and in some cases may be less costly to city governments than more bottom-up approaches involving extensive community engagement. However, it can also be a high-risk strategy with some potential pitfalls to avoid. To improve the chances of success, city governments should be mindful of the following lessons identified through our research.

- **Be evidence-based.** Regulation and legislation can generate opposition. To deal constructively and quickly with concerns as they arise, public health leaders in a city need to be well versed with the evidence and able to clearly articulate the scientific rationale for a proposal, including in terms of the anticipated health benefits for the city's population.
- **Know the law** and have access to expert legal advice. In New York, having an in-house legal team with specialised health lawyers who can be accessed easily and regularly was identified as a critical enabler, and was seen as being more effective than drawing on non-specialist legal advice (Isett *et al* 2015).
- **Avoid using regulation in isolation.** In both New York and Amsterdam, regulatory/legislative approaches have been one component in a broader strategy based on intervention at multiple levels using a range of different levers.



Cities are not the only tier of government capable of taking regulatory or legislative action – national and local governments also possess powers and have an important role to play in exercising them. There are several reasons, however, why cities are in a good position to take action of this kind. First, legislating at more local levels risks creating conflicting laws in different parts of a city and a loss of overall coherence. Second, regulatory changes that require large businesses to change their practices or reformulate their products need to happen at a sufficient scale to be viable. Third, experience suggests that cities can sometimes be quicker to act than national governments – interviewees in our research argued that on some issues, effective regulation is more likely to come from city governments than national governments, with cities acting as a test bed for changes that may be scaled up in time.

Large cities also have the scale and clout to influence industry through other means in addition to formal regulation. In both New York and Amsterdam, city governments have lobbied the food and drink industry to promote health through voluntary codes of practice and other non-binding agreements. In Amsterdam this has included a partnership with the largest supermarket chain in the Netherlands, which has agreed to take a number of measures including experimenting with removing unhealthy products from checkouts ([Theis 2017](#)).

Mobilising the population

Some of the boldest attempts to improve population health in cities have been fuelled by the involvement and leadership of local people. Many interviewees stressed the critical role that engaged citizens and strong advocacy groups had played in bringing about change in their city. For example, concerted political action on air quality in Berlin was attributed in part to the strength of prominent environmental advocacy groups and to a general culture in which citizens expect to be able to influence policy-making processes. City governments can harness the resourcefulness and creativity of local people by creating the conditions for active citizenship and acting as a catalyst of locally led initiatives. Our research found several examples illustrating how this has been done in practice.

In Paris, the current city administration under Mayor Anne Hidalgo has placed significant emphasis on public engagement and participation. One tool used to support this is participatory budgeting, introduced in 2014. Participatory budgeting



is an approach developed first in Brazilian cities in the 1980s and now used throughout the world in various guises, involving allocating a proportion of a city's budget through some form of public vote, with choices often including proposals put forwards by citizens. In Paris, the results of the 2015 'budget participatif' demonstrated strong public support for action on cycling and walking, including through a proposal called 'Paris for pedestrians' that consisted of various measures to reduce road traffic, allocate more space to pedestrians and diversify activities in public spaces. The significance of this result has been twofold – first, it meant that public money was made available for these specific proposals (a total of €65 million was allocated through the 'budget participatif' in 2015). Second, and perhaps most significantly, it signalled to city politicians that they had a strong public mandate to take wider action to promote cycling and walking and improve air quality. Public engagement in this programme of work has also been supported through other means, including public workshops and community outreach work led by universities.

In recent years, New York, London and several other major cities have launched city-wide programmes aiming to improve the mental health and wellbeing of the population and prevent mental health problems. The Thrive NYC and Thrive LDN programmes have both used participatory techniques as a way of seeking to engage local communities in efforts to improve public mental health (see box page 42).

Tokyo provides another example of how community-led changes can support population health improvement. City leaders increasingly see part of their role as being to empower citizens to influence the design of their neighbourhoods, including through the concept of 'machizukuri' (community or neighbourhood-led planning) (McCay *et al* 2017). For example, much value is placed on systematically integrating greenery into the urban environment through enabling small-scale action by individuals and neighbourhood groups. Government plays an enabling role in this, including by delivering workshops; sharing methodologies; offering tax incentives to residents and businesses; encouraging local fundraising initiatives; and creating opportunities for community groups to work in partnership with professional urban designers, planners and developers to put local ideas into practice. The emphasis on greenery is driven largely by aesthetic rather than health concerns, but given the evidence on the health impact of access to green spaces (Parliamentary Office of Science and Technology 2016; Fields in Trust 2018), there is clearly a potential public health benefit as a by-product of this work.



Public mental health in cities: Thrive LDN and Thrive NYC

The Thrive LDN and Thrive NYC programmes involve taking a public health approach to improving the mental health and wellbeing of the populations of London and New York City respectively. Although the two programmes differ in a number of important ways, they both share an emphasis on mobilising local communities to promote positive mental health and reduce stigma.

Thrive NYC was launched by the Mayor and First Lady of New York City in 2015. The programme is based on the premise that good population mental health is critical if a city is to thrive socially, civically and economically. A key question at the heart of Thrive NYC is whether city governance can support community life, social ties and civic participation in ways that promote mental health. The programme is framed around 6 guiding principles and 54 specific initiatives, supported by more than \$850 million of city funding over its initial four years. One of the major themes running throughout the programme is empowering communities and strengthening the voluntary sector organisations that work with them. For example, one of the initiatives, Connections to Care, involves integrating mental health support within community-based organisations by giving non-specialists the skills and knowledge they need to deliver basic mental health interventions. Thrive also aims to train 250,000 New Yorkers in 'mental health first aid', initially prioritising police officers, firefighters, health professionals and other city employees involved in delivering frontline services.

Thrive LDN was launched in 2017 with a mission to start a city-wide movement around mental health. In its first year the emphasis has been on engagement and awareness-raising, including through a multimedia campaign, community workshops, and the use of creative techniques such as 'problem-solving booths' to encourage people to talk about their own mental health and wellbeing. Those leading the programme believed that developing its contents in a highly emergent, bottom-up way had helped to establish a richer understanding of the needs of different communities in London, as well as helping to secure the support of a wide range of different partner organisations across the city. The London-wide programme has catalysed the development of local Thrive programmes in a number of boroughs, and also a Black Thrive programme focusing on the mental health of black Londoners. In subsequent years of the programme, the intention is to identify a small number of 'once-for-London' initiatives to be implemented at city level. The programme is hosted by the Healthy London Partnership (see section 4) and supported by the Mayor.



The concept of ‘machizukuri’ in Japan has some commonality with ‘tactical urbanism’, an idea that has gained popularity in recent years in American and European cities (Lydon and Garcia 2015). This is an umbrella term referring to quick, low-cost, participatory projects that aim to improve local neighbourhoods, often led by communities but with the consent of (and in some cases a small amount of funding from) local or city governments. The ethos is to get organised, develop a plan, seek agreement from city authorities and then put it into practice. A significant focus within the tactical urbanism movement has been on creating people-friendly urban environments that promote health, wellbeing and quality of life.

Digital technologies are increasingly used by city governments to give citizens a way of participating directly in decision-making. In Madrid, the city government has been using an online platform, Decide Madrid, since 2015 to allow residents to put forward their own proposals, participate in public debates, respond to consultations, and take part in the city’s new participatory budgeting process (Simon *et al* 2017). This is part of a wider drive by the Madrid city government to improve civic participation and decentralise decision-making, which also includes new face-to-face participatory structures within neighbourhoods.

Using planning powers to create healthy places

An important tool at the disposal of city and local governments is the place-making abilities afforded to them by their planning powers. While the exact powers available vary, most city governments have some degree of control over spatial planning decisions and can use this to create built environments that promote health and wellbeing. High-quality built environments can improve population health in several ways, including by encouraging people to be physically active, creating opportunities for social interaction, providing access to green spaces, and minimising exposure to air pollution and other pollutants (Public Health England 2017; Sallis *et al* 2016). Public Health England’s guidance offers insights into how spatial planning can be used to promote health (Public Health England 2017).

As well as shaping the built environment, the planning responsibilities held by city and local governments also extend to promoting economic development. Employment status has a major effect on health, particularly mental health (van der Noordt *et al* 2014), and the various powers that city authorities have over economic development can also be used to promote population health.



Notable examples in our research of cities using their planning powers to promote health include the Active City programme in Amsterdam and a new ‘super block’ approach in Barcelona.

- The Active City programme in Amsterdam aims to encourage designers and urban planners to create spaces that encourage physical activity (drawing on the Active Design Guidelines developed in New York City). The programme has published a book bringing together examples of healthy planning across the city, to serve as a source of inspiration and to articulate the principles underpinning healthy planning (Urhahn 2017). The programme is city wide but also targets specific neighbourhoods with the highest levels of need and deprivation, many of which are also targeted by the Amsterdam Healthy Weight Programme (see page 31).
- The ‘super block’ system in Barcelona involves reorganising the road network so that most traffic is channelled on to a smaller number of larger roads, radically reducing the amount of traffic on the smaller roads within each block. The intention is to cut the amount of pollution, congestion and noise in residential neighbourhoods, improving the quality of the environment for residents and promoting physical activity. The concept was piloted in one area of the city in 2017, and another five pilots have been approved for the next few years. The government’s ambition is to roll it out across the whole city if the pilots prove successful.

In some cities, there has been a marked cultural change in terms of how planning departments and other related parts of government conceive their roles, with a shift in emphasis towards creating liveable, sustainable cities that improve the quality of everyday life and wellbeing, including by promoting physical activity and social interaction (Hall 2014; Gehl 2010). The concepts of ‘people-centred’ or ‘life-sized’ planning and design are proving popular with mayors and electorates in cities as diverse as Bogotá, Calgary and Rotterdam. A significant part of this agenda centres on reduced reliance on cars in favour of more active forms of transportation, with a steadily growing list of cities aiming to make their central districts car free in the near future, including Hamburg, Oslo and Madrid.

Data and measurement are critical enablers of this shift in priorities. In Copenhagen, city authorities have been gathering data on the volume and patterns of movement of cyclists and pedestrians for many years. This provides quantitative evidence



that can be used to inform policy decisions, construct a robust case for change (for example, involving further investment in cycling infrastructure), and defend proposals against critics. In many cities this kind of detailed data on how people use public spaces is simply unavailable. The broader point here is that if city governments are to reorient their planning and other activities to place greater emphasis on promoting population health, this must be reflected in the forms of data collected by city agencies – what matters must be measured.

Measuring the right things is paramount. A growing number of cities are interested in investing into cycling and walking, but often they struggle to have the solid statistics about cycling or walking that they would need to guide their investments and measure and demonstrate their impacts.

Francesca Racioppi, World Health Organization Regional Office for Europe (research interview)

Research indicates that in the UK, professionals involved in planning and designing the built environment in cities have a good level of awareness of the principles of healthy place-making, but encounter a number of barriers in putting these principles into practice. These include the perception that creating healthy places may be more costly than alternatives. This highlights the need to draw on and strengthen the international evidence base on the economic and social value of healthy place-making ([Hunstone et al 2018](#)).



4 Case study: London

To provide a more in-depth illustration of the challenges and opportunities for cities in improving population health, this section offers an extended case study of the UK's largest and most complex city.

London is an outlier in almost every sense. In terms of the population living within the formal city administrative boundaries, it is by far the largest city in western Europe, with almost 9 million people living in Greater London and many more in the surrounding metropolitan area. Its economic output is the fifth largest of any metropolitan area in the world – after Tokyo, New York, Los Angeles and Seoul ([Berube et al 2015](#)). More than 300 languages are spoken by its residents, with more than a third of residents being born outside the UK ([Office for National Statistics 2013](#)). The population is relatively young, even for a large global city, although the proportion of older people is projected to grow ([Office for National Statistics 2016](#)).

Despite its economic power (and in some cases because of it), London faces profound challenges. Huge inequalities in income and wealth have created a dysfunctional housing market that is pricing many people out of the city, changing the nature of communities and creating difficulties in terms of delivering public services, as well as contributing to a surge in homelessness ([Fransham and Dorling 2018](#)). In some local authority areas in London, economic output per head is below the UK average, while in others it is significantly greater than the average ([Douglass and Sobrevilla-Quiton 2017](#)). Seven of the ten local authorities with the highest levels of income deprivation among older people in England are in London ([Department for Communities and Local Government 2015](#)).

This economic inequality is mirrored in inequalities in health outcomes. Health inequalities across the capital are stark and persistent, with healthy life expectancy varying between boroughs by as much as 15 and 19 years for men and women respectively, and with even wider variations between local neighbourhoods ([Greater London Authority 2017](#)). London's most deprived children are twice as likely to



be obese than the least deprived, and death rates from common causes such as cardiovascular disease and respiratory disease vary by more than twofold between boroughs ([Public Health England 2015](#)).

The economic prospects for the city post Brexit are highly uncertain – the King’s Commission on London, in its recent report exploring the city’s future up to 2030, argued that ‘one of the most serious threats to London’s future success is complacency – the assumption that London will continue to thrive’ ([King’s Commission on London 2018](#), page 21).

In this section, we apply the framework developed in sections 2 and 3 to London, appraising the opportunities and challenges faced in improving the health of its population. We start by outlining the governance structures that provide the backdrop for city-wide work on population health.

Governing for health in London

In the terminology of urban governance, London is a ‘two-tier’ system, and is unusual in that the lower tiers of government (local authorities) have more resources and, in some respects, more powers than the upper tier (the Greater London Authority).

The Mayor of London is responsible for strategic planning and has formal powers in relation to economic development, transport, policing, and fire and emergency planning. London’s 32 local boroughs (plus the City of London Corporation) are responsible for most other issues, including public health, social care, regeneration (including housing and planning functions), waste and recycling, environmental protection and leisure services. Collectively, spending at local authority level is around three times the budget available to the GLA (Travers 2003).

The high profile of the Mayor of London means that the informal powers of the GLA are often far greater than the powers it has on paper. However, in many policy areas the Mayor is reliant on influence and persuasion to get things done, rather than exercising direct control.



The mayor is responsible for devising strategies that in the main require the boroughs to implement them. How the mayor can convince the boroughs to implement his strategies and policies is a key question.

(Travers 2003)

The regional mayoral structure creates huge opportunities for public health, but there is nothing built into the structure to give the mayor the levers.

Helen Walters, former Head of Health at the GLA (research interview)

In relation to health care, the GLA and boroughs have few direct powers and no responsibilities for delivering health care services. However, through exercising their other functions, the GLA and boroughs have significant opportunities to influence population health, and since 2007 the Mayor has had a statutory responsibility to produce a health inequalities strategy.

London's boroughs have responsibility (or in some cases shared responsibility) for a wide range of issues that affect population health, including housing, transport and the built environment. Their control of public health budgets gives them access to expertise in health improvement, and they also play an important role in convening health and wellbeing boards. Complex relationships exist between the GLA and local authorities, and at times a degree of tension – some of it healthy. The principle of subsidiarity is held to be highly important, with boroughs leading on many issues and aggregating on a case-by-case basis.

There is no single mechanism for collaboration between boroughs – approaches to this vary depending on the issue. Political priorities vary from one borough to another, and there is a natural dynamic to operate on a single-borough basis by default. Some structures exist to enable collaboration at the city and 'sub-regional' levels, for example, through the membership organisation London Councils. Increasingly there is a degree of collaboration between boroughs beneath the London level based around four 'sub-regions', each represented by an informal partnership (Central London Forward, South London Partnership, West London Alliance, and Local London). These partnerships between boroughs have emerged organically and do not map on to geographies organised by the NHS (for example, sustainability and transformation partnerships, which local authorities are also involved in). Within the public health sector, public health teams based in boroughs collaborate on some projects via the London network of the Association of



Directors of Public Health, which plays a more significant role in London than in some regions of England.

The distinction between inner and outer London boroughs is often important, with the latter generally covering much larger geographies and at times facing different challenges. Internationally, London is unusual for having its city centre divided into at least eight separate local government units.

Both the GLA and London's boroughs are significantly constrained in terms of financial autonomy. The boroughs are dependent on national government for around 61 per cent of their income ([Department for Communities and Local Government 2017](#)), although this is set to fall as the government devolves control over money raised through business rates. The Mayor has to negotiate annually with national government over the size of the GLA grant, and it is harder for the GLA to move resources from one budget to another than it is for local authorities (Travers 2003). There have been several calls for a more devolved approach, including from the London Finance Commission, which recommended that London should have local control over a range of taxes including in relation to property, capital gains and business rates ([London Finance Commission 2017](#)).

London has few revenue-raising tools compared to most major cities around the world, and other UK cities have even less autonomy.

(Slack and Côté 2014)

In recent years a set of pan-London structures have been developed to create a vehicle for strategic oversight of city-wide work on health and social care. From a population health perspective, the key structures are listed below.

- **London Health Board (LHB)** – Chaired by the Mayor of London, the LHB is the platform through which the Mayor and boroughs have shared strategic oversight and can enter into a dialogue about health and care in London. Membership comprises the Mayor, three leaders of London local authorities appointed through London Councils, and senior representatives of the health sector. It meets quarterly, and the minutes are publicly available.
- **London Health and Care Strategic Partnership Board (SPB)** – Brings together partners from across the health and care system, including representatives from London Councils, the GLA, the Office of London CCGs, sustainability



and transformation partnerships, Public Health England, NHS England, NHS Improvement, Health Education England and the Care Quality Commission. The SPB has strategic and operational responsibility for promoting collaboration and integration across health and social care, enabling whole-system planning and prioritisation, sharing learning across the system, implementing the new London Health and Care Devolution programme, and overseeing other London-level governance structures and workstreams including the London Prevention Board, London Estates Board and London Workforce Board. The SPB was formed in 2017 and reports to the London Health Board. Its terms of reference envisage it having increasing control over certain budgets over time ‘subject to phased progression, with gateways to ensure that governance and accountability mechanisms are sufficiently robust to proceed to the next phase’ ([Healthy London Partnership 2018](#)).

- **London Prevention Board (LPB)** – The newly reconstituted London Prevention Board is intended to be the key place in the system where city-wide decisions about prevention and population health are taken. It will have an important role in overseeing the implementation of the Mayor’s health inequalities strategy. The intention is that partner organisations use the LPB to hold each other to account for delivering the system’s collective ambitions on prevention.
- **Healthy London Partnership (HLP)** – Set up in 2015 to support implementation of the 10 city-wide aspirations identified by the London Health Commission in *Better health for London* (see box page 52), and now also working to support delivery of the national *NHS five year forward view*. HLP is funded by London’s 32 clinical commissioning groups and the London office of NHS England, and works in partnership with other organisations including the GLA, London Councils and Public Health England. HLP leads a number of London-wide programmes of work relating to prevention and population health, including on obesity and public mental health (see box on the ‘Thrive LDN’ programme, page 43). It also hosts the SPB and acts as its secretariat.
- **National bodies** such as NHS England, NHS Improvement and Public Health England also have a presence in London through their regional teams. However, these do not have the capacity or the breadth of responsibilities possessed by their predecessor organisation, NHS London, which played an overarching system management role prior to the abolition of strategic health authorities in 2013 ([Ham et al 2013](#)).



The London Health Commission: 10 city-wide ambitions

The London Health Commission, chaired by Professor Lord Ara Darzi, was established by the Mayor in 2013 to provide an independent view on the priorities for improving health and care in London. A year later, the commission's report *Better health for London* identified over 60 recommendations. The formal response from the London system, *Better health for London: next steps*, set out how partners across the city intended to take forward these recommendations and work towards London becoming 'the world's healthiest major city'. The programme of action, now overseen by the Healthy London Partnership, is framed around 10 city-wide ambitions.

- Give all London's children a healthy, happy start to life.
- Get London fitter with better food, more exercise and healthier living.
- Make work a healthy place to be in London.
- Help Londoners to kick unhealthy habits.
- Care for the most mentally ill in London so they live longer, healthier lives.
- Enable Londoners to do more to look after themselves.
- Ensure that every Londoner is able to see a GP when they need to and at a time that suits them.
- Create the best health and care services of any world city, throughout London and on every day.
- Fully engage and involve Londoners in the future health of their city.
- Put London at the centre of the global revolution in digital health.

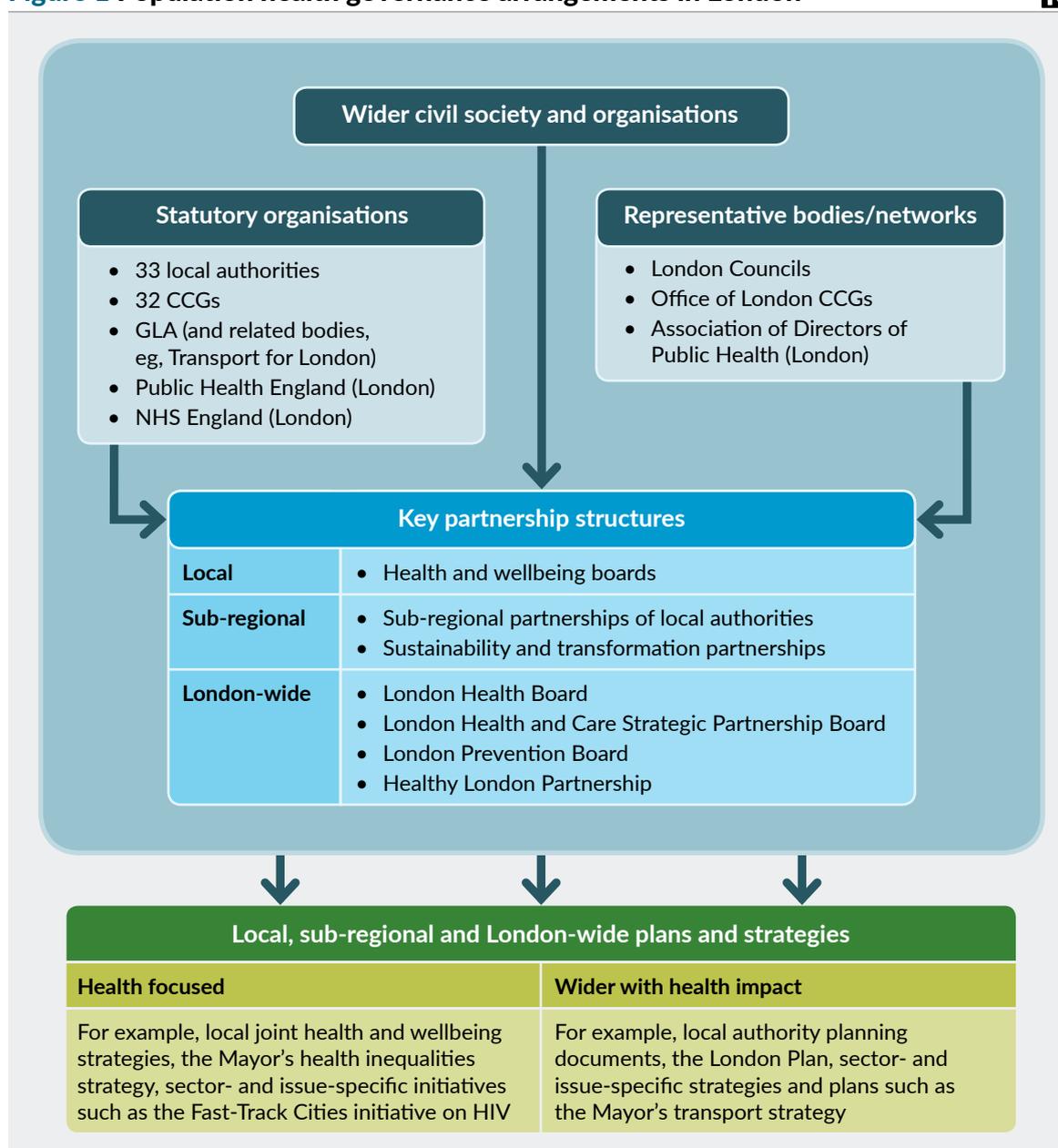
Early progress against these ambitions was reviewed in the 2015 publication *Better health for London: one year on*.

These partnership structures are intended to bring some cohesion to what can be a highly complex and at times fragmented governance environment in London. In most cases, their primary focus is on supporting integration and other improvements in health and care services, with less emphasis on the wider determinants of health (as reflected in the membership of the various bodies listed). There are separate structures that support partnership working on some wider determinants – for example, there is some collaboration between boroughs on employment and skills.



Figure 1 provides a map illustrating how these partnership structures relate to other organisations and bodies involved in population health in London. For brevity, we have focused this diagram on commissioning and decision-making structures, and have omitted a large number of organisations involved in the delivery of health and care services. Even so, the diagram shows the large number of stakeholders involved.

Figure 1 Population health governance arrangements in London





Applying our framework to London: summary of findings

Sections 2 and 3 described key roles that city governments can play in relation to population health, and enabling conditions that allow cities to take up these roles successfully. The table below summarises key messages that emerge when we apply this framework to London. The most significant challenges and opportunities listed in the table are explored in greater depth in the sections that follow.

Table 2 Assessment of London’s ability to conduct city-wide work on population health improvement

	Strengths and opportunities	Challenges
Enablers		
Governance arrangements	<ul style="list-style-type: none"> • Mechanisms for pan-London collaboration maturing over time • New structures for pan-London decision-making on health, eg, London Prevention Board 	<ul style="list-style-type: none"> • Highly complex system. Decision-making processes not always clear. Collective ‘weight’ of system can lead to inertia • Lack of accountability for delivery on some issues • Collaboration between local authorities happens on an ad hoc basis and can be time consuming
Powers	<ul style="list-style-type: none"> • Mayor has high level of control over integrated transport authority (TfL) • Some levers other regions of England do not have, eg, in relation to planning 	<ul style="list-style-type: none"> • Fewer regulatory powers than some international comparators • Limited powers to raise revenue locally • Mayor and boroughs have few direct powers over health sector
Expertise	<ul style="list-style-type: none"> • Lots of specialist expertise across public health teams in local boroughs • Strong London-wide network of directors of public health 	<ul style="list-style-type: none"> • Insufficient expert public health capacity at city level • No public health budget given to GLA as part of 2012 reforms
Leadership	<ul style="list-style-type: none"> • Mayor can use significant informal powers to push for changes • Opportunities to make a virtue of distributed leadership – potentially leads to better decision-making with broader support 	<ul style="list-style-type: none"> • Perceived lack of ‘whole-system mentality’ in some parts of the system • Dependent on public health professionals and others employed at borough level doing London-wide work – but not all boroughs willing to see staff use time in this way
Connectivity	<ul style="list-style-type: none"> • Global city – other cities want to connect with London 	<ul style="list-style-type: none"> • Risk of London-centricity – less visible commitment to learning from others • Internal connectivity challenging given complexity of system and number of partners

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Table 2 Assessment of London’s ability to conduct city-wide work on population health improvement *continued*

	Strengths and opportunities	Challenges
Roles		
Co-ordinating system-wide action	<ul style="list-style-type: none"> • Convening power of elected mayor helpful in bringing partners together across the system 	<ul style="list-style-type: none"> • Large number of stakeholders means that partnership working has a high transaction cost • Limited resource for programme management at London level to co-ordinate activities across system partners
Promoting innovation	<ul style="list-style-type: none"> • Unrivalled assets – world-class universities, businesses and philanthropic foundations • Boroughs provide a natural test bed for new approaches (eg, devolution pilots) • Opportunities to create new funding partnerships as a result of London’s strong brand 	<ul style="list-style-type: none"> • Insufficient use being made of existing assets • Connections between London’s universities and city/local government institutions not always strong • No concerted attempt to strengthen the infrastructure for social innovation • Weak mechanisms for spreading and scaling up successful innovations across London
Mobilising the population	<ul style="list-style-type: none"> • Some examples of large-scale engagement, eg, Talk London, Thrive, Great Weight Debate, as well as public engagement activities at borough level 	<ul style="list-style-type: none"> • Highly diverse population • Transient, mobile population
Using planning powers to create healthy places	<ul style="list-style-type: none"> • Health objectives integrated into London Plan and London Transport Strategy • London Plan provides a potentially powerful lever to influence planning • Healthy Streets Approach embedded in TfL and gaining international renown • Multiple large regeneration projects and new housing developments 	<ul style="list-style-type: none"> • Little evidence of strategic alignment between planning processes and health and wellbeing board objectives in most boroughs (Town and Country Planning Association 2015) • Limited and shrinking capacity in planning departments as a result of funding cuts to local authorities • Weak mechanisms for holding TfL, boroughs and others to account for delivering the Healthy Streets Approach
Using regulatory and legislative levers	<ul style="list-style-type: none"> • Scope to do more within existing powers – these are not yet being used fully by local authorities • Size of the city gives it clout over industry 	<ul style="list-style-type: none"> • Compared with health departments in some city governments outside the UK, limited access to specialist legal expertise to provide advice on use of regulatory powers



Challenges

Dealing with complexity

Challenges arising from the complexity of London's governance environment were by far the most dominant theme in our interviews with system leaders in the city. Initiating city-wide health improvement in the context described above requires strong central co-ordination of activities, and we saw little evidence of the pan-London structures for health and care currently providing this (it should be acknowledged that many of the key structures have been established or revamped relatively recently and will need more time to prove themselves in practice). The whole-system approach to population health improvement adopted in international exemplars such as the Amsterdam Healthy Weight Programme requires more significant investment in central programme management, as discussed in section 2.

An important consequence of system complexity is the high transaction costs associated with any attempts at partnership working, particularly between boroughs. There are some recent examples of very successful partnership working across London, but those involved reflected that the efforts required even to agree the principle that taking a London-wide approach was the right way forward were enormous, and that this work needs to be repeated for each issue.

The system is not set up particularly well to work on London-wide issues... It feels like whenever we want to do something collaboratively, we have to put the system together each time.

Director of Public Health from a London borough (research interview)

Another major cost arising from the complicated governance environment is slowness to act. System leaders described how the 'collective weight' of the London system leads to inertia, particularly in relation to implementation. A widely held view was that while London's partners are able to agree strategy, the system is less good at then putting agreements into practice and holding partners to account for delivery.

The system is good at talking about priorities but not at agreeing what that means in terms of delivery... We seem to be unable to spread and scale the things that are obvious.

George Howard, Healthy London Partnership (research interview)



Some of the most high-profile city-wide changes to health services have had a very long gestation period (more than 10 years in the case of the transformation of stroke and trauma care), and were made at a time when there was central NHS leadership in the form of the London Strategic Health Authority ([Ham et al 2013](#)).

A further problem related to complexity is the challenges it creates for accountability. Interviewees observed that it is not always clear which organisation(s) are responsible for delivering on ambitions that have been collectively identified as priorities for London. This creates a risk of weak accountability, and this risk may be particularly high in relation to population health improvement, which by its nature often involves multi-faceted, cross-sectoral action. The new London Prevention Board may be able to help strengthen accountability for this, provided that its membership is sufficiently broad and that partners are able to hold each other to account for delivering on commitments.

How this complexity plays out in practice can be illustrated by two examples of London's response to HIV, showing both how London sometimes struggles to navigate complexity, and the success that can follow when it does. The first example is how the boroughs are working well together through the London HIV Prevention Programme. The second is the story of London's membership of the Fast-Track Cities initiative, a United Nations initiative established in 2014 to support cities and their leaders to enhance their HIV response by learning from others.

Collaborating across boroughs on HIV prevention in London

The London HIV Prevention Programme, first established in 2014, is an example of cross-borough collaboration on public health. The programme has included a number of components, starting with a comprehensive needs assessment that was used to inform face-to-face and online outreach work, free condom distribution, and a series of major multimedia campaigns under the brand 'Do It London'. It aims to increase the frequency of HIV testing and promote the adoption of safer sexual behaviours, including uptake of pre-exposure prophylaxis (PrEP), and has already achieved significant progress against its core objectives.

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Collaborating across boroughs on HIV prevention in London *continued*

The programme was the result of successful collaboration between public health directors across London, with all boroughs participating to 2017, and all but two boroughs agreeing to commit funding to 2019. However, it has required significant efforts to bring the collaboration together, and the programme was seen as being heavily dependent on a few key individuals being willing and able to play a co-ordinating role outside of their core job responsibilities. This illustrates the complexity of London – arguably, it should be standard practice to work together on a city-wide basis on an issue like HIV prevention where there are significant spillover effects across government boundaries.

The UN Fast-Track Cities initiative

The Fast-Track Cities (FTC) initiative is a United Nations programme supporting mayors and other city leaders to play an active role in ending the global AIDS epidemic. Cities involved in the initiative pledge to accelerate their local AIDS responses by committing to reaching four interconnected targets: 90 per cent of people living with HIV know their status, 90 per cent of them are on treatment, 90 per cent of people on treatment have an undetectable viral load, and there is no stigma or discrimination connected to HIV or AIDS – the first three targets being known as ‘90-90-90’. Modelling suggests that achieving these targets by 2020 will bring the global epidemic to a halt by 2030, generating profound health and economic benefits.

The benefits of being part of the programme include securing high-level city-wide political commitment, having a mechanism to bring all parties together around a common purpose, augmenting and strengthening ongoing local work with best use of existing resources, and connecting with other cities and their leaders to share learning and expertise. In order to become a member of FTC each city needs to develop a city-wide plan agreed by all relevant partners.

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The UN Fast-Track Cities initiative *continued*

Although among the first cities to be approached when the initiative was launched in 2014, it was not until January 2018 that London was able to sign up. Several factors introduced delays into the process, including the following.

- The requirement to develop a city-wide plan raised questions about whose plan would it be, who would be accountable to whom for what, and how any new investment would be managed and spent within the system.
- Because the Mayor does not have overarching responsibility for health, there were very practical questions about which agency or agencies would sign the pledge and then have responsibility for delivering on the commitments.
- The impact of national policy decisions following the Health and Social Care Act 2012 has been particularly disruptive to the HIV care pathway ([Baylis et al 2017](#)). Making sense of the new arrangements in London has consumed capacity and resources, leaving little time for new initiatives.

The catalyst came with the inclusion of HIV as a priority in the Mayor's 2016 election manifesto and subsequently in the Mayor's 2017 draft health inequalities strategy ([Greater London Authority 2017](#)). This provided a vehicle for bringing stakeholders together around a common purpose. Intense activity over a six-month period resulted in representatives of four statutory bodies (NHS England, Public Health England, London Councils and the GLA) signing the Fast-Track Cities commitment on behalf of London in January 2018. The experience of joining the FTC initiative illustrates both the impact of complexity in London, but also the fact that the system is capable of overcoming this complexity when there is the will to do so.

Dependence on high-quality system leadership

Navigating the London system and getting things done despite the challenges described requires high-quality leadership and a specific set of skills around partnership working, consensus building, political astuteness and stakeholder management. When leaders possess these skills (and when they have sufficient time available to deploy them), the London system can be made to work. This puts a very high premium on building the right kind of leadership. It also requires that local authorities and other partners see the value in playing a leadership role in the



wider system beyond their organisational boundaries, and encourage their senior staff to make time available for this – something that interviews indicated does not happen universally at present.

I think we can improve outcomes for our residents through – as Directors of Public Health for our boroughs – working both locally and at a London level. However, the current system relies on us being employed by a local authority; unfortunately, we can't always give the London-level work the attention it needs, or it isn't prioritised by our boroughs.

Director of Public Health from a London borough (research interview)

When a major city challenge such as child obesity is posed by any party, others must first agree to cooperate... This works as long as there is good partnership and leadership skills in evidence at every level particularly among the professionals who work behind-the-scenes to enable political action.

(Doyle et al 2017)

Insufficient public health capacity and resources at city level

In section 2 we argued that the appropriate level for locating public health expertise depends on the nature of the governance arrangements in any given city. In London's two-tier system, where the decisions made by both city and local government have a significant impact on population health, there needs to be sufficient public health capacity at both levels.

A clear message from our research is that the limited number of expert public health personnel at city level places significant constraints on London's capacity to undertake collaborative, city-wide work on population health improvement. While there is expertise available in the GLA, Public Health England's London office (PHE London) and specific functional bodies such as Transport for London (TfL), the relevant teams are stretched too thinly to have the influence and impact that they could, and are fragmented across multiple organisations.

This fragmentation makes it hard to measure precisely the funds available in London for work on public health (and for primary prevention in particular), or to compare this with other cities in England or internationally. Including organisations



at the local level, funding is spread across close to 70 commissioning organisations in the public sector alone. In the boroughs the trajectory for local authorities' public health funding is falling, in line with the government's announced cuts to the grant they receive and ongoing cuts to wider local authority funding (Ham et al 2017). This raises doubts over whether the total sum of resources available for public health in London is adequate or on the same scale as that seen in other global cities.

The opportunities to improve the health of London's population by involving public health professionals in decision-making processes across the full sweep of city government activity could be significant – but having this expertise available depends on there being sufficient capacity and funding within the GLA, the city-wide bodies it works with, and in the boroughs. At present Public Health England's London office is able to support city agencies by providing world-class data and public health surveillance tools to inform decision-making, but has limited capacity to be directly involved in decision-making processes or to advise and influence.

There may not be a sufficient critical mass of people at city level to have difficult, knotty debates about complex issues and to develop a vision.

Harry Rutter, London School of Hygiene & Tropical Medicine (research interview)

It's not about bringing in a load of new health laws, it's about influencing the decisions that are being made constantly across city government.

Helen Walters, former Head of Health at the GLA (research interview)

This does not detract from the leading role of local authorities in public health. There are strong arguments for keeping the bulk of public health capacity in the boroughs, which have a more detailed neighbourhood-by-neighbourhood understanding of their local population, and where there are significant opportunities for integration with other public services. We found no appetite in any part of the system for a large-scale structural change that would see centralisation of public health teams currently based in local authorities. Instead, the argument is that a strengthened public health function at London level, focused specifically on making the most of the various levers that exist at that level, would be additional and complementary to the work of public health teams in the boroughs.



Strengths and opportunities

Harnessing London's innovation potential

London has a wealth of assets supporting innovation. The city is home to some of the most prestigious universities in the world, dynamic businesses (large and small), and influential philanthropic organisations. It is the country's cultural and artistic capital as well as the political and financial one. There is a thriving digital industry, and access to funding streams unavailable elsewhere. The work done in London's universities was described by one of our international interviewees as 'a lighthouse for public health researchers around the globe'.

A key question is whether London currently makes full use of these assets to improve the health of its own population. There are certainly examples that illustrate the potential. Some of the major businesses based in London fund health improvement work in local communities as part of their corporate social responsibility programmes. Guy's and St Thomas' Charity, a large philanthropic foundation connected to the hospital of the same name, is leading innovative place-based work on childhood obesity and multi-morbidity in the boroughs of Southwark and Lambeth. And the recent King's Commission on London provides an example of collaborative working between the university sector and city authorities ([King's Commission on London 2018](#)).

Despite these examples, a consistent message from interviewees was that there is scope to do more. In particular, there was a view that many of London's most prestigious universities have a global focus and do not always identify closely with the city itself. With some exceptions, relationships between universities and city government do not appear to be as strong as in some cities outside the UK, such as Copenhagen. With the right set of incentives, London's universities could play a much more active role in supporting social innovation with the goal of tackling the wider determinants of health in the city and reducing inequalities. The city's three academic health sciences centres and networks could play an important role in this (as is argued by the King's Commission ([2018](#))) by supporting research on public health interventions alongside clinical and biomedical research.

London's decentralised political system could itself provide fertile ground for innovation. Several interviewees argued that one way of securing faster gains in



public health would be to make it easier for local boroughs to experiment with different approaches, and to quickly scale up interventions that have the most positive effect. This could involve some form of London-wide body to support evaluation and spread.

As described in section 3, some cities have made deliberate attempts to catalyse social innovation by using mechanisms such as challenge prizes and innovation funds, establishing innovation labs to help city governments work in different ways, and mobilising the public as a source of ideas and creativity. There is scope for London to do much more in this space than at present ([Centre for London 2017](#)).

Making the most out of distributed leadership

London does not have a simple, linear chain of command, certainly in relation to health. As already discussed, this can create challenges in terms of decision-making and co-ordination. However, there is also a significant opportunity for London to make a virtue out of its distributed leadership arrangements and to develop a form of urban governance that is well adapted to the challenges and complexity of running a major global city in the 21st century.

Many of the system leaders involved in our research saw important benefits to distributed leadership. Decision-making may be slower, but the breadth of test and challenge encountered during the process can make for a better result that is endorsed by a wider range of stakeholders. The inbuilt tensions in the system can be constructive when they force people to work together and build consensus. London's system is undeniably complicated, but it is not the only city grappling with complexity. If it can succeed in building arrangements that support effective governance based on the SPB's principles of collaboration, co-development and subsidiarity, there is no doubt that the lessons would be of interest to cities around the world.

If this is to happen, London will need to actively cultivate the kind of leadership and behaviours needed to suit the system it is trying to build. Investing in leadership development and creating sufficient space for building strong relationships across the system may deliver bigger returns than structural change.



Seizing the opportunity presented by devolution

The financial dependency of the GLA and London boroughs on national government was widely seen by interviewees as being a major barrier to change. As described in section 2, England has one of the most centralised political systems in the western world with regard to tax-raising powers. Cities elsewhere have been able to invest in building a healthy, liveable city in part as a result of having greater control over their finances (Katz and Noring 2016). London also lacks the regulatory powers that exist in some cities outside the UK.

Many of the London system leaders we interviewed highlighted the opportunities presented by the memorandum of understanding signed in November 2017, which outlined a set of agreements between local, regional and national organisations concerning health and care devolution in London (see box page 65). Although this does not immediately give London any significant new regulatory or fiscal powers, it does create a platform for ongoing discussions with national bodies about devolving further powers and making the most of existing powers, and has brought London's system partners together around a shared programme of activity.

London can build on the 2017 agreement by continuing to press for further devolution of powers. Several interviewees argued that giving London greater control over how it uses the proceeds of the new sugar tax (introduced in April 2018) to support work on childhood obesity and other public health priorities would be a very helpful first step. Developing a London-wide response to the planned devolution of receipts from business rates will also be important, with bodies at the city level potentially playing a role in smoothing inequalities that may arise from some boroughs being able to raise more revenue from local businesses than others.

There are some areas where London is already well positioned to go further than other cities. For example, Amsterdam has so far not been able to use planning regulations to restrict unhealthy products and advertising around schools as part of their programme of work on obesity. This is something that London is now actively exploring through the devolution programme (see box page 65). If London could successfully introduce 'super zones' of this kind, that would be a significant achievement, and it has a number of assets that it may be able to use in doing so, including the planning capacity of the GLA and the recently updated London



Plan, which sets planning parameters for boroughs to follow (and that includes a commitment to assess the health impact of proposed developments). This provides one example of how London can capitalise on the momentum around devolution and press for further change.

The London Health and Care Devolution programme

In November 2017 a memorandum of understanding was signed by all the main players in the London health and care system and key national bodies, agreeing that some control over health and care will be delegated to the capital ([London Partners 2017](#)). The intention is to give the Mayor, local authorities and London health leaders more control over key decisions. The most significant agreements include the following.

- **Estates** – National bodies have agreed in principle that money raised through sales of NHS land and property in London will be kept within the city, with the London Estates Board identifying reinvestment opportunities to support city-wide priorities.
- **Integration** – Various measures intended to make it easier for the London health and care system to function in an integrated way, including through aligning regulatory processes and piloting a place-based framework for system regulation.
- **Workforce** – A new London Workforce Board could also facilitate integrated working, and may act as a locus for pooled funding from Health Education England, Skills for Care and others.
- **Transformation funding** – Agreement to delegate responsibility for transformation funding to the London Health and Care Strategic Partnership Board from April 2018.

In relation to prevention and population health, there is a commitment to ‘explore options’ for further restrictions on advertising unhealthy food and drinks, and the prospect of collaborative, city-wide action on some issues ‘where this is the most effective scale’. A programme of activity has been initiated by Public Health England’s

continued on next page



The London Health and Care Devolution programme *continued*

London office in response to the agreement, to explore the options for further city-wide action in the following areas:

- reducing access to illicit tobacco and counterfeit alcohol
- developing 'super zones' around schools limiting children's exposure to unhealthy food and drink (and associated advertising), gambling, smoking, alcohol and air pollution
- restricting advertising of unhealthy food and drink in specific locations
- controlling gambling and fixed-odds betting
- introducing water-only schools
- exploring how taxation can be better used to promote public health objectives
- supporting people with mental health needs and long-term conditions back into employment.

Working as a system to reduce health inequalities

One of the welcome peculiarities of London is that the Mayor has a legal duty to have a strategy on health inequalities. The legislation requires the Mayor to identify health inequalities in London's population; specify priorities for reducing those inequalities; and describe the role to be performed by relevant bodies in terms of implementing the strategy. The current draft strategy is being revised and is due to be published in summer 2018 ([Greater London Authority 2017](#)).

As set out earlier, the Mayor has no direct role in the funding or provision of the NHS or social care system. The draft strategy therefore interprets the legal duty on the Mayor as providing leadership in three ways: first, by ensuring that all the work



of the GLA contributes to reducing inequalities in health (eg, through exercising its powers in relation to planning, housing and transport); second, by championing work across London (eg, by speaking out publicly, challenging the health care sector and seeking consensus); and third, by directing support from City Hall (eg, through a limited number of health programmes) and reporting on actions and progress.

The requirement to produce a health inequalities strategy presents a real opportunity for London's partners to work together around a common set of goals. The draft is based on a comprehensive analysis of London's health inequalities and what drives the health of Londoners, and it demonstrates the knowledge and expertise in the 'London system' about the critical wider determinants of health that could be targets for action. There has been wide, transparent and meaningful engagement in its development, with many people and organisations having had the opportunity to share their knowledge and views.

To make the most of this opportunity, several things are required. Most importantly, there needs to be effective governance arrangements to ensure clear accountability for delivering the outcomes identified in the strategy and to ensure that they are focused appropriately on inequalities. This will be a key test of London's governance and the pan-London boards described above. As part of that, the strategy needs to strengthen its approach to sub-regional inequalities within London. This is notable by its absence and reflects London being a 'two-tier' governance model with the prime players being the 33 local authorities and the GLA. This leads to a lack of attention to issues between these levels, including inequalities in health. Finally, the strategy also needs to be adequately resourced – the draft does not direct any major additional resources to tackling inequalities in health, despite the scale of the problem in London. Further analysis of the opportunities to strengthen the strategy are provided in The King's Fund's response to the consultation ([The King's Fund 2017](#)).

Despite these suggestions for improvement, it should be remembered that few other global cities have any form of strategy to tackle health inequalities, or a legal obligation to produce one. This in itself creates an opportunity to build on in London.



Becoming a world leader in healthy transport strategy

London is envied by other cities for having an integrated transport authority, TfL, covering the whole transport system, including public transport provision and responsibility for major roads. London has much higher levels of public transport use than most other cities in the UK or internationally. Transport is also the area that accounts for most of the GLA's budget – 59 per cent of the total in 2018/19 ([Greater London Authority 2018](#)).

The 2018 Mayor's Transport Strategy makes public health a central concern in transport planning, based on the Healthy Streets Approach (see box below). Globally, few other cities have framed the purpose of transport planning as being about health improvement in such an explicit and prominent way, and London is becoming somewhere that other cities look to on this subject.

It is quite unique that a public transport authority like Transport for London makes a specific objective to contribute to improving the health of the population, not just moving them around more efficiently.

Francesca Racioppi, WHO Regional Office for Europe (research interview)

Given the assets that London has in relation to transport strategy, and the attention that the Healthy Streets Approach is receiving internationally, this is an area where London can and should aspire to become a leading global authority. But doing so will require putting principles into practice – London still has further to go to develop a health-promoting transport system and lags behind other cities on some metrics (Kodukula *et al* 2018). Overseeing the implementation of the Healthy Streets Approach will need adequate resourcing within TfL, and it will need to become fully embedded across the organisation and its partners. The system must be held to account for implementing the Healthy Streets Approach at city level and within local boroughs, and for evaluating the impact it is having. By doing so, London can build on the significant progress that has already been made.



The Healthy Streets Approach

In 2017 TfL committed to taking the Healthy Streets Approach to inform planning decisions throughout the city. The approach aims to encourage walking, cycling and public transport use, both by improving the associated infrastructure (such as cycle lanes) and by ensuring that local high streets and neighbourhoods are appealing places that people enjoy spending time in. The core idea is that planners should make decisions on the basis of what the human experience will be for people standing or walking on the street. The Healthy Streets Approach is framed around 10 indicators assessing factors that influence people's decisions about how and where to travel and spend time.

- The air is clean.
- People feel safe.
- It is not too noisy.
- Streets are easy to cross.
- There are places to stop and rest.
- Shelter and shade are provided.
- People feel relaxed.
- There are things to see and do.
- People choose to walk, cycle or use public transport rather than driving.
- People of all ages and from all communities choose to spend time on streets.

The Healthy Streets Approach forms the overarching framework for the 2018 Mayor's Transport Strategy, which set an objective that by 2041 all Londoners do at least 20 minutes of active travel each day, with a reduction in total traffic volumes of 10 to 15 per cent by the same year. Specific proposals in the strategy included a new London-wide network of cycling routes and more traffic-free areas.

For more information visit <https://healthystreets.com>



Recommendations for London

- Modest investment in additional public health expertise at city level could deliver sizeable returns by making the most of opportunities to use city-wide functions and bodies to promote health. A strengthened public health function at London level, focused specifically on influencing decision-making and using levers at that level, would be additional and complementary to the work of public health teams in the boroughs.
- The causes of ill health do not respect borough boundaries. Local authorities need to be able to engage in city-wide and sub-regional work, and boroughs should see collaboration of this kind as being an important part of delivering their public health responsibilities. Collaboration between boroughs should include a focus on tackling the large health inequalities that exist across the city.
- Major London-wide public health programmes need effective leadership and robust governance, and should be supported by adequately resourced programme management to ensure co-ordination of activities across the city. International experience suggests that trying to minimise programme management costs can be a false economy.
- One of London's assets is the presence of an integrated transport authority and a transport strategy that makes public health a central concern in transport planning. To take full advantage of this, there should be a concerted focus on implementing the Healthy Streets Approach at city and borough level. London should aim to be the world's leading authority and pioneer in using strategic transport planning to promote health.
- The progress made in terms of embedding health objectives in transport strategy should be replicated in other spheres of policy-making. Housing and planning should be priority areas for those involved in population health improvement, given the serious pressures on housing in London and the links between housing and health outcomes.
- London should explore ways of promoting social innovation, learning from approaches taken to this in other cities. One component of this could include building closer connections between city government and London's universities, and creating incentives for research teams to focus on issues



relevant to London. Crucially, there should be stronger mechanisms to support the spreading and scaling up of successful innovations across London, including through knowledge sharing between boroughs.

- To allow the GLA, boroughs and others to work together in a co-ordinated, complementary way to improve the health of Londoners, the new pan-London partnership structures for health and care will need to have a clear focus on the wider determinants of health, and will need a membership that reflects this.
- London should actively cultivate the kind of leadership and behaviours needed to suit the distributed governance system it is trying to build. Investing in leadership development and creating space for building relationships and trust across the system will be an important part of this.
- System partners in London should make a shared commitment to strengthening connections with other cities in the UK and beyond. There are substantial opportunities both for sharing learning and for working together on issues of common concern. Research funders can support this by funding comparative analyses examining health governance in other UK and international cities.
- We recognise that many of these recommendations come with resource implications. London needs to identify and commit the resources to take advantage of its strengths and the opportunities it has to be a world-leading city for health. To do this, further devolution of revenue-raising powers may be necessary.



5 Conclusion

The examples described in this report illustrate the important and distinctive role that cities can play in relation to population health improvement. City governments and their partners are well placed to co-ordinate cross-sectoral activities; create an environment that fosters innovation; mobilise communities to pursue citizen-led improvement; and to use regulatory levers and planning powers to create health-promoting environments. At their best, cities have the clout to bring about change at scale while managing to retain the local responsiveness and agility that national policy-making can sometimes lack.

As this report has shown, every city is different and the way that each chooses to fulfil this role will vary according to history, how powers are distributed, and the tools, levers and resources available. How these factors play out in each city will determine how it 'governs for health'. Accepting this variation of approach, we believe that in England (and more broadly) cities are likely to take a greater role in health in the future, for the reasons set out in previous sections. As they do so, it is important that they take the opportunity to learn from others' experience.

This is not to argue that cities are the right level for everything. National governments will continue to have an indispensable part to play in population health. For example, the economic success of major urban areas can itself risk creating inequalities with other regions, and national governments are needed to manage these risks and smooth any inequities that arise. Equally, there will also continue to be an important role for more local tiers of government within cities – indeed, much population health improvement work must be rooted in an understanding of local needs and context within neighbourhoods or localities sitting beneath the local authority level. Fundamentally, decision-making needs to happen at multiple levels – what matters is the distribution of powers and responsibilities across these levels, and the effectiveness of mechanisms for co-ordination between them.



What is needed now?

The examples described in this report provide high-level insights into the roles that cities can take in relation to population health improvement. However, much more evidence is needed to guide city leaders in taking action. Surprisingly, there has been relatively little comparative research examining the effectiveness of different approaches or systems. For example, evaluations of the WHO Healthy Cities initiative have tended to focus on surveying the uptake of recommended processes within member cities, with limited analysis of the impact seen in different contexts, or of how the specific governance arrangements in a given city have supported or hindered progress (Rydin *et al* 2012).

England's new metropolitan mayors are a significant experiment in new forms of governance for large city regions, and there is a need for more information and evidence to inform these changes. As these regions take on new powers through their devolution deals, ongoing learning and evaluation will be crucial and should include analysis of the impact on health and inequalities.

Although this report has focused on large cities and extended metropolitan regions, it should also be noted that there is valuable learning on population health improvement (and on urban governance more broadly) from smaller cities and towns. Despite the differences in context, London and other major global cities can gain useful insights from approaches taken in a wide variety of settings, from the 'Wigan Deal' in north-west England (see page 19) to the pioneering work on sustainable urban planning in Freiburg, Germany (see page 8). NHS England's Healthy New Towns programme offers a further source of ideas and learning, and shows how thinking about population health might be conducted in tandem with work on the built environment and community development (NHS England 2016). City leaders will need to draw on all of these varied forms of evidence to make the most of the opportunities for health improvement.

The thematic framework presented in sections 2 and 3 of this report can be used by city governments and their partners to self-assess the strengths and weaknesses in their system, and to identify opportunities for building capabilities in relation to population health. We have shown how this might apply to London, and the same framework could also be used by other cities as they think through how they can make the most of their powers and influence to improve health. We also



hope the insights in the report will help to inform the ongoing work of multi-city collaborations and networks focused on health in cities, particularly the European and UK healthy cities networks supported by the WHO.

National governments have a critical role in creating the conditions for cities to succeed. Policy-makers in England can support cities to improve population health by allowing further devolution of powers to cities and city regions, potentially including fiscal and regulatory powers, while ensuring that this does not lead to unjustifiable inequalities and divergence. Areas with existing devolution deals (London plus the seven metropolitan regions with newly elected mayors) should continue to explore how devolved powers can be used to drive improvements in population health.

This report offers a relatively brief survey of the broad expanse of issues associated with governing for health in complex urban environments. This is an area where too little is known, yet also one which is clearly set to become more significant over time. We therefore need a commitment to ongoing learning, through formal research and other means, on how governance for health in our cities and other places actually works in practice. If we can shed light on that question, the health of the nation stands to benefit considerably.



References

Alderwick H, Ham C, Buck D (2015). *Population health systems: going beyond integrated care*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/population-health-systems (accessed on 30 April 2018).

Barber B (2013). *If mayors ruled the world: dysfunctional nations, rising cities*. Newhaven and London: Yale University Press.

Baylis A, Buck D, Anderson J, Jabbal J, Ross S (2017). *The future of HIV services in England: shaping the response to complex needs*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/future-hiv-services-england (accessed on 30 April 2018).

Berube A, Trujillo J, Ran T, Parilla J (2015). *Global city GDP 2014*. Washington DC: The Brookings Institution. Available at: www.brookings.edu/research/global-metro-monitor/ (accessed on 30 April 2018).

Bliss L (2017). 'Can cities actually meet the Paris commitments on their own?'. CityLab website. Available at: www.citylab.com/equity/2017/06/can-us-cities-meet-the-paris-commitments-on-their-own/528996/ (accessed on 30 April 2018).

Buck D (2016). 'Should local business rates fund local public health? There's not a simple answer'. Blog. The King's Fund website. Available at: www.kingsfund.org.uk/blog/2016/11/should-local-business-rates-fund-local-public-health (accessed on 30 April 2018).

del Castillo A, Sarmiento O, Reis R, Brownson R (2011). 'Translating evidence to policy: urban interventions and physical activity promotion in Bogotá, Colombia and Curitiba, Brazil'. *Translational Behavioural Medicine*, vol 1, no 2, pp 350–60.

Centre for Cities (2017). *Business rates: maximising the growth incentive across the country*. Briefing. London: Centre for Cities. Available at: www.centreforcities.org/publication/business-rates-maximising-growth-incentive-across-country/ (accessed on 30 April 2018).

Centre for Cities (2016). 'Everything you need to know about metro mayors: an FAQ'. Centre for Cities website. Available at: www.centreforcities.org/publication/everything-need-know-metro-mayors (accessed on 30 April 2018).

Centre for London (2018). *Next-door neighbours – collaborative working across the London boundary*. London: Centre for London. Available at: www.centreforlondon.org/publication/collaboration-across-london-boundary/ (accessed on 30 April 2018).



Centre for London (2017). *Growing well: making London's new places fit for the future*. London: Centre for London. Available at: www.centreforlondon.org/publication/growing-well/ (accessed on 30 April 2018).

Cole HVS, Garcia Lamarca M, Connolly JJT, Anguelovski I (2017). 'Are green cities healthy and equitable? Unpacking the relationship between health, green space and gentrification'. *Journal of Epidemiology and Community Health*, doi:10.1136/jech-2017-2092. Available at: <http://jech.bmj.com/content/71/11/1118> (accessed on 30 April 2018).

Department for Communities and Local Government (2017). *Local authority revenue expenditure and financing: 2017–18 budget, England*. London: Ministry of Housing, Communities and Local Government. Available at: www.gov.uk/government/statistics/local-authority-revenue-expenditure-and-financing-england-2017-to-2018-budget (accessed on 30 April 2018).

Department for Communities and Local Government (2015). 'English indices of deprivation 2015'. GOV.UK website. Available at: www.gov.uk/government/statistics/english-indices-of-deprivation-2015 (accessed on 30 April 2018).

Douglass G, Sobrevilla-Quiton I (2017). *Examining GVA in London's local authorities in a London and UK context, 1997–2015*. Current Issues Note 55. London: GLA Economics. Available at: www.london.gov.uk/business-and-economy-publications/gva-londons-local-authorities (accessed on 22 May 2018).

Doyle Y, Mills A, Korkodilos M (2017). 'Addressing London's modern urban health challenges: learning from other global cities'. *Journal of Public Health*, vol 39, no 4, pp 685–90.

Fields in Trust (2018). 'Revaluing parks and green spaces: measuring their economic and wellbeing value to individuals'. Fields in Trust website. Available at: www.fieldsintrust.org/research (accessed on 22 May 2018).

Florida R (2017). 'The geography of innovation'. Citylab website. Available at: www.citylab.com/life/2017/08/the-geography-of-innovation/530349/ (accessed on 30 April 2018).

Font A, Fuller G (2016). 'Did policies to abate atmospheric emissions from traffic have a positive effect in London?' *Environmental Pollution*, vol 218, pp 463–74.

Fransham M, Dorling D (2018). 'Homelessness and public health'. *BMJ*, 360: k214. Available at: www.bmj.com/content/360/bmj.k214.long (accessed on 22 May 2018).

Freudenberg N, Atkinson S (2015). 'Getting food policy on the mayoral table: a comparison of two election cycles in New York and London'. *Public Health*, vol 129, no 4, pp 295–302.

Freudenberg N, Libman K, O'Keefe E (2010). 'A tale of two obesCities: the role of municipal governance in reducing childhood obesity in New York City and London'. *Journal of Urban Health*, vol 87, no 5, pp 755–70.



Gehl J (2010). *Cities for people*. Washington DC: Island Press.

Glouberman S, Gemar M, Campsie P, Miller G, Armstrong J, Newman C, Siotis A, Groff P (2006). 'A framework for improving health in cities: a discussion paper'. *Journal of Urban Health*, vol 83, pp 325–38.

Greater London Authority (2018). *The Greater London Authority consolidated budget and component budgets for 2018–19*. London: GLA. Available at: www.london.gov.uk/about-us/governance-and-spending/spending-money-wisely/mayors-budget (accessed on 11 May 2018).

Greater London Authority (2017). *Better health for all Londoners: consultation on the London health inequalities strategy*. London: GLA. Available at: www.london.gov.uk/what-we-do/health/have-your-say-better-health-all-londoners (accessed on 22 May 2018).

Greater Manchester Health and Social Care Partnership (2017a). *Making smoking history: a tobacco free Greater Manchester* [online]. GMHSCP website. Available at: www.gmhsc.org.uk/assets/Tobacco-Free-Greater-Manchester-Strategy.pdf (accessed on 30 April 2018).

Greater Manchester Health and Social Care Partnership (2017b). *The Greater Manchester population health plan 2017–2021* [online]. GMHSCP website. Available at: www.gmhsc.org.uk/news/publichealthplanforgreatermanchester/ (accessed on 30 April 2018).

Hall P (2014). *Good lives, better cities: how Europe discovered the lost art of urbanism*. Abingdon: Routledge.

Ham C, Alderwick H (2015). *Place-based systems of care: a way forward for the NHS in England*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/place-based-systems-care (accessed on 30 April 2018).

Ham C, Alderwick H, Edwards N, Gainsbury S (2017). *Sustainability and transformation plans in London: an independent analysis of the October 2016 STPs*. London: The King's Fund and Nuffield Trust. Available at: www.kingsfund.org.uk/publications/sustainability-and-transformation-plans-london (accessed on 30 April 2018).

Ham C, Edwards N, Brooke B (2013). *Leading health care in London: time for a radical response*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/leading-health-care-london (accessed on 30 April 2018).

Harkness A, Katz B, Conroy C, Tilchin R (2017). *Leading beyond limits: mayoral powers in the age of new localism*. Washington: The Brookings Institution.

Healthy London Partnership (2018). *London Health and Care Strategic Partnership Board operating framework*. London: Healthy London Partnership. Available at: www.healthylondon.org/our-work/london-health-care-strategic-partnership-board/ (accessed on 30 April 2018).



Hunstone K, Mesari A, Pinchera E (2018). *Healthy placemaking: why do built environment practitioners create places that contribute to preventable disease and early death, despite evidence on healthy placemaking?* London: Design Council and Social Change UK. Available at: www.designcouncil.org.uk/resources/report/healthy-placemaking-report (accessed on 22 May 2018).

Isett K, Laugesen M, Cloud D (2015). 'Learning from New York City: a case study of public health policy practice in the Bloomberg administration'. *Journal of Public Health Management Practice*, vol 21, no 4, pp 313–22.

Kania J, Kramer M (2011). 'Collective impact'. Stanford Social Innovation Review website. Available at: https://ssir.org/articles/entry/collective_impact (accessed on 30 April 2018).

Katz B, Noring L (2016). 'Why Copenhagen works'. The Brookings Institution website. Available at: www.brookings.edu/research/why-copenhagen-works/ (accessed on 30 April 2018).

Kelly P, Davies A, Greig A, Lee K (2016). 'Obesity prevention in a city state: lessons from New York City during the Bloomberg administration'. *Front Public Health*, vol 4, p 60.

King's Commission on London (2018). *London 2030 and beyond*. Report of the King's Commission on London. London: King's College London. Available at: www.kcl.ac.uk/sspp/policy-institute/Research-Analysis/Kings-Commission-on-London.aspx (accessed on 30 April 2018).

Kodukula S, Rudolph F, Jansen U, Amon E (2018). *Living, moving, breathing: ranking of European cities in sustainable transport*. Hamburg: Greenpeace Germany.

London Finance Commission (2017). *Devolution: a capital idea*. The report of the London Finance Commission. London: London Finance commission. Available at: www.london.gov.uk/what-we-do/business-and-economy/promoting-london/london-finance-commission (accessed on 10 May 2018).

London Partners (2017). *London health and social care devolution. Memorandum of understanding* [online]. london.gov.uk website. Available at: www.london.gov.uk/what-we-do/health/london-health-and-care-devolution/what-health-and-care-devolution-means-london (accessed on 22 May 2018).

Lydon M, Garcia A (2015). *Tactical urbanism: short-term action for long-term change*. Washington DC: Island Press.

McCay L, Suzuki E, Chang A (2017). 'Urban design and mental health in Tokyo: a city case study'. *Journal of Urban Design and Mental Health*, vol 3, no 4. Available at: www.urbandesignmentalhealth.com/journal-3---tokyo-case-study.html (accessed on 30 April 2018).



McGovern L, Miller G, Hughes-Cromwick P (2014). 'The relative contribution of multiple determinants to health outcomes'. *Health Affairs*. Available at: www.rwjf.org/en/library/research/2014/08/the-relative-contribution-of-multiple-determinants-to-health-out.html (accessed on 30 April 2018).

Miller H, Roantree B (2017). 'Tax revenues: where does the money come from and what are the next government's challenges?' Institute for Fiscal Studies website. Available at: www.ifs.org.uk/publications/9178 (accessed on 30 April 2018).

NHS England (2016). 'Healthy New Towns'. NHS England website. Available at: www.england.nhs.uk/ourwork/innovation/healthy-new-towns/ (accessed on 22 May 2018).

van der Noordt M, IJzelenberg H, Droomers M, Proper K (2014). 'Health effects of employment: a systematic review of prospective studies'. *Occupational and Environmental Medicine*, vol 71, no 10, pp 730–6.

OECD (2016). 'Revenue statistics – taxes by level of government'. OECD website. Available at: www.oecd.org/ctp/tax-policy/revenue-statistics-levels-of-government.htm (accessed on 30 April 2018).

Office for National Statistics (2016). 'How the population of England is projected to age'. Office for National Statistics website. Available at: www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/compendium/subnationalpopulationprojections/2014basedprojections/howthepopulationofenglandisprojectedtoage (accessed on 30 April 2018).

Office for National Statistics (2013). '2011 census: local characteristics on ethnicity, identity, language and religion for output areas in England and Wales'. ONS website. Available at: www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/2011censuslocalcharacteristicsonethnicityidentitylanguageandreligionforoutputareasinenglandandwales (accessed on 30 April 2018).

Ostrom E (1972). 'Metropolitan reform: propositions derived from two traditions'. *Social Science Quarterly*, vol 53, no 3, pp 474–93.

Parliamentary Office of Science and Technology (2016). *Green space and health*. POSTnote 538. parliament.uk website. Available at: <http://researchbriefings.parliament.uk/ResearchBriefing/Summary/POST-PN-0538> (accessed on 22 May 2018).

Population Reference Bureau (2017). '2017 world population data sheet with a focus on youth'. PRB website. Available at: www.prb.org/2017-world-population-data-sheet/ (accessed on 30 April 2018).



Public Health England (2017). *Spatial planning for health: an evidence resource for planning and designing healthier places* [online]. GOV.UK website. Available at: www.gov.uk/government/publications/spatial-planning-for-health-evidence-review (accessed on 22 May 2018).

Public Health England (2015). *Health inequalities in London* [online]. GOV.UK website. Available at: www.gov.uk/government/publications/health-inequalities-in-london (accessed on 30 April 2018).

Rydin Y, Bleahu A, Davies M, Dávila J, Friel S, De Grandis G, Groce N, Hallal P, Hamilton I, Howden-Chapman P, Lai K, Lim C, Martins J, Osrin D, Ridley I, Scott I, Taylor M, Wilkinson P, Wilson J (2012). 'Shaping cities for health: complexity and the planning of urban environments in the 21st century'. *Lancet*, vol 379, no 9831, pp 2079–108.

Sallis J, Cerin E, Conway T, Adams M, Frank L, Pratt M, Salvo D, Schipperijn J, Smith G, Cain K, Davey R, Kerr J, Lai P, Mitáš J, Reis R, Sarmiento O, Schofield G, Troelsen J, Van Dyck D, De Bourdeaudhuij I, Owen N (2016). 'Physical activity in relation to urban environments in 14 cities worldwide: a cross-sectional study'. *Lancet*, vol 387, no 10034, pp 2207-17.

Simon J, Bass T, Boelman V, Mulgan G (2017). *Digital democracy: the tools transforming political engagement*. London: Nesta. Available at: www.nesta.org.uk/publications/digital-democracy-tools-transforming-political-engagement (accessed on 30 April 2018).

Slack E, Bird R (2013). *Merging municipalities: is bigger better?* Toronto: Institute on Municipal Finance and Governance, University of Toronto.

Slack E, Côté A (2014). *Comparative urban governance: future of cities* [online]. Working paper. GOV.UK website. Available at: www.gov.uk/government/publications/future-cities-comparative-urban-governance (accessed on 30 April 2018).

Theis D (2017). *Off the scales: tackling England's childhood obesity crisis*. London: Centre for Social Justice. Available at: www.centreforsocialjustice.org.uk/library/off-scales-tackling-englands-childhood-obesity-crisis (accessed on 30 April 2018).

The King's Fund (2017). *The King's Fund's response to the Mayor of London's draft health inequalities strategy*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/mayor-londons-draft-health-inequalities-strategy (accessed on 30 April 2018).

The King's Fund (2013). 'Broader determinants of health: future trends'. The King's Fund website. Available at: www.kingsfund.org.uk/projects/time-think-differently/trends-broader-determinants-health (accessed on 30 April 2018).

Town and Country Planning Association (2015). *Public health in planning: good practice guide for London boroughs*. Policy review of borough local plans and joint health and wellbeing strategies. London: TCPA.



Travers T (2011). 'The localism plans of Compassionate Conservatives, Red Tories and Blue Labour will struggle to succeed so long as Whitehall powers remain in the hands of ministers'. London School of Economics website. Available at: <http://eprints.lse.ac.uk/36730/> (accessed on 30 April 2018).

Travers T (2003). *The politics of London: governing an ungovernable city*. Basingstoke: Palgrave Macmillan.

Urhahn (2017). *The active city*. Amsterdam: City of Amsterdam.

Walker N (2018). "Oi EU – give Birmingham a good deal!" City leader flies to Brussels to demand best Brexit deal for Brum'. Birmingham Live website. Available at: www.birminghammail.co.uk/news/midlands-news/oi-eu-give-birmingham-good-14296292 (accessed on 30 April 2018).

Watts N, Amann M, Ayeb-Karlsson S, Belesova K, Bouley T, Boykoff M, Byass P, Cai W, Campbell-Lendrum D, Chambers J, Cox P, Daly M, Dasandi N, Davies M, Depledge M, Depoux A, Dominguez-Salas P, Drummond P, Ekins P, Flahault A, Frumkin H, Georgeson L, Ghanei M, Grace D, Graham H, Grojsman R, Haines A, Hamilton I, Hartinger S, Johnson A, Kelman I, Kiesewetter G, Kniveton D, Liang L, Lott M, Lowe R, Mace G, Odhiambo Sewe M, Maslin M, Mikhaylov S, Milner J, Latifi A, Moradi-Lakeh M, Morrissey K, Murray K, Neville T, Nilsson M, Oreszczyn T, Owfi F, Pencheon D, Pye S, Rabbaniha M, Robinson E, Rocklöv J, Schütte S, Shumake-Guillemot J, Steinbach R, Tabatabaei M, Wheeler N, Wilkinson P, Gong P, Montgomery H, Costello A (2018). 'The Lancet Countdown on health and climate change: from 25 years of inaction to a global transformation for public health'. *Lancet*, vol 391, no 10120, pp 581–630.



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Cities are playing a growing role in population health improvement and have enormous potential to be health-generating places. However, they also face considerable challenges and need to be governed in a way that gives all citizens the opportunity to enjoy good health. So how can cities and their leaders maximise opportunities to improve population health?

Drawing on international case studies, *The role of cities in improving population health* explores how city governments and their partners can work together to improve the health of the population, and the conditions needed for success. It is based on 50 interviews with leaders from 14 cities and includes an extended case study on London that examines the lessons the city might learn from elsewhere.

The authors conclude that improving population health depends on a number of factors, including:

- co-ordinated action at multiple levels
- bold political leadership
- empowered citizens
- effective use of planning powers, regulatory measures and other tools to create healthy places.

In England, the seven new combined authorities and 'metropolitan mayors' cover one-fifth of the population, creating significant opportunities for a large-scale approach to population health. The report recommends that policy-makers explore the case for giving cities more fiscal and regulatory freedoms to allow them to tackle population health challenges more effectively.

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