

Better urban planning essential to improve health of 60% of global population that will be living in cities by 2030

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The proportion of the world's population that lives in cities has been steadily rising, so that three in five of all people globally will live in a city by 2030. The University College London/*Lancet* Commission on Healthy Cities explores the many issues other than health services that contribute to population health in a city environment.

The Commission has been prepared by lead author Professor Yvonne Rydin, UCL Bartlett School of Planning, and colleagues at UCL and worldwide. The authors address issues that apply globally and use specific examples from cities as diverse as London, Bogota, Accra, and Toronto to illustrate the issues.

Just as London's first modern, large-scale, urban sewage treatment system resulted in a 15-year increase in [life expectancy](#) between the 1880s and the 1920s, so other large-scale planning initiatives can radically change the health outcomes of city-dwellers – especially for the poorest. In this report the authors recommend focussing on the delivery of a variety of urban projects that have a positive impact on health.

Examples from the report include community-led sanitation infrastructure programmes in the slums of Mumbai, India; action for urban greening to protect against heat stress in London summers; and transportation initiatives that encourage physical activity in Bogota, Colombia.

Professor Rydin says: "While cities have the potential to be healthier places for their citizens, this requires active planning. Economic growth cannot be assumed to lift all urban citizens into a zone of better health. Even in scenarios where health in a city has improved, without active maintenance of investments, gains made can be reversed, leading to increased rates of death and disease."

Today, around 3.4 billion live in urban areas, projected to rise to 6.3 billion by 2050. This growth will likely lead to more megacities (population 10 million+) concentrated in Asia, and more medium-sized cities in all locations, especially Africa. Among the projected world population of 9 billion in 2030, some 2 billion could be living in slum-like conditions in cities worldwide.

There is a perception that living in a city gives a person an 'urban advantage' over their rural neighbours. Today, in high-income countries, health outcomes are generally better in city than rural populations. But people living in poor areas in wealthy cities can often have much worse health indicators than both their wealthier city neighbours and some within the rural populations.

Professor Rydin says: "In many urban areas, rich people and poor people live in different epidemiological worlds, and the burden of ill-health is highest in the poorest groups. The double burden of communicable and non-communicable diseases is borne predominantly by poor people."

The Commission authors looked at cities as complex, interactive entities in which changes in one part of the system can have impacts on others. They use five case studies to illustrate important themes for healthy cities.

Each case study supports the argument for a new way of planning for urban health. Planners need to recognise that conditions of complexity

make it difficult to capture all the necessary information about the links affecting urban health in one plan or strategy. Unintended consequences of policy action are likely to persist. Instead planners should be working with all urban health stakeholders, including local communities, particularly vulnerable communities.

Professor Rydin says: "There should be an emphasis on experimenting with and learning from diverse urban health projects. This can mean supporting communities in their own urban health projects, as with community latrines in Mumbai slums or urban food projects in London and Detroit."

The Commission concludes with five recommendations:

1. City governments should build political alliances for urban health.
2. Governments need to identify the health inequalities in cities.
3. Urban planners should include health concerns in their plans, regulations, and decisions.
4. Policy makers need to recognise that cities are complex systems and urban [health outcomes](#) have multiple causes.
5. Experimentation and learning through projects involving local communities is often the best way forward.

Case studies

1. Sanitation and Wastewater management

In Mumbai, India, the Slum Sanitation Programme (SSP) was the largest programme of its kind in India. It sought to provide access to adequate sanitation (one toilet per 50 people), by 2025, to one million people who were living in slums on municipal land in 1995. Backed by World Bank

and State Government funding, the scheme builds on the idea that a sense of ownership encourages communities to maintain the toilet blocks more effectively than would the state. Fees for use cover maintenance, water, and electricity costs. Some toilet blocks have become community centres, providing space for teaching and meeting. Fees have allowed high standards of care to be maintained, but evidence exists that in some of the poorer settlements, only the relatively wealthier families are able to pay the fees, with the remaining population still having to resort to open defecation.

2. Building standards, thermal comfort, and indoor air quality

Buildings account for about 38% of total global primary energy use and 25% of energy-related CO₂ emissions; of which buildings in cities account for two-thirds. The key elements relating to health here are (1) indoor temperature and protection against cold and heat and (2) indoor air quality, which is governed by air exchange, outdoor pollutant levels, and production of indoor pollutants.

In London there are 3.2 million dwellings, almost all of which will need some modification to meet decarbonisation targets. The UK Government has a national CO₂ commitment of a 34% reduction by 2020 and 80% reduction by 2050 from 1990 levels. London has set itself an even more challenging target by requiring that existing emissions are reduced by 60% by 2025 from the 1990 level. A large proportion of these emission reductions are proposed to come from London's buildings. Care needs to be taken that retrofitting energy efficiency measures does not create other health problems, such as mould.

3. Transportation, mobility, and physical activity

In Bogota, Colombia, Transmilenio, a mass-transit system that uses Bus Rapid Transit technology was introduced in 2000, with dedicated lanes

and fixed bus stations. Covering 25% of daily public transport trips in 2010, this system has not only reduced car use and average commuting times of its users, but has also prompted users to walk longer distances to stations than the system previously used whereby buses stopped wherever users asked them to do so. The physical improvements in pavements and public spaces introduced as part of the construction of the system have also encouraged greater use of these places by pedestrians. Implementation of the system has also been associated with improvements in air quality by helping to reduce congestion, thus increasing average speeds, as well as by transporting more passengers in shorter times.

4. The urban heat island effect

In August, 2003, a heatwave in the UK was associated with at least 600 excess deaths in London alone. This was part of a much larger European phenomenon; the urban heat island effect seems likely to have contributed to this burden in many major cities. However, London also has a substantial burden of cold-related morbidity and mortality, and the urban heat island effect might in part help to reduce it during the winter. This requires careful consideration of appropriate planning measures.

In London's climate-change adaptation strategy, specific reference to heat islands as a cause for concern is made, especially their ability to exacerbate heatwaves and their associated health effects. The strategy identifies a series of measures to manage the urban heat island effect, including a possible Urban Heat Island Action Area, where green space and vegetation will be increased and major new developments would need to meet specific requirements to reduce their effect on the urban heat island.

5. Urban food production

Urban agriculture is often sidelined in urban planning policies, especially in high-income countries, despite the fact that access to healthy food in poor neighbourhoods is an important concern. Active horticulture can also reduce obesity, diabetes, and heart disease in populations.

In Accra, Ghana in 1972, Ghana's food movement, called the Feed Yourself Operation (FYO), initiated city dwellers to farm in enclosed gardens around their homes and on the edges of cities. In Accra, poor people in urban areas and rural migrants to urban areas often engage in open-space food cultivation without official access on undeveloped community land belonging to central and municipal governments, including railways, parks, and university campuses. The benefits of urban agriculture extend beyond the planting of greenery and management of public spaces; it also reduces refuse dumping and illegal drug-related activities.

More information: Paper online:

[www.thelancet.com/journals/lancet/article/PIIS0140-6736\(12\)60435-8/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)60435-8/abstract)

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