Working with local governments to support health through the built environment: A scoping review

Executive Summary

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The way communities are planned and built, and the services and resources provided within them, directly influence people's physical, mental, and social health. A commitment to health equity means planning communities to support the health of all community members including low income families, children, older adults, newcomers, Indigenous groups, and people living with physical or mental health challenges.

This report examines peer-reviewed empirical research on health equity and the built environment published since 2010. The aim of the report is to identify opportunities for public health staff and local governments to apply a health equity lens in support of healthy communities. The scope of the review corresponds with the five physical features of the built environment as outlined in the BC *Healthy Built Environment Linkages Toolkit*.

The evidence demonstrates that neighbourhood deprivation is a significant predictor of fair/poor health in all geographic regions in Canada, and is significantly associated with increased chronic health conditions, depression, anxiety and body mass index, as well as decreased general health and physical activity. In particular, there is growing consensus that differences in health outcomes may be influenced by variations in neighbourhood density, availability of public spaces and facilities, and the integration of different functions within the same neighbourhood (i.e., complete communities).

Emerging evidence in Canada shows residents of deprived neighbourhoods are often anchored in a setting of social disadvantage with little neighbourhood change over time. Research also documents a social gradient of health related to air pollution exposure, heat-related illness, and green space access. Socio-economic status, especially low income, is strongly and significantly associated with household crowding, increased exposure to environmental risks at home and poor residential quality. Low income children are particularly vulnerable and are more likely to suffer from multiple and cumulative exposures to biological and chemical hazards, insufficient sanitation and derelict public spaces. They are also more likely to be exposed to unsafe environments, including traffic, because they are typically more dependent on active transportation.

The evidence shows that the built environment can positively contribute to health, independent of a person's socioeconomic position. Neighbourhoods with greater resources, informal social control and cohesion are significantly associated with less depression, anxiety, lower body mass index and better general health. Integrated action to provide community-based resources is essential to advancing health equity. For example, evidence shows that affordable housing may have the greatest influence on food security for low income families. Other key factors include access to affordable healthy food, affordable child-care, safe and connected transportation routes, nearby and linked green-spaces, safe and welcoming community spaces, and adequate sanitation services.

More inclusive community-based research is needed to further identify the specific needs of priority groups. While the scientific evidence examined in this review identifies key priority areas for improving health equity in the built environment, it says less about what should be done. There is a need for inter-sectoral approaches to knowledge translation to link scientific evidence with relevant policy and planning contexts used by local governments, as well as a need for natural experiments and evaluations of interventions to support healthy communities for all.

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