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Land-Use Planning and Urban Governance: Lessons from the Pandemic

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**LAND-USE PLANNING AND URBAN GOVERNANCE—
LESSONS FROM THE PANDEMIC**

Malcolm Grant*

ABSTRACT

It is a privilege to have been invited to contribute to this festschrift for a scholar whose work I have known and admired for decades. We have explored and debated together many aspects of land-use planning in our respective jurisdictions over that time, including a protracted effort in the 1990s to develop a model for impact fees for the UK planning system. Several other contributors to this festschrift were also part of that team, from which all of us learned a great deal. One is that complex systems of government develop deep resistance to change, and that it often takes a radical external threat to compel us all to step back and think again about not just the processes by which decisions are taken—fascinating though they are for planning lawyers such as myself—but the outcomes for people. The Second World War, with its huge threat to the lives of the civilian population, was followed by an era of transformational political and societal change in the United Kingdom. Is it too much to hope that the coronavirus pandemic, which has so far claimed many more civilian lives, might be the starting point for the changes needed for the twenty-first century? The tools of the last century, in healthcare and land-use planning, have been found wanting in the face of the global pandemic.

INTRODUCTION

The global coronavirus pandemic has shaken the world order. It has caused over 2.5 million deaths, damaged severely the physical and mental health of millions more, and wreaked serious economic damage. Millions are grieving for lost ones; millions more face unemployment and exacerbated social inequality. As the incidence of the disease begins to diminish, so the post-mortem must begin. Why is it that the league tables of death should have been led by two of the wealthiest and most scientifically advanced nations in the world, the UK and the USA? What does the impact of the pandemic tell us about the health of our respective populations? What does it tell us about the failures of our respective systems of healthcare, of land-use planning, and of urban governance? And what is the route to recovery?

It has been a catalyst for significant change already in these two countries, especially in working patterns, including the widespread shift to working from home and the freeze of international business travel. There will

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undoubtedly be long lasting implications for property markets and for the development industries, dependent upon how far the basic habits and assumptions of the nature of office work have been upended rather than temporarily stalled. A shift in demand for property occupation will in turn impact planning processes. But all of this remains some way down the line. Is the pandemic itself a one-off or, as is reasonably suspected, a harbinger of a different world ahead, haunted by new varieties and variants of infectious disease?

Yet the focus of this paper is different. The pandemic has thrown into stark relief the underlying state of the health of our respective populations and found it wanting, despite record levels of investment in our healthcare systems. Population health has much more to do with genetics and with how people live, and the environment around them. So it is legitimate to ask to what extent our respective land-use planning systems are culpable in consistently failing to deliver human settlement patterns that positively promote health and well-being, protect citizens from harm from polluting emissions, and offer our children the best chances in life.

THE IMPACT OF THE PANDEMIC

First, some data points. By March 2021, there were 114 million confirmed cases globally, of which 28.5 million were in the USA and 4.2 million in the UK. Global deaths exceeded 2.5 million, of which 512,346 were in the USA and 123,830 in the UK.¹ Only the US, India, Brazil and Russia had by then experienced higher numbers of deaths, but in terms of deaths per million population, the UK (1,823) shared the top 4 out of 156 places with Belgium (1,916), Czechia (1,859), and Slovenia (1,824); the USA was two places behind (1,576). The ultimate total in the UK is on target to exceed double the nation's total civilian death toll of 70,000² over the six years of the Second World War.

By comparison, the reported figures at the other end of the global spectrum were for New Zealand (5.3), Singapore (5.08), and China (3.46).³ These are extremes, each with particular characteristics, notably the political strength to shut down decisively on human physical interaction, using the force of law, including closing national borders and allowing virtually no exceptions. Yet there was a less extreme but more puzzling difference in deaths per million

¹ Source: Johns Hopkins Coronavirus Resource Centre: <https://coronavirus.jhu.edu>

² Total armed forces deaths were in the region of 384,000.

³ Source: <https://www.statista.com/statistics/1104709/coronavirus-deaths-worldwide-per-million-inhabitants/>; based on numbers collected by Johns Hopkins but expressing certain reservations: “. . . it very much relies on data that has become more difficult to compare. As the coronavirus pandemic developed across the world, countries already used different methods to count fatalities, and they sometimes changed them during the course of the pandemic.”

even with some countries that might be thought to be more closely comparable in terms of demography and geography to the US and the UK respectively, such as Canada (582) and Germany (834).

NATIONAL RESPONSES

There are several possible explanations. Poor political leadership at the national level was apparent in both countries, at times actually in denial, and politically vulnerable to libertarian lobbying. Those nations with recent experience of pandemic conditions, including China itself but also Taiwan, Singapore, Hong Kong, and Korea acted swiftly and decisively. Not only were they able to lockdown their respective populations – and expect their decrees to be obeyed – but they ran highly effective public health systems for testing, tracking and tracing, to ensure that people who had contracted the infection, plus those with whom they had come into contact, would be kept under strictest isolation.

They also shut their borders almost completely. New Zealand was the global standout case here. Borders were closed and live cases were tracked and isolated, so that for much of 2020 there were no cases at all. Even at their peak point, there were more cases in the White House than in the whole of New Zealand (population 5 million).

National statistics however conceal significant regional and local variations. This should be little surprise in the US, where state governors adopted widely varying responses, reflecting also the nation's political partisan divides in the year of a presidential election. But it was true also in the UK, though at first glance, less obviously why.

THE DIFFERENTIAL IMPACT

The answer is to be found at least in part in the differential impact of the pandemic on different parts of the population. Care homes for the elderly experienced raised levels of infection in both countries, and the same effect was seen right across Europe. Inadequate protection for both residents and staff had been built insufficiently early, and once the virus entered that environment, it tended to spread rapidly and inflict heavy casualties amongst a vulnerable population.

The virus was cruel to elderly people and was merciless to those with pre-existing respiratory disease and/or compromised immune systems. But it also had a much wider impact. Younger people were by no means exempt from its effects. Moreover, mortality figures are only part of the story. Some who contracted the disease experienced few if any symptoms; others suffered seriously, especially in the first wave in 2020, and the adverse effects for many of them seem likely to be long lasting.

THE IMPACTS IN CONTEXT

I will return to these issues. But first, some further context. We need to place deaths from the pandemic in the context of the annual death rates of the US and the UK. At one time, infectious diseases were a major cause of death across the world, but with the development and deployment of antibiotics since the mid-twentieth century, they have been superseded by non-communicable diseases (NCDs). The major causes of death in both countries are cardiovascular disease (665,000 US deaths annually⁴; UK 170,000; globally 17.9 million) and cancer (US 607,000⁵; UK 165,000; globally 9 million), followed by respiratory diseases and diabetes.

Many of those who fell victim to coronavirus may have died over the same period in any event from these or other conditions, and we might expect as the data become available that they will indicate some reduction in recorded deaths from NCDs over and beyond the period of the pandemic. But that does nothing to change the conclusion that the pandemic has brought about an extraordinary level of premature death amongst our populations. Moreover, we can expect that the pandemic will have exacerbated pre-existing conditions amongst the population by blocking or delaying access to diagnosis and treatment while the healthcare systems were overrun coping with coronavirus victims. In the UK, at its peak in 2020-21, over 45% of all acute hospital beds were occupied by coronavirus patients, and clinical staff from all specialities were transferred to the frontline for their care. Access to diagnosis and treatment for others was seriously compromised through this time, and there is now a significant backlog waiting to be addressed.

At this point it is necessary to widen our focus to inquire about the extent and nature of the burden of disease in our respective countries. To what extent should death on this scale have actually been avoidable in two of the wealthiest nations on earth? There are two issues here. First, the overall state of population health and the capability of our respective health care systems to improve it. Second, the differential effect of the virus on particular groups of the population, notably by ethnicity and culture, poverty, and employment.

THE STARTING POINT: POPULATION HEALTH

The past five decades have seen a significant increase in life expectancy in the world's wealthier countries. By 2017, life expectancy at birth in the UK rose to 79.5 for men and 83.1 for women; in the US the rate of change has been

⁴ <https://www.cdc.gov/heartdisease/facts.htm>

⁵ <https://www.cancer.org/research/cancer-facts-statistics/all-cancer-facts-figures/cancer-facts-figures-2019.html>

more gradual to 76.1 for men and 81.1 for women by the same year.⁶ The rate of growth in the UK levelled off then started to fall around 2010, as it did from 2013 in the UK,⁷ and now ranks as the lowest life expectancy at birth among all large and wealthy countries. Within the US population, Black people have a shorter life expectancy than White and Hispanic people, but the gap has been closing over the past decade.

However, recent projections suggest that Covid-19 will have reduced US life expectancy in 2020 by 1.13 years, and that the estimated reductions for the Black and Latino populations will be 3 to 4 times that of Whites. That would be sufficient to reverse the last decade of progress in reducing the gap.⁸

THE INFLUENCE OF HEALTHCARE SYSTEMS

One of the puzzling aspects of these figures is the lack of correlation between life expectancy and national expenditure on healthcare. In the US, for example, healthcare spending grew 4.6% in 2019, reaching \$3.8 trillion or \$11,582 per person. As a share of the nation's GDP, it accounted for 17.7%.⁹ The comparable figures for the UK (2018 figures) are £214 billion, equating to £3,227 (US\$4,485) per person, and 10% of GDP.¹⁰ Although the total cost is far below that of the US, the UK National Health Service (NHS) is a tax-funded government commitment to providing universal health care, free to all at the point of clinical need, meaning that UK healthcare is 78% funded by the state; that figure, in turn represents over 25% of public spending.

Yet it is evident, and highlighted by the impact of Covid-19, that these vast expenditures have failed to promote and protect the health across their respective populations. Nor have the improvements in life expectancy been matched by an improvement in *healthy* life expectancy. In particular, there are

⁶ Health System Tracker (2019): https://www.healthsystemtracker.org/chart-collection/u-s-life-expectancy-compare-countries/#item-le_life-expectancy-at-birth-in-years-1980-2017_dec-2019-update

⁷ UK Office for National Statistics, National Life Tables – life expectancy in the UK : 2017-2019 (<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/bulletins/nationallifetablesunitedkingdom/2017to2019>).

⁸ Andrasfay T, Goldman, N “Reductions in 2020 US life expectancy due to Covid-19 and the disproportionate impact on the Black and Latino populations » Proceedings of the National Academy of Sciences of the USA 2021 (<https://www.pnas.org/content/118/5/e2014746118>).

⁹ CMS Gov : Center for Medicare and Medicaid Services reporting National Health Expenditure Accounts (<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical>) .

¹⁰ Office of National Statistics, Healthcare expenditure (<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/ukhealthaccounts/2018>)

significantly raised levels of ill-health in our older populations, and significant differences between different ethnic groups and different geographies.

Although estimates vary, it is probably true to say that the contributions of our formal systems of healthcare contribute no more than 15% towards maintaining and improving the actual health of the population. The reasons are obvious. They are too focused on a model of fix and repair once ill-health has manifested itself rather than on prevention and early detection and treatment. The bulk of healthcare funding therefore goes to supporting interventional activity. It provides perverse incentives to over-investigation and over-intervention when damage has already occurred. Our hospitals are cathedrals of modern medical science. But instead of being the providers of last resort, they have become too often the first responders. The emergency room is where diagnosis too often takes place for the first time, and too late for cure.

In responding to these realities, our respective healthcare systems have failed to adapt to the late 20th century, let alone the 21st. They, and our governments, have largely neglected the true causes of ill health. This should come as no surprise in an individualistic-focused societal culture, where the liberty of the subject takes priority over the welfare of the community, in a battle played out so dramatically over the past 18 months. Despite international evidence that draconian restrictions on human interaction were going to be essential to contain the spread of infection and to save lives, governments held back while the death toll rose steadily and became almost normalised into our daily lives. A false dichotomy opened up between science and personal liberty, to the extent that some quarters of a fundamental belief system began emerging from which science was totally excluded.

PARTICULAR RISK FACTORS

More light is cast when we look more closely at the crude mortality data through the lens of ethnicity and geography. There are various correlations: for example, between disease incidence and density of population settlement; with poverty (both countries have amongst the highest levels of income inequality of 57 nation states assessed by the OECD¹¹) and with household overcrowding. It is unsurprising that workers with manual employment, who could not work from home, will have been significantly more exposed to the virus; and that transmission rates will have been higher in multi-occupied households, commonly multi-generational, whether as a consequence of poverty, or of cultural preference or custom, or both. In parallel, it is well understood that the virus has had the most deleterious effect on those with pre-existing health conditions, a context where there is also a high level of association with poverty and poor housing.

¹¹ OECD, Income inequality (<https://data.oecd.org/inequality/income-inequality.htm#indicator-chart>).

Early evidence demonstrated that people of ethnic minority background in the UK and the USA were disproportionately affected by Covid-19, compared to white populations. An observational study of 29 million adults in England found that in the first wave all ethnic minority groups were at elevated risk of death; and that in the second wave the risk was substantially higher for people from Bangladeshi background and even worse for those of Pakistani background.¹² Another recent study suggests that, in the UK, patients who were hospitalised in wave 2 of the pandemic were younger, more ethnically diverse, and had fewer co-morbidities and milder disease presentation on admission. After matching for these factors against first wave patients, mortality was found to have been reduced, but without differences in intensive care admissions.¹³ The reasons for these observed differences are not yet clear, but a significant conclusion from the researchers was that focus on treating underlying conditions may not be enough and needs to be underpinned by focused public health policy, community mobilisation and participatory public health campaigns in order to reduce the existing and widening health inequalities in Covid-19 mortality.

OBESITY

Another common feature between the US and the UK is the rising incidence of obesity. A 2016 study by the McKinsey Global Institute¹⁴ (MGI), concluded that more than 2.1 billion people—close to 30 percent of the global population—today are overweight or obese. That figure greatly exceeds the number of people—adults and children—who are undernourished. If the growth rate in the prevalence of obesity continues on its current trajectory, almost half of the world’s adult population is projected to be overweight or obese by 2030. As MGI comment:

“This has huge personal, social, and economic costs. Obesity is responsible for around 5 percent of all global deaths. The global economic impact from obesity is roughly \$2.0 trillion, or 2.8 percent of global GDP, roughly equivalent to the global impact from smoking or armed violence, war, and terrorism.

“The toll of obesity on health-care systems alone is between 2 and 7 percent of all health-care spending in developed economies. That does not include the large cost of treating associated diseases, which takes the health-care cost toll up to 20 percent by some estimates.”

Nonetheless, the UK ranks amongst the worst in Europe, and in 2016/17 some 617,000 admissions to NHS hospitals recorded obesity as a primary or

¹² Ethnic differences in Covid-19 mortality during the first two waves of the pandemic: <https://www.medrxiv.org/content/10.1101/2021.02.03.21251004v1>

¹³ <https://www.medrxiv.org/content/10.1101/2021.02.07.21251297v1.full>

¹⁴ MGI, *Overcoming Obesity: an initial economic analysis* 2014

secondary diagnosis.¹⁵ Childhood obesity is today a national scandal and a health time bomb, with a marked socio-economic correlation.

Obesity and poor diet are linked with type 2 diabetes, high blood pressure, high cholesterol and increased risk of respiratory, musculoskeletal, and liver diseases. Obese people are also at increased risk of certain cancers, including being three times more likely to develop colon cancer. Likewise cardiovascular diseases: medical advances mean that people are more likely to survive a heart attack today, yet heart disease is paradoxically still the biggest killer worldwide. It has been accurately observed that “we do everything in our modern lifestyle to hurt the heart.”¹⁶

Notably, obesity emerged as a significant risk factor in mortality and morbidity from Covid-19, at two levels. First, the raised susceptibility to infection and hospitalisation amongst obese populations. In the UK an estimated 36% of Covid hospitalisations have been attributed to lack of physical activity and excess body weight, leading also to admission to intensive or critical care, and to mechanical ventilation, and death. Notably, these risks have been found after adjusting for age, ethnicity, income, and other demographic and socio-economic factors.¹⁷ Second, the startling finding of the World Obesity Federation in 2021 that Covid-19 deaths have been 10 times higher in countries where more than half the adult population is classified as overweight. Of the 2.5 million deaths, 2.2 million were in countries where over half the population had a BMI over 25. At the other end of the spectrum were countries like Vietnam, with the lowest death rate in the world and the second lowest levels of population overweight. Japan and South Korea had similar correlations, and have prioritised public health measures - including population weight - which has paid off in the pandemic.¹⁸

This is a particularly telling finding for the US and the UK. In both countries, we have fostered the development of what has been labelled an obesogenic environment. We are shaped by our environments. Lifestyles in these modern economies, whether through choice or necessity, are fostering ill-health. And the greatest scandal is with childhood obesity, where we are creating a health time bomb for the future. Some 10% of English children entering school at the age of 5 are currently overweight or obese; by the age of

¹⁵ NHS Long term plan, 2019, 2.13; <https://www.longtermplan.nhs.uk/online-version/chapter-2-more-nhs-action-on-prevention-and-health-inequalities/obesity/>

¹⁶ Oakes, Kelly, Haider Warraich: ‘We do everything in our modern lifestyle to hurt the heart’ , *The Guardian* 4 August 2019, <https://www.theguardian.com/society/2019/aug/03/haider-warraich-interview-cardiology-state-of-the-heart-health-medicine>

¹⁷ WOF, Covid-19 and Obesity: the 2021 Atlas <https://www.worldobesityday.org/assets/downloads/COVID-19-and-Obesity-The-2021-Atlas.pdf>

¹⁸ Wise, J Covid-19: highest death rates seen in countries with most overweight populations *British Medical Journal* 2021; 372: n 623 (<https://www.bmj.com/content/372/bmj.n623>)

11 the proportion has risen to 20%. Allowed to drift forward, we are potentially dooming a whole generation to a lifetime of ill-health.

THE COVID LESSONS

The impact of the pandemic demonstrates that, in two of the wealthiest countries in the world, a political unwillingness and inability to proscribe social interaction sufficiently in the face of a lethal infection, combined with having a surprisingly unhealthy population living in unhealthy conditions has led to an extraordinary eruption of premature death. To what extent were these phenomena avoidable and therefore what steps could be taken now to mitigate the impact of a future—and likely—pandemic; bearing in mind also the potential impact of global climate change, which has been forecast by Bill Gates¹⁹ and others to be likely to be even more devastating for the global population than this and future pandemics.

Hence it is curious that in neither the UK nor the US is there a developed relationship between healthcare and urban planning. That was not true historically in the UK, when a comprehensive planning system was introduced at exactly the same time as the launch of the National Health Service (NHS), in July 1948, and the pioneering Minister of Health, Nye Bevin, was also Minister of Housing. It was reflected in the mega-urban projects of the new towns of the 1950s-1970s and the slum clearances they permitted. But the two have since evolved far too much into separate siloes, with land-use planning more explicitly concerned with matters of green belt protection, land allocation, urban design, and aesthetics.

Even though there is in the UK, unlike in the USA, a national healthcare service, there are obvious reasons for this divide. The two systems operate within different cultures, with different objectives, within different regulatory structures and with different lines of funding and of political accountability. The NHS is strongly centralised, though devolved operationally out to general practitioners (primary care) and local hospital providers; land-use planning is primarily a matter for local governments, albeit within a national framework. There are too few points of intersection, and a siloed model of funding.

An obvious example of the dysfunction that results is the case of adult social care. This is a function of local governments, yet the ageing population it serves has the highest incidence of chronic disease, and constant dependency on agencies of the NHS. It has become something of a one-way street. As many as 6% of beds in acute hospitals have come to be occupied by elderly patients with no clinical need to be kept in hospital care, but for whom there is no available alternative care facility to be discharged into.

¹⁹ Gates, Bill, *How to avoid a climate disaster* (2021)

COVID AND THE FUTURE OF LAND-USE PLANNING

So how can we start to bridge this divide between land-use and health?

Land-use planning as a regulatory function has no social purpose other than to advance public welfare. It can clearly contribute to alleviating some of the causes of ill-health identified above. It can, for example, prevent an accumulation of fast-food outlets in close proximity to schools; ensure safe walking and cycling zones for both children and adults and provide ample green parks and public spaces in towns and cities. And it can have a significant long-term impact by promoting new settlements that better promote healthy lifestyles, breakdown social inequalities and maintain the incorporation of older generations within family and community life.

A model for this approach was promoted by the NHS in England in 2018 in a unique intervention into the planning system in partnership with local authorities, NGOs, professional bodies and developers, selected through a national competitive process. The healthy new towns project became engaged in the provision of over 100,000 new homes in England, through 10 demonstrator sites, in order to bring innovative health-focused thinking into new urban developments throughout England.²⁰ Developers were challenged on their willingness and ability to think differently and innovatively, pursuing the promotion of healthy living as the key point of their objectives. Local governments were challenged to envisage new partnerships with the same objective, and to use their regulatory powers to achieve them by withholding planning permission for poor quality schemes. And some of the pioneering professional bodies have helped steer the scheme, including the Town and Country Planning Association with a proposal for a new Act of Parliament, The Healthy Homes Act, that would require all homes and neighbourhoods to be of decent quality, and effectively outlaw those which undermine residents' health and wellbeing.²¹

The US has seen similar initiatives, notably those launched by the Urban Land Institute²² on countering obesity through innovative urban and building design, and the Partnership for a Healthier America²³ which has focused on bringing fresh food to communities in need through the Covid crisis. Yet we are still a long way in both countries to being able to weave a fundamental objective into both our land-use and our healthcare systems of improving the health of

²⁰ NHSE Healthy New Towns: <https://www.england.nhs.uk/ourwork/innovation/healthy-new-towns/>

²¹ TCPA Campaign: *The Healthy Homes Act* (<https://www.tcpa.org.uk/healthy-homes-act>).

²² See eg the ULI *Building Healthy Places Initiative* founded in 2013: <https://americas.uli.org/research/centers-initiatives/building-healthy-places-initiative/>

²³ <https://urbanland.uli.org/inside-uli/uli-housing-leaders-join-partnership-healthier-america-coalition-industries-fighting-obesity/>

our populations and discouraging the further development of obesogenic environments.

These are not proposals to impose a form of architectural determinism. There is much more to us as human beings than where and how we live. Yet poor quality urban environments are directly correlated to poor equality health outcomes for their occupants. There are obviously many other factors at work here as well, such as race, education, pollution, and poor childhood nutrition. But it is with the quality of the built environment that our planning and local government systems have regulatory responsibility, and there is a clear need to capture the promotion of healthy living as one of their key objectives.

But to start, we need to do the same in our healthcare systems.

THE IMPLICATIONS FOR HEALTHCARE SYSTEMS

Modern healthcare is not a totally broken system. The US and the UK lead the world in terms of scientific innovation in biomedicine, including drug discovery, vaccines, medical technologies, and novel therapies. The survival trend of patients and reduction of morbidity has risen continuously over recent decades as a consequence of high-quality hospital care. But despite their aspirations, neither country has succeeded in shifting their focus upstream away from the treatment of injury and disease to the prevention of ill-health. It requires a different funding structure to shift recompense away from clinical activity, and towards population health. The US has examples of such an approach already working well through private providers, such as with Kaiser Permanente in California and Intermountain Healthcare in Utah²⁴, and with experimentation through Medicare, Medicaid and Veterans, but the model has not yet achieved nationwide traction.

In England the NHS is currently in the slow and complex process of shifting the whole of its work into a more integrated model, bringing together different providers into regional integrated care systems, with a primary focus on the promotion and maintenance of good health of the population of that region. Several models are already functioning across the country, and parliamentary legislation has recently been announced to provide a solid statutory basis for the new model,²⁵ explicitly learning lessons from the Covid experience which saw unprecedented levels of collaboration between NHS

²⁴ As to which see Marc Harrison, CEO of Intermountain Health (23 March 2021), “We are better served by health systems that aim to keep people healthy, not wait until they get sick”: <https://www.linkedin.com/pulse/we-better-served-health-systems-see-keep-people-healthy-harrison>

²⁵ A government pre-legislation White Paper was published in February 2021: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/960549/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-print-version.pdf

institutions and local governments. It carries through proposals advanced by the NHS itself in its long-term plan published in 2019.²⁶

The proposed legislation faces detailed parliamentary scrutiny, but the general thrust of these reforms is now widely accepted, especially in the light of the learning flowing from the pandemic. One of the lessons relates to the use and sharing of patient data recorded in electronic medical records, which has for years been the subject in both the UK and US of prolonged wrangling amidst privacy fears. Urgent crisis measures were taken to ensure that data could be shared swiftly and safely with different providers, and also interrogated by researchers to assess the efficacy of therapies and preventive measures.

But what is still missing is any comprehensive approach to addressing the social determinants of health that lie beyond the reach of our physicians and their hospitals. Poverty and social inequality have long been acknowledged as the principal cause for the huge gap in life expectancy within our respective populations, well highlighted in the work of Michael Marmot.²⁷ The key one of his brief proposals is “to create and develop healthy and sustainable places and communities”.

The NHS experiment with healthy new towns that I described demonstrates that the path for change requires close partnership between healthcare providers and land-use regulators. The concept of “integration” in relation to healthcare is not simply integration within a closed system of financing and providing fix and repair services for unhealthy people, but integration across government systems, and partnerships with and between private and social providers of healthcare and of urban development. The prospectus for reform in England has a clear starting point in the proposals for the future design of the NHS but also requires the fundamental engagement of the land-use planning community in decisions about the commissioning of healthcare, and the engagement of the healthcare community in land-use decisions about, for example, providing and maintaining public open space. In light of the uneven impact on human life of the pandemic, the time has clearly come for the promotion and protection of human health of the whole population to be made a—if not the—key statutory objective of the land-use planning system.

²⁶ See: <https://www.longtermplan.nhs.uk/online-version/chapter-7-next-steps/possible-legislative-change/>

²⁷ See eg *Status Syndrome: how your place on the social gradient directly affects your health* (Bloomsbury: 2004) and *Build back fairer: the Covid-19 Marmot review* (UCL Institute of Health Equity, 2021): <http://www.instituteoftheequity.org/resources-reports/build-back-fairer-the-covid-19-marmot-review>

CONCLUSIONS

The Covid-19 pandemic has wreaked unprecedented damage in the UK and USA. The scale of death on both sides of the Atlantic has been truly shocking. Others will, over time, assess how much of it was reasonably avoidable. My concern in this paper has been to understand its impact on vulnerable populations, and to understand why such large populations in these two countries should have proved so vulnerable to it. As the post-mortems get underway, we must expect that there will be uncomfortable truths for all of our political and social institutions, and not least for healthcare, urban governance, and land-use planning. Deaths on this scale cannot simply be somehow normalised.