

LONDON HEALTH PROFILE

London Health Data Collaborative

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All findings reflect data available as of 30th June 2026.
Please refer to linked sources for updated data as they become available.

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Executive Summary

London is home to 9.1 million people and remains the youngest and most diverse region in England. The city is experiencing rapid demographic change, with an ageing population projected to grow faster than in many other urban areas, creating new demands on health, care and public services. Deprivation remains concentrated in specific communities and neighbourhoods contributing to significant variations in health outcomes across the capital.

Overall, London continues to outperform England on many headline health indicators. Life expectancy and healthy life expectancy remain among the highest in the country, and infant mortality rates are lower than the national average. However, this positive picture masks a growing challenge: Londoners are living longer but spending more years in poor health. Large inequalities persist, with men living in the most deprived areas experiencing nearly eight fewer years of life expectancy than those in the least deprived areas, while women experience a gap of almost five years. Deprivation continues to be a major driver of avoidable illness and premature mortality.

The burden of disease in London is increasingly dominated by long-term conditions. Cancer, cardiovascular disease, mental ill health and musculoskeletal disorders account for more than half of all disability-adjusted life years lost. Mental health has emerged as one of the most significant public health challenges across the life course, with rising demand for services among both children and adults. Persistent inequalities are evident, particularly among deprived communities and some ethnic groups, where rates of detention under the Mental Health Act and barriers to accessing care remain disproportionately high.

Cardiovascular disease remains the leading cause of premature death, while cancer continues to account for a substantial proportion of illness and mortality. Although there have been improvements over the past two decades, progress has slowed in recent years and inequalities remain pronounced between population groups and local areas. London also faces ongoing challenges in maternal and child health, including low birth weight, lower coverage of developmental reviews and the lowest childhood immunisation uptake of any English region.

Modifiable risk factors continue to drive a large share of ill health and early death. Smoking rates have fallen substantially and remain below the national average, but inequalities persist. Excess weight, physical inactivity, unhealthy diets, high blood pressure and harmful alcohol consumption continue to affect large numbers of Londoners.

Performance on prevention is mixed. London exceeds the national average for NHS Health Check delivery but has the lowest uptake of breast, cervical and bowel cancer

screening programmes in England. Childhood vaccination coverage remains consistently below national levels and well below the threshold required for herd immunity, increasing the risk of outbreaks of vaccine-preventable diseases. These gaps represent significant missed opportunities for prevention and early diagnosis.

This report also highlights the severe health inequalities experienced by inclusion health populations, including people experiencing homelessness, those living in temporary accommodation, Gypsy, Roma and Traveller communities, vulnerable migrants, people in contact with the criminal justice system and those with substance dependence. These groups often experience multiple and overlapping disadvantages, poorer health outcomes, reduced life expectancy and substantial barriers to accessing healthcare and wider support services.

Many of the most important drivers of health lie beyond healthcare itself. London continues to experience some of the highest levels of income inequality in the UK, alongside rising child poverty, housing insecurity and affordability pressures. While educational attainment is generally strong, significant inequalities remain linked to deprivation, ethnicity and special educational needs. Employment opportunities are extensive, but gaps persist for people with long-term health conditions, and mental health-related economic inactivity is increasing.

Environmental and societal factors are also shaping health outcomes. Climate change is increasing risks from extreme heat, flooding and infectious diseases, with vulnerable populations bearing the greatest burden. Although London benefits from extensive public transport infrastructure and high levels of active travel, inequalities in transport access, road safety, housing quality, digital inclusion and community safety continue to affect health and wellbeing across the city.

Taken together, the evidence shows that London remains one of the healthiest regions in England on many measures, but inequalities persist. Improving health outcomes in the coming decade will require sustained action on prevention, early intervention and the wider determinants of health, alongside targeted efforts to address the unequal distribution of opportunities, resources and risks across London's communities.

Introduction

London possesses a unique combination of world-leading universities, life sciences expertise, digital innovation, cultural influence, a dynamic labour market, diverse communities and strong civic leadership. Its advantage lies not only in the scale of these assets, but in the density of relationships between universities, councils, businesses, communities, faith organisations, the NHS and the voluntary sector. These partnerships are more than background features of the capital; they are operational assets for population health. By aligning them around a shared mission, London can improve health outcomes locally while establishing itself as a global leader in population health.

Background

The London Health Profile has been developed to support strategic action to improve the health of Londoners, such as the London Health Improvement Plan (LHIP), a shared city-wide commitment to improving health, reducing inequalities and strengthening prevention across London. It brings together publicly available data from a range of national, regional and local sources to provide a consistent overview of population health across the capital, while avoiding duplication of existing analytical products and complementing work already undertaken across the health and care system.

Purpose

The London Health Profile provides an overview of the health of Londoners and the factors that shape health outcomes. It brings together evidence on population health, inequalities, risk factors and the wider determinants of health, recognising that good health underpins London's economic prosperity, productivity and resilience. The profile also highlights emerging themes and challenges across the life course, helping to identify where collective action may be needed to improve outcomes and reduce inequalities.

Using this report

The London Health Profile is intended as an overview rather than an exhaustive source of data. It is designed to support understanding of key health challenges facing London, identify inequalities and their underlying drivers, and help frame priorities for action and more detailed analysis.

This narrative report, offering interpretation, context and commentary on the evidence presented, should be read alongside the two companion products that together make up the London Health Profile:

1. **Summary slide deck** – presenting headline findings and key messages.

2. **Data slide deck** – providing detailed charts, maps and visualisations.

Used together, these three products aim to provide a comprehensive picture of health in London, combining high-level messages, detailed data and narrative insight to support planning, partnership working and health improvement across the capital.

Chapter 1- Demographic overview of London

In 2025, London was home to an estimated 9.1 million residents, making it the most populous city in the country. The capital is characterised by a notably young population.¹ Despite having the youngest age profile of any English region, London is also undergoing significant demographic change. Looking ahead, the capital's population is projected to age rapidly, faster than other UK cities, and at a rate comparable to rural areas.² This shift will have important implications for the city's future planning, services and workforce.

London is one of the world's most diverse cities, shaped by sustained international migration and a wide range of ethnic, cultural and linguistic backgrounds. In 2021, 54% of residents identified as White, down six percentage points since 2011, reflecting increasing ethnic diversity. London also has the highest proportion of people identifying as LGBTQ+ among English regions, with 9.1% of adults identifying as gay, lesbian, bisexual or another sexual orientation in 2024. In 2021, 91% of residents aged 16 and over reported a gender identity matching their sex registered at birth. Additionally, 12.9% of Londoners were disabled under the Equality Act 2010 definition.^{3,4}

Taken together, London's characteristics paint a picture of a city that is not only diverse in its origins and identities, but also distinct in its social profile.

Across London's 4,994 Lower Layer Super Output Areas (LSOAs), deprivation remains a significant but unevenly distributed challenge. The patterns of deprivation across London points to the importance of place-based approaches that reflect both the scale and spatial nature of deprivation across the capital.⁵

¹ [Estimates of the population for England And Wales mid-2024](#). ONS.

² [Ageing in the fast and slow lane](#) (January 2025), The Resolution Foundation.

³ ONS Census, 2021.

⁴ [Sexual orientation, Annual Population Survey 2024](#). ONS.

⁵ [Indices of Deprivation 2025: an exploratory analysis \(November 2025\)](#). GLA.

Chapter 2 - Health status of London

Life Expectancy and Healthy Life Expectancy⁶

Recent trends in life expectancy and healthy life expectancy have been strongly influenced by the COVID-19 pandemic. Mortality rates rose sharply in 2020 and remained elevated throughout 2021, leading to a decline in life expectancy across England, including London. This pattern is visible in both single-year life expectancy, which fell markedly in 2020 before recovering, and in three-year rolling estimates, which continue to reflect the higher mortality experienced during the pandemic years up to 2021–23.

While overall life expectancy has started to recover, this improvement has not been matched by equivalent gains in healthy life expectancy.

In 2022–24, London recorded the second highest healthy life expectancy in England for both men and women, behind only the South East, and remained above the national average. Healthy life expectancy was equal for men and women at 62.9 years, marking a decline from 2017–19 levels (63.7 years for men and 64.0 years for women). Although healthy life expectancy fell for both sexes, the decline in London was less pronounced than in England overall. Notably, between 2019–21 and 2022–24, female healthy life expectancy fell by more than two years in every English region except London.

However, these headline successes mask a growing disconnect between length of life and quality of health. Between 2017–19 and 2022–24, the number of years lived in poor health increased for both men and women. As a result, Londoners are living longer overall but spending a greater proportion of life experiencing poor health.

Years Spent in Poor Health and Inequalities⁷

While healthy life expectancy in London remains higher than the national average, this advantage is not shared equally across the population. The proportion of life spent in poor health is closely linked to deprivation, disproportionately affecting disadvantaged communities, reinforcing existing inequalities and highlighting the need for sustained, action on the building blocks of health.

Life Expectancy Inequalities by Deprivation

Large and persistent inequalities in life expectancy by deprivation remain a defining feature of London's health profile. Analysis for 2022–24 shows a clear social gradient, with residents in more deprived areas experiencing significantly shorter lives than those

⁶ ONS via [Fingertips](#), OHID. See Fingertips indicator details in the [Appendix](#).

⁷ ONS via [Fingertips](#), OHID.

in the least deprived neighbourhoods. This gradient is summarised by the Slope Index of Inequality (SII), which measures the difference in life expectancy across the full spectrum of deprivation. In London in 2022-24 the estimated gap in life expectancy at birth between the most and least deprived areas was 4.7 years for women and 7.9 years for men, highlighting both the scale of inequality and the steeper social gradient experienced by men.⁸ The largest contributors to these gaps in 2022–23 were circulatory diseases and cancer.⁹ Despite average life expectancy getting longer, inequalities persist.

⁸ ONS via [Fingertips](#), OHID. See Fingertips indicator details in the [Appendix](#).

⁹ [Segment Tool](#), OHID. Based on ONS death registration data and provisional mid-year population estimates for the relevant years, and MHCLG IMD-2019.

Chapter 3 - Burden of disease & morbidity¹⁰

Burden of disease in London

Disability-adjusted life years (DALYs) provide a comprehensive measure of disease burden by combining years of life lost due to premature death with years spent living with ill-health or disability. They capture not only how long people live, but also how well they live.

In 2023, the leading contributors to overall disease burden in London were cancers, mental disorders, cardiovascular disease and musculoskeletal conditions, which together accounted for just over half (53%) of all DALYs. Within these broad disease groups, the conditions contributing most to DALYs across all ages were depressive disorders, ischaemic heart disease, anxiety disorders and low back pain, alongside injuries from falls, headache disorders, chronic obstructive pulmonary disease (COPD), diabetes, lung cancer and stroke. These leading contributors have remained largely unchanged over the past decade, reflecting the continuing impact of long-term mental health conditions, chronic physical diseases and injuries on population health in the capital.

While these conditions dominate at a population level, patterns of morbidity vary when broken down by sex and age, although the overall profile remains broadly consistent.

Closer Look at the Health of Londoners

The experiences of children and young people, people with mental health needs, and those living with or at risk of cardiovascular disease reflect many of the wider challenges highlighted throughout this profile.

Babies, Children and Young People in London

The early years of life, play a critical role in shaping lifelong health, wellbeing and life chances. In London, this life stage is characterised by both strengths and significant inequalities, reflecting the city's diverse population and unequal social and economic conditions.

More than half of all births in London (54%) are to women from ethnic minority backgrounds, the highest proportion of any region and significantly above the England average of 31%.¹¹ While London has seen long-term improvements in infant health outcomes, inequalities remain. Infant mortality rates have reduced significantly over

¹⁰ Global Burden of Disease study: Institute for Health Metrics and Evaluation (IHME). GBD Compare Data Visualization. Seattle, WA: IHME, University of Washington, 2025. Available from <https://vizhub.healthdata.org/gbd-compare>.

¹¹ [Fingertips](#), OHID. See Fingertips indicator details in the [Appendix](#).

recent decades and have been lower than the England average since 2011-23; however, marked variation persists across the capital, closely linked to deprivation and ethnicity.

Birth outcomes continue to reflect underlying maternal health and the wider determinants of health. Low birth weight, which is associated with poorer health across the life course, remains a particular concern in London. The capital has the highest regional proportion of low-birth-weight term babies in England, and large inequalities persist between population groups and areas.¹²

Early identification and prevention through child health reviews are less consistent in London than elsewhere. In 2024/25, coverage of the universal 6-to-8-week infant check was significantly below the England average, with an estimated 15,000 infants missing a review by the age of eight weeks.¹³ Similarly, only 68% of children received a 2-to-2½-year developmental review, compared with 81% nationally,¹⁴ raising concerns about delayed identification of developmental or health needs.

London also has the lowest coverage of routine childhood immunisation programmes of any region. Immunisation uptake among children in care is particularly low, falling well below the England average,¹⁵ increasing the risk of preventable infectious disease and compounding existing vulnerabilities.

Mental Health in London

Mental health needs represent a substantial and growing challenge across the life course in London. Among children and young people, the proportion of school pupils identified as having social, emotional and mental health needs remains lower than the national average, but has been increasing over time in both London and England.¹⁶ This upward trend is reflected in increasing demand for mental health services.

Children in care face particular disadvantage: 37% of looked-after children in London have emotional wellbeing identified as a cause for concern in 2024/25.¹⁷

Mental health needs are also widespread among adults in London. In 2022/23, around a quarter (24%) of adults report experiencing high levels of anxiety, and around 9% report low levels of happiness on the previous day, proportions broadly in line with those seen nationally. In primary care, approximately 10% of patients aged 18 and over registered with GPs are recorded as having depression (2024/25).¹⁸

¹² [Fingertips](#), OHID. See Fingertips indicator details in the [Appendix](#).

¹³ [Fingertips](#), OHID.

¹⁴ [Fingertips](#), OHID.

¹⁵ [Fingertips](#), OHID.

¹⁶ [Fingertips](#), OHID.

¹⁷ [Fingertips](#), OHID.

¹⁸ [Fingertips](#), OHID.

Although London's rate of emergency hospital admission for intentional self-harm (52 per 100,000) is substantially lower than the England average (117 per 100,000), there were still 4,805 emergency hospital admissions for intentional self-harm in the capital in 2023/24, highlighting a considerable ongoing burden despite comparatively lower rates.¹⁹

At the most severe end of the spectrum, suicide remains a critical concern. In 2022–24, London's suicide rate was 8 per 100,000 – significantly lower than the England average – but this still represents a substantial and largely preventable cause of death, with 1,754 suicides recorded over this period, 73% of which were among men.²⁰

Taken together, these findings show that while London often performs better than the national average on headline indicators, mental health needs are increasing across all ages, and closely linked to deprivation and co-occurring risks.

Inequalities in mental health in London are marked and persistent, reflecting disparities across ethnicity, deprivation, and access to care.

Heart Health in London

Heart and circulatory diseases cause one in four deaths²¹ in London each year and are the leading cause of early death in the capital.²² Approximately 37% of Londoners with a work-limiting cardiovascular health condition are economically inactive.²³

In 2003–05, the under-75 mortality rate from cardiovascular disease (CVD) in London was 128.4 per 100,000 and in 2023–25 this had reduced to 71.7 per 100,000, noticeably lower than the rate for England (74.4 per 100,000) in the same period. However, rates have plateaued over the last six years. The rate varies significantly by London borough, ranging from 43.5 per 100,000 in Richmond upon Thames to 113.1 per 100,000 in Barking and Dagenham. At the national level, the rates are strongly correlated with levels of deprivation, with the rate over two times higher in the most deprived IMD decile (109.6 per 100,000) compared to the least deprived decile (54.5 per 100,000).²⁴

In 2025, among patients with GP recorded hypertension, Black adults (64.5%) are less likely to have well-controlled blood pressure (64.5%) than Mixed (65.4%), Other (69.0), White (71.4%) or Asian patients (72.9%).²⁵

¹⁹ [Fingertips](#), OHID. See Fingertips indicator details in the [Appendix](#).

²⁰ [Fingertips](#), OHID.

²¹ [Mortality statistics - underlying cause, sex and age, 2024](#). ONS, NOMIS.

²² OHID, based on ONS data

²³ [Long-term sickness and the London labour market \(February 2025\)](#), GLA Economics

²⁴ [Fingertips](#), OHID.

²⁵ [Office for Health Improvement and Disparities, NHS Benchmarking Network. Cardiovascular Disease Prevention Audit \(CVDPREVENT\)](#). (2024)

Broader themes highlighted elsewhere within the London Health Profile are sexual and reproductive health, older adults and palliative and end of life care.

Chapter 4 - Leading causes of mortality in London

Leading Causes of Death and Mortality Patterns in London

Patterns of mortality in London continue to show marked differences by sex, age and cause, alongside longer-term improvements in some areas. In 2024, premature mortality (deaths under the age of 75) accounted for a substantial proportion of deaths, particularly among males.

Deaths under 75 years²⁶

Among males, premature mortality accounted for 43% of all male deaths in London in 2024. The leading cause of death for males under 75 was ischaemic heart disease, which has remained the top cause over time and accounted for 14.7% of deaths. This was followed by lung cancer (6.1%) and cirrhosis and other diseases of the liver (4.7%).

Among females, premature mortality accounted for a smaller share of all deaths, with 30% of female deaths occurring under the age of 75 in 2024. The leading causes of death for females in this age group were breast cancer (7.4%), ischaemic heart disease (7.3%), and lung cancer (7.1%).

Infant mortality²⁷

Infant mortality has improved substantially in London over the long term. The rate fell from 5.7 deaths per 1,000 live births in 2001–03 to 3.3 per 1,000 live births in 2022–24. London's infant mortality rate is now significantly lower than the England average, which stood at 4.2 deaths per 1,000 live births in 2022–24.

Despite this overall improvement, significant inequalities remain within the capital. In 2022–24, infant mortality rates varied more than threefold across London local authorities, ranging from 1.5 deaths per 1,000 live births in Richmond upon Thames to 4.8 per 1,000 in neighbouring Hounslow. Richmond upon Thames was the only local authority with a rate significantly lower than the London average, while Hounslow had a significantly higher rate; all other boroughs recorded rates broadly in line with the London average.

Older age mortality

Deaths at older ages continue to account for the majority of deaths in London. In 2024, 57% of male deaths and 70% of female deaths occurred among those aged 75 years and over.²⁸

²⁶ OHID analysis based on ONS data.

²⁷ [Fingertips](#), OHID. See Fingertips indicator details in the [Appendix](#).

²⁸ OHID analysis based on ONS data .

Chapter 5 - Risk factors of morbidity and mortality in London

Modifiable risk factors continue to be the leading drivers of ill health and early death in London. Smoking, high alcohol use, excess weight, physical inactivity, diet, high blood pressure and high fasting plasma glucose together account for a substantial proportion of morbidity and premature mortality, despite progress in some areas.²⁹

Smoking^{30,31}

The prevalence of smoking among adults has continued to fall over the past decade in London, decreasing from 19.2% in 2011 to 10.2% in 2024. Rates remain higher among men (12.8%) than women (7.6%), and marked inequalities persist with rates considerably more common among certain groups such as those in routine and manual occupations, those with long-term mental health conditions and those admitted for treatment related to substance misuse. Among young people, regular smoking prevalence remains low but use of e-cigarette products appears more common. Positively, smoking in pregnancy is less common in London than the rest of England.

Alcohol

Around one in five adults aged 16 and over in London (19%) consume more than 14 units of alcohol per week, a level associated with an increased health risk (2024). Drinking at this level was more common among men (24%) than women (14%).³² These patterns translate into health impacts: in 2023/24, there were over 118,500 (1,724 per 100,000) hospital admissions among London residents for alcohol-related conditions, significantly lower than England (1,824 per 100,000).³³

Alcohol consumption among young people in London is comparatively low. In 2023, one in five secondary school pupils reported ever having consumed alcohol (21%), and only 3% reported drinking in the past week, the lowest recorded levels of any English region. At the national level, alcohol consumption among young people varies substantially by ethnicity, with White pupils significantly more likely to report ever having consumed alcohol (46%) than Black (19%) or Asian pupils (10%).³⁴

²⁹ Global Burden of Disease 2023, [GBD Compare](#)

³⁰ [Fingertips](#), OHID. See Fingertips indicator details in the [Appendix](#).

³¹ [Fingertips](#), OHID.

³² Estimated weekly level of alcohol consumption, [Table 11, Adults' health-related behaviours tables](#), Health Survey for England 2024

³³ [Fingertips](#), OHID.

³⁴ Smoking, Drinking and Drug Use among Young People in England, 2023: [Data table part 5](#)

Excess weight³⁵

Excess weight remains one of the most significant health challenges in London. More than half of adults in London (57.8%) are overweight or obese (2023/24).

Around one in five (21.1%) children aged 4-5 years are overweight or obese, rising to one in three (37.3%) among those aged 10-11 years in 2024/25. Inequalities are stark: in 2024/25, 44.0% of children aged 10-11 in the most deprived areas were overweight or obese, compared with 25.7% in the least deprived areas.

Physical inactivity

Physical activity levels are consistently low. In London, only 47% of children and young people aged 5-16 are physically active, the lowest proportion in England (2024/25). 22% of adults in London were physically inactive.³⁶ Nationally, physical activity levels generally decrease with age, with the sharpest decrease coming at age 75+. There are differences in activity levels based on ethnic background, and activity is less common among adults with a disability or long-term health condition than for those without.³⁷ Physical inactivity is also notably higher in more deprived areas.³⁸

Diet³⁹

Fruit and vegetable consumption in London remains below recommended levels and has declined in recent years. In 2024/25, only 30% of London adults met the 5-a-day recommendation, down from 34% in 2020/21 and slightly below the England average of 31.4%. There is a clear socioeconomic gradient in fruit and vegetable intake, with lower consumption strongly associated with deprivation. Nationally, only 19.8% of adults in the most deprived communities meet the 5-a-day recommendation, compared with 38.4% in the least deprived communities. Similarly, unemployed adults are less likely to meet the recommendation (19.7%) than those who are employed (29.0%).

High blood pressure⁴⁰

Crude recorded prevalence of hypertension in London is lower than in England. In 2025, GP-recorded prevalence was 13.2% in London compared with 18.4% in England. However, these differences largely disappear when prevalence is age-standardised with London (19.0%) having similar prevalence to England (19.3). In addition, GP-recorded

³⁵ [Fingertips](#), OHID. See Fingertips indicator details in the [Appendix](#).

³⁶ [Fingertips](#), OHID.

³⁷ [Sport England \(2026\) Active Lives Adult Survey: November 2024-25 Report](#).

³⁸ Physical inactivity by IMD (2024/25): Active Lives Adult Survey 2024/25, Sport England.

³⁹ [Fingertips](#). OHID.

⁴⁰ GP recorded hypertension (CVD001HYP), [CVDPrevent](#).

prevalence is known to significantly underestimate true population levels of hypertension.

High blood glucose⁴¹

Among the non-diabetic population in London, 8.1% have blood glucose levels that are raised but below the diabetic level (based on the HbA1c test) indicating that they are pre-diabetic, up from 5.2% in 2020/21. Although this proportion is consistently lower in London than in England, these are crude (non-age-standardised) rates and comparisons may be influenced by London's younger age profile. Both rates have increased over time.

There is significant inequality among boroughs, e.g. 15.6% in Barking & Dagenham and 2.7% in Hackney.

Chapter 6 - Coverage of key prevention interventions

Childhood vaccination uptake ⁴²

Vaccination uptake in London continues to lag behind the England average, with declines observed across several programmes in recent years. These trends raise concerns about increasing susceptibility to vaccine-preventable diseases, particularly in the context of high population density and global connectivity. For example, MMR levels are well below the World Health Organization target of 95% required to achieve herd immunity, increasing the risk of outbreaks of measles and other vaccine-preventable infections.

Particularly concerning are vaccination outcomes for children in care, a group already facing multiple disadvantages. In 2023/24, only 74% of children in care in London were up to date with their immunisations, compared with 82% across England.

Health checks and screening⁴³

London performs well on some preventative health measures but less so on cancer screening.

NHS Health Checks are offered every five years to people aged 40 to 74 years who do not already have a long-term cardiovascular condition, providing an opportunity for early identification of risk factors and targeted intervention. Over the five-year period from 2020/21 to 2024/25, London exceeded the England average for NHS Health Check delivery, achieving 41% coverage compared with 30% nationally. However, this stronger performance is not reflected in cancer screening, with consistently lower uptake across

⁴¹ [Fingertips](#), OHID. See Fingertips indicator details in the [Appendix](#).

⁴² [Childhood vaccination coverage, UKHSA data dashboard](#).

⁴³ [Fingertips](#), OHID.

breast, cervical and bowel screening programmes indicating a continued need to improve participation in early detection services.

Substance Misuse Treatment Outcomes and Continuity of Care⁴⁴

London performs in line with the England average on successful completion of opiate treatment programmes.

However, London lags behind nationally in supporting individuals to re-engage with treatment after incarceration. Only 43% of people released from prison successfully engage with community-based substance misuse treatment in London, compared with 57% across England in 2024/25.

⁴⁴ [Fingertips](#), OHID. See Fingertips indicator details in the [Appendix](#).

Chapter 7 - Inclusion health

“Inclusion health” is an increasingly recognised area within population health. It is a catch-all term describing population groups who are socially excluded and who experience the worst health outcomes in society. Intersectionality of experience and need are key. Effective responses require trauma-informed care and support, and multi-agency coordination. Key factors driving poor health outcomes include:

- exclusion across the wider determinants of health (such as housing, employment, education)
- multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma)
- discrimination and stigmatisation
- greater barriers to accessing services (including wrongful registration refusal in primary care due to no fixed address or proof of immigration status, lack of accessible information, digital exclusion, and others)
- lack of visibility and inconsistent recording in electronic records and datasets.

Inclusion health groups include, but are not necessarily limited to:

People who experience homelessness: People experiencing homelessness face some of the worst health outcomes in society. In 2021 the average age of death was 43 for women and 45 for men.⁴⁵ Many people experiencing homelessness experience co-occurring physical, mental health and drug and alcohol needs, barriers to care, and frequent emergency service use.⁴⁶

Gypsy, Roma and Traveller Communities: As a result of historic persecution and ongoing social exclusion, Gypsy, Roma and Traveller communities experience significant inequalities across the wider determinants of health, and greater barriers to care.⁴⁷

Migrants in Vulnerable Circumstances⁴⁸: Migrants in vulnerable circumstances include asylum seekers and refugees, unaccompanied children, people who have been trafficked, undocumented migrants (those living in the UK with no legal status – No Recourse to Public Funds (NRPF)), and low paid migrant workers. These groups may

⁴⁵ [Deaths of homeless people in England and Wales: 2021 registrations](#). November 2022. ONS

⁴⁶ National Institute for Health and Care Excellence (NICE). (2022). [Integrated health and social care for people experiencing homelessness \[NICE Guideline NG214\]](#).

⁴⁷ House of Commons Women and Equalities Committee. (2019). [Tackling inequalities faced by Gypsy, Roma and Traveller communities \(Seventh Report of Session 2017–19, HC 360\)](#). UK Parliament.

⁴⁸ NRPF Network. [NRPF Connect data report 2024-25](#).

have complex health needs influenced by experiences prior to, during, or after migration to the UK.

Sex Workers: Sex work is diverse and difficult to quantify. Many people engaged with sex work experience unmet health needs, including barriers to non-judgemental care and preventative services, alongside risks of violence, and poor sexual health.⁴⁹

People Subject to Modern Slavery: Modern slavery remains under-reported. Physically demanding forced labour combined with long working hours, in poor, unsafe working conditions can result in a high incidence of physical injury, and sexual exploitation brings with a high prevalence of sexually transmitted infections.⁵⁰

People in Contact with the Justice System (CJS): People in contact with the criminal justice system experience significantly worse outcomes than the general population, including high levels of preventable ill health, including poor mental health, substance misuse and chronic disease.⁵¹ Prison leavers face particularly acute risks, with increased risk of mortality relating to drug-use and suicide, poor continuity of care, and ongoing barriers to care in the community.⁵²

People with Drug and/or Alcohol Dependence: People experiencing drug and/or alcohol dependency face particularly high risks of premature death, driven by liver, lung, cardiovascular disease and blood-borne infections.^{53,54}

Victims/survivors of domestic abuse: Many people fleeing domestic violence and in need of safe accommodation experience particularly acute risk of homelessness and support needs, including poor mental health, substance use needs, and poverty.⁵⁵

⁴⁹ O'Rourke, K., White, C., et al. (2022) 'Access to healthcare for street sex workers in the UK: perspectives and service needs', *BMC Health Services Research*, 22, 189.

⁵⁰ [Modern slavery and public health](#). December 2017. PHE.

⁵¹ Owolabi, B., Lad, S. and Bhattacharya, C. (2023) 'Core20PLUS5: His Majesty's Prison and Probation Service – an approach to address inequities in healthcare for people in contact with the criminal justice system', *BMJ Leader*, 7(Suppl. 2). Available at: <https://doi.org/10.1136/leader-2023-000818> (Accessed: 3 August 2026)

⁵² Prisons and Probation Ombudsman (2024) *Fatal Incident Investigations Learning Lessons Bulletin Issue 19: Post-release death investigations 2*. 18 July. Available at: https://ppo.gov.uk/learning_research/learning-lessons-bulletin-issue-19-post-release-death-investigations-2/ (Accessed: 4 August 2026).

⁵³ Lewer D, Tweed EJ, Aldridge RW, Morley KI. Causes of hospital admission and mortality among 6683 people who use heroin: A cohort study comparing relative and absolute risks. *Drug Alcohol Depend*. 2019;204:107525. doi:10.1016/j.drugalcdep.2019.06.027.

⁵⁴ [What are other health consequences of drug addiction?](#) National Institute on Drug Abuse (2020)

⁵⁵ [Domestic abuse safe accommodation and support](#), 2025. GLA.

Chapter 8 - Building blocks of health

The social, environmental and economic determinants are the building blocks of health, and they play a critical role in shaping the health of Londoners. While the capital benefits from strong assets and investment, significant inequalities persist, and these continue to drive avoidable ill health and premature mortality.

Structural racism and health inequalities – a cross-cutting determinant⁵⁶

Health inequalities in London are shaped in part by the cumulative and enduring impacts of structural racism across the life course. It reflects differences in exposure to risk factors, access to resources and wider social conditions. Experiences of racism and discrimination influence health at every stage of life, from pregnancy and early childhood through to education, employment and older age. Taken together, these factors demonstrate how structural racism can act as a key driver of health inequality in London.

Income and economy

Household income inequality⁵⁷

London's economy supports a large number of high-paying jobs; however, there remains a pronounced disparity between the incomes of the richest and poorest households. Median household income in London remains higher overall. After housing costs, the median equivalised income is approximately £632 per week, around 10% higher than the UK median of £574 per week. However, latest data from the Department for Work and Pensions show that the highest-earning tenth of Londoners receive around 11 times the income of the lowest-earning tenth, based on a three-year average covering 2021/22 to 2023/24.

Poverty⁵⁸

Poverty remains a significant determinant of health in London, with housing costs playing a critical role in driving financial hardship. High housing costs continue to drive poverty and reduce disposable income for London households. While the relative poverty rate before housing costs stands at 15%, this rises sharply to 26% once housing costs are taken into account, a much larger increase than observed in the rest of England (2021/22-2023/24). Following a steady decline to a historic low of 32%

⁵⁶ Marmot, M., Allen, J., Goldblatt, P., Wollos, S., Noferini, J., Callaghan, O. [Institute of Health Equity. Structural Racism, Ethnicity and Health Inequalities in London.](#)

⁵⁷ [State of London- Economy.](#) June 2026. GLA.

⁵⁸ [HBAI, DWP. Population in Poverty. GLA.](#)

(2020/21–2022/23), the child poverty rate rose sharply to 35% in the latest period (2021/22–2023/24).

Overall, these trends highlight the increasing pressures on household incomes in London, particularly driven by housing costs. Rising poverty, especially among children, has significant implications for health, education and long-term outcomes, and reinforces existing inequalities across the capital.

Employment and Health

Economic conditions and employment are key determinants of health in London, shaping income, living standards and access to resources. While the capital offers significant employment opportunities, inequalities persist, particularly between different population groups and those with underlying health conditions.

As recognised in the Marmot Review, good work is generally protective of health, while poor-quality work may be harmful and does not confer the same health benefits. In 2024, the average job quality score for employees in London reached 78.2%, the highest level recorded since 2020. Despite this improvement, London's score remains below the UK average, although the gap has narrowed between 2022 and 2024. The primary driver of this difference is the higher proportion of jobs classified as low paid at a regional level. London employees were more likely to work unpaid overtime, with 77.1% reporting that they did not do so compared with 83.4% across the UK.⁵⁹

However, London performed more strongly in areas such as employee involvement, with 60.6% reporting positive experiences compared with 55.9% nationally, and career progression, where the figures were 51.9% and 51.4% respectively.⁶⁰

Pay gaps remain significant across gender, ethnicity and disability in London.⁶¹

Health also plays a critical role in shaping labour market participation. In 2022/23, people in London with a physical or mental health condition were around 10 percentage points less likely to be in employment compared with the general population. This gap is similar to the England average, highlighting persistent inequalities for people with health conditions.⁶²

Work-Limiting Health Conditions⁶³

⁵⁹ [State of London - Economy](#). June 2026. GLA.

⁶⁰ [State of London - Economy](#). June 2026. GLA.

⁶¹ [Fingertips](#), OHID. See Fingertips indicator details in the [Appendix](#).

⁶² [Fingertips](#), OHID.

⁶³ [Long-term sickness and the London labour market \(February 2025\)](#), GLA Economics.

The prevalence of work-limiting health conditions (WLHC) in London has increased over the past decade, with a more recent rise observed since the COVID-19 pandemic, particularly among younger people.

Mental health conditions are now the most common type of work-limiting condition in London's working-age population, having increased by 62% between 2014 and 2022. Unlike most long-term conditions, mental health issues are most prevalent among younger adults and are strongly associated with economic inactivity. In contrast, older adults (aged 50–64) are more affected by physical conditions, including a post-pandemic increase in musculoskeletal disorders. As a result, inactivity due to long-term illness is concentrated among both younger and older working-age groups.

Employment participation among people with work-limiting health conditions has improved over time, with slightly more individuals now in work (51%) than out of work in 2023.

There are also marked inequalities in the distribution of work-limiting health conditions. In London, people with no formal qualifications are nearly four times more likely to have a WLHC than those with a degree. Differences are also evident across ethnicity, occupation and industry, reflecting wider structural inequalities that influence both health and employment outcomes.

Education, Attainment and Youth Engagement

Educational outcomes in London are generally strong compared to the England average, but inequalities remain and outcomes vary across age groups and measures.

School readiness⁶⁴

Children are defined as having a Good Level of Development, or 'school ready', if they are at the expected level for the 12 early learning goals within five areas of learning relating to: communication and language; personal, social and emotional development; physical development; literacy; and mathematics. Performance in school readiness is relatively high in London. In 2024/25, 70.7% of children in London achieved a good level of development at age five, exceeding the England average of 68.3%.

When examined by characteristics such as ethnicity, first language, eligibility for free school meals and special educational needs (SEN) support, pupils in London tend to perform at least as well as, and often better than, their peers across England with similar profiles. However, disparities between sub-groups remain, and socio-economic and ethnic inequalities are still evident.

⁶⁴ [Early years foundation stage profile results, academic year 2024/25, DfE.](#)

Overall, the profile reflects strong early years outcomes in London, but also underline persistent gaps between groups, particularly in relation to deprivation, ethnicity and special educational needs.

Key Stage 4/GCSE⁶⁵

Strong outcomes continue for into secondary education, with London maintaining higher attainment levels than the national average at Key Stage 4.⁶⁶ London pupils outperform those nationally across all elements of the Attainment 8 measure and for almost all pupil characteristics, including ethnicity and eligibility for free school meals (FSM). The main exception is among Black pupils, whose average Attainment 8 scores in London are slightly lower than those of Black pupils across England as a whole.

Despite overall strong performance, inequalities across groups persist in London. In 2024/25, differences in attainment were evident by sex, ethnicity, first language, FSM eligibility, special educational needs (SEN) and disadvantage status.

Socio-economic disparities remain pronounced. Pupils eligible for FSM achieved an average Attainment 8 score of 42.0, compared with 54.4 among those not eligible. These inequalities broadly reflect national patterns, although there are some differences in magnitude. Notably, while Asian pupils achieve the highest scores in both London and England, White pupils have the lowest average nationally, whereas in London, Black pupils have the lowest average.

Special Education Needs (SEN)

In addition, a significant proportion of pupils require additional support. In 2024/25, around 19% of pupils in London were identified as having special educational needs, equivalent to over 260,000 children, and this number appears to be increasing.⁶⁷

Together, these findings highlight both the strengths of London's education system and the ongoing inequalities experienced by different groups of pupils.

Housing

Access to good quality, affordable and stable housing conditions is a key determinant building block of health in London, influencing exposure to hazards, stability, overcrowding and access to services.

Homelessness⁶⁸

Rough sleeping remains a significant concern in London. A total of 12,938 people were seen rough sleeping in London in 2025/26. This is a 2% decrease on 2024/25, compared

⁶⁵ [Key stage 4 performance, academic year 2024/25](#). DfE.

⁶⁶ [Key stage 4 performance, academic year 2024/25](#). DfE.

⁶⁷ [Fingertips](#), OHID. See Fingertips indicator details in the [Appendix](#).

⁶⁸ [CHAIN Annual Report- Greater London 2025/26](#)

to a 10% increase from 2023/24 to 2024/25. According to MHCLG homelessness statistics, London's rate is nearly double the rest of England. Furthermore, London has more households in temporary accommodation than the rest of England's regions combined, with an estimated 102,000 homeless children – an 8% increase since last year, and a 35% increase compared to 2021.

Housing Affordability⁶⁹

Housing affordability remains a significant concern in London, with a substantial proportion of residents experiencing difficulty meeting housing costs. In April 2026, 34% of Londoners reported that they had either fallen behind or were struggling to keep up with rent or mortgage payments.

Since the pandemic, financial pressures have increasingly been concentrated among private renters. In 2018, tenants in the social housing sector were more likely to report difficulties, with 39% struggling to pay rent compared with 35% of private renters. By 2023/24, this pattern had reversed: 44% of private renters reported difficulty paying rent, compared with 38% of social housing tenants. This shift highlights the growing affordability challenges within the private rented sector.

Quality of Homes^{70,71}

The quality of housing in London has improved substantially over time, although some concerns remain across different tenures. The proportion of homes meeting the official Decent Homes Standard increased from 63% in 2006 to 89% in 2023. The highest level was recorded in 2021, when 91% of homes were classified as decent.

Six groups of people have been identified as typically at greater risk of harm from their housing conditions: those with dependent children; those registered disabled; those in receipt of means-tested benefits; those aged over 65; recent migrants; and those on a low income and not receiving benefits. The impacts of poor housing standards are not felt equally between different ethnic groups. Londoners of Asian ethnicity are more likely to live in homes that fail to meet the Standard, and Black Londoners are more likely than people of other ethnicities to have damp problems in their homes.⁷²

Overcrowding

Overcrowding remains a significant issue and is linked to poor physical and mental health outcomes. In 2023/24, an estimated 6.7% of London households were overcrowded, down from 9.2% in 2019/20. Rates are substantially higher among renters, affecting 15.7% of social renting households and 8.5% of private renting

⁶⁹ [State of London - Housing](#). June 2026. GLA.

⁷⁰ [State of London - Housing](#). June 2026. GLA.

⁷¹ [Housing in London 2025](#). April 2026. GLA.

⁷² [IHE Evidence Review: Housing and Health Inequalities in London](#). September 2022. IHE.

households, compared with just 1.6% of owner-occupied homes.⁷³ Around 29% of children in London live in overcrowded household, the highest in England.⁷⁴

Air Quality⁷⁵

Air quality remains one of the most significant environmental determinants of health in London. There is strong evidence linking air pollution to the development and worsening of coronary heart disease, stroke, respiratory disease and lung cancer, as well as exacerbation of asthma.⁷⁶ In 2024, an estimated 6.6% of all deaths in London were attributable to exposure to particulate air pollution, the highest proportion of any region in England.⁷⁷

Data from the London Atmospheric Emissions Inventory (2026 update) show continued progress in reducing emissions across the capital since 2016, particularly for nitrogen oxides (NO_x) and fine particulate matter (PM_{2.5}). Despite these improvements, all major pollutants remain a concern, and further action is required, particularly to reduce PM₁₀ levels. Air pollution exposure in London continues to be unevenly distributed, with people living in more deprived communities generally experiencing higher levels of pollution. Significant inequalities also exist by ethnicity, geography and communities.⁷⁸

Recently, the landmark CHILL study of more than 3,400 children, led by Queen Mary University of London, has found that air quality improvements following the introduction of London's Ultra Low Emission Zone (ULEZ) are strongly associated with accelerated lung growth in children.⁷⁹

Climate Risk and Health in London

London faces a distinct and growing set of climate-related risks that present significant threats to population health. The capital experiences the hottest summer conditions in the UK, a risk amplified by high population density, extensive built infrastructure and social inequalities. Climate change is increasing both the frequency and intensity of extreme weather events, with disproportionate impacts on vulnerable groups.

Heat Risk

Extreme heat is currently the most significant climate-related health risk in London. The urban heat island effect can raise overnight temperatures in central London by up to

⁷³ [Housing in London 2025](#). April 2026. GLA.

⁷⁴ [Children in Overcrowded Households in the UK. Research Springboard Briefing Note](#), March 2025. De Santis, G., Kovesdi, F., Stewart, K., & Taylor, S., University of Essex.

⁷⁵ [London Atmospheric Emissions Inventory LAEI 2022](#). GLA and TFL air quality.

⁷⁶ [Improving outdoor air quality and health: review of interventions](#), March 2019. PHE.

⁷⁷ [Fingertips](#), OHID. See Fingertips indicator details in the [Appendix](#).

⁷⁸ [Air Pollution and Inequalities in London- update 2023](#). GLA.

⁷⁹ [CHILL study](#). August 2026. QMUL.

10°C, limiting opportunities for the body to recover from daytime heat exposure.⁸⁰ UK-wide, heat-related hospital attendances and admissions could triple by 2050 compared to current levels, with impacts disproportionately concentrated in London.^{81,82}

Heat Ready London highlighted that Londoners aged 45-65 are at greater risk of a premature death during hot weather than their national counterparts.⁸³ Cardiovascular disease, the leading cause of premature mortality among Londoners under 75, is particularly affected by heat, with extreme temperatures increasing cardiovascular mortality risk by around 20%.⁸⁴ Certain socioeconomic groups are especially vulnerable.

Flood Risk

More intense rainfall events, combined with extensive impermeable surfaces and high urban density, raise the risk of surface water flooding.

Infectious Disease and Vector Risk⁸⁵

London's climate is already warm enough to support the establishment of harmful disease vectors. The risk is shaped by temperature, rainfall, population density and global travel patterns, with potential implications for health protection systems.

Inequalities and Future Risk^{86,87}

Climate risks in London intersect strongly with existing health inequalities. Individuals with long-term conditions, mental ill-health, insecure housing, homelessness or precarious employment are consistently more exposed and less able to adapt. UK-wide projections suggest that heat-related deaths could triple by the 2050s, meaning that without action, climate change is likely to worsen existing inequities in health outcomes.

⁸⁰ Climate Change Committee (2026) [Cost-effective adaptation research: Heat and health. UK Climate Risk Independent Assessment \(CCRA4-IA\).](#)

⁸¹ [Risks to Health and Health Services from Extreme Heat \(Edge Health and Greencroft Economics\).](#) May 2026. UK Climate Risk.

⁸² Heat-related hospital admissions 2050: [A Well-Adapted UK, May 2026. The Fourth Independent Assessment of UK Climate Risk \(CCRA4-IA\).](#) Climate Change Committee.

⁸³ [Heat Ready London: Adapting the city to a warmer climate. London: Greater London Authority.](#) 2026. GLA.

⁸⁴ Liu J, Varghese BM, Hansen A, Zhang Y, Driscoll T, Morgan G, et al. (2022) Heat exposure and cardiovascular health outcomes: a systematic review and meta-analysis. *Lancet Planet Health.*

⁸⁵ UK Health Security Agency (UKHSA) (2023) Health Effects of Climate Change (HECC) in the UK: State of the evidence 2023. London: UK Health Security Agency.

⁸⁶ Edge Health and Greencroft Economics (2026) [Risks to Health and Health Services from Extreme Heat: A report for the Climate Change Committee.](#) UK Climate Risk Independent Assessment (CCRA4-IA).

⁸⁷ Climate Change Committee (2026) [A Well-Adapted UK: The Fourth Independent Assessment of UK Climate Risk \(CCRA4-IA\).](#) London: Climate Change Committee.

Transport

Transport is a fundamental building block of health, influencing air quality, levels of physical activity, and people's ability to access employment, education, healthcare, and other essential services. In London, access to public transport is generally high. In 2024, 97% of Londoners lived within 400 metres of a bus stop, ensuring that the vast majority of residents had convenient access to bus services.⁸⁸

A broader measure of public transport accessibility is the Public Transport Access Level (PTAL), which captures connectivity across the transport network. PTAL scores show a well-established pattern of higher connectivity in central and inner London, around town centres, and along major rail corridors. As of autumn 2024, around 32% of London's population lived in areas with a PTAL score of four or above, indicating a high level of public transport connectivity.⁸⁹ However, connectivity is not equally distributed across the capital. Outer London boroughs tend to have much lower levels of accessibility, with boroughs such as Hillingdon and Enfield having an average PTAL score of 1b, indicating very low public transport accessibility.⁹⁰

Despite London's extensive transport network, inequalities in transport outcomes remain. Road safety is strongly associated with deprivation, with residents of the most deprived 30% of London neighbourhoods being 1.5 times more likely to be killed or seriously injured in a road traffic collision than those living in the least deprived 30%.⁹¹

This profile highlights that while public transport access is extensive across London, its benefits are not evenly shared. Geographical inequalities in transport connectivity and road safety persist, disproportionately affecting more deprived communities and some outer London boroughs, with important implications for health equity across the city.

Physical Activity and Active Travel⁹²

Physical activity levels in London show a mixed picture, with adults benefiting from active travel opportunities while children and young people remain less active than their peers elsewhere in England.

Active travel makes an important contribution to adult physical activity in the capital. Adults in London are significantly more likely than those in England overall to walk or cycle as part of their daily travel. Nearly three in ten adults (28.9%) report walking for travel at least three days per week, compared with 18.6% in England, while cycling rates are almost double those seen nationally (4.4% compared with 2.5%). This reflects London's higher population density, public transport use and infrastructure that

⁸⁸ [Travel in London 2025](#). Annual Overview. Transport for London.

⁸⁹ [Travel in London 2025](#). Annual Overview. Transport for London

⁹⁰ [PTAL Statistics | WebCAT 3.0 - Web-based Connectivity Assessment Toolkit](#). Transport for London.

⁹¹ [Vision Zero Action Plan](#), March 2026. Transport for London.

⁹² [Fingertips](#), OHID. See Fingertips indicator details in the [Appendix](#).

supports walking and cycling. However, Transport for London (TfL) analysis highlights significant inequalities in active travel across the city. Engagement in walking, wheeling and cycling varies by geography, ethnicity, and income. People with lower household income are less likely to cycle than high income groups, whilst walking trips remain similar.⁹³ In the most deprived areas (IMD 1-3), 32.8% of adults are inactive, compared with 19.3% in the least deprived areas (IMD 8-10).⁹⁴

Availability of sports facilities is associated with higher levels of adult physical activity. Twelve London boroughs are among the 15 English local authorities with the lowest provision of publicly accessible sports facilities per 10,000 population.⁹⁵

Crime, Safety and Social Cohesion

Crime and safety in London present a mixed picture, with improvements in some areas alongside ongoing challenges, particularly in relation to violence against women and girls (VAWG). Reported VAWG offences have increased, and actual figures will be much higher, reflecting a wider problem with underreporting in VAWG ⁹⁶.

Hospital admissions due to violence have declined over time, ⁹⁷ and more severe forms of violence have also shown improvement. London's homicide rate has fallen to 1.1 per 100,000 population,⁹⁸ the lowest level since records began and lower than other UK cities as well as many comparable international cities.

Among young people, there has been significant progress in reducing contact with the criminal justice system. In 2024, the rate of first-time entrants aged 10 to 17 was 156.5 per 100,000, a marked decrease from 432.8 in 2014. ⁹⁹ Despite this improvement, the rate remains higher than the England average, indicating continued disparities.

Overall, while London has seen encouraging reductions in serious violence, particularly homicide and youth offending, the rise in reported VAWG-related offences is of concern. Addressing these issues requires sustained efforts.

Social cohesion¹⁰⁰

London generally reports strong levels of community cohesion and social support. In December 2025, 96% of Londoners agreed that people from different backgrounds get on well together in their local area, up from 73% in 2008, with levels remaining above

⁹³ [Travel in London 2025](#). Annual Overview. Transport for London.

⁹⁴ Physical inactivity by IMD (2024/25): [Active Lives Adult Survey 2024/25](#), Sport England.

⁹⁵ [Access to sports facilities, supermarkets and museums in your local area](#). March 2024. ONS.

⁹⁶ [MPS Crime Dashboard](#)

⁹⁷ [Fingertips](#), OHID. See Fingertips indicator details in the [Appendix](#).

⁹⁸ [London's Homicide rate](#). January 2026. London City Hall.

⁹⁹ [London's Homicide rate](#). January 2026. London City Hall.

¹⁰⁰ [State of London - Social justice](#). June 2026. GLA.

90% throughout the post-pandemic period. Similarly, in 2024/25, 93% of Londoners said there were people they could rely on for help if needed, comparable to the England average (94%). However, some groups remain at greater risk of exclusion and isolation.

Digital exclusion

Digital exclusion remains an important inequality in London, affecting access to services, information and social participation. Data from the Survey of Londoners (2021/22) indicate that 4.5% of Londoners are digitally excluded. However, this risk is not evenly distributed across the population. Older adults are particularly affected, with almost one in five Londoners aged 65 and over (19.9%) experiencing digital exclusion. Similarly, people with disabilities are more than twice as likely to be digitally excluded as the general population, with a rate of 10.5%.¹⁰¹

Other built environment factors

Other factors in the built environment continue to shape exposure to health risks in London. The density of fast-food outlets increased across all regions between 2017 and 2024, with London's rate rising from 101.6 to 138.5 per 100,000 population. This is among the highest rates nationally and above the England average of 115.9 per 100,000. There are also substantial inequalities across the capital, ranging from 417.4 per 100,000 in Camden, the highest rate in England, to 65.5 per 100,000 in Richmond upon Thames.^{102,103}

Gambling is another important commercial determinant of health, associated with financial, health and relationship harms for individuals, families and communities.¹⁰⁴ In 2025, London had one of the highest densities of gambling premises in England, with 16.9 premises per 100,000 population compared with 12.9 nationally. Exposure varies considerably between boroughs, from 40.2 per 100,000 in Westminster to 8.5 in Sutton.

¹⁰⁵

¹⁰¹ [Survey of Londoners 2021/22](#). GLA.

¹⁰² 2024 data: [Fingertips](#). OHID. See Fingertips indicator details in the [Appendix](#).

¹⁰³ 2017 data: [Wider Determinants of Health](#), OHID.

¹⁰⁴ [Understanding gambling harms among communities experiencing marginalisation and inequality](#) (July 2024), NatCen.

¹⁰⁵ [Fingertips](#). OHID.

Conclusion

London remains one of the healthiest regions in England on many measures, with high life expectancy, a young and diverse population, and strong assets that support health and wellbeing. However, the evidence presented throughout this profile demonstrates that these positive overall outcomes mask deep and persistent inequalities between places, communities and population groups. People living in more deprived areas, inclusion health populations, and many ethnic minority communities continue to experience worse health outcomes and reduced opportunities for good health. These unequal outcomes reflect the combined effects of multiple factors including deprivation, structural racism, systemic challenges and inequalities in the building blocks of health that influence health throughout the life course.

The profile highlights a changing health landscape. While Londoners are living longer, many are spending more years in poor health, often affected by long-term physical and mental health conditions. At the same time, significant opportunities remain to prevent ill health through action on risk factors, increased uptake of prevention programmes, and earlier intervention across the life course.

Importantly, the findings reinforce that health is shaped by much more than healthcare. Housing, income, education, employment, transport, environmental quality, community safety and climate resilience all influence the health of Londoners and contribute to the unequal distribution of health outcomes across the capital.

Addressing these challenges will require sustained collaboration across organisations, sectors and communities. By focusing on prevention, tackling inequalities and acting on the building blocks of health, London has the opportunity to improve both the length and quality of life for current and future generations. The London Health Profile provides a shared evidence base to inform that collective action and support delivery of strategic activities, such as the London Health Improvement Plan.

Appendix – Fingertips Indicators

Below is full list of Fingertips indicators (indicator ID and description) by chapter in this report.

2. Health Status of London

[90366: Life expectancy at birth \(Female, All ages, 3 year range\)](#)

[90366: Life expectancy at birth \(Female, All ages, 1 year range\)](#)

[90366: Life expectancy at birth \(Male, All ages, 3 year range\)](#)

[90366: Life expectancy at birth \(Male, All ages, 1 year range\)](#)

[92901: Inequality in life expectancy at birth \(Female, All ages\)](#)

[92901: Inequality in life expectancy at birth \(Male, All ages\)](#)

[90362: Healthy life expectancy at birth \(Female, All ages\)](#)

[90362: Healthy life expectancy at birth \(Male, All ages\)](#)

3. Causes of early morbidity

[92973: Deliveries to women from ethnic minority groups \(Female, All ages\)](#)

[92196: Infant mortality rate \(Persons, <1 yr\)](#)

[20101: Low birth weight of term babies \(Persons, >=37 weeks gestational age at birth\)](#)

[93470: Proportion of infants receiving a 6 to 8 week review \(Persons, 6-8 weeks\)](#)

[93472: Proportion of children who received a 2 to 2 and a half year review \(Persons, 2-2.5 yrs\)](#)

[811: Children in care immunisations \(Persons, <18 yrs\)](#)

[93563: Percentage of 5 year olds with experience of visually obvious dental decay \(Persons, 5 yrs\)](#)

[91871: School pupils with social, emotional and mental health needs \(Persons, School age\)](#)

[92315: Percentage of looked after children whose emotional wellbeing is a cause for concern \(Persons, 5-16 yrs\)](#)

[93623: New referrals to secondary mental health services, per 100,000 \(Persons, <18 yrs\)](#)

[93622: Attended contacts with community and outpatient mental health services, per 100,000 \(Persons, <18 yrs\)](#)

[90813: Hospital admissions as a result of self-harm \(10 to 24 years\) \(Persons, 10-24 yrs\)](#)

[22304: Self reported wellbeing: people with a high anxiety score \(Persons, 16+ yrs\)](#)

[22303: Self reported wellbeing: people with a low happiness score \(Persons, 16+ yrs\)](#)

[848: Depression: QOF prevalence](#)

[41001: Suicide rate \(Persons, 10+ yrs\)](#)

[40401: Under 75 mortality rate from cardiovascular disease \(Persons, <75 yrs\)](#)

5. Risk factors of morbidity and mortality

[92443: Smoking Prevalence in adults \(aged 18 and over\) - current smokers \(APS\) \(Persons, 18+ yrs\)](#)

[92445: Smoking prevalence in adults in routine and manual occupations \(aged 18 to 64\) - current smokers \(APS\) \(Persons, 18-64 yrs\)](#)

[94247: Smoking prevalence in adults with a long-term mental health condition \(aged 18 and over\) - current smokers \(GPPS\) \(Persons, 18+ yrs\)](#)

[93672: Smoking prevalence in adults \(aged 18 and over\) admitted to treatment for substance misuse \(NDTMS\) - all opiates \(Persons, 18+ yrs\)](#)

93675: Smoking prevalence in adults (aged 18 and over) admitted to treatment for substance misuse (NDTMS) - alcohol & non-opiates (Persons, 18+ yrs)

93085: Smoking status at time of delivery (Female, All ages)

93675: Smoking prevalence in adults (aged 18 and over) admitted to treatment for substance misuse (NDTMS) - alcohol & non-opiates (Persons, 18+ yrs)

91183: Smoking prevalence age 15 years, regular smokers (Persons, 15 yrs)

91184: Smoking prevalence age 15 years, occasional smokers (Persons, 15 yrs)

94189: Regular e-cigarette users, 15 year olds (Persons, 15 yrs)

94190: Have ever used e-cigarettes, 15 year olds (Persons, 15 yrs)

93765: Admission episodes for alcohol-related conditions (Broad) (Persons, All ages)

93088: Overweight (including obesity) prevalence in adults, (using adjusted self-reported height and weight) (Persons, 18+ yrs)

20601: Reception prevalence of overweight (including obesity) (Persons, 4-5 yrs)

20602: Year 6 prevalence of overweight (including obesity) (Persons, 10-11 yrs)

93014: Percentage of physically active adults (Persons, 19+ yrs)

93015: Percentage of physically inactive adults (Persons, 19+ yrs)

93570: Percentage of physically active children and young people (Persons, 5-16 yrs)

93797: Non-Diabetic Hyperglycaemia (NDH): QOF prevalence (Persons, 18+ yrs)

811: Children in care immunisations (Persons, <18 yrs)

91101: Cumulative percentage of the eligible population aged 40 to 74 who received an NHS Health check (Persons, 40-74 yrs)

22001: Cancer screening coverage: breast cancer (Female, 53-70 yrs)

93560: Cancer screening coverage: cervical cancer (aged 25 to 49 years old) (Female, 25-49 yrs)

93561: Cancer screening coverage: cervical cancer (aged 50 to 64 years old) (Female, 50-64 yrs)

91720: Cancer screening coverage: bowel cancer (Persons, 60-74 yrs)

90244: Successful completion of drug treatment: opiate users (Persons, 18+ yrs)

92544: Adults with substance misuse treatment need who successfully engage in community based structured treatment following release from prison (Persons, 18+ yrs)

8. Building blocks of health

90282: Gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate (Persons, 16-64 yrs)

90898: Pupils with special educational needs (SEN) (Persons, School age)

93861: Air pollution: estimated fraction of mortality attributable to particulate air pollution (Persons, 30+ yrs)

93014: Percentage of physically active adults (Persons, 19+ yrs)

93015: Percentage of physically inactive adults (Persons, 19+ yrs)

93570: Percentage of physically active children and young people (Persons, 5-16 yrs)

11201: Violent crime - hospital admissions for violence (including sexual violence) (Persons, All ages)

10401: First time entrants to the youth justice system (Persons, 10-17 yrs)