

Neighbourhood health: an international exploration

What does a community-led approach to neighbourhood health look like?
Leila Morris looked at models in Brazil and New Zealand to learn more.

Supporting community-centred approaches to neighbourhood health

Across England, neighbourhood health has become an increasingly prominent idea in the future of health and care. It is often framed as a way to improve outcomes and experience, reduce inequalities, and relieve pressure on acute services by shifting care closer to people's homes.

Despite growing interest in neighbourhood health, there remains uncertainty about what neighbourhood health looks like in practice, what the ambitions for it should be, and what it takes to implement it effectively.

[In a previous long read](#), we explored the range of ideas and approaches captured by the term 'neighbourhood health' and set out a typology to help make sense of this variation. Drawing on The King's Fund's work across the health and care system, we suggested that neighbourhood health is commonly understood in three broad ways, each reflecting a different starting point for action at neighbourhood level.

First, neighbourhood health is used to describe how health and care services are delivered to patients, with a focus on improving access, continuity and co-ordination of care closer to home. Second, it refers to how a wider set of services come together locally – including health, social care, local government and the voluntary sector – to improve health and wellbeing in a place. Third, neighbourhood health is understood as a way of working in which communities play a central role in shaping, leading and delivering change.

This range of approaches is acknowledged in current national policy around neighbourhood health in England and reflected to different extents and in different ways across local systems. However, [national NHS frameworks](#) have given immediate priority to areas within health and care services such as GP access and clinical care for people with the highest health needs. This most closely reflects the first of the three approaches we have identified, as above.

As neighbourhood health develops, it will be essential to ensure that more weight is given to the other two aspects identified above. These approaches are essential to

delivering better health and wellbeing, as highlighted in previous work by The King's Fund and others on [population health](#), [place-based care](#), and [working differently with communities](#). Many of the factors that shape health sit outside formal services, and more relational, community-based ways of working are needed to tailor care and prevention so that they are most effective and address persistent gaps in equitable access. In this work, we have therefore chosen to explore two neighbourhood health models where sustained, community-centred approaches to neighbourhood health have been pursued.

- **The Family Health Strategy in Brazil** places neighbourhood health at the core of its primary care model, delivered through multidisciplinary teams with community health workers providing universal, proactive household outreach.
- **Healthy Families in New Zealand** represents a non-clinical, community led approach focused on strengthening local prevention systems by reshaping environments, relationships and decision-making across sectors.

These examples place community knowledge, leadership and relationships at the centre of how neighbourhood health is conceived and implemented. In this sense, their starting point aligns most closely with the third, community-led approach outlined above, whereas in England the emphasis has more often been on service delivery as described in the first approach. In both examples, preventive approaches are integral to the model itself, rather than treated as a separate priority – again, a contrast to how, in England, the ‘three shifts’ are often approached as distinct rather than mutually reinforcing.

By looking at these two examples, we aim to offer international experience not as a blueprint for replication, but as a way to sharpen thinking about ambition, design and delivery in the English context. This builds on our [recent work exploring what England and Singapore can learn from each other on neighbourhood health](#), offering different perspectives from different systems and approaches.

In the first part of this long read, the two case studies from Brazil and New Zealand are presented in detail, setting out their origins, design, workforce models, implementation journeys and evidence of impact. In describing these case studies, we draw on evidence from the literature and interviews with experts (see below for more information on methods). The latter part of the long read returns to the English context, setting out what lessons can be learnt from the international examples.

Methods

Identifying case studies

We chose the two case studies based on a combination of factors, focusing on:

- models that demonstrate a community-led approach to neighbourhood health
- models for which there is some published evidence of impact
- availability of documented information, specifically about the implementation of the models.

Evidence scan

We conducted a rapid evidence scan of the relevant and available literature on each of the case studies. This involved reviewing journal papers, academic and news articles, policy analysis and research reports.

Interviews with experts

We held semi-structured conversations with three key experts in each case study area. These individuals had been involved in, or had knowledge of, the design or implementation of the neighbourhood health models. In these conversations we also explored the insights gathered from the evidence scan.

Analysis

Our approach to the data analysis was iterative and inductive. Key findings from the literature and conversations with experts were recorded and summarised in a framework to aid thematic analysis. We held a series of internal discussions with the project team to draw together findings from the different activities and bring these together with relevant work previously produced by The King's Fund.

The broader health context in Brazil and New Zealand

Brazil's Unified Health System (Sistema Único de Saúde – SUS) is a large, publicly funded system established in the 1980s as part of wider social reform. It enshrines health as a universal right and places strong emphasis on primary care as the foundation of the system. Delivery is highly decentralised, with municipalities responsible for organising services for their populations. Historically, primary care provision was uneven, particularly in more deprived areas, and the development of the Family Health Strategy (see below) formed a central part of efforts to expand access and reduce inequalities. Over time, Brazil has seen significant improvements in key outcomes such as child mortality and life expectancy, though large geographic and socio-economic inequalities remain. The system continues to face pressures related to workforce availability, regional variation in capacity, and fiscal and political constraints.

New Zealand operates a publicly funded health system with strong national stewardship and a longstanding – albeit fluctuating – policy commitment to equity, including for Māori and Pacific communities. Although overall health outcomes are relatively strong compared with many countries, persistent disparities remain between population groups. Like many other countries, New Zealand faces ongoing pressures from an ageing population, chronic disease and service demand. In response, there has been an episodic emphasis on prevention and population health in recent years, recognising that many drivers of health sit outside clinical services. This context has created space for initiatives such as Healthy Families New Zealand, which work across sectors to influence the wider environments that shape health and wellbeing.

Brazil: The Family Health Strategy

Background and origins of the model

[Brazil's Family Health Strategy](#), introduced in 1994, is one of the most extensive and long-running neighbourhood-based primary care models globally. It emerged from major political and social reform following [Brazil's return to democracy in the late 1980s](#).

Before the Family Health Strategy, primary care was weak or absent in many areas, particularly poorer regions. Care was largely hospital-centred and reactive, with many people accessing services only once illness had become severe. This contributed to high levels of avoidable morbidity and mortality, especially among children and mothers, and placed sustained pressure on hospitals. The literature documents stark regional inequalities, with people in the poorest municipalities experiencing the worst outcomes.

Early community health worker initiatives in northeastern Brazil during the 1980s laid the groundwork for reform. In response to cholera outbreaks, locally recruited workers went door-to-door identifying cases and providing basic support, demonstrating the effectiveness of proactive household outreach.

Core design principles and defining features

The Family Health Strategy formalised early community health worker initiatives into a neighbourhood-based primary care model with a clear, prescriptive national design, centred around Family Health Teams.

The make-up of these teams [developed over time](#):

Based on the infrastructure they then developed it, they included a nurse to support the community health workers so that they would look not just at infectious disease outbreaks... but also chronic disease management, child health, breastfeeding support... and then over time, in around 1994... they started to incentivise the deployment of GPs into those teams as well.

(Co-national lead for the Community Health and Wellbeing Workers (CHWW) programme)

Today, there are around [240,000 community health workers \(CHWs\) in Brazil, supporting nearly 160 million people to access health and care support](#). That is around 60%–70% of the population nationally, and close to universal coverage in poorer, more deprived regions.

Each Family Health Team is responsible for a defined geographic population of around 100 to 150 households (3,000 to 5,000 residents). [Teams are multidisciplinary](#), typically comprising a doctor, a nurse, a nurse auxiliary, and 4 to 6 CHWs. The latter are recruited locally and are expected to visit every household at least once a month, regardless of whether a health need has been identified.

This universal, proactive household outreach is consistently identified in the literature as central to the model's effectiveness. Rather than targeting only high-risk individuals, [the model establishes continuous relationships with all households](#), enabling early identification of risk, ongoing support for long-term conditions, and improved population-level surveillance.

Although limited local adaptation is permitted, the core components are nationally protected. Interviewees and findings from the literature strongly emphasise the importance of this clear national direction:

There's always going to be some flex in the way it's delivered... And that's important to do because it depends on the demographic and epidemiological aspects of that context... [however, overall], the model [has been] very prescriptive.

(Co-national lead for the CHWW programme)

Workforce model and ways of working

The literature consistently identifies Brazil's CHWs as the backbone of the Family Health Strategy. Each CHW typically covers around 120 to 150 households, providing health promotion – eg, by monitoring pregnancies and child development,

supporting people with long-term conditions, and identifying social and environmental risks.

Training for CHWs is relatively short and pragmatic. [The literature shows](#) that they are typically recruited from the communities they serve and are not required to have extensive prior health training. Initial preparation usually consists of a short structured programme – commonly around 6–8 weeks of classroom-based learning followed by a period of supervised fieldwork (typically 4 weeks). This model emphasises learning by doing, with training closely tied to the realities of doorstep work, including communication, health promotion, and identifying social and clinical needs within households.

Community health workers act as a bridge between families and clinical teams. Information gathered during household visits is discussed in regular meetings with nurses and doctors, shaping proactive care planning and contributing to the generation of population-level insights. This household-level intelligence has also [improved health surveillance and data quality](#) in many regions.

Interviewees highlighted the relational nature of the role. Trust, continuity and cultural alignment were repeatedly cited as critical.

They're from that community, so they're more trusted. They speak the language metaphorically and literally, know the people, know the assets, know what the problems are in each of those micro areas and can tailor and adapt.

(Co-national lead for the CHWW programme)

Over time, CHWs have gained strong professional recognition, including unionisation and extensive employment protections enshrined in law. Although this has supported workforce stability, both interviewees and the literature note tensions within teams where employment conditions differ between roles.

Implementation journey and scaling

The implementation of the Family Health Strategy is widely regarded as a global exemplar of scaling neighbourhood-based primary care. A key enabling factor was the ability to design the model largely from scratch.

Political champions from Brazil's collective health movement translated early local innovation into national policy, supported by a strong academic evidence base. [Federal funding mechanisms were critical](#). Municipalities received funding conditional on adopting the Family Health Strategy model, aligning national priorities with local delivery while allowing some adaptation.

Despite these strengths, implementation was not without challenges. Both the literature and interviewees highlighted uneven municipal capacity, gaps in clinical and public health expertise, shortages of primary care doctors, and ongoing difficulties in integrating with secondary care.

Outcomes, impacts and evidence base

Brazil's Family Health Strategy has a very strong evidence base, in part due to the length of time it has been in place. Across Brazil, [the strategy's coverage has supported](#):

- a reduction in under-five mortality by 75%
- a reduction in maternal mortality by nearly 60%
- increased immunisation coverage – up to 98% in 2000
- [reduced avoidable hospitalisations for conditions such as cardiovascular disease, asthma and stroke](#)
- a narrowing of health inequalities between poorer and wealthier regions.

The model is also considered to be highly cost-effective, with earlier studies estimating [costs of \\$31– \\$50 per person per year](#).

Interviewees acknowledged attribution challenges in a complex policy environment, but emphasised the strength and consistency of the evidence, and the role of rigorous evaluation in supporting the sustainability of the model.

Sustainability, adaptation and current risks

The literature shows that the Family Health Strategy has [demonstrated remarkable durability](#), surviving multiple political cycles and periods of austerity. Supporting factors include its low per capita cost, extensive employment protections, and high visibility to communities.

There are three key things that happened over the years that [have been] absolutely critical to the [programme's] sustainability. The first was that the funding was secure and from the central federal government... The second thing was the role of higher education institutions that conducted research about the implementation of CHWs, which showed health outcomes were improving at a national level... And then the third very important thing was that there were changes to the curriculum around training doctors and nurses that [included] the importance of family medicine and community medicine.

(Professor, Public Health School of the federal district)

However, interviewees highlighted the emerging risks, including the role of the CHW drifting towards more clinic-based work, as well as workforce fatigue and political pressures that threaten funding and fidelity:

They're drifting increasingly into being more clinic-based rather than street-based, becoming more medical rather than community... There are other issues around the fact that it's been going for 30 years and it's not easy work. Dealing with the same houses over and over again, inevitably, you're going to lead to some sort of boredom or attrition or lack of motivation.

(Co-national lead for the CHWW programme)

Community health workers in England

Community health worker models have been piloted across England, including in Westminster, Warrington, Calderdale and Cornwall, drawing on lessons from Brazil. In England, these roles are called community health and wellbeing workers (CHWWs). They aim to address a system that remains largely reactive, where care is often accessed at points of crisis, leading to late intervention and unequal access.

As in Brazil, [CHWWs in England are non-clinical, hyperlocal roles](#), prioritising relationship-building, continuity and neighbourhood presence over task-based activity. Their role is to identify unmet need early and act as a consistent, trusted point of contact, particularly for people less likely to engage with formal services.

Integration with primary care was a core ambition of the English CHWWs model, mirroring the team-based approach seen in Brazil's Family Health Strategy. However, interview evidence suggests that this integration has been uneven and fragile in practice. Although some sites have developed constructive relationships with GP practices and primary care networks (PCNs), others have struggled to secure engagement due to workload pressures, data-sharing concerns, and scepticism about new roles. In many areas, integration depended less on formal structures and more on the presence of trusted local champions and strong interpersonal relationships.

It's supposed to be a primary care intervention. They're supposed to have that integrated relationship with their primary care team... but just getting the buy-in, getting time from GPs, from PCNs [is challenging]...

(Health services researcher)

A major constraint on the English CHWW model relates to funding and sustainability. The literature shows that [most English pilots have relied on short-term, locally assembled funding streams](#), typically lasting between 12 and 24 months – a striking contrast with how the roles were financed in Brazil. It is worth noting, however, that England is still in the early stages of developing neighbourhood health approaches, and may be better compared to Brazil in the early 1990s, when the model was first being established and scaled. Interviewees were clear that these timescales are

fundamentally misaligned with the relational nature of the work, but the Brazilian experience suggests that longer-term commitment and more stable funding arrangements emerged over time as the model matured and became embedded within the wider system.

The fragility of funding arrangements also undermines workforce stability, and risks damaging trust with communities when programmes are withdrawn or scaled back just as relationships begin to embed.

The literature on the English CHWWs model notes that many of the earliest impacts of CHWWs model include increased engagement with preventive services, earlier identification of risk, improved co-ordination between services, and stronger continuity of support for people with complex needs. Evaluations also point to improved trust and confidence among residents who are less likely to engage with traditional services, suggesting that the model's value lies as much in reshaping relationships between communities and the system as in reducing activity in any single part of it. Some pilot sites have also been able to report [specific positive outcomes for their populations](#), such as, in Westminster, increased vaccination and screening rates, and a 7% drop in unscheduled GP visits in the first year.

However, measuring impact was identified as a challenge by interviewees who expressed concern that conventional metrics, such as changes in GP appointment volumes or hospital use, fail to capture the most meaningful outcomes of relational neighbourhood work.

How you measure the impacts of the relational approach [is challenging]. The fact that old Janet was isolated for years and now she has somebody coming round every couple of months and feels a bit better and she's less likely to fall and be forgotten about... how do you measure that?

(Health services researcher)

Further reading

[Horizontal equity in health care utilization in Brazil, 1998-2008](#)

[Evaluating the impact of community-based health interventions: evidence from Brazil's Family Health Program](#)

[Brazil's community health workers inform primary care reforms in England](#)

[Work of community health agents in the Family Health Strategy: meta-synthesis](#)

[Primary health care in Brazil](#)

New Zealand: Healthy Families

Background and origins of the model

[Healthy Families New Zealand](#) was launched in 2014 in response to rising chronic disease and persistent health inequities, including affecting Māori and Pacific communities. Although New Zealand performs relatively well on overall health indicators, [preventable illness and inequalities in health outcomes have persisted over time](#), reflecting the ongoing influence of wider social determinants and the limits of existing public health approaches.

The literature highlights concerns that decades of [programme-based health promotion – often focused on individual behaviours or single risk factors – had not delivered sustained, population-level change](#). Many of the drivers of poor health sat outside the health system itself, shaped by food environments, housing, transport, education, and local policy decisions. This context led to growing interest in place-based and systems-change approaches capable of addressing the wider determinants of health.

HFNZ was therefore conceived as a deliberate shift away from programme delivery towards [long-term prevention through place-based systems change](#), with a strong focus on equity, community leadership and cross-sector collaboration. Although it does not deliver neighbourhood health through clinical services directly, it operates at a defined local level, working with communities and partners to reshape the conditions that influence health. In this sense, it represents a distinctive form of neighbourhood health – one centred on enabling communities and local systems to drive change.

Core design principles and model logic

Healthy Families New Zealand was explicitly designed as a non-clinical, place-based systems change initiative. Rather than delivering services directly to individuals, it seeks to reshape the environments and systems that influence health in the places where people live, learn, work and play.

Across the literature and interviews, several defining features stand out:

- a systems change approach (more information in the box below)
- delivery through locally embedded lead providers, including Māori and Pacific-led organisations, local governments and regional sports trusts
- community codesign as a core expectation

- high-trust, long-term commissioning (four-year contracts), allowing adaptation within clear national principles.

The literature emphasises that this design represented a [significant departure from traditional health promotion models](#) and required considerable effort to establish shared understanding of what ‘systems change’ meant in practice.

Healthy Families New Zealand draws on a systems change approach that is grounded in public health and complexity theory literature, particularly work on whole-systems approaches to prevention. Rather than delivering programmes or services to individuals, a systems change approach focuses on altering the structures, relationships, policies and norms that shape health outcomes across a community. For example, rather than running a programme to encourage individuals to eat more healthily, a systems change approach might work with local councils, schools and retailers to change food environments – such as improving access to healthy food in public facilities, influencing local procurement policies, or reducing the availability of sugary drinks.

In this model, systems change is articulated through frameworks such as the [Six Conditions of Systems Change](#) and the [Building Blocks for Prevention](#), which emphasise changes to power, relationships, resource flows, formal rules and shared norms. Progress is understood not only as changes to health behaviours and outcomes, but also as changes in how systems operate – for example, how decisions are made, how organisations work together, and whose knowledge is valued.

[The] systems change approach recognises that there are [many] pieces of the jigsaw and the more you can connect those pieces up, the better chance you have of achieving the impact you want – you can't just look at two pieces of the jigsaw.

(Group Manager)

Workforce and ways of working

Although frontline clinical roles remain central to the health landscape in New Zealand, the Healthy Families New Zealand teams add a distinct function as non-clinical system connectors, working alongside existing services to build relationships, align organisations, and enable community leadership rather than provide care directly. Teams typically include a location manager, communications roles and ‘systems innovators’ whose work focuses on influencing policy, strengthening relationships and enabling collective action across sectors.

The literature describes these teams as acting as connective infrastructure between organisations, helping to align councils, schools, sports organisations, businesses, Māori organisations and health services around shared goals. Rather than owning

delivery, Healthy Families New Zealand teams add value by building relational infrastructure supporting local leadership and building capacity within communities.

Early national investment in professional development was critical to building systems change capability across the workforce. However, interviews and evaluation evidence both note that ongoing capability development is required as staff turnover occurs, and that [skills in relationship-building, facilitation and adaptive leadership are central to success](#).

Implementation and governance

[Healthy Families New Zealand was inspired by the Healthy Together Victoria initiative in Australia](#). The programme operates across 11 locations (which together cover around [1.4 million people](#)), selected on the basis of deprivation, population need, and readiness to implement a systems change approach.

Implementation has been supported through four-year contract cycles, allowing reflection, learning and adaptation over time. The literature highlights that longer-term contracting has helped stabilise the workforce and support relationship-building.

Interview evidence points to the importance of strong national leadership in the early years, providing coherence, shared narrative and opportunities for collective learning across sites, particularly about how to effectively implement systems change approaches. Interviewees emphasised that systems change was a novel approach in 2014 and required sustained effort to communicate. Over time, this has become a well-understood and practised approach, integral to the model.

One thing we learnt really early on was to have common narrative. We were all saying the same thing, explaining systems change in the same way across our 11 teams.

(Principal Service Development Manager)

Implementation success has varied by local context. The literature and interviews suggest that delivery has often been strongest where lead providers are well embedded in local systems, and when lead providers were able to connect and influence local government, who were likely to hold policy levers aligned to prevention and place-based working.

At the same time, [reductions in national team capacity](#) have increased fragility and limited opportunities for scaling.

Outcomes, impacts and measurement

Alongside the Healthy Families New Zealand initiative, a long-term evaluation was commissioned, and has now been running for more than 10 years. This reflects an

explicit recognition that systems change approaches take time to deliver meaningful results, and that short-term evaluation would not capture the full range of impacts. As a result, the programme has been evaluated with a focus on understanding change over time, rather than expecting rapid, measurable shifts in health outcomes.

Both the literature and interviews indicate that many of the most visible impacts of Healthy Families New Zealand to date are at the systems level. [Evaluations](#) report strengthened local prevention systems, improved collaboration across sectors, and tangible changes to local policies and environments, including food systems, physical activity opportunities and community spaces. They also highlight increased community leadership and capability, and the embedding of Māori worldviews and relational approaches within prevention practice. Interviewees consistently suggested that these changes are foundational to longer-term improvements in population health and equity.

Quantitative population-level outcomes have been slower to emerge and, to date, mixed. This reflects both the long-term nature of partnership working and community development, and the challenges and nuances of attributing change within complex systems.

We actually don't expect that the population are going to be well after two years, but [we should ask ourselves] what are the signals to show that we're shifting and moving in the right direction?

(Principal Service Development Manager)

This perspective has led to an emphasis on tangible changes evidenced by the local teams, and identifying 'signals of change' – such as shifts in policy, partnerships and norms – rather than relying solely on short-term health indicators. For example, rather than delivering a new maternal health programme, the HFNZ Rotorua team worked with communities to redesign how services were organised locally, with progress evidenced through stronger partnerships, improved access pathways and community leadership.

There is [some promising quantitative evidence of improvements](#) in health outcomes, including better child health measures and reductions in adult smoking rates. However, a core feature of the initiative – its flexibility to respond to local priorities – also makes consistent evaluation challenging. Evaluation has therefore relied heavily on qualitative methods, [building detailed case studies to illustrate how change happens over time](#).

All the different communities have different priorities and focus on different things, so it's very hard to evaluate with any kind of consistent measures. So [the evaluation] has been more qualitative and focused on [tangible local changes and] the 'how'.

(Evaluation team, Principal Investigator)

Sustainability, adaptation and scale

[Healthy Families New Zealand](#) has demonstrated political resilience, continuing through changes in government and repeated funding reviews. It is relatively low cost and is flexibly implemented, which has supported this durability.

The flexibility – teams being... guided by quite general principles but being able to look at what's happening locally and act on those things – that's been key.

(Evaluation team, Principal Investigator)

However, the literature and interviews also note [ongoing fragility](#). Prevention funding remains vulnerable during periods of wider system pressure, and scaling beyond existing sites has been constrained by lack of new investment rather than lack of demand or evidence.

The initiative has adapted incrementally at each contract renewal, with increasing attention to sustainability, national co-ordination, and clearer articulation of outcomes to policy-makers.

Further reading

[New Zealand Health Strategy: future direction](#)

[Interim evaluation report – Healthy Families NZ](#)

Linking back to the English context

Plans for the implementation of neighbourhood health are developing at pace in England. By looking to these models within Brazil and New Zealand, we aim to offer international experience not as a blueprint for replication, but as a way to sharpen thinking about ambition, design and delivery in the English context.

How neighbourhood health is currently being implemented

In England, the government's [neighbourhood health framework](#) sets out five goals for neighbourhood health over the next three years.

1. Improve health outcomes, focused on high priority cohorts.
2. Improve access to general practice.
3. Improve experience of planned care, including diversion of referrals from secondary care and introducing neighbourhood-based follow-up.
4. Improve urgent and emergency care performance, including reducing emergency department attendances for high priority cohorts.
5. Improve patient and staff satisfaction.

Health and wellbeing boards, integrated care boards and local authorities can also set their own priorities and outcomes depending on community need.

Although the intention of national policy over the longer term is for neighbourhood health to improve the health of communities, the immediate priority areas are focused on improving health and care service delivery and reducing pressure on secondary care services. Immediate actions for the next year include reducing hospital demand, improving access to general practice, elective care reform, and reducing community health waiting times. This contrasts with the international case studies that we have focused on in this report, which have a more upstream prevention focus, rooted in local communities.

However, there are many examples of initiatives in England that are taking a broader approach that is more aligned with the models we have studied:

The Whitehawk Health Hub

[The Whitehawk Health Hub](#), hosted by the East and Central Brighton Primary Care Network, is a [community-based initiative designed to reduce health inequalities](#) in one of Brighton's most deprived areas. Operating as a weekly drop-in service at a community hall, the hub brings together a multidisciplinary team (including clinicians, mental health practitioners, social prescribers and benefits advisers) to provide integrated, person-centred support without the need for appointments. By addressing both the medical and social determinants of health, the hub aims to ease pressure on GP services, improve access to care, and build community resilience.

High Intensity Use services

[High Intensity Use \(HIU\) services](#) are delivered across England by a range of organisations, including the British Red Cross (BRC). These have a focus on interdisciplinary working, prevention, and delivering care and support in the community. The BRC's HIU services are based on the NHS RightCare model, in which an agreed number of people who frequently attend accident and emergency (A&E) in a particular area are identified by practitioners and asked if they would like

to try something different. The support provided involves a [person-centred and strengths-based approach to identifying unmet needs](#) that are worsening people's mental and/or physical health. This may involve connecting people to social networks, and housing and wellbeing resources.

The Hub in Fleetwood

[The Hub in Fleetwood](#), Lancashire, is a former hospital building, now owned by the Fleetwood Trust and operating as a community hub. It offers a range of services to local people, including access to affordable food, mental health support, social prescribing, and volunteering opportunities. The space is designed to be informal and inclusive, encouraging people to drop in, connect and contribute. It is not just a service centre; it is a place where relationships are built and where residents, local organisations and public sector partners collaborate to tackle issues such as isolation, poverty and poor health. [The approach shifts power to the community](#), recognising local people as assets and co-creators of solutions, rather than passive recipients of care.

The Wigan Deal

Wigan has adopted a citizen-led, asset-based approach to health and care ([the Wigan Deal](#)), built on a renewed relationship between public services and local people. It focuses on [recognising community strengths, empowering residents, and fostering collaboration](#) across health, social care and other sectors within neighbourhoods. In practice, this includes initiatives such as community link workers connecting residents to local support groups, social activities and volunteering opportunities, as well as neighbourhood hubs where people can access advice, health checks and social prescribing in one welcoming space. Based on the success and learnings from the Wigan Deal, Wigan Council has now developed the [Progress with Unity plan](#) – a new movement for change over the next decade, with a core focus on enabling neighbourhoods to flourish.

What can we learn from these case studies?

Taken together, the experiences of Brazil's Family Health Strategy and Healthy Families New Zealand illustrate that neighbourhood health can be realised in different ways, but that success appears to depend on a set of shared enabling conditions. These provide a useful frame for considering how neighbourhood health is being developed in England, and what might support its progress over time.

Clarity of ambition and shared narrative

In both case studies, neighbourhood health was underpinned by a clear and coherent purpose. In Brazil, the ambition was to make neighbourhood-based, proactive primary care the default model. In New Zealand, it was to shift towards prevention, equity and systems change.

For England, an important starting point is how clearly the purpose of neighbourhood health is articulated. What is it intended to change, and how does that shape priorities, design and expectations across the system?

Long-term commitment and sustained investment

Both models have been supported by long-term political backing and relatively stable funding. Progress has been built over time, reflecting the nature of relational and preventive approaches, where impact is often gradual and cumulative.

In the English context, this highlights the importance of considering how neighbourhood health is supported over the short, medium and long term, and how expectations about pace and outcomes align with the work involved.

Balancing national direction and local flexibility

A further lesson is the balance between national direction and local responsiveness. The Family Health Strategy provides a clearly specified national model, while HFNZ allows greater flexibility for local adaptation. In practice, both combine a strong overarching framework with space for local interpretation.

For England, this points to the importance of achieving clarity and consistency at a national level while enabling local systems to respond to their specific contexts and communities.

Investing in relational capacity

Across both case studies, neighbourhood health is fundamentally relational. Sustained, trusting connections between people, communities and services enable early identification of need, continuity of care, and stronger engagement with prevention.

These examples highlight the importance of considering how workforce models, support structures and ways of working can enable this relational approach, and how such work is recognised and sustained over time.

Aligning funding, workforce and measurement

In both models, neighbourhood health has been supported by alignment between funding arrangements, workforce design and approaches to evaluation. Notably, both recognise that conventional performance metrics do not fully capture the value of relational and preventive work.

This draws attention to how success is defined and measured in England, including how systems balance short-term performance expectations with longer-term goals, and how progress in the early stages of implementation is understood.

The role of commissioning and system leadership

Commissioning and system leadership have played a central role in shaping delivery in both case studies. Funding models, contractual arrangements and outcome frameworks have helped signal priorities while enabling flexible ways of working that focus on long-term change.

Within England, this connects closely to the role of strategic commissioners in setting direction and creating the conditions for delivery. Consideration of how commissioning approaches can support collaboration, flexibility and longer-term change will be an important part of implementation.

Looking ahead

Overall, these case studies exemplify neighbourhood health as a broader shift in how systems are organised around people and communities. They highlight the importance of aligning ambition, funding, workforce and measurement, while recognising the time and conditions required for relational ways of working to take root.

In both Brazil and New Zealand, neighbourhood health is closely connected to community leadership and prevention, with these elements embedded in the core design of the models rather than developed separately or at a later stage.

These case studies strongly suggest there is value in extending the English shared narrative around neighbourhood health to more explicitly encompass community-led approaches alongside service-based delivery models. Doing so could help unlock wider benefits – not only in improving health and reducing inequalities, but also in supporting the longer-term ambition of re-orienting the health and care system towards prevention.

The opportunity for England therefore lies not only in bringing together the enabling conditions for neighbourhood health in practice, but also in how the ambition itself develops over time – building on current priorities while creating space for a broader, more integrated understanding of what neighbourhood health can achieve.