sustainability

MDPI

Article

Compliance with COVID-19 Regulations in Cities vs. Suburbs: The Role of Communities' Forms of Capital in Communities' Health Sustainability

Emil Israel * and Tal Feder

Faculty of Architecture and Town Planning, Technion—Israel Institute of Technology, Haifa 3200003, Israel
* Correspondence: emil.israel@technion.ac.il; Tel.: +972-73-3784069

Abstract: Urban areas are regarded as a sustainable form of settlement, while the planned and built environments of cities are considered essential for the development of healthier communities. Nonetheless, urban sprawl has caused disparities in the health of those living in cities vs. suburbs. One explanation for this disparity is the willingness of residents to comply with the recommendations and instructions of health care experts or public directives. Compliance is an essential part of what makes communities resilient. However, we know little about the factors that influence this compliance. To fill this gap, we examined data from Israeli municipalities in cities and suburbs about compliance with the government's COVID-19 regulations. We investigated whether social and physical aspects of cities and suburbs explain differences in compliance. We researched how the residents' economic, social, and cultural capital, as well as their spatial distribution, influenced their compliance during the pandemic. The results demonstrate the important role of the spatial distribution of these various forms of capital in the residents' compliance. Specifically, those living in suburban areas benefited from their capital accumulation, making them more inclined to adhere to the health regulations. This new perspective on the dynamics between cities and suburbs may strengthen community resilience and help mitigate regional disparities.

Keywords: city suburb; compliance; public health; COVID-19; capital forms

Academic Editor: Robert Krzysztofik

Received: 21 October 2024
Revised: 15 January 2025
Accepted: 19 January 2025
Published: 25 January 2025

Citation: Israel, E.; Feder, T. Compliance with COVID-19 Regulations in Cities vs. Suburbs: The Role of Communities' Forms of Capital in Communities' Health Sustainability. *Sustainability* **2025**, *17*, 983. https://doi.org/10.3390/su17030983

1. Introduction

Urban areas are considered to be an ecologically sustainable form of settlement. Nevertheless, urban sprawl has generated and exacerbated various conditions—economic, social, and political—that have resulted in health disparities between urban and suburban communities [1,2]. One explanation for this disparity is the willingness of residents to comply with the recommendations and instructions of health care experts or public directives [3]. The evidence indicates that urban communities' social status influences their health [4,5]. Compliance, in the context of health behavior, is defined as "the extent to which a person's behavior coincides with medical or health advice" (Ref. [6], p. 718), and is essential for communities' resilience [7,8]. However, we know little about the factors that influence compliance. To fill this gap, we examined compliance with COVID-19 regulations in Israeli cities and suburbs.

During the COVID-19 pandemic, many countries implemented different measures to reduce the spread of the virus [9]. However, individuals showed varying degrees of adherence to these limits [10,11]. Scholars have identified various factors that prompted people to do so [12,13]. The COVID-19 pandemic has also highlighted the link between people's health and where they live [14,15]. Densely populated and poorer urban areas

were affected more severely than suburban localities by the spread of the disease [16,17]. The image of suburbs as safer and less prone to restrictions led to a shift in housing demands away from cities and toward the suburbs [18]. Indeed, previous studies have indicated that those who live in small and relatively homogeneous suburbs enjoy better life chances than those who live in large and diverse cities [19]. Given the importance of cities on human health [20], and considering the fierce competition with suburban enclaves, identifying the factors that promote or impede healthy communities is imperative.

This paper sets out to explain how differences between cities and suburbs influence people's adherence to health directives. As one step in this direction, we investigated the differences between the residents of Israeli cities and suburbs in their level of compliance with the government's COVID-19 regulations. We also explored whether these cities and suburbs' physical and social characteristics played a role in shaping compliance. To this end, we utilized Pierre Bourdieu's [21] concept of three forms of capital—economic, cultural, and social—and their role in the communities' spatial opportunity structures [22,23]. We used regression models to evaluate the influence of capital and the physical characteristics of communities on their residents' compliance with health directives and recommendations. By adopting this approach, we concur with Keil [24], who noted that "in a majority urban world, most activity in terms of the expansion and contraction of urban population, built form and economic activity will occur in peripheral areas. So that our urban century is really a suburban one" (p. 15). Developing a new perspective on the reciprocal interactions between cities and suburbs with regard to compliance with COVID-19 regulations might shed light on the social mechanisms that drive health behaviors in both types of communities.

This study contributes to the existing literature on geographical inequality, providing methods for measuring the relationship between social stratification and individual behavior, location, and community sustainability in terms of health. By developing a multi-disciplinary approach that connects sociology to geo–urban variations in compliance with COVID-19 laws during the pandemic, we address and measure the adherence to medical and health advice, which aids in the identification of health disparities between forms of localities.

The relationship between an individual's living environment, their status within the social hierarchy (i.e., types of capital), and the influence of this relationship on general well-being and health deserves further analysis. Integrating spatial elements present in the built environment of various social classes provides novel insights into health-related behaviors regarding compliance and adherence. Consequently, we contribute to the literature on local health policy and aim to enhance urban public health initiatives in cities and suburban areas. Such actions can bolster community resilience, potentially diminishing regional disparities linked to geographic location.

2. Review of Research

2.1. Suburbs and Cities, Health and Compliance

Suburbanization is a widespread, multifaceted phenomenon that has taken place worldwide. Suburbanization in North America and Israel is characterized by low population density, encompassing both residential and non-residential land uses [25,26]. In Western Europe, suburbs are much more densely populated [27]. In nations where rapid urbanization has taken place, such as China or Turkey, suburbanization frequently receives support from government initiatives, resulting in more compact physical structures. However, the prevailing pattern of suburban development, characterized by low population density, persists in various regions across the globe, including Africa and Eastern Europe [24,28]. Conversely, cities are much more diverse in the social mix of people who

inhabit them and are likely to feature multifamily housing, gridiron street patterns, and mixed land uses [29,30]. Evidence from North America, where the phenomenon has received the most scholarly attention, shows that, despite the distinction between cities and suburbs, the latter are seeing an increase in socioeconomically, racially, and ethnically diverse populations [31–34], providing a refuge for individuals who lack the resources required to maintain a satisfactory standard of living in urban areas [35]. From a global perspective, suburbs are increasingly regarded as the preferred option for a growing middle class [36,37], while simultaneously being perceived as "vulgar" sites of consumption and excess [38,39]. This present study focuses on the latter manifestation, wherein suburbs are frequently portrayed as centers of distinction [40,41].

The results of studies about the health of people living in cities vs. suburbs have been inconclusive. Some have linked living in cities with poorer health outcomes, a phenomenon sometimes referred to as the "urban health penalty" [42,43]. Living in cities is also associated with lower life satisfaction [44] and health problems including respiratory disease and cancer [45,46]. However, there is also evidence that city life is associated with better health care infrastructure and people's well-being [47,48].

Suburbanization also affects its residents' health [1]. Suburban areas provide several benefits, including increased life satisfaction, a sense of purpose, and happiness [2,49–52]. Additional factors contributing to the "smaller is better" advantage are the homogeneous population and informal social contacts in small communities that create more robust social networks [53]. Nevertheless, there are studies documenting the negative effects of life in suburban areas, such as decreased life expectancy [54], compromised nutrition and dietary habits [55], higher rates of obesity [56,57], greater incidences of cancer, and more mental health issues. This last impact is related to suggestions linking suburbanization to isolation and loneliness [58,59].

Unsurprisingly, research has found a link between socioeconomic class and community health [60,61]. Economic wealth in suburban communities is linked to more expansive housing and better health [62]. In contrast, low-income urban and rural communities often have less access to stores selling healthy food and instead have an abundance of unhealthy options [4,63,64]. Cities frequently have higher poverty levels than suburbs [65,66]. Acevedo-Garcia et al. [67] found that urban ethnic segregation negatively affects health, whereas strong social networks and social support positively impact it [68,69]. Socially homogeneous suburbs have stronger social networks and more trusting relationships than cities do [70]. There is an increasing body of research suggesting that large and ethnically diverse cities have a detrimental impact on the social solidarity and subsequent social capital of its residents [71].

In certain global contexts, suburban life is frequently linked to conformity and cohesion [40,41,72]. Increasing a community's socioeconomic variety may exacerbate existing inequalities, undermining the effectiveness of social norms meant to encourage people to follow recommended health practices [12,73]. Thus, a strong sense of community belonging may boost its residents' commitment to its well-being and keep them from engaging in behaviors that would jeopardize it [74].

Conversely, research shows that city dwellers are more likely than suburbanites to adhere to healthy behaviors related to dietary recommendations [5,75]. Better compliance was associated with a higher educational level and a healthier overall lifestyle [11,76]. We see echoes of these findings with regard to the COVID-19 pandemic. For instance, English and Li [77] reported that people in Shanghai, China wore masks more frequently in places with higher population densities than in the suburbs, which posed less of a risk than in the city. Or, consider the United States, where partisanship significantly influenced the adherence to COVID-19 protocols, resulting in increased excess mortality rates among

Republicans [78]. Partisanship is not evenly distributed across space, with Democrats clustering in cities and Republicans in rural and outlying suburban areas [79].

2.2. Compliance and COVID-19

Compliance was important in reducing the spread of the COVID-19 pandemic. However, research has yet to produce a clear metric for determining compliance and the environmental and human factors that influence it.

Researchers have used traditional survey methodologies and big data techniques to measure COVID-19-related compliance. Survey methods recorded respondents' levels of adherence to government-imposed restrictions by asking about actual or intended behavior [11,80,81]. Big data methods included GPS data from cellphone providers, apps such as Google and Uber that use location information, and information about traffic congestion and public transportation use to assess attempts to reduce mobility [82–84].

While survey-based research can collect sociodemographic information, attitudes, and behavioral data at the individual level and examine how they affect compliance, big data methods are constrained by privacy and data availability limitations. They also cannot capture rich individual-level information and must use spatial-level factors as compliance predictors. For example, Painter and Qiu [83] used regional trust levels, voting patterns, and state partisanship as explanatory variables for compliance, while Wright et al. [84] utilized regional economic levels. The study revealed that those with higher incomes and more economic stability were more likely to comply with COVID-19 regulations.

Other studies have identified risk perceptions and fear of the pandemic as having significant positive correlations with compliance with COVID-19 limitations [80,85–88]. Trust in science and the government are also positively correlated with compliance [10,11,80]. However, the association between compliance and social factors such as conformity, mutual responsibility, and ingroup loyalty is more ambiguous [10,11,86]. Likewise, studies examining the relationship between educational level and compliance are inconclusive. Some suggest a positive correlation [11,89] but others present a more ambiguous link [80] or a negative association [10].

Thus, situational and individual factors can affect compliance [85]. Additionally, cities and suburbs vary in their resources and characteristics. Therefore, we used Pierre Bourdieu's theoretical framework of three forms of capital—economic, social, and cultural—to examine their impact on community adherence to the COVID-19 regulations.

2.3. Three Forms of Capital in a Spatial Perspective

Bourdieu's theory introduces the concepts of habitus, field, and three forms of capital: economic, cultural, and social [21]. *Economic* capital refers to financial or other tangible resources of wealth that may be exchanged for money. *Social* capital usually refers to the strength of people's ties to the social groups and networks they are part of. Consequently, this can influence community cohesion, in-group solidarity, and thus the commitment of its members to the well-being of people in their community (see also: Refs. [90,91]). Lastly, *cultural* capital is acquired through education and the development of cultural competencies.

In theory, the sum of a community's capitals determines its character. Thus, different structural fields (such as health and community) in which people deploy their capital create social stratification, or the Bourdieusian social space [21,92]. The extent to which people internalize their capital determines their inclinations and dispositions, also known as their habitus [93]. According to the field theory, a person's agency is shaped by the habitus in terms of which actions will be considered reasonable [94]. The combined influence of the

social space and the individual's habitus creates mechanisms of social control that result in compliance, social beliefs, and health-related lifestyles [95,96].

Bourdieu's theory has been used to explain civic compliance [97] and COVID-19-related behavior; for example, in vocational and educational fields [98,99]. Cockerham [100] formulated the concept of a "health lifestyle" based on the interaction between social structure (social group membership) and human agency (health behavior and its associations with one's personal identity). Health lifestyles consist of individual behaviors formed by the habitus [101] and involve group-level components, such as identities and norms that may promote or harm one's health [100,102]. Such is the case with social capital, which can promote rule-following and reduce monitoring expenses [103,104].

Bourdieu's theory has also been conceptualized in spatial terms at the community level. According to Bourdieu [105], the materiality of a place affects its social aspects. Thus, "even if it is the internalization of social practices in its origin, in its actual performance a given habitus is a reaching out to place, a being or becoming in place" (Ref. [106], p. 687). Mace [23] highlighted the potential of Bourdieu's idea of cultural capital for creating narratives that explain people's behaviors within a geographical place and the effect of the location on them. Israel [40] identified the presence of disparities between urban and suburban areas that have resulted in the emergence of a distinct local habitus. In the case of suburbs, this habitus is attributed to the cohesive leadership of a particular social class. Unlike in urban areas, middle-class parents in the suburbs are able to confidently assert their objectives in the presence of local officials.

Capital in its various forms within communities is an emerging area of research. Studies frequently use economic indicators that quantify economic capital at the municipal level. City-level indicators of social capital have also been employed, as in Foster's [107] analysis of how urban policy affects cooperation and trust within social networks [108,109]. The use of measures of cultural capital on the municipality level is less common. Notable exceptions are Savage et al.'s [110] study of cultural capital in Brussels and London, and Frenkel and Porat's [22] model for municipal strategic planning, which is based on the idea of spatial capital. Israel and Frenkel [19] measured economic, social, and cultural capital in Israeli cities. They showed that urban centers have not acquired as much capital as suburban communities, which has had consequences for their residents' life chances. Similarly, Israel and Frenkel [92] studied how capital forms and their implications for people's life chances are related to questions of spatial social justice.

Recently, Israel and Feder [3] proposed a theoretical framework that elucidates the impact of variations in a community's accumulation of Bourdieusian capital on compliance and the adoption of healthy lifestyles. Consistent with prior investigations that support the correlation between class homogeneity and individuals' adherence to healthy living guidelines [89,111], Israel and Feder identified a positive correlation.

2.4. Capital and COVID-19 Compliance in Cities and Suburbs

This current paper aims to add a spatial dimension to the analytical study of compliance with health recommendations and regulations. By differentiating between urban and suburban communities, we examined how the social stratification of places influenced people's adherence to health directives or health care advice during the COVID-19 pandemic. To do so, we operationalized Bourdieu's theory of forms of capital into measurable indices. *We hypothesized that communities will be more likely to adhere to the government's COVID-19 restrictions if they have more economic, social, and cultural capital*. The cumulative capital in a specific community represents collective forms of behavior that could be referred to as the community's habitus [3,40]. We reasoned that identifying differences between cities and

suburbs in their capital accumulation would provide insights into inequalities in resilience based on location. The existing literature suggests potential avenues for such exploration.

2.4.1. Economic Capital

Studies have linked lower economic status with less compliance with medical advice [112–114]. During the COVID-19 pandemic, people in low-income areas of the US were less likely to follow shelter-at-home guidelines [84]. On the one hand, higher-income individuals were more likely to change their behavior and adopt measures to protect them from the pandemic [13]. Interestingly, in Japan, financially secure individuals were less likely to practice proper hand hygiene. Wealthier individuals were also less likely to maintain social distancing during the pandemic [115].

However, occupations that permit individuals to work from home are associated with increased economic capital, which in turn leads to improved overall health, but with the potential to automatically comply with COVID-19 regulations, without requiring a substantial amount of effort to alter one's lifestyle or routine.

An additional factor that may have influenced individuals' economic capital during the COVID-19 pandemic is the economic and financial measures taken by municipalities. Municipalities' assistance to citizens and businesses, such as tax and fee exemptions, may mitigate the instability of individuals' economic capital in light of the pandemic and subsequent regulations, including job losses and business closures. Despite disparities and inequalities across municipal policies within the same nation [116], there is no substantial evidence of the impact of such variation on the compliance levels of residents.

2.4.2. Social Capital

Strong interpersonal interactions create communities with higher social capital levels, inspiring trust and reciprocity [117]. Consequently, members of strong communities are more inclined to demonstrate conformist and socially responsible conduct when their peers engage in similar behavior [118]. Studies conducted during the pandemic showed that countries with higher levels of social capital had lower rates of COVID-19 infections and morbidity [119,120]. Additionally, social capital promotes compliance with control measures at the individual level [121].

2.4.3. Cultural Capital

Unlike economic and social capital, little research has been conducted on the relationship between cultural capital and community resilience. Communities with a high level of cultural capital tend to have higher educational levels, which leads to more trust in scientific institutions and methods [122]. Researchers have established a link between higher education and knowledge about the COVID-19 virus and the adoption of preventive behavior [87,88,123,124]. In addition, studies have shown a positive correlation between educational attainment and trust in the government, leading to greater compliance with restrictions on movement during the pandemic [82,125]. However, other studies have reported conflicting results [126].

Some researchers have claimed that the social homogeneity of suburbs (wherever this is the case) promotes the production, accumulation, and transfer of all three forms of capital in a manner that exceeds that of those living in cities [92,127]. Accordingly, *we hypothesized that suburbanites have more ample and diverse capital resources than many of their urban counterparts. As a result, suburbanites will be more likely to comply with the government's COVID-19 restrictions*.

Furthermore, the claim that small and relatively homogeneous suburbs (wherever this is the case) have better life chances than those who live in large and diverse cities [19] may obscure the fact that more diverse areas will have a higher proportion of minorities and

low-income residents. Such compositional effects may diminish the average life chances for local populations. If awareness of a healthy lifestyle represents a life chance, then adhering to the guidance of health care professionals or public health guidelines may actualize these prospects. Consequently, we hypothesize that *rising community heterogeneity will negatively influence compliance with the COVID-19 guidelines established by the government*.

2.5. COVID-19 and Israel

We conducted our study in Israel, a country of 9.6 million people (2022). Israel is very urbanized (see https://data.worldbank.org/indicator/SP.URB.TOTL.IN.ZS, accessed on 18 January 2025), and its strong economic growth has led to extensive suburbanization [26,128]. Numerous small towns and rural areas saw population growth in the 1990s, resulting in the typical residential suburbs that surround major cities [129,130]. Large segments of the wealthier social strata moved from cities to the fringes of metropolitan areas [131]. Comparative studies revealed that suburban areas house people with higher levels of wealth and life opportunities compared to cities [40,132]. Given that these patterns are similar to those of other developed countries [133], we believe that our study's insights could be generalized to other countries.

The first lockdown in Israel in response to COVID-19 occurred on 17 March 2020, with restrictions, such as mask-wearing mandates, imposed in the following weeks. Also, due to the country's size and institutional structure, there was no variance in masking mandates and other COVID rules across place and time, nor was there any variation in regulation between cities and suburbs. Pandemic regulatory enforcement and tax base management have not been extensively explored in Israeli cities and suburbs. Municipalities' coping strategies were explored as a whole [134,135]. Municipalities are often closer to their populations and better able to tailor policies to their needs. While there may have been sporadic local initiatives by municipalities to aid businesses, data on these initiatives are unavailable in Israel.

Throughout the subsequent waves of the pandemic in the country, the degree of adherence to the national restrictions varied depending on time, social class, and geographical location [135]. Some studies have noted that minorities were less likely to comply with the state's regulations [136]. Minority or sub-cultural groups had less trust in the government, leading them to disobey physical distancing regulations [81,87] and refuse to be vaccinated [137]. One example in Israel was the ultra-Orthodox Haredi community, which tends to distrust the State and obey its religious leaders in case of any conflict between the two [138]. The ultra-Orthodox communities had some of the highest morbidity rates from COVID-19 [139], as some Haredi school principals deliberately defied the regulations, seeing them as an attack on their lifestyle [136]. Other studies in Israel indicated minorities' stronger intentions to comply [140,141]. These variations were influenced by community class divisions [3], suggesting that the distinction between suburban and urban populations can impact compliance with government instructions for public health.

3. Materials and Methods

3.1. Data and Analysis

Research Population

This study analyzes data from Israeli urban municipalities. We defined an urban municipality as a community residing inside a delineated geographic region characterized by a unique local habitus—that is, the collective inclinations and communal customs of the inhabitants, arising from their mutual access to forms of capital [3,142].

Urban local governments in Israel are defined by two types of administered territories: a city led by a mayor, which is usually a community with more than 20,000 inhabitants, or

a local council, which, despite being urban, does not meet the criteria to be classified as a city [143] (due to its rural nature, the "regional council" municipal category was excluded from the study). Out of the 201 cities and local councils in Israel, we chose to focus on the 120 predominantly Jewish or ethnically mixed cities. Arab cities have not developed similar suburbs as in the Jewish sector, and no new Arab towns or localities have been established in Israel that can be defined as suburbs [144,145]. Therefore, for the most part, the distinction between city and suburb is irrelevant to the Israeli Arab population [19].

Due to the absence of a formal distinction in Israel between those who belong to the urban and suburban sectors, we used cluster analysis to distinguish between these entities in our sample. Based on previous studies, we defined a set of variables that distinguished suburbs from cities [25,146–148]. This approach resulted in a classification of 68 cities and 52 suburbs that were validated through *t*-tests as being significantly distinct (see Supplementary File S1).

In Israel, municipalities function as administrative entities that have a specific level of autonomy in terms of the distribution and management of their resources [149]. We used two complementary measures of the three forms of capital held by the community residents—aggregated individual-level and municipal-level indicators [19]. For example, economic capital can be proxied by the residents' mean income or by the municipality's budget per capita size. In the same way, we can treat cultural capital as a latent variable that can be measured using both aggregated individual-level and municipal-level indicators. According to Bourdieu [21], academic accomplishment is an expression of cultural capital. Thus, aggregated metrics of the population's educational attainment can function as appropriate markers of cultural capital at the local level. We can capture cultural capital at the municipal level by spending on and investing in education. Given that cultural capital is closely associated with cultural competency and involvement in cultural activities, we consider additional indicators related to participation in cultural activities and the municipal investment in cultural events. Municipal expenditures reflect how important citizens find these activities and their demand for them. Similarly, social capital at the municipality level can be proxied by looking at the levels of social capital indicators [3].

3.2. Indicators and Regression Models

To calculate the urban communities' economic, social, and cultural capital levels, we used data from several public sources, including the national police, government ministries, and municipalities. Supplementary File S2 contains information on the variables we used to build our indicators.

We created an index for each form of capital. We used the Frenkel and Ashkenazi [26] method, which involved an exploratory factor analysis (EFA) with Varimax rotation. The EFA allowed us to identify different dimensions of the forms of capital, which we used when analyzing compliance and the variables of the Bourdieusian forms of capital. We employed the eigenvalue criteria to determine the number of factors for each element.

We then classified and assigned labels to the factors based on the variables associated with each element while also considering Bourdieu's theoretical definitions of the forms of capital. Next, we used the EFA loadings to calculate factor scores for each municipality. Here, we set the lowest value to 0 and standardized each element using z-score adjustments. The resulting scores functioned as indicators of various dimensions of the forms of capital.

In accordance with Frenkel and Ashkenazi [26] and Israel and Frenkel [19], we calculated a weighted mean of the original component scores to create a combined index for each form of capital. We assigned each form of capital's share of the total variance explained by all factors as the weight for that form of capital's factors and then normalized these combined variables.

To measure compliance, we used three separate proxy variables (see Supplementary File S2):

Police fines per capita—The Israeli police were deployed during the lockdowns to enforce the rules and penalize individuals who ignored them [150,151]. We used the number of COVID-19-related police fines in each municipality per capita (during the third infection wave) as recorded in the Israeli police register.

Vaccination rate—Israel had the quickest COVID-19 vaccine implementation [152]. The Israeli government actively encouraged immunizations and placed limitations on those who were not vaccinated. Nevertheless, many Israeli residents hesitated about or even opposed getting vaccinated [153]. We used here the proportion of residents of vaccination-approved age with two doses of the vaccine (on the day the third dosage was approved) as reported by the Ministry of Health.

Morbidity rates—Morbidity was connected to public COVID-19 regulations [154]. We used the highest daily number of new confirmed COVID-19 cases per capita in each municipality as reported by the Ministry of Health.

We validated the differences between urban and suburban communities in these indices using a difference-of-means *t*-test. Lastly, we examined the impact of the different types of capital on the community's level of compliance with multiple linear ordinary least squares regression models. We used the primary factors from the factor analysis scores for each form of capital to explain our dependent variable—local compliance measures. The estimation included several spatial control variables to test the difference between cities and suburbs and to investigate their contribution to compliance given the place's social space characteristics.

Equation (1) specifies the proposed models:

$$\begin{aligned} \mathrm{CPLC}_i = \beta_0 + \sum_{j=1}^{q} \beta_j ECF_{ij} + \sum_{h=1}^{r} \beta_{h+q} CCF_{ih} + \sum_{m=1}^{t} \beta_{m+r} SCF_{im} + \beta_{t+1} CS_i + \beta_{t+2} UO_i \\ + \beta_{t+3} \ln(POP_i) + \beta_{t+4} PDS_i + \beta_{t+5} DIV_i + \varepsilon_i \end{aligned} \quad (1)$$

where

CPLC_i represents community compliance in municipality i.

ECF_{ij} is the score on the economic capital factor j (j = 1. . .q) in municipality i.

CCF_{ij} is the score on the cultural capital factor h (h = 1. . .r) in municipality i.

SCF_{im} is the score on the social capital factor m (m = 1. . .t) in municipality i.

CS_i is a dummy variable that denotes a given municipality I as a city or suburb.

UO_i is a dummy control variable that distinguishes between ultra-Orthodox Jewish (Haredi) communities and communities that are not Haredi (in municipality i). During the pandemic, the distinctive characteristics of the ultra-Orthodox Jewish community made it more prone to defy regulations.

POP_i, PDS_i, and DIV_i are additional sets of control variables in municipality i. POPi (Population size): The natural logarithm of the population size of municipality i. We used here a logarithmic transformation due to the skewed distribution of population size. PDSi (Population density): Population size divided by the municipality's size. DIVi (Population diversity): Ethnic diversity of the population of municipality i (see Supplementary File S3, Section S3c for index details). We decided against adding more control variables due to the relatively small sample size (With the exception of the variable that denoted the median age of the municipality (refer to footnote number 13).

β are the parameters to be estimated, and ε_i is the error term so that E(ε) = 0.

4. Results

4.1. Forms of Capital and Compliance in Cities and Suburbs

Tables S1–S3 in Supplementary File S3, Section S3a show the factor loadings obtained from the EFA of the list of variables in each of the three forms of capital. We identified two dimensions of economic capital, two of social capital, and three of cultural capital. We used the scores on the factors obtained from the EFA and ran *t*-tests to examine the hypothesis that suburbs would have higher levels of economic, social, and cultural capital than cities. Table 1 summarizes the findings.

Table 1. Cities and suburbs and forms of capital—means, standard deviation, and *t*-tests.

	Characteristic	Cities, N = 68 [1]	Suburbs, N = 52 [1]	*p*-Value [2]
Combined indices of forms of capital	Economic capital	1.96 (0.56)	2.10 (0.65)	0.3
	Missing	0	15	
	Social capital	1.06 (0.52)	1.38 (0.37)	<0.001
	Missing	3	6	
	Cultural capital	1.43 (0.47)	2.12 (0.46)	<0.001
	Missing	6	17	
Economic capital	Wealth	1.37 (0.63)	2.27 (1.05)	<0.001
	Missing	0	15	
	Economic Security	3.01 (0.95)	1.77 (0.75)	<0.001
	Missing	0	15	
Social capital	Social Integration	−2.03 (0.97)	−0.79 (0.80)	<0.001
	Missing	3	6	
	Mutual Responsibility	−2.27 (0.71)	−3.06 (0.86)	<0.001
	Missing	3	6	
Cultural capital	School Achievement	1.42 (0.56)	2.99 (1.15)	<0.001
	Missing	6	17	
	Professional–Academic Attainment	2.94 (0.89)	3.39 (0.76)	0.010
	Missing	6	17	
	Urban Cultural Fostering	1.98 (0.51)	1.69 (1.18)	0.2
	Missing	6	17	

Note: Missing values are due to missing data points on the components that create the dimensions of the forms of capital. [1] Mean (SD). [2] Welch Two Sample *t*-test.

4.1.1. Economic Capital

The "Wealth" factor includes elements that quantify material wealth regarding income and housing (Supplementary File S3, Section S3a) and indicate a polarized urban structure. Suburbs have higher wealth levels than cities (Table 1). Secondly, "Economic Security" measures social security transfers in a community. Unlike "Wealth", "Economic Security" indicates lower economic risk levels in the urban social space compared to suburban.

An examination of the combined economic capital (Table 1) does not indicate any statistically significant variation among the communities. Interestingly, as Figure 1 illustrates, cities have the lowest levels of economic capital, while suburbs have the highest. While most of the researched communities have a mid-range level of economic capital, its distribution in cities is more concentrated than in suburbs. An explanation for this result could be the existence of impoverished suburbs in Israel's periphery, which drive down their mean level of economic capital.

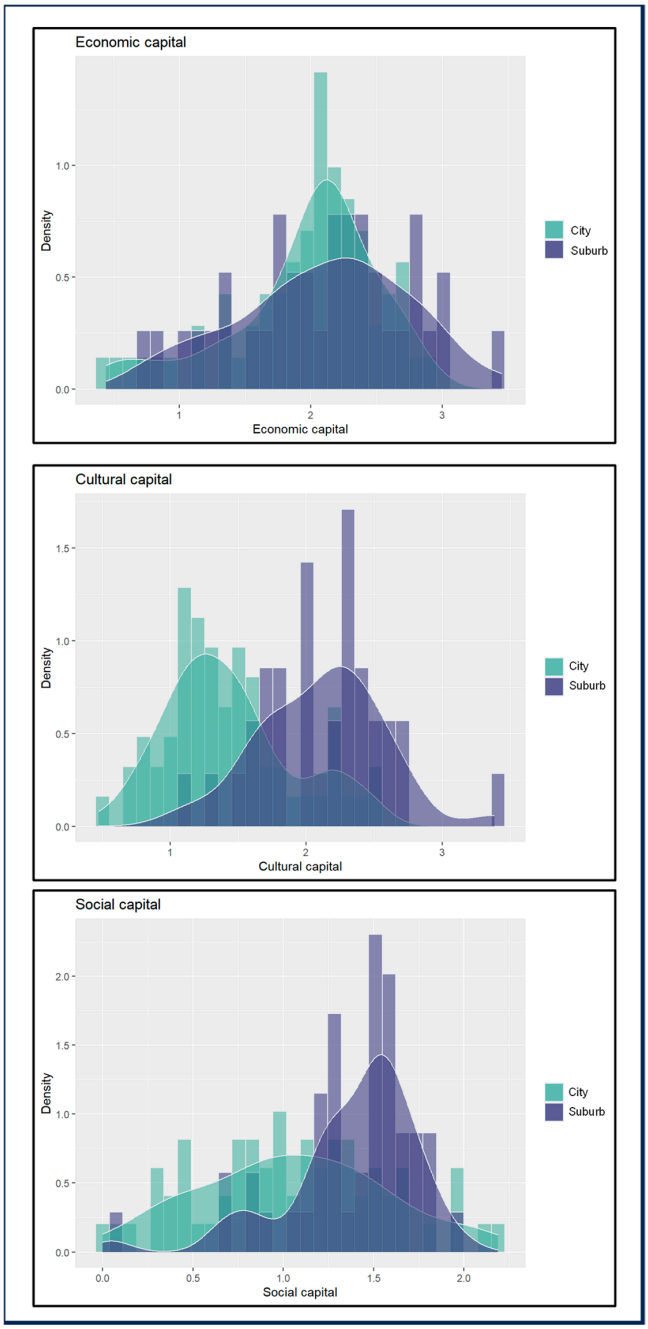

Figure 1. The distribution of the forms of capital (combined indices) within cities and suburbs.

4.1.2. Cultural Capital

Table 1 indicates that the level of the suburbanites' cultural capital is greater than that of city dwellers. Figure 1 illustrates that while certain cities have more cultural capital than some suburbs, most cities have less cultural capital. For instance, "School Achievement", measured as being admitted to a university and graduating from one, is higher in suburbs than in cities (Table S2, Supplementary File S3, Section S3a). The second indicator, "Professional Academic Attainment" shows that suburbs outperform cities, as their residents are more likely to achieve higher levels of education.

Notwithstanding these differences, Table 1 shows that cities have higher levels of "Urban Cultural Fostering" than suburbs. Thus, the leaders of cities are more willing and able to invest in institutions that promote cultural capital (Table S2, Supplementary

File S3, Section S3a). Nevertheless, when comparing both sectors, their differences are not significant.

4.1.3. Social Capital

Table S3 in Supplementary File S3, Section S3a lists two components of social capital. However, as Figure 1 shows, while some suburbs have limited social capital, their distribution is more concentrated around higher values than in cities. Thus, suburban communities have much higher levels of social integration than cities (Table 1), indicating more social cohesion, which is evident in the levels of government spending on community integration and social ties (Table S3, Supplementary File S3, Section S3a). One reason for these expenditures may be the increasing ethnic diversity brought about by growing immigrant populations [71,155]. Ethno–racial and linguistic fragmentation might obstruct the formation of inter-group connections, hence diminishing social capital [90]. Nonetheless, this relationship is vigorously contested from a theoretical perspective, as the determination of whether societal adaptations to diversity result in integration or division hinges on the positions of minorities and immigrants within the social structure and economic system, as well as the institutional frameworks governing their political inclusion [90]. Thus, faced with the threat of community disintegration and social instability, municipalities have invested in strengthening the cohesiveness of civil society. This decision underscores the issue's importance for the suburbs' political leadership, which seems to differ from that of cities. We reversed the value of this factor in the regression models to make higher levels indicate more capital.

Conversely, as Table 1 indicates, cities have higher levels of the second dimension of social capital—"Mutual Responsibility". This reflects economic disparities, the political leadership's efforts to encourage civil involvement, and civil activity, reflected in the voting rate in local elections. The results indicate that Israeli cities are less socially divided than the suburbs. According to the previous literature, urbanites seem more active in municipal politics than suburbanites [147,156]. We used an indirect measure of social capital, which might be somewhat imprecise. Surveys measuring factors such as social support and social trust can be used to evaluate social capital directly at the individual level [157,158]. However, there was no municipal information on these factors. Thus, we relied on metrics indirectly related to these kinds of measures.

To summarize, the variations between cities and suburbs in their social spaces partly support the hypothesis that suburbanites have more ample and diverse capital resources than many of their urban counterparts. Israeli suburbs have more material and cultural capital than Israeli cities. However, the findings concerning social capital indicate that the gap between cities and suburbs is nuanced and not clear-cut.

4.2. Compliance with Government Regulations During COVID-19

Suburban inhabitants are significantly more obedient in getting vaccinated (Table 2). Figure 2 shows that most cities have lower vaccination rates than the suburbs.

Table 2. Cities and suburbs and compliance indicators—means, standard deviation, and *t*-tests.

Characteristic	Cities, N = 68 [1]	Suburbs, N = 52 [1]	*p*-Value [2]
Vaccinations	0.69 (0.13)	0.80 (0.09)	<0.001
Missing	0	5	
Morbidity rates	1.86 (1.46)	1.67 (1.25)	0.47
Missing	0	5	
Police fines	0.22 (0.09)	0.13 (0.07)	<0.001
Missing	0	0	

[1] Mean (SD); [2] Welch Two Sample *t*-test.

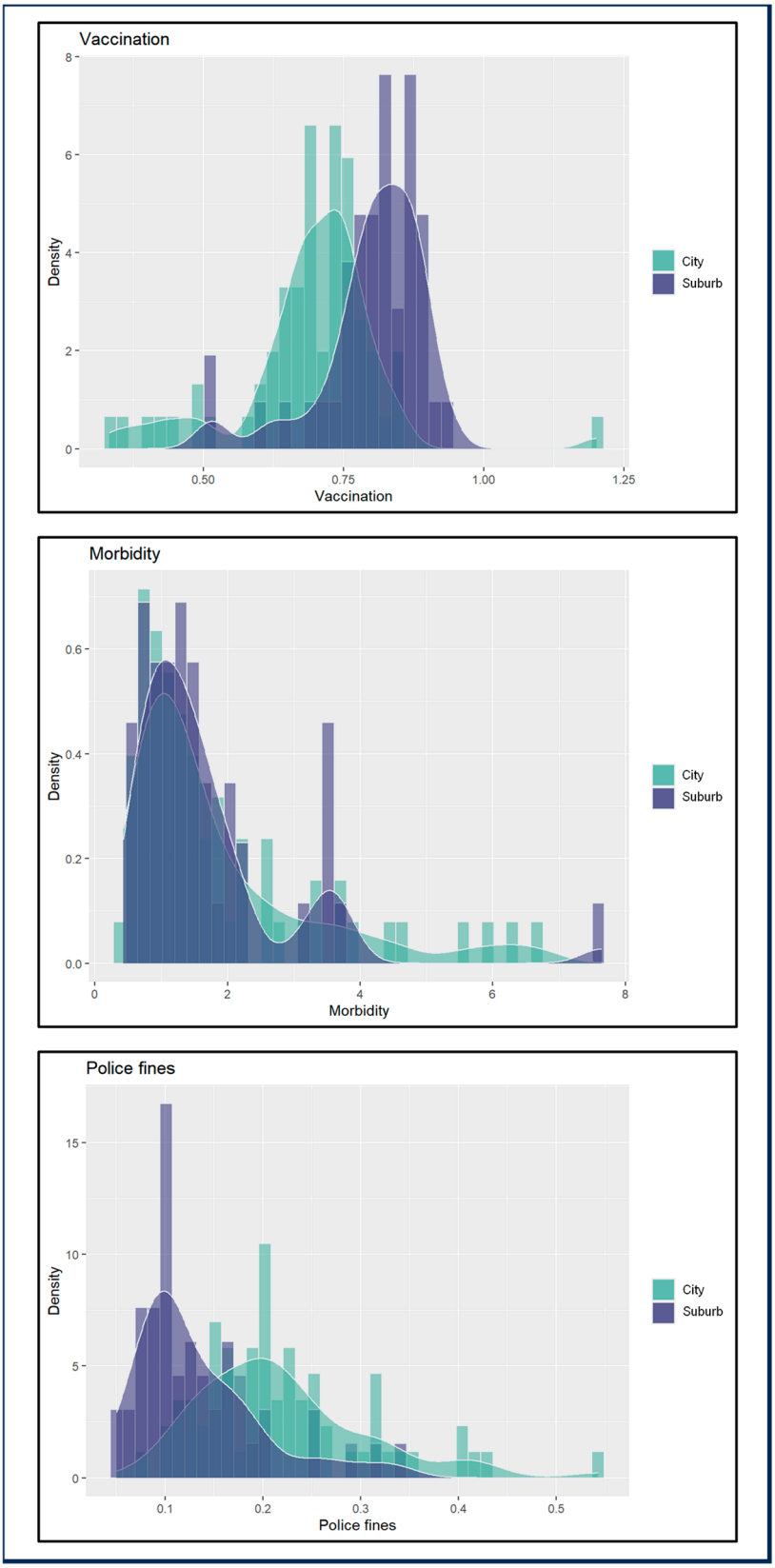

Figure 2. Differences between cities and suburbs in compliance indices.

Based on the data about police fines, suburbanites were more likely to comply with the government's regulations. Figure 2 suggests that while certain suburbs have high COVID-19-related fine rates and some cities have low rates, the distribution of the penalties in the suburbs is more concentrated around lower values than the cities' mean level.

The findings in Table 2 also show that the average morbidity rate in the cities was higher than in the suburbs, but not at a statistically significant level. Figure 2 demonstrates that the discrepancy in morbidity rates was not dichotomous, as most of the communities were in the lower-end range.

4.3. The Social Space of Cities and Suburbs and Its Relationship to Compliance with Health Regulations—Regression Models' Results

Table 3 presents the results of the OLS regression models that explored how community type and the levels of different capitals affected compliance with COVID-19 regulations (Equation (1)). Here, we used the combined indicators of the economic, social, and cultural forms of capital due to the relatively small size of the sample, which did not allow us to include many covariates in the regression models (see Supplementary File S3, Section S3b for models with separate factors for the various forms of capital). We conducted the estimation in a stepwise manner. We began with a simple regression of the compliance indicators on the binary suburb/city variable, with cities as the reference group. We then added controls and, finally, the variables related to the three forms of capital (i.e., the social space). Initially, we also included the median age variable, but after finding a strong correlation between the average age of the municipality and economic capital, which rendered the economic capital index non-significant, we omitted it from the models.

Models 1–4 in Table 3 look at compliance as measured by the vaccination rate indicator. Model 1 indicates that compliance is greater in suburbs than in cities. Adding the controls for Haredi communities and the spatial characteristics of the municipality (Model 2), Haredi communities and those areas with denser populations are suggested to have lower compliance rates. Interestingly, we find a smaller difference between suburbs and cities when controlling these variables.

Including the components of social space (i.e., the forms of capital) in Model 3 shows that the effect of residing in a suburb, compared to a city, is close to zero and statistically insignificant. This finding implies that the variation in compliance rates between suburbs and cities can be attributed to differences in the levels of capital between the two sectors. Model 3 indicates that the forms of capital positively and significantly affect compliance. The effect of Haredi communities diminishes in size but remains statistically significant.

In Model 4, we include interaction terms between the suburbs variable and the three capital variables to test whether the type of locality moderates the effect of the capitals on compliance. We find evidence of such a moderation effect only in the case of economic capital. The negative coefficient for the interaction term indicates that the effect of economic capital on compliance is weaker in suburbs compared to cities.

Models 5–8 show how suburbs and forms of capital affect COVID-19 morbidity rates. Model 5 indicates no significant difference in morbidity between living in a suburb and a city. However, Model 6 shows that after adding spatial characteristic variables, suburbs are found to have fewer morbidities. The morbidity rate in Haredi communities and in densely populated areas is higher, while population size negatively affects morbidity. Adding the social space capital renders the effect of the suburbs variable insignificant again. Morbidity decreases with higher economic and cultural capital, supporting the hypothesis that forms with capital promote compliance, thus reducing morbidity rates. According to Model 7, social capital has no significant effect on morbidity. Model 8 includes interaction terms between the suburbs variable and the three capital variables. The results indicate a moderation effect of the locality type, specifically in the case of social capital. We find that the effect of social capital on compliance is weaker in suburbs compared to cities.

Table 3. OLS regression results of the determinants of community compliance—combined indices.

	Dependent Variable											
	Vaccinations					**Morbidity Rate**				**Police Fines**		
	(1)	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**	**(8)**	**(9)**	**(10)**	**(11)**	**(12)**
Suburb	0.112 ***	0.082 ***	0.015	0.024	−0.190	−0.393 **	0.202	0.977	−0.087 ***	−0.101 ***	−0.039	−0.053
	(0.022)	(0.020)	(0.018)	(0.092)	(0.261)	(0.184)	(0.199)	(1.036)	(0.015)	(0.017)	(0.023)	(0.124)
Haredi		−0.214 ***	−0.123 ***	−0.106 ***		3.331 ***	1.317 ***	1.259 ***		0.025	0.043	0.048
		(0.036)	(0.030)	(0.030)		(0.331)	(0.335)	(0.344)		(0.031)	(0.039)	(0.041)
Population size (ln)		0.012	0.002	0.004		−0.460 ***	−0.201 **	−0.203 **		−0.009	−0.0005	0.002
		(0.011)	(0.008)	(0.008)		(0.099)	(0.087)	(0.088)		(0.009)	(0.010)	(0.010)
Population density		−0.420 **	−0.399 ***	−0.418 ***		2.814 *	1.713	1.653		−0.036	−0.0004	−0.030
		(0.165)	(0.104)	(0.104)		(1.512)	(1.175)	(1.179)		(0.141)	(0.138)	(0.141)
Population diversity		−0.004	−0.031	0.010		−0.341	−1.196	−1.196		0.640 ***	0.695 ***	0.717 ***
		(0.198)	(0.131)	(0.131)		(1.808)	(1.476)	(1.482)		(0.168)	(0.173)	(0.177)
Economic capital			0.047 ***	0.133 ***			−0.570 ***	−0.786			0.038 **	0.066
			(0.013)	(0.043)			(0.149)	(0.487)			(0.017)	(0.058)
Social capital			0.068 ***	0.051			0.224	1.096 **			−0.014	0.026
			(0.014)	(0.048)			(0.159)	(0.539)			(0.019)	(0.064)
Cultural capital			0.070 ***	0.020			−0.548 ***	−0.580			−0.091 ***	−0.163 **
			(0.015)	(0.047)			(0.165)	(0.531)			(0.019)	(0.063)
SuburbXEco. capital				−0.060 **				0.128				−0.026
				(0.029)				(0.329)				(0.039)
SuburbXSoc. capital				0.022				−0.807 *				−0.036
				(0.040)				(0.448)				(0.054)
SuburbXCul. capital				0.044				0.017				0.061
				(0.038)				(0.430)				(0.051)
Constant	0.579 ***	0.709 ***	0.508 ***	0.426 ***	2.051 ***	1.323	3.406 ***	2.781	0.308 ***	−0.091	−0.123	−0.111
	(0.032)	(0.142)	(0.098)	(0.160)	(0.390)	(1.300)	(1.108)	(1.809)	(0.022)	(0.121)	(0.130)	(0.216)
Observations	115	115	91	91	115	115	91	91	120	115	91	91
R^2	0.191	0.568	0.769	0.784	0.005	0.693	0.701	0.719	0.230	0.376	0.542	0.554

Note: Standard errors in parentheses. * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$. The variables "SuburbXEco. Capital", "SuburbXSoc. Capital", and "SuburbXCul. Capital" denote the interaction between the "Suburb" variable and the three capital variables.

Models 9–12 measure compliance based on reports about police fines for violating the COVID-19 regulations. Model 9 shows that the number of fines in the suburbs was smaller than in the cities. This finding holds when Model 10's controls are added. Interestingly, Haredi communities, which were less likely to comply with the regulations [136], did not receive more fines, implying that the police enforced the regulations less strictly in those communities. We also find that more ethnically diverse populations get more fines. In this regard, no discrepancies in enforcement were recorded between urban and suburban areas, according to the Israeli literature and media. When the factors related to the various forms of capital are included, the difference between cities and suburbs becomes statistically insignificant (Model 11). The analysis implies that the factors related to the various forms of capital, rather than the type of community, explain differences between the cities and suburbs in COVID-19-related police fines. Ethnic diversity still positively affects the number of fines. This result can be explained by the fact that the most diverse cities are those with Arab populations, which experienced over-policing during the pandemic [3]. Cultural capital has a negative effect on the number of fines, which is consistent with explanations that link compliance with educational attainment. However, economic capital positively affects the number of police fines issued. In this case, we do not observe any evidence of a moderating effect of the locality type (Model 12).

Table 4 presents standardized coefficients for the capital variables, allowing for a comparison of the effect sizes of the different forms of capital on compliance. The results indicate that the most influential factor among the three is cultural capital, which has the largest effect on all three compliance indicators. Economic capital has an effect size comparable to cultural capital in the case of the morbidity indicator but ranks second for police fines and third for the vaccination indicators. Lastly, social capital is significant only in the case of the vaccination indicators, where its size effect is slightly weaker than that of cultural capital.

Table 4. Standardized coefficients from OLS regression of the determinants of community compliance—combined indices. *** $p < 0.001$.

Model (Table 3)	Vaccinations		Morbidity Rate		Police Fines	
	(3)	(4)	(7)	(8)	(11)	(12)
Economic capital	0.256 ***	0.291 ***	−0.311 ***	−0.337	0.218 ***	0.185
Social capital	0.319 ***	0.378	0.106	0.015 ***	−0.071	−0.105
Cultural capital	0.382 ***	0.426	−0.301 ***	−0.307	−0.527 ***	−0.480 ***
SuburbXEco. capital		−0.152 ***		0.033		−0.070
SuburbXSoc. capital		0.049		−0.179 ***		−0.084
SuburbXCul. capital		0.113		0.004		0.165

5. Discussion

The COVID-19 pandemic provided a unique opportunity to explore long-standing debates about spatial health inequalities, such as the existence of an "urban health penalty" [42,43]. Our study shows that disparities in health outcomes between urban and suburban communities are largely influenced by differences in behavioral patterns. Specifically, we demonstrate that the rate of virus transmission was not affected just by the physical elements of urban environments such as population density but also, and perhaps more critically, by variations in compliance with the government's health regulations [3,135]. These findings support the argument that the strong sense of belonging that characterizes suburban communities fosters conformity and motivates individuals to prioritize collective well-being [40,41,74].

Building on previous research that highlights additional factors such as socioeconomic status and educational attainment on compliance [11,84], our study contributes to the literature by examining the role of social stratification in both urban and suburban settings,

specifically focusing on the multiple expressions of Bourdieusian forms of capital and their influence on compliance with health-related regulations.

This study examined suburbanization as a key mechanism for the growth of behavioral disparities and health inequalities, rather than as the main driver of underlying behavioral or social inequalities. One important effect of pre-existing basic social inequality is suburbanization into smaller and distinctive communities. Given that social gaps are one measure of community resilience, the observed difference between communities most likely leads to the geographic deprivation of equality of opportunity, which has an impact on health outcomes.

Factors related to the physical environment play a role in influencing compliance to a limited extent. Our findings indicate that those living in smaller and less densely populated localities such as suburbs were most likely to comply with the regulations. At the same time, we found a strong association between the communities' levels of economic, social, and cultural capital and their degree of compliance. Communities with high economic capital were more likely to comply with health guidelines, aligning with findings from previous studies [113]. Our results are also consistent with earlier studies reporting that suburban communities have higher levels of community cohesion and engagement than cities [41,159] and lend support to the claim that education is positively linked to health compliance [123,124].

Analyzing the three forms of capital at the municipality level enabled us to characterize the "community's habitus" [40] and explain behavioral elements of the population's conduct. This approach highlights the distinct habitus of urban and suburban communities. The higher levels of economic, social, and cultural capital associated with suburban habitus collectively shape predispositions that encourage lifestyles that are more compliant with health recommendations [160].

The disparate accumulation of capital resources between suburban and urban residents likely affects the former's ability to pursue or select various lifestyles more freely. This theoretical assertion indicates that the present geographical distribution reveals disparities in health conditions and opportunities across various settlement types. It is important to recognize that this relationship is an evolutionary process that may continue to strengthen and reproduce.

Bourdieu's theoretical framework posits that disadvantage results in an unconscious acquiescence to domination, hence limiting broader aspirations and inhibiting the development of cognitive potential beyond one's relative status. Consequently, impoverishment and social stratification are perpetuated for many of the least privileged in urban areas, in stark contrast to the affluent who inhabit some of the suburbs. A detrimental loop is established, as people's capacity to amass capital, and consequently influence their health or welfare within a specific social space (i.e., class stratification), is negatively impacted. For instance, it influences the environment in which the subsequent generation develops. According to this theory, offspring inherit perceptions of what it entails to inhabit a specific social space, thereby validating the same behavioral distinctions as their parents' lives, which consequently influences their future well-being [93].

The evolutionary representation of power dynamics in space may provoke concerns regarding causation and consequence. Does the presence of diverse forms of capital influence the residential location and consequently health disparities? Does geography facilitate the attainment of these forms and, as a result, compliance and well-being? Currently, we are unable to provide an answer; nonetheless, it is speculated that securing a residence in the suburbs necessitates a substantial quantity of financial resources. Furthermore, lacking adequate cultural or social capital, an individual or family might struggle to integrate into communities that are markedly distinctive, such as many Israeli suburbs.

Using the social space framework to examine the social composition of local communities is a fruitful approach for exploring people's behavior during crises such as the COVID-19 pandemic, as well as the implementation of policy during ordinary times. Thus, strengthening a community's social space with regard to its economic, social, and cultural capital may improve its resilience during trying times. While health-promoting policies during COVID-19 largely centered on enforcement, our findings suggest that empowering communities could be a more effective strategy for achieving these goals.

In developed economies, economic growth is unequally distributed, which diminishes the social standing of many members of society [161,162]. This current research aims to further the study of well-being by expanding the tools that are used to assess a place's sustainability and health.

6. Conclusions

Our study highlights the critical role of various forms of capital in promoting compliance with health directives during public health crises, emphasizing the significance of geographical and social context in shaping how these forms of capital influence compliance.

The research findings indicate that residents in settlement types such as suburbs better comply with health limitations. Additionally, we discovered a robust correlation between the communities' degrees of compliance and their levels of social, cultural, and economic capital. Consistent with prior research, we found that economically well-off communities were more inclined to follow health recommendations. The results indicate that cultural capital is the paramount component among the three, exerting the greatest influence on all three compliance metrics. Regarding the morbidity indicator, economic capital exhibits an effect magnitude equivalent to that of cultural capital; nevertheless, it ranks second for police penalties and third for vaccine indicators. Social capital is significant solely in the context of vaccination plans, where its impact is slightly less substantial than that of cultural capital. Additionally, we demonstrated that places with higher population densities demonstrate lower compliance rates.

In order to determine if the type of locale moderates the effect of the capital on compliance, interaction terms between the suburbs variable and the three forms of capital showed that economic capital had a moderating influence. Here, suburban areas seem to have a less robust impact of economic capital on compliance than cities. When looking at the relationship between social capital and morbidity, the results show that location type acts as a moderator. The impact of social capital on compliance is weaker in suburbs compared to urban settings.

The rich insights that emerge from this study therefore suggest valuable conclusions for informing public policies and actions aimed at enhancing compliance and promoting long-term health sustainability. Currently, numerous public policies that are designed to stimulate economic growth disregard the broader contexts in which individuals reside [163]. A more comprehensive perspective would investigate the social space of a location.

This study's findings may aid policymakers in developing municipal policies that promote sustainability. The economic, cultural, and social capital that individuals acquire and perpetuate functions as human resources accessible to locations and regions. Consequently, they may be employed to implement diverse initiatives aimed at enhancing the economic, social, and political underpinnings that could advance the interests of an expanding array of socioeconomic sectors within a nation. For example, our findings show that the effect of economic capital on compliance is weaker in suburbs compared to cities. Therefore, a policy that emphasizes the economic prosperity and resilience of city dwellers in this area can have a greater impact than one that would be implemented in suburban areas if it is intended to influence adherence to medical recommendations regarding a

healthy lifestyle or government action on related issues. The findings also indicate that social capital increases morbidity, in cities in particular, where social ties and community gatherings appear to increase morbidity even further. Given this understanding, cities should invest in education and outreach activities, as well as initiatives to raise awareness about the necessity of implementing health guidelines during times of crisis. Additionally, because the effect of social capital on morbidity was found to be weaker in suburbs compared to cities, policies that foster the importance of compliance through community engagement, social integration, and shared accountability will yield superior outcomes in cities compared to suburban regions. Given the apparent larger direct social relationships in cities as opposed to suburbs, such a strategy would place an emphasis on individual responsibility for community health and, thus, the significance of compliance in the context of this study. Therefore, utilizing analogous methodologies and indices used in this study, municipal and community leadership might undertake capital resource initiatives that would facilitate residents' adherence to health recommendations and directives, ultimately enhancing their quality of life.

While our study makes several contributions to the literature, it also has some limitations that could be the basis for future studies. On one hand, Israel is similar to other developed countries in its preference for privatization and reluctance to impose excessive regulations. Given the parallel developments of functional decentralization observed in numerous major Western cities [128,133], subsequent research may seek to reproduce our findings by employing a similar framework. One question that merits investigation is whether the impact level of the different forms of capital on compliance differs in cities and suburbs. To conduct such an analysis, it would be necessary to estimate the interaction between suburbs and the three forms of capital. Due to the limited sample size in the Israeli case, we could not perform such an analysis. However, replicating this study in a larger country with more municipalities might result in more insights.

Supplementary Materials: The following supporting information can be downloaded at: https://www.mdpi.com/article/10.3390/su17030983/s1. Ref [164] is cited in supplementary materials.

Author Contributions: Conceptualization, E.I.; Software, T.F.; Validation, T.F.; Formal analysis, E.I. and T.F.; Investigation, E.I. and T.F.; Resources, E.I. and T.F.; Data curation, T.F.; Writing – original draft, E.I. and T.F.; Writing – review & editing, E.I. and T.F.; Supervision, E.I.; Project administration, E.I.; Funding acquisition, E.I. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Informed Consent Statement: Not applicable.

Data Availability Statement: The data presented in this study are available on request from the corresponding author. The data are taken from institutional databases belonging to the State of Israel. Their processing is done for research purposes.

Conflicts of Interest: The authors declare no conflicts of interest.

References

1. Genovese, D.; Candiloro, S.; D'Anna, A.; Dettori, M.; Restivo, V.; Amodio, E.; Casuccio, A. Urban Sprawl and Health: A Review of the Scientific Literature. *Environ. Res. Lett.* **2023**, *18*, 083004. [CrossRef]
2. Morris, E.A. Do Cities or Suburbs Offer Higher Quality of Life? Intrametropolitan Location, Activity Patterns, Access, and Subjective Well-Being. *Cities* **2019**, *89*, 228–242. [CrossRef]
3. Israel, E.; Feder, T. Compliance and the Social Space of Cities: Variations in Compliance with COVID-19 Regulations and Capital Forms in Urban Communities. *Cities* **2023**, *141*, 104491. [CrossRef]

4. Mahabee-Gittens, E.M.V.; Vidourek, R.A.; King, K.A.; Merianos, A.L. Disparities in Neighborhood Characteristics among U.S. Children with Secondhand and Thirdhand Tobacco Smoke Exposure. *Int. J. Environ. Res. Public Health* **2022**, *19*, 4266. [CrossRef] [PubMed]
5. Poklar Vatovec, T.; Jenko Pražnikar, Z.; Petelin, A. Adherence and Sociodemographic Determinants of Adherence to the Mediterranean Diet among Slovenian Adults and the Elderly. *Nutrients* **2023**, *15*, 3219. [CrossRef]
6. Winnick, S.; Lucas, D.O.; Hartman, A.L.; Toll, D. How Do You Improve Compliance? *Pediatrics* **2005**, *115*, e718–e724. [CrossRef]
7. Hassen, H. Leveraging Built Environment Interventions to Equitably Promote Health during and after COVID-19 in Toronto, Canada. *Health Promot. Int.* **2022**, *37*, daab128. [CrossRef]
8. Lowe, M.; Adlakha, D.; Sallis, J.F.; Salvo, D.; Cerin, E.; Moudon, A.V.; Higgs, C.; Hinckson, E.; Arundel, J.; Boeing, G.; et al. City Planning Policies to Support Health and Sustainability: An International Comparison of Policy Indicators for 25 Cities. *Lancet Glob. Health* **2022**, *10*, 882–894. [CrossRef] [PubMed]
9. Deb, P.; Furceri, D.; Ostry, J.D.; Tawk, N. The Economic Effects of COVID-19 Containment Measures. *Open Econ. Rev.* **2022**, *33*, 1–32. [CrossRef]
10. Nivette, A.; Ribeaud, D.; Murray, A.; Steinhoff, A.; Bechtiger, L.; Hepp, U.; Shanahan, L.; Eisner, M. Non-Compliance with COVID-19-Related Public Health Measures among Young Adults in Switzerland: Insights from a Longitudinal Cohort Study. *Soc. Sci. Med.* **2021**, *268*, 113370. [CrossRef] [PubMed]
11. Wang, D.; Marmo-Roman, S.; Krase, K.; Phanord, L. Compliance with Preventative Measures during the COVID-19 Pandemic in the USA and Canada: Results from an Online Survey. *Soc. Work Health Care* **2021**, *60*, 240–255. [CrossRef]
12. Kalagy, T.; Abu-Kaf, S.; Braun Lewensohn, O. Effective Ways to Encourage Health-Care Practices among Cultural Minorities in Israel during the Covid-19 Pandemic. *Int. J. Environ. Res. Public Health* **2021**, *18*, 9563. [CrossRef] [PubMed]
13. Papageorge, N.W.; Zahn, M.V.; Belot, M.; Van den Broek-Altenburg, E.; Choi, S.; Jamison, J.C.; Tripodi, E. Socio-Demographic Factors Associated with Self-Protecting Behavior during the COVID-19 Pandemic. *J. Popul. Econ.* **2021**, *34*, 691–738. [CrossRef]
14. Schiller, B.; Toensing, D.; Kleinert, T.; Boehm, R.; Heinrichs, M. Effects of the COVID-19 Pandemic Nationwide Lockdown on Mental Health, Environmental Concern, and Prejudice against Other Social Groups. *Environ. Behav.* **2022**, *54*, 516–537. [CrossRef]
15. Zhang, X.; Sun, Z.; Ashcroft, T.; Dozier, M.; Ostrishko, K.; Krishan, P.; Douglas, M. Compact Cities and the COVID-19 Pandemic: Systematic Review of the Associations between Transmission of COVID-19 or Other Respiratory Viruses and Population Density or Other Features of Neighbourhood Design. *Health Place* **2022**, *76*, 102827. [CrossRef]
16. Stier, A.J.; Berman, M.G.; Bettencourt, L.M.A. Early Pandemic COVID-19 Case Growth Rates Increase with City Size. *npj Urban Sustain.* **2021**, *1*, 31. [CrossRef]
17. Turok, I.; Visagie, J. COVID-19 Amplifies Urban Inequalities. *S. Afr. J. Sci.* **2021**, *117*, 129–132. [CrossRef]
18. Liu, S.; Su, Y. The Impact of the COVID-19 Pandemic on the Demand for Density: Evidence from the U.S. Housing Market. *Econ. Lett.* **2021**, *207*, 110010. [CrossRef]
19. Israel, E.; Frenkel, A. The Distribution of Capital Forms between Cities and Suburbs and Their Impact on Social Justice in Space. *Urban Geogr.* **2015**, *36*, 578–607. [CrossRef]
20. Leeuw, E. Healthy Cities. In *Handbook of Settings-Based Health Promotion*; Kokko, S., Baybutt, M., Eds.; Springer: Cham, Switzerland, 2022; pp. 91–104.
21. Bourdieu, P. The Forms of Capital. In *The Sociology of Economic Life*; Routledge: London, UK, 2018; pp. 78–92, ISBN 0-429-49433-5.
22. Frenkel, A.; Porat, I. An Integrative Spatial Capital-Based Model for Strategic Local Planning—An Israeli Case. *Plan. Pract. Res.* **2017**, *32*, 171–196. [CrossRef]
23. Mace, A. Spatial Capital as a Tool for Planning Practice. *Plan. Theory* **2017**, *16*, 119–132. [CrossRef]
24. Keil, R. Extended Urbanization, "Disjunct Fragments" and Global Suburbanisms. *Environ. Plan. D* **2018**, *36*, 494–511. [CrossRef]
25. Airgood-Obrycki, W.; Hanlon, B.; Rieger, S. Delineate the US Suburb: An Examination of How Different Definitions of the Suburbs Matter. *J. Urban Aff.* **2021**, *43*, 1263–1284. [CrossRef]
26. Frenkel, A.; Ashkenazi, M. The Integrated Sprawl Index: Measuring the Urban Landscape in Israel. *Ann. Reg. Sci.* **2008**, *42*, 99–121. [CrossRef]
27. Keil, R. *Suburban Planet: Making the World Urban from the Outside 2017*; John Wiley & Sons: Hoboken, NJ, USA, 2017.
28. Kovács, Z.; Farkas, Z.J.; Egedy, T.; Kondor, A.C.; Szabó, B.; Lennert, J.; Baka, D.; Kohán, B. Urban Sprawl and Land Conversion in Post-Socialist Cities: The Case of Metropolitan Budapest. *Cities* **2019**, *92*, 71–81. [CrossRef]
29. Sander, T.H. Social Capital and New Urbanism: Leading a Civic Horse to Water? *Natl. Civ. Rev.* **2002**, *91*, 213–235. [CrossRef]
30. Talen, E. Sense of Community and Neighbourhood Form: An Assessment of the social doctrine of new urbanism. *Urban Stud.* **1999**, *36*, 1361–1379. [CrossRef]
31. Beck, B. Broken Windows in the Cul-de-Sac? Race/Ethnicity and Quality-of-Life Policing in the Changing Suburbs. *Crime Delinq.* **2019**, *65*, 270–292. [CrossRef]
32. Eom, H.; Dawkins, C.J. Decomposing Changes in the Geography of Metropolitan Inequality. *J. Urban Aff.* **2022**, *46*, 1002–1019. [CrossRef]

33. Garrison, J.D.; Huxman, T.E. A Tale of Two Suburbias: Turning up the Heat in Southern California's Flammable Wildland-Urban Interface. *Cities* **2020**, *104*, 102725. [CrossRef]
34. Sweeney, G.; Hanlon, B. From Old Suburb to Post-suburb: The Politics of Retrofit in the Inner Suburb of Upper Arlington, Ohio. *J. Urban Aff.* **2016**, *39*, 241–259. [CrossRef]
35. Kotkin, J. Suburbia as class issue. In *Infinite Suburbia*; Berger, A., Kotkin, J., Eds.; Chronicle Books: San Francisco, CA, USA, 2018; pp. 56–64.
36. Jun, M.-J.; Kim, J.I.; Kwon, J.H.; Jeong, J.-E. The Effects of High-Density Suburban Development on Commuter Mode Choices in Seoul, Korea. *Cities* **2013**, *31*, 230–238. [CrossRef]
37. Modarres, A. Narrating the Suburbs. *Cities* **2010**, *27*, 122–125. [CrossRef]
38. Knox, P. Vulgaria: The Re-Enchantment of Suburbia. *Opolis* **2005**, *1*, 33–46.
39. Knox, P. *Metroburbia, USA*; Rutgers University Press: New Brunswick, NJ, USA, 2008; ISBN 0-8135-4357-6.
40. Israel, E. Place Habitus in the City and Suburbs: The Politics of Middle-Class Education and the Perspective of Elite Decisionmakers. *Cities* **2021**, *114*, 103199. [CrossRef]
41. Williamson, T. *Sprawl, Justice, and Citizenship: The Civic Costs of the American Way of Life*; Oxford University Press: Oxford, MA, USA, 2010.
42. Freudenberg, N.; Galea, S.; Vlahov, D. Beyond Urban Penalty and Urban Sprawl: Back to Living Conditions as the Focus of Urban Health. *J. Community Health* **2005**, *30*, 1–11. [CrossRef] [PubMed]
43. Zhu, D.; Ye, X.; Li, W.; Ding, R.; He, P. Urban Health Advantage or Urban Health Penalty? Urban-Rural Disparities in Age Trajectories of Physiological Health among Chinese Middle-Aged and Older Women and Men. *Health Place* **2021**, *69*, 102559. [CrossRef]
44. Rodríguez-Pose, A.; Maslauskaite, K. Can Policy Make Us Happier? Individual Characteristics, Socio-Economic Factors and Life Satisfaction in Central and Eastern Europe. *Camb. J. Reg. Econ. Soc.* **2012**, *5*, 77–96. [CrossRef]
45. Hoogerbrugge, M.M.; Burger, M.J. *The Urban Happiness Paradox Evidence from the United Kingdom*; Working Paper 56; Erasmus University: Rotterdam, The Netherlands, 2019.
46. Pineo, H.; Rydin, Y. Cities, Health and Well-Being. 2018. Available online: https://discovery.ucl.ac.uk/id/eprint/10107484/1/Cities%20health%20and%20well-being%20insight%20WEB.pdf (accessed on 18 January 2025).
47. Dye, C. Health and Urban Living. *Science* **2008**, *319*, 766. [CrossRef] [PubMed]
48. Ou, J.Y.; Peters, J.L.; Levy, J.I. Self-Rated Health and Its Association with Perceived Environmental Hazards, the Social Environment, and Cultural Stressors in an Environmental Justice Population. *BMC Public Health* **2018**, *18*, 970. [CrossRef] [PubMed]
49. Jalaludin, B.B.; Garden, F.L. Does Urban Sprawl Impact on Self-Rated Health and Psychological Distress? A Multilevel Study from Sydney, Australia. *EcoHealth* **2011**, *8*, 268–276. [CrossRef] [PubMed]
50. Pasqualini, M. Subjective Well-Being in Rural and Urban Areas under the COVID-19 Crisis in France. In *Rural Quality of Life*; Manchester University Press: Manchester, UK, 2023; pp. 383–404.
51. Pfeiffer, D.; Cloutier, S. Planning for Happy Neighborhoods. *J. Am. Plan. Assoc.* **2016**, *82*, 267–279. [CrossRef]
52. Seliske, L.; Pickett, W.; Janssen, I. Urban Sprawl and Its Relationship with Active Transportation, Physical Activity and Obesity in Canadian Youth. *Health Rep.* **2012**, *23*, 17–25.
53. De Vos, J.; Van Acker, V.; Witlox, F. Urban Sprawl: Neighbourhood Dissatisfaction and Urban Preferences. Some evidence from Flanders. *Urban Geogr.* **2016**, *37*, 839–862. [CrossRef]
54. Restivo, V.; Cernigliaro, A.; Casuccio, A. Urban Sprawl and Health Outcome Associations in Sicily. *Int. J. Environ. Res. Public Health* **2019**, *16*, 1350. [CrossRef] [PubMed]
55. Ewing, R.; Meakins, G.; Hamidi, S.; Nelson, A.C. Relationship between Urban Sprawl and Physical Activity, Obesity, and Morbidity—Update and Refinement. *Health Place* **2014**, *26*, 118–126. [CrossRef] [PubMed]
56. Näyhä, S.; Lankila, T.; Rautio, A.; Koiranen, M.; Tammelin, T.H.; Taanila, A.; Rusanen, J.; Laitinen, J. Body Mass Index and Overweight in Relation to Residence Distance and Population Density: Experience from the Northern Finland Birth Cohort 1966. *BMC Public Health* **2013**, *13*, 938. [CrossRef] [PubMed]
57. Vandegrift, D.; Yoked, T. Obesity Rates, Income, and Suburban Sprawl: An Analysis of US States. *Health Place* **2004**, *10*, 221–229. [CrossRef]
58. Glaeser, E.L.; Gottlieb, J.D. Urban resurgence and the consumer city. *Urban Stud.* **2006**, *43*, 1275–1299. [CrossRef]
59. Putnam, R.D. *Bowling Alone: The Collapse and Revival of American Community*; Simon and Schuster: New York, NY, USA, 2000; ISBN 0-7432-0304-6.
60. Gatrell, A.C.; Popay, J.; Thomas, C. Mapping the Determinants of Health Inequalities in Social Space: Can Bourdieu Help Us? *Health Place* **2004**, *10*, 245–257. [CrossRef]
61. Hu, X.; Wang, T.; Huang, D.; Wang, Y.; Li, Q. Impact of Social Class on Health: The Mediating Role of Health Self-Management. *PLoS ONE* **2021**, *16*, 0254692. [CrossRef] [PubMed]

62. Demakakos, P.; Nazroo, J.; Breeze, E.; Marmot, M. Socioeconomic Status and Health: The Role of Subjective Social Status. *Soc. Sci. Med.* **2008**, *67*, 330–340. [CrossRef] [PubMed]
63. Gittelsohn, J.; Kasprzak, C.M.; Hill, A.B.; Sundermeir, S.M.; Laska, M.N.; Dombrowski, R.D.; DeAngelo, J.; Odoms-Young, A.; Leone, L.A. Increasing Healthy Food Access for Low-Income Communities: Protocol of the Healthy Community Stores Case Study Project. *Int. J. Environ. Res. Public Health* **2022**, *19*, 690. [CrossRef] [PubMed]
64. Raskind, I.G.; Vishwakarma, M.; Schleicher, N.C.; Andersen-Rodgers, E.; Henriksen, L. The Changing Retail Landscape for Tobacco: Dollar Stores and the Availability of Cheap Cigarettes among Tobacco-Related Priority Populations. *Tob. Control* **2022**, *31*, 140–147. [CrossRef]
65. Giles-Corti, B.; Saghapour, T.; Turrell, G.; Gunn, L.; Both, A.; Lowe, M.; Higgs, C. Spatial and Socioeconomic Inequities in Liveability in Australia's 21 Largest Cities: Does City Size Matter? *Health Place* **2022**, *78*, 102899. [CrossRef] [PubMed]
66. Graham, C.; Felton, A. Inequality and Happiness: Insights from Latin America. *J. Econ. Inequal.* **2006**, *4*, 107–122. [CrossRef]
67. Acevedo-Garcia, D.; Lochner, K.A.; Osypuk, T.L.; Subramanian, S.V. Future Directions in Residential Segregation and Health Research: A Multilevel Approach. *Am. J. Public Health* **2003**, *93*, 215–221. [CrossRef] [PubMed]
68. Galea, S.; Freudenberg, N.; Vlahov, D. Cities and Population Health. *Soc. Sci. Med.* **2005**, *60*, 1017–1033. [CrossRef] [PubMed]
69. Leviton, L.C.; Snell, E.; McGinnis, M. Urban Issues in Health Promotion Strategies. *Am. J. Public Health* **2000**, *90*, 863.
70. Brueckner, J.K.; Largey, A.G. Social Interaction and Urban Sprawl. *J. Urban Econ.* **2008**, *64*, 18–34. [CrossRef]
71. Hero, R.E. *Racial Diversity and Social Capital: Equality and Community in America*; Cambridge University Press: New York, NY, USA, 2007.
72. Savage, M.; Bagnall, G.; Longhurst, B.J. *Globalization and Belonging*; Sage: London, UK, 2005.
73. McCartney, G.; Bartley, M.; Dundas, R.; Katikireddi, S.V.; Mitchell, R.; Popham, F.; Walsh, D.; Wami, W. Theorising Social Class and Its Application to the Study of Health Inequalities. *SSM-Popul. Health* **2019**, *7*, 100315. [CrossRef]
74. Rosenbaum, M.S.; Kuppelwiese, V.G.; Contreras Ramirez, G.; Manthiou, A. People and Place Attachment: Exploring Compliance in Neighborhood Health Centers. *Health Mark. Q.* **2023**, *40*, 375–395. [CrossRef] [PubMed]
75. Ruggiero, E.; Mignogna, C.; Costanzo, S.; Persichillo, M.; Castelnuovo, A.; Esposito, S.; Moli-LOCK Study Investigators. Changes in the Consumption of Foods Characterising the Mediterranean Dietary Pattern and Major Correlates during the COVID-19 Confinement in Italy: Results from Two Cohort Studies. *Int. J. Food Sci. Nutr.* **2021**, *72*, 1105–1117. [CrossRef] [PubMed]
76. Ljubičić, M.; Sarić, M.M.; Klarin, I.; Rumbak, I.; Barić, I.C.; Ranilović, J.; El-Kenawy, A.E.; Papageorgiou, M.; Vittadini, E.; Černelič-Bizjak, M.; et al. Motivation for Health Behaviour: A Predictor of Adherence to Balanced and Healthy Food Across Different Coastal Mediterranean Countries. *J. Funct. Foods* **2022**, *91*, 105018. [CrossRef]
77. English, A.S.; Li, X. Mask Use Depends on the Individual, Situation, and Location—Even without COVID-19 Transmission: An Observational Study in Shanghai. *Front. Psychol.* **2021**, *12*, 754102. [CrossRef] [PubMed]
78. Wallace, J.; Goldsmith-Pinkham, P.; Schwartz, J.L. Excess Death Rates for Republican and Democratic Registered Voters in Florida and Ohio during the COVID-19 Pandemic. *JAMA Intern. Med.* **2023**, *183*, 916–923. [CrossRef] [PubMed]
79. Gimpel, J.G.; Lovin, N.; Moy, B.; Reeves, A. The Urban–Rural Gulf in American Political Behavior. *Political Behav.* **2020**, *42*, 1343–1368. [CrossRef]
80. Plohl, N.; Musil, B. Modeling Compliance with COVID-19 Prevention Guidelines: The Critical Role of Trust in Science. *Psychol. Health Med.* **2021**, *26*, 1–12. [CrossRef]
81. Shibli, H.; Palkin, D.; Aharonson-Daniel, L.; Davidovitch, N.; Daoud, N. Inequalities in Trust Levels and Compliance With Physical Distancing During COVID-19 Outbreaks: Comparing the Arab Minority and Jewish Populations in Israel. *Int. J. Public Health* **2022**, *67*, 1604533. [CrossRef]
82. Bargain, O.; Aminjonov, U. Trust and Compliance to Public Health Policies in Times of COVID-19. *J. Public Econ.* **2020**, *192*, 104316. [CrossRef]
83. Painter, M.; Qiu, T. Political Beliefs Affect Compliance with COVID-19 Social Distancing Orders. *Covid Econ.* **2020**, *4*, 103–123. [CrossRef]
84. Wright, A.L.; Sonin, K.; Driscoll, J.; Wilson, J. Poverty and Economic Dislocation Reduce Compliance with COVID-19 Shelter-in-Place Protocols. *J. Econ. Behav. Organ.* **2020**, *180*, 544–554. [CrossRef]
85. Clark, C.; Davila, A.; Regis, M.; Kraus, S. Predictors of COVID-19 Voluntary Compliance Behaviors: An International Investigation. *Glob. Transit.* **2020**, *2*, 76–82. [CrossRef] [PubMed]
86. Harper, C.A.; Satchell, L.P.; Fido, D.; Latzman, R.D. Functional Fear Predicts Public Health Compliance in the COVID-19 Pandemic. *Int. J. Ment. Health Addict.* **2021**, *19*, 1875–1888. [CrossRef]
87. Khatib, M.; Mansbach-Kleinfeld, I.; Zaid, D.; Ifrah, A.; Yousef, M.; Sheikh Muhammad, A. Compliance with COVID-19 Regulations among Palestinian Citizens of Israel in the Context of Social Norms and Gender Roles. *Sustainability* **2023**, *15*, 11354. [CrossRef]
88. Son, S.; Lee, Y.H.; Jang, S. Factors Influencing Compliance with COVID-19 Disinfection Safety Guidelines among Disinfection Workers in South Korea. *Sustainability* **2023**, *15*, 12645. [CrossRef]
89. Vitale, M. The Social Ecology of COVID-19 Prevalence and Risk in Montreal, QC, Canada. *Health Place* **2022**, *78*, 102919. [CrossRef]

90. Baldassarri, D.; Abascal, M. Diversity and Prosocial Behavior. *Science* **2020**, *369*, 1183–1187. [CrossRef]
91. Churski, P.; Kroczak, H.; Łuczak, M.; Shelest-Szumilas, O.; Woźniak, M. Adaptation Strategies of Migrant Workers from Ukraine during the COVID-19 Pandemic. *Sustainability* **2021**, *13*, 8337. [CrossRef]
92. Israel, E.; Frenkel, A. Social Justice and Spatial Inequality: Toward a Conceptual Framework. *Prog. Hum. Geogr.* **2018**, *42*, 647–665. [CrossRef]
93. Sayer, A. Habitus, Work and Contributive Justice. *Sociology* **2011**, *45*, 7–21. [CrossRef]
94. Bourdieu, P. *Outline of a Theory of Practice*; Cambridge University Press: Cambridge, UK, 1977.
95. Cockerham, W.C. Bourdieu and an Update of Health Lifestyle Theory. In *Medical Sociology on the Move*; Springer: Berlin/Heidelberg, Germany, 2013; pp. 127–154.
96. Kamoche, K.; Kannan, S.; Siebers, L.Q. Knowledge-Sharing, Control, Compliance and Symbolic Violence. *Organ. Stud.* **2014**, *35*, 989–1012. [CrossRef]
97. Ugwudike, P. Understanding Compliance Dynamics in Community Justice Settings: The Relevance of Bourdieu's Habitus, Field, and Capital. *Int. Crim. Justice Rev.* **2017**, *27*, 40–59. [CrossRef]
98. Akkermans, J.; Richardson, J.; Kraimer, M.L. The COVID-19 Crisis as a Career Shock: Implications for Careers and Vocational Behavior. *J. Vocat. Behav.* **2020**, *119*, 103434. [CrossRef] [PubMed]
99. Frohn, J. Troubled Schools in Troubled Times: How COVID-19 Affects Educational Inequalities and What Measures Can Be Taken. *Eur. Educ. Res. J.* **2021**, *20*, 667–683. [CrossRef]
100. Cockerham, W.C. Health Lifestyle Theory and the Convergence of Agency and Structure. *J. Health Soc. Behav.* **2005**, *46*, 51–67. [CrossRef] [PubMed]
101. Bourdieu, P. *Distinction: A Social Critique of the Judgement of Taste*; Harvard University Press: Cambridge, MA, USA, 1984.
102. Krueger, P.M.; Bhaloo, T.; Rosenau, P.V. Health Lifestyles in the United States and Canada: Are We Really so Different? *Soc. Sci. Q.* **2009**, *90*, 1380–1402. [CrossRef]
103. Pretty, J. Social Capital and the Collective Management of Resources. *Science* **2003**, *302*, 1912–1914. [CrossRef]
104. Scott-Arthur, T.; Brown, B.; Saukko, P. Conflicting Experiences of Health and Habitus in a Poor Urban Neighbourhood: A Bourdieusian Ethnography. *Sociol. Health Illn.* **2021**, *43*, 697–712. [CrossRef] [PubMed]
105. Bourdieu, P. *The Weight of the World: Social Suffering in Contemporary Society*; Stanford University Press: Palo Alto, CA, USA, 2000.
106. Casey, E.S. Between Geography and Philosophy: What Does It Mean to Be in the Place-World? *Ann. Assoc. Am. Geogr.* **2001**, *91*, 683–693. [CrossRef]
107. Foster, S.R. The City as an Ecological Space: Social Capital and Urban Land Use. *Notre Dame Law Rev.* **2006**, *82*, 527–582.
108. Blokland, T.; Savage, M. *Networked Urbanism: Social Capital in the City*; Routledge: London, UK, 2016; ISBN 1-315-59780-2.
109. Lannoo, S.; Verhaeghe, P.-P.; Vandeputte, B.; Devos, C. Differences in Social Capital between Urban and Rural Environments. *J. Urban Aff.* **2012**, *34*, 373–394. [CrossRef]
110. Savage, M.; Hanquinet, L.; Cunningham, N.; Hjellbrekke, J. Emerging Cultural Capital in the City: Profiling London and Brussels. *Int. J. Urban Reg. Res.* **2018**, *42*, 138–149. [CrossRef]
111. Madden, E.F. Cultural Health Capital on the Margins: Cultural Resources for Navigating Healthcare in Communities with Limited Access. *Soc. Sci. Med.* **2015**, *133*, 145–152. [CrossRef] [PubMed]
112. Ishizawa, H.; Jones, A. Immigrant Neighborhood Concentration, Acculturation and Obesity among Young Adults. *J. Urban Aff.* **2016**, *38*, 298–311. [CrossRef]
113. Ligthart, K.A.M.; Buitendijk, L.; Koes, B.W.; van Middelkoop, M. The Association between Ethnicity, Socioeconomic Status and Compliance to Pediatric Weight-Management Interventions—A Systematic Review. *Obes. Res. Clin. Pract.* **2017**, *11*, 1–51. [CrossRef] [PubMed]
114. Traoré, S.G.; Fokou, G.; Wognin, A.S.; Heitz-Tokpa, K.; Tetchi, S.M.; Ouattara, F.A.; Orou Seko, M.; Akoua-Koffi, C.; Tiembre, I.; Bonfoh, B. Preventive Measures against Ebola and COVID-19 and Their Impact on Human Dirty-Hand Disease Mitigation in Côte d'Ivoire. *Sustainability* **2023**, *15*, 6810. [CrossRef]
115. Sulemana, A.-S.; Lal, S.; Nguyen, T.X.T.; Khan, M.S.R.; Kadoya, Y. Pandemic Fatigue in Japan: Factors Affecting the Declining COVID-19 Preventive Measures. *Sustainability* **2023**, *15*, 6220. [CrossRef]
116. Dvorak, J. Response of the Lithuanian Municipalities to the First Wave of COVID-19. *Balt. Reg.* **2021**, *13*, 70–88. [CrossRef]
117. Carpiano, R.M. Neighborhood Social Capital and Adult Health: An Empirical Test of a Bourdieu-Based Model. *Health Place* **2007**, *13*, 639–655. [CrossRef] [PubMed]
118. Van Rooij, B.; de Bruijn, A.L.; Reinders Folmer, C.; Kooistra, E.B.; Kuiper, M.E.; Brownlee, M.; Olthuis, E.; Fine, A. Compliance with COVID-19 Mitigation Measures in the United States. Amsterdam Law School Research Paper. 2020. Available online: https://ssrn.com/abstract=3582626 (accessed on 18 January 2025).
119. Alfano, V. Does Social Capital Enforce Social Distancing? The Role of Bridging and Bonding Social Capital in the Evolution of the Pandemic. *Econ. Politica* **2022**, *39*, 839–859. [CrossRef] [PubMed]
120. Makridis, C.A.; Wu, C. How Social Capital Helps Communities Weather the COVID-19 Pandemic. *PLoS ONE* **2021**, *16*, e0245135.

121. Wu, C. Social Capital and COVID-19: A Multidimensional and Multilevel Approach. *Chin. Sociol. Rev.* **2021**, *53*, 27–54. [CrossRef]
122. Achterberg, P.; De Koster, W.; Van der Waal, J. A Science Confidence Gap: Education, Trust in Scientific Methods, and Trust in Scientific Institutions in the United States, 2014. *Public Underst. Sci.* **2017**, *26*, 704–720. [CrossRef]
123. Alves, R.F.; Samorinha, C.; Precioso, J. Knowledge, Attitudes and Preventive Behaviors toward COVID-19: A Study among Higher Education Students in Portugal. *J. Health Res.* **2020**, *35*, 318–328. [CrossRef]
124. Gomes da Silva, J.; Silva, C.S.; Alexandre, B.; Morgado, P. Education as a Predictor Factor for COVID-19 Knowledge in Portugal. *Front. Public Health* **2021**, *9*, 680726. [CrossRef] [PubMed]
125. Foster, C.; Frieden, J. Crisis of Trust: Socio-Economic Determinants of Europeans' Confidence in Government. *Eur. Union Politics* **2017**, *18*, 511–535. [CrossRef]
126. Van Elsas, E. Political Trust as a Rational Attitude: A Comparison of the Nature of Political Trust across Different Levels of Education. *Political Stud.* **2015**, *63*, 1158–1178. [CrossRef]
127. Jargowsky, P.A. Sprawl, Concentration of Poverty, and Urban Inequality. In *Urban Sprawl—Causes, Consequences and Policy Response*; Squires, G.D., Ed.; Urban Institute Press: Washington, DC, USA, 2001; pp. 39–71.
128. Berger, T. Suburban realities: The Israeli case. *CLCWeb Comp. Lit. Cult.* **2019**, *21*, 3. [CrossRef]
129. Adolfsson, J. Settler Suburbia in the Negev/Naqab: The Start-up Pioneer in the Desert. *Geogr. Rev.* **2024**, *114*, 180–205. [CrossRef]
130. Schwake, G. The Community Settlement: A Neo-Rural Territorial Tool. *Plan. Perspect.* **2020**, *36*, 237–257. [CrossRef]
131. Schwake, G. An Officer and a Bourgeois: Israeli Military Personnel, Suburbanization and Selective Privatization. *Plan. Perspect.* **2021**, *36*, 183–194. [CrossRef]
132. Yacobi, H.; Tzfadia, E. Neo-Settler Colonialism and the Re-Formation of Territory: Privatization and Nationalization in Israel. *Mediterr. Politics* **2018**, *24*, 1–19. [CrossRef]
133. Razin, E.; Shachar, A. Deconcentration in a Context of Population Growth and Ideological Change: The Tel-Aviv and Beer-Sheva Metropolitan Areas. In *Employment Deconcentration in European Metropolitan Areas: Market Forces Versus Planning Regulations*; Razin, E., Dijst, M., Vazques, C., Eds.; Springer: Dordrecht, The Netherlands, 2007; pp. 179–207.
134. Zaychik, D.; Beeri, I.; Rein-Sapir, Y.; Avni, N.; Altshuler, A. Innovation and Adaption in Local Governments in the Face of COVID-19: Determinants of Effective Crisis Management. *Risk Hazards Crisis Public Policy* **2024**. [CrossRef]
135. Barak, N.; Sommer, U.; Mualam, N. Urban Attributes and the Spread of COVID-19: The Effects of Density, Compliance and Socio-Political Factors in Israel. *Sci. Total Environ.* **2021**, *793*, 148626. [CrossRef]
136. Corren, N.B.; Perry-Hazan, L. Bidirectional Legal Socialization and the Boundaries of Law: The Case of Enclave Communities' Compliance with COVID-19 Regulations. *J. Soc. Issues* **2021**, *77*, 631–662. [CrossRef] [PubMed]
137. Green, M.S.; Abdullah, R.; Vered, S.; Nitzan, D. A Study of Ethnic, Gender and Educational Differences in Attitudes toward COVID-19 Vaccines in Israel–Implications for Vaccination Implementation Policies. *Isr. J. Health Policy Res.* **2021**, *10*, 26. [CrossRef] [PubMed]
138. Halbertal, D. 7. Religion and State, One and the Same. In *Handbook of Israel: Major Debates*; De Gruyter Oldenbourg: Berlin, Germany, 2016; p. 122.
139. Shomron, B.; David, Y. Protecting the Community: How Digital Media Promotes Safer Behavior during the COVID-19 Pandemic in Authoritarian Communities—A Case Study of the Ultra-Orthodox Community in Israel. *New Media Soc.* **2022**, *26*, 1484–1504. [CrossRef]
140. Goren, T.; Vashdi, D.R.; Beeri, I. "Apples and Oranges": Examining Different Social Groups' Compliance With Government Health Instructions During the COVID-19 Pandemic. *Int. J. Health Policy Manag.* **2021**, *11*, 1172–1186. [CrossRef] [PubMed]
141. Mevorach, T.; Cohen, J.; Apter, A. Keep Calm and Stay Safe: The Relationship between Anxiety and Other Psychological Factors, Media Exposure and Compliance with COVID-19 Regulations. *Int. J. Environ. Res. Public Health* **2021**, *18*, 2852. [CrossRef] [PubMed]
142. Simpson, A. A Four-Step Process to Studying the Field through the City of London. *Cities* **2016**, *51*, 96–105. [CrossRef]
143. Nyadera, I.N.; Kisaka, M.O. The State of Israel. In *The Palgrave Handbook of Comparative Public Administration*; Palgrave Macmillan: Singapore, 2022; pp. 567–592.
144. Meyer-Brodnitz, M.B.; Czamanski, D.T. Industrialization of the Arab Village in Israel. *Econ. Q.* **1986**, *128*, 533–546.
145. Yiftachel, O. *Ghetto Citizenship: Palestinian Arabs in Israel. Israel and the Palestinians–Key Terms (56–60)*; Mada Center for Applied Research: Haifa, Israel, 2009.
146. Gordon, D.L.; Janzen, M. Suburban Nation? Estimating the Size of Canada's Suburban Population. *J. Archit. Plan. Res.* **2013**, *30*, 197–220.
147. Moore, A.A. Motivations for Mobilization: Comparing Urban and Suburban Residents' Participation in the Politics of Planning and Development. *Urban Aff. Rev.* **2022**, *58*, 1124–1151. [CrossRef]
148. Oliver, J.E. *Democracy in Suburbia*; Princeton University Press: Princeton, NJ, USA, 2001.
149. Razin, E. Needs and Impediments for Local Government Reform: Lessons from Israel. *J. Urban Aff.* **2004**, *26*, 623–640. [CrossRef]

150. Yogev, D. Social Capital Transformation and Social Control: What Can We Learn from the Changing Style in Communication between Religious Communities and the Police during COVID-19. *Polic. Soc.* **2021**, *32*, 794–815. [CrossRef]
151. Perry, G.; Jonathan-Zamir, T. Expectations, Effectiveness, Trust, and Cooperation: Public Attitudes towards the Israel Police during the COVID-19 Pandemic. *Polic. J. Policy Pract.* **2020**, *14*, 1073–1091. [CrossRef]
152. Rosen, B.; Waitzberg, R.; Israeli, A. Israel's Rapid Rollout of Vaccinations for COVID-19. *Isr. J. Health Policy Res.* **2021**, *10*, 6. [CrossRef]
153. Shacham, M.; Greenblatt-Kimron, L.; Hamama-Raz, Y.; Martin, L.R.; Peleg, O.; Ben-Ezra, M.; Mijiritsky, E. Increased COVID-19 Vaccination Hesitancy and Health Awareness amid COVID-19 Vaccinations Programs in Israel. *Int. J. Environ. Res. Public Health* **2021**, *18*, 3804. [CrossRef]
154. Talic, S.; Shah, S.; Wild, H.; Gasevic, D.; Maharaj, A.; Ademi, Z.; Li, X.; Xu, W.; Mesa-Eguiagaray, I.; Rostron, J. Effectiveness of Public Health Measures in Reducing the Incidence of COVID-19, SARS-CoV-2 Transmission, and COVID-19 Mortality: Systematic Review and Meta-Analysis. *bmj* **2021**, *375*, e068302. [CrossRef] [PubMed]
155. Forrest, R.; Kearns, A. Social cohesion, social capital and the neighborhood. *Urban Stud.* **2001**, *38*, 2125–2143. [CrossRef]
156. Navarro, C.J. The Political Ecology of the Spanish Metropolis–Place, Socio-Economic and Regional Effects. In *The Political Ecology of the Metropolis. Metropolitan Sources of Electoral Behaviour in Eleven Countries*; Sellers, L., Kubler, D., Walter-Rogg, M., Eds.; ECPR Press: Essex, UK, 2013; pp. 267–297.
157. Mouratidis, K. Built Environment and Social Well-Being: How Does Urban Form Affect Social Life and Personal Relationships? *Cities* **2018**, *74*, 7–20. [CrossRef]
158. Poortinga, W. Social Relations or Social Capital? Individual and Community Health Effects of Bonding Social Capital. *Soc. Sci. Med.* **2006**, *63*, 255–270. [CrossRef] [PubMed]
159. Magre, J.; Vallbé, J.J.; Tomas, M. Moving to Suburbia? Effects of Residential Mobility on Community Engagement. *Urban Stud.* **2016**, *53*, 17–39. [CrossRef]
160. Collyer, F.M.; Willis, K.F.; Franklin, M.; Harley, K.; Short, S.D. Healthcare Choice: Bourdieu's Capital, Habitus and Field. *Curr. Sociol.* **2015**, *63*, 685–699. [CrossRef]
161. Piketty, T. *Capital in the Twenty-First Century*; Harvard University Press: Cambridge, MA, USA, 2014; ISBN 0-674-43000-X.
162. Dorling, D. *Injustice: Why Social Inequality Still Persists*; Policy Press: London, UK, 2015; ISBN 1-4473-2076-X.
163. Israel, E.; Frenkel, A. Justice and Inequality in Space—A Socio-Normative Analysis. *Geoforum* **2020**, *110*, 1–13. [CrossRef]
164. Kiernan, D. *Natural Resources Biometrics*; SUNY Open Textbooks: New York, NY, USA, 2024.