

Urban Health Literature Review

May 2004

Theme: What is urban health?

Topic A. Theoretical perspectives on urban health

Topic B. Topics in Urban Health; examples of studies that ask, “How does urbanicity affect health?”

Topic C. Global trends in urbanization

Topic A. Theoretical perspectives on urban health

1. Source: Annu Rev Public Health. 2000;21:473-503.

Title: Health promotion in the city: a review of current practice and future prospects in the United States.

Author: Freudenberg N.

Affiliation: Program in Urban Public Health, Hunter College School of Health Sciences, City University of New York, New York 10010, USA.

Abstract: To achieve its health goals, the United States must reduce the disproportionate burden of illness and poor health borne by urban populations. In the 20th century, patterns of immigration and migration, changes in the global economy, increases in income inequality, and more federal support for suburbanization have made it increasingly difficult for cities to protect the health of all residents. In the last 25 years, epidemics of human immunodeficiency virus infections and substance abuse and increases in homelessness, lack of health insurance, rates of violence, and concentrations of certain pollutants have also damaged the health of urban residents. Several common strategies for health promotion are described, and their relevance to the unique characteristics of urban populations is assessed. To identify ways to strengthen health promotion practices in U.S. cities, lessons have been taken from five related fields of endeavor: human rights, church- and faith-based social action, community economic development, youth development, and the new social movements. By integrating lessons from these areas into their practice, public health professionals can help to revitalize the historic mission of public health, contribute to creating healthier cities, and better achieve national health objectives.

2. Source: Discussion of Defining urban health In: Journal of Urban Health Vol., 81, no 2 pg 165-169. Journal of Urban Health, Vol 81, no 2 Pg. 165

Title: Urban health: discipline or field – does it matter?

Author: Guyer B and Gibbons MC.

Affiliation; Zanvyl Krieger Professor of Children’s Health and the Department of Population and family health Sciences at the Johns Hopkins Medical Institution

Discussion: Urban health does not need to be a discipline for the health of urban populations to be important. As the presentations at the Second International Conference on Urban Health amply demonstrated, the Earth’s population is increasingly concentrated in cities, urban environments create physical and social problems of enormous consequence for human health, and disparities in health must be addressed. Of equal importance was the celebration of the assets of the world’s cities: excitement, energy diversity and complexity. Most of us would not want to live anywhere else.

3. Source: Journal of Urban Health Vol., 81, no 2 pg 168

Title: **Urban Health: A future focus for career development**

Author :Trudy Harpham

Affiliation: London South Bank University and London School of Hygiene and Tropical Medicine, United Kingdom

Discussion: Spending too much time debating whether urban health is a discipline is probably unwise as there are so many definitions of discipline. For example, a sampling of definitions includes the following: "A subject area with distinct research methods, terminology and styles of communication"; "A subject that is taught, a field of study"; "Institutionalization of a scientific specialty"; "Institutionalized subdivision of the various activities making up an academy"; "A conceptual framework with paradigmatic structures which are commonly subscribed to by members". Settling on a definition is probably a lengthy debate in itself.

4. Source: Am J Public Health. 2004 Apr 94(4):541-6.

Title: **Confronting the challenges in reconnecting urban planning and public health.**

Author: Corburn J.

Affiliation: Urban Public Health Program, Hunter College, City University of New York, NY 10010,

Abstract: Although public health and urban planning emerged with the common goal of preventing urban outbreaks of infectious disease, there is little overlap between the fields today. The separation of the fields has contributed to uncoordinated efforts to address the health of urban populations and a general failure to recognize the links between, for example, the built environment and health disparities facing low-income populations and people of color. I review the historic connections and lack thereof between urban planning and public health, highlight some challenges facing efforts to recouple the fields, and suggest that insights from ecosocial theory and environmental justice offer a preliminary framework for reconnecting the fields around a social justice agenda.

5. Source: Am J Public Health. 2000 Jun;90(6):858-62.

Title: **Community, service, and policy strategies to improve health care access in the changing urban environment.**

Author: Andrulis DP.

Affiliation: State University of New York Health Science Center/Brooklyn, Department of Preventive Medicine and Community Health 11203.

Abstract: Urban communities continue to face formidable historic challenges to improving public health. However, reinvestment initiatives, changing demographics, and growth in urban areas are creating changes that offer new opportunities for improving health while requiring that health systems be adapted to residents' health needs. This commentary suggests that health care improvement in metropolitan areas will require setting local, state, and national agendas around 3 priorities. First, health care must reorient around powerful population dynamics, in particular, cultural diversity, growing numbers of elderly, those in welfare-workplace transition, and those unable to negotiate an increasingly complex health system. Second, communities and governments must assess the consequences of health professional shortages, safety net provider closures and conversions, and new marketplace pressures in terms of their effects on access to care for vulnerable urban populations; they must also weigh the potential value of emerging models for improving those populations' care. Finally, governments at all levels should use their influence through accreditation, standards, tobacco settlements, and other financing streams to educate and guide urban providers in directions that respond to urban communities' health care needs.

6. Source: Rev Environ Health. 1999 Jan-Mar;14(1):1-10. Related Articles, Links

Title: **Urban health: an ecological perspective.**

Author: Lawrence RJ.

Affiliation: Centre for Human Ecology and Environmental Sciences, University of Geneva, Switzerland.

Abstract: At the Second European Conference on Environment and Health held in Helsinki in June 1994, urban health was attributed a high priority. This decision by the Ministers of Environment and Health from European countries reflects and reinforces a growing worldwide concern in the 1990s about the health status of residents of urban areas in all continents. The reasons for this concern include the rapid rate of urbanization and the increasing number of environmental, economic, and social problems, which have a negative impact on health and well-being in cities. This review presents a theoretical and methodological framework for the study of this vast and complex subject area. The paper proposes and illustrates an ecological perspective by discussing housing conditions and homelessness, as well as the concentration of poverty and deprivation in precise neighborhoods. To promote health and well-being more effectively, the ecological perspective presented in this paper can be applied by public health officers, by urban planners, and by policy decision-makers at national and local levels to promote our understanding of the multi-dimensional nature of health disorders of citizens. This approach should be a high priority for the beginning of the 21st century.

7. Source: March 2003, Vol 93, No. 3, American Journal of Public Health 371-379

Title: **Consuming Research, Producing Policy?**

Author: Robert G. Evans, PhD and Greg L. Stoddart, PhD

Affiliation: Department of Clinical Epidemiology and Biostatistics, HSC-2D1, McMaster University, Ontario L8N 3Z5, Canada

The authors' 1990 article "Producing Health, Consuming Health Care" presented a conceptual framework for synthesizing a rapidly growing body of findings on the nonmedical determinants of health. The article received a very positive response, and here the authors reflect on what lessons might be learned from that response about the style or content of effective interdisciplinary communication.

Much substantive knowledge has been accumulated since 1990, and a number of different frameworks have been developed before and since. The authors situate theirs within this literature and consider how they might have modified it if they "knew then what they know now." They ask what impact this article, and the much broader stream of research on the determinants of health, has had on public policy?

8. Source: Am J Public Health. 2004 Apr;94(4):546-9.

Title: **Ranking of cities according to public health criteria: pitfalls and opportunities.**

Author: Ham SA, Levin S, Zlot AI, Andrews RR, Miles R.

Affiliation: Physical Activity and Health Branch, Centers for Disease Control and Prevention, Atlanta, GA 30341, USA.

Abstract: Popular magazines often rank cities in terms of various aspects of quality of life. Such ranking studies can motivate people to visit or relocate to a particular city or increase the frequency with which they engage in healthy behaviors. With careful consideration of study design and data limitations, these efforts also can assist policymakers in identifying local public health issues. We discuss considerations in interpreting ranking studies that use environmental measures of a city population's public health related to physical activity, nutrition, and obesity.

Ranking studies such as those commonly publicized are constrained by statistical methodology issues and a lack of a scientific basis in regard to design.

9. Source: Journal of Urban Health Vol. 79, no. 4 Supplement 1, 2002

Title: **Urbanization, urbanicity and health**

Author: Vlahov D, Galea S

Affiliation: Center for Urban Epidemiologic Studies, New York Academy of Medicine, New York, NY

Abstract: A majority of the world's population will live in urban areas by 2007. The most rapidly urbanizing cities are in less wealthy nations, and the pace of growth varies among regions. There are few data linking features of cities to the health of populations. We suggest a framework to guide inquiry into features of the urban environment that affect health and well-being. We consider two key dimensions: urbanization and urbanicity. Urbanization refers to change in size, density, and heterogeneity of cities. Urbanicity refers to the impact of living in urban areas at a given time. A review of the published literature suggests that most of the important factors that affect health can be considered within three broad themes: the social environment, the physical environment, and access to health and social services. The development of urban health as a discipline will need to draw on the strengths of diverse academic areas of study (e.g. ecology, epidemiology, sociology). Cross national research may provide insights about the key features of cities and how urbanization influences population health.

10. Source: The New York Times Magazine, October 12, 2003, Sunday, Late Edition - Final, Section 6, Page 75, Column 3.

Title: **Ghetto miasma; Enough To Make You Sick?**

ABSTRACT - Helen Epstein's article on plight of America's urban poor, especially blacks, who are disproportionately afflicted with debilitating diseases that leave them unable to function and often kill them at very young age; black infant death rate in Westchester County, NY, far exceeds national rate; black youths in Harlem, central Detroit and Chicago's South Side have same probability of dying by age 45 as whites nationwide do by age 65; correlation of health and living conditions of poor blacks and Hispanics supports contention that much chronic disease among minority groups is not genetic as once thought, but may be function of living conditions; researchers are struggling to ascertain why chronic diseases are so much more common among people in poor neighborhoods; behavioral indicators do not fully account for why rich people are healthier than poor people; one theory holds that stress is major culprit, while another focuses on impact of deprivation; depression and anxiety are also cited as factors; several cases of families moving from extremely poor to middle class neighborhoods appear to validate theories about stress and deprivation, which cannot be separated when discussing miasma of poverty.

Topic B. Topics in Urban Health; examples of studies that ask, "How does urbanicity effect health?"

11. Source: Obes Res. 2003 Nov;11(11):1325-32.

Title: **The sweetening of the world's diet.**

Author: Popkin BM, Nielsen SJ.

Affiliation: Carolina Population Center, and Department of Nutrition, University of North Carolina at Chapel Hill, NC

Abstract: Using data from many countries in the world combined with in-depth U.S. dietary data,

we explored trends in caloric sweetener intake, the role of urbanization and income changes in explaining these trends, and the contribution of specific foods to these changes. **RESEARCH METHODS AND PROCEDURES:** Food disappearance data from 103 countries in 1962 and 127 in 2000 were coupled with urbanization and gross national income per capita data in pooled regression analysis to examine associations between these factors and caloric sweetener intake. Three nationally representative surveys from 1977 to 1978, 1989 to 1991, and 1994 to 1996 plus 1998 are used to examine caloric sweetener intake trends in the United States and the foods responsible for these changes. **RESULTS:** Increased consumption of caloric sweetener is one element in the world's dietary changes, represented by a 74-kcal/d increase between 1962 and 2000. Urbanization and income growth represent 82% of the change. U.S. data show an 83-kcal/d increase of caloric sweetener consumed—a 22% increase in the proportion of energy from caloric sweetener. Of this increase, 80% comes from sugared beverages; restaurant and fast food sources are represented in greater proportions. **DISCUSSION:** Caloric sweetener use has increased considerably around the world. Beverage intake seems to be a major contributor.

12. Source: Am J Public Health. 2004 Apr;94(4):525-7.

Title: Integrating the environment, the economy, and community health: a Community Health Center's initiative to link health benefits to smart growth.

Authors: McAvoy PV, Driscoll MB, Gramling BJ.

Affiliations: Department of Environmental Health, Sixteenth Street Community Health Center, Milwaukee, WI 53204, USA.

Abstract: The Sixteenth Street Community Health Center (SSCHC) in Milwaukee, Wis, is making a difference in the livability of surrounding neighborhoods and the overall health of the families it serves. SSCHC is going beyond traditional health care provider models and working to link the environment, the economy, and community health through urban brownfield redevelopment and sustainable land-use planning. In 1997, SSCHC recognized that restoration of local air and water quality and other environmental conditions, coupled with restoring family-supporting jobs in the neighborhood, could have a substantial impact on the overall health of families. Recent events indicate that SSCHC's pursuit of smart growth strategies has begun to pay off.

13. Source: Am J Public Health. 2001 Sep;91(9):1487-93.

Title: Neighborhood poverty and the resurgence of tuberculosis in New York City, 1984-1992.

Author: Barr RG, Diez-Roux AV, Knirsch CA, Pablos-Mendez A.

Affiliation: Division of General Medicine, College of Physicians and Surgeons, Columbia University, New York, NY, USA.

OBJECTIVES: The resurgence of tuberculosis (TB) in New York City has been attributed to AIDS and immigration; however, the role of poverty in the epidemic is unclear. We assessed the relation between neighborhood poverty and TB at the height of the epidemic and longitudinally from 1984 through 1992. **METHODS:** Census block groups were used as proxies for neighborhoods. For each neighborhood, we calculated TB and AIDS incidence in 1984 and 1992 with data from the Bureaus of Tuberculosis Control and AIDS Surveillance and obtained poverty rates from the census. **RESULTS:** For 1992, 3,343 TB cases were mapped to 5,482 neighborhoods, yielding a mean incidence of 46.5 per 100,000. Neighborhood poverty was associated with TB (relative risk = 1.33; 95% confidence interval = 1.30, 1.36 per 10% increase in poverty). This association persisted after adjustment for AIDS, proportion foreign born, and race/ethnicity. Neighborhoods with declining income from 1980 to 1990 had larger increases in TB incidence than did neighborhoods with increasing income. **CONCLUSIONS:** Leading up to and at the height of the TB epidemic in New York City, neighborhood poverty was strongly associated with TB incidence. Public health interventions should target impoverished areas.

14. Source: Aust N Z J Psychiatry. 2002 Feb;36(1):104-13.

Title: **High prevalence disorders in urban and rural communities.**

Authors: **Judd FK, Jackson HJ, Komiti A, Murray G, Hodgins G, Fraser C.**

Affiliation: Centre for Rural Mental Health, Bendigo Health Care Group, PO Box 126, Bendigo 3552, Australia.

OBJECTIVE: High prevalence disorders (anxiety, depressive and substance use) are generally assumed to be more common in urban than rural dwellers. The aims of this paper are (i) to critically review studies measuring prevalence in rural as opposed to urban location, and (ii) to argue the need to look beyond the 'quantity' question to the quality question: how does urban or rural place influence mental health? METHOD: A literature review (Medline and PsychLIT) was carried out using the words 'rural, urban, mental/psychiatric, illness/disorders and prevalence', as well as a review of relevant papers and publications known to the authors. RESULTS: Many studies examining urban/rural differences in the rate of high prevalence disorders have been reported. Most use a 'one size fits all' definition of urban and rural, which assumes location is the key issue. The majority fail to show the purported difference in prevalence between the two settings. In general, studies have not examined interaction effects, but have simply treated the independent variables as main effects. Available data suggest that a variety of socio-demographic factors are more powerful predictors of difference in prevalence than is the location of residence. CONCLUSION: Further studies are required to understand if and how rural or urban place contributes to the development of psychiatric morbidity. These studies should mirror the clinical situation by taking into account a variety of individual and community-based (including urban/rural place) risk factors which may be important determinants of mental health and mental illness, and examining the interaction between them. This may then identify the nature of any differences or what issues are specific to, or especially important, in the rural setting.

15. Source: Urban Studies, Vol 33, No. 6 879-894 1996, pg 879-894

Title: **Health levels influenced by urban residential conditions in a megacity - Tokyo**

Tanaka A, Takano T, Nakamura K, Takeuchi S.

Department of Public Health and Environmental Science, School of Medicine, Tokyo Medical and Dental University, Tokyo.

Abstract: Influences of residential conditions in a megacity on the health levels of residents were investigated. Correlations between morbidity and specified residential-condition indicators in study areas randomly selected from the megacity Tokyo were examined. Indicators representing housing and city planning were significantly correlated with mortalities after adjusting for socio-economic differences between the communities. Urbanization to a certain level seems to have been associated with good health: however, the most densely developed artificial urban environment seems to be associated with negative health outcomes. Coping skills with regard to health problems are discussed in relation to health levels. A survey elucidated that the coping attitude of the elderly is related with their educational level, family structure, and frequency of receiving health information and contact with a family doctor.

Topic C. Global trends in urbanization.

16. Source: Int J Hyg Environ Health. 2003 Aug;206(4-5):269-78.

Title: **Global urbanization and impact on health.**

Author: Moore M, Gould P, Keary BS.

Affiliation: Office of Global Health Affairs, U.S. Department of Health and Human Services, Rockville, Maryland.

Abstract: Nearly half the world's population now lives in urban settlements. Cities offer the lure of better employment, education, health care, and culture; and they contribute disproportionately to national economies. However, rapid and often unplanned urban growth is often associated with poverty, environmental degradation and population demands that outstrip service capacity. These conditions place human health at risk. Reliable urban health statistics are largely unavailable throughout the world. Disaggregated intra-urban health data, i.e., for different areas within a city, are even more rare. Data that are available indicate a range of urban health hazards and associated health risks: substandard housing, crowding, air pollution, insufficient or contaminated drinking water, inadequate sanitation and solid waste disposal services, vector-borne diseases, industrial waste, increased motor vehicle traffic, stress associated with poverty and unemployment, among others. Local and national governments and multilateral organizations are all grappling with the challenges of urbanization. Urban health risks and concerns involve many different sectors, including health, environment, housing, energy, transportation, urban planning, and others. Two main policy implications are highlighted: the need for systematic and useful urban health statistics on a disaggregated, i.e., intra-urban, basis, and the need for more effective partnering across sectors. The humanitarian and economic imperative to create livable and sustainable cities must drive us to seek and successfully overcome challenges and capitalize on opportunities. Good urban planning and governance, exchange of best practice models and the determination and leadership of stakeholders across disciplines, sectors, communities and countries will be critical elements of success.

17. Source: Int J Health Serv. 1999;29(3):579-95.

Title: **Globalization and global health.**

Author: Berlinguer G.

Abstract: Along with the positive or negative consequences of the globalization of health, we can consider global health as a goal, responding to human rights and to common interests. History tells us that after the "microbial unification" of the world, which began in 1492, over three centuries elapsed before the recognition of common risks and attempts to cope with them in a cross-boundary effort. In the 19th and 20th centuries, the struggle against epidemics united countries, world health became a common goal, and considerable results were achieved. However, in recent decades the notion of health as a cornerstone of economic development has been replaced by the idea that public health and health services are an obstacle to the wealth of nations. Meanwhile, new common threats are growing: among them, the exacerbation of old infections and emergence of new ones, the impact of environmental changes, drug traffic on a world scale, and destructive and self-destructive violence. New and stronger empirical motives relate the interests of peoples to universal rights and to global health. The author concludes with some proposals for policies.

18. Source: http://www.prb.org/Template.cfm?Section=PRB&template=/Content/ContentGroups/04_Articles/Urbanization_An_Environmental_Force_to_Be_Reckoned_With.htm (April 2004)

Title: **Urbanization: An Environmental Force to Be Reckoned With**

Author: Barbara Boyle Torrey

Abstract: Human beings have become an increasingly powerful environmental force over the last 10,000 years. With the advent of agriculture 8,000 years ago, we began to change the land.¹ And with the industrial revolution, we began to affect our atmosphere. The recent increase in the world's population has magnified the effects of our agricultural and economic activities. But the growth in world population has masked what may be an even more important human-

environmental interaction: While the world's population is doubling, the world's urban population is tripling. Within the next few years, more than half the world's population will be living in urban areas (see Figure 1).²

The level and growth of urbanization differ considerably by region. Among developing countries, Latin American countries have the highest proportion of their population living in urban areas. But East and South Asia are likely to have the fastest growth rates in the next 30 years. Almost all of future world population growth will be in towns and cities. Both the increase in and the redistribution of the earth's population are likely to affect the natural systems of the earth and the interactions between the urban environments and populations.

The best data on global urbanization trends come from the United Nations Population Division and the World Bank.³ The UN, however, cautions users that the data are often imprecise because the definition of urban varies country by country. Past projections of urbanization have also often overestimated future rates of growth. Therefore, it is important to be careful in using urbanization data to draw definitive conclusions.

19. Source: Dev Econ. 1990 Dec;28(4):503-23.

Title: **Migration from rural to urban areas in China.**

Author: Wakabayashi K.

Abstract: During the regime of Mao Zedong the migration of rural population to urban areas was forbidden. In 1982 the people's communes were dissolved creating surplus labor. In 1984 permission was given to peasants to move to towns of 100,000 inhabitants or less. In 1986 the state allocation of jobs and lifetime employment practices were abolished leading to the migration of peasants. Urban population has increased 30-50 million annually since 1985. In 1988-89 urban population consisted of urban registry holders numbering 200 million protected by the government, 100 million new residents unqualified for food rations who had moved into towns of 100,000 population, and the so-called floating population getting no government services numbering about 60-80 million in February 1990. Rural towns grew as a result of promotion of smaller sized cities. In 1983 there were 62,310,000 people in such cities, and by 1984 there were over 134 million mainly in the 15-29 age group. The increasing inflow of population into major cities also occurred in 1984-5 owing to the dissolution of communes. 23 cities with populations over 1 million received 10 million migrants/year, and 50 million migrate to towns and cities every year. In 1988 Shanghai had a mostly male floating population of 2.08 million/year, and Beijing had 1,310,000. This phenomenon led to the emergence of surplus agricultural labor. Village and township enterprises absorbed this surplus: in 1988 there were 18,888,600 such entities employing 95,454,600 people or 23.8% of the labor force. Surplus labor totals 220 million out of 400 million agricultural labor force. The gap between the hinterland and the rich coastal areas with special economic zones is widening, reminiscent of the north-south problem. This phenomenon is the harbinger of the transformation of China into a freer society with higher population mobility.