Editorials

Time for a National Agenda to Improve the Health of Urban Populations

To achieve the vision of "healthy people in healthy communities" articulated in Healthy People 2010,[1] the United States must do more to promote health and prevent disease in urban areas. Despite some significant improvements in health status in the last decade, the failure to achieve more than 15% of the goals identified in Healthy People 2000[2] stems in large measure from the disproportionate burden of certain health problems in urban areas—HIV infection, asthma, violence, substance abuse, and preterm delivery as well as heart disease, cancer, and stroke.[3–7] Although rural areas also experience higher-than-average morbidity and mortality that demand attention, in the last 50 years, the excess mortality and morbidity experienced by the poor and by people of color have become increasingly concentrated in cities.[8]

More than 80% of the US population lives in metropolitan areas, which include both cities and their surrounding suburbs. In the last 25 years, cities and suburbs have become more similar, and the demographic and health profiles that were previously uniquely urban are now shared by "edge cities" and poor and minority suburbs. More than a quarter of the US population still lives in central cities. Moreover, after more than 5 decades of federal support for suburbanization, cities continue to be the economic engine of the US economy and the focal point for global interchanges of people, services, products, and money.[9]

Even though cities have a disproportionate impact on the nation's economy and health status, the United States lacks a clearly articulated urban agenda. Equally disturbing, the public health community has not defined a research or action agenda for urban health. What explains these failures, and how can public health workers contribute to reducing the health disparities now concentrated in the nation's cities?

The lack of a political agenda for improving social conditions in cities stems from several related phenomena. First, over the last half century, the political machines and social movements that won new resources for cities have declined.[10,11] In many states, political power shifted to suburban regions, where elected officials pursued tax and spending policies that favored their areas at the expense of cities. At the same time, the national government, which during the New Deal and the post–World War II era had served as the protector of urban and other vulnerable populations, lost power both to the states and to multinational corporations. After 1980, more conservative state and national governments began to cut back the safety net programs that had protected people in previous decades. Between 1970 and 1990, the number of people living in poor inner-city neighborhoods doubled.[12]

Public health emerged as a modern profession in the late 19th and early 20th centuries, born out of popular and elite efforts to improve living conditions in US and European cities.[13,14] More recently, however, organized public health in the United States shifted its attention to the organization and financing of the health care system. Faced with budget cuts and limited political support, municipal health departments shed responsibilities, taking on staff and programs only in response to crises like the HIV or tuberculosis epidemics of the 1980s and 1990s.

Cities also posed formidable challenges to public health researchers. Investigators found it difficult to create variables that captured the multiple, unique dimensions of urban life; as a result, race and ethnicity, in the United States, and social class, in Europe, were more frequently used variables than urban status. The complexity of cities posed both methodological and financial ob-

stacles, leading many investigators to carry out community studies in smaller towns or suburban areas. Because of this, we lack a systematic body of literature characterizing the health consequences of urban vs nonurban environments or of different types of urban settings. This gap makes it more difficult to design interventions to improve health in urban areas.

Strategies to Promote Urban Health

In this issue, several articles raise questions that can help to frame an action and research agenda designed to improve the health of urban populations. Three commentaries examine distinct strategies for promoting health and preventing disease in urban areas: increasing access to and the quality of health care,[15] reducing risk behavior,[16] and improving social conditions.[17] These are not mutually exclusive approaches, but each offers unique contributions and each has specific limitations.

Numerous studies have shown that significant proportions of urban populations lack health insurance coverage and access to primary care and, as a result, experience higher rates of hospitalization for preventable conditions.[6,18,19] By increasing access to care and improving its quality, argues Andrulis,[15] public policy can contribute to reducing disparities between the urban poor and the rest of the population. Leviton et al.[16] note that urbanization, the increase in the size, density, and heterogeneity of populations, and the specific environment of the inner city influence health behaviors such as exercise, diet, sexual behavior, alcohol and substance use, and others. The authors describe the intricate relationships between environment and behavior and suggest health promotion strategies, such as strengthening social networks, organizing coalitions, and building the capacity of neighborhood organizations, to reduce risk behavior by creating a more supportive social environment. Finally, Geronimus[17] emphasizes the importance of addressing the structural factors that produce inner-city poverty and of promoting policies and programs that reduce poverty, racism, and income inequality—the underlying causes of the disproportionate urban mortality and morbidity.

The challenge is to weave these and other strategies into a comprehensive and integrated effort to improve the health of urban populations. The experience of the last 25 years offers urban health promoters diverse methods for achieving their goals, including campaigns to increase health knowledge and awareness, to boost social support, to reduce stigmatization and marginalization, to advocate health-promoting policies, to improve physical environments, to meet basic needs, and to create more supportive social environments.[20] Some initiatives can be categorical; for example, asthma programs that increase access to quality primary care, improve housing to reduce exposure to allergens, and control local sources of air pollution. Other endeavors, such as increasing the minimum wage or earned income tax credit or creating new parks, playgrounds, and recreational facilities, may yield improvements in many health outcomes. The limited success in improving the health of low-income urban populations is not primarily a result of the lack of a knowledge base of intervention strategies; rather, it is the failure to apply what we know with sufficient intensity, duration, and comprehensiveness.

Too often, public health practitioners have focused all their attention on only 1 of these strategies, even while acknowledging the importance of all 3. However, emphasizing only access to health care, for example, overlooks the fundamental role of urban social conditions. Targeting only individual risk behavior condemns health promoters to the Sisyphean task of perpetually undoing the damage of disease promoters such as the gun industry, the drug trade, or the fast (high-fat) food industry, which are often concentrated in urban areas because of their market density. Finally, relying on efforts to improve social conditions—a long-term strategy—may require sacrificing the current generation of vulnerable urban populations, a triage that violates fundamental public health ethics. Finding practical and efficient ways to integrate the 3 strategies constitutes an important priority for urban health promoters. Several recent initiatives, such as the Urban Research Centers and other projects sponsored by the US Centers for Disease Control and Prevention,[21] the Robert Wood Johnson Foundation's Urban Health Initiative[22] and similar foundation-supported efforts, and the global Healthy Cities movement,[23] promise new insights into how best to accomplish such an integration. In practice, and in these and other similar projects, it has been difficult to attribute changes in health status in urban communities to interventions, which highlights the importance of further developing evaluation methods for complex settings.[24]

Role of the Economy

The broader task of defining an agenda for improving the health of urban populations requires the consideration of several questions. First, how can we best adapt public health programs to meet the changing social and economic conditions in US cities? Earlier this year, the United States celebrated its longest period of economic expansion in history, almost 9 years of uninterrupted economic growth. In the last 5 years, some of these economic benefits have in fact trickled down to poor urban populations. Between 1996 and 1997, the overall rate of inner-city poverty dropped 10%; the income disparities between Blacks and Whites have gone down for the first time in several years, unemployment rates are the lowest in years, and many cities and states are enjoying budget surpluses.[25] Public health and public safety have also improved. Violent crime dropped in big cities by 27% between 1993 and 1997,[25] deaths from HIV infection fell 48% between 1996 and 1997,[26] and teen pregnancy rates have fallen for the last decade[27]—all improvements that have especially benefited urban residents.

What role has economic growth played in achieving these health improvements? Certainly it is plausible that increased job opportunities and improved living conditions reduce risk behavior by providing new incentives for healthier behavior, by facilitating more effective parenting, and by increasing social cohesion.[28] Other improvements seem more directly related to specific medical or public health measures, such as the increased use of directly observed therapy to control tuberculosis and the increased use of condoms that has helped to reduce the incidence of teen pregnancy, some sexually transmitted diseases, and HIV infection.[29,30] At the same time, other health conditions that affect low-income urban populations—for example, asthma, diabetes, the use of heroin, and the prevalence of obesity—have changed little or have even worsened.[1]

In the longer run, prosperity has had contradictory results, bringing additional problems as well as benefits to US cities. Income inequality has increased dramatically in the last 30 years,[31] a factor increasingly associated with poor health outcomes.[32–34] Cities have the greatest disparity in wealth, serving as home to both the very rich and the very poor.[8] Moreover, the prosperity continues to bypass many urban residents. Many small or midsized cities continue to experience high rates of unemployment and persistent poverty.[25] A recent study by the Urban Institute found that 65% more Americans had an episode of homelessness in 1996—a boom year—than in 1987.[35] And the proportion of Americans who lack health insurance continues to grow, reaching 30% in some US cities.[36]

To play a more effective role in advocating policies that promote the health of urban residents, we need better evidence on the pathways by which economic conditions influence health. Public health historians have long debated the relative impact of specific public health measures vs improved social conditions.[13,37,38] The continuing prosperity may provide unique opportunities to improve the health of urban populations, an option that could dissipate when the inevitable economic downturn arrives. By exploiting the variability in both economic conditions and public health interventions in US cities, researchers may be able to discover relationships between specific economic conditions and various health outcomes that can guide social policy and public health practice.

Protecting Vulnerable Populations

In the last 2 decades, many US cities experienced epidemics that challenged the complacent belief that such outbreaks in developed nations were a thing of the past. The striking but obvious characteristic of those affected by HIV, violence, substance abuse, asthma, infant mortality, and tuberculosis, to name a few, is that they are primarily the urban poor. More specifically, those at the margins of society—the homeless, those involved in the criminal justice system, some recent immigrants, those living in extreme poverty—experience rates of poor health many times higher than those for the rest of the population.[4,5,39–41] Too often, Blacks and Hispanics are disproportionately represented in these populations, indicating the continuing influence of racism.[42]

Focusing public health interventions on improving the living conditions of our most vulnerable populations (now heavily concentrated in cities) could reduce our reliance on after-the-fact responses to epidemics revealed by public health surveillance. This post hoc strategy, which has characterized our reaction to such diverse conditions as tuberculosis, HIV, asthma, and mosquito-borne West Nile fever, has required body counts to precipitate action. Developing new measures to identify vulnerable populations and improve their conditions prior to the outbreak of disease is a first step toward making "healthy people in healthy communities" a reality rather than a slogan.

To protect the health of the public adequately, public health professionals need to identify the populations that may be pushed into poor health, either by social and economic forces or by specific public policies. In this regard, the article by Chavkin et al.[41] raises concern that "welfare reform," especially in the more punitive forms it has taken in some states, may contribute to declines in health insurance coverage. Other evidence suggests that enrollment in the Food Stamp Program has also declined at a higher rate than the improvements in the economy would predict.[43] Thus, some portion of those being forced off welfare rolls may be at risk of losing health care and nutrition support.

These circumstances, combined with the continued shortage of low-income housing in most cities, provide a recipe for increasing disease rates, especially in urban neighborhoods with high concentrations of extreme poverty. In a similar vein, policies that circulate large numbers of urban young adults through the criminal justice system without addressing underlying problems, such as substance abuse, mental illness, or lack of employment skills, contribute to the creation of an isolated, stigmatized, and therefore vulnerable population. By creating a new paradigm for municipal health departments to identify and protect vulnerable urban populations, public health professionals may be able to reduce the likelihood or toll of future epidemics. Developing such plans now, rather than after an economic downturn, will bring both public health and financial benefits.

Overcoming Political Opposition

Political opposition to a national focus on urban areas poses a powerful obstacle to action. This opposition appears to be based both in politicians' desire to appeal to suburban middle-class populations, who vote at higher rates than inner-city residents, and in a more sinister racism, in which "urban" is code for "minority." Mustering greater political support for addressing urban health disparities will require careful analysis of strategic options. One approach is to appeal to historic American values of fairness and equality, making a moral case that all people deserve the basic necessities of life, especially in a time of unprecedented prosperity. Campaigns to increase health insurance coverage for low-income children have often used this approach. Another strategy is to appeal to self-interest: Failure to contain the urban epidemics of violence, substance abuse, or infectious diseases, or to treat those with mental illness, increases the likelihood that these conditions will spread to wealthier areas, both urban and nonurban.

A third approach is to emphasize the shared interests of urban and nonurban populations. By pushing middle-class people out of downtown areas, for example, deteriorating inner cities contribute to urban sprawl, which in turn increases air and water pollution and ruins open space for everyone. Free market principles dictate that the same housing policies that lead to urban homelessness by decreasing the supply of low-income units also increase the cost of housing for all sectors of the population. Creating the cross-class, cross-race coalitions that can advocate for policies to improve living conditions for the lower half of the socioeconomic spectrum may contribute as much to improvements in public health as more targeted interventions.[44]

Unfortunately, the empirical data needed to make informed choices about which political strategies would best contribute to solving the specific public health problems facing urban populations are generally lacking. Creating such evidence will require new interdisciplinary collaboration among public health researchers, political scientists, economists, and urban planners.

It will also require a closer integration of the scientific and political dimensions of public health. For example, Chavkin et al. argue that their evidence that punitive welfare policies may increase the rates of lack of health care insurance[41] should inform congressional debates on the reauthorization of the Personal Responsibility Work Opportunity and Reconciliation Act in 2002, even though additional research is needed.

Defining Roles for Public Health Workers

Finally, public health professionals need to identify the roles they can play in shaping an agenda to improve living conditions in US cities. Once again, both scientific and political competencies will be needed. Skills in surveillance and needs assessment can contribute to the identification of vulnerable populations and settings that can be addressed with programmatic or policy interventions. Policy analysis can identify the intended and unintended consequences of policies on welfare, health care, food, housing, criminal justice, and transportation—all sectors that influence the health of urban populations. Public health workers can also educate citizens, activists, and policymakers about the health impact of urban social conditions, enabling a wider range of stakeholders to participate in the political arenas where decisions are made. Finally, public health specialists can help to organize the coalitions and movements that will be needed to bring about the reallocation of resources needed to improve the quality of life and the health of urban populations.

By embracing these roles and making the creation of a national urban agenda a priority, the public health community has an opportunity both to contribute to improved health in the coming decades and to apply our profession's historic mission to the current era. □

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