

# Urban Health

## Toward an Urban Health Advantage

David Vlahov, Sandro Galea, and Nick Freudenberg

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Urban Health is a regular column within the *Journal of Public Health Management and Practice*. **Claude Earl Fox, MD, MPH**, the Column Editor, is Director of the Johns Hopkins Urban Health Institute and Public Health Professor of the Johns Hopkins Bloomberg School of Public Health, Baltimore, Md. Readers of *JPHMP* are encouraged to contribute current urban health issues to this feature. Contributions should be limited to 750 words and can be sent to the column editor at [cefox@jhsph.edu](mailto:cefox@jhsph.edu).

The dominant conception of urban health in the existing literature is concerned primarily with the "urban health penalty."<sup>1,2</sup> This approach posits that cities concentrate on poor people and expose residents to unhealthy environments leading to a disproportionate burden of poor health or health inequalities, especially in what some have called "inner cities."<sup>3,4</sup> In the past 50 years, the departure of the middle class and jobs to the surrounding suburbs in the United States has led to intense urban poverty and increased racial segregation leaving cities with diminished capacity to meet the needs of increasingly impoverished populations.<sup>5</sup> This approach points to the necessity improving health conditions particularly among disadvantaged urban populations. However, this approach tends to equate "urbaness" with issues of disadvantage and urban health becomes synonymous with conditions among the minority poor of the inner cities. In so doing, this approach does not consider the broader population or the many factors in addition to poverty that account for urban population health.

We suggest that this view of health is limited and does not consider emerging evidence that living in cities might instead confer an advantage for health.

Eberhardt and colleagues,<sup>6</sup> using a US Census definition of *urban/rural*, noted that the proportion of urban/rural populations that are below the poverty level is similar (15 percent vs 18 percent) to the proportion of those with private insurance (69 percent vs 64 percent) or who are Medicare beneficiaries (20 percent vs 23 percent). However, health outcomes tend to be somewhat better for those who live in cities. The proportion of those who describe their health status as fair/poor is somewhat lower in urban than rural areas (21 percent vs 28 percent). Likewise, the death rates per 100,000 for ages 1 to 24 years among males in urban areas is 60 versus 80 in rural; the corresponding figures for females are 30 and 40.

Some data show that health indicators are not only better in urban than rural areas (especially in less wealthy nations) but that the urban poor fare better than the nonurban poor. For example, the infant mortality rates (per 1,000 live births) across developing countries using the Demographic and Health Surveys were 86 for rural areas, 75 for the urban poor, and 56 for the urban nonpoor.<sup>7</sup>

What may account for an "urban health advantage"? Several hypotheses warrant further investigation. One possibility is that close proximity of wealth and poverty within cities brings benefits to those less well-off. Wen et al found that measures of neighborhood affluence were positively associated with health even after adjusting for neighborhood-level poverty, income

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inequality, aggregated educational attainment, and lagged levels of neighborhood health; the rationale for this finding is that a proximity of affluence, more evident in denser urban than rural areas, may help "to sustain neighborhood social organization which in turn positively affects health."<sup>8</sup> The presence of affluent members of society may attract the attention of politicians and government agencies and help win external funding as well as provide a strong base for civic and other community-based activities. Thus, socioeconomic heterogeneity, one of the hallmarks of cities, may bring benefits such as health care and education within the reach of the more disadvantaged urban residents.<sup>7</sup>

A second urban characteristic that may contribute to health advantage is the availability of higher levels of social support and greater social cohesion in urban than nonurban areas. Both social support and social cohesion are associated with a number of positive health outcomes.<sup>9</sup> Factors that may contribute to higher levels of support in urban areas include the previously described presence of wealthier individuals, who can better afford to provide instrumental support to their neighbors; denser social networks, offering more opportunities for support; and the availability of multiple communities of identity (eg, ethnic, cultural, professional, geographic), offering urban residents many opportunities to acquire the benefits of cohesion with others.<sup>10</sup>

A third possible explanation is that cities offer more access to the necessities of life. Dense populations and wealth make cities attractive venues for markets including those that sell food, housing, health care, and education, among others. Healthy food, a wide variety of housing opportunities, and medical care are generally more available in urban than nonurban areas. Even if markets distribute these goods inequitably within cities, the absolute advantage over nonurban areas may contribute to health. Throughout the world, millions of people have moved to cities in search of better employment, demonstrating their belief that opportunities for advancement are greater in urban than nonurban areas.

Fourth, cities may have a physical environment that is conducive to health. For example, compared to suburbs, cities may encourage walking, the most common form of physical activity for adults.<sup>11</sup> Surveys show that residents of poor neighborhoods are more likely to walk than those in less disadvantaged areas,<sup>12</sup> suggesting that physical design may help overcome some of the health burdens of low-income urban neighborhoods.

Finally, cities through their size and density offer the potential for political mobilization and social movements, enabling urban populations to win more resources for health, another possible route to a health advantage.<sup>7,13</sup> Historically, cities have often preceded

nonurban areas in setting housing standards, establishing a public health infrastructure, and improving public education, often in response to the organized efforts for change.

The picture of an urban health advantage becomes more problematic when using more refined definitions of *urban*. Moving from the dichotomy of urban/rural or metropolitan statistical areas (MSA)/non-MSA to area definitions of proximity in the United States shows that rates of disease or adverse health outcomes tend to be worse in "MSA central cities" than in "MSA noncentral city" or "non-MSA adjacent" but that the "non-MSA nonadjacent" (or truly rural) is similar to the MSA central city.<sup>14</sup> This pattern suggests that an "urban health advantage" may not apply equally across segments of US cities for all outcomes, and that parts of urban areas might have similar outcomes to rural areas so that both require special attention.

In fact, it may not be useful to think of the urban penalty and the urban advantage approaches as mutually exclusive. All cities have characteristics that both promote and harm health. The ultimate health status can be viewed as the sum of the urban advantages minus the sum of the penalties. We note that the plight of the disadvantaged in cities remains as a core area of concern in urban health. However, identifying more clearly those characteristics of cities that contribute to the urban health advantage will help us achieve the goal of healthier cities for all.

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