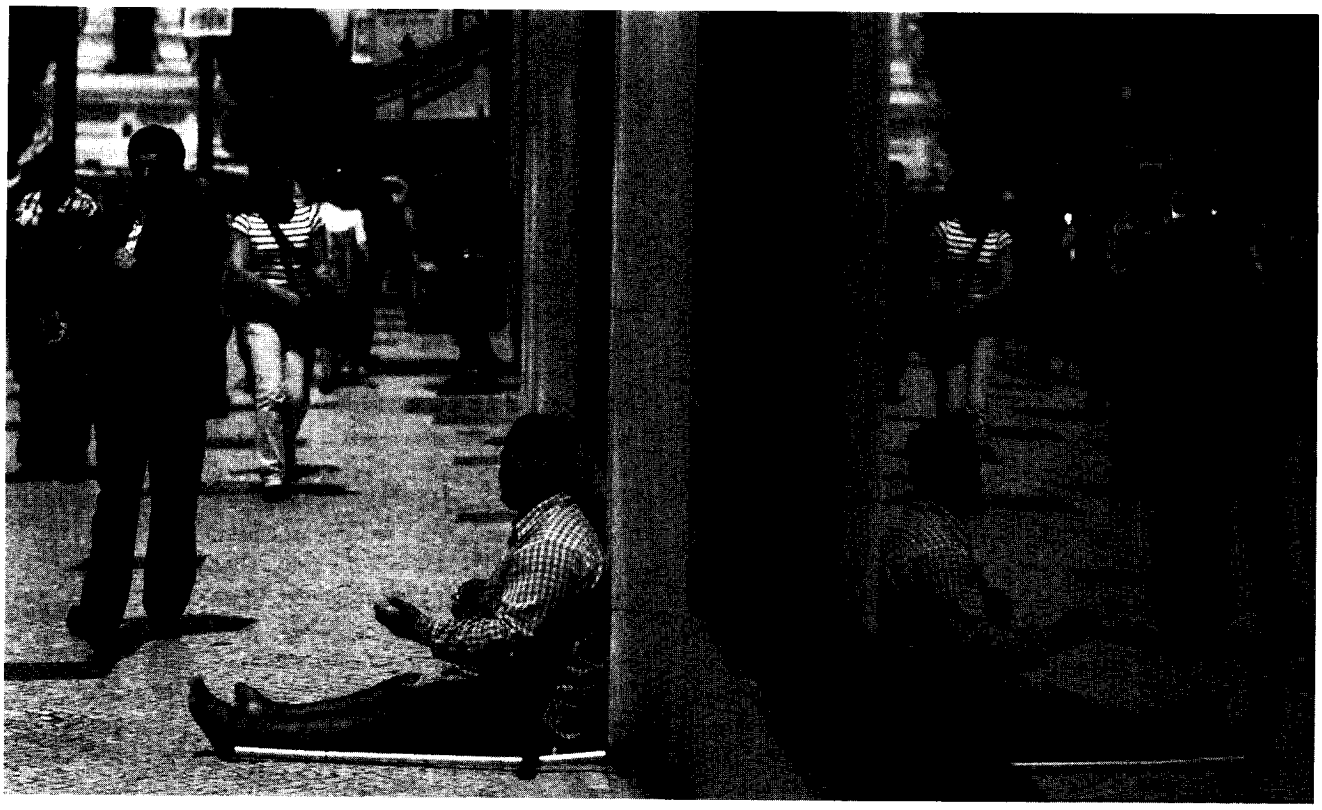

Contextualizing Health

Accounting for the Urban Environment

ZSUZSANNA JAKAB

Dr. Margaret Chan, Director General of the World Health Organization, begins her foreword to the 2010 WHO/HABITAT report *Hidden Cities*:

"It is well known by now that half of humanity lives in urban areas – and the proportion is growing. Cities, with their concentration of culture, infrastructure, and institutions have long driven the progress of civilization and have been the focus of opportunity and prosperity."

However, cities are also the nexus of negative economic, environmental, and economic forces jeopardizing the lives and poor health of many inhabitants. The aim of *Hidden Cities* is to unmask these deprivations, less visible in Europe than elsewhere, often hidden beneath glittering facades and marginalized in prosperous economies. It is our responsibility to overcome the great health inequalities which still prevail between and within the nations of Europe.

The first part of this article highlights some specific challenges facing urban communities in Europe. The second part summarizes how urban institutions and citizens of Europe are meeting these challenges, which is absolutely relevant to the work of the European Region of the WHO. Improving health and reducing health inequities has been the constant first priority of the Region, from the first of our targets for Health for All, published in 1984, through to Health 2020, the new *European Strategy for Health*. Health 2020 adopts a whole systems approach, acknowledging both the central role of national governments in the provision of health services, as well as the role of local government and its partners in influencing the wider determinants of health.

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Part One: Challenges

Urbanization is an irresistible social phenomenon and has been a dominant global demographic trend over the last two centuries. The level of world urbanization today is unprecedented. Cities are currently home to half the world's population, and it is estimated that over the next 30 years, most of the more than two billion person increase in the global population will occur in urban areas. Today, some 400 cities contain one million people or more, and about 70 percent are in the developing world. By 2017, the developing world is likely to be more urban than rural in character.

In the modern era, the European Region was the first of the WHO regions to urbanize, with industrialization inducing exponential population growth in the nineteenth and twentieth centuries. Now, our population of 900 million in 53 countries has stabilized overall, and we are not subject to the intense pressure of population growth experienced by other regions. Nevertheless, Figure 1 shows a divergence in the trajectories of urban populations in groups of European countries. In southern and eastern Europe, migration from rural settlements has been a major reason for population growth in cities. Since 1989 migration flows from eastern to western countries have increased, and some cities have accommodated high numbers of refugees and migrants.

The fragmentation of urban populations, alongside social and economic development, can create a number of serious management issues affecting individual and social life. There is pressure stemming from physical infrastructure, environmental degradation, traffic congestion and pollution, housing shortages, overcrowding, and other stress-related phenomena. These trends have heavily burdened social, health and welfare services in the host cities as well as the housing and employment markets, particularly during times of economic recession, when public authorities have reduced expenditure on housing and urban infrastructure and cutting allowances for welfare, health and community care.

Aging

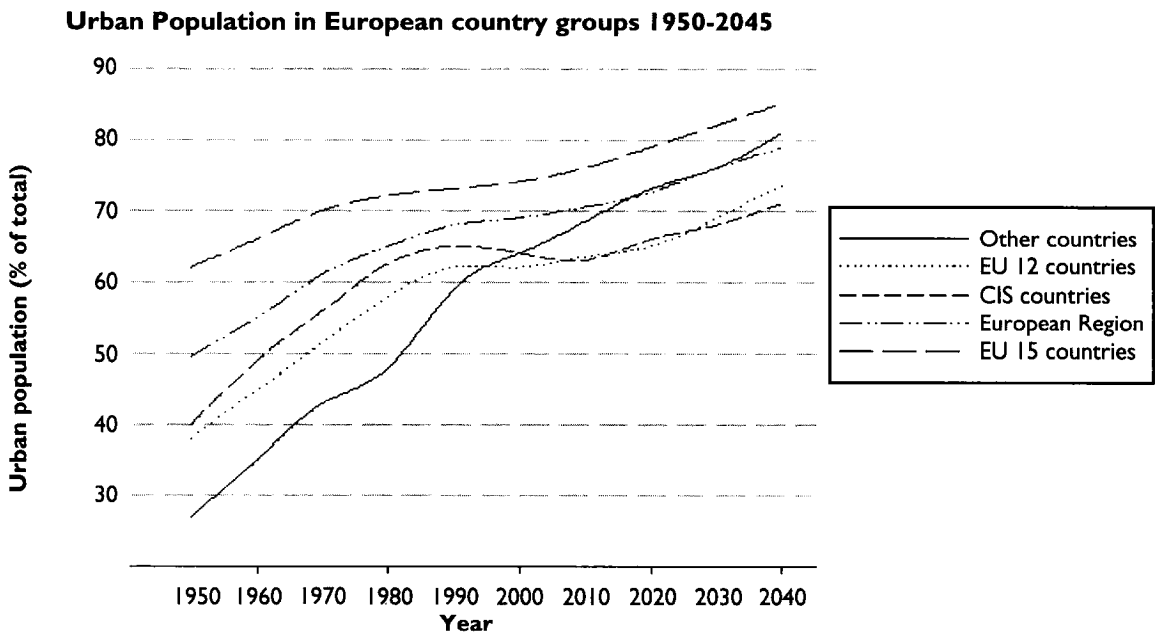
Besides migration, the other salient demographic in Europe is an aging population. The age "pyramid" has become an age "mushroom." In earlier eras of European development, and now in most developing cities in Global South, high fertility rates expanded the base of the age pyramid and limited life expectancy reduced the apex. Now in European cities, reduced fertility rates have diminished the base and increased life expectancy has increased the base of older people.

Population aging is both a triumph and a challenge, according to Active Ageing, WHO's report supplementing the Second United Nations World Assembly on Ageing in Madrid in 2002. In 21st century Europe, it is the increase in our older population rather than an increase in the population per se that is creating increased social and economic demands and straining the capacity of our health and social care systems. Older people are very significant consumers of health and social care resources, which are subject to acute financial pressure in an era of austerity.

Violence and Disorder

Three major threats to the safety and security of cities are urban crime and violence, insecurity of tenure and forced evictions, and natural and human-made disasters. Crime and violence are typically most severe in urban

Figure 1: Population Distribution in Europe



UN Population Division, World Urbanization Prospects, 2009.

Photos Courtesy Reuters

areas and compounded by their rapid growth and, in Europe especially, by migration and an erosion of social cohesion in poor city neighbourhoods. Both perceived and real levels of crime and violence in urban areas influence health. Crime directly affects the quality of life of not only victims, but also of their friends, family, and the general community in which they live.

Fear of crime isolates communities and has financial repercussions for individuals, governments and the private sector. Concerns about violence isolate the poor in their homes and the rich in their segregated spaces. For all, fear and insecurity pervade people's lives, with serious implications for trust and well-being among communities. Violence in urban areas takes a variety of forms, self-directed, interpersonal violence, and collective. Acts of violence are often concentrated in ghettos with a devastating impact on people's health and livelihoods in many urban areas. For example, when compared with average neighborhoods, residents of those with low levels of cohesion and high levels of disorder are significantly more likely to suffer a heart attack, even after adjusting for socio-economic status.

Basic Infrastructure

The basic public health infrastructure of sanitation, clean water supply and decent housing was developed in many European cities during the 19th and early 20th centuries to combat the spread of infectious diseases. In today's Europe, it is easy to forget how our advanced urban infrastructure critically underpins public health. This is evident in a minority of cities and neighbourhoods where the infrastructure is dysfunctional and the water distribution is inadequate, typically serving only the city's upper and middle class neighborhoods. The scarcity of public water supplies forces many low income urban residents to use other water sources, such as private water vendors, who charge high prices for lower quality water than is available to better-off urban residents. Failure to collect solid waste as well as inadequate waste management and recycling policies and practices means that some cities are literally inundated with waste.

In modern European cities, the infrastructure of affluence has contributed to a second generation of public health challenges. Re-engineered to respond to the exponential growth of motorized traffic, exhaust fumes often contribute more air pollution than smokestack factories. Concentrations of carbon monoxide, oxides of nitrogen, lead and suspended particulate matter contribute to asthma and learning disability in young children. Car dependency has also reduced the prevalence of walking and cycling as part of everyday living, contributed to lower levels of exercise and the higher levels of obesity, which is a risk factor for cardiovascular disease and diabetes.

Urban Inequality

The inter-related values of tolerance, fairness, social justice and good governance are as vital in sustaining urban life and development as physical planning. An urban society cannot be said to be harmonious if large sections of its population are deprived of basic needs while other sections live in opulence, or if some groups harness concentrated resources and opportunities while others remain impoverished or marginalized. In many cities rich, well-serviced neighborhoods and gated residential communities coexist alongside dense inner-city or peri-urban slum communities that lack even the most basic of services. Slum dwellers in many cities experience multiple deprivations that are direct expressions of poverty: many of their houses are unfit for human habitation, and they often lack adequate food, education, health care, and basic services. Many residents suffer severe environmental challenges associated with insufficient access to clean drinking water, inadequate sewerage facilities, and insufficient solid waste disposal.

Doctors of the World offers health services in a camp in western France. The infrastructure of living environments is an important determinant of health.

High levels of inequality have destabilizing social and economic consequences, with lower life expectancy than predicted by gross national product per capita. Inequalities can create social and political tensions leading to social unrest, especially in urban areas experiencing both high levels of inequality and endemic poverty. Health, both mental and physical, is often a casualty. Evidence indicates that the health benefits of economic growth are not realized in societies that experiencing very high levels of inequality and poverty. Inequality is not a natural consequence

of economic growth and, while the relationship between economic growth and urban income inequality is complex, levels of inequality can be controlled or reduced by forward-looking government action.

Part II: Urban Governance for Better Health

The new *European policy for health – Health 2020* takes a whole-of-society and whole-of-government approach to improving health in the European Region. The policy should be formally adopted by the European Region of WHO in September 2012. It focuses on improving health and reducing health inequities in all of the diverse circumstances of the 53 member States of the European Region of WHO. It embodies the latest international evidence on the determinants and consequences of population health and health inequalities. It summarises which interventions work and which provide the 'best buys,' and provides a framework for the work of the European Region of WHO and our member states. Two aspects are of crucial importance for the health of urban areas – first, a renewed emphasis on the wider determinants of health, and second, the critical role of urban governance.

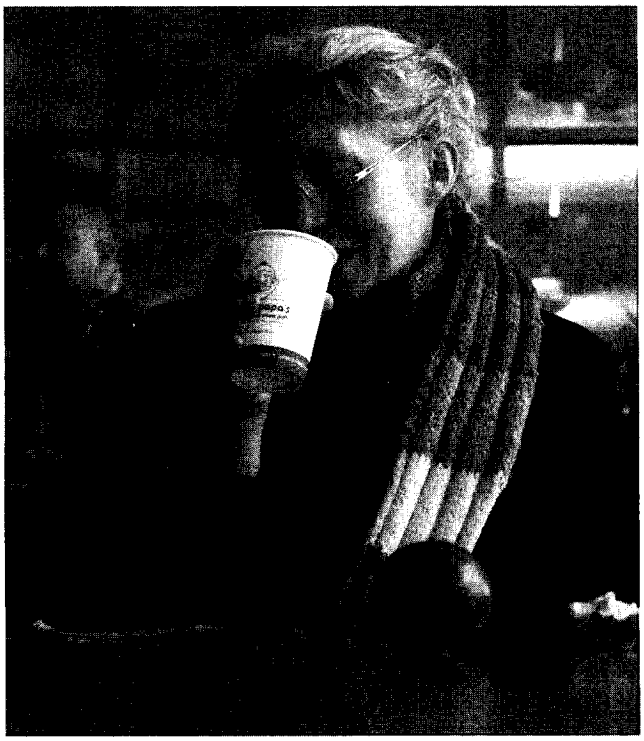
Wider Determinants of Health

The importance of societal influences in the broad policy framework of 2020 can be traced back to two key policy advances. First is the famous Alma Ata Declaration– that the best possible population health is to be achieved by a switch of resources from curative health services to primary health care, broadly defined by WHO in 1978 to include, 'in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors.'

Second, the ground breaking Health for All model and strategy adopted by member states of the WHO European Region again emphasised societal influences on health and was given renewed impetus in 2008 by Closing the Gap in a Generation, the global report of the WHO Commission on Social Determinants of Health (CSDH). The conceptual underpinning of this approach is that population health is rooted in socio-economic context, and contexts (schools, workplaces, living conditions, whole cities) can be changed by good governance and salutogenic investment. Cities were identified as key settings to promote Health for All and municipal governments are promoted as lead partners at the launch of the first phase of its European Healthy Cities Network (WHO-EHCN) in 1987. The human settlement map developed for the Network by Barton and Grant shows how the multiple and many layered influences on health identified earlier by Whitehead and Dalhgren, come together in cities.

Urban Governance

The sustained support of our Regional Office for Healthy Cities over 25 years and five phases (1987-2013) reflects our experience that city governments and their partners have a major influence and responsibility for shaping the health of their citizens. In all but the very smallest countries of Europe, formal powers and competences are allocated to nested tiers of elected government – differing combinations of central, regional, provincial and local tiers. In parallel, central governments often operate from decentralized offices, usually at the provincial level. Most local governments in the European Region have a general duty to promote the well-being of their citizens and provide equal and similar access to municipal resources and opportunities. Cities can achieve this through their influence in several domains such as health, social services, environment, education, economy, housing, security, transport and sport.



A woman drinks tea at a regional homeless center in London. Increasing aging populations are placing growing stress on nations' health and social systems.

Until the mid-20th century, public, environmental and health functions were combined at the municipal level. Sanitary and epidemiological centres characterized the systems in central and eastern Europe until the USSR dissolved in 1990. Currently, the functions tend to be separated, with public health typically allocated to central and regional governments as part of the environmental and health service to municipalities, although this varies between countries. Public health professionals tend to focus on the immediate physiological risk factors for poor health such as obesity, high blood pressure and susceptibility to infection, whereas environmental health services focus on proximal causes such as air pollution and

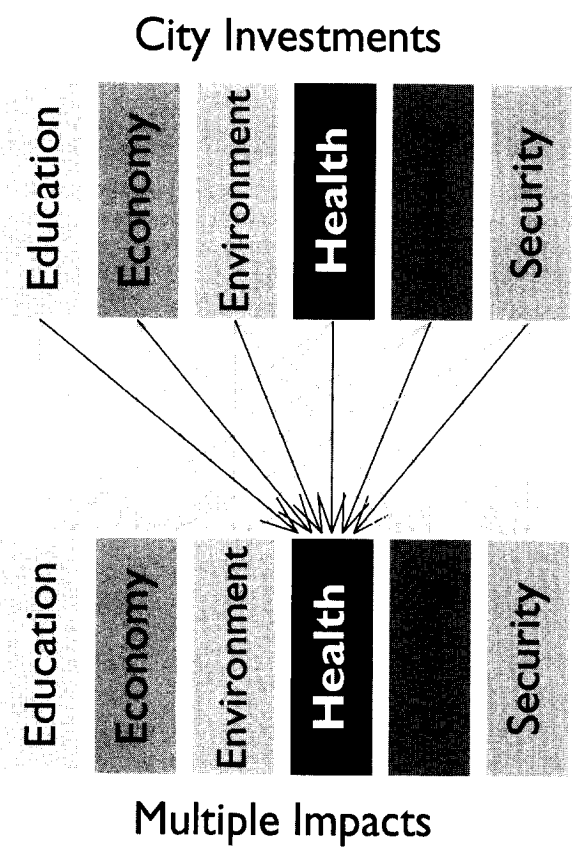
unsanitary living conditions.

Hospital treatment and care is most often directly administered by central and regional governments; primary care is most often decentralized. On the other hand, local governments often take primary responsibility for managing long-term illness and disability. Local governments administer or directly provide many health and social support services, especially for older people. In addition, local governments provide many housing services for older people, such as sheltering housing schemes, residential homes, dual care homes, hospices, and community nursing.

Urban governance extends beyond these formal, tiered and divided responsibilities. Health 2020 defines it as 'the attempts of governments or other actors to steer communities, whole countries, or even groups of countries in the pursuit of health as integral to well-being through both a whole-of-government and whole-of-society approach.' City governments may formally provide control or regulate services or investment in each of the six domains summarized in Figure 2. Equally, they may seek to persuade partners of the health impacts of services they provide or control, highlighting, for example, how the provision of warm and comfortable homes or the creation of safe neighborhoods reduces the risk of cardiovascular disease. Traditional hierarchical means of governance are increasingly complemented by mechanisms such as soft power and soft law, alliances networks, and open methods of coordination.

For sustained city development for Health, WHO has identified four basic elements. First is leadership; courage and vision are required of city mayors whose remit does not extend to formal responsibility for health services. Second is an intersectoral partnership of agencies and NGOs responsible for investing, regulating or managing intervention in the key domains which impact on health. Health is the business of every sector and mayors have a key role in orchestrating the contribution of many actors. Third is a city health profile and strategic plan which identifies the mechanisms and investments which takes population health status from where it is now to where it should be in five or ten years time. Fourth is networking, the informal alliances that refresh the partnership with new evidence and ideas, with examples good and bad practice drawn from beyond the city.

Figure 2: Multi-Sector Investment



Courtesy Author.

Strategies that work

Municipal governments and their partners intervene in three distinct phases of the life course of their citizens. In childhood health visitors are attentive to the development of physical and mental health. In middle life they provide the supportive social, economic, and physical environments for health, deferring the onset of illness, disability and dependency. In later life, they share responsibility for managing long-term illness and disability, providing many health, social support and housing services. There is substantial evidence to demonstrate that these support services facilitate independent lives for many ill and disabled people, deferring on onset of dependency.

Distal or 'upstream' interventions to provide a supportive environment to those in the middle life course take complex pathways to positive health outcomes. The provision of clean water and sanitation in 19th century cities in Europe has a very clear attributable link to the reduction of water-borne diseases. In the modern era we are yet to fully understand the causalities between distal determinants and the proximal behaviours embodied in lifestyles. What can be said with certainty is that schools which promote exercise, good diet and social interaction reduce the risk of obesity and mental health problems in later life. Safer neighborhoods reduce stress and the risk of cardiovascular problems. Houses which are warm and comfortable reduce the risk of cardiovascular disease and good design reduces the risk of falls. Parks, which encourage walking, and designated pathways, which encourage cycling, reduce obesity, and add to zest for life. And supporting and sustaining all these salutogenic interventions are cities, their citizens and institutions, with vision and purpose, intervening as primary agents of change. ■