

CHAPTER 3

URBAN HEALTH INEQUITY AND WHY IT MATTERS



While it is generally understood that city dwellers, on average, enjoy better health than their rural counterparts, very little is known about health differences that exist *within* cities. Health information is usually aggregated to provide an average of all urban residents – rich and poor, young and old, men and women, migrants and long-term residents – rather than disaggregated by income, neighbourhood or other subgroup characteristics. As a result, the different worlds of city dwellers remain in the shadows, and the substantial health challenges of the disadvantaged go overlooked.

In particular, poor city dwellers are often totally neglected because public health authorities do not collect information in informal or illegal settlements, and miss homeless people altogether.

Understanding urban health begins with knowing which city dwellers are affected by which health issues, and why. By turning the spotlight on the information in this way, municipalities will better understand what the problems are, where they lie and how best to address them.



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Health inequality and health inequity explained

Health inequalities are simply differences in health between groups of people. These differences might be due to non-modifiable factors such as age or sex, or modifiable factors such as socioeconomic status.

Health inequities refer to the subset of health inequalities that are systematic, socially produced (and therefore modifiable) and unfair.⁹⁸ They are not distributed randomly, but rather show a consistent pattern across the population, often by socioeconomic status or geographical location. For example, a child who lives in a slum in Nairobi, Kenya, is far more likely to die before the age of five than a child living in another part of the city.⁴⁷ In Glasgow, Scotland, male life expectancy varies from 54 to 82 years, depending on the part of the city in which the person lives.⁹⁹ No law of nature decrees that these health differences must exist.⁹⁸ Rather, they are the result of the circumstances in which people grow, live, work and age, and the health systems they can access, which in turn are shaped by broader political, social and economic forces.³¹ Because they originate from

socioeconomic status, living conditions, and other social and environmental determinants, health inequities are inherently unfair.

Some health inequalities are not health inequities. For example, death rates among people in their eighties are higher than those among people in their twenties, but this is not a socially produced, unfair health inequity. Rather, it is the result of the natural biological process of ageing.

Opposite to health inequity, **health equity** implies that everyone has a fair opportunity to attain their full health potential, and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstances.⁹⁸ Health equity refers to situations where there are no systematic or unfair disadvantages to individuals and communities in health outcomes, access to health care and quality of health care because of race, gender, nationality, age, ethnicity, religion, sexual orientation, immigration status, language skills, socioeconomic status, or geographical location or neighbourhood.

Urban health equity implies that all city dwellers are provided with opportunities to reach the highest attainable standard of health. More pragmatically, it means that no one is hindered from achieving his or her full health potential, and that equal opportunities for health are available and accessible across all urban subgroups.

Importantly, equality does not in itself confer equity. If, for example, health problems in a poor community are greater than in a wealthier one (as they tend to be), then the poor community would require a relatively greater level of service provision to achieve a fair or equitable distribution among the population as a whole.

Despite their importance, urban health inequities are often missed altogether because health information is typically collected and analysed to look at urban averages. Although some forward-thinking urban leaders have systematically examined intra-urban differences in health status, the majority of municipalities have no clear information about the type and extent of health inequities that lie within their cities.

Why urban health inequity must be unmasked and overcome

Conventional wisdom takes for granted that for several health conditions rural outcomes are worse than urban outcomes. For example, globally chronic malnutrition among under-five children is lower in urban areas in comparison to rural areas. However, in Figure 3.1 we can see that with respect to health inequity, urban inequity is higher in Africa and Asia and similar to rural inequity in the Americas.

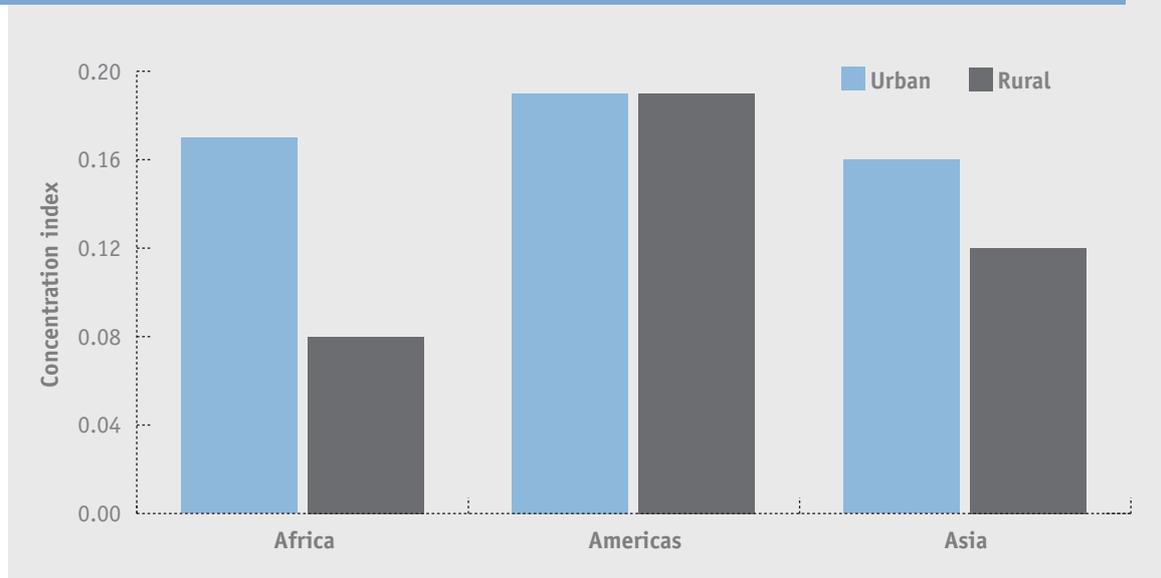
This figure presents the results of a study of Demographic and Health Surveys (DHS) data for 47 developing countries in 1994–2004 which estimated the median urban proportion of stuntedⁱ under-five children to be 28% compared to 43%

in rural areas.¹⁰⁰ Interestingly, the study pointed to two main conclusions that challenge the myth of better conditions in urban areas. First, it is mainly higher levels of household wealth in urban areas that account for lower average rates of stunting. According to the study, in a number of countries, the rural environment is healthier than the urban.¹⁰¹ Second, the degree of socioeconomic inequity in stunting was higher in urban areas in comparison to rural areas, for 32 of the 47 countries.

Reducing urban health inequity should be a central objective of cities' health and development plans. Available evidence indicates that health inequities exist in all cities. No city – large or small, rich or poor, east or west, north or south – has been shown to be immune to the problem.

Urban health inequities are detrimental to all city dwellers. Disease outbreaks, social unrest, crime and violence are but a few of the ways that urban health inequities affect everyone. These threats

FIGURE 3.1
INEQUITY IN CHRONIC MALNUTRITION AMONG CHILDREN LESS THAN FIVE YEARS OF AGE FOR 47 DEVELOPING COUNTRIES, COMPARING URBAN TO RURAL INEQUALITIES, 1994 – 2004



Note: These results represent averages of those countries for which urban DHS data were available in 1994-2004 (Africa = 28 countries, Americas = 9 countries, Asia = 10 countries). As such they are not representative of the region as a whole. The figure uses a concentration index which is an appropriate measure of inequity.

i. "Stunting" refers to children less than five years who have a height-for-age below minus two standard deviations of the National Center for Health Statistics (NCHS)/WHO reference median. Stunting is an expression of long-term exposure to nutritional inadequacy and indicates chronic malnutrition. It is an indication of poor environmental conditions and long-term restriction of a child's growth potential.



André, 25
Gualhueros, Brazil
OVERCOMING DRUG ADDICTION

André grew up surrounded by violence and crime. He lived with his mother and three brothers. "There were not many opportunities for me," explains André. "My brothers were involved with drugs and there were always fights in the house. I left when I was 13 because I wanted some freedom and quiet."

He soon found himself living in a house with many other kids and shared the rent. At first he sold soft drinks to make some money. "The house was full of drugs and guns, and eventually I got involved. I stole things, got drunk, and started to use cocaine when I was 14. But at that

time the drugs were occasional and just for fun."

In his sixth year of taking drugs, André knew it had become a problem. He went to a local Social Centre for Alcohol and Drug Addicts for help. "The Centre really helped me. They had no preconceived notions or prejudice and they understood me. One of the best things was meeting other patients and sharing our experiences."

Yet most of the activities at the Centre were for older people – knitting, sewing, woodwork and painting. "Teenagers don't really connect when they come here. Most are here because they are forced to be." With the approval of the Centre, he started a breakdance and rap

music programme to reach youth, enabling them to tell their stories at shows and health presentations.

"I take it as a responsibility and it makes me feel good when the younger ones listen to me and change their lives. There was a boy of just 12 who was already taking drugs and working in organized crime. I talked to him. He quit drugs and the criminal lifestyle and went back to school. His mother came to me crying and hugged me, thanking me for helping her son."

"Before all this, I thought I would only get rid of my addiction through death, but now I believe I can beat it and that belief feels like a huge victory to me."

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can spread easily beyond a single neighbourhood or district to endanger all citizens and taint a city's reputation.

On the other hand, taking action to reduce health inequities creates numerous benefits. It strengthens the branding strategies of cities and makes them more attractive to the private sector, investors, residents and institutions in a globally competitive environment. In addition, social cohesion is often improved, while violence and crime are reduced. Tackling health inequities can also generate action for integrating health into urban planning and for improving transport systems, housing and green spaces, while focusing on addressing the needs of vulnerable and disadvantaged groups. This brings immediate health benefits, and better prepares cities for natural disasters and future health-related impacts of climate change.

Ultimately, health inequities are an excellent social accountant: they are a reliable way to measure and monitor how well a city is meeting the needs of its residents. They can also be a rallying point for public demands for change; political resistance and inertia are often diminished when actions are undertaken in the name of health and health equity for all.¹⁰²

Local leaders have direct influence over a wide range of health determinants, including housing and transport policies, social services and smoking regulations. As such, they have numerous entry points for taking meaningful action against urban health inequities.¹⁰³

Urban health equity is related to human rights and international frameworks

Health equity is an ethical principle and is related closely to human rights principles. Health itself has been enshrined as a human right at the international level since the adoption of the Constitution of the World Health Organization in 1946.¹⁰⁴ The enjoyment of the highest attainable



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standard of health is one of the fundamental rights of every human being. This “right to health” has since been recognized in numerous internationally binding treaties¹⁰⁵ and national constitutions around the world.¹⁰⁶

Numerous international frameworks provide additional justifications for taking action on urban health inequity. These include the World Health Assembly's resolution on environmental health in rural and urban development and housing, Agenda 21, the United Nations Millennium Declaration, and the Alma-Ata Declaration, and subsequent calls for renewed action on primary health care.

In 1991, the World Health Assembly adopted a resolution on environmental health in rural and urban development and housing. The resolution recognized the rapid demographic transition towards urban areas and called on countries to strengthen their capacity for healthy urban development. Partnerships between government and community organizations, including nongovernmental organizations, the private sector and the local people, were identified as a key strategy for success.¹⁰⁷

Following this, Agenda 21 was adopted by the United Nations Conference on Environment and Development in Rio de Janeiro, 1992.¹⁰⁸ It embraces a comprehensive view of sustainable development, including the notion that sustainable development meets present needs without compromising the ability of future generations to

meet their own needs. Because so many issues addressed by Agenda 21 have their roots in local activities, it was recognized from the outset that the participation and cooperation of local authorities would be a determining factor in fulfilling its objectives. The Local Agenda 21 campaign promotes a participatory, long term, strategic planning process that helps municipalities identify local sustainability priorities and implement long-term action plans. It supports good local governance and mobilizes local governments and their citizens to undertake such a multistakeholder process. The process leads to the preparation and implementation of a long-term strategic plan that addresses priority local sustainable development concerns.

The United Nations Millennium Declaration is another international framework that recognizes the importance of action to reduce health inequities.¹⁰⁹ The Declaration was adopted in 2000 and translated into eight Millennium Development Goals (MDGs) to be achieved by 2015.¹¹⁰ Goals include eradicating extreme poverty and hunger, improving education, promoting gender equality, improving health and combating disease, ensuring environmental sustainability, and building a global

partnership for development. Although the MDGs do not explicitly include the need to improve health equity, it is commonly understood that addressing health inequities is an important aspect of meeting MDG targets in most countries. It is also broadly acknowledged that to achieve the MDGs, urban settings must be considered. The MDGs are explored further in Chapter 5 of this report.

The renewal of focus on primary health care lends additional legitimacy to the health equity agenda. The Alma-Ata International Conference on Primary Health Care,¹¹¹ held in 1978, was the first to put health equity on the international political agenda. The World Health Report 2008 called for a return to primary health care, arguing that its values, principles and approaches are more relevant now than ever before.⁸⁴ As the report noted, inequities in health outcomes and access to care are much greater today than they were in 1978. In 2009, the WHO World Health Assembly welcomed the publication of the report and reaffirmed its strong commitment to the values and principles of primary health care, including equity, solidarity, social justice, universal access to services, multisectoral action, decentralization and community participation.¹¹²

CHAPTER SUMMARY

This chapter has introduced the challenge of urban health inequity and made the case for why it matters. Health inequities are health inequalities that are systematic, socially produced (and therefore modifiable) and unfair. They are not distributed randomly, but rather show a consistent pattern across the population, often by socioeconomic status or geographical location. ■ Opposite to health inequity, health equity implies that everyone has a fair opportunity to attain their full health potential, and no one is disadvantaged from achieving that potential because of their social position or other socially determined circumstance. As such, health equity can be considered as a reliable way to measure and monitor how well a city is meeting the needs of its residents. Health equity is, above all, an issue of social justice, and related to several human rights principles and international frameworks. ■ Despite their importance, urban health inequities are often missed altogether because health information is typically collected and analysed to look at urban averages. It is only through looking for differences within cities through disaggregated data that urban health inequities can be brought out of the shadows. The remaining chapters in Part Two present results highlighting these inequities.