

Inner city health

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It is estimated that nearly half of the world's population now live in urban areas and that in a few years, for the first time in human history, the world's urban population will be greater than its rural population.¹ Canada, which was the host of the first United Nations Conference on Human Settlements (Habitat, 1976) and an active participant in the follow-up "City Summit" conference (Habitat II, 1996),² has recognized that urbanization issues must be a national priority. The Canadian International Development Agency in its statement on sustainable cities identified key problems within urban environments, such as poverty and pollution, but also observed that urbanization offers considerable opportunities for solutions. These include poverty reduction strategies and access to health care, education, family planning, sanitation and shelter.³

Our country's international commitment to sustainable cities must be applied to the problems of inner city health in Canada, some of which are described in this issue (page 229) by Stephen Hwang.⁴ Within the broader concept of the urban environment, inner cities have been defined as "areas generally characterized by above average concentrations of unemployment, full-time workers living on low pay, single parents and the sick and the disabled who are living in poor quality and deteriorating housing conditions."⁵ Inner cities, however, can become vibrant centres of regeneration and innovation, and poverty and disadvantage are seldom confined neatly to identifiable geographic areas. Nevertheless, significant threats to public health in inner city environments continue to emerge. These include the rise of homelessness, the increased availability of illicit drugs, the spread of HIV infection and treatment-resistant tuberculosis and a concentration of certain types of pollutants, such as carbon monoxide and moulds. Public policies in urban areas can also lead to a worsening of the inner city environment for the urban poor, including a lack of social housing and reductions in welfare payments. In addition, according to the diffusion hypothesis,⁶ the failure to contain health problems that begin in inner cities allows them to spread to other urban, suburban and even rural communities. Many suburbs in the United States are experiencing rising rates of violence, substance abuse, HIV infection and tuberculosis.

The relationship between socio-economic status and health has been well documented in the United States and

the United Kingdom. Poverty has been shown to be a cause of poor health and also limits access to both preventive and remedial health care. In the United States, strong correlations have been demonstrated between lower income and higher mortality, regardless of ethnic origin. Poverty has also been shown to increase the likelihood of encountering violence, to produce high rates of child abuse and to cause family and community breakdown in urban environments. In addition, US researchers have demonstrated adverse impacts on health related to inequality in the distribution of income within states, independent of the effect of household income.⁷ In other words, in states where income inequalities are greatest, all residents are at higher risk for poor health outcomes. Thus, distribution of income within a society has begun to emerge as a predictor of health status.

In 1997 the American College of Physicians identified the health problems most commonly associated with US inner cities as violence, teenage pregnancy, drug abuse and HIV infection and also emphasized the challenges posed by people living with chronic illnesses such as tuberculosis, asthma and diabetes.⁸ The college referred to the extent of the disadvantage — social, economic and health-related — experienced by inner city populations as resulting in an "urban health penalty" and made a series of recommendations to address inequalities. Chief among these recommendations was the development of a comprehensive urban policy that addresses the root causes of poverty. More specific recommendations included increasing the number of health care providers in the inner city and involving both public health workers and communities in tackling problems such as tobacco, drug and alcohol abuse, teenage pregnancy and violence.

In the United Kingdom in 1980, the "Black report" warned that inequalities in health were increasing in that country and that differences in material deprivation were a major cause.⁹ In 1998 an independent inquiry into inequalities in health was carried out by a scientific advisory group under the chairmanship of Sir Donald Acheson.¹⁰ The "Acheson report" espoused the same priorities as the Black report, focusing on the need "to reduce income inequalities and improve the living standards of households in receipt of social security benefits." An innovative approach to improving living standards in the United Kingdom involves

the identification of 17 disadvantaged districts in which community-based plans to improve well-being will be developed, covering everything from jobs and education to health and housing.¹¹

Because Canada is seen as a particularly egalitarian society with a commitment to comprehensive, accessible health care, there has been a tendency to assume that there will be fewer health inequities and inequalities in relation to socio-economic status. Recently, however, evidence has emerged that challenges this assumption. For example, in a large cohort of Ontario residents who had a myocardial infarction, individuals living in the wealthiest neighbourhoods had 23% more coronary angiograms than those in the poorest neighbourhoods and had 45% shorter waiting times to have an angiogram. Furthermore, a strong inverse relationship was observed between income and mortality 1 year after myocardial infarction ($p < .001$).¹² The authors also report that, in keeping with the consistently observed relationship between health status and socio-economic status, there were significantly more patients with acute myocardial infarction in the lowest income quintile.

St. Michael's Hospital, a teaching hospital in a poor inner city area of Toronto, was founded in 1892 and has, as its founding mission, a mandate to provide compassionate, effective care to disadvantaged populations. The hospital has established a large Inner City Health Program that brings together departments of family medicine, emergency medicine, internal medicine and relevant subspecialty divisions, psychiatry and women's health to focus on the needs of identified inner city subpopulations. These subpopulations include homeless individuals, people with HIV infection, people with severe and persistent mental illnesses, women at risk due to social isolation, poverty, working in the sex trade or the stresses of single parenthood, and people with addictions. In addition to developing clinical programs to ensure access and support through methods such as active outreach to hostels and shelters for the homeless, the program has established an endowed research chair in inner city health and an inner city health research unit. The mission of the research unit is to carry out research to improve health and health care for inner city populations. Three similar units have been established in the United States, sponsored by the US Centers for Disease Control and Prevention, in New York, Detroit and Seattle. Furthermore, the Fitzgerald Academy at St. Michael's Hospital, in conjunction with the "Determinants of Community Health" course offered by the Faculty of Medicine at the University of Toronto, provides all second-year medical students with opportunities to study illnesses such as treatment-resistant tuberculosis, addictions, chronic mental illnesses and HIV infection as they express themselves and are dealt with in the inner city community. It is hoped that these experiences will be to some

extent transformative and will facilitate participation by the next generation of physicians in what will need to be a highly inclusive strategy to reduce inequities and inequalities in inner city health.

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