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Health in Cities: The Role for Public Health

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Introduction and Rationale

Health in Cities is a subject of growing public concern, however there is currently little consensus on how to define and conceptualize this issue. The OPHA Urban Health Work Group seeks to develop a comprehensive and integrated policy position that supports health in cities.

Considering both the large portion of Ontarians who live in cities and the impact that these urban settings have on the health of individuals and populations, the development of a policy position on Health in Cities would necessarily fall under the mandate of the OPHA. Emerging interest in urban health issues makes addressing Health in Cities at this moment both timely and relevant.

An Emerging Approach to Health in Cities

Current conceptual approaches to understanding Health in Cities include the "urban health" approach, which targets particular problems or groups for intervention, and the ecological or "healthy cities" model which is based on the notion that the conditions of the social, political and natural environments have a strong impact on the health of its inhabitants. A new approach to Health in Cities is starting to emerge. This approach is based on the assumption that health is a complex state of well-being, and that the complexity, diversity, concentration and population density found within cities have a fundamental impact on health. This new approach challenges earlier assumptions of rationality in policy development and contends that complex and diverse systems such as Health in Cities are ambiguous, uncertain, unpredictable and dynamic.

This new policy framework is based on the idea that all self-organizing communities found within cities have the expertise, assets, capacities, strengths and resources required to direct change. It also highlights the potential of multiple small-scale initiatives that are locally based and defined, and which leverage local resources and strengths. To implement this kind of policy framework however, would require tolerance for flexibility, multiplicity and less deterministic approaches. Under this policy framework, the role of community and health agencies is to dismantle barriers and act as facilitators to local Health in Cities initiatives. It is also integral that these initiatives have a "future orientation to guide change in a purposeful direction."

1. Preface

At its 2002 Annual Meeting, the Ontario Public Health Association (OPHA) passed a motion calling for "increased awareness and enhanced focus on urban health issues" (Ontario Public Health Association, 2002). The motion called on the OPHA Board to take appropriate measures to disseminate the approved motion to the Association of Local Public Health Agencies (alPHa), Association of Municipal Organizations (AMO), Canadian Public Health Association (CPHA), Federation of Canadian Municipalities (FCM), Ontario Ministry of Health and Long Term Care, and Health Canada. The motion also called for the OPHA to convene a Work Group with appropriate stakeholders to develop a provincial urban health strategy and to collaborate with the Canadian Public Health Association in furthering the development of a national urban health strategy.

The passing of this motion expresses the keen interest of the OPHA in urban health. Please note that, in order to ensure breadth, consistency and clarity, the term "Health in Cities" will be used instead of "urban health," through this position paper[1]. The purpose of this position paper is to articulate a public health approach to Health in Cities. The paper provides an outline of current conceptual approaches to Health in Cities, a detailed conceptual framework, suggests strategies to address the issue, and makes specific recommendations for public health action on Health in Cities.

2. Introduction

As the process of urbanization progresses around the world, Health in Cities is a subject of growing public concern. In the year 2000, it was estimated that nearly one-half of humanity (47 percent) lived in urban areas (Lawrence, 2000; UN-Habitat, 2002). Around the world, the urban share is expected to rise to 60 per cent by the year 2030 (UN-Habitat, 2002). Canada has not escaped this process and is now one of the most urbanized nations in the world, according to the Organization for Economic Cooperation and Development (OECD) (Statistics Canada, 2003b). In 2001, 79.4 percent of Canadians lived in urban areas with a population of 10,000 people or more (Statistics Canada, 2003b). **{**PRIVATE**}{**PRIVATE "TYPE=PICT;ALT=Census Metropolitan Area growth rates"**}**In 2001, just over 64 percent of Canada's population, or about 19,297,000 people, lived in the nation's 27 largest metropolitan areas, up slightly from 63 percent in 1996. In Ontario, the "extended Golden Horseshoe", which consists of the urban centres of Oshawa, Toronto, Hamilton and St. Catharines-Niagara, plus Kitchener, Guelph and Barrie, had a census-counted population of 6.7 million in 2001, a 9.2 percent increase from 1996 (Statistics Canada, 2003a).

Around the world, Canada's cities are held in high regard and have been ranked as some of the best places to live, offering high employment rates, low poverty rates and a clean environment (Federation of Canadian Municipalities, 2002; TD Bank Financial Group, 2002). There is mounting evidence however, that Canadian cities are ailing and finding it

[1] The term "Health in Cities" was first coined by Sholom Glouberman (2002a) and the Wellesley Central Health Corporation, in the report "A Toolbox for Improving Health in Cities."

increasingly difficult to provide basic services and maintain infrastructure. As Canada's urban areas face increased poverty, housing and homeless crises and a deteriorating quality of life, Health in Cities is a subject of growing public concern (Federation of Canadian Municipalities, 2002; Prime Minister's Caucus Task Force on Urban Issues, 2002; Wasylenki, 2001). While a considerable amount of research exploring the relationship between urban areas and health has been produced, this knowledge has not been translated into effective public policy. This position paper will make the case for an OPHA focus on health in urban contexts, discuss the main urban health issues currently facing Ontario, outline an emerging policy framework on Health in Cities, and provide a series of policy options and recommendations.

3. Why Should the OPHA Focus on Health in Cities?

While the passage of the 2002 motion on urban health indicated the OPHA's interest in this issue, the following section will explicitly identify the reasons why the OPHA should take an official position on Health in Cities and it addresses potential arguments against this course of action.

3.1. A large portion of the Ontario population live in cities.

With 84.7 percent of Ontarians living in urban areas with a population of 10,000 people or more, issues around Health in Cities will necessarily affect a large portion of Ontario's population (Statistics Canada, 2001 & 2003c).

Some may contend however, that when such a high portion of the Ontario population lives in cities, it is redundant to focus on Health in Cities. Inherent in this critique is the assumption that location and context (be it physical, social or economic) do not play a major role in determining individual and population health. Indeed, there are many health issues that cut across rural and urban areas and therefore, will not be affected by a Health in Cities focus. In spite of this critique however, there are, in fact, many health issues that are necessarily affected by geography and context, and are found only in cities. The OPHA thus maintains that location and context do indeed have an effect on health and, therefore, are relevant variables to consider. In addition, opening the analysis to include location and context as factors provides a justification for a focus on rural issues.

3.2. Cities have both a protective and destructive impact on health.

Cities have a major impact on the health of populations, both positively and negatively. On the positive side, people living in cities are healthier than their rural counterparts and have access to the many physical and human resources of the city (Glouberman, 2002a & 2003a; Leviton, Snell & McGinnis, 2000). Cities provide access to a wide range of health care services including some of the best hospitals and outpatient care. Cities also provide easy access to diverse cultures and educational opportunities, among other health promoting factors. (Glouberman, 2002a & 2003a; Leviton, Snell & McGinnis, 2000). Cities are also replete with self-organized communities that provide support and can develop solutions when there are gaps in services (Glouberman, 2003a).

On the negative side, cities also house some of the most unhealthy populations and have been identified as having high incidence and prevalence of illness and death from such conditions as tuberculosis, asthma, diabetes, renal disease, cardiovascular disease, hypertension, mental illness, cancer, AIDS, HIV infection, sexually transmitted disease, infant mortality and trauma caused by violence and substance abuse (American College of Physicians, 1997). Urban environments also tend to have large concentrations of populations with particular health concerns, such as drug users, unemployed youth, homeless people, refugees, people with mental illness, and the physically disabled (Glouberman, 2002a & 2003a). In reference to the greater prevalence of health problems and risk factors in cities, the term "urban health penalty" was developed (American College of Physicians, 1997; Andrulis, 1997; Leviton, Snell & McGinnis, 2000; Wasylenki, 2001). The urban health penalty is effectively a merging of several determinants that impact health in a negative way (Toronto District Health Council, 1999a).

Health in Cities will necessarily have major implications for public health policy, programming and practice in Ontario. As such, focusing on Health in Cities falls under the Mission Statement of the OPHA, which is "to strengthen the impact of people who are active in community and public health throughout Ontario."

3.3. Health in Cities initiatives are not new.

Although a Health in Cities focus would be new for the OPHA, Health in Cities initiatives, in general, are not new. Many of the public health and health care initiatives currently being undertaken in urban settings are inherently Health in Cities initiatives, but have not yet been defined as such. One role of the new framework would be the recognition of existing initiatives within the larger context of Health in Cities action.

3.4. Health in Cities is an emerging issue.

Finally, the outcome of a cursory environmental scan shows that there are currently a number of initiatives focusing on "urban issues." On a national level, the Prime Ministers' Task Force on Urban Issues was initiated on May 9, 2001 to "…engage in a dialogue with citizens, experts and other orders of government on the opportunities and challenges facing Canada's urban regions (Prime Minister's Caucus Task Force on Urban Issues, 2002). The Canadian segment of the Metropolis Project has been underway since 1996 and acts as "…a forum for research and public policy on… migration, cultural diversity and the challenges of immigrant integration in cities in Canada and around the world" (Metropolis, n.d.). While these two initiatives do not focus specifically on health issues, their emphasis on such vital determinants of health as social and material infrastructure, migration, cultural diversity and social cohesion places their work firmly within the broad definition of health accepted by the OPHA.

A growing number of initiatives that focus specifically on Health in Cities have been undertaken around the world. Internationally, one need only look to the World Health Organization's Healthy Cities Project and the Centres for Disease Control and Prevention's more recent Urban Health and Megacities project to see the increasing importance of Health in Cities (Centres for Disease Control, 2003; WHO, 2003a). The

American College of Physicians has a well-established set of policy initiatives on both the "urban health penalty" and inner city health (American College of Physicians, 1997; Andrulis, 1997) while the Canadian Public Health Association passed a resolution in 2002 calling for the development of a national urban health strategy (Canadian Public Health Association, 2002). Finally, a number of local and municipal initiatives have been undertaken to address Health in Cities. Although only a few can be mentioned here, these include, in Toronto, the St. Michael's Hospital Inner City Health Unit, the South East Toronto Organization (SETO) and the Wellesley Urban Health Corporation, and in Ottawa, the Ottawa Inner City Health Project which is run out of the University of Ottawa Medical School.

At present, there appears to be no provincial initiatives on Health in Cities in Ontario. In light of the fact that Health in Cities is an emerging issue, and that there have been no other initiatives implemented on a provincial level, focusing on Health in Cities would be a sound and justified next step for the OPHA. An OPHA Health in Cities initiative would be timely, relevant and ground breaking.

It should be noted however that a focus on Health in Cities is not an attempt to shift attention away from rural health issues in favour of city-based issues. It is important that this initiative is not perceived as being a form of competition with rural health issues for either resources or attention. The point of this position paper is not to claim that Health in Cities is more important rural health issues. Instead, the OPHA maintains that Health in Cities does not need *more* attention than rural health issues but rather *different* attention.

4. Current Approaches to Health in Cities

Cities pose a formidable challenge to public health researchers, programmers and policymakers (Freudenberg, 2000b). According to the literature, there are two main conceptual frameworks that are used to understand Health in Cities. Each of these will be discussed in turn.

The first conceptual framework is the more traditional "urban health" approach, which tends to target particular problems or groups for medical and health interventions (Glouberman, 2002a & 2003a). The focus of this approach is on identifying and understanding the various issues, "problems" or high-risk groups that are unique to or concentrated in cities (Glouberman, 2002a & 2003a; Open Space Forum, 2001; Vlahov & Galea, 2002). In focusing on specific problems and issues this approach ignores the contribution of numerous physical and social dimensions of the environment that can affect health and, therefore lacks a holistic or macro analysis of Health in Cities (Lawrence, 2002). It also does not have a strong sense of hierarchy nor does it show how some problems are more detrimental to health than others. Finally, this approach does not recognize that some factors may override other and how individuals are enabled to overcome difficult situations.

The second conceptual framework used to understand Health in Cities has been the ecological approach which is based on the notion that the conditions of the social, cultural, political, built and natural environments have a strong impact on the health of its inhabitants (Lawrence, 1999 & 2000; Tsouros, 2000). According to Lawrence (1999), this ecological model is:

> …based on the hypothesis that some individuals become more susceptible to certain illnesses because of their differential exposure to several environmental, economic and social factors that can either promote or harm health and well-being (3).

The focus of this ecological model is not on the individual or "high risk groups" or even on particular "problems", but rather on the wealth of environmental factors or determinants that necessarily affect the health of populations within cities. One initiative that follows this model is the World Health Organization's Healthy Cities Project (WHO, 2003a & b). This approach falls in line with the new public health framework that maintains that health can only be understood if environmental factors (broadly defined) are taken into account.

While this conceptual framework has been very successful around the world, this approach faces a number of important critiques. To begin, some contend that the ecological approach downplays the importance of particular problems or vulnerable groups (Glouberman, 2002a & 2003a). Still others maintain that this model "…reflects the modernist belief in the power of science and expertise to solve problems and that its continuing use within the new public health reinforces professional dominance and the search for technical-rational solutions to complex socio-political problems" (Petersen, 1996, 157). Finally, the Healthy Cities approach has been criticized for its tendency to reduce cities to a series of smaller communities and overstate community values over diverse individual ones (Glouberman, 2002b).

5. An Emerging Approach to Health in Cities

A new approach to Health in Cities, that attempts to incorporate the positive aspects of both of the approaches described above, is starting to emerge. This approach stresses the dynamics of multiple groups with diverse health needs competing for resources and emphasizes their strengths and assets, rather than focusing on particular types of problems. In order describe and explain this emerging approach, it is necessary to begin with an exploration of the terms 'health' and 'city' from an OPHA standpoint.

5.1 Health

Health is a concept that can embody a huge range of meanings (Naidoo & Wills, 2000). According to its core values, the OPHA seeks to "encourage a broad definition of health." As such, for the purpose of this position paper, health will be defined positively and refer to a state of well being, not merely the absence of illness or disease (Naidoo & Wills, 2000; WHO, 1946). According to this definition, health is also understood to be

influenced and affected by numerous factors, sometimes referred to as the "determinants of health." (Naidoo & Wills, 2000). This assumption moves beyond the strict confines of the biomedical model of health to one that explores the multitude of factors that both positively and negatively shape our lives.

While this "determinants of health" model has grown in popularity over the years some contend that this framework is overly deterministic. As such a new definition of health is emerging which attempts to incorporate and account for both the individual and his or her context. According to this definition, health is defined as the outcome of the "…non-linear interaction" between an individual *and* his or her social, economic and political context (Glouberman, 2003a). In defining health as such, it becomes clear that health is not a simple or straightforward concept, but rather one that is inherently complex, multiple and dynamic.

5.2 Cities

Just as health is a contested concept, there is also no simple way to define the term "city." At present there is little consensus among national and international bodies on the meaning of the term, and definitions vary both within countries and across borders, making comparative evaluation and analysis difficult (Vlahov & Galea, 2002).

The two most common ways of defining cities are by geography and demography. For example, Statistics Canada defines urban areas as "an area with a population of at least 1,000 and no fewer than 400 persons per square kilometre" (Statistics Canada, 2001). This shows how size and density parameters are used to delineate urban from non-urban areas (Vlahov & Galea, 2002). While the process of classifying areas as dichotomously urban/non-urban may be helpful in some circumstances, a more nuanced appreciation of the gradations of urbanicity may be more helpful (Vlahov & Galea, 2002). Indeed, it may be more useful to position urban areas on a spectrum moving from completely rural on one end to highly urban on the other (Vlahov & Galea, 2002). Finally, others contend that urban areas and cities should be defined not according to their geographical or demographic size but rather, according to their role in the larger regional context. In such a case, cities or urban areas that are smaller may still play the role of a larger city if it acts as a magnet or "hub" within its larger context (Clement, 2003). According to this view, cities should therefore be defined not by statistics but by its role and practice.

Although the above discussion is important to deepening and expanding our understanding of cities, for the purpose of this position paper, entering into the intricacies of this debate is not necessary. Instead, it will be more useful to discuss those characteristics of cities that have an impact on health (Vlahov & Galea, 2002). Each characteristic will be discussed in turn.

5.2.1 Complexity

One of the most important characteristics of cities is their complexity (American College of Physicians, 1997; Andrulis, 1997; Freudenberg, 2000a; Glouberman, 2003a; Grosz, 1995; Petersen, 1996). Grosz (1995), in an essay entitled "Bodies-Cities," defines cities as follows:

> By 'city', I understand a *complex* and *interactive* network that links together, often in an unintegrated and ad hoc way, a number of disparate social activities, processes, relations with a number of architectural, geographical, civic and public relations (382, in Price & Shildrick (Eds), 1999, emphasis added).

This new definition is based on the idea that cities are complex adaptive systems. Complex adaptive systems are:

> …systems made up of many individuals, self-organizing elements capable of responding to others and to their environment. The entire system can be seen as a network of relationships and interactions, in which the whole is very much more than the sum of the parts (Glouberman, 2003a, 1-2).

By defining it as such, cities are distinguished from being merely a large and complicated system. Complicated systems, such as a car, are amenable to simplification and can be reduced to smaller parts. Complex systems, on the other hand, are heavily interconnected, and each part of the system interacts and changes in the face of changing circumstances, often in ways that cannot necessarily be predicted (Glouberman, 2003a & b).

5.2.2 Cities reflect their context

While cities may be characterized by their complexity, it is important to remember that this complexity exists within a context. This context plays an important role in defining and delimiting social phenomena. As such, cities reflect existing ethical and ideological discourses as well as the various social, political and economic discourses that make up society.

When discussing Health in Cities, of particular interest is the way in which, built into the social, political, economic and physical structures of the city, are the ideologies of oppression that remain historically rooted in our collective unconscious. Indeed, the social hierarchy of power between groups and individuals can be found reflected in the spatial forms of the city (Fainstein & Campbell, 1996). This social inscription on to the body of the city provides the outlines and borders within which the complexity of the city thrives.

5.2.3 Diversity and multiplicity

Cities are also characterized by extreme heterogeneity and diversity (Andrulis, 1997; Centres for Disease Control and Prevention, 2003; Freudenberg, 1998 & 2000b; Harvey, 1996; Lawrence, 2002). This heterogeneity may be considered in terms of a number of factors including culture, ethnicity, race, income or socioprofessional status (Andrulis, 1997; Freudenberg, 2000; Lawrence, 2002).

Ethno-racial, linguistic and cultural diversity is particularly relevant in Ontario (Strike, Goering & Wasylenki, 2002; TD Bank Financial Group, 2002). For example,

while immigrants constituted 18.4 percent of Canada's population in 2001, they made up to 44 percent of the Toronto Census Metropolitan Areas (CMA), which is higher than any other city in North America (Seidle, 2002). In Ottawa, 26.42 percent of the Ottawa population speak a non-official language (French and English) with the top five being Arabic, Spanish, Italian, Chinese and German (Lauriault, 2000). According to Toronto Public Health (1998), over 160 languages and dialects are spoken in Toronto and approximately 29 percent of residents speak a language other than English or French in their homes, compared to 12 percent in Ontario. Finally, in 2001, 48 percent of all immigrants and refugees to Canada settled in Toronto while many others settled in Ottawa-Carleton, Hamilton and London (Seidle, 2002). Ontario's cities are becoming much more ethno-racially, linguistically and culturally diverse (Seidle, 2002).

Over and above this diversity, cities are characterized by a multiplicity of interconnected social networks, community organizations, and coalitions (Freudenberg, 1998). According to many theorists, this diversity is fundamental to the health of cities and must be both nurtured and promoted. For example, Young (1990, cited in Harvey, 1996) contends that social justice, which is a vital prerequisite for health, requires "not the melting away of differences, but institutions that promote reproduction of and respect for group differences without oppression" (417). Young (1990, cited in Harvey, 1996) further argues that social justice in cities must,

> …promote the ideal of a heterogeneous public, in which persons stand forth with their differences acknowledged and respected, though perhaps not completely understood, by others" (417).

This heterogeneity has major implications for Health in Cities in terms of health planning, programming, policy, research, and community development. This diversity can have a salutogenic impact on individual and population health as, for example, "…urban residents are likely to interact with people with different values, ethnicities, religions, and national origins, creating opportunities for new knowledge and growth…" (Freudenberg, 2000a). This diversity also creates the conditions for multiple social networks and identities (Freudenberg, 2000a; Petersen, 1996).

However, while it is maintained that this heterogeneity is to be celebrated, in many contexts, structures of oppression play themselves out through this diversity. Indeed, the social, cultural, political and economic structures within cities often promote the inclusion of some groups and the exclusion of others (Clutterbuck & Novick, 2003). These perceptions of inequity can contribute to "…disaffection, alienation and social conflict" (Freudenberg, 1998). As such, the exclusion of certain marginalized groups, minorities and new Canadians, is an issue of particular concern in Ontario.

5.2.4 Concentration and Population Density

Population density and concentration is another characteristic of cities that has an impact on health and health initiatives. To begin, concentration of people can facilitate the transmission of infectious disease (Freudenberg, 1998 & 2000a;

McMichael, 2000). Some contend that crowding can also contribute to stress, alienation, and social isolation and can "weakened social values that may contribute to mental illness, drug addiction and violence" (Freudenberg, 1998 & 2000a; McMichael, 2000). That said, this population density can have similarly positive impacts on the health of individuals and populations. For example, the concentration of individuals typically leads to greater access to necessary services and cities offer multiple opportunities of experience and stimulation, and community life that can be "rich and fulfilling" (Freudenberg, 2000a; McMichael, 2000).

Of particular concern to Health in Cities however, is the concentration of vulnerable populations into urban areas. Some such vulnerable subpopulations include single-parent families, Aboriginal people, recent immigrants, visible minorities, the elderly, and people living with HIV/AIDS, chronic disorders such as mental illness, addictions or disabilities (Seidle, 2002; Wasylenki, 2001). The concentration of these vulnerable populations within cities places an added burden on both public health and health care (Glouberman, 2002a). Finally, high population density that brings extreme poverty and wealth together can also have a detrimental impact on the health of individuals and populations. Indeed, cities tend to have the greatest disparity in wealth, a situation that can lead to "disaffection, alienation and social conflict" (Freudenberg, 2000a & b).

5.2.5 Linked to External World

Although there is a tendency to think of urban areas as bounded entities, in reality cities are inherently linked to their wider context. As communities, states and economies become more interlinked through the process of globalization, it is likely that cities will be increasingly affected by situations and processes outside their borders. This characteristic is fundamental when considering Health in Cities, as can be seen with the recent outbreak and spread of Severe Acute Respiratory Syndrome (SARS) around the world and in Toronto. This example illustrates how the movement of people across time, space and borders (be it to another country, another city or to a rural area) can have major implications on the movement and spread of disease and/or infection.

5.2.6 Dynamic

Finally, the culmination of all these features of the city points to its inherent dynamism. Indeed, systems such as these are often characterized as being in a constant state of flux and evolution (Andrulis, 2000; Glouberman, 2001). "Cities are not static or passive, but are constantly changing and responding to change" (Glouberman, 2002a). Thus, cities are not static entities with fixed boundaries or essential qualities, but instead are constantly transforming, growing, contracting, evolving and being recreated from both the inside out and the outside in.

5.3 Health in Cities in the Ontario Context

In order to explore this issue for the OPHA, it is necessary to outline the various Health in Cities issues that Ontario cities currently face. Each of these issues will be discussed in turn.

5.3.1 Economic Security

The link between economic security and health has been well established and, it has been found that, as wealth increases, so does health (Association of Ontario Health Centres, 2003). Conversely, economic insecurity is a major cause of poor health and the poor tend of have higher incidences of disease, illness and premature death (Andrulis, 1997; Geronimus, 2000; Kawachi & Kennedy, 1997; Wasylenki, 2001). Poverty causes poor health through, among other things, poor nutrition, crowding, homelessness and exposure to violence. In addition, poverty and concentrations of poverty in neighbourhoods negatively influence family functioning, childhood trauma and stress, housing security, neighbourhood safety and behavioural problems (Geronimus, 2000; Strike, Goering & Wasylenki, 2002). Children in low-income neighbourhoods are at higher risk for infant death and low birth-weight, are more likely to have developmental delays, be exposed to environmental contaminants, and experience higher rates of both intentional and unintentional injuries, than children who grow up in families with higher incomes. (Strike, Goering and Wasylenki, 2002). Poverty has also been found to limit access to preventive and remedial health care (Andrulis, 1997; Wasylenki, 2001). Finally, there appears to be a dose-response relationship to poverty and health, with longer-term deprivation "…being more devastating to health than short poverty spells" (Geronimus, 2000). As such, the various levels of economic security found in the city will necessarily play a vital role in the complex interaction of factors that support Health in Cities.

Recent research raises serious concerns about the future health status of Ontario's cities. Economic insecurity and poverty have been increasing, and are becoming more concentrated, in urban Canada, particularly in the country's large urban centres (Seidle, 2002). According to K.K. Lee (2000) in the report *Urban Poverty in Canada: A Statistical Profile,* while metropolitan populations grew by only 6.9 percent between 1990 and 1995, poor populations in these areas grew by 33.8 percent (Lee, XV). In contrast, poverty outside of Canada's metropolitan areas has risen by only 18.2 percent (Lee, XV). Further, between 1980 and 1995 the number of high-poverty neighbourhoods increased, as did economic segregation in many of Canada's largest cities (Lee, 2000; Seidle, 2002).

5.3.2 Socio-Economic Equality

Research has emerged to suggest that, since the 1950s, inequalities in cities around the world are increasing (Freudenberg, 2000b; Kawachi & Kennedy, 1997; Lawrence, 2002). In Canada, recent studies suggest that economic and social segregation increased in the 1990s (Ross, N.A., et al., 2000).

The debate over the effect of socio-economic equality on health continues with many researchers maintaining that level of equality has a major impact on the health status of both individuals and populations. The relationship between socio-economic status and health has been well documented (Statistics Canada, 1999; Wasylenki, 2001). Kawachi, et al (1997) maintain that the degree of income inequality in a given society is strongly related to that society's level of mortality. Numerous other examples of the

relationship between socio-economic inequality and health have been published, arguing that "…what makes the difference to health is more a matter of people's *relative* income and status in society than of their *absolute* material living standards" (Wilkinson, 1997, 1505, *emphasis added*). Although the pathways and mechanisms underlying this association remains to be established, it is hypothesized that rising income inequality results in increased levels of frustration, which may have deleterious behavioural and health consequences (Kawachi, 1997). This relationship suggests that, "…the psychosocial causes of the health gradients …are more powerful than the direct physical effects of exposure to poorer material circumstances" (Wilkinson, 1997, 1505).

In Canada, recent evidence has emerged that outlines one of the many deleterious effects of inequality on health. For example, in a large cohort of Ontario residents who had a myocardial infarction, a higher portion of the cohort was from the lowest income quintile (Wasylenki, 2001). In addition, a strong inverse relationship was observed between income and mortality, one year after the myocardial infarction (Wasylenki, 2001). Further, a report produced by Dennis Raphael (2001) for the North York Heart Health Network, estimated that income differences accounted for a "…24% excess in premature deaths prior to 75 years from cardiovascular disease among Canadians" (xi). Finally, this same study also found that "were all Canadians' rates of death from cardiovascular disease equal to those living in the wealthiest quintile of neighbourhoods, there would be 6,366 fewer deaths each year from cardiovascular disease" (Raphael, 2001, xi).

The link between inequality and health has not gone uncontested however, with a growing number of voices questioning the research outlined above. For example, in the Working Paper entitled "Poverty, Income Inequality and Health," Judge and Paterson (2001) conclude that the relative effect of income inequality as a determinant of population health "…has been greatly exaggerated" (1). Indeed, some contend that there is no good evidence to substantiate the relationship between income inequality and population health (Judge, Mullivan & Benzeval, 1998). Still others contend that the relationship between inequality and health is neither non-existent nor absolute, but rather depends largely on the social and cultural environment in which income differences are experienced (Evans & Stoddart, 2003). Further, a recent analysis of the relationship between income inequality and mortality in Canada and in the United States found that there were no significant associations between income inequality and mortality in Canada at the metropolitan or city area level (Ross, N.A., et al, 2000). These associations were found in US metropolitan areas.

While this debate continues, some contend that it is acting to lessen inequalities is of paramount importance. For example, Geronimus (2000) contends that in order to address poor health in cities, two approaches are typically used: ameliorative approaches and fundamental approaches. Ameliorative approaches target the risk factors that link socio-economic position to health in a particular context and are necessary to avoid the further widening of health inequalities (Geronimus, 2000).

However, no matter how effective these ameliorative approaches are, they will never "…fundamentally alter the context or underlying inequalities" and therefore will never lead to the elimination of health inequalities within cities (Geronimus, 2000). In other words, any change less than structural will be ephemeral (Cohen and Northridge, 2000). Fundamental approaches, on the other hand, seek to address the underlying structures and ideologies of oppression that ultimately produce health inequalities (Geronimus, 2000). As such, fundamental approaches demand both political struggle and the confrontation of the role and effects of structural oppression in determining health inequalities (Cohen and Northridge, 2000).

5.3.3 Increased pressures on municipalities and communities

The past decade has witnessed the emergence of neo-liberal ideologies characterized by (among other things) the withdrawal of government from the public sector. This ideological shift has been operationalized through the rapid cutting back of many social services on the federal, provincial and municipal levels. Indeed, a "…decade of federal disengagement from national social programs and provincial restructuring of social policy responsibilities…" have had a major impact on municipalities and communities across Canada (Clutterbuck & Novick, 2003). On a federal level, the literature point to how the federal government has,

> "…withdrawn from its national leadership role in supporting and funding social housing; placed eligibility restrictions on Employment Insurance, which offloaded people onto social assistance caseloads; and eliminated the Canada Assistance Plan, the only national anti-poverty program cost-shared with provincial and municipal governments" (Clutterbuck & Novick, 2003, 2).

This federal withdrawal from its leadership role on social and housing support has led some provinces to further download "service and cost responsibilities onto municipalities without providing the fiscal capacities to sustain these new responsibilities" (Clutterbuck & Novick, 2003, 2; TD Bank Financial Group, 2002). Key areas of provincial downloading to cities have been in transit, childcare, social housing and social assistance, among others (TD Bank Financial Group, 2002).

This downloading of responsibilities not only occurred with incredible speed but the municipalities were not provided with the fiscal or constitutional capacities to sustain these new responsibilities. As creations of the provinces, municipalities have no independent status of their own and typically have limited power to spend and raise revenues (Federation of Canadian Municipalities, 2001; TD Bank Financial Group, 2002). In general, most provinces "keep a very tight rein on municipal legislative tax powers" leaving most municipalities heavily reliant on property tax or other user fees. (TD Bank Financial Group, 2002, 16). This combination of heavy downloading and weak revenue growth has had a major impact on the municipalities, many of which have had to "…run up debt, defer infrastructure projects, draw down reserves, sell assets and cut services…" (TD Bank Financial Group, 2002,18). This has left the

municipalities in many provinces, including Ontario's, in a very tight financial situation which has, in turn, has had major implications for Health in Cities.

5.3.4 Infrastructure

Physical infrastructure is important to providing Health in Cities and includes such services as public transit, affordable housing, roads and sidewalks, sewers and water quality, waste management, and power systems and information networks (Andrew & Morrison, 2002). Physical infrastructure contributes to the quality of urban life in Ontario and generally permits the healthy existence, growth, and development of cities (Andrew & Morrison, 2002). From the point of view of physical infrastructure, Canada's cities are held in high regard and have been ranked as some of the best places to live (Federation of Canadian Municipalities, 2002; TD Bank Financial Group, 2002). However, there is mounting evidence that Canadian cities are ailing and finding it increasingly difficult to provide basic services and maintain infrastructure. Indeed, many Canadian cities are facing increasing poverty, housing and homeless crises, inadequate transportation infrastructure, increasing risks from worsening air quality and water quality, and deteriorating quality of life (Federation of Canadian Municipalities, 2002; Prime Minister's Caucus Task Force on Urban Issues, 2002; Wasylenki, 2001). In addition, a report by the TD Bank Financial Group (2002) contends that Canada's aging city physical infrastructure of roads, bridges and transit systems require not only maintenance but modernization as well. In light of this, it is fundamental that any policy position on Health in Cities include an analysis of the role of physical infrastructure on health.

Social infrastructure in cities refers to such services as recreation, children's services, libraries and the network of non-profit agencies that provide community services (Clutterbuck & Howarth, 2002). Social infrastructure also plays an important part in maintaining quality of life in the city however unfortunately, there is a tendency within governments to focus primarily on physical infrastructure and overlook social infrastructure (Clutterbuck & Howarth, 2002). Concerns over the state of Toronto's social and community infrastructure have been raised in the report, "Toronto's Quiet Crisis" by Clutterbuck & Howarth (2002).

Health as an infrastructure refers to all health and health care services provided within a city, from health promotion and prevention to primary, secondary and tertiary care. Examples of health infrastructure include all public health programs, hospitals, ambulance services and public health clinics. Included in this infrastructure are all private health care services which, in Ontario, include dental care, massage therapy, physiotherapy and naturopathic care, among others. Concern over the future of Canada's health and healthcare system has grown over the years as evidenced by the numerous commissions, such as those led by Romanow and Kirby, mandated to explore these issues.

In sum, through a review of the literature on Health in Cities the issues of economic security, socio-economic equality, increased pressures on municipalities and communities, and infrastructure have all, been raised. While this listing of issues

facing Health in Cities is important, it in no way represents a complete or holistic representation of the many issues that Ontario's cities face. There will necessarily be other important issues that have been overlooked by existing researchers.

5.4. A policy framework for addressing Health in Cities

A new understanding of Health in Cities is emerging. This emerging approach is not based on rationalism or a "linear" reductive model. Instead it is argued that Health in Cities must be understood in terms of the dynamic interaction between individuals, communities and environments within a constantly changing complex context. In other words, Health in Cities:

> …involves multiple groups, with multiple health needs, and potentially competing interests, connected in a non-linear fashion to multiple urban environments, each of which interacts with the groups and individuals within those groups (Glouberman, 2003a, 9).

It is assumed that this complex and dynamic interaction does not follow a linear or even circular pattern, but rather emerges spontaneously, self-organizing in a manner similar to a multi-layered spider web (Glouberman, 2001). Health in Cities is therefore not understood in a holistic manner or as an entity that is inherently stable (Grosz, 1995). Instead, Health in Cities must be understood as a collection of parts "…capable of crossing the thresholds between substances to form linkages, machines, provisional and often temporary sub- or micro- groupings" (Grosz, 1995, 385, in Price & Shildrick, eds, 1999).

In light of the above definition of Health in Cities, what kind of policy framework would be the most effective in addressing Health in Cities? Thus far, traditional policy frameworks have generally been ineffective in addressing Health in Cities. Over the years, two frameworks for thinking about policy have dominated. The first approach "…stresses the hierarchical structure of bureaucracies and the top down nature of power and public policy decision-making" (Glouberman, 2001). The second, and more recent, approach focuses on a rational planning framework that breaks the policy process down into a cyclical series of stages and procedures (Glouberman, 2001; Patton & Sawicki, 1986). Fundamental to this model is the assumption that policy-making is a rational process with a single decision maker or decision-making unit at the apex of the information system (Patton & Sawicki, 1986). While it is argued that this model allows for the creation of clear, bold and innovative recommendations in the face of extreme complexity, a growing number of voices contend that this complexity must be addressed more readily when developing policy. It is further argued that policy analysis outlined in such a manner can seem deceptively simple when, in reality, policy development and analysis is much more complex, fluid, interactive, unstable and messy. It is therefore argued that this model greatly overstates the rational nature of policy development and analysis.

As a result of these criticisms, a new policy framework is emerging in both the literature and related public health agencies. This new framework differs from the rational planning

approach by challenging the assumptions of rationality of earlier policy development approaches (Dudgeon, 2003; Glouberman, 2001 & 2003b; Petersen, 1996). According to this framework, complex and diverse systems, such as Health in Cities, tend to be ambiguous, uncertain and dynamic. These characteristics ensure that a rational, monolithic and strict approach to policy will produce ineffective policy outcomes (Dudgeon, 2003; Glouberman & Zimmerman, 2002). In addition, unlike the more linear and rational framework, the complexity of the interactions found in Health in Cities "…suggests that the outcome of interventions can not be predicted accurately" (Glouberman, 2003a). Finally, due to the complexity of health in cites, it is no longer assumed that health issues found in cities can be "fixed" through external, bureaucratic interventions into the policy or programming process (Glouberman, 2003a; Petersen, 1996; Grosz, 1995).

Considering these criticisms of the rational policy-planning model, what does this new policy framework for Health in Cities look like? To begin, a new policy framework for Health in Cities must be based on the idea that all cities and communities within cities, no matter how oppressed or unhealthy, have assets, capacities, strengths and resources. Indeed, many members of marginalized groups have "historically participated in community networks of exchange and support in order to mitigate social and economic adversity" (Geronimus, 2000, 869). These self-organizing networks not only provide material and social support to members of the marginalized community but can act as forms of resistance to systems of oppression and create identity-affirming frameworks in face of hardship and oppression (Geronimus, 2000). In doing so, this new policy framework will bypass the use of external experts and highlight existing resources within the community as it is assumed that that is where most of the required expertise can be found (Petersen, 1996).

The new policy framework will also highlight the potential of multiple small-scale initiatives that are locally based and defined (Dudgeon, 2003; Glouberman, 2003b). Indeed, it is argued that a multiplicity of small-scale policies that respond to local conditions may be better than policies set out from above because they will recognize and leverage local resources and strengths (Dudgeon, 2003; Glouberman, 2003b). Inherent is the idea that "institutional richness can offset urban penalty" (Dudgeon, 2003). As such, no single permanent approach would be supported but rather the accumulation of small initiatives. These initiatives, although not necessarily a 'movement', can have a large impact on the health of populations. To implement this kind of policy framework however, would require, tolerance for flexibility, multiplicity and less deterministic approaches (Dudgeon, 2003).

While this framework has much potential for the creation of effective, relevant and timely Health in Cities policy, there are a number of factors that must be taken into account. To begin, each of these small initiatives exist within a larger social, political and economic context that may erect structural barriers to the creation and implementation of the various small initiatives. In light of this, the role of various community and health agencies may be to dismantle these barriers and act as facilitators to the policy development and implementation process. Another issue is whether the many small

initiatives will ultimately lead to conflict and a multitude of competing and contrasting interests. In order to prevent this, it is integral that these initiatives have a "future orientation to guide change in a purposeful direction" (Jackson, 1992, 5).

Finally, considering the impact that the social, political and economic context has on the health of individuals and populations, in addition to highlighting multiple small-scale initiatives, the new policy framework would also incorporate both ameliorative and fundamental approaches. Ameliorative approaches are those initiatives that target the risk factors that link socio-economic position to health in a particular context but do not fundamentally alter the context (or underlying inequalities) (Geronimus, 2000). It is argued that while ameliorative approaches are important and necessary to addressing health disparities, they will not result in the *elimination* of health disparities (Geronimus, 2000). As such, this approach will include fundamental approaches, which attempt to address the underlying social, political, and economy inequalities that are associated with health disparities in the first place (Geronimus, 2000). Examples of more fundamental approaches includes advocacy for political, social and economic transformation and community development. It is argued that by addressing these inequalities, the risk factors that lead to health disparities will be fundamentally eradicated.

6. Health in Cities in Ontario – Recommendations for OPHA Action

Public Health in Ontario is positioned to provide a substantial contribution to addressing Health in Cities. A commitment to develop and implement effective Health in Cities initiatives can be made through the implementation of the strategies outlined below.

6.1. Considering both the large portion of Ontarians who live in cities and the impact that these urban settings have on the health of individuals and populations, the development of a policy position on Health in Cities would necessarily fall under the mandate of the OPHA. The emerging interest in urban health issues and the precedence provided by the Ontario government in developing a strategic framework to address healthcare issues in rural area, makes addressing Health in Cities at this moment both timely and relevant.

It is therefore recommended that the OPHA:

- Advocate, in collaboration with other relevant Ontario-based agencies, such as the Association of Local Public Health Agencies (alPHa), the Ontario Medical Association (OMA), and the Ontario Hospital Association (OHA), for the development of a broad based and progressive urban health strategy in Ontario.
- Collaborate with the Canadian Public Health Association (CPHA) in furthering the development of and advocating for a national Health in Cities strategy.

6.2. Considering the important role that social networks play in promoting the health of vulnerable and/or marginalized populations, it is vital that any public health activity actively incorporate these existing local structures into the health planning process.

Indeed, while some public health activity may attempt to "develop" a community, it is fundamental that the existing community be considered, nurtured and supported. This community must act as the foundation for any public health activity, rather than be torn down in favour of a newly "developed community."

It is therefore recommended that the OPHA:

- advocate for the development of a Health in Cities strategy that is built around existing community agencies and organizations, leverages local resources and highlights multiple small scale initiatives;
- support and facilitate the community-based efforts to dismantle barriers towards the development and implementation of community-based health in cities initiatives.

6.3. Considering the well-documented effect of poverty on Health in Cities, to improve the well-being of city residents, it is necessary to recognize and address the various social, political and economic structures that have led to increasing poverty and economic insecurity. It is therefore necessary to focus on both the risk factors that link socio-economic position to health and the antecedents of socio-economic inequality.

It is therefore recommended that the OPHA:

- *support the* development *and implementation of both ameliorative and fundamental public health initiatives.*

7. Conclusion

This position paper has outlined why the OPHA should focus on Health in Cities, developed an emerging policy framework, highlighted the various urban health issues in Ontario, that have been discussed in the literature and, finally, outlined a preliminary framework for action. Through discussion and debate with relevant partners, this final framework for action will be more fully developed and implemented.

8. References

American College of Physicians. (1997). Inner-city health care. *Annals of Internal Medicine, 126,* 485-490.

Andrew, C & Morrison, J. (2002). Infrastructure. *Urban Policy Issues: Canadian Perspectives*, 2nd Edition, E.P. Fowler & D. Siegel, eds., Toronto: Oxford University Press.

Andrulis, D.P. (1997). The Urban Health Penalty: new dimensions and directions in inner-city health care. Washington, DC: The National Public Health and Hospital Institute from http://www.acponline.org/hpp/pospaper/andrulis.htm

_____. (2000). Community, service, and policy strategies to improve health care access in the changing urban environment. *American Journal of Public Health, 90*(6), 858-862.

Ashton, J., ed. (1992). *Healthy Cities.* Philadelphia: Open University Press.

Association of Ontario Health Centres. (2003). *Factors that Affect Health,* website, http://www.aohc.org/determinants.asp.

Barton, H. & Tsourou, C. (2000). *Healthy Urban Planning.* London & New York: World Health Organization.

Canadian Public Health Association. (2002). CPHA Resolution No. 4: National Urban Health Strategy, Ottawa: Canadian Public Health Association. http://www.cpha.ca/english/policy/resolu/2000s/2002/res2002e.pdf.

Centres for Disease Control and Prevention. (2003). Urban Health and Megacities: Healthy Living in Healthy Cities, website, http://www.cdc.gov/nceh/globalhealth/GHAR/priorities/urbanhlth/UrbanHlth.htm

Clement, C. (2003). Meeting with Connie Clement, Executive Director, Ontario Prevention Clearinghouse, February 26, 2003.

Clutterbuck, P. & Howarth, R. (2002). *Toronto's Quiet Crisis: The Case for Social and Community Infrastructure Investment,* Research Paper 198, Centre for Urban and Community Studies, University of Toronto.

Clutterbuck, P. & Novick, M. (2003). *Building Inclusive Communities: Cross-Canada Perspectives and Strategies,* Prepared for the Federation of Canadian Municipalities and the Laidlaw Foundation.

Cohen, H.W. & Northridge, M.E. (2000). Getting Political: Racism and Urban Health, *American Journal of Public Health, 90*(6), 841-842,

Damba, C. & Vahabi, M. (2002). *Toronto Local Health System Monitoring Report: Highlights,* Toronto: Toronto District Health Council.

Day, N., Fleiszer, P. & Basrur, S.V. (2001*). Toronto's Health Status: A Profile of Public Health in 2001*. Toronto: Toronto Public Health.

Dube, P. (1998). *Towards Developing a Healthier Urban Planning Process.* Full Paper #62, International Healthy Cities Conference, Athens, Greece, 20-23 June 1998.

_____. (2000). Urban health: An urban planning perspective. *Reviews on Environmental Health, 15*(1-2), 249-265.

Dudgeon, S. (2002). *Meeting the Challenges of Urban Health in the 21st Century*. Presentation to the GTA Forum, Toronto: Toronto District Health Council, February 2002.

_____. (2003). Personal communication, Toronto District Health Council, Toronto, Ontario, February 17, 2003.

Duhl, L.J. & A.K. Sanchez (1999). *Healthy Cities and the City Planning Process*. Copenhagen: World Health Organization.

Ellaway, A., Macintyre, S. & Kearns, A. (2001). Perceptions of place and health in socially contrasting neighbourhoods. *Urban Studies, 38*(12), 2299-2316.

Evans, R.G. & Stoddart, G.L. (2003). Consuming research, producing policy*? American Journal of Public Health, 93*(3), 371-379.

Fainstein, S. & Campbell, S. (1996). Introduction: Theories of urban development and their implications for policy and planning. *Readings in Urban Theory,* Susan Fainstein & Scott Campbell, eds. Oxford: Blackwell Publishers Ltd., 1-7.

Federation of Canadian Municipalities. (2001 - Updated 2002). *Early Warning: Will Canadian Cities Compete? A Comparative Overview of Municipal Government in Canada, the United States and Europe,* Ottawa: Federation of Canadian Municipalities.

_____. (2002). *Bridging the Innovation Gap: Count Cities In.* Ottawa: Federation of Canadian Municipalities.

Fitzpatrick, K.M. & LaGory, M. (2003). "Placing" health in an urban sociology: Cities as Mosaics of Risk and Protection. *City and Community, 2*(1), 33-46.

Freudenberg, N. (1998). Community-based health education for urban populations: An overview. *Health Education & Behavior, 25*(1), 11-23.

_____. (2000a). Health promotion in the city: A review of current practice and future prospects in the United States, *Annual Review of Public Health, 21*, 473-503.

_____. (2000b). Time for a national agenda to improve the health of urban populations. *American Journal of Public Health, 90*(6), 837-840.

Freudenberg, N. & Manoncourt, E. (1998). Urban health promotion: Current practices and new directions. *Health Education & Behavior, 25*(2), 138-145.

Geronimus, A.T. (2000). To mitigate, resist, or undo: Addressing structural influences on the health of urban populations. *American Journal of Public Health, 90*(6), 867-871.

Goldstein, G. (2000). Healthy cities: Overview of a WHO international program. *Reviews on Environmental Health, 15*(1-2), 207-214.

Glouberman, S. (2001). *Towards a New Perspective on Health Policy.* Ottawa: Canadian Policy Research Networks.

_____. (2002a). *A Toolbox for Improving Health in Cities* – Draft. Toronto: Wellesley Central Health Corporation.

_____. (2002b). *A Toolbox for Improving Health in Cities: From Theory to Action,* Presentation, July 2002.

_____. (2003a). *A Toolbox for Improving Health in Cities: A Discussion Paper,* Unpublished Draft, February 2003.

_____. (2003b). Personal communication. Baycrest Centre for Geriatric Care, Toronto, Ontario, February 17, 2003.

Glouberman, S & Zimmerman, B. (2002). *Complicated and Complex Systems: What Would Successful Reform of Medicare Look Like?* Discussion Paper No.8, Ottawa: Commission on the Future of Health Care in Canada.

Grosz, E. (1999). Bodies-Cities, in *Feminist Theory and the Body,* Janet Price & Margrit Shildrick, eds., Edinburgh: Edinburgh University Press, 381-387.

Harpham, T. (1997). Urbanization and health in transition. *Lancet, 349* (Supplement III), 11-13.

Harvey, D. (1996). Social Justice, postmodernism and the city. *Readings in Urban Theory,* Susan Fainstein & Scott Campbell, eds. Oxford: Blackwell Publishers Ltd., 415-435.

Healthy Connections (2002). *Progress to Possibilities: A Celebration of Networks and Partnerships in South East Toronto.* Healthy Connections 2002 South East Toronto Conference.

House, J.S., Lepkowski, J.M., Williams, D.R., Mero, R.P., Lantz, P.M., Robert, S.A., & Chen, J. (2000). Excess mortality among urban residents: How much, for whom and why? *American Journal of Public Health, 90*(12), 1898-1904.

Jackson, S.F. (1992). *Adapting to turbulence: Application in a municipal context.* Unpublished draft. Toronto, Ontario.

Judge, K. & Paterson, I. (2001). Poverty, Income Inequality and Health. Treasure Working Paper 01/29, New Zealand Treasury. www.treasury.govt.nz/workingpapers/2001/01-29.asp

Judge, K., Mulligan J. & Benzeval, M. (1998). Letter to the Editor: Reply to Richard Wilkinson, Social Science & Medicine, 47(7), 983-985.

Kawachi, I. & Kennedy, B.P. (1997). Health and social cohesion: Why care about income inequality? *BMJ, 314*, 1037-1040.

Kawachi, I., Kennedy, B.P., Lochner, K. & Prothrow-Stith, D. (1997). Social capital, income inequality and health, *American Journal of Public Health, 87*(9), 1491-1498.

Kenzer, M. (2000). Healthy cities: A guide to the literature. *Public Health Reports,* 115, 279-289.

Labonte, R. & Torgerson, R. (2002). *Frameworks for Analyzing the Links Between Globalization and Health (draft).* A Paper prepared for the Globalization, Trade and Health Group, World Health Organization. http://www.spheru.ca/PDF%20Files/Labonte-Frameworks-Links.PDF

Lauriault, T. (2000). Diversity presentation to the RMOC multicultural health workshop, September 21, 2000. Ottawa, Social Planning Council of Ottawa-Carleton.

Lawrence, R.J. (1999). Urban health: An ecological perspective. *Reviews on Environmental Health, 14*(1), 1-10.

_____. (2000). Urban health: A new agenda? *Reviews on Environmental Health, 15*(1-2), 1-11.

_____. (2002). Inequalities in urban areas: innovative approach to complex issues. *Scandinavian Journal of Public Health, 30* (Supplement 59), 34-40.

Lee, K.K. (2000). *Urban Poverty in Canada: A Statistical Profile,* Ottawa: Canadian Council on Social Development.

Leviton, L.C., Snell, E. & McGinnis, M. (2000). Urban issues in health promotion strategies, *American Journal of Public Health, 90*(6).

McCarthy, M. (2002). Urban development and health inequalities. *Scandinavian Journal of Public Health, 30* (Supplement 59), 59-62.

McDade, T.W., Adair, L.S. (2001). Defining the "urban" in urbanization and health: a factor analysis approach. *Social Science & Medicine, 53,* 55-70.

McMichael, A.J. (2000). The urban environment and health in a world of increasing globalization: issues for developing countries. *Bulletin of the World Health Organization, 78*(9), 1117-1126.

Metropolis, (no date). What is Metropolis? http://canada.metropolis.net/index_e.html

Ministry of Health and Long Term Care. (1998). Access to Quality Health Care in Rural and Northern Ontario: The Rural and Northern Health Care Framework. http://www.gov.on.ca/MOH/english/pub/ministry/ruralca.html

Naidoo, J., & Wills, J. (2000). *Health Promotion: Foundations for Practice,* 2nd Edition. London: Bailliere Tindall.

Ontario Public Health Association. (no date). Website. www.opha.on.ca.

____. (2002). *Development of National and Provincial Urban Health Strategies*. Motion adopted at the 2002 OPHA Annual General Meeting. Toronto: Ontario Public Health Association. http://www.opha.on.ca/ppres/2002-01_mt.pdf.

Open Space Forum. (2001). *What is Urban Health? Collaborating to improve the health status of diverse communities living in Toronto,* Report #2. Forging New Directions: Urban Health Research and Policy, Open Space Forum, April 3rd, 4th & 5th.

Pal, L. (1989). *Public Policy Analysis: An Introduction,* Scarborough: Nelson Canada.

Papillon, M. (2002). *Immigration, Diversity and Social Inclusion in Canada's Cities,* Ottawa: Canadian Policy Research Networks.

Patton, C.V. & Sawicki,, D.S. (1986). *Basic Methods of Policy Analysis and Planning,* New Jersey: Prentice Hall.

Petersen, A. (1996). The 'healthy' city, expertise, and the regulation of space. *Health & Place, 2*(3), 157-165.

Perkins, F. (1998). Toronto Healthy City Initiative: From project to office to corporate voice, Full paper #147, International Healthy Cities Conference, Athens, Greece, 20-23 June 1998.

Prime Minister's Caucus Task Force on Urban Issues. (2002). Canada's Urban Strategy: A vision for the 21st Century – Interim Report. Ottawa: Prime Minister's Caucus Task Force on Urban Issues, Chair: Judy Sgro, MP.

Raphael, D. (2001). *Inequality is Bad for Our Hearts: Why Low Income and Social Exclusion are Major Causes of Heart Disease in Canada.* Toronto: North York Heart Health Network.

Ross, C.E. & Mirowsky, J. (2001). Neighborhood disadvantage, disorder and health. Journal of Health and Social Behavior, 42, 258-276.

Ross, N.A., Wolfson, M.C., Dunn, J.R., Berthelot, J.M., Kaplan, G.A. & Lynch, J.W. (2000). Relation between income inequality and mortality in Canada and in the United States: cross sectional assessment using census data and vital statistics. British Medical Journal, 320 (7239), 898-902.

Seguin, A.M. & Divay, G. (2002). Urban Poverty: Fostering Sustainable and Supportive Communities. Discussion Paper F/27, Family Network, Ottawa: Canadian Policy Research Networks.

Seidle, F.L. (2002). The Federal Role in Canada's Cities: Overview of Issues and Proposed Actions, Discussion Paper F/27, Family Network, Ottawa: Canadian Policy Research Networks.

Statistics Canada. (1999). Income inequality and mortality among working-age people in Canada and the US, Health Reports, 11(3), 77-82.

_____. (2001). Geographic units: Urban area, *2001 Census*, http://www.statcan.ca/english/census2001/dict/geo049.htm.

_____. (2003a). Profiling our large metropolitan areas, http://geodepot.statcan.ca/Diss/Highlights/Page8/Page8_e.cfm

_____. (2003b). Sub-provincial population dynamics, http://geodepot.statcan.ca/Diss/Highlights/Page7/Page7_e.cfm

_____. (2003c). Population Counts, for Canada, Provinces and Territories, and Census Divisions by Urban and Rural, 2001 Census - 100% Data, http://www12.statcan.ca/english/census01/products/standard/popdwell/Table-UR-D.cfm?PR=35

Steele, L.S., Lemieux-Charles, L., Clark, J.P. & Glazier, R.H. (2002). The impact of policy changes on the health of recent immigrants and refugees in the inner city: A qualitative study of service providers' perspectives. *Canadian Journal of Public Health, 93*(2), 118-122.

Strike, C., Goering, P. & Wasylenki, D. (2002). A population health framework for inner-city mental health. *Journal for Urban Health: Bulletin of the New York Academy of Medicine. 79*(4), Supplement 1, S13-S19.

TD Bank Financial Group (2002). *A Choice Between Investing in Canada's Cities or Disinvesting in Canada's Future*, TD Economics, Special Report.

Toronto District Health Council (TDHC). (1999a*). Toward the Development of an Urban Health Framework: A Discussion Paper - Draft*, Toronto: Toronto District Health Council.

_____ (TDHC). (1999b*).* Toward an urban health framework for Toronto. *Health Planner*, Fall 1999, Toronto: Toronto District Health Council.

Toronto Public Health (1998). *The State of the City's Health: Implications for Public Health,* Toronto: Toronto Public Health. http://www.city.toronto.on.ca/health/state_health.htm

Tsouros, A.D. (2000). Why urban health cannot be ignored: The way forward. *Reviews on Environmental Health, 15*(1-2), 267-271.

UN-Habitat. (2002). *Sustainable Urbanisation: Achieving Agenda 21*, Nairobi, Kenya: UN-Habitat.

Vlahov, D. & Galea (2002). Urbanization, urbanicity, and health. *Journal of Urban Health: Bulleting of the New York Academy of Medicine*. 79(4) Supplement 1.

Wasylenki, D.A. (2001). Inner city health. *Canadian Medical Association Journal, 164*(2).

Wellesley Central Hospital (1997). *Toward an Ontario Urban Health Policy for Concentrated Urban Environments.* Unpublished briefing note.

Wilkins, R., Berthelot, J.M. & Ng, E. (2002). Trends in mortality by neighbourhood income in urban Canada from 1971 to 1996. *Health Reports* (Supplement), Statistics Canada, 13.

Wilkinson, R.G. (1997). Comment: Income, inequality and social cohesion, *American Journal of Public Health, 87*(9), 1504-1506.

World Health Organization (WHO). (1946). *Preamble to the Constitution of the World Health Organization* as adopted by the International Health Conference, New York, 19-22 June, 1946.

_____. (1986). *Ottawa Charter for Health Promotion,* Geneva: World Health Organization.

_____. (1998). *Health Promotion Glossary,* Geneva: World Health Organization.

_____. (2000). Social Determinants of Health: The Solid Facts, R. Wilkinson & M. Marmot, eds., Copenhagen: World Health Organization.

_____. (2003a). Healthy Cities Make a Difference, Copenhagen, World Health Organization, http://www.who.dk/document/hcp/hcpwebuk.pdf.

_____. (2003b). What is a healthy city? WHO, http://www.who.dk/healthy-cities/How2MakeCities/20020114_1.