

Promoting urban health equity in a post-COVID world: A view from Latin America



As COVID-19 emerged and began to spread rapidly around the world in early 2020, some labeled the new pandemic a “great equalizer.” Yet the impacts of this virus are anything but equally distributed. Pre-existing socioeconomic and health inequities have contributed to major inequities in the rate and severity of COVID-19 cases in cities across the world. Understanding the social and physical characteristics of the urban environment that contribute to health inequities is critical to achieving a healthy, equitable, and sustainable recovery.

Cities are home to large health inequities

Existing data show persistent inequities in health based on social class and race or ethnicity. These inequities are manifested spatially and reinforced by the residential segregation that characterizes many cities. In Latin America, as in many other areas across the globe, major gaps in life expectancy can be observed based on where people live in a city.

Figure 1. Gaps in life expectancy in six large Latin American cities. Together, these cities house more than 50 million people. Each city shows important differences in life expectancy according to the area where people live. Santiago de Chile and Panama City are two of the cities with the greatest differences. For example, in Santiago, the gap in life expectancy between areas in the city is almost nine years for men and 18 years for women. Panama City presents a difference of almost 15 years for both men and women. Important inequalities were also observed in Buenos Aires, Belo Horizonte, San José, and Mexico City. Source: [Bilal et al. 2019](#)

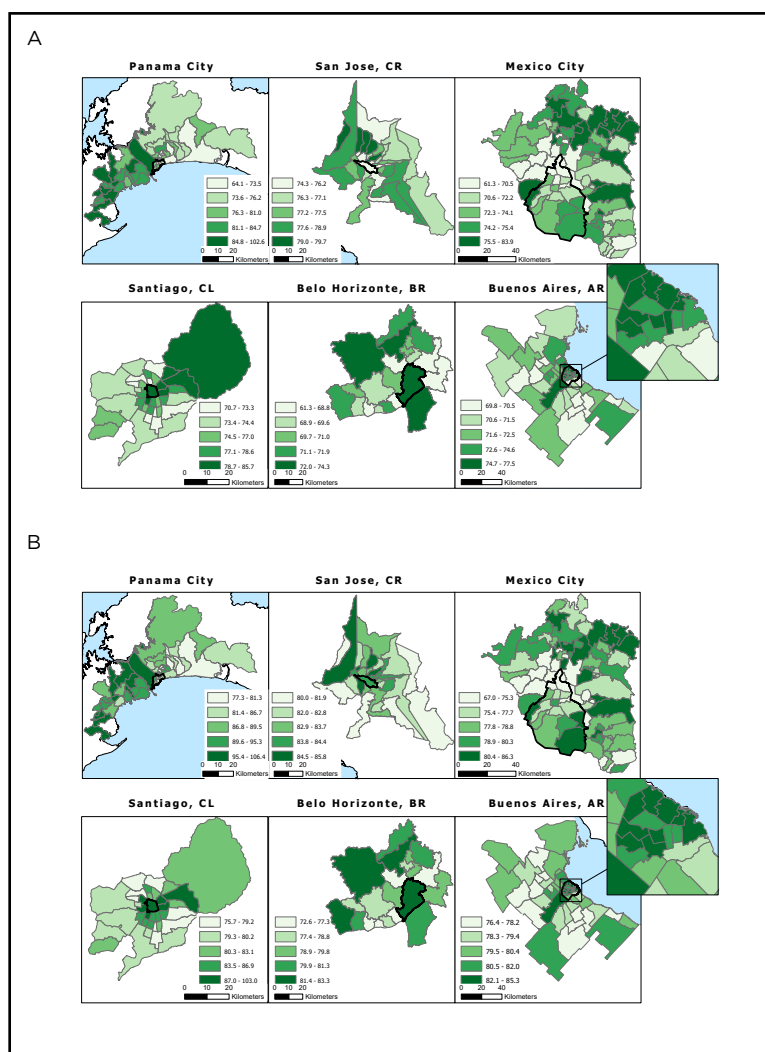


Figure 1: The maps in Set A show life expectancy for men, and Set B for women.

These differences in life expectancy across city neighborhoods are correlated with neighborhood socioeconomic features such as education.

Figure 2. Life expectancy and educational attainment for different areas in six large cities in Latin America. Source: Bilal et al. 2019. For both men and women, life expectancy is greater in neighborhoods where a higher percent of residents have completed secondary education, a marker for socioeconomic circumstances.

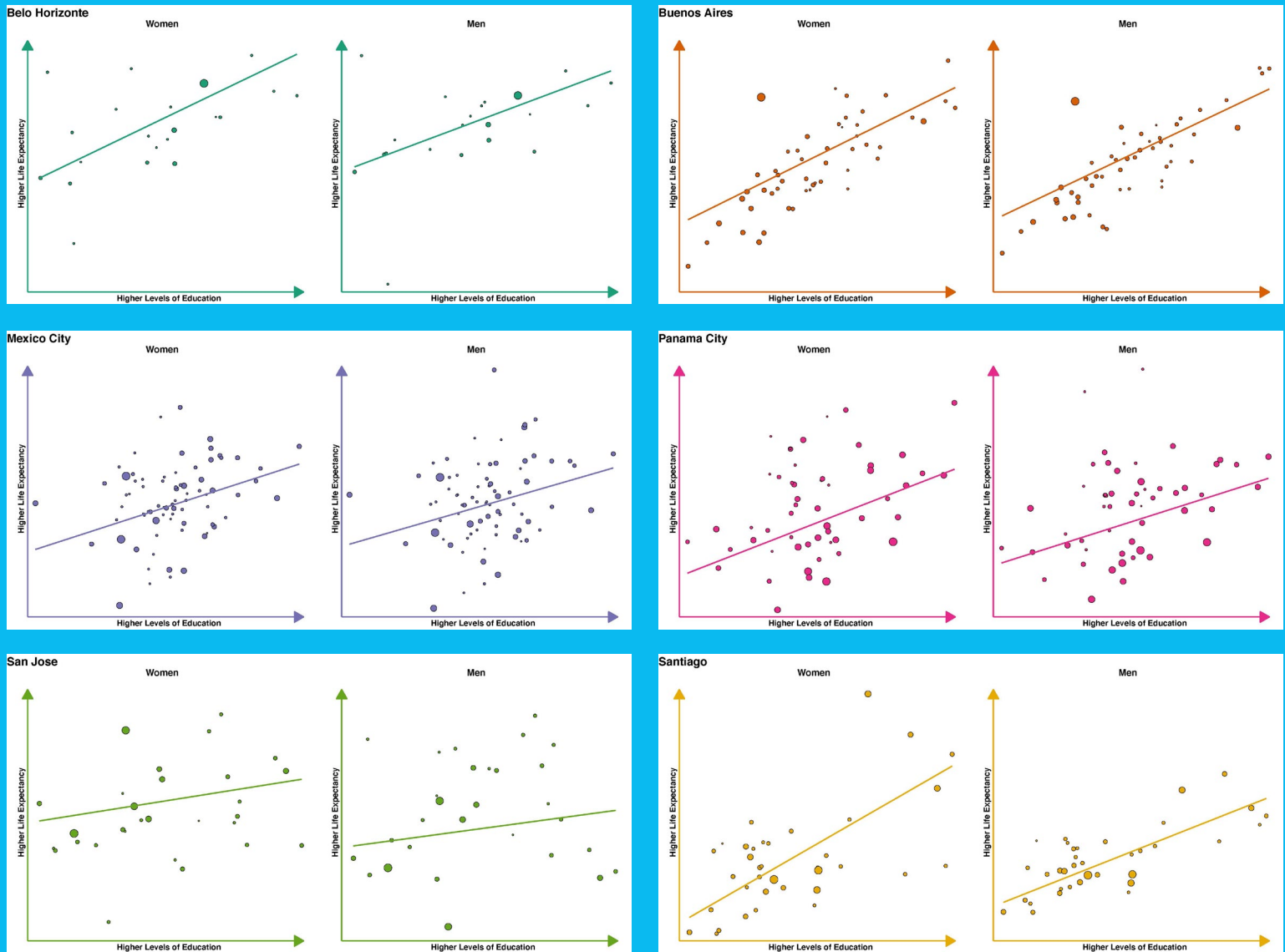


Figure 2

COVID-19 is further magnifying health inequities in cities

Evidence of marked inequities in COVID-19 cases and deaths based on race, ethnicity, and social class has emerged from around the world. The inequities being highlighted by COVID-19 in many cases mirror the economic, social, environmental, and health inequities that existed before the virus emerged.

Three types of factors contribute to inequities in COVID-19:

Increased exposure to the virus and increased rates of infection

Living conditions like overcrowding and poor access to water and sanitation facilitate exposure to the virus. Work conditions such as jobs that do not allow work from home or physical distancing, and long commute times in crowded transportation also facilitate exposure and result in higher incidence rates. Stresses resulting from social disadvantage facilitates the development of infection among people who are exposed to viruses. Residents of informal settlements are especially affected by these factors.

Increased severity of disease and increased death rate from COVID-19

The presence of health conditions such as hypertension, diabetes and other chronic illnesses has been shown to increase the COVID-19 severity and fatality. These conditions are more common in more disadvantaged neighborhoods, as a result of living and working conditions. Health care access can affect survival among those affected by COVID-19. Long-term air pollution exposure may also interact with infection, leading to more severe disease.

Lack of a coordinated and effective government response

Many cities have limited public health infrastructure, hampering their ability to implement surveillance and testing activities including case identification, isolation, and contact tracing critical to limiting the spread of disease. Disadvantaged neighborhoods are likely to be most affected by the absence of necessary public health interventions to stop transmission.

The inequitable impacts of the COVID-19 crisis are particularly apparent in cities in Latin America, where extreme inequity existed pre-COVID and where some of the most devastating outcomes of COVID-19 have been observed to-date.



Figure 3. Two neighborhoods side by side in Santa Fe, Mexico City. Latin America is one of the most unequal regions in the world, and this inequality contributes to health inequities – across countries, and within countries and cities. Source: Johnny Miller, mediarumimages.com

Health inequities are the result of multiple factors acting together in interlocking systems

Health inequities are linked to social and economic systems and environments:

- Economic systems that reinforce inequality produce inequities in income, work conditions and educational opportunities.
- Systems of racism and discrimination create inequities in living conditions based on race, ethnicity, and migration status.
- Systems of residential segregation result in inequitable physical and social environments across neighborhoods.

- Existing health systems produce fragmented, inequitable health care and inadequate funding for public health.

Health inequities occur when unfair and unjust differences in health exist and create additional disadvantages for already disadvantaged groups. Health equity means that everyone has a fair opportunity to attain their full health potential, and no one is disadvantaged from achieving this potential. Achieving health equity requires eliminating obstacles to health by addressing the social determinants of health.

SALURBAL and the LAC Urban Health Network

Salud Urbana en América Latina (SALURBAL), or Urban Health in Latin America, is a five-year project that studies how urban environments and urban policies impact the health of city residents throughout Latin America. [The Urban Health Network for Latin America and the Caribbean \(LAC Urban Health\)](#) promotes regional and multi-sectoral collaboration in order to generate evidence on the drivers of urban health and health equity and translate this evidence into policies to improve health across cities in Latin America.

Figure 4. SALURBAL cities. The Urban Health in Latin America project is collecting data on 371 cities with a population of 100,000 or more across 11 countries in the region. Source: SALURBAL 2020.



Climate change will magnify health inequities in cities

Climate change exacerbates existing health inequities by introducing new health risks and by placing disproportionate stress on vulnerable urban systems and communities.

There are two ways in which climate change can increase health inequities:

Differences in exposure

Higher temperatures and flooding have significant health consequences and are likely to be concentrated in poorer neighborhoods where people have less resources to manage these risks. Higher average temperatures can increase the range of the spread of virus and disease, and hot days or heat waves can exacerbate cardiovascular

and respiratory conditions. Increased precipitation and floods and can increase the spread of vector borne diseases like dengue or malaria.

Differences in vulnerability

Inadequate housing, lack of green spaces, and air pollution are more concentrated in poor neighborhoods. These factors increase the vulnerability of residents to the adverse health effects of heat and floods.

Acting to reduce the impacts of climate change will help reduce health inequities, and acting to address the fundamental social and environmental drivers of health inequities will reduce the health and social impacts of climate change.

Cities can promote urban health equity, climate resilience, and environmental sustainability post-COVID

The experience of COVID-19 highlights the need for cities to address the drivers of urban health inequities. In so doing, cities can also create environmental co-benefits and reduce the impact of future epidemics and climate change.

- **Housing:** Design requirements for new housing and interventions to retrofit existing structures to reduce crowding, improve ventilation, reduce hazardous indoor exposures, and increase energy efficiency.
- **Public spaces:** Promote equitable greening and tree cover and improve quality and availability of public spaces for walking, cycling and recreation.
- **Transport:** Increase infrastructure and incentives to promote active transport including cycling and walking; expand bus and BRT lanes; prioritize

and fund mass transit with increased frequency, passenger limits and screening, expanded waiting space, increased ventilation, and regular disinfection.

- **Social programs and employment:** Promote job security, minimum wage, and job benefits, including sick leave.
- **Food systems:** Promote the consumption of unprocessed foods and reduced meat consumption (through education, regulation, taxes and subsidies) to support health and mitigate climate change.
- **Public health and health care:** Provide adequate funding for public health infrastructure and provide universal access to quality care.

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