Journal of Transport & Health 2 (2015) 618–619

Contents lists available at ScienceDirect

Journal of Transport & Health

journal homepage: www.elsevier.com/locate/jth

Viewpoint

Inclusive and healthy cities: Commentary on transport, social exclusion and health

Jason Corburn *,[1]

School of Public Health and Department of City and Regional Planning, University of California, Berkeley, CA 94720, USA

Social connections can save your life, and transport has a role to play in supporting or stymieing those connections. The paper in this issue, "Transport, Social Exclusion and Health," by Mackett and Thoreau (forthcoming), offers an excellent and timely contribution to the literature linking transport, social exclusion and human health. They offer important definitions of social exclusion and the multiple ways exclusion interacts with transport to influence human health. Mackett and Thoreau (forthcoming) also highlight that social exclusion is an issue of equity, since the same populations experiencing health inequities are those with limited access to life-supporting transport services, including those with disabilities, older adults, women, immigrants and racial/ethnic minorities (Mackenbach and Bakker, 2002).

A significant contribution of Mackett and Thoreau (forthcoming)'s review paper is that the authors highlight that transport, social exclusion and health must be understood as a relational, multi-dimensional concept. What this means is that exclusion occurs, and influences transport access and related-hazardous exposures, along social, political, physical, cultural and economic dimensions. Thus, for these authors, to study and address social exclusion, transport and related human health impacts, is to view the issue as a dynamic, not static, concept.

Mackett and Thoreau (forthcoming) offer many important insights for this relational view of transport and health, including emphasizing the overlapping and even synergistic health impacts of high transport costs, mobility limitations due to disability, age-specific challenges, and gender, racial and ethnic discrimination. The authors note 'psychological barriers' but missed an opportunity to include the literature linking lack of and unsafe transport to 'toxic stress' and related human health impacts (McEwen, 1998).

While stress can be life saving for most – think of the fight-or-flight mechanism – constant adversity is toxic. Chronic exposure to multiple adverse events in the family, workplace, school or community has a cumulative 'weathering' effect on the body's immune system, and contributes to arterial plaque, poor glucose regulation, hypertension, limits cognitive development and can damage chromosomes. Some known 'toxic stressors' include chronic poverty and neglect, violence, workplace and housing instability, long commute times, lack of access to essential services and exposure to pollution and noise (Schulz et al., 2012).

Mackett and Thoreau (forthcoming) do emphasize the 'double burden' of social exclusion on the health of already marginalized and vulnerable populations. They note that socially excluded populations have poorer access to different transport options (automobile, cycling, walking, etc.) and in reaching life-supporting services due, in part, to limited transport access. The second health burden from social exclusion is exposure to what Mackett and Thoreau (forthcoming) call the 'externalities' of transport, or the road causalities, injuries, pollution, noise and other health-hazards tied to different modes of transport. This means that place matters for health and social exclusion, and interventions must improve neighborhood environments as well as individual transport opportunities.

Transport and health professionals should add a third dimension to research and practice into social exclusion and health, namely power, or the ability to change the policies and plans that create unhealthy circumstances. The multiple disadvantages from social exclusion are the result of a set of processes embedded in power relationships that produce unequal conditions of inclusion and exclusion. Exclusion rarely happens by accident. Inequalities in opportunities to participate fully in social, political, cultural and economic relationships and decision-making contribute to inequities in health and well-being (Marmot et al., 2008).

The relational approach to social exclusion, transport and health has a set of further implications for research and practice. First, researchers must do better to investigate processes of advantage and exclusion, not just constructing variables that define some groups and/or places as "excluded." (Sen, 2000) By focusing on processes, not just outcomes, research and practice can move toward greater understanding of 'how' policy and planning decisions act to include or exclude certain groups and/or places. A focus on processes can also encourage investigation into the institutions that create social and health inequities and thereby move research beyond the narrow focus of individual opportunity.

* Tel.: +1 510 643 4790.
E-mail address: jcorburn@berkeley.edu
[1] www.jasoncorburn.com

http://dx.doi.org/10.1016/j.jth.2015.10.002
2214-1405/

Second, a relational approach demands that health equity research grapple with transport governance, or the policies, programs and directives of national and local governments (Corburn, 2015). Mackett and Thoreau (forthcoming) remind us that transport decisions can and do make a difference in terms of exclusion, such as through cost reduction, directing transport investments to the most deprived areas, and dedicating service to high-need populations. Surprisingly, the authors fail to mention how emerging local and national climate change planning and policy ought to respond to the overlapping challenges of social exclusion, transport and human health (Grant, 2015). Important work by the European Healthy Cities Network has highlighted that integrating planning, transport, housing, environmental and health systems, among others, is essential for promoting health equity and social inclusion.

Finally, social exclusion, transport and health research must identify policies and plans that reverse current trends of exclusion in cities (EUKN, 2014). Land use, immigration, cultural, economic development and transport policies all run the risk of increasing displacement and social exclusion of the poor, as well as religious, ethnic and racial minorities. Transport planners must question these practices and work with other sectors for more inclusive and healthy cities for all. Inclusive city planning is a democratic process that includes participation by marginalized and vulnerable populations (Corburn, 2015; Popay et al., 2008).

Health begins where we live, learn, work and play, and transport has a critical role in providing access to healthy communities, schools and workplaces for all. Yet, transport policy alone will not address social exclusion or health. A Health in All Policies approach, now advanced by the WHO, the All-Party Parliamentary Group on Health in all Policies in the UK, and the European Commission, is necessary to ensure decisions and resources are directed toward populations and places most in need (McQueen et al., 2012). Mackett and Thoreau (forthcoming) have offered an important review to help inform this action-research agenda.

References

Corburn, J., 2015. City planning as preventive medicine. J. Prev. Med. 77, 48–51.

European Urban Knowledge Network (EUKN), 2014. The Inclusive City: Approaches to Combat Urban Poverty and Social Exclusion in Europe, The Hague ⟨http://www.eukn.eu/eukn-research/publications/the-inclusive-city-approaches-to-combat-urban-poverty-and-social-exclusion-in-europe/⟩.

Grant, M., 2015. European healthy city network phase V: patterns emerging for healthy urban planning. Health Promot. Int. 30 (Suppl. 1), i54–i70.

Mackenbach, J., Bakker, M., 2002. Reducing Inequalities in Health: A European Perspective. Routledge, London.

Mackett, R.L., Thoreau, R., 2015. Transport, social exclusion and health. J. Transp. Health 2 (4) (forthcoming).

Marmot, M., Friel, S., Bell, R., et al., 2008. the Commission on Social Determinants of Health, 2008. Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health. WHO, Geneva, http://www.who.int/social_determinants/thecommission/finalreport/en/.

McEwen, B.S., 1998. Protective and damaging effects of stress mediators. N. Engl. J. Med. 338, 171–179 1998.

McQueen, D., Wismar, M., Lin, V., Jones, C.M., Davies, M., 2012 (Eds.). Intersectoral Governance for Health in All Policies. Structures, Actions and Experience. On behalf of the European Observatory on Health Systems and Policies, WHO Regional Office for Europe, Copenhagen.

Popay, J., et al., 2008. Understanding and tackling social exclusion. Final Report to the WHO Commission on Social Determinants of Health from the Social Exclusion Knowledge Network. Available: ⟨http://www.who.int/social_determinants/knowledge_networks/final_reports/sekn_final%20report_042008.pdf⟩.

Schulz, A.J., Mentz, G., Lachance, L., Johnson, J., Gaines, C., Israel, B.A., 2012. Associations between socioeconomic status and allostatic load: effects of neighborhood poverty and tests of mediating pathways. Am. J. Public Health 102 (9), 1706–1714.

Sen, A., 2000. Social Exclusion: Concept, Application, and Scrutiny (Social Development Papers no. 1). Asian Development Bank, Manila. ISBN 971-561-274-1.