Chapter 16

Health Services Research and the City

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1.0. INTRODUCTION

Health services research is, by nature, multidisciplinary, for it draws on the methods, concepts, and theories of social sciences, which are relevant to the study of how the organization and financing of health services can improve the delivery of health care services (Gray, et al., 2003). While medicine and public health, too, are multidisciplinary enterprises drawing on such disciplines as molecular biology, physiology, anatomy, genetics, epidemiology and more, health services research departs from these disciplines in focusing not on the nature of disease and health but rather on the financing and organization of health systems.

So it is with urban health services research albeit that this field is more narrowly focused on health services in cities. The city focus has resulted in a large body of research on vulnerable groups, barriers to service access, public health clinics and community health centers. Likewise, it has led to important investigations of safety-net institutions, e.g. public hospitals and health centers, which serve a disproportionate share of uninsured and low-income patients. In addition, urban health services research has focused on a host of specific services associated with subpopulations suffering from TB, HIV/AIDS, drug addiction and other social pathologies that are typically associated with the “inner city.”

If one views the field of urban health services research through a kind of intellectual telescope, what is most striking are the many issues that have escaped careful scrutiny. The city, after all, is more than a center of disease, poor health and pervasive poverty (Rodwin, 2001; Glouberman, 2003). Since the oracle of Delphi and the miracles of Lourdes, the city has also functioned as an economic base for medical cures. Most large cities serve as headquarters for academic medical centers (Ginzberg and Yohalem, 1974), places where health professionals congregate, and more generally, strategic locations for health promotion (Freudenberg, 2000) as well as the diffusion of healthy lifestyles among the well-to-do. There is a significant
literature on academic medical centers, hospitals, health centers and multiple organizational forms of medical practice but most studies do not explore the relationships between these institutions and the city. What is more, there are few comparative analyses of health systems and services among cities (Rodwin, 2005).

These gaps in the field are unfortunate for several reasons. First, they leave open a host of important and unanswered questions. For example, does the density of tertiary health services – academic medical centers, sub-specialists, and state-of-the-art medial technologies – improve access and quality of urban health care? Does it confer any discernable benefits on the health status of the urban populations who reside in their proximity? Do the teaching programs, hospital clinics and affiliated health centers provide significant benefits to those most in need of basic health services, including primary care? What side effects, other than employment (Vladeck, 1999) diffuse down to the most disadvantaged “inner city” populations who live in the shadow of the academic medical center? And what is the optimal location of public facilities for the provision of health services to the most disadvantaged?

Second, given significant differences among cities and their health systems, there are clearly ample opportunities for comparative learning. For example, cities as different as New York, Los Angeles, Chicago, and Houston could clearly learn from one another’s experience in organizing their public health infrastructure and providing health services to their residents? Often it is easier to implement policy changes at the local level, particularly when decision-making is decentralized, fragmented and responsive to local preferences, traditions and distinctive conditions. Typically, local authorities are able to move faster than their national governments in learning from city-to-city exchanges (O’Meara, 1999). Thus, it would be fruitful for the field of urban health services research to initiate systematic comparisons of urban health systems – both among cities as well as among neighborhoods within them.

In this chapter, we review some of the more salient studies at the intersection of urban and health services research. In addition, we propose a research agenda to address the gaps noted above. Finally, to illustrate some small steps along an international dimension of the proposed research agenda, we provide some examples of our own on-going urban health services research on world cities.

2.0. URBAN STUDIES AND HEALTH SERVICES RESEARCH

As Scott Greer (1983) observed over two decades ago, “What is striking to those who have been immersed in urban studies and then have become interested in the social response to health and ill health is the extreme segregation of the two areas of inquiry.” From the heyday of 19th century European public health movements which focused on the importance of sanitation (clean water supply, sewers and garbage disposal) and improvements in housing conditions, to twentieth century interventions aimed at improving access to health services, the main body of research on public health, as well as on medical care, was largely focused on cities. Moreover, the triumph of public health is largely responsible for making cities more habitable. Yet, the field of urban studies has largely ignored public health (Coburn, 2004), and the field of health services research has followed the growth of the welfare state in veering away from local territorial concerns and focusing largely on statistical aggregates ranging from regions, states and nations.

Urban planners typically study cities from perspectives that span across architecture, urban design, transportation, economic development, the environment,