Urban sociologists are very engaged with questions about health. We are more mindful now than ever before that we all live in social landscapes of particular places that have their own power to shelter or harm us. Cities are, as the title of a recent article on urban health puts it, “mosaics of risk and protection” (Fitzpatrick and LaGory, 2003).

Our inquiries on the problem gathered momentum in the 1980s, and then took off in the 1990s. Research questions, methods, and findings flowed together from a wide variety of sources: from work on the impact of social capital on the welfare of communities (Putnam, 1993) and children (Elliot, et al., 1996), from the perception and experience of new “species of trouble” (Erikson, 1994) traumatizing entire communities, from organizational sociologists’ attempts to explain the urban patterns of corporate pollution (Grant and Jones, 2003), from the rise of the environmental justice movement (EJM), (Foreman, 1998), a fight to eradicate the racial and social-class penalties of toxic waste in urban areas (Camcho, 1998), from the efforts of urban historical sociologists to understand the “power of place” (Sennett, 1993; Hayden, 1997), from the attempts of business-studies scholars to explain why, in the post-industrial age of internet globalization, geography still matters (Florida, 2002), and even from the study of neighborhoods as sites of consumption by sociologists who pioneered the use of zip code cluster profiles for direct marketing (Weiss, 1988).

Those authors and more gave rise to exciting intellectual developments the most promising of which involve the convergence of three factors: substantive questions about health, the exploration of health questions through urban ethnographic and statistical research methods, including multi-level models and geographic information systems, and the effort to use theoretically nuanced models of mechanisms to establish the causal links between the social environment and our health.
If there is a core analytic framework common to those working in this new direction, it is the importance of “neighborhood effects”* (Sampson, et al., 2002). The intellectual move was from a medical-sociological model that prioritized individual-level characteristics, to an urban-sociological model that emphasized community-level effects. To questions about how one’s health was influenced by “what one is,” were added questions about the effects of “where one lives.” Medical sociologists conventionally thought about the “what one is” question in terms of demographic stratification. The idea was to measure the effects of individual attributes, such as income, education, occupation, ethnicity, gender, and age on the individual’s health. Then, building on the medical model, urban sociologists began to explore the “where” question with reference to neighborhood or community-level characteristics that have a weight and impact all their own on the individual’s as well as the public’s health.

Medical sociologists gave us many robust findings on the “what” question. The hypothesis that one’s bank account affects one’s health, for example, has been abundantly verified. There are few correlations in the field stronger than the link between income and mortality. The association holds up historically and comparatively; the power of money keeps one alive regardless of time period or society (Wilkinson, 1992). The income-mortality correlation is not the only sociological generalization with broad, if not universal, validity – social status works the same way. Separate from income or wealth, people in prestigious positions have better health than those below them (Marmot, 2004). Although prestige rankings lack the obvious physicality and direct resource mobilizing power of money, their effects are just as real and just as quantifiable. Prestige rankings of occupations are a reliable source of demographic information available to health researchers (for an updated rank order see: Nakao and Treas, 1994).

On the “where” question, urban sociologists are now able to demonstrate that neighborhood-level characteristics are important in shaping health patterns. For example, features of one’s community, such as its relative number of civic associations, can determine how much pollution there is in the local environment (Grant, et al., 2004; Wakefield, et al., 2001). Even whether or not one lives in a tightly knit community, with dense social ties, matters to the mortality rate of one’s locale. Witness Roseto, Pennsylvania, where an Italian-American community for nearly fifty years enjoyed better health than neighboring areas; until it too suffered the effects of declining social ties (Egolf, et al., 1992).

To provide an overview of the sociology of urban health, this chapter will briefly look at the history of the field and the role racial issues played in giving rise to our current focus on neighborhood effects. Then we will discuss the difficulties of doing empirical research on the social and physical environments that affect the health of individuals. It is not easy to distinguish the effects of areas from the attributes of the people who live there. Does a disadvantaged family carry the same burden regardless of location, or does it face additional hurdles if it resides in a disadvantaged community? And how does one measure community disadvantage? The role of particular statistical techniques, mixed or multi-level models, in resolving the neighborhood-effects conundrum will be reviewed. And the importance of researchers knowing how to draw the relevant boundaries of communities, and how to specify the causal pathways between neighborhood characteristics and individuals’ health, will be explored in some detail. We will see how the field’s most fruitful

*Although some social epidemiologists refer to the move as “ecological” (MacIntyre and Elaaway, 2000), sociologists more commonly use the “neighborhood” trope.