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Obesity, Poverty, and the Built Environment: Challenges and Opportunity

Wendy Collins Perdue
University of Richmond, wperdue@richmond.edu

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Public Health Law and Ethics

A Reader
Revised and Updated Second Edition

Edited by Lawrence O. Gostin
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which the built and socioeconomic environments interact to fuel the obesity epidemic in the United States.

**OBESITY, POVERTY, AND THE BUILT ENVIRONMENT: CHALLENGES AND OPPORTUNITY**

*Wendy C. Perdue*

Obesity and its associated chronic diseases have become a major health concern in the United States. Approximately two thirds of adults in the United States are either overweight or obese, and the condition is linked to diabetes, high blood pressure and other chronic conditions requiring ongoing medical supervision. Obesity is a particular health concern for the poor. Not only are obesity rates generally higher among those with lower socioeconomic status, but the chronic conditions caused by obesity may present a particular challenge for the poor who often lack access to necessary ongoing medical supervision.

Obesity is linked to behaviors related to food consumption and physical activity. Although the factors affecting these behaviors are complex, there is growing evidence that the physical characteristics of many of our communities, and particularly poorer communities, encourage obesity-generating behaviors.

**OBESITY AND THE BUILT ENVIRONMENT**

Even before researchers began to focus on obesity, the connection between human behavior and physical surroundings was observed and documented. Jane Jacobs' pioneering work on public spaces observed that some parks and public spaces feel welcoming and safe and draw people in, while other spaces, because of their design, have the opposite effect. Except for people inhabiting highly rural and undeveloped areas, the primary features of people's physical environment are man-made, and encompass everything from land use patterns and urban planning, to the design, location, uses and interrelations among buildings, to transportation systems. All of these man-made physical features are known collectively as the "built environment." Increasingly, evidence suggests that the features of the built environment affect behaviors related to obesity.

Studies suggest that proximity to stores stocking healthier food choices has measurable effects on health. Unfortunately, access to healthy foods can be particularly problematic for the poor.

In the United States, small grocery stores and convenience stores tend not to stock much selection of healthier foods, and supermarkets are the primary source of (healthy) foods. However, as supermarkets have moved to larger size store formats, the total number of grocery stores in the U.S. has actually declined. Fewer stores that are larger and further apart may not be a problem for affluent residents with cars, but it can be a challenge for poorer residents.

While healthy food may be relatively hard to find in poorer neighborhoods, less

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The Future of the Public’s Health

Environments interact to fuel the rise of our communities, and the overall health of a society.

The Future of the Public’s Health Environment:

As becoming a major health concern in adults in the United States are linked to diabetes, high blood pressure, and medical supervision. Obesity is not only a chronic condition, but the poor who often lack access to healthy foods and abundant access to unhealthy foods.

In addition to impacting food consumption, characteristics of the built environment may impact levels of physical activity. Studies showed that less dense, automobile-dependent patterns of development correlate with lower levels of physical activity and an increased risk of being overweight. This research has significant implications for the poor who often confront neighborhood characteristics that discourage physical activity. Crime and perceptions of crime are affected by features such as abandoned buildings, vacant lots and poor lighting and may be significant deterrents to outdoor activity such as walking or using parks or playgrounds."

Another factor which may impact levels of physical activity is access to recreation facilities. Although... empirical studies do not show consistent results among all populations in all locations, some studies show a clear association between greater proximity to recreation facilities and frequency of exercise or lower weight. One study of over 20,000 adolescents found that not only were private facilities more plentiful in wealthier communities, public and quasi-public facilities including schools, parks, YMCAs and youth organizations were as well.

This brief summary highlights that the behaviors associated with obesity do not occur in a vacuum. The choices that people make concerning food and physical activity are significantly influenced by the environment in which those choices are made.

Challenges to Changing the Built Environment

In light of the studies on food and physical activity, a growing chorus of researchers has begun to argue that changing our built environment may be an important component to our public health strategy. [However,] there are some practical, political, and empirical challenges to such a strategy.

First, the empirical data on the correlations between health, healthy behavior, and particular aspects of the built environment are sometimes inconsistent and, among some populations in some locations, these correlations are weak. Even where there is reasonably strong correlation evidence, we lack data that would allow one to draw general conclusions concerning priorities with respect to changes in the built environment. As one study observes, the data on diet and exercise are "disappointingly ambiguous about the contribution of eating vs. that of a lack of physical activity to the obesity epidemic, much less the contribution of specific behaviors" (Joffrey and Utter 2003, 135).

Second, changing our physical environment can be slow and expensive. For
example, bringing a supermarket to a community requires finding a site, securing financing and [a] permit, and then designing and constructing the facility. It is a process that can easily take five years or more. Efforts to improve public facilities can be similarly slow and, even with the best of intentions, small design defects can doom the effectiveness of the changes. . . .

Third, the complex web of land use and other laws that impact the built environment may be far outside the expertise of public officials. At the same time, improvements in the built environment will require the collaboration of a variety of professionals for whom public health is outside their training. . . . Most issues concerning land use, transportation and development are allocated to urban planners, architects, engineers and offices of economic development. Although there is a growing academic literature on the connection between public health and the built environment, this literature has not necessarily penetrated into the day-to-day focus of those who make land use decisions. . . .

Fourth, to the extent land use and transportation decisions turn on input from surrounding neighbors, poor communities may be at a disadvantage. Language barriers, lower education levels, lack of information, and the inability to get child care or time off from work negatively affect the ability of poorer communities to organize effectively. In addition, poorer citizens may have come to expect less and therefore demand less. For all these reasons, land use processes that are dependent on neighborhood-initiated requests or complaints may be less effective in addressing the needs of poorer communities. For example, some have advocated that fast food restaurants be subject to a special use permit process that would require a showing of need or a demonstration that there is not already an undue concentration. Yet, if this process is structured as a quasi-adversarial proceeding that requires communities to come forward in opposition, such a process may not be particularly effective in slowing the expansion of fast food restaurants into poorer communities. . . . The point is not that planning decisions should be disconnected from the community, but rather that attention must be paid to the procedures used to assure both that the community’s voice can be effectively heard and that needed change is not dependent on communities becoming politically engaged. . . .

Finally, it is important to appreciate that efforts to change the built environment may encounter some resistance from entrenched interests that have a stake in the status quo. The built environment as it currently exists has been structured by a complex web of laws, regulations, and incentives, and private property and investment decisions may have been made in reliance on these rules. Changes in these rules can create a complex “politics of ‘place making’” (Corburn 2004, 543). . . . Moreover, efforts to alter the built environment are sometime understood as an inappropriate government intrusion into the private sphere. Thus, some public officials have questioned whether encouraging supermarket development in underserved communities is properly within their mission. . . .

OPPORTUNITIES TO CHANGE THE BUILT ENVIRONMENT

Notwithstanding these challenges, there are several reasons why attention to the built environment should continue as a component of our public health agenda. First, small changes in behavior may yield significant long-term benefits to obesity and other such chronic diseases and conditions. . . . Noting that a pound of body weight
Concluding Reflections on the Field

The Future of the Public's Health

Efforts to improve public health are connected to the community's ability to organize and construct the day-to-day public facilities, including parks, sidewalks, and recreation facilities. Although most of the changes that occur may not be particularly effective in addressing the needs of the community, they may still be accomplished by spending old money more wisely. Projects are likely to occur anyway, so we can locate, design, and construct them so that they are more likely to contribute to a healthy environment. Moreover, focusing on the potential health benefits of some investments may bring renewed urgency and funding priority to the infrastructure needs of neglected communities. If parks, sidewalks, and recreation facilities are understood as an important part of a broader agenda to improve public health, maybe we can provide a justification for further necessary fiscal resources. Finally, all useful changes may require new money but may be accomplished by spending that money more wisely. [Thus, where] projects are likely to occur anyway, we can locate, design, and construct them so that they are more likely to contribute to a healthy environment. Moreover, focusing on the potential health benefits of such investments may bring renewed urgency and funding priority to the infrastructure needs of neglected communities. If parks, sidewalks, and recreation facilities are understood as an important part of a broader agenda to improve public health, maybe we can provide a justification for further necessary fiscal resources. Finally, not all useful changes are necessarily large and expensive. Small improvements, such as adding lights to pathways, may increase safety and therefore increase usage.

In addition to public projects, private owners are also constantly building and changing their properties. What and where owners build is influenced by a complex web of zoning, land use, and environmental laws, building codes, and tax laws. Changes in these legal frameworks can change what gets built. Indeed, some of our current zoning and land use laws may have the effect of discouraging a healthy environment. Building codes written for new construction that are applied to existing buildings may have the effect of discouraging the rehabilitation of old properties and thereby contribute to neighborhood deterioration. Thoughtful reexamination of these laws can encourage a redirection of private investment without necessarily requiring an infusion of public money.

Third, the challenge of gaining institutional expertise of other critical players is beginning to be addressed. City and state planning departments have begun to try systematically to integrate planning and public health. For example, San Francisco convened a multi-stakeholder process that brought together community representatives as well as professionals from multiple fields. The group developed the Healthy Development Measurement Tool which identifies a number of health-related data such as neighborhood proximity to grocery stores and recreation facilities along with basic health data. The Tool is not intended to be regulatory but nonetheless applies a community health 'lens' to planning (San Francisco Department of Public Health 2006). The San Francisco experience is noteworthy not only for the tool that was ultimately developed but also for the inclusive process that was used. As one commentary by a public health official observed, "Public health, by definition, is a group activity."

Finally, although most of the physical components of the built environment are typically represents 3500 calories, one research study has estimated that "most of the weight gain seen in the population could be eliminated by some combination of increasing energy expenditure and reducing energy intake by 100 kcal/day" (Hill et al. 2003, 854-55). ... One hundred calories is equivalent to walking a mile ... or drinking a 12 ounce serving of Coca-Cola. Thus, environmental changes that cause people to be even a little more active or to eat a little more healthy diet, can produce over-all public health benefits.

Second, while some changes to the built environment can be slow and expensive, changes are constantly occurring and will continue to occur, regardless of the engagement of the public health community. Roads are constructed or repaired, government facilities, private homes and business are all being sited and constructed. To the extent that these changes are happening anyway, there may be an opportunity to locate and build in ways that are more likely to be health promoting. Some improvements may not require new money but may be accomplished by spending old money more wisely. Projects are likely to occur anyway, so we can locate, design, and construct them so that they are more likely to contribute to a healthy environment. Moreover, focusing on the potential health benefits of such investments may bring renewed urgency and funding priority to the infrastructure needs of neglected communities. If parks, sidewalks, and recreation facilities are understood as an important part of a broader agenda to improve public health, maybe we can provide a justification for further necessary fiscal resources. Finally, not all useful changes are necessarily large and expensive. Small improvements, such as adding lights to pathways, may increase safety and therefore increase usage.

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Beyond the built, economic, and informational environments, the social environment appears to play a significant role in determining obesity levels. Social connectedness and the social capital that such networks yield are correlated with obesity rates—those with greater social capital are less likely to be obese than those who are socially isolated. In a further complication, being overweight or obese seems to contribute to social isolation, thereby promoting a vicious cycle in which weight gain and its psychosocial correlates fuel one another.

Some researchers have begun to examine the nature of social networks and their impact on obesity more closely. In 2007, Nicholas Christakis and James Fowler, two well-regarded social scientists, published a study tracking the weight patterns of participants and of persons within their social networks. The results indicated that obesity is "socially contagious." The likelihood of an individual becoming obese jumped by 57 percent if a friend within his or her social network was obese. Christakis and Fowler's work suggests that overweight and obesity are closely linked to social norms and interpersonal relationships. If so, social networks might also be useful for spreading "good" behaviors, such as a healthful diet and active lifestyle. Although Christakis and Fowler's study remains controversial, it "highlights the necessity of approaching obesity not only as a clinical problem but also as a public health problem" (2007, 378).

Concluding Reflection:

B. The Obesity Panorama

In the developing world, overweight and obesity in adults have traditionally been seen as sign[s] of affluence. Internationally, as the new"middle class" grows, Rapid globalization and modernization have led to rapid lifestyle changes in countries with traditionally high rates of undernutrition, where obesity is on the rise. In developing countries, the rise of obesity has been accompanied by increases in nutrition, dietary habits, and sedentary lifestyles. In the United States, obesity is a public health crisis that disproportionately affects low-income populations and communities of color. Obesity is not just a medical issue; it is a public health issue, with significant economic implications for individuals and society as a whole.

The poor health of communities, and the mark of affluence. Instead, particularly in low-income and underserved communities, the public health crisis of obesity awaits[...]. Obesity is a significant public health issue in the United States, affecting millions of people and contributing to a wide range of health problems. Obesity is not only a medical issue; it is a social issue, with significant economic implications for individuals and society as a whole. In the United States, obesity is a public health crisis that disproportionately affects low-income populations and communities of color.

Determinants of Health

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