Transportation for Health

By Lili Farhang and Rajiv Bhatia

Our transportation system has direct and unequivocal effects on morbidity and mortality. Motor vehicle emissions are the largest and fastest growing source of air pollution and greenhouse gases. Exposure to air pollution causes respiratory illness and cardiovascular disease, and motor vehicles are also the most important source of environmental noise, interfering with sleep, work performance, and childhood brain development. Pedestrian injuries result from street designs that favor cars rather than people. Urban sprawl has made us less physically active, and populations in low-density communities experience higher rates of obesity than populations in higher-density areas.

More and more, the public health community is acknowledging that living and working conditions determine whether we have the opportunity to live healthy lives. Those living close to highways or busy roadways cannot control the air pollution entering their windows. Children are less physically active wherever parks are unsafe or there are no sidewalks. In areas without full-service grocers and produce markets, families have to make do with low-quality, high-priced food.

Decades of research has shown that social class, race/ethnicity, geography, housing, and employment are the most significant predictors of health status. There is also mounting evidence that our "built environment"—land use patterns, neighborhood design, transportation systems—creates or obstructs opportunities for healthy living. So public health practitioners must now go beyond merely proscribing behaviors and treating symptoms, and start challenging the root causes of poor health.

In June 2005, single-room occupancy hotel residents of the Tenderloin district in San Francisco participated in a focus group on public transit access and their physical and mental health. Citing factors such as stress, overcrowding, violence, and cost of living, the participants describe situations in which they were unable to access basic needs—food, healthcare, family, and friends. Many in the group are positive about San Francisco's public transit infrastructure, but emphasize that its benefits are distributed in a way that effectively reinforces neighborhood segregation. Regarding the most recent round of fare hikes, one participant says, the transit system's "strategy is to raise fares to keep poor people in a certain area. Everything in the neighborhood is contained—housing, food, and liquor stores. It's like an ant farm. It's not a good feeling… not to be able to leave."

Participants credit a history of community action as the primary reason for the city's decent public transit system. "Unless low-income people are down at City Hall raising a ruckus, their neighborhoods get bypassed for improvement, their interests marginalized during budget decisions. When it comes to transit policy, it's almost like they're invisible to the city," said Casey Mills, an organizer with the Coalition for Transit Justice, a group formed this year to fight the recent San Francisco Municipal Railway fare increases.

These experiences highlight the urgency with which broad coalitions, including the public health community, must come together to solve our transportation crises. Today, chronic health conditions like heart disease, diabetes, and asthma are taking an ever-increasing toll on the health of this country, and the situation warrants the involvement of the public health community. Traditional public health dogma blames poor health on bad personal choices, such as

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overeating, sedentary lifestyles, and risky behaviors, but it takes healthy environments to create or break opportunities for healthy choices.

Transportation clearly affects health by determining access to daily necessities, as highlighted by the experiences of San Francisco's Tenderloin residents. With low car-ownership rates, access is a greater challenge for low-income communities that depend on public transportation and walking. In a study of 15 low-income Bay Area neighborhoods, 66 percent of residents had no transit access to hospitals and 48 percent could not walk to a supermarket.

Lack of transit access can have severe consequences. For instance, hospitalizations for many chronic diseases can be prevented with effective, regular, and timely care. Transit barriers—mainly cost and inadequate service—make healthcare even more unavailable to those who need it most. A Metropolitan Transportation Commission study found that Bay Area residents may not utilize medical services when they are difficult to get to. The result? Individuals may go without medications, develop more serious illnesses, and experience lengthier recovery times.

For transit-dependent populations, quality of transportation also impacts health. Lengthy transit routes with multiple transfers and long wait times translate to less time for family or leisure activities and make daily commutes stressful. Stress has a direct relationship to physical and mental health outcomes, such as depression, tiredness, parent-child bonding, and immune response. For the elderly and disabled especially, limited access to public transit creates barriers to participation in community and civic life, leading to depression and alienation.

The Tenderloin residents also viewed public transit as a means to get out of a community where they felt "penned in" by city policies that concentrated housing, poverty, and drug use in a controlled environment. But many factors prohibited them from "escaping." Among them, the cost of ridership, the humiliation of getting kicked off the bus for being unable to pay, overcrowded buses, fear of violence, and the unreliability of schedules. Participants pointed out that they often would rather walk long distances than deal with the bus. One solution proposed by the focus group was the possible extension of the disability discount to city residents with an economic disability.

These findings provide more than enough impetus for the public health community to push towards more effective and more equitable transportation policies. Innovative efforts, like those found at the Program on Health, Equity, and Sustainability at the San Francisco Department of Public Health, bring health perspectives and evidence into the work of transportation agencies and advocates, and have begun to build a shared understanding of the inextricable link among health, equity, and transportation and land use decisions. Public health practitioners ought to ensure that decision-makers consider the health benefits of transportation planning and policy-making, including the economic costs of adverse human health outcomes. They also should advocate for transportation funding priorities and policy-making that accurately reflect and address the needs of people who depend on transit the most. ■

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Race, Poverty & the Environment

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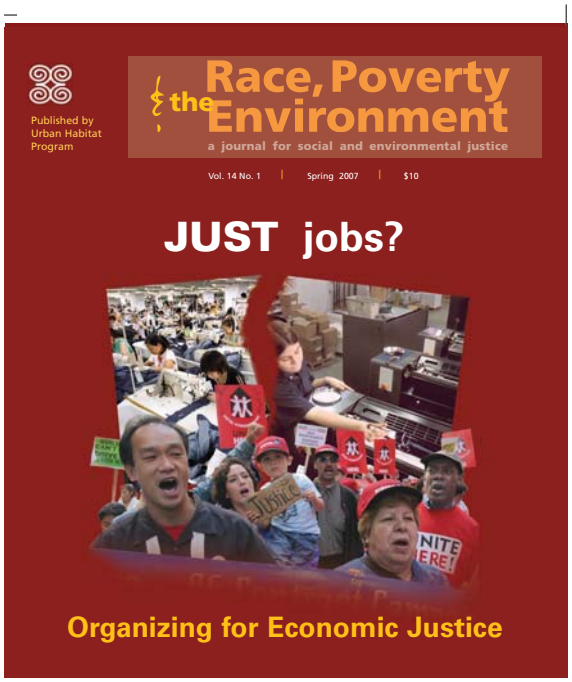

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