

Article

# The Factors Influencing Urban Health Services among Ethnic Groups in the U.S.

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**Abstract:** The purpose of this study is to conduct a non-systematic meth-analysis of a literature review by way of reviewing research that was found in any databases under the terms “urban health services” in order to document the major factors influencing urban health among minorities; and if there are any policies that promote health and prevent disease. Data from current the U.S. Bureau of Labor Statistics and the World Health Organization also provided significant findings. This study also explores the underlying conditions and root causes contributing to health inequities and the interdependent nature of the factors that create them, by drawing from existing literature and syntheses on health disparities and health inequities. Even though public services, such as health and health service provisions in urban areas may be much better than those in rural areas, it has not been proven if it is the case for less disadvantaged populations living in the urban cities. This study highlights many of the issues leading to health inequities, such as social economic status, ethnicity, and age differences. There is a need to reduce health inequities among high-middle and low-income groups by providing or equalizing health opportunities across the socioeconomic groups.

**Keywords:** access to health care; disability; urban vs rural; ethnic; minority; urban; rural

## 1. Introduction

Urbanization is one of the leading global trends that has a significant impact on health and how the urban living or rural setting influences the place of work and how much one earns, including expenditures on housing, transportation, food, clothing and other human needs. At the same time, it is significant to identify why health disparities affect millions in rural areas in the United States. According to the Bureau of Labor Statistics (LBS) [1], urban households spent an average of \$57,059 on a pre-tax income of \$71,578 compared to spending of \$45,031 on a pre-tax income of \$49,841 for rural households; about 79% of rural households owned homes compared with 61% of urban households, which suggested that housing accounted for the highest share of total spending for both urban households (33.4%) and rural households (26.8%).

Urban communities are characterized by a high burden of asthma and for children specifically, a report from Gern [2] revealed higher rates of morbidity due to asthma for those living in crowded urban neighborhoods. This is also attributed to the presence of environmental hazards, such as pollution, pest allergens, and exposure to indoor and outdoor smoke, while some other findings suggest that other factors, such as race, ethnicity, and income may have more important roles in shaping the risk of asthma in children, than their physical environment [3].

A recent report from the World Health Organization WHO [4] suggested that by 2050, over 68% of the world's population will live in the cities. The factors influencing urban health include urban governance; population characteristics; the natural and built environment; social and economic development; services and health emergency management; and food security. Major cities with a solid

economic base often provide opportunities for better health for minorities, while cities with economic challenges provide additional challenges for better health for the population, especially the minorities with lower social economic status. Major cities are actually facing major threats concerning infectious diseases like HIV/AIDS, TB, pneumonia, diarrheal diseases; non-communicable diseases like asthma, heart disease, cancer and diabetes; and violence and injuries, including road traffic injuries [4].

The percentage of the world's population living in urban areas is projected to increase to 60% by 2030 from 54% in 2015; and to 66% by 2050 (Who, 2019). The population of people living in urban areas in the United States is expected to continue to increase into the year 2050. According to WHO [4], the population of adults living in urban areas will increase to 82.5% in 2020, and then increase to 84.2% by 2030, by the year 2040, is to be increased to 85.9% and in 2050, it is projected to increase to 87.4%. The United Nations also estimates that more than 90% of future urban population growth will be in low-income and middle-income countries (LMICs) [4].

The differences in health across the population can be observed in any city, as genetic and constitutional variations ensure that the health of individuals varies and especially, older people tend to be sicker than younger people due to the natural aging process; and most likely, the differences in health inequity may be related to the fact that health is systematic because it is not distributed randomly, but shows a consistent pattern across the population as per different socioeconomic groups. Health is socially produced by differential social circumstances and is not biologically determined and therefore modifiable. In an article by Chen, Orom, Hay, Waters, Schofield, Yuelin, and Kiviniemi [5], it was found that an additional factor in the difference between rural and urban healthcare is the access and use of health information. The researchers suggested that the difference in accessibility to health knowledge could be accounted for by socioeconomic differences, which is more support for the idea that inequity does often arise from socioeconomic status. Finally, health inequity is unfair because inequity is unfair. When the ruling forces fail to take action, even in the face of inequities, it creates an unequal and unfair situation. This is especially unsettling because there are methods to reduce inequities with known intervention and failure to take action when it is avoidable and preventable is unconscionable. The WHO constitution adopted in 1946 asserted that "the highest standards of health should be within reach of all, without distinction of race, religion, political belief, economic or social condition" [6] (p. 7). Urban poverty and unhealthy living conditions are associated with health determinants and urban poverty. When communities are properly managed and resources for health are shared and used efficiently, investments in urban health can create major returns for the economy [7].

## 2. Purpose of the Study

The purpose of this research is to determine how to reduce health inequities in urban areas in the U.S. and to determine how to assist communities to identify gaps, priorities and required interventions to promote health equity and to reduce inequities in health between population groups and to provide better health and social status for people living in cities. Generally, there are differences in health across populations in any city. These differences are created by social economic status, ethnicity, and age differences. This research focus is on one question, are there inequities among people according to socioeconomic status and are there effective strategies in place for intervention to reduce inter and intra city health inequities?

There are three main approaches that can be applied to measure and tackle inequities in health and they are:

- Targeting disadvantaged population groups or **social classes**
- Narrowing the health gap
- Reducing inequities throughout the whole population

### 3. Problems

One of the main challenges of urban cities is the fast-growing populations and the demand for the limited housing, food and other resources necessary to meet basic needs, as well as placing pressure on transport systems and other forms of infrastructure. In addition, the U.S. economic crisis has deeply affected the lives of millions in America, leading to financial burdens that are associated with pay reductions, job layoffs, bankruptcies and skyrocketing foreclosures. This economic crisis plunged many families and individuals into severe economic hardships, especially those living in low-income communities. This deepening poverty is inextricably linked with rising levels of homelessness for many Americans in urban cities, as well as rural dwelling Americans [8].

Unfortunately, the deepening poverty is also affecting youth in America today. American children are also becoming homeless due to many families living below the poverty level or at the edge of poverty. It is mind boggling that about 1.4 million students between the ages of 6 to 18 experienced homelessness in the 2016–2017 school year; in 2017 alone, about 87% these children and youth were experiencing homelessness. About 15% were staying in shelters, 7% in hotels or motels and 4% were unsheltered, living outside in either abandoned buildings, cars or other places not suitable for habitation by humans [9]. Therefore, homelessness presents urban planners with numerous problems concerning policy and administration, specifically as it relates to a lack of medical healthcare coverage for the homeless, including lack of affordable housing. There are numerous reasons that often prohibit securing basic housing. These reasons include such factors, as a lack of job skills and work experience, little or no education and training, drug and alcohol abuse and mental illness [8].

The rapid expansion of low income and middle income cities increases health risks on multiple fronts and factors like pollution, road traffic congestion and lack of safe walking and cycling routes, creating limited opportunities for physical activity; all these contributed to rising health issues, including rising death rates, high risk of strokes, heart disease, cancer, respiratory illness and injuries, often due to a lack of exercise. According to WHO [4], poor urban sanitation and waste management perpetuate transmission of vector-borne and infectious diseases. Additionally, people living in substandard housing are more prone to health impacts from heat waves, and cold or extreme weather. Another problem identified by WHO [4] was the fact that many poor urban households still rely on smoky biomass and coal cook stoves whose particles are a source of indoor air pollution, as well as of emissions of black carbon that lead to a short-lived climate pollutant. Therefore, urgent action is needed.

### 4. Research Methodology

A non-systematic meta-analysis of the literature review of the research found in the major databases under the terms “urban health research” since the year 2010, was conducted in order to document the major primary reason for epidemics of non-communicable diseases (NCDs) and how new urban health initiatives can provide a model for healthy urban planning and policies. For the purposes of this article, we are using the definition for non-systematic approach provided by Huelin, Iheanacho, Payne, and Sandman, “A non-systematic literature review that is meant to be an informative, rather than all-encompassing, review of the literature on a topic. Generally takes an in-depth but not systematic approach to a specific research question” [10] (para. 7). The major groups of urban consumers, such as the retiring and the elderly are projected to generate three-quarters of global urban consumption growth by 2030. This group alone is expected to grow by more than one-third to 222 million by 2030 which will generate 51% of urban consumption growth in developed countries and 19% of global urban consumption growth [11]. The review for this study included peer-reviewed publications that studied and investigated new approaches to planning and development and they are part of references listed for this study. Articles from non-peer-reviewed publications were excluded and not listed from the review. The remaining articles were retrieved for further screening and were included in the review, as they evaluated urban health. Other bibliographies included in this research were hand-searched and therefore, no limitations were placed on study scope.

## 5. Data Extraction and Synthesis

From the over 55 articles identified from the database search, about 30 articles upon title and abstract screening were excluded. For example, Johnson [12] discusses health inequalities in regards to socioeconomic class in the U.S. and believed that America has the largest gap between the wealthy citizens and the poorer ones. Johnson [12] further believes that having health insurance for all is not going to solve the problem, even though the wealthier always have access to better healthcare. Those excluded are based on duplicate records, studies older than 10 years old, editorials, and opinion pieces. About 10 of these articles did not address urban health issues. Findings were summarized for each study according to certain criteria such as: type of data analyzed, measure of liability and risk associated with cost, study design and main findings.

## 6. Findings

Evidence revealed health disparities and differential health outcomes across and within all races and ethnicities, including the individual's ability to achieve optimal health between racial or ethnic groups, and other dimensions, such as gender, sexual orientation, age, disability status, socioeconomic status, and geographic location. It is evident that the health equity for rural communities is not as prevalent in urban and suburban communities, as rural areas strive to improve life expectancy [13]. Social dynamic process does affect health disparities in urban environments and these processes include, but are not limited to growth, purchase, preparation, consumption and sharing of food within communities that can shape how residents in urban food areas interact with food. Major cities like Chicago, Illinois; Houston, Texas; Los Angeles, California; New York, New York; and Phoenix, Arizona have the highest number of food-insecure individuals in the country [14,15].

Major issues concerning urban regions are the higher rates of violence that lead to injuries and trauma. According to Prevention Institute [16], about two-thirds of all U.S. firearm homicides occur in large urban areas, defining why inner cities are most affected by firearm homicide. Findings from Levi, et al. [17] suggested that youth violence is higher in cities, about 469 per 100,000 and less in metropolitan counties, which is about 259 per 100,000 and suburban areas around 252 per 100,000. All of these issues are the leading downstream effects of violence that is associated with chronic stress, including living in an unsafe community. Pinderhughes et al [18], indicated that in urban areas, where violence is pervasive, community-level trauma usually manifests itself with residents experiencing psychological trauma, with some exhibiting signs of Post-Traumatic Stress Disorder (PTSD). According to Pinderhughes et al [18], 35% of urban youth exposed to community violence develop PTSD and this rate is higher than that among soldiers deployed to combat. Another report from Egerter et al [19], suggested that unsafe neighborhoods can also lead to anxiety, depression, and stress, all of which are in turn associated with preterm births and low birth weight.

The data from the 2013–2015 National Health Interview Surveys compare access and use between Medicaid beneficiaries in urban and rural areas, and by disability. The results proved major findings as outlined below:

- Adults and children with Medicaid coverage in both rural and urban areas are more likely than those with private coverage and less likely than their uninsured counterparts to report barriers to care or unmet needs.
- Adults with Medicaid, regardless of whether they live in rural or urban areas, have more difficulty accessing eyeglasses, prescription drugs, and maintaining a usual source of care compared to those with private coverage, but on average, use some services, such as emergency departments more frequently.
- Medicaid beneficiaries in urban areas and those in rural areas show few differences on measures related to their difficulty accessing care or use of services.

Table 1 below distinctly outlines differences between adults with Medicaid residing in rural areas and those in urban areas. The table also suggested that adult Medicaid beneficiaries in rural areas are

more likely to report having unmet needs, prescription drugs and having more difficulty accessing transportation than those in urban areas, while these adults are less likely to be worried about paying medical bills or to have trouble getting through to a provider on the phone, than those in urban areas.

**Table 1.** Adults' difficulties accessing care in urban and rural areas by insurance status, 2013–2015.

State	Urban			Rural		
	Medicaid	Private	Uninsured	Medicaid	Private	Uninsured
Usual source of care						
Has a usual source of care	86.1%	88.9%	46.0%	85.7%	89.8%	53.8%
Unmet due to cost in the past 12 months						
Medical care	7.9	3.7 *	24.4 *	8.9	4.6 *	26.0 *
Specialist care	6.5	2.5 *	13.9 *	7.9	2.4 *	13.2 *
Eyeglasses	11.3	3.7 *	16.4 *	14.5 *	4.8 *	18.9 *
Follow up care	5.1	1.9 *	13.6 *	6.2	2.4 *	12.7 *
Prescription drugs	10.1	4.0 *	18.7 *	15.1 *	4.9 *	21.0 *
Cost concerns						
Get sick or have accident, worried about paying medical bills	49.5	44.9 *	82.8 *	44.9 *	48.3 *	79.4 *
Reason for delay in getting care in the past 12 months						
Could not get appointment soon enough	8.4	5.2 *	4.3 *	9.1	4.5 *	5.0 *
Could not get through on phone	4.7	1.8 *	2.3 *	3.4 *	1.7 *	2.2
Not open when you go	3.4	2.6 *	2.6 *	3.8	3.2	2.8
No transportation	5.5	0.5 *	2.4 *	8.8 *	0.4 *	3.3 *
Finding a doctor in the past 12 months						
Trouble finding a doctor	5.4	2.1 *	5.7	6.3	1.9 *	5.8
Doctor does not accept health insurance	7.4	2.4 *	3.3 *	7.0	1.3 *	2.9 *

Notes: \* Difference from Medicaid within the same geographic area is statistically significant at the 0.05 level; \* Difference from urban Medicaid beneficiaries is statistically significant at the 0.05 level; Source: Reprinted from Access in brief: Rural and urban health care (October 2018), MACPAC 2018 analysis of 2013–2015 (Table 4).

In the area of access to services, adult Medicaid beneficiaries in both urban and rural areas are more likely to use all services, compared to those who are uninsured. Table 2 below fully suggested that among Medicaid beneficiaries, rural residents are more likely to visit the emergency department or any health professional, but less likely to visit an OB/GYN or dentist than urban residents. Uninsured adults in both rural and urban areas are less likely to have any visits to a general doctor, the dentist or the emergency room.

Another major contributing factor to urban health is the impact of changing demographics on consumption which suggests that as population growth slows, growth in urban consumption will increasingly depend on each individual spending. Additionally, as incomes rise and population's age, the weight of consumption will shift toward services leading to dependence on innovative and efficiently delivered services [20].

The data from the Consumer Price Index program, which is not seasonally adjusted, were employed to further review and analyze the results in order to provide a concise summary of the report presented from the U.S. Bureau of Labor Statistics [20]. The 2018 consumer expenditures average per consumer unit was \$61,224; this is a 1.9% increase from 2017; and during the same period, the consumer price index (CPI-U) rose to 2.4% and the average pretax income increased by 6.9%. From December 2017 to December 2018, the Consumer Price Index for All Urban Consumers (CPI-U) rose 1.9 percent. Consumer prices rose 2.1 percent in both 2016 and 2017. Table 3 below is a breakdown of changes in the consumer price index for all urban consumers, using selected items that are not seasonally adjusted.

**Table 2.** Access to health care among adults age 19–64 with a disability in urban and rural areas by insurance status, 2013–2015.

State	Urban			Rural		
	Medicaid	Private	Uninsured	Medicaid	Private	Uninsured
Usual source of care						
Has a usual source of care	87.7%	91.5% *	52.7% *	86.80%	93.8% *	60.7% *
Unmet due to cost in the past 12 months						
Medical care	11.8	9.5 *	43.3 *	11.4	10.4	46.2 *
Specialist care	11.3	7.1 *	31.8 *	10.8	6.9 *	29.2 *
Eyeglasses	17.9	10.1 *	35.4 *	18.3	13.0 *	38.1 *
Follow up care	8.7	5.8 *	29.1 *	8.1	6.1	27.3 *
Prescription drugs	16.8	10.8 *	38.3 *	20.0 *	12.5 *	41.6 *
Cost concerns						
Get sick or have accident, worried about paying medical bills	48.9	56.5 *	89.1 *	46.7	60.7 *	87.0 *
Reason for delay in getting care in the past 12 months						
Could not get appointment soon enough	12.6	10.8 *	9.7 *	10.4	9.7	10.8
Could not get through on phone	8.2	3.9 *	4.7 *	3.6 *	4.2	4.3
Not open when you go	5.3	5.1	6.0	4.5	6.3	5.3
No transportation	10.2	1.6 *	5.7 *	12.8	1.5 *	7.2 *
Finding a doctor in the past 12 months						
Trouble finding a doctor	8.7%	4.1% *	12.2% *	6.6%	3.8% *	10.9% *
Doctor does not accept health insurance	11.2	4.9 *	6.3 *	7.1 *	2.2 *	5.0

Notes: \* Difference from Medicaid within the same geographic area is statistically significant at the 0.05 level; \* Difference from urban Medicaid beneficiaries is statistically significant at the 0.05 level; Source: Reprinted from Access in brief: Rural and urban health care (October 2018), MACPAC 2018 analysis of 2013–2015 (Table 5).

The report from the bureau of Labor Statistics [21] also provided the following conclusions that Food prices increased by 1.6% from December 2017 to December 2018 and prices for food at home rose 0.6% in 2018, after rising 0.9% in 2017. Consumer prices rose for four of the six major grocery store food groups between 2017 and 2018, while prices declined over the year in the other two groups. Prices for fruits and vegetables rose 1.6% in 2018, after rising 1.5% in 2017. Prices for cereals and bakery products increased 1.7% in 2018, while prices for nonalcoholic beverages and beverage materials increased 1.4%. Prices for other food at home increased 0.2% in 2018.

Meats, poultry, fish, and eggs prices fell 0.4% in 2018, following a 2.8% increase in 2017 while prices for dairy and related products fell 0.1% in 2018, and this is fourth straight yearly decline. There is also a decrease in energy prices by 0.3% in 2018, and also, this is after a 6.9% increase in 2017. Gasoline prices decreased 2.1% in 2018, following a 10.7% increase in 2017. Prices for natural gas increased for the third straight year in 2018, rising 2.3%, compared with 4.7% in 2017. Prices for electricity increased 1.1% in 2018, after rising 2.6% in 2017. There is also a jump in medical care prices which increased to 2.0% in 2018, following a 1.8% increase in 2017 while prescription drug prices fell 0.6% in 2018. However, prices rose to 3.7% for hospital services and 0.6% for physicians' services.

**Table 3.** Twelve-month percentage change in the Consumer Price Index for All Urban Consumers, selected items, not seasonally adjusted.

Item	December 2015 to December 2016	December 2016 to December 2017	December 2017 to December 2018
All items	2.1%	2.1%	1.9%
Motor vehicle insurance	7.0	7.9	4.6
Hospital services	4.4	5.1	3.7
Tobacco and smoking products	3.6	6.5	3.4
Shelter	3.6	3.2	3.2
Food away from home	2.3	2.5	2.8
Education	2.7	2.0	2.6
Utility (piped) gas service	7.8	4.7	2.3
All items less food and energy	2.2	1.8	2.2
Household furnishings and operations	−1.1	−0.8	2.1
Medical care	4.1	1.8	2.0
Alcoholic beverages	1.4	1.4	1.8
Personal care	1.7	0.9	1.8
Cereals and bakery products	−0.7	−0.6	1.7
Fruits and vegetables	−2.4	1.5	1.6
Food	−0.2	1.6	1.6
Nonalcoholic beverages and beverage materials	−0.9	0.0	1.4
Used cars and trucks	−3.5	−1.0	1.4
Recreation	0.8	1.5	1.2
Electricity	0.7	2.6	1.1
Food at home	−2.0	0.9	0.6
Physicians' services	3.8	−1.8	0.6
Other food at home	−0.3	0.5	0.2
Apparel	−0.1	−1.6	−0.1
Dairy and related products	−1.3	−0.5	−0.1
New vehicles	0.3	−0.5	−0.3
Energy	5.4	6.9	−0.3
Meats, poultry, fish, and eggs	−5.4	2.8	−0.4
Prescription drugs	6.2	2.8	−0.6
Communication	−2.6	−4.9	−1.8
Airline fares	−4.7	−4.0	−2.6

Notes: Reprinted from U.S. Bureau of Labor Statistics consumer price index for all urban consumers.

## 7. Conclusions

Urban health is fundamental to economic growth and provides opportunity for stakeholders in urban planning, governance and finance to find ways to incorporate health as a central consideration in the decision-making process. According to the WHO [22,23] report, expected health impacts should be assessed during the development of urban policies and to ensure that health outcomes and equity are the attainment of the highest level of health for all people; and to be used as key indicators in monitoring the impact of those policies that will lead to achieving the ultimate goals for success.

Access to healthcare is another factor reviewed in the study and the review of the latest data revealed that people living in the rural areas are more likely to have Medicaid coverage compared to those living in the urban areas. Finally, physicians in rural areas are more likely to accept new Medicaid patients than those in urban areas [24]. The makeup of Medicaid coverages among adults and children populations can be seen along racial makeup lines. This has a negative effect on poor children. For example, there are significant differences in the racial makeup of adults /children with Medicaid compared to those with private insurance in urban and rural areas. Adults/children with Medicaid are less likely to be non-Hispanic white and more likely to be Hispanic or non-Hispanic black than their privately insured counterparts in both urban and rural areas [25].

In most cases, more people lived in cities and towns than in rural areas and providing accessibility and improving health, education and social services should be a priority. However, promoting health

equity in cities may be challenging when determining how to facilitate policy-making and prioritization of interventions. Even though the differences in health across the population can be observed in any city, older people tend to be sicker than younger people, due to the natural aging process and differences in health accessibility are systematic, socially produced, and unfair. The differential social circumstances differ to a certain degree and are a leading factor that may affect their access to healthcare coverage.

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