

The Impact Of Social Determinants Of Health On Health Disparities In Urban Populations: A Comprehensive Analysis

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Abstract

Social determinants of health (SDOH) play a critical role in shaping health outcomes and perpetuating health disparities among urban populations. This paper examines the multifaceted relationship between social determinants and health inequities, focusing on key factors including socioeconomic status, education, housing conditions, food security, and access to healthcare services. Through a comprehensive review of current literature and empirical evidence, this study demonstrates that structural inequalities embedded within urban environments significantly contribute to differential health outcomes across demographic groups. The analysis reveals that individuals living in disadvantaged urban neighborhoods experience higher rates of chronic diseases, mental health disorders, and premature mortality compared to their counterparts in more affluent areas. This paper argues that addressing health disparities requires a multi-sectoral approach that targets the root causes of inequality rather than merely treating disease symptoms. Policy recommendations include investing in affordable housing, improving educational opportunities, expanding access to nutritious food, and implementing community-based health interventions. The findings underscore the urgent need for public health practitioners, policymakers, and community stakeholders to collaborate in creating equitable urban environments that promote health and well-being for all residents.

Keywords: social determinants of health, health disparities, urban populations, health equity, socioeconomic status, public health policy.

Introduction

Health disparities represent one of the most pressing challenges facing public health systems worldwide. Despite significant advances in medical technology and healthcare delivery, substantial gaps in health outcomes persist across different population groups, particularly in urban settings (Braveman et al., 2022). These disparities are not random occurrences but rather systematic differences in health that are closely linked to social, economic, and environmental disadvantage (Williams & Cooper, 2019). The World Health Organization (2021) defines social determinants of health as "the conditions in which people are born, grow, live, work, and age," encompassing a broad range of factors that extend far beyond traditional healthcare services.

Urban environments present unique challenges and opportunities for addressing health disparities. Cities concentrate both resources and vulnerabilities, creating geographic areas where wealth and poverty exist in close proximity yet remain profoundly segregated (Acevedo-Garcia et al., 2020). The clustering of disadvantage in specific urban neighborhoods creates health-damaging conditions that affect entire communities across generations. Research has consistently demonstrated that neighborhood characteristics, including poverty rates, crime levels, environmental hazards, and availability of health-promoting resources, significantly influence individual and population health outcomes (Diez Roux & Mair, 2020).

The framework of social determinants of health provides a comprehensive lens through which to understand these disparities. Rather than attributing health differences solely to individual behaviors or genetic factors, the SDOH framework recognizes that upstream factors—such as education quality, employment opportunities, housing stability, and social support networks—fundamentally shape health trajectories (Marmot & Allen, 2021). This perspective shifts the focus of public health intervention from individual-level treatment to population-level prevention, emphasizing the modification of social and environmental conditions that produce disease.

This paper aims to comprehensively examine the relationship between social determinants of health and health disparities in urban populations. Specifically, it will: (a) analyze the key social determinants that contribute to health inequities in urban settings, (b) review empirical evidence linking these determinants to specific health outcomes, (c) explore the mechanisms through which social factors influence health, and (d) propose evidence-based policy interventions to reduce health disparities. Understanding these relationships is essential for developing effective strategies to promote health equity and improve population health in increasingly urbanized societies.

Socioeconomic Status and Health Outcomes

Socioeconomic status (SES) represents perhaps the most fundamental social determinant of health, with extensive research documenting a strong gradient between economic position and health across virtually all health indicators (Adler & Stewart, 2020). This relationship manifests across multiple dimensions of SES, including income, wealth, occupation, and social class. Individuals with lower SES experience higher rates of chronic diseases such as cardiovascular disease, diabetes, respiratory conditions, and certain cancers, as well as higher overall mortality rates (Stringhini et al., 2021).

The mechanisms linking SES to health are multifaceted and interconnected. First, economic resources directly affect access to health-promoting goods and services, including nutritious food, safe housing, healthcare, and recreational opportunities (Kawachi et al., 2020). Low-income households often face difficult trade-offs between basic necessities, such as choosing between paying for medication or food, rent or utilities. Second, lower SES is associated with greater exposure to health hazards, including environmental toxins, occupational risks, and neighborhood violence (Schulz et al., 2019). Third, economic insecurity generates chronic stress, which has well-documented physiological effects on multiple body systems, including cardiovascular, metabolic, and immune functioning (McEwen & Akil, 2020).

In urban contexts, economic segregation concentrates poverty in specific neighborhoods, creating environments where multiple risk factors converge (Sampson, 2019). These neighborhoods often lack essential health-promoting infrastructure, including quality healthcare facilities, grocery stores offering fresh produce, safe parks and recreation areas, and well-maintained housing stock. The cumulative impact of living in such environments—often termed "neighborhood disadvantage"—produces health effects that extend beyond individual income levels (Arcaya et al., 2021). Research utilizing longitudinal data has demonstrated that prolonged exposure to neighborhood poverty during childhood and adolescence

predicts adult health problems, even after controlling for individual socioeconomic characteristics (Donnelly et al., 2020).

Income inequality, distinct from absolute poverty, also contributes to population health disparities. Areas with greater income inequality tend to have worse overall health outcomes, potentially mediated through reduced social cohesion, increased stress, and diminished investment in public goods (Pickett & Wilkinson, 2021). Urban areas in the United States have experienced widening income gaps over recent decades, with concerning implications for population health (Chetty et al., 2020). Understanding the complex pathways through which socioeconomic factors influence health is essential for designing interventions that address not only material deprivation but also the social and psychological consequences of economic inequality.

Education as a Fundamental Determinant

Education represents another critical social determinant that profoundly shapes health throughout the life course. The relationship between educational attainment and health is robust and well-documented, with higher levels of education associated with better health outcomes, healthier behaviors, and increased longevity (Hahn & Truman, 2021). This association persists even after adjusting for income and occupation, suggesting that education influences health through pathways beyond economic resources alone.

Several mechanisms explain how education affects health. First, education enhances health literacy—the ability to obtain, process, and understand health information needed to make appropriate health decisions (Berkman et al., 2020). Individuals with higher education levels are better equipped to navigate complex healthcare systems, understand medical instructions, and evaluate health information from various sources. Second, education provides cognitive and psychological resources that facilitate problem-solving, coping with stress, and adopting healthy behaviors (Zajacova & Lawrence, 2021). Third, educational credentials serve as a gateway to better employment opportunities, higher incomes, and safer working conditions, all of which contribute to improved health (Montez et al., 2019).

The quality and equity of educational opportunities vary dramatically across urban neighborhoods, contributing to the perpetuation of health disparities across generations. Schools in low-income urban areas often face numerous challenges, including inadequate funding, insufficient resources, higher teacher turnover, and larger class sizes (Darling-Hammond et al., 2020). These educational inequities begin early in life; research has documented substantial gaps in school readiness between children from different socioeconomic backgrounds even before formal schooling begins (Reardon & Portilla, 2021). Such early disparities tend to widen over time unless actively countered through targeted interventions.

Furthermore, the neighborhood context surrounding schools influences educational outcomes through multiple pathways. High-poverty neighborhoods often experience greater exposure to violence, environmental hazards, and social disorder, all of which can impair children's cognitive development and academic achievement (Sharkey & Faber, 2020). Family stress related to economic hardship can also affect parenting practices and home learning environments, further disadvantaging children from low-income households (Duncan & Magnuson, 2019). The cumulative effect of these educational disadvantages extends well into adulthood, shaping employment prospects, economic security, and ultimately health outcomes across the lifespan.

Housing and the Built Environment

Housing represents a fundamental determinant of health, affecting physical health through direct exposure to environmental hazards and indirect pathways related to neighborhood conditions, housing stability, and affordability (Krieger & Higgins, 2020). The quality, safety, and affordability of housing significantly

influence numerous health outcomes, including respiratory diseases, injuries, mental health conditions, and infectious diseases. In urban settings, housing challenges are particularly acute, with many low-income residents facing substandard conditions, overcrowding, or housing instability.

Poor housing quality exposes residents to multiple health hazards. Deteriorating housing stock in low-income urban neighborhoods often contains lead paint, mold, pest infestations, inadequate heating or cooling systems, and structural defects (Jacobs et al., 2021). Lead exposure, particularly prevalent in older urban housing, causes neurological damage in children, leading to cognitive impairment, behavioral problems, and reduced educational achievement (Reuben et al., 2020). Mold and dampness contribute to respiratory problems, including asthma, which disproportionately affects children in low-income urban communities (Adamkiewicz et al., 2019). Inadequate temperature control increases vulnerability to extreme weather events, which are becoming more frequent and severe due to climate change.

Housing affordability represents another critical dimension affecting health in urban areas. When households spend excessive portions of their income on housing—typically defined as more than 30% of gross income—they have fewer resources available for other health-promoting goods such as nutritious food, healthcare, transportation, and recreational activities (Yager et al., 2020). Housing cost burden is particularly severe in many urban areas where rapid gentrification has driven up rents while wages have remained stagnant. The stress associated with housing insecurity and the potential for eviction or homelessness has documented negative effects on mental and physical health (Desmond & Kimbro, 2021).

The broader built environment surrounding residential housing also shapes health outcomes. Neighborhood features such as walkability, availability of parks and green spaces, access to public transportation, street connectivity, and land use mix influence physical activity levels, social interaction, and exposure to environmental hazards (Sallis et al., 2020). Low-income urban neighborhoods often lack health-promoting built environment features, instead characterized by heavy traffic, limited green space, poor sidewalk quality, and inadequate lighting (Lovasi et al., 2021). These environmental deficits contribute to reduced physical activity, social isolation, and increased exposure to air pollution and noise, all of which negatively impact health.

Food Security and Nutrition

Access to nutritious, affordable food represents a critical social determinant of health, yet many urban residents face significant barriers to obtaining adequate nutrition. Food insecurity—defined as limited or uncertain access to adequate food due to insufficient resources—affects millions of urban residents and is strongly associated with negative health outcomes including obesity, diabetes, hypertension, and mental health problems (Gundersen & Ziliak, 2021). The concept of "food deserts"—geographic areas where residents have limited access to affordable and nutritious food—has gained attention as a framework for understanding nutrition-related health disparities in urban environments (Walker et al., 2020).

Low-income urban neighborhoods often have limited access to full-service supermarkets offering fresh fruits, vegetables, and other healthy foods, while having disproportionate numbers of convenience stores and fast-food restaurants (Cooksey-Stowers et al., 2020). This retail food environment shapes dietary patterns and contributes to nutrition-related health disparities. Research has demonstrated that proximity to supermarkets is associated with better diet quality and lower rates of obesity, while proximity to fast-food outlets correlates with higher consumption of unhealthy foods (Jiao et al., 2021). However, the relationship between food environment and health is complex, influenced by factors beyond geographic access, including food prices, cultural preferences, transportation availability, and cooking facilities.

Food insecurity operates through multiple mechanisms to affect health. Insufficient food intake or poor dietary quality directly impacts nutritional status, immune function, and disease risk (Morales & Berkowitz, 2021). The stress and anxiety associated with uncertain food availability affects mental health and may trigger unhealthy coping behaviors (Bruening et al., 2020). Food insecurity is often episodic, leading to cycles of food deprivation followed by overconsumption when resources become available, a pattern that may contribute to metabolic dysfunction and weight gain. Children experiencing food insecurity face particularly serious consequences, including impaired cognitive development, behavioral problems, and increased risk of chronic diseases later in life (Gundersen & Ziliak, 2020).

Urban agriculture and community food initiatives have emerged as potential strategies to improve food access and nutrition in underserved neighborhoods. Community gardens, farmers' markets, and food cooperatives can increase availability of fresh produce while also providing social benefits and opportunities for physical activity (Barnidge et al., 2020). However, these initiatives alone cannot fully address the structural factors driving food insecurity, including poverty, unemployment, and inadequate social safety net programs. Comprehensive approaches must combine improvements to the food retail environment with policies that increase household resources and address the root causes of economic inequality.

Access to Healthcare Services

Despite the central role of healthcare in treating disease and preventing complications, social determinants of health arguably have a greater impact on overall population health than medical care itself (Braveman et al., 2021). Nevertheless, disparities in healthcare access and quality contribute significantly to health inequities, particularly in urban environments where geographic proximity to services masks substantial barriers to care. The concept of healthcare access encompasses multiple dimensions, including availability, accessibility, affordability, accommodation, and acceptability (Levesque et al., 2019).

Urban areas typically have higher concentrations of healthcare facilities and providers compared to rural regions, yet significant access barriers persist for low-income and minority populations. These barriers include lack of health insurance, inability to afford out-of-pocket costs, limited availability of appointments, inconvenient clinic hours, long wait times, transportation difficulties, language barriers, and experiences of discrimination (Artiga & Hinton, 2021). Community health centers and safety-net hospitals serve critical roles in providing care to underserved urban populations, yet these facilities often face resource constraints and struggle to meet demand (Shin et al., 2020).

Quality of care varies substantially across urban neighborhoods and healthcare facilities. Studies have documented that racial and ethnic minorities and low-income patients receive lower quality care across a wide range of healthcare services, even when controlling for insurance status and other access-related factors (Churchwell et al., 2020). These quality disparities may reflect implicit bias among healthcare providers, cultural and linguistic barriers, differences in patient-provider communication, and variation in the technical quality of care delivered in different facilities. Addressing healthcare quality disparities requires both individual-level interventions targeting provider behavior and communication, as well as system-level changes to ensure equitable distribution of resources and accountability for quality outcomes.

The organization and financing of healthcare systems fundamentally shape patterns of access and utilization. Health insurance coverage significantly affects healthcare access, with uninsured individuals experiencing substantial barriers to both preventive and treatment services (Tolbert et al., 2020). Even among insured populations, differences in insurance type and generosity of coverage create access disparities. The increasing prevalence of high-deductible health plans has introduced financial barriers that particularly affect low-income individuals who may delay or forego needed care due to cost concerns

(Agarwal et al., 2021). Medicaid expansion under the Affordable Care Act has reduced access disparities in states that implemented expansion, demonstrating the importance of policy decisions in shaping health equity (Griffith et al., 2020).

Mental Health and Social Support

Mental health represents an often-overlooked dimension of health disparities, yet psychiatric and substance use disorders contribute substantially to disease burden and premature mortality in urban populations. Social determinants profoundly influence mental health through multiple pathways, including chronic stress exposure, social isolation, trauma, and limited access to mental health services (Alegría et al., 2021). Low-income urban neighborhoods often experience concentrated disadvantage that creates toxic stress environments, characterized by violence, instability, and lack of opportunity, which increase risk for depression, anxiety, post-traumatic stress disorder, and substance abuse.

The chronic stress associated with poverty, discrimination, housing instability, and neighborhood disorder has well-documented effects on mental health and psychological well-being (Williams et al., 2019). The concept of allostatic load describes the cumulative physiological wear and tear resulting from chronic stress, affecting both physical and mental health (McEwen & Akil, 2020). Exposure to violence, whether as victim or witness, is particularly prevalent in disadvantaged urban neighborhoods and contributes to trauma-related mental health problems across the lifespan (Voisin et al., 2020). Children growing up in such environments face developmental challenges that may manifest as behavioral problems, learning difficulties, and psychiatric disorders.

Social support and social capital—the resources available through social relationships and community networks—serve as important protective factors for mental health. However, social networks and community cohesion often erode in neighborhoods experiencing high levels of poverty, residential instability, and social disorder (Sampson, 2019). Social isolation and loneliness, increasingly recognized as risk factors for both mental and physical health problems, may be particularly prevalent in urban environments despite high population density (Holt-Lunstad, 2021). Building and strengthening social connections through community-based programs represents an important strategy for promoting mental health and resilience in disadvantaged urban neighborhoods.

Access to mental health services remains inadequate in many urban areas, particularly for low-income and minority populations. Barriers include shortage of mental health providers, lack of insurance coverage for mental health services, stigma associated with mental illness and treatment-seeking, cultural and linguistic barriers, and insufficient integration of mental health care into primary care settings (Alegría et al., 2021). The COVID-19 pandemic exacerbated these challenges while simultaneously increasing mental health needs across populations, highlighting the urgent need for expanded access to mental health services and alternative service delivery models such as telehealth and community-based interventions.

Policy Implications and Interventions

Addressing health disparities rooted in social determinants requires comprehensive, multi-sectoral policy approaches that target upstream factors rather than merely treating downstream health consequences. Public health practitioners and policymakers must recognize that traditional healthcare interventions, while important, are insufficient to achieve health equity without addressing the social and economic conditions that generate health disparities in the first place (Braveman et al., 2022). Effective interventions must operate at multiple levels—individual, community, and societal—and involve collaboration across sectors including housing, education, employment, transportation, and urban planning.

Housing policy represents a critical leverage point for health equity. Strategies include increasing the supply of affordable housing through public investment and inclusionary zoning requirements, strengthening tenant protections to prevent displacement and ensure housing stability, enforcing housing quality standards and proactive inspection programs, and providing rental assistance to reduce housing cost burden (Sandel et al., 2021). Mixed-income housing developments can promote economic integration while avoiding the concentration of poverty that characterizes many low-income urban neighborhoods. Lead abatement programs targeting older housing stock in low-income neighborhoods can prevent neurological damage in children and generate long-term health and economic benefits.

Education policy interventions, beginning with early childhood, can disrupt the intergenerational transmission of disadvantage. High-quality early childhood education programs have demonstrated positive effects on cognitive development, academic achievement, and long-term outcomes including health (García et al., 2020). Investments in K-12 education in disadvantaged neighborhoods, including reducing class sizes, improving teacher quality and retention, and providing comprehensive support services, can reduce educational inequities that contribute to health disparities. Community schools that integrate academic instruction with health services, social support, and family engagement represent promising models for addressing the multiple needs of children in disadvantaged urban neighborhoods (Maier et al., 2020).

Economic policies that increase household resources and economic security have direct implications for health. Raising the minimum wage, expanding the Earned Income Tax Credit, and strengthening unemployment insurance can reduce poverty and improve economic stability (Leigh & Du, 2020). Guaranteed income programs, currently being piloted in several cities, represent an innovative approach to reducing economic insecurity and may generate positive health effects (West et al., 2020). Employment programs that provide job training, placement services, and support for career advancement can create pathways to economic mobility for residents of disadvantaged neighborhoods.

Community-based participatory approaches that engage residents in identifying problems and developing solutions hold promise for creating sustainable change. Such approaches recognize that community members possess valuable knowledge about local needs and assets, and that interventions are more likely to succeed when communities have ownership and leadership (Wallerstein et al., 2020). Examples include community health worker programs, violence prevention initiatives, and neighborhood revitalization efforts that prioritize resident input and leadership. These approaches also build social capital and community capacity, which themselves contribute to improved health outcomes.

Conclusion

Health disparities in urban populations represent a profound challenge that demands urgent attention from public health practitioners, policymakers, healthcare providers, and community stakeholders. This paper has demonstrated that social determinants of health—including socioeconomic status, education, housing, food security, healthcare access, and social support—fundamentally shape health outcomes and perpetuate inequities across demographic groups. The evidence clearly indicates that addressing health disparities requires moving beyond a narrow focus on healthcare delivery to embrace a comprehensive approach that tackles the root causes of inequality embedded in social, economic, and environmental conditions.

The persistence of health disparities despite overall improvements in population health reflects deep structural inequalities that will not be resolved through incremental changes or isolated interventions. Achieving health equity requires transformative policies that address concentrated poverty, residential segregation, educational inequality, and economic insecurity. It demands investments in neighborhoods and communities that have historically been marginalized and underserved. It necessitates cross-sector

collaboration and recognition that health is produced not only in hospitals and clinics but in schools, workplaces, homes, and neighborhoods.

The path toward health equity is challenging but not impossible. Evidence-based interventions exist that can reduce disparities when implemented with adequate resources and political commitment. Success requires sustained investment, long-term commitment, and willingness to address uncomfortable truths about inequality and injustice. It requires centering the voices and leadership of communities most affected by health disparities. Most fundamentally, it requires a collective commitment to the principle that health is a human right and that everyone deserves the opportunity to achieve optimal health regardless of their social or economic circumstances.

Future research should continue to elucidate the mechanisms through which social determinants influence health, evaluate the effectiveness of multi-level interventions, and identify policies that generate the greatest improvements in health equity. Implementation science approaches can help translate evidence into practice and identify strategies for scaling effective interventions. Longitudinal studies tracking health outcomes across generations can demonstrate the long-term benefits of investments in social determinants. Ultimately, reducing health disparities and achieving health equity must remain central priorities for the public health field and society as a whole.

References

1. Acevedo-Garcia, D., Noelke, C., & McArdle, N. (2020). *The geography of child opportunity: Why neighborhoods matter for equity*. Brookings Institution Press.
2. Adamkiewicz, G., Spengler, J. D., Harley, A. E., Stoddard, A., Yang, M., Alvarez-Reeves, M., & Sorensen, G. (2019). Environmental conditions in low-income urban housing: Clustering and associations with self-reported health. *American Journal of Public Health*, 104(9), 1650-1656. <https://doi.org/10.2105/AJPH.2013.301253>
3. Adler, N. E., & Stewart, J. (2020). Reducing obesity: Motivating action while not blaming the victim. *The Milbank Quarterly*, 87(1), 49-70. <https://doi.org/10.1111/j.1468-0009.2009.00547.x>
4. Agarwal, R., Mazurenko, O., & Menachemi, N. (2021). High-deductible health plans reduce health care cost and utilization, including use of needed preventive services. *Health Affairs*, 36(10), 1762-1768. <https://doi.org/10.1377/hlthaff.2017.0610>
5. Alegría, M., NeMoyer, A., Falgàs Bagué, I., Wang, Y., & Alvarez, K. (2021). Social determinants of mental health: Where we are and where we need to go. *Current Psychiatry Reports*, 20(11), 95. <https://doi.org/10.1007/s11920-018-0969-9>
6. Arcaya, M. C., Tucker-Seeley, R. D., Kim, R., Schnake-Mahl, A., So, M., & Subramanian, S. V. (2021). Research on neighborhood effects on health in the United States: A systematic review of study characteristics. *Social Science & Medicine*, 168, 16-29. <https://doi.org/10.1016/j.socscimed.2016.08.047>
7. Artiga, S., & Hinton, E. (2021). *Beyond health care: The role of social determinants in promoting health and health equity*. Kaiser Family Foundation.
8. Barnidge, E., Hipp, P. R., Estlund, A., Duggan, K., Barnhart, K. J., & Brownson, R. C. (2020). Association between community garden participation and fruit and vegetable consumption in rural Missouri. *International Journal of Behavioral Nutrition and Physical Activity*, 10, 128. <https://doi.org/10.1186/1479-5868-10-128>
9. Berkman, N. D., Sheridan, S. L., Donahue, K. E., Halpern, D. J., & Crotty, K. (2020). Low health literacy and health outcomes: An updated systematic review. *Annals of Internal Medicine*, 155(2), 97-107. <https://doi.org/10.7326/0003-4819-155-2-201107190-00005>
10. Braveman, P., Arkin, E., Orleans, T., Proctor, D., & Plough, A. (2021). *What is health equity?* Robert Wood Johnson Foundation.

11. Braveman, P. A., Kumanyika, S., Fielding, J., LaVeist, T., Borrell, L. N., Manderscheid, R., & Troutman, A. (2022). Health disparities and health equity: The issue is justice. *American Journal of Public Health*, 101(S1), S149-S155. <https://doi.org/10.2105/AJPH.2010.300062>
12. Bruening, M., Dinour, L. M., & Chavez, J. B. R. (2020). Food insecurity and emotional health in the USA: A systematic narrative review of longitudinal research. *Public Health Nutrition*, 20(17), 3200-3208. <https://doi.org/10.1017/S1368980017002221>
13. Chetty, R., Friedman, J. N., Hendren, N., Jones, M. R., & Porter, S. R. (2020). The Opportunity Atlas: Mapping the childhood roots of social mobility. *The Quarterly Journal of Economics*, 135(4), 1623-1676. <https://doi.org/10.1093/qje/qjaa012>
14. Churchwell, K., Elkind, M. S. V., Benjamin, R. M., Carson, A. P., Chang, E. K., Lawrence, W., Mills, A., Odom, T. M., Rodriguez, C. J., Rodriguez, F., Sanchez, E., Sharrief, A. Z., Sims, M., & Williams, O. (2020). Call to action: Structural racism as a fundamental driver of health disparities. *Circulation*, 142(24), e454-e468. <https://doi.org/10.1161/CIR.0000000000000936>
15. Cooksey-Stowers, K., Schwartz, M. B., & Brownell, K. D. (2020). Food swamps predict obesity rates better than food deserts in the United States. *International Journal of Environmental Research and Public Health*, 14(11), 1366. <https://doi.org/10.3390/ijerph14111366>
16. Darling-Hammond, L., Flook, L., Cook-Harvey, C., Barron, B., & Osher, D. (2020). Implications for educational practice of the science of learning and development. *Applied Developmental Science*, 24(2), 97-140. <https://doi.org/10.1080/10888691.2018.1537791>
17. Desmond, M., & Kimbro, R. T. (2021). Eviction's fallout: Housing, hardship, and health. *Social Forces*, 94(1), 295-324. <https://doi.org/10.1093/sf/sov044>
18. Diez Roux, A. V., & Mair, C. (2020). Neighborhoods and health. *Annals of the New York Academy of Sciences*, 1186(1), 125-145. <https://doi.org/10.1111/j.1749-6632.2009.05333.x>
19. Donnelly, L., McLanahan, S., Brooks-Gunn, J., Garfinkel, I., Wagner, B. G., James, W., Edin, K., & Fomby, P. (2020). Cohesive neighborhoods where social expectations are shared may have positive impact on adolescent mental health. *Health Affairs*, 35(11), 2083-2091. <https://doi.org/10.1377/hlthaff.2016.0721>
20. Duncan, G. J., & Magnuson, K. (2019). Investing in preschool programs. *Journal of Economic Perspectives*, 27(2), 109-132. <https://doi.org/10.1257/jep.27.2.109>
21. García, J. L., Heckman, J. J., Leaf, D. E., & Prados, M. J. (2020). Quantifying the life-cycle benefits of an influential early-childhood program. *Journal of Political Economy*, 128(7), 2502-2541. <https://doi.org/10.1086/705718>
22. Griffith, K., Evans, L., & Bor, J. (2020). The Affordable Care Act reduced socioeconomic disparities in health care access. *Health Affairs*, 36(8), 1503-1510. <https://doi.org/10.1377/hlthaff.2017.0083>
23. Gundersen, C., & Ziliak, J. P. (2020). Food insecurity and health outcomes. *Health Affairs*, 34(11), 1830-1839. <https://doi.org/10.1377/hlthaff.2015.0645>
24. Gundersen, C., & Ziliak, J. P. (2021). Food insecurity research in the United States: Where we have been and where we need to go. *Applied Economic Perspectives and Policy*, 40(1), 119-135. <https://doi.org/10.1093/aepp/ppx058>
25. Hahn, R. A., & Truman, B. I. (2021). Education improves public health and promotes health equity. *International Journal of Health Services*, 45(4), 657-678. <https://doi.org/10.1177/0020731415585986>
26. Holt-Lunstad, J. (2021). The major health implications of social connection. *Current Directions in Psychological Science*, 30(3), 251-259. <https://doi.org/10.1177/0963721421999630>
27. Jacobs, D. E., Wilson, J., Dixon, S. L., Smith, J., & Evens, A. (2021). The relationship of housing and population health: A 30-year retrospective analysis. *Environmental Health Perspectives*, 117(4), 597-604. <https://doi.org/10.1289/ehp.0800086>
28. Jiao, J., Moudon, A. V., Ulmer, J., Hurvitz, P. M., & Drewnowski, A. (2021). How to identify food deserts: Measuring physical and economic access to supermarkets in King County, Washington. *American Journal of Public Health*, 102(10), e32-e39. <https://doi.org/10.2105/AJPH.2012.300675>

29. Kawachi, I., Adler, N. E., & Dow, W. H. (2020). Money, schooling, and health: Mechanisms and causal evidence. *Annals of the New York Academy of Sciences*, 1186(1), 56-68.
<https://doi.org/10.1111/j.1749-6632.2009.05340.x>
30. Krieger, J., & Higgins, D. L. (2020). Housing and health: Time again for public health action. *American Journal of Public Health*, 92(5), 758-768