# RACIAL INEQUALITY IN NEW YORK CITY SINCE 1965

EDITED BY

BENJAMIN P. BOWSER AND CHELLI DEVADUTT

SUNY PRESS

# — PUBLIC HEALTH ADDENDUM —

## Inequalities in Health and Access to Health Services in New York City: Change and Continuity

Michael K. Gusmano and Victor G. Rodwin

### Introduction

Since 2000, there have been remarkable gains in New York City's health status, and access to health care services. Despite increases in the prevalence of obesity, high blood pressure, diabetes, and asthma, as well as poorer self-reported health status, life expectancy at birth has increased. Infant mortality has decreased, and the percentage of people who report having a regular source of care has increased (NYC Dept. Health and Mental Hygiene, 2013). Former Mayor Bloomberg's administration emphasized the importance of improving NYC's population health status, and it endorsed reducing disparities in access to health services. Bloomberg's successor, Mayor Bill de Blasio, continued this focus. Despite these efforts, however, we have found that inequalities in racial, ethnic, and neighborhood-level access to health care services persist (Gusmano, Rodwin, & Weisz, 2017).

One dimension of health system performance is particularly important in New York City. In the 12-year period between 2000 and 2012, access to community-based ambulatory care, as measured by hospital discharge rates for avoidable hospital conditions (AHC rates) fell by nearly 50 percent in Manhattan. Racial, ethnic, and neighborhood-level inequalities hardly declined. Our research shows how difficult it is to address health care inequalities at the local level when national policies prompt large and growing income and wealth inequalities.

### Racial, Ethnic and Spatial Inequalities in NYC

In our analysis of population health, and of access to health care in Manhattan (Gusmano et al., 2010), we discovered a significant correlation between the

neighborhood of residence, infant mortality, and "amenable mortality," that is, deaths that could be avoided if access to care is assured. Looking at these measures, we find that people living in Manhattan's lowest-income neighborhoods have notably higher mortality rates than the rest of the borough (Rodwin & Neuberg, 2005; Weisz, Gusmano, Rodwin, & Neuberg, 2008).

We also determined that there are significant neighborhood effects in access to heart disease treatment (Gusmano, Rodwin, & Weisz, 2010; Weisz, Gusmano, & Rodwin, 2004), and in lower-extremity joint replacement. Lack of access also affects treatment of breast cancer (Gusmano, Weisz, & Rodwin, 2009) and access to community-based ambulatory care. Differences between Manhattan and the urban core of other global cities are clear, even after controlling for patient age, co-morbidities, gender, and insurance status. When comparing Manhattan to other global cities, it appears that a person's neighborhood has an independent effect on access to health care services.

## The National Context and Beyond

New York City, like the rest of the country, enjoyed economic growth from the beginning of the 1990s until the Great Recession of 2008. Yet, concurrent with this aggregate gain in wealth, was an uninterrupted increase in economic inequality. Although Mayor Bloomberg had several positive public health achievements during his 12-year term, income inequality and homelessness grew even so. NYC's economy still centers on its role as a global financial center, with large shares of revenue generated by its bankers, corporate managers, and specialized attorneys. Nevertheless, NYC is the most economically polarized large city in the United States (Chicago, Los Angeles, and Houston) (Fiscal Policy Institute 2016).

## Change and Continuity

Over the course of Bloomberg's time in office, there were distinct improvements in the AHC rate in Manhattan, compared to figures at the end of the Giuliani administration. When correlating the periods 1999 to 2001, and 2011 to 2013, the AHC rate decreased by nearly 50 percent in all neighborhoods (Gusmano et al., 2017). However, while overall health status had improved, infant mortality and life expectancy at birth, obesity and obesity-related illnesses, diabetes and high blood pressure increased in Manhattan (table 11.1a).

Table 11.1a. Changes in Health and Access to Care, New York City, 2002–2010

| | | |
|---|---|---|
| Self-Reported Health Status (% Reporting Fair or Poor Health) | 19.5% | 20.9% |
| Life Expectancy at Birth | 77.9 (2001) | 80.9 (2010) |
| Infant mortality | 5.83/1000 Live Births | 4.48/1000 Live Births (2012) |
| Do You Have One Person or More Than One Person You Think of As Your Personal Doctor or Health Care Provider? | 73.6% | 83.7% (2014) |
| Obesity (CI) | 18.2% (17.2–19.2) | 24.2% (22.8–25.5) |
| High Blood Pressure Ever | 25.9 % (24.9–26.9) | 27.8% (26.6–29.0) |
| Diabetes Ever | 8.0% (7.4–8.7) | 10.7% (9.9–11.9) |
| Asthma Ever | 12.1% (11.3–12.9) | 12.5% (11.5–13.7) |

*Sources:* Life expectancy: New York City Department of Health and Mental Hygiene; Infant mortality: Wang et al., 2013; Personal doctor or health care provider: New York City Community Health Survey, 2002 and 2014.

Despite the decline in Manhattan's avoidable hospital conditions rate, the disparities among the AHC rates, based on insurance status, race, ethnicity, and neighborhood, did not change over this period (Gusmano et al., 2017). The New York Community Health Survey reinforces this finding. Disparities data for Manhattanites show that racial and ethnic differences in self-reported health, and the incidence of most acute and chronic illnesses, were largely the same in 2014 as they were in 2002 when the survey was launched. This stagnation reflects inadequate investment in social programs that address broader social and economic determinants of health. In comparison to other wealthy nations, the U.S. spends a lower share of its GDP on social programs that affect population health, as shown by Bradley and colleagues (2011).

Cities in the United States share many common "urban problems," such as the geographic concentration of poverty, income inequality, and the persistent inequalities in population health and health care. Yet other wealthy nations have proven these conditions are not inevitable in modern cities (Dreier, Mollenkopf, & Swanstrom, 2001). Instead, the disparities in wealth and income in America have been heightened by our country's national

policies and political decisions, which do not protect our population from racial and ethnic injustice.

## References

Dreier, P., Mollenkopf, J., & Swanstrom, T. (2001). *Place matters: Metropolitics for the twenty-first century* (3 ed.). Lawrence, KS: University Press of Kansas.

Fennell, M. L., Pallas, S. W., Berman, P., Shortell, S. M., Curry, L. (2011). *Health Services Research 46*(6, pt. 2), 2019–2028.

Gusmano, M. K., Rodwin, V. G., & Weisz, D. (2010). *Health care in world cities.* Baltimore: Johns Hopkins University Press.

Gusmano, M. K., Rodwin, V. G., & Weisz, D. (2017). World medical and health policy. doi:101002/wmh3.226.

Gusmano, M. K., Weisz, D., & Rodwin, V. G. (2009). Achieving horizontal equity: must we have a single-payer health system? *Journal of Health Politics, Policy and Law, 34*(4), 617–33.

NYC Dept. Health and Mental Hygiene. (2013). *Increased life expectancy in New York City: What accounts for the gains? Epi Research Report.*

Rodwin, V. G., & Neuberg, L. G. (2005). Infant mortality and income in 4 world cities: New York, London, Paris, and Tokyo. *American Journal of Public Health, 95*(1), 86–90.

Weisz, D., Gusmano, M. K., & Rodwin, V. G. (2004). Gender and the treatment of heart disease in older persons in the United States, France, and England: A comparative, population-based view of a clinical phenomenon. *Gender medicine, 1*(1), 29–40.

Weisz, D., Gusmano, M. K., Rodwin, V. G., & Neuberg, L. G. (2008). Population health and the health system: A comparative analysis of avoidable mortality in three nations and their world cities. *The European Journal of Public Health, 18*(2), 166–72.