Global Journal of Medicine & Public Health

Health inequalities in New York City, USA – a public health challenge

*Kavitha P Das**

ABSTRACT

Inequity in health has been documented all across the world, with higher risks recorded amongst minorities, indigenous populations and socially disadvantaged populations. The United States mirrors this pattern in Blacks, Hispanics, Native Americans and immigrant populations, all of whom experience worse health than White Americans. These inequities, exacerbated in emergency situations such as national disasters, pandemics and other emergencies, natural or man-made, have emerged again during the COVID-19 pandemic.

Keywords: Health inequalities, COVID-19, Minorities, Indigenous populations

GJMEDPH 2021; Vol. 10, issue 6 | OPEN ACCESS

***Corresponding author** Kavitha P Das, Senior Scientist, Department of Cardiology, Icahn School of Medicine at Mount Sinai, NYC

Conflict of Interest—none | **Funding—**none

BACKGROUND

Inequity in health has been documented worldwide with a higher proportion of minorities, indigenous populations and socially disadvantaged populations at risk.[1] The United States mirrors the same pattern in Blacks, Hispanics, Native Americans and immigrant populations, all of whom are at higher risk than White Americans.[2] These inequities are exacerbated in emergency situations such as national disasters, pandemics and other emergencies, natural or man-made. This discrepancy in health equity has been made apparent once again during the COVID-19 pandemic. Differences in disease severity in situations such as the COVID-19 pandemic can be ascribed to higher levels of pre-existing conditions[3] but this alone does not correlate to the higher incidence of the disease in communities of colour.

Health inequalities in New York City

Urban areas with higher populations, higher numbers of daily wage income residents and higher use of public transportation show higher health inequities during health emergencies.[4] New York City is considered to have a robust emergency preparedness and public health response programme[5] but it was the worst hit US city during the COVID-19 pandemic with 40,000 deaths reported by March 2022.[6]

Racism has been declared a public health crisis by the American Public Health Association[7] and it has been widely acknowledged that this exacerbate the impact of the COVID-19 pandemic and resulted in higher COVID-19 deaths in communities of colour.[8] Boroughs with higher Black, Latinx and immigrant populations were the worst hit. In New York City, the age-adjusted fatality rate per 100,000 population was highest for Blacks (244/100,000), followed by Latinx populations (238/100,000) and lower for Whites (122/100,000).[9] The majority of the essential workers and front-line workers (75%) in New York City are from communities of colour, who also have lower access to healthcare. The pandemic made such populations more vulnerable to illness and death.

Health inequity has led to an upsurge in preventable diseases, premature death, asthma, cardiovascular disease, hypertension, diabetes, suicide and poor birth outcomes in Blacks, Hispanics and immigrant communities. These health disparities are multifactorial and include individuals with lower income, reduced access to nutritious food, unsafe housing, limited access to preventative health, limited access to good primary care and poorer educational options. For example, it has been

reported by the U.S. Bureau of Labor Statistics that only 19.7% of Black and 16.2% of Latinx workers were in jobs that allowed remote work.[10]

The COVID-19 pandemic has heightened the already existing health disparities by race, ethnicity, gender and income level in New York City and exposed weaknesses in the public health infrastructure in a city with a population of more than eight million residents. Social determinants, which are the underlying conditions in which people are born, live, grow, work and age are a strong predictor of health: communities with poorer access to healthcare, lower quality education, daily wage earners and the elderly have been those worst hit by the pandemic.

Structural policies and interventions at local, state and national levels can act as barriers or facilitators to health. Examining structural barriers and taking steps to eliminate these is the first step towards reaching a more equitable state. Inequality can be reinforced through access to quality housing, availability of employment, benefits, accesses to high-quality healthcare and an unbiased criminal justice system.[11] New York City lacks a unified citywide hospital network that caters to the needs of the uninsured and low-income residents, however. The communities where hospitals have closed were the same communities where higher numbers of disease and fatality due to COVID-19 were reported. Despite the lockdowns due to the pandemic and loss of jobs across many sectors, hospitals have continued to require medical bills to be paid. This has been addressed to some extent by the COVID–19 Medical Debt Collection Relief Act of 2021: this bill, passed in June 2021, temporarily limits the collection of certain medical debts by healthcare providers.[12]

The lowest vaccination rates in New York City are in boroughs with higher Black, Asian, Latinx and immigrant populations in whom there is historic mistrust due to past experiences with doctors and the healthcare system. The Bronx and Queens, which reported the highest numbers of COVID-19, also have higher numbers of multigenerational homes and higher crowding in homes. Inequity in access to housing can also lead to poorer health outcomes. They also have communities with higher population density, higher poverty and limited or no access to health insurance. These pre-existing inequalities in public housing in NYC boroughs, and homelessness, were exacerbated by the impact of COVID-19. Poverty is a strong indicator of reduced access to equitable healthcare.[13] Lack of a good income makes it challenging to access resources that promote health and prevent illness. For example, people living in low-income neighbourhoods may have limited access to exercise, reduced ability to buy healthy fruits and vegetables, reduced time to cook healthy meals and to visit a doctor for routine primary care health checkups. Living in poverty, with significantly reduced resources, also increases stress and anxiety. Consequently, bad health and limited access to disease mitigation can prevent people from accessing better education and training that can lead to gainful employment and subsequent poverty alleviation, creating a vicious circle.

RECOMMENDATION

The COVID-19 pandemic highlighted already existing gaps in the public health infrastructure. The city, state and federal governments must allocate funds to help improve this. A robust local Department of Health at the city level and an increase in allocation of funds to hire, train and develop new protocols to prevent future pandemics from destabilizing the city will be the first step to minimizing health inequities.

The Pandemic Response Institute for New York City has been created to address future health emergencies and epidemics in the city, using a more impactful and equitable approach. This will be implemented by a public-private partnership between the New York City Economic Development Corporation, the New York City Department of Health and Mental Hygiene, Columbia University, and the City University of New York Graduate School of Public Health and Health Policy.[14] Continued support for initiatives such as the Pandemic Response Institute, irrespective of change in local governments and leaderships, are recommended. Other measures that can be implemented are increasing access to culturally sensitive prevention and education measures to reduce the onset of chronic diseases such

as diabetes, hypertension and cardiovascular diseases that were the cause of higher mortality in COVID-19 patients with pre-existing conditions. Additionally, reducing preventable chronic diseases will lead to a decrease in healthcare expenditures even in non-pandemic situations. Improving programmes that address the needs of individuals who have limited English language proficiency and tailoring healthcare access programmes to minimize barriers to care for non-English speaking individuals will also see the situation improve, as will increased funding for strong public health-focused institutions that review and update health policies pertaining to economic development, improved education and employment. Improved housing may also reduce health disparities over the long term. Health equity can be built by training healthcare workers to interact with communities of colour without implicit bias.

CONCLUSION

New York City was one of the most severely impacted cities in the world at the onset of the COVID-19 pandemic. Sustained efforts by local governments, community-based organizations, hospitals and private institutions have resulted in a significant drop in the number of COVID-19 cases and higher COVID-19 vaccination rates compared to other cities in the United States. Increasing access to free COVID-19 testing services also aided in reducing the spread of the disease. Sustained measures that continue to reduce health inequities and prepare the city for future emergencies are needed. Building strong public health infrastructure, creating a unified citywide hospital network to address the healthcare needs of vulnerable populations in the city, and creating universal health insurance for all New Yorkers will aid in reducing health inequities.

REFERENCES

1. Ivers, L. C., & Walton, D. A. (2020). COVID-19: Global Health Equity in Pandemic Response. The American journal of tropical medicine and hygiene, 102(6), 1149–1150. https://doi.org/10.4269/ajtmh.20-0260
2. DeBruin, D., Liaschenko, J., & Marshall, M. F. (2012). Social justice in pandemic preparedness. American journal of public health, 102(4), 586–591. https://doi.org/10.2105/AJPH.2011.300483
3. Centers for Disease Control & Prevention (2013). CDC Health Disparities and Inequalities Report—United States, 2013. https://www.cdc.gov/mmwr/pdf/other/su6203.pdf
4. S. H., Galiatsatos, P., Wilson, C., Page, K. R., Jones, V., Tolson, T., Lugo, A., McCann, N., Wilson, A., & Hill-Briggs, F. (2021). Approaching the COVID-19 Pandemic Response With a Health Equity Lens: A Framework for Academic Health Systems. Academic medicine : journal of the Association of American Medical Colleges, 96(11), 1546–1552. https://doi.org/10.1097/ACM.0000000000003999
5. Dorn, A. V., Cooney, R. E., & Sabin, M. L. (2020). COVID-19 exacerbating inequalities in the US. Lancet (London, England), 395(10232), 1243–1244. https://doi.org/10.1016/S0140-6736(20)30893-X
6. New York Times. Tracking Coronavirus in New York: latest. https://www.nytimes.com/interactive/2021/us/new-york-covid-cases.html
7. The American Public Health Association (October 2021), Advancing Racial Equity, Analysis: Declarations of Racism as a Public Health Crisis, https://www.apha.org/media/Files/PDF/topics/racism/Racism_Declarations_Analysis.ashx
8. S. H., Galiatsatos, P., Wilson, C., Page, K. R., Jones, V., Tolson, T., Lugo, A., McCann, N., Wilson, A., & Hill-Briggs, F. (2021). Approaching the COVID-19 Pandemic Response With a Health Equity Lens: A Framework for Academic Health Systems. Academic medicine : journal of the Association of American Medical Colleges, 96(11), 1546–1552. https://doi.org/10.1097/ACM.0000000000003999
9. Dunker, A., Benjamin, E.R., (June, 2020), How Structural Inequalities in New York's Health Care System Exacerbate Health Disparities During the COVID-19 Pandemic: A Call for Equitable Reform, https://smhttp-ssl-58547.nexcesscdn.net/nycss/images/uploads/pubs/Covid_Healthcare_V1.pdf
10. US Bureau of Labor Statistics (September 24, 2019), Job Flexibilities and Work Schedules — 2017-2018 DATA From The American Time Use Survey. https://www.bls.gov/news.release/pdf/flex2.pdf
11. Krieger N. (2014). Discrimination and health inequities. International journal of health services : planning, administration, evaluation, 44(4), 643–710. https://doi.org/10.2190/HS.44.4.b
12. Congress.Gov (22, February, 2021), S.355 - COVID–19 Medical Debt Collection Relief Act of 2021, https://www.congress.gov/bill/117th-congress/senate-bill/355
13. New York City Department of Health and Mental Hygiene (April 2010), Health Disparities in Life Expectancy and Death, Mind the Gap: What are health disparities? https://www1.nyc.gov/assets/doh/downloads/pdf/episrv/disparitiesone.pdf
14. NYC Office of the Mayor, (29, September, 2021), Mayor de Blasio Announces Columbia University Will Operate and Oversee Pandemic Response Institute, https://www1.nyc.gov/office-of-the-mayor/news/660-21/mayor-de-blasio-columbia-university-will-operate-oversee-pandemic-response-institute