MONITORING POVERTY AND WELL-BEING IN NYC

SPECIAL SERIES:

HEALTH AND HEALTH CARE IN NEW YORK CITY

SECOND REPORT

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Introduction

In February 2022, we released the first report in a series examining health and health care among vulnerable populations in New York City who experience poverty, material hardship, and housing hardship.[1] **The report highlighted that in 2019, before the COVID-19 pandemic, one third of adults in New York City — more than two million people — experienced high health care needs, defined as having multiple chronic health conditions, a work-limiting health condition, and/or serious psychological distress.** People with high health care needs face elevated rates of poverty, material hardship, and inability to pay for health-promoting necessities such as housing, food, medical care, and utilities.

In this second report of the series, we examine healthcare utilization experiences and preferences among New Yorkers with high health care needs and who face economic disadvantage.

We asked about a range of healthcare utilization issues in order to:

(1) understand the challenges related to healthcare utilization — including preventive, urgent care, and telehealth services – among New Yorkers facing high health needs and economic disadvantage;

(2) identify the barriers that cause city residents to delay or forgo needed care;

(3) understand experiences of discrimination — racial, economic, or otherwise — in health care settings;

(4) assess facilitators of healthcare utilization and high-quality care.

Given the unique and severe health challenges faced by those with inadequate and unaffordable housing in the city, we also dive deeper into how housing hardship in particular is related to respondents' reported healthcare needs and utilization. We considered housing hardship to include overcrowding, inability to make housing payments, moving in with others because of the cost, and bouts of homelessness. We also supplement the quantitative analysis with qualitative data from interviews conducted with respondents experiencing housing hardships.

Our data collection began shortly after the start of the COVID-19 pandemic, a unique time that overwhelmed the nation's health care system, resulted in the deaths of tens of thousands of New Yorkers, and highlighted and exacerbated deep racial and socioeconomic inequities in health and economic insecurity. This timing made it all the clearer that improving the physical and mental health of New Yorkers requires us to continually examine New Yorkers' healthcare needs. Keeping equity in mind is critical as we work to make our health systems more responsive to the needs of all New Yorkers.

[1] *Maury, Allen, Bushman-Copp, Cargill, Collyer, Liu, Neckerman, and Wimer (2022)*

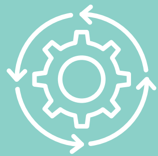
KEY FINDINGS

With the aim of better understanding the economic lives of New Yorkers with the highest health care needs, this series offers insights for those who are working to improve the city's health care system and its ability to serve all New Yorkers. As the data for this report was collected during the COVID-19 pandemic, these results provide an understanding of health and health care utilization among vulnerable New Yorkers during the pandemic.
We find:

HEALTH CARE NEED

New Yorkers who faced poverty or material hardship were 1.5 times more likely to have high health care needs[2] compared to those not facing economic disadvantage (48% vs. 31%). This was driven by 3.6 times higher rates of serious psychological distress (18% vs. 5%) and 1.6 times higher rates of work-limiting health conditions (27% vs. 17%).

1.5X 3.6X 1.6X



HEALTH CARE UTILIZATION

Among New Yorkers with high health care needs:

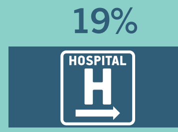
Those facing economic disadvantage were slightly less likely to be covered by health insurance compared to those not facing disadvantage (94% vs. 97%).

Those facing economic disadvantage were 6 times more likely (than those without disadvantage) to report a walk-in clinic, urgent care center, or retail clinic as their most common place of care (12% vs. 2%) and less likely to report a doctor's office as their most common place for care (75% vs. 87%).

Those facing economic disadvantage were 1.6 times more likely (than those without disadvantage) to say they had visited a hospital emergency room in the past six months (30% vs. 19%).

30%

19%



UNMET HEALTH NEED: DELAYED AND FORGONE TREATMENT

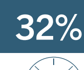
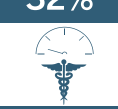
Among New Yorkers with high health care needs:

Those facing economic disadvantage were 1.6 times more likely (than those without disadvantage) to report need for mental health care (48% vs. 30%) while they were about 1.1 times more likely to report physical health care need (57% vs. 51%).

Those facing economic disadvantage experienced 1.5 times higher rates (than those without disadvantage) of delayed or forgone physical health care (49% vs. 32%) and 1.3 times higher rates of delayed mental health care (59% vs. 46%). Overall, it was more common to delay mental health care.

49%

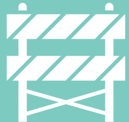
32%

59%

46%

[2] *The bulk of our analysis focuses on New Yorkers with high health care needs, based on responses from 850 survey participants. We combine two Poverty Tracker panels, the first sampled in 2017 (n = 268) and the second sampled in 2020 (n = 582).*



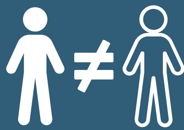
ACCESS AND BARRIERS TO CARE

Among New Yorkers with high health care needs:

The most common reason for delayed health care was COVID-19. However, those facing economic disadvantage (compared to those not facing this disadvantage) were less likely to report the COVID-19 pandemic as a reason for delayed care (52% vs. 64%).

Those facing economic disadvantage were 7.8 times more likely (than those without disadvantage) to delay or forgo care because of the cost to see a doctor (39% vs. 5%), 6.5 times more likely to delay care because of a lack of transportation (13% vs. 2%), and 8 times more likely to delay care because of an inability to afford a prescription medication (8% vs. <1%) or a lack of adequate health insurance coverage (8% vs. <1%).

Those facing disadvantage were 1.5 times more likely to say it was difficult to get to their last appointment (24% vs. 16%), which they attributed to difficulty with pain (24% vs. 11%), paying for transportation (16% vs. 1%), or an inability to get out of work (7% vs. <1%).

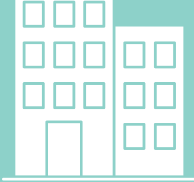


EXPERIENCES OF UNFAIR JUDGMENT, DISRESPECT, OR DISCRIMINATION

Among New Yorkers with high health care needs:

Those facing economic disadvantage reported 1.6 times higher rates (than those without disadvantage) of feeling that they were judged unfairly, treated with disrespect, or discriminated against (22% vs. 14%).

The most common perceived reason for unfair judgment/disrespect/discrimination was race/ethnicity, with 22% of those facing economic disadvantage reporting such experiences.



HEALTH AND HOUSING

Among all respondents:

A majority reported a housing hardship (71%). This includes an issue with housing condition (66%) or housing insecurity (19%). The most common housing condition issues were living with pests (44%), using alternative sources of heat such as kitchen stoves or portable space heaters during the winter (22%), and living in overcrowded households (12%).

New Yorkers with high health care needs faced 1.2 times higher rates of housing hardship compared to those without high needs (79% vs. 66%). Rates of housing hardship were particularly high among those who experienced serious psychological distress (89%).

Among New Yorkers with high health care needs:

Those facing housing hardship (compared to those without such hardships) reported 6.8 times higher rates of difficulty getting to their last medical appointment (27% vs. 4%).

Those facing housing hardship experienced issues related to unsafe living conditions (11%), not having a clean/comfortable place to recover (10%), not having a regular place to be contacted (6%), and difficulty storing medication or medical supplies (1%).

Acknowledgements

This research was made possible with funding from The Leona M. and Harry B. Helmsley Charitable Trust. We are grateful for their commitment to working towards solutions to improve health stability for New Yorkers by paying close attention to root causes such as homelessness and access to quality care. Read more about their work to improve health in New York City here.

We would also like to thank the staff on the Poverty Tracker team at Columbia University who go above and beyond to make this research possible. To the administrators, interviewers and field coordinators, technology support staff, data cleaners, and those not mentioned- none of this work would be possible without your contributions.

Finally, we would like to thank Robin Hood for their commitment to ending poverty in New York City and their continued partnership which makes the Poverty Tracker and associated research possible.

Launched in 2012, the Poverty Tracker surveys a representative sample[3] of New Yorkers every three months, providing critical information on the dynamics of poverty and other forms of disadvantage in the city. Unlike other surveys, the Poverty Tracker explores how New Yorkers experience poverty and material hardship over time, rather than in a single day, month, or year. The Poverty Tracker follows the same households by contacting an adult in each household via online, phone, and paper surveys every three months, allowing us to build a better understanding of New Yorkers' actual lives. In addition, the Poverty Tracker focuses on more than just income poverty; we also collect data on other core measures of disadvantage, material hardships, and health problems. We use these alternative measures to understand how certain disadvantages, or multiple, overlapping disadvantages, make it harder for New Yorkers to survive. The Poverty Tracker also collects data on other aspects related to New Yorkers' well-being, from asset and debt accumulation, to social service program utilization, to spending and consumption patterns, in order to form a better understanding of how New Yorkers make decisions about their own lives.

This report uses data from Poverty Tracker surveys fielded between October 2020 and May 2021 that asked respondents about their health, medical care need, and experiences accessing medical care and interacting with medical care providers.

[3] A representative sample is a subset of the population that seeks to accurately reflect the properties of the population it is selected from (D'Exelle, 2014). To ensure Poverty Tracker samples are representative of adults in New York City, respondents are sampled using a Random-Digit Dial (RDD) methodology and data are adjusted using survey weights. RDD is a commonly used probability sampling method in survey research to select a representative sample (Wolter, Chowdhury, and Kelly, 2009). To adjust for selection (Alexander, Lopes, Ricchetti-Masterson, Yeatts, 2015), nonresponse (Davern, 2013), and attrition biases (Nunan, Aronson, Bankhead, 2018), samples are weighted to be representative of the adult population in New York City with respect to demographic characteristics such as race, education, and gender. To read more information on Poverty Tracker weighting procedures, see Appendix B in the Poverty Tracker codebooks (CPSP, 2020). In this report, we use data from Poverty Tracker panels sampled in 2017 (n=853) and 2020 (n=1,912). Each weighted sample aims to be independently representative of New York City adults in the year of sampling. While both samples were sampled through RDD, the 2020 sample also includes a supplementary oversample of New Yorkers of Chinese origin. The Chinese oversample was collected by combining an RDD method, which targeted census block groups with high concentrations of Chinese origin New Yorkers, and community-based purposive sampling method (Campbell et al., 2020) which involved recruiting from WeChat community groups. Due to the oversample, additional adjustments were considered when weighting the 2020 panel by adjusting for selection biases related to location, language spoken in the household, ancestry, and WeChat community accessibility. Each panel is followed for approximately six years after receiving intake surveys.

About our approach

Health conditions used to define New Yorkers with high health care needs

HEALTH CONDITION	
Multiple chronic health conditions	Two or more of the following chronic health conditions: asthma, diabetes, hypertension, cancer, heart disease.
Work-limiting health condition	A health problem or disability which prevents one from working or which limits the kind or amount of work one can do.
Serious psychological distress	A value of 13 or greater on the Kessler Psychological Distress Scale (K6), which indicates serious psychological distress.[4,5]

Measuring Poverty: The Supplemental Poverty Measure (SPM)

Every September, the U.S. government releases the latest results on national poverty using the Official Poverty Measure (OPM). The OPM was developed in the 1960s and compares families' total before-tax cash income with a poverty line, or threshold. The threshold was defined as three times the cost of a minimally adequate food budget during that time. With the exception of some minor adjustments, this measure has only been updated annually to account for inflation.

Over time, this formula has become increasingly outdated. Food costs have become less important in family budgets, while expenses such as housing and child care have become costlier. A focus on before-tax cash income ignores benefits that many families receive through the tax system, such as the Earned Income Tax Credit, or in non-cash form, such as food stamps or housing vouchers. Importantly, the poverty threshold under the OPM does not vary with costs of living, particularly housing costs, which are notoriously high in New York City.

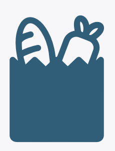
The SPM improves the measurement of poverty on all of these fronts. The poverty threshold is based on contemporary spending on food, as well as on other necessities like clothing, shelter, and utilities. The poverty threshold in places like New York City is also higher given its higher than average housing costs, and the threshold is different for renters and homeowners. In 2021, the SPM threshold for a two-adult, two-child family of renters in New York City was $39,950. In the SPM, tax credits and non-cash benefits are also counted as income, and for families who incur them, medical, work, and child care costs are subtracted from income. The Poverty Tracker collects all the data necessary to directly calculate the SPM in its sample of New Yorkers, and this data forms the basis of our income poverty statistics.

[4] Prochaska, Sung, Max, Shi, and Ong (2021)

[5] Questions about work-limiting health conditions are asked about in annual surveys. We use responses from the most recent annual survey prior to the health and health care module. For the 2017 Poverty Tracker sample, mental health questions are similarly asked in annual surveys and we use the most recent response. For the 2020 Poverty Tracker sample, respondents received mental health questions across multiple surveys that occurred either before or after the health and health care module. If respondents did not receive these questions as part of the health and health care module, we use their responses from the closest survey.

Measuring Material Hardship: Food, Housing, Bills, Financial Hardship

The Poverty Tracker measures material hardship in five domains: **food, housing, bills, general financial hardship, and medical care** (see definitions below). In other Poverty Tracker reports, New Yorkers who face one or more of these forms of hardship in a year are identified as having faced material hardship. In this report we remove medical hardship, as medical costs are correlated with many of the outcomes we examine.



SEVERE FOOD HARDSHIP

Often running out of food or often worrying food would run out without enough money to buy more.

SEVERE HOUSING HARDSHIP

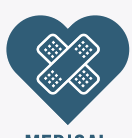
Having to stay in a shelter or other place not meant for regular housing, or having to move in with others due to costs.

SEVERE BILLS HARDSHIP

Having utilities cut off due to a lack of money.

SEVERE FINANCIAL HARDSHIP

Often running out of money between paychecks or pay cycles.



MEDICAL HARDSHIP

Not being able to see a medical professional due to cost.

Measuring housing hardship

The Poverty Tracker health care survey module, which collects data on health and health care utilization, also asks about housing issues:

In the past 12 months…

- *Did you not pay the full amount of rent or mortgage because there wasn't enough money?*
- *Did you move in with other people, even for a little while, because of financial problems?*
- *Did you stay at a shelter, in an abandoned building, an automobile, or any other place not meant for regular housing, even for one night?*

The Poverty Tracker also collects data on the number of people and bedrooms in the household[6] to create a measure of overcrowding (an overcrowded household is defined as having more than two people per bedroom). Finally, respondents are asked about issues of housing quality, such as presence of pests/bugs, safety in public spaces, need to use alternative heat sources, unsafe living conditions, and damage within the home.[7]

- *How safe from crime are the public spaces in your current residence, for example, the lobby, elevators, and stairwells?*

[6] *Questions about the number of bedrooms and people living in the household are asked in annual surveys (not in the same survey as the health care module). For each respondent we use information from their most recent annual survey.*
[7] *Questions about housing quality were asked in a different survey than questions about health and health care.*

- *Does your home or apartment have open cracks or holes in the interior walls, ceiling, or floors? Do NOT include very small hairline cracks.*
- *In the past 90 days, have you seen any of the following in your residence? (Cockroaches, mice or signs of mice, rats, and bedbugs)*
- *During this past winter, did you at any time have to use additional sources of heat because your residence did not have enough heat? Additional sources could include the kitchen stove, a fireplace, or a portable or space heater.*

We refer to moving in with others or staying at a place not meant for regular housing as *severe housing hardship*.

The context of COVID-19

Data collection for this report took place from October 2020 to May 2021. These surveys were originally planned before the pandemic; since then, millions of New Yorkers have been diagnosed with COVID-19, health care systems have been overwhelmed, and New Yorkers have faced unprecedented economic and social challenges. The results presented in this report should be understood within this context.

Statistical Significance

Statistical significance is a method for reporting confidence that results indicate true differences and are not due to chance.[8] In this report we examine differences in health and health care consumption among New Yorkers with high health care needs, comparing those facing economic disadvantage to those not facing such disadvantage. To indicate when observed differences are unlikely to be attributable to chance, we bold point estimates to highlight statistically significant differences. We report significant differences using a standard significance threshold of at least $p<.05$ which can be interpreted as a less than 5% chance that a difference between two estimates is the result of chance.[9] It is important to note that when differences are not statistically significant it does not mean they do not represent real differences. Rather non-significant results indicate instances where there is a greater than 5% chance that the difference is attributable to chance. Statistical significance should be interpreted carefully with this understanding in mind.

[8] *Tenny S, Abdelgawad I. (2022).*
[9] *Many of our results are also significant at $p<.01$ and $p<.001$ which indicate a less than 1% and .1% chance that a difference is attributable to chance.*

Findings

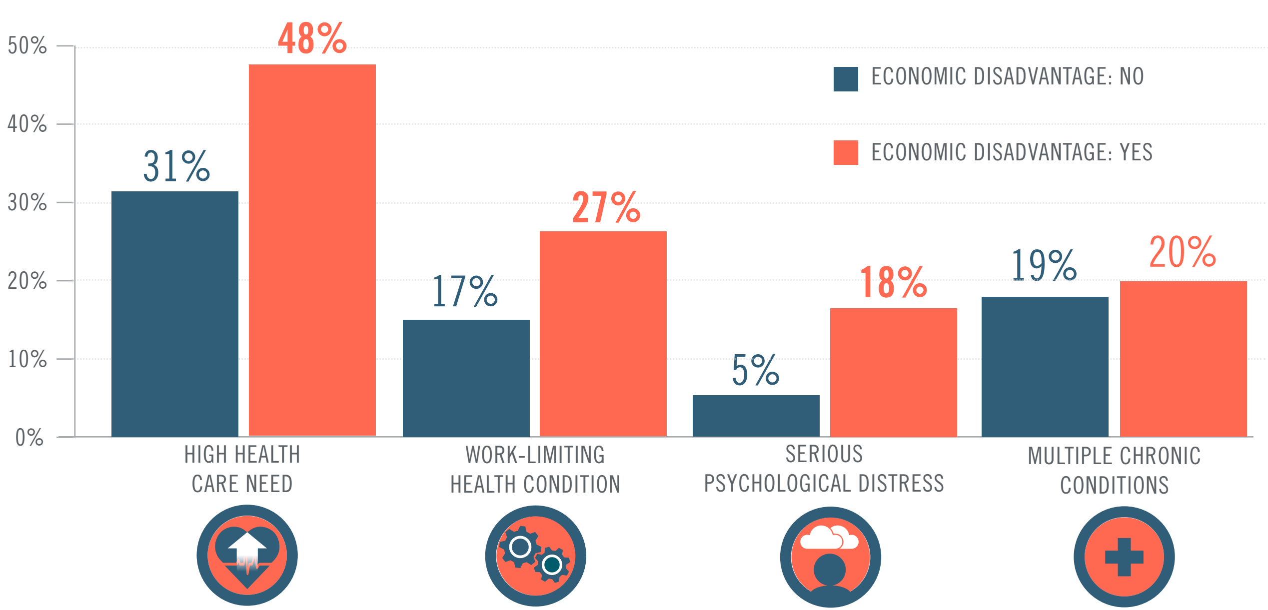
With the goal of better understanding the state of health and health care among vulnerable populations in New York City, this report presents findings on health care need and unmet need, utilization, access, and barriers to care. We examine these topics within the context of economic disadvantage, which we define as facing poverty or material hardship. Given the unique and severe health challenges related to inadequate and unaffordable housing, the report goes beyond an overall measure of economic disadvantage and examines the health care needs and challenges experienced by New Yorkers facing housing issues such as living in overcrowded households, inability to make housing payments, and having unstable housing.

Health and health care need in New York City by economic disadvantage

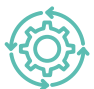
We begin by examining health care need and specific health issues. **Figure 1** highlights the share of New Yorkers, by economic disadvantage status, who had high health care needs—defined as those with a work-limiting health condition, serious psychological distress, or multiple chronic conditions. **Tables A1, A2, and A3** in the Appendix repeat these findings for individual chronic health conditions (asthma, diabetes, etc.) and breakdowns by demographic indicators. **Figure 1** shows that New Yorkers who experienced economic disadvantage faced elevated rates of high health care needs. This difference was driven by increased rates of work-limiting health conditions and serious psychological distress.

Figure 1

Share of New York City adults with high health care needs, a work-limiting health condition, serious psychological distress, and multiple chronic conditions by economic disadvantage



Poverty Tracker 2017 and 2020 samples. Majority of surveys fielded between October 2020 and May 2021. Bolded point estimates indicate statistically significant differences at the p<.05 level or higher. Significance determined using adjusted Wald test where the no economic disadvantage group is the reference group.

Health care utilization 

We also wanted to understand how those with high health care needs use and interact with the health care system. Given the status of the United States as one of the few industrialized nations without universal health insurance, we start by examining rates of insurance coverage. We also examine health care services used, the most common location where health care is received, and experiences getting health care from emergency rooms, urgent care centers, or through telehealth services. Are those who face economic disadvantage more or less likely to access preventative care? Are they more likely to end up in the emergency room, which is often accompanied by a costly bill? Do they use emerging health care services like telehealth? Understanding the answers to these questions is essential to improving health care experiences.

Table 1 shows that New Yorkers with high health care needs who faced economic disadvantage were less likely to be covered by health insurance and less likely to have had a prescription for medication in the past six months. Despite a status indicating increased healthcare needs, about 15% of high need New Yorkers had not seen a doctor for a checkup in the past 12 months.

Table 1

Health care utilization among New York City adults with high health care needs by economic disadvantage

	ECONOMIC DISADVANTAGE: NO	ECONOMIC DISADVANTAGE: YES
Currently covered by health insurance	97%	94%
Saw doctor for physical/check-up - past 12 months	86%	85%
Saw dentist/oral physician - past 12 months	55%	56%
Had prescription for medication - past 6 months	85%	80%

Poverty Tracker 2017 and 2020 samples. Majority of surveys fielded between October 2020 and May 2021. Bolded point estimates indicate statistically significant differences at the p<.05 level or higher. Significance determined using adjusted Wald test where the no economic disadvantage group is the reference group.

The most common source of medical care for high need New Yorkers was a doctor's office or health center (**Table 2**). Those facing disadvantage were less likely to use a doctor's office or health center and more likely to use walk-in clinics, urgent care centers, and retail clinics. It is important to keep in mind that these results were collected during the COVID-19 pandemic, when health care utilization may have been different. In a future report we will look at these same measures after the peak of COVID-19, when businesses opened back up, most New Yorkers were vaccinated, and the city's medical system was not as strained.

Table 2

Most common location of medical care among New York City adults with high health care needs by economic disadvantage

	ECONOMIC DISADVANTAGE: NO	ECONOMIC DISADVANTAGE: YES
Doctor's office or health center	**87%**	**75%**
Walk-in clinic/urgent care center/retail clinic	**2%**	**12%**
Emergency room	<1%	1%
A VA medical center	1%	<1%
Some other place	9%	10%
No usual place	1%	2%

Poverty Tracker 2017 and 2020 samples. Majority of surveys fielded between October 2020 and May 2021. Bolded point estimates indicate statistically significant differences at the p<.05 level or higher. Significance determined using adjusted Wald test where the no economic disadvantage group is the reference group.

Table 3 highlights overall use of non-primary care settings in the last six months, such as urgent care centers, telehealth, and emergency rooms. Those facing disadvantage were more likely to have used urgent care or a clinic in a drug/grocery store and a hospital emergency room (differences in urgent care use were statistically significant at the p<.05 level while differences in use of a hospital emergency room were marginally significant at the p<.1 level). They were also more likely to report use of telehealth services, though this difference was not statistically significant.

Table 3

Use of urgent care centers, telehealth, and emergency rooms (last 6 months) among New York City adults with high health care needs by economic disadvantage

	ECONOMIC DISADVANTAGE: NO	ECONOMIC DISADVANTAGE: YES
Urgent care or clinic in a drug/grocery store	**38%**	**53%**
Telehealth	36%	41%
Hospital emergency room	19%	30%

Poverty Tracker 2017 and 2020 samples. Majority of surveys fielded between October 2020 and May 2021. Bolded point estimates indicate statistically significant differences at the p<.05 level or higher. Significance determined using adjusted Wald test where the no economic disadvantage group is the reference group.

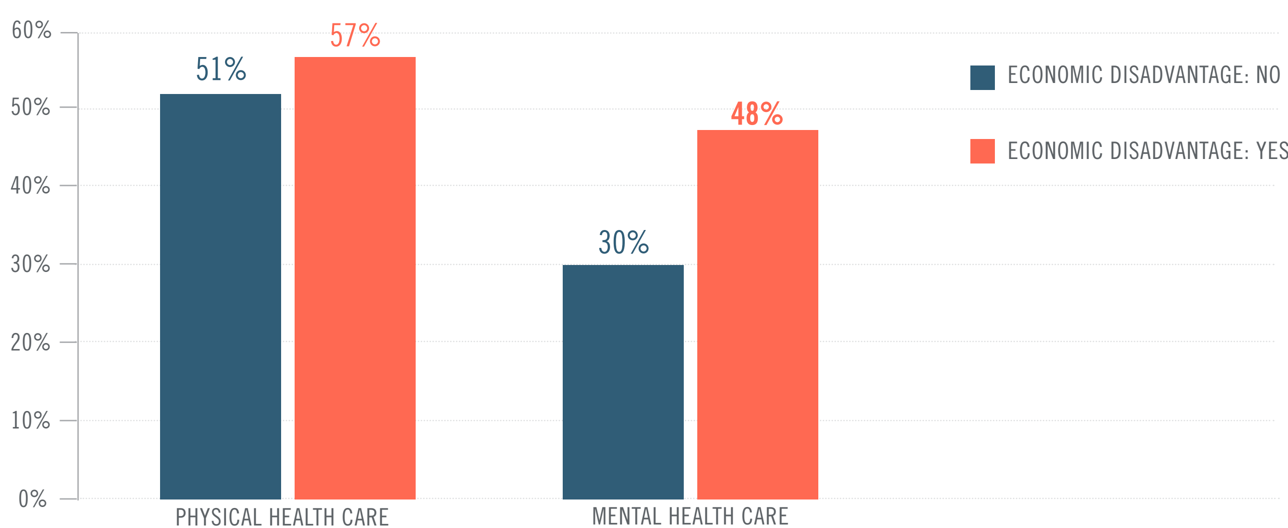
In-depth qualitative interviews with New Yorkers underscore that use of ER services is a last resort. One respondent who avoided seeking health care due to the cost but had gone to the ER for an urgent health issue explained, "*You wait too long to see anybody, even in the emergency, and they're understaffed. There's no reason we should go to the ER and have to wait five and six hours.*" Another respondent added, "*I could be near death before I go to the emergency room… Because the way we be treated at the emergency room is just ridiculous. I had some good experiences, but most of the time it's been a bad experience.*"

Unmet health need: delayed and forgone treatment

Beyond health insurance coverage and sources of health care received, we wanted to understand whether those with high needs receive essential care. This section focuses on the need for physical and mental health care services, rates of delayed and forgone care, and delaying the use of medication or filling prescriptions because of the cost. We find (**Figure 2**) that high need New Yorkers facing disadvantage reported significantly higher rates of needing mental health care and slightly higher rates of need for physical health care, though this latter difference was not statistically significant.

Figure 2

Need for physical and mental health care among New York City adults with high health care needs by economic disadvantage

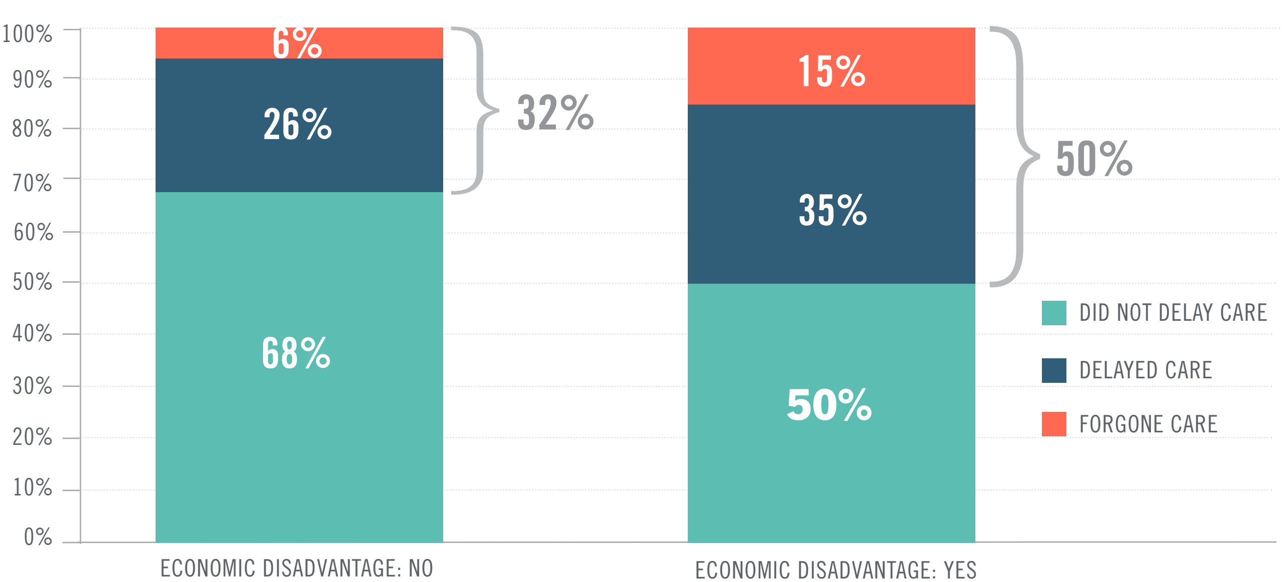


Poverty Tracker 2017 and 2020 samples. Majority of surveys fielded between October 2020 and May 2021. Bolded point estimates indicate statistically significant differences at the p<.05 level or higher. Significance determined using adjusted Wald test where the no economic disadvantage group is the reference group.

We also asked whether respondents had delayed or forgone care in the last six months. As illustrated in **Figure 3,** delayed or forgone physical health care was more common among those facing disadvantage. We also found that delayed and forgone mental health care was more common than delayed or forgone physical health care (**Figure 4**). Again, those facing disadvantage reported higher rates of delayed or forgone mental health care than those who did not.

Figure 3

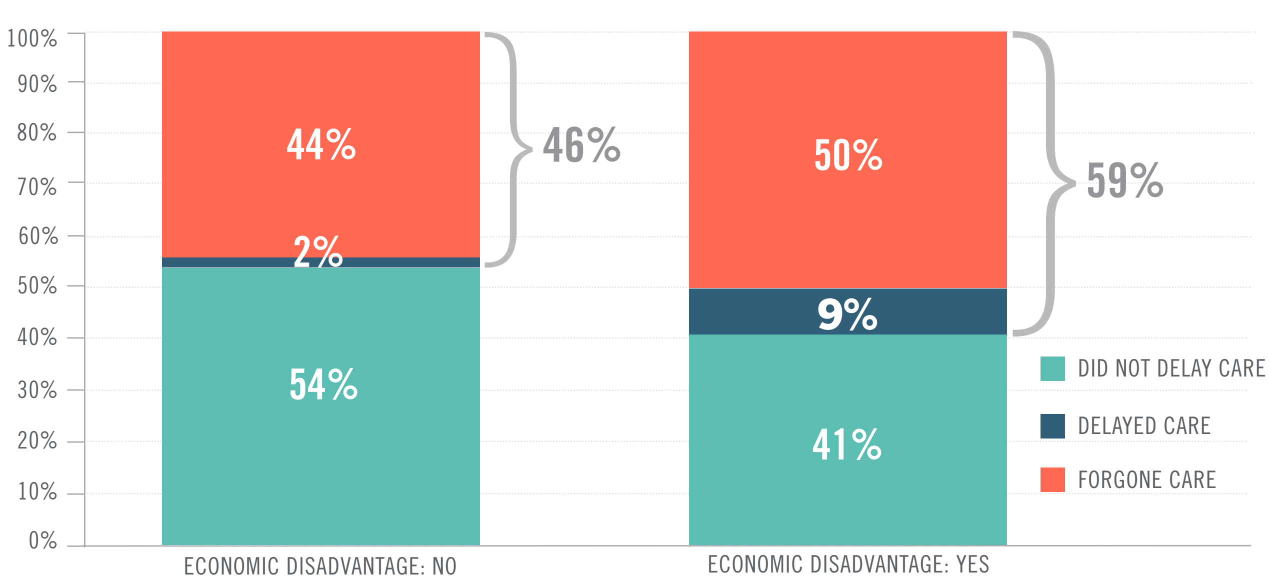
Delayed and forgone physical health care among New York City adults with high health care needs by economic disadvantage



Poverty Tracker 2017 and 2020 samples. Majority of surveys fielded between October 2020 and May 2021. Bolded point estimates indicate statistically significant differences at the p<.05 level or higher. Significance determined using adjusted Wald test where the no economic disadvantage group is the reference group.

Figure 4

Delayed and forgone mental health care among New York City adults with high health care needs by economic disadvantage

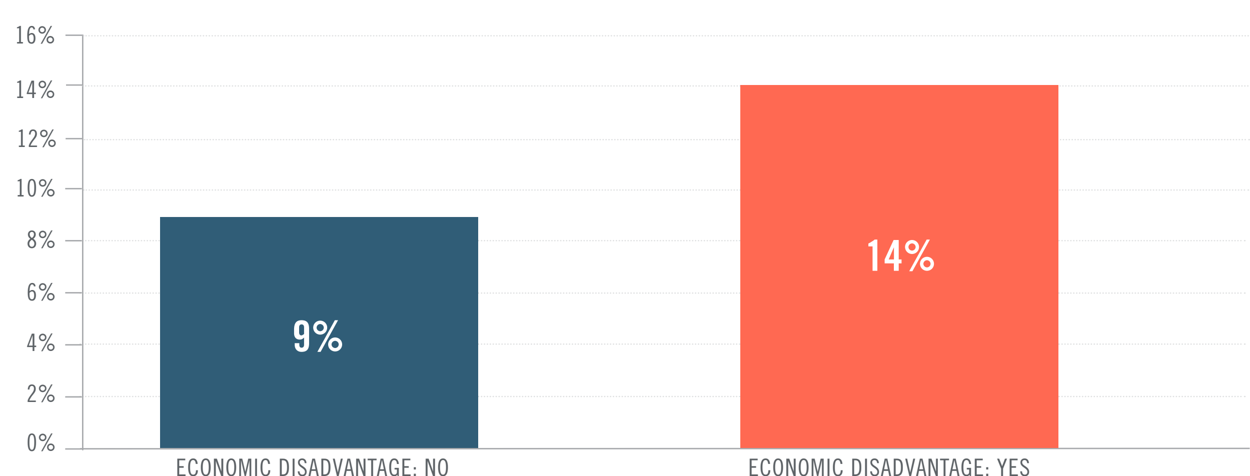


Poverty Tracker 2017 and 2020 samples. Majority of surveys fielded between October 2020 and May 2021. Bolded point estimates indicate statistically significant differences at the p<.05 level or higher. Significance determined using adjusted Wald test where the no economic disadvantage group is the reference group.

Similarly, **Figure 5** shows that those facing economic disadvantage were more likely to delay the use or refilling of prescription medication, though this difference was not statistically significant.

Figure 5

Skipped taking medication, took less medication, or delayed filling prescription because of cost in the past six months among New York City adults with high health care needs by economic disadvantage



Poverty Tracker 2017 and 2020 samples. Majority of surveys fielded between October 2020 and May 2021. Bolded point estimates indicate statistically significant differences at the p<.05 level or higher. Significance determined using adjusted Wald test where the no economic disadvantage group is the reference group.

Access and barriers to care

How do high-need New Yorkers access care? What barriers do they face? We examine reasons for delayed care and the likelihood that these delays lead to forgone care. We also investigate challenges getting to appointments, the logistics of receiving care, and experiences with doctors or health care professionals.

Table 4 shows the most common reasons New Yorkers with high health care needs delayed physical and mental health care.

Table 4

Reason for delayed physical or mental health care in the past six months among New York City adults with high health care needs by economic disadvantage

	ECONOMIC DISADVANTAGE: NO	ECONOMIC DISADVANTAGE: YES
Delay related to COVID-19	64%	52%
Cost to see doctor or health care professional was too high	**5%**	**39%**
Didn't know where to go	17%	19%
Concerns about treatment	20%	11%
Haven't gotten around to it	11%	17%
Didn't have a regular doctor	13%	11%
Lack of transportation	**2%**	**13%**
Didn't know how to make an appointment	4%	6%
No insurance	**<1%**	**8%**
Couldn't afford prescription	**<1%**	**8%**

Poverty Tracker 2017 and 2020 samples. Majority of surveys fielded between October 2020 and May 2021. Bolded point estimates indicate statistically significant differences at the p<.05 level or higher. Significance determined using adjusted Wald test where the no economic disadvantage group is the reference group.

A recurring theme was difficulty finding a provider who accepted the respondent's insurance. One respondent with Medicare and Medicaid stated, *"There are a lot of doctors that don't wanna take [me] because the insurance that I have—I think it's because the insurance doesn't pay them maybe as well as some others do."* Respondents also reported exhausting experiences that resulted in forgoing needed physical and mental health care. One said that, after struggling to find a mental health care provider, *"You do eventually give up... It's something about calling the doctors over and over. It's just really exhausting… It's so hard to find a doctor that I'm like, 'Is it hard? Or am I doing it incorrectly?' I don't think I'm doing it wrong because I have googled it and I don't see a different way of doing it."*

Table 5 examines difficulty getting to appointments[10] and the reasons for such difficulties. Those facing disadvantage were more likely to report difficulty getting to their last appointment, with the most common reasons being difficult transportation, such as inconvenient subway/bus stops or Access-a-Ride being late, pain that made it difficult to travel, the visit being far away, and difficulty paying for transportation.

[10] *Defined as saying it was somewhat or very difficult to get to the last appointment.*

Table 5

Difficulty getting to appointments among New York City adults with high health care needs by economic disadvantage

	ECONOMIC DISADVANTAGE: NO	ECONOMIC DISADVANTAGE: YES
Very/somewhat difficult to get to last appointment	16%	24%
What are some of the things that made it difficult…		
Difficult transportation (subway/bus was inconvenient; Access-A-Ride was late)	41%	42%
You were in pain and it was difficult to travel	11%	24%
Visit was far away	18%	18%
Difficulty paying for transportation	**1%**	**16%**
Couldn't get out of work	<1%	7%
Couldn't find someone to care for child or family member	12%	3%

Poverty Tracker 2017 and 2020 samples. Majority of surveys fielded between October 2020 and May 2021. Bolded point estimates indicate statistically significant differences at the p<.05 level or higher. Significance determined using adjusted Wald test where the no economic disadvantage group is the reference group.

Expanded access to telehealth can reduce the cost burden of transportation to and from doctors' visits. One respondent noted, "*One good thing about COVID is that we've gotten comfortable doing video and phone visits, which I think is a lot better for both [me and my doctor] 'cause there are times when I don't have money. I live all the way up in the North Bronx. To get down to Chelsea, it's a subway ride, and there are times when I don't have a dime in my pocket."* However, in-person tests and procedures may remain unaffordable, leading New Yorkers to postpone or even forgo needed care. The same respondent who commended increased access through telehealth services had delayed scheduling a recommended colonoscopy: "*I don't know anybody in New York that I can trust with [taking me home], that would show up, that I could count on 'em. To pay for the medical taxi, it's 100 bucks. That's money that I didn't have."* Finding a health care provider who offers transportation can improve utilization for New Yorkers who experience difficulty paying for transportation or have access issues due to disability. One respondent who had recently found a provider that offers transportation to appointments said, *"That's a major thing 'cause I don't drive… The only thing I can do is cab it, and that runs into a lot of money."*

New Yorkers were asked to think about their experiences obtaining health care in general and to rate the frequency of encountering potential facilitators and barriers to care on a five-point scale: always, often, sometimes, occasionally, or never. In the following analyses, those who report "often" and "always" are coded as having experiences frequently, and those who report "sometimes," "occasionally," and "never" are coded as having experiences infrequently. In **Table 6** the question about confidence filling out medical forms has different response options: extremely, quite a bit, somewhat, a little bit, or not at all confident filling out medical forms. Those who report being "extremely" or "quite a bit" are coded as having confidence in filling out medical forms.

Among New Yorkers with high health care needs, those facing economic disadvantage were less likely to be confident filling out medical forms (**Table 6**). Economic disadvantage did not affect reported rates of receiving appointment reminders, ease in making appointments, and ability to get care outside of standard hours.

Table 6

Logistics when receiving care among New York City adults with high health care needs by economic disadvantage

	ECONOMIC DISADVANTAGE: NO	ECONOMIC DISADVANTAGE: YES
Receive appointment reminders	72%	68%
Confident filling out medical forms	**72%**	**57%**
Very easy to make appointments	63%	65%
Can you get care outside of standard hours (weekend/evening)	23%	24%

Poverty Tracker 2017 and 2020 samples. Majority of surveys fielded between October 2020 and May 2021. Bolded point estimates indicate statistically significant differences at the p<.05 level or higher. Significance determined using adjusted Wald test where the no economic disadvantage group is the reference group.

We also examined New Yorkers' experiences with doctors and health professionals answering their questions, explaining what is happening, listening to concerns, and receiving appointment reminders. We find similar rates of having positive experiences with doctors by disadvantage status (**Table 7**).

Table 7

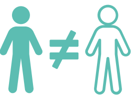
Experiences with doctors among New York City adults with high health care needs by economic disadvantage

	ECONOMIC DISADVANTAGE: NO	ECONOMIC DISADVANTAGE: YES
Doctors/health professionals answer questions	79%	80%
Doctors/health professionals explain what is happening	73%	74%
Doctors/health professionals listen to concerns	71%	71%
Doctors/health professionals **do not** believe you	25%	24%

Poverty Tracker 2017 and 2020 samples. Majority of surveys fielded between October 2020 and May 2021. Bolded point estimates indicate statistically significant differences at the p<.05 level or higher. Significance determined using adjusted Wald test where the no economic disadvantage group is the reference group.

One respondent, who had been in the shelter system with four children for over a year, highlighted the importance of clear communication with providers and the usefulness of technology: *"Scheduling appointments, they're very honest about that 'cause sometimes it's too booked, and they'll have to call me back for an appointment, and they've always been good at that, which with MyChart, just makes it more convenient now. I get an email."* This respondent also reported a positive experience with a case manager, who was assigned specifically to help them apply for benefits and services to support their two children with developmental disabilities: *"There's a big [process], and she keeps everything straight. She keeps all the papers straight. I didn't even think there was a form I didn't know how to fill out, but there's tricky things on the form… She helps me with that."*

Experiences of unfair judgment, disrespect, or discrimination



An additional challenge of delivering and receiving high quality health care is fostering relationships built on trust and respect. We found that among high-need New Yorkers, those experiencing disadvantage reported higher rates of feeling that they were judged unfairly, disrespected, or discriminated against (**Table 8**). The most commonly perceived reason for discrimination, across all groups, was race/ethnicity. Among those who perceived discrimination, those facing disadvantage were more likely to attribute it to income level, language/accent, or health status/ability than to race/ethnicity, age, insurance status, or gender/sex. Given that New Yorkers are insured at a high rate, it is concerning that so many report experiences of discrimination based on insurance status.

Table 8

Perceived reason for unfair judgment, disrespect, or discrimination in health-care settings among New York City adults with high health care needs by economic disadvantage

	ECONOMIC DISADVANTAGE: NO	ECONOMIC DISADVANTAGE: YES
Felt judged unfairly, treated with disrespect, or discriminated against	14%	22%
Perceived reason among those reporting discrimination…		
Race/ethnicity, or skin color	41%	35%
Age	33%	12%
Insurance status or type	16%	9%
Gender/sex	16%	2%
Body weight	10%	5%
Income level	9%	12%
Language/accent	6%	14%
Sexual orientation	6%	5%
Religion	5%	1%
Health status or disability	2%	7%
Immigration status	<1%	<1%

Poverty Tracker 2017 and 2020 samples. Majority of surveys fielded between October 2020 and May 2021. Bolded point estimates indicate statistically significant differences at the p<.05 level or higher. Significance determined using adjusted Wald test where the no economic disadvantage group is the reference group.

Experiences of perceived discrimination in health care settings can have long-lasting impacts on health care utilization. Despite struggling with chronic pain, one respondent had not had a health care appointment for years due to previous experiences of discrimination: *"All the doctors I went to just [didn't] try anything, they didn't test me for [anything], nothing for the pain. They just didn't believe me or didn't care… You finally get there and they treat you like garbage basically and won't help you even, [it] is emotionally and psychologically the most debilitating thing. Then you're leaving there, still in terrible pain, can barely walk and have accomplished nothing."* The respondent attributed these experiences to racial discrimination, saying, *"[Doctors] dismiss what patients say. They don't take patients seriously. I think doctors basically feel patients are stupid. I don't know if it's all patients, I have a feeling this might be. I think it's particularly minority patients or they just don't care."*

Housing and health

Next, we narrow in on one type of material hardship that is particularly relevant in a high-cost city like New York: housing. Not only can housing directly impact health (e.g., lead paint, mold, and disease-carrying pests), but housing difficulties can lead to challenges accessing appropriate care and adhering to the treatment and prevention of health conditions.

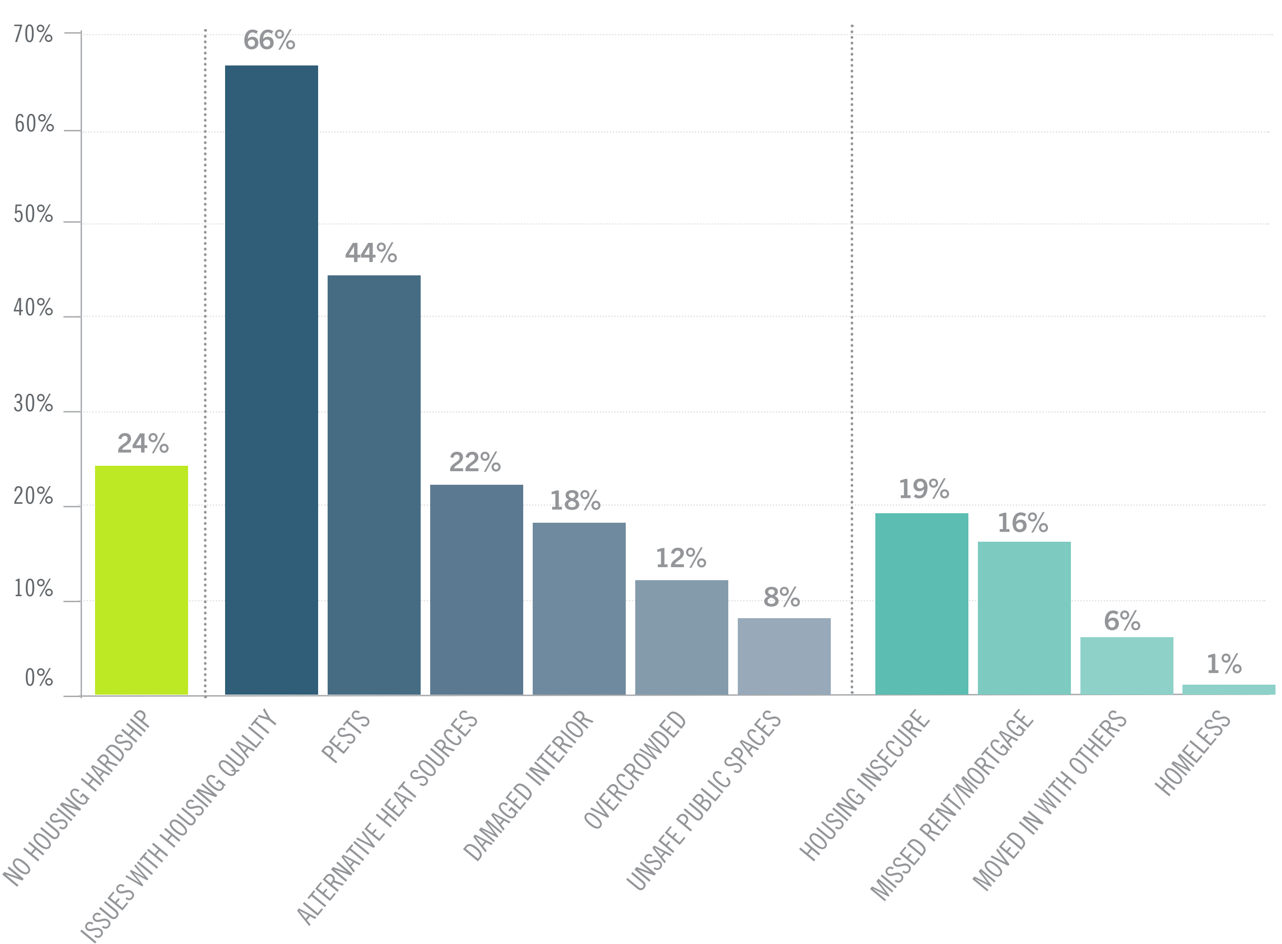
We investigated the presence of poor housing conditions, including pests, which are known to carry diseases and impact allergies/asthma; living in overcrowded households, which is associated with mental health challenges and infectious disease; and having unsafe public spaces in an apartment building. We also examined experiences of housing insecurity such as missing a rent or mortgage payment, moving in with others because of the cost, or a bout of homelessness. It is worth noting that some researchers and advocates include specific forms of doubling up in their definitions of homelessness.[11] In our analysis we do not include those who moved in with others or lived in overcrowded households as experiencing homelessness. Beyond highlighting the share of New Yorkers facing these health-related housing issues, we also examine the relationship between housing hardship and specific health issues.

Two-thirds of New York City adults who experienced housing hardship reported an issue with their housing conditions (**Figure 6**). We refer to these reported issues as poor housing conditions, which include living with pests, using alternative sources of heat such as kitchen stoves or portable space heaters during the winter, having cracks in the ceilings or walls, living in an overcrowded household, or living in a building where public areas such as lobbies or elevators are not safe from crime. Nearly one in five reported experiencing housing insecurity at some point in the past 12 months, such as not paying the full rent or mortgage, moving in with others because of financial problems, or staying somewhere not meant for regular housing.

[11] *Richard, Dworkin, Rule, Farooqui, Glendening, and Carlson (2022)*

Figure 6

Housing hardship among New York City adults



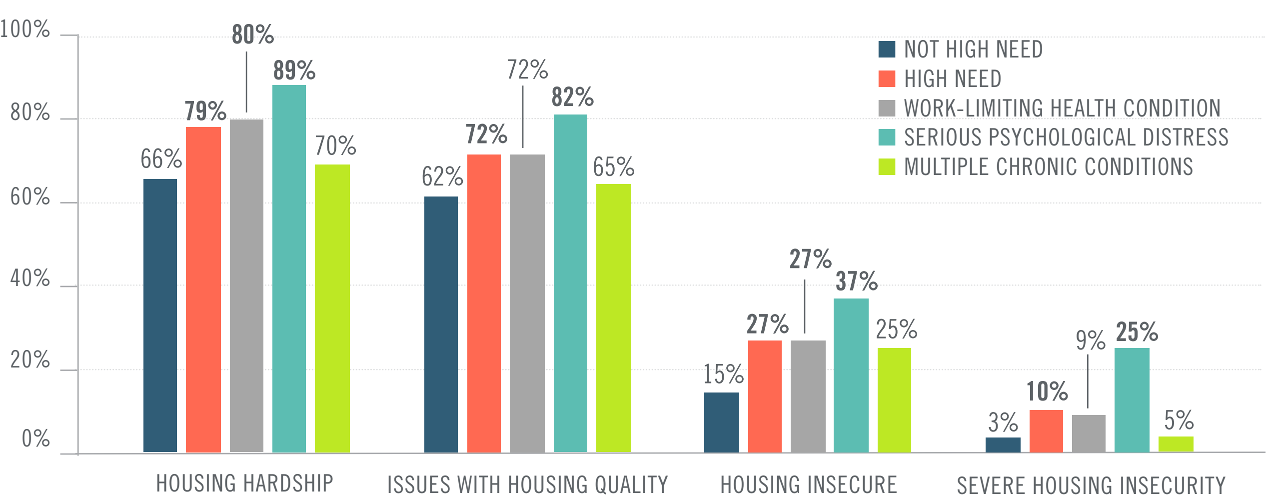
Poverty Tracker 2017 and 2020 samples. Majority of surveys fielded between October 2020 and May 2021.

Poor housing and neighborhood conditions intersect with health in myriad ways, as described by several respondents. One explained, *"The elevator is usually not working. Those little things have been difficult, and I don't know if that has anything to do with COVID that they're [not] able to maintain the building . . . or if they're just neglecting it. . . The dog pee, the defecation, those are even more bigger concerns."* A respondent who uses a walker and lives in a Section 8 apartment explains, *"I don't go out much because of the steps. I'm on the second floor. I don't have an elevator in my building. I don't go out much at all. . . When I do have to go out, I hate going out and having to come back in."* They also explained, "*Well, I have plenty of rats. I have gotten a cat. I'm not supposed to have any cat because it's bad for my health because of my asthma. It triggers it. It's either the rats or the cat. I keep the cat.*"

In **Figure 7** we examine, by health care need, rates of housing hardship. We see that those with higher needs also had higher rates of housing hardships. Particularly stark were rates of housing hardship among those who experienced serious psychological distress.

Figure 7

Share of New York City adults facing housing hardships by health need



Poverty Tracker 2017 and 2020 samples. Majority of surveys fielded between October 2020 and May 2021. Bolded point estimates indicate statistically significant differences at the p<.05 level or higher. Significance determined using adjusted Wald test where those not facing the relevant health condition are used as the reference group.

Those facing housing hardship were more likely to use urgent care centers and hospital emergency rooms (**Table 9**). They were also more likely to use telehealth services, though differences were not statistically significant. Use of hospital emergency rooms is particularly concerning, as ERs are intended for more severe and acute health issues and often result in expensive bills. During a pandemic when emergency rooms are overrun, these findings highlight potential risks of additional exposure and disruptions in care.

Table 9

Use of urgent care centers, telehealth, and hospital emergency rooms (last 6 months) among New York City adults with high health care needs by housing hardship

	NO HOUSING HARDSHIP	ISSUES WITH HOUSING QUALITY	HOUSING INSECURE
Urgent care	**28%**	**55%**	**51%**
Telehealth	36%	43%	46%
Hospital emergency room	**12%**	**30%**	**36%**

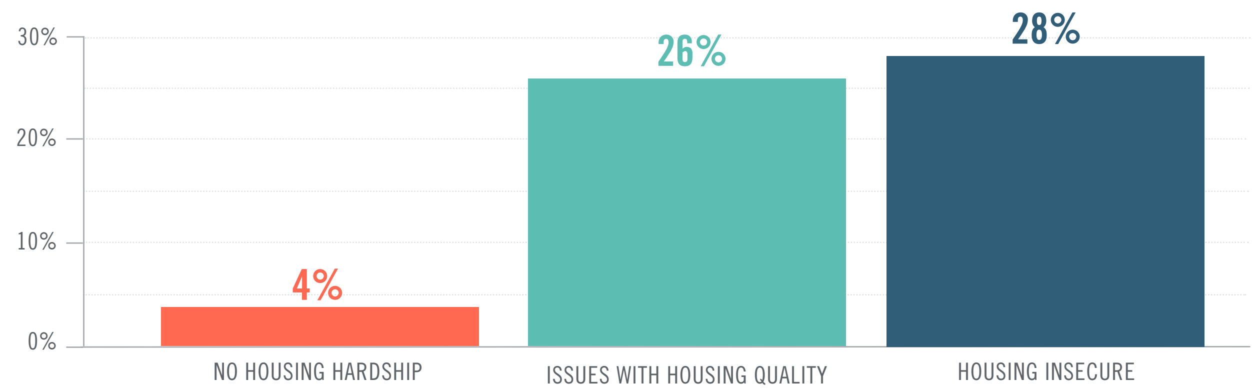
Poverty Tracker 2017 and 2020 samples. Majority of surveys fielded between October 2020 and May 2021. Bolded point estimates indicate statistically significant differences at the p<.05 level or higher. Significance determined using adjusted Wald test where those not facing any housing problems are used as the reference group.

Just 4% of high-need New Yorkers with no housing hardship reported difficulty getting to appointments (**Figure 10**), but this rate rises to 26% among those who live in poor conditions and 28% among those who face housing insecurity. **Table 10** lists factors that made travel to appointments difficult. Those who lived in poor conditions were most likely to report difficulties with transportation such as inconvenient subway/bus stops or Access-a-Ride being late, the visit being far away, or having pain that made travel difficult.

The most common challenge faced by those who were housing insecure was in paying for transportation, followed by the visit being far away, difficult transportation, and an inability to get out of work. These findings highlight that it is not only housing conditions and housing security that matter but also the location of that housing. Those facing housing insecurity may face unique challenges related to living far from their usual providers. Using transportation systems, taking time off of work, and paying to travel all impact people's ability to get the care they need.

Figure 10

Difficulty getting to appointments among New York City adults with high health care needs by housing hardship



Poverty Tracker 2017 and 2020 samples. Majority of surveys fielded between October 2020 and May 2021. Bolded point estimates indicate statistically significant differences at the p<.05 level or higher. Significance determined using adjusted Wald test. Those not facing any housing problems were used as the reference group.

Table 10

Reason for difficulty getting to appointments among New York City adults with high health care needs by housing hardship

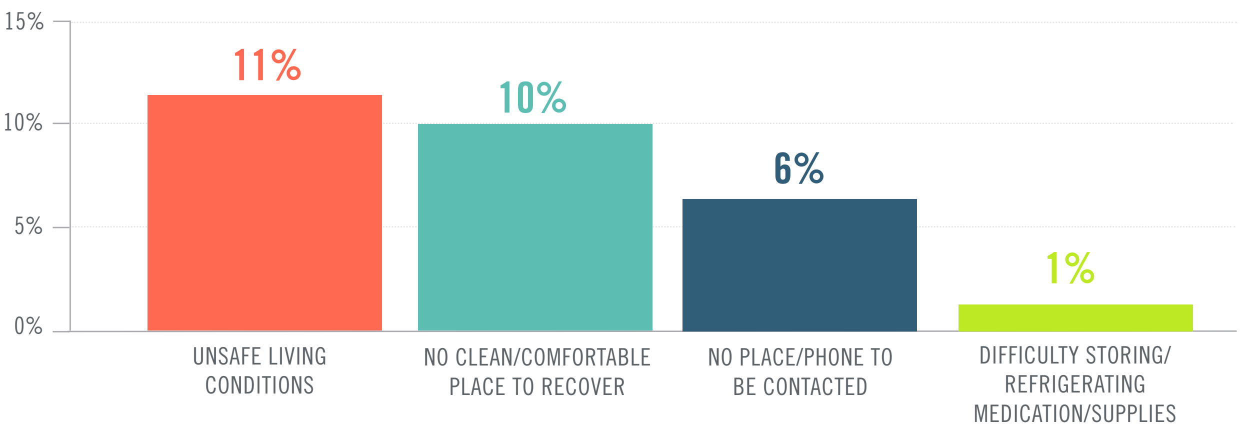
	ISSUES WITH HOUSING QUALITY	HOUSING INSECURE
Visit was far away	20%	28%
Difficult transportation	44%	26%
Difficulty paying for transportation	11%	37%
Couldn't get out of work	6%	24%
Couldn't find someone to care for child or family member	5%	7%
You were in pain and it was difficult to travel	13%	7%

Poverty Tracker 2017 and 2020 samples. Majority of surveys fielded between October 2020 and May 2021.

The most common health-related housing issues among high-need New Yorkers who experienced housing hardship were unsafe living conditions, such as mold, lead exposure, inadequate heat, or missing railings (**Figure 11**). Some people also reported challenges related to having a clean and comfortable place to recover and treat health problems, a regular place or phone where they can be contacted by a doctor or medical professional, and storing or refrigerating prescription medications or other medical supplies.[12]

Figure 11

Share of New York City adults with high needs who experienced health care challenges related to housing (among housing insecure)



Poverty Tracker 2017 and 2020 samples. Majority of surveys fielded between October 2020 and May 2021.

[12] *While the share of high need New Yorkers facing housing insecurity who reported difficulty storing or refrigerating medication or medical supplies was just 1%, the rate when not limited to high need New Yorkers was higher (3%; n = 148), and even higher among those facing a severe housing insecurity like homelessness (8%; n = 36).*

Eli's story

Eli is a 45-year-old HIV-positive man who lives alone in a shelter and has struggled with homelessness, unemployment, and substance use. Eli described the years leading up to the pandemic, telling us, "*I was really out on the streets. I wasn't taking my medicine, the high viral load, all that stuff.*" The previous year represented a major turning point in terms of his health, and at the time of the interview he was managing his HIV with medication. He said, *"I just wanted to get my life together… By the end of last year I wanted to have a full-time job, a permanent apartment and [be in the best health I could be], making my doctor's appointments, all that stuff. And all I really got done was the health.*"

Rejected by the drug treatment program he applied to, Eli stopped using drugs on his own: "*Once I got off the drugs, it was so much clearer and easier to see, 'Hey, if I do these things, that really is gonna make the health care piece a lot more effective. We'll get more out of it, so I'm not gonna miss any appointments.'"* Technology helps him stay on top of his care. "*The communication with my doctor—I can send her, through that [patient] portal, I can send her an email. I have a cell phone number for her. I can text her. I can text at any time. Right away, she gets back to me. All my history is all there. Every test I've ever taken, all my blood work, everything is all on there."*

"I just wanted to get my life together… By the end of last year I wanted to have a full-time job, a permanent apartment and [be in the best health I could be], making my doctor's appointments, all that stuff. And all I really got done was the health."

He recalled negative health care experiences prior to making this investment in building a partnership with his provider: *"I didn't always get back, or I missed doctor's appointments, and so I feel like they were dismissive… Communication wasn't great, but to be fair, I wasn't doin' what I was supposed to do. Now that I am, and my doctor and I have good communication…she's becoming a better doctor… I'm learning to be a better patient."*

After cycling through five shelter facilities in 18 months, Eli was relatively happy with his current residence, saying, "*The neighborhood is good. It's pretty safe,"* and the room is *"very clean. No roaches, no nothing."* But some issues persist. *"The staff steals from me sometimes… Somebody*

stole 15 bucks from me two weeks ago. When you don't have any money, 15 bucks is a lot of money." There have also been problems with building maintenance. When the bathroom above his room flooded, Eli lost half of his clothing. He described difficulties eating nutritiously when shelters do not provide kitchens. *"They're called non-cooking facilities, and the staff, actually, will give you a hard time if you even have a hot pot or a little burner that you bought yourself. Part of me [staying] healthy is preparing my own meals and not eating processed foods and things like that. I eat very healthy. Even now, I make the best of it. I've got a little George Foreman grill, and there's a microwave, and I have a little burner. I make it work with that."* Living in this environment has taken a toll on Eli's mental health, as residents are not allowed guests. *"It's very lonely. It's very isolating. If my family came up, they couldn't even come in to see me… I fight depression, and it's hard to fight it when people can't even come visit you. It's easy to get caught up in the cycle, especially when you don't have employment, where I could be in my room for days at a time."*

Eli has also struggled to find support in his housing search. "*[The case manager] and I don't see eye-to-eye on things. I actually had an opportunity with housing, and it didn't go my way, but it wasn't my fault. All she did was really, I felt, berate me, and she wasn't listening… Because I never really got a chance to work with the other, the case manager at my doctor's office, everything—I don't feel like I have much help… I'll just figure this stuff out on my own, just like I did with the drugs."* He believes his housing options will expand once he has secured employment. "*I'm waiting until I get full-time employment so that when I put in an application for an apartment, they'll know—because having a voucher makes people nervous. If you have a job and you have a housing voucher, they love you because they know that you're not gonna be sitting around just getting high. If they know you're out working and the rent's guaranteed, oh, you need to go to the top of the list."*

"It's very lonely. It's very isolating. If my family came up, they couldn't even come in to see me… I fight depression, and it's hard to fight it when people can't even come visit you. It's easy to get caught up in the cycle, especially when you don't have employment, where I could be in my room for days at a time."

Conclusion

The first report in this series, released in February 2022, used Poverty Tracker survey data from before the COVID-19 pandemic to examine health care needs in New York City, finding that about a third of New York City adults reported having high health care needs. The report highlighted that, in addition to older New Yorkers, those with less education, who were born in the United States, and who identify as Black or Latino had elevated rates of high health care needs relative to their counterparts. Those with high health care needs were more likely to live in poverty, have a low-income status, face material hardship, and face persistent economic disadvantage.

In this report we focused specifically on how New Yorkers facing economic and housing challenges used the city's health care systems. We looked at where they got care, the logistics of getting care, and the barriers they faced. We notably found that many people facing economic hardships also faced challenges to their health, including elevated risks of work-limiting health conditions and serious psychological distress. Among those with high health care needs, those facing economic disadvantage were more likely to forgo needed care, driven by issues of access related to cost, transportation, and mobility. Inequalities were even more stark among those facing housing challenges. High need New Yorkers facing economic disadvantage also faced challenges getting out of work to attend health appointments and filling out medical forms.

Use of urgent care centers and emergency rooms was greater among those facing economic disadvantage and housing hardship. Given the challenges disadvantaged patients face in obtaining primary and preventative care[13] and the well-documented overuse of expensive and unnecessary emergency room visits,[14] urgent care and telehealth services represent opportunities to lower the cost to individuals and the overall system while expanding access to those facing economic and housing challenges. Policy makers, health care providers, and leaders should focus on addressing the most pressing challenges to disadvantaged communities — such as improving care affordability, making transportation easier and more affordable or rethinking the locations of care, expanding paid time off for obtaining health care, and promoting culturally competent health care.

[13] *Martin, Liaw, Bazemore, Jetty, Petterson, and Kushel (2019)*
[14] *Honigman, Wiler, Rooks, and Ginde (2013)*

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Appendix

Table A1

Chronic conditions by economic disadvantage

	ECONOMIC DISADVANTAGE: NO	ECONOMIC DISADVANTAGE: YES
Asthma	13%	21%
Diabetes	14%	13%
Hypertension	34%	32%
Heart disease	8%	6%
Cancer	7%	6%

Poverty Tracker 2017 and 2020 samples. Majority of surveys fielded between October 2020 and May 2021.

Table A2

Share of New York City adults with high health care needs and individual health conditions by demographics

	HIGH HEALTH CARE NEEDS	MULTIPLE CHRONIC CONDITIONS	WORK-LIMITING HEALTH CONDITION	SERIOUS PSYCHOLOGICAL DISTRESS
White non-Latino	31%	16%	20%	8%
Black non-Latino	47%	24%	28%	10%
Asian non-Latino	19%	4%	9%	9%
Latino	53%	26%	28%	16%
Male	35%	14%	18%	10%
Female	42%	23%	25%	11%
18-24	32%	4%	10%	22%
24-35	22%	6%	8%	12%
35-45	33%	9%	18%	11%
45-55	39%	19%	26%	10%
55-65	48%	29%	29%	6%
65+	57%	44%	39%	5%
Less than a high school degree	65%	37%	46%	15%
High school degree or GED	37%	19%	20%	12%
Some college or associate's degree	40%	19%	24%	8%
Bachelor's degree or more	28%	11%	11%	10%
U.S. born	40%	20%	24%	10%
Foreign born	37%	18%	19%	11%
Manhattan	35%	17%	17%	10%
Brooklyn	32%	15%	18%	12%
Bronx	61%	37%	37%	13%
Queens	39%	16%	22%	10%
Staten Island	24%	10%	18%	3%

Poverty Tracker 2017 and 2020 samples. Majority of surveys fielded between October 2020 and May 2021.

Table A3

Share of New York City adults with chronic condition by demographics

	ASTHMA	DIABETES	HYPERTENSION	HEART DISEASE	CANCER
White non-Latino	15%	9%	28%	6%	10%
Black non-Latino	16%	19%	45%	8%	5%
Asian non-Latino	3%	6%	17%	2%	1%
Latino	25%	19%	36%	10%	6%
Male	11%	13%	28%	7%	4%
Female	21%	14%	37%	7%	8%
18-24	18%	3%	7%	1%	<1%
24-35	12%	3%	13%	2%	<1%
35-45	11%	4%	24%	2%	5%
45-55	13%	17%	36%	4%	6%
55-65	21%	21%	52%	10%	9%
65+	23%	31%	60%	22%	16%
Less than a high school degree	31%	25%	49%	16%	7%
High school degree or GED	17%	15%	34%	6%	3%
Some college or associate's degree	15%	15%	35%	6%	6%
Bachelor's degree or more	11%	7%	23%	5%	8%
U.S. born	18%	13%	32%	6%	8%
Foreign born	14%	14%	32%	8%	4%
Manhattan	20%	10%	24%	9%	9%
Brooklyn	15%	11%	27%	6%	5%
Bronx	23%	31%	48%	11%	6%
Queens	11%	10%	39%	5%	6%
Staten Island	18%	6%	21%	3%	6%

Poverty Tracker 2017 and 2020 samples. Majority of surveys fielded between October 2020 and May 2021.

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