

POVERTY TRACKER



CENTER ON
POVERTY &
SOCIAL POLICY
at Columbia University



Columbia
Population
Research
Center

ROBIN HOOD

THE LEONA M. AND HARRY B.
HELMSLEY
CHARITABLE TRUST

MONITORING POVERTY AND WELL-BEING IN NYC

SPECIAL SERIES:

HEALTH AND HEALTH CARE IN NEW YORK CITY



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Introduction

Over the past year and a half, New York City, the United States, and the world have endured one of the deadliest pandemics in modern history. As a result of COVID-19, up to 800,000 Americans¹ and tens of thousands of New Yorkers have died.² The pandemic has led to immense strains on federal and local health care systems as well as serious economic and social tensions, manifested through business and school closures, widespread layoffs, and an increased reliance on public and private assistance to make ends meet.

Though challenges have been widespread, research from the Poverty Tracker, a longitudinal study on economic well-being in New York City, shows that already disadvantaged groups, such as those with low incomes and Black and Latino New Yorkers, have disproportionately borne the economic brunt of the pandemic.³ And across the country, these same communities face higher risks of serious illness from COVID-19 and higher rates of COVID-19-related mortality.⁴

While recent events have imposed novel challenges to individual and collective health, issues with health and health care in the United States, and health-related inequities are not new. Despite spending more on health care than other similarly wealthy countries, the U.S. has the shortest life expectancy.⁵ Given the context that the U.S. has high levels of inequality in accessing health care,⁶ compounded by high rates of suicide,⁷ opioid consumption,⁸ and obesity,⁹ shorter and shortening lifespans are perhaps unsurprising. With respect to common chronic diseases, the U.S. ranks among the top in diabetes prevalence (behind Turkey and Mexico), above average in cancer incidence, and slightly below average with respect to heart attack or heart disease related mortality.¹⁰

Not only does the U.S. lag behind other countries in health and life expectancy, it also exhibits stark inequalities with respect to health outcomes. The economist Raj Chetty and his colleagues recently found, for example, that the difference in life expectancy between the top and bottom one percent of the income distribution in the U.S. was nearly 15 years for men and about 10 years for women; and these inequalities have grown over time (from 2001 to 2014).¹¹ In addition to disparities by income, there are also disparities by race/ethnicity¹² and education.¹³ These findings present a troubling reality whereby those with resources and socioeconomic standing live longer and healthier lives than those without such benefits.

¹ Johns Hopkins Coronavirus Resource Center. (2021).

² New York City Department of Health. (2021).

³ Williams, M. (2021), Collyer, S., Huq, S., Washington, K., Wimer, C. (2020).

⁴ Koma, W., Artiga, S., Neuman, T., Claxton, G., Rae, M., Kates, J., Michuad, J. (2020).

⁵ Tikkanen, R., Abrams, M. (2020).

⁶ Kurani, N., Kamal, R., Amin, K., Ramirez, G., Cox, C. (2020).

⁷ OECD Indicators. (2020).

⁸ OECD Opioids. (2019).

⁹ OECD Obesity Update. (2017).

¹⁰ OECD Indicators. (2020).

¹¹ Chetty, R., Stepner, M., Abraham, S., Lin, S., Scuderi, B., Turner, N., Bergeron, A., Cutler, D. (2016).

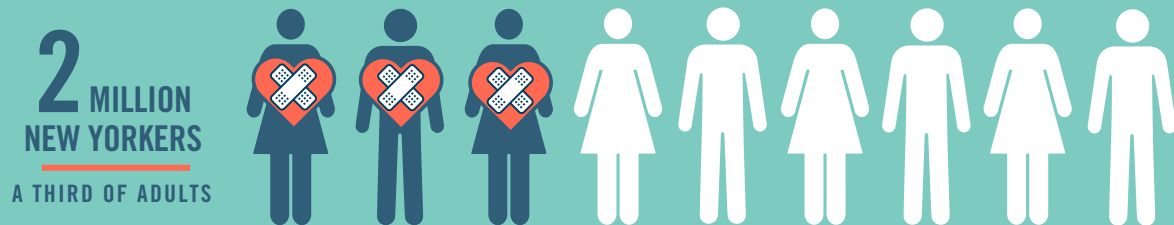
¹² Arias, E., Tejada-Vera, B., Ahmad, F. (2021).

¹³ Hummer, R., Hernandez, E. (2015).

KEY FINDINGS

With the aim of providing a better understanding of the economic lives of New Yorkers with the highest health care needs, this series offers insights for those aiming to improve the city's health care system and its ability to serve all New Yorkers. As the data for this report, the first in the series, was collected before the pandemic, these results provide a baseline understanding of health in NYC and the economic lives of those with the highest needs. In future reports we will analyze data on health care utilization, collected during the pandemic. We find:

About a third of adults in New York City — more than two million New Yorkers — have high health care needs,¹⁴ defined as living with multiple chronic health conditions, a work-limiting health condition, and/or severe psychological distress.



HIGH
HEALTH CARE NEEDS



=

MULTIPLE
CHRONIC HEALTH
CONDITIONS



WORK-LIMITING
HEALTH
CONDITION



SEVERE
PSYCHOLOGICAL
DISTRESS



THOSE WITH HIGH HEALTH CARE NEEDS

Specific subgroups report higher health care needs including, older New Yorkers, U.S. born New Yorkers, those with less education, and Black and Latino New Yorkers.



OLDER NEW YORKERS



LESS EDUCATION



U.S. BORN

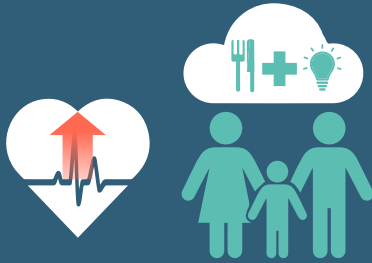


BLACK AND LATINO

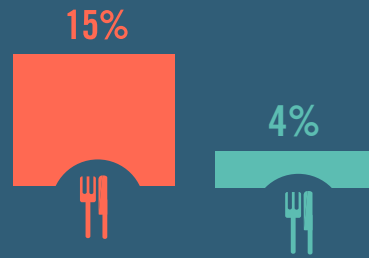
¹⁴ Our analysis is based off of responses from 2,939 survey participants. Data included in this finding is representative of NYC in 2019.



Those with **high health care needs** are more likely than other New Yorkers to face economic disadvantage, potentially compounding the challenges they face and their ability to access care.



Those with high health care needs are more likely to live in poverty and have trouble paying for routine expenses including **food, medical care, and utilities** (compared to those without such health care needs).



15% of those with high health care needs have trouble paying for food, compared to just **4%** of those without such needs.

Over a five-year period, about **60%** of those with high health care needs faced poverty in at least one year. Nearly **70%** faced a material hardship in at least one year.

Among those with high health care needs, over a 5 year period

60%

LIVED IN POVERTY IN AT LEAST ONE YEAR



70%

FACED MATERIAL HARDSHIP FACED MATERIAL HARDSHIP IN AT LEAST ONE YEAR



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.

The Poverty Tracker

Launched in 2012, the Poverty Tracker surveys a representative sample of New Yorkers every three months, providing critical information on the dynamics of poverty and other forms of disadvantage in New York City. In addition to measures of poverty and disadvantage, the Poverty Tracker collects information from detailed modules on other topics such as health, assets and debts, and employment.

This report uses data from Poverty Tracker surveys fielded in 2019 which asked respondents questions about their health,¹⁵ income, and economic well-being. In 2020 and 2021 a new survey module was added,¹⁶ asking New Yorkers detailed questions about their access to health care and the adequacy of care they received. Our second and third reports will harness this recently collected data to provide insight into how New Yorkers with high health care needs interact with the health care system and how health and health care in New York City can be improved.

¹⁵ See Appendix A for Poverty Tracker survey module on health.

¹⁶ See Appendix B for Poverty Tracker survey module on health and health care utilization asked to survey respondents in 2020 and 2021.




About our Approach

The goal of this report is to provide a better understanding of the state of health and health care in New York City. Given inequities in health outcomes and that the majority of health care dollars in the U.S. are spent on a small percentage of patients with high health care needs, we start by providing a definition of high-need New Yorkers. We classify New Yorkers as having high health care needs if they face multiple chronic health conditions, have a work-limiting health condition, and/or experience severe psychological distress. Throughout the remainder of this report we refer to those with high health care needs as “high-need” New Yorkers. See Table 1 below for definitions of these three facets of health.¹⁷

It is important to note that a consensus on who high-need patients are has not been reached, though much of the research focuses on high-cost high-need patients (HCHN) with functional limitations.¹⁸ As we are not solely concerned with cost, but are more broadly interested in health and healthcare access and utilization, we use a broadened definition, expanded to include those with multiple chronic health conditions and severe psychological distress.

Table 1

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.
	Severe psychological distress	A value of 13 or greater on the Kessler Psychological Distress Scale (K6), which indicates severe psychological distress. ¹⁹

Using these definitions and questions to identify those with high needs, we go on to compare rates of poverty and material hardship among high need New Yorkers compared to those with fewer needs. Our goal here is to see to what extent coping with health conditions overlaps with challenges to economic well-being and security. Finally, we look at more detailed measures of income and hardship to gain a better understanding of how health is related to economic well-being over time. See the text boxes below for detailed descriptions of our definitions of poverty, hardship, and race/ethnicity.

¹⁷ See Appendix A for a complete list of survey questions used to identify New Yorkers with high health care needs.

¹⁸ Long, P., Abrams, M., Milstein, A., Anderson, G., Apton, K.L., Dahlberg, M.L., Whicher, D. E. (2017).

¹⁹ Prochaska, J., Sung, H.Y., Max, W., Shi, Y. Ong, M. (2021).

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 2019, the SPM threshold for a two-adult, two-child family of renters in New York City was \$36,819. 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.

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

The Poverty Tracker measures material hardship in five domains: **food, housing, bills, general financial hardship, and medical care** (see definitions below). New Yorkers who face one or more of these severe forms of material hardship in a year are identified as having faced material hardship.



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.

How do we identify race and ethnicity?

Throughout this report, we discuss race and ethnicity in the context of health disparities among New Yorkers. We identify the race and ethnicity of adults in the Poverty Tracker sample using questions asked by the Census Bureau on various population-level surveys.²⁰ These questions allow us to better understand the needs of communities within New York City and to ensure that we are surveying a representative sample of New York City’s racial and ethnic groups.

In this report we refer to New Yorkers who identified as Hispanic, Latino, or of Spanish origin as Latino New Yorkers, and to Black non-Latino and white non-Latino New Yorkers as Black and white New Yorkers, respectively. In addition, when we say, “New Yorkers,” we are referring to adults in New York City.

See Appendix C for a more detailed discussion regarding the questions used to identify race and ethnicity, terminology used in this report, and our justification for this terminology.

While recent events have imposed novel challenges to individual and collective health, issues with health and health care in the United States, and health-related inequities are not new.

²⁰ Historically, the Census asks race and origin questions to gain an understanding of the makeup of the population and to help construct civil rights protections for all. These questions have helped to reveal gaps within various social policies and to address the economic, educational, and infrastructural needs of different communities. See Brumfield, C., Goldvale, C., and Brown C. (2019).

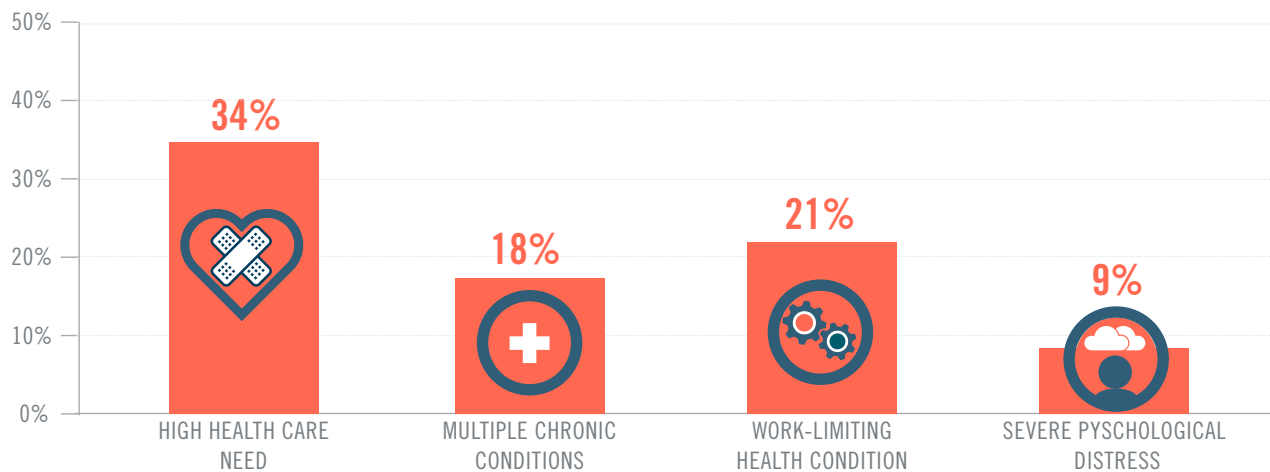
Findings

More than two million adult New Yorkers have high health care needs, defined as experiencing multiple chronic health conditions, a work-limiting health condition, and/or severe psychological distress.

In Figure 1 we show that about one third of New Yorkers have high health care needs. We also examine the share of the city's population experiencing any of these forms of health need, finding that overall, 18% of New Yorkers have multiple chronic health conditions, 21% have work-limiting health conditions, and 9% face severe psychological distress. These numbers highlight that, even before the pandemic, severe health problems impacted millions of New Yorkers. Building on these findings, we look at differences in the likelihood of having high needs among various demographic groups across the city.

Figure 1

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



Source: 2019 Annual Poverty Tracker survey data, second and third panels.







We find that older New Yorkers, those with less education, U.S. born, and those who identify as Black or Latino have elevated rates of high needs compared to their counterparts.

In addition to overall rates of health problems in New York City, the Poverty Tracker allows us to examine rates of health problems among different demographic groups. In Table 2, we see that New Yorkers ages 65 and older are the age group most likely to have high needs (60%). Those ages 55-64 (44%) and 45-54 (35%) also face elevated levels compared to those who are 18-34 years old (20%). While it is expected that older New Yorkers would have higher levels of health care need, we also find elevated rates of need among other groups. Notably,

we see that New Yorkers without college degrees, those who are U.S. born, and Black and Latino New Yorkers²¹ had elevated rates of high needs. These findings tell us which New Yorkers are most likely to have high health care needs and, in turn, are more likely to need services from New York City's health care system.

Table 2

Share of New York City adults with high health care needs (by demographic group)

		OVERALL	HIGH HEALTH CARE NEED
RACE 	RACE/ETHNICITY		
		White	32%
		Black*	37%
		Latino**	38%
AGE 	AGE		
		<35 years old	19%
		35-44 years old	20%
		45-54 years old***	35%
		55-65 years old***	44%
		65+ years old***	60%
GENDER 	GENDER		
		Male	32%
	Female	36%	
EDUCATION 	EDUCATION		
		Bachelor's degree or more	24%
		Some college or associate's degree**	37%
	HS graduate or less***	43%	
FOREIGN BORN 	FOREIGN BORN		
		No	37%
	Yes**	31%	
BOROUGH 	BOROUGH		
		Manhattan	32%
		Brooklyn	33%
		Bronx	39%
		Queens	34%
		Staten Island	34%

Source: 2019 Annual Poverty Tracker survey data, second and third panels.

Note: The results included in this table represent the observed weighted rates among each group. Significant differences were determined using weighted logistic regressions: † $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$. Comparison groups are listed first.²²

²¹ Differences by race and foreign-born status are marginally significant and thus should be interpreted with caution.

²² See table D1 in Appendix D for a detailed breakdown of health conditions by demographic groups.

This leads us to the question of what drives such health inequities. Despite facing socioeconomic disadvantage, immigrants fare better with respect to health outcomes compared to those born in the U.S. This falls in line with the “Healthy Immigrant Paradox,” which highlights that immigrants in the U.S. have better health outcomes compared to non-immigrants.²³ Worth noting is that immigrant health declines over time and that second and third-generations have worse health outcomes than their parents.²⁴

Other notable disparities are those between groups with varying levels of socioeconomic standing. As we see in Table 2, Black and Latino New Yorkers are more likely to have high health care needs and as we have seen in previous Poverty Tracker Reports also have lower incomes compared to white New Yorkers. Both health and income inequality are functions of structural racism in U.S. policy and institutional practices where white families are systematically advantaged relative to people of color in all areas of American life related to health and wealth, such as access to high quality education, employment opportunities, timely, affordable, high-quality health care, asset building, housing, transportation, fairness in the criminal justice system, and environmental safety.²⁵

To improve the state of health and health care in New York City, it is important that we continue working to address the root causes of health disparities. This includes understanding which New Yorkers are most likely to face serious health conditions, the underlying causes of these conditions, and how government and non-profit leaders, as well as other policymakers, can better address these needs.

Black and Latino New Yorkers are more likely to have high health care needs and as we have seen in previous Poverty Tracker Reports also have lower incomes compared to white New Yorkers.

²³ Constant, A.F. (2017).

²⁴ Gordon-Larsen, P., Harris, K.M., Ward, D.S., Popkin, B.M. (2003).

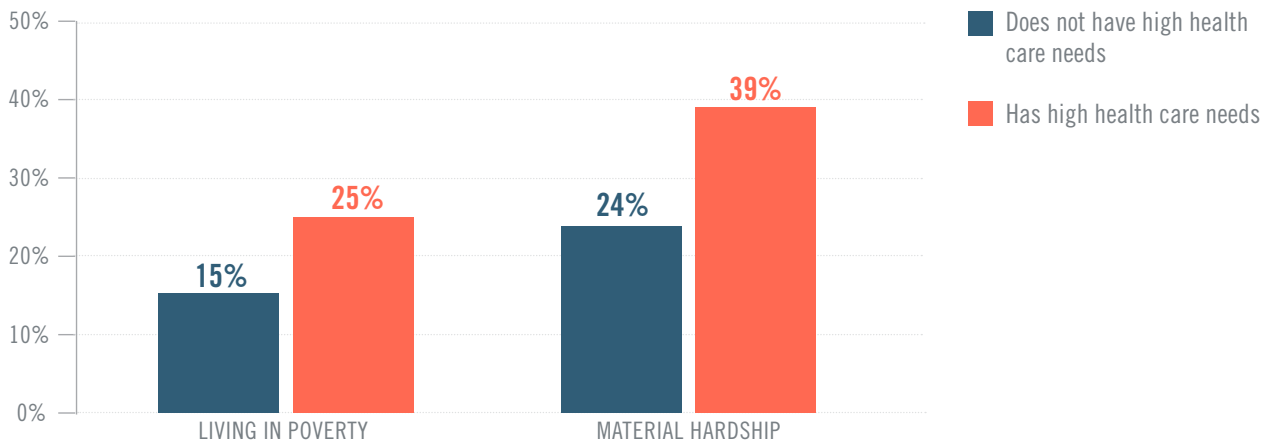
²⁵ Bailey, Z.D., Feldman, J.M., Bassett, M.T. (2021).

Those with high health care needs are more likely to live in poverty compared to those without such needs, and are more likely have trouble paying for routine expenses like housing, food, and utilities.

Recent research in the Journal of the American Medical Association provides some good and bad news.²⁶ The bad news is that, in the U.S., medical debt is the most common form of unpaid debt. The good news is in that states that expanded Medicaid in 2014, like New York, low-income families face much lower levels of medical debt. With these results in mind, it is important to remember other ways that health influences income and financial security. In Figure 2, we see that those with high needs face elevated struggles related to income and expenses. We find that those with high needs are more likely to live in poverty than those without such needs (25% vs. 15%) and more likely to face material hardships (39% vs. 24%). Given the relationship between health and one’s ability to work, it is unsurprising that those with health problems face elevated levels of economic hardship. Still, these rates highlight a troubling reality where a significant portion of New Yorkers with high needs face difficulties meeting the routine expenses of everyday life — including difficulties affording adequate housing, uninterrupted access to utilities, prescriptions, and healthy food, all of which contribute to physical and mental health.

Figure 2

Poverty and material hardship rates among New Yorkers with and without high health care needs



Source: 2019 Annual Poverty Tracker survey data, second and third panels.

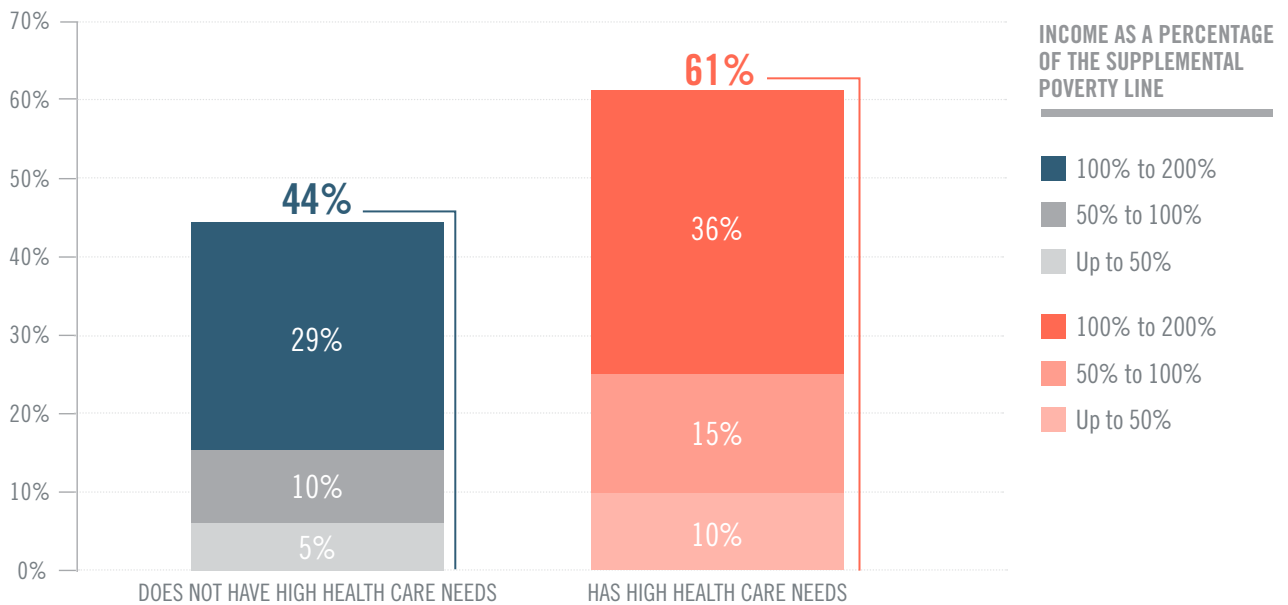
²⁶ Kluender, R., Mahoney, N., Wong, F. (2021).

New Yorkers with high health care needs are similarly more likely to be defined as “low-income” (i.e., below 200% of the poverty line).

As we know from previous Poverty Tracker research, experiences of material hardship do not stop at the poverty line, and medical issues may be an economic burden for those up and down the income distribution.²⁷ In addition to poverty itself, researchers who study poverty, income, and economic well-being also consider “deep poverty” (below 50% of the poverty line) and “low-income” status (below 200% of the poverty line).²⁸ In Figure 3, we see that 61% of New Yorkers with high needs have low incomes compared to 44% of those without such needs. These findings highlight that when we expand the income threshold we find an even larger percentage, in fact a majority, of high-need New Yorkers who face precarious economic circumstances. This result is important given previous Poverty Tracker research, which finds that families who exit poverty and are living above 200% of the poverty threshold are less likely to fall back into poverty compared to those who exit poverty but do not pass this threshold.²⁹

Figure 3

Income as a percentage of the poverty line among New Yorkers with and without high health care needs



Source: 2019 Annual Poverty Tracker survey data, second and third panels.

²⁷ Collyer, S., Maury, M., Bushman-Copp, L., Garfinkel, I., Kennedy, L., Neckerman, K., Teitler, J., Waldfogel, J., Wimer, C. (2020).

²⁸ For example, we define New Yorkers as having low incomes if their income is below 200% of the poverty threshold. This breaks down to \$34,128 for a single adult without children and \$73,638 for a married or cohabiting couple with two children.

²⁹ Wimer, C., Collyer, S., Maury, M., Garfinkel, I., Kennedy, L., Neckerman, K., Teitler, J., and Waldfogel, J. (2018).

Similarly, we have more detailed measures of material hardship, which allow us to look more closely at what specific expenses those with high health care needs are having trouble meeting.

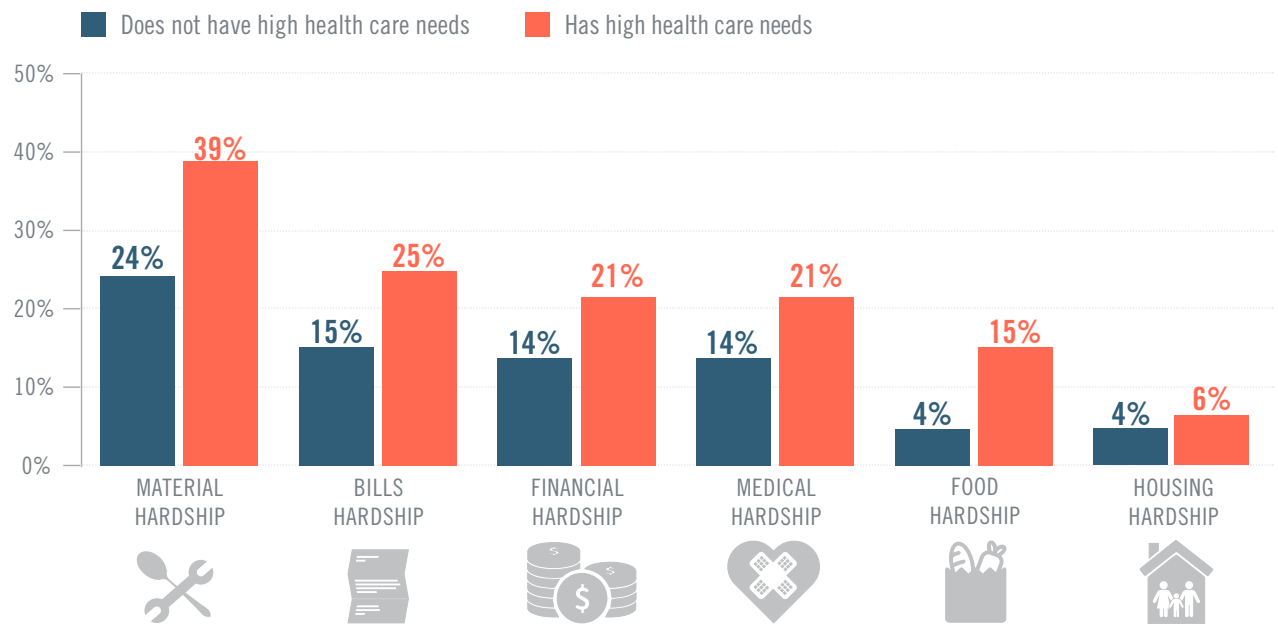
Fifteen percent of those with high health care needs have trouble paying for food compared to just 4% of those without such needs.

The Poverty Tracker measures five specific domains of material hardship, which make up our overall hardship measure. We find that New Yorkers with high needs are less likely to report being able to meet routine expenses in each of these five domains. For example, only 4% of New Yorkers without high needs reported a food hardship — defined as often running out of or worrying about running out of food — a rate that jumps to 15% among those with high needs. Similar patterns exist with respect to one’s ability to pay for medical costs, utilities, and other expenses. These findings show that New Yorkers coping with high health needs often face a variety of economic challenges at the same time.

This provides detail on how the health-poverty trap functions by highlighting the specific expenses related to health (food, housing, medical, etc.) that New Yorkers with high needs are being forced to forgo.

Figure 4

Global and individual material hardships rates among New Yorkers with and without high health care needs



Source: 2019 Annual Poverty Tracker survey data, second and third panels.

Over a five-year period, about 60% of those with high health care needs faced poverty in at least one year. Nearly 70% faced a material hardship in at least one year. Forty-three percent faced a material hardship in three or more years.

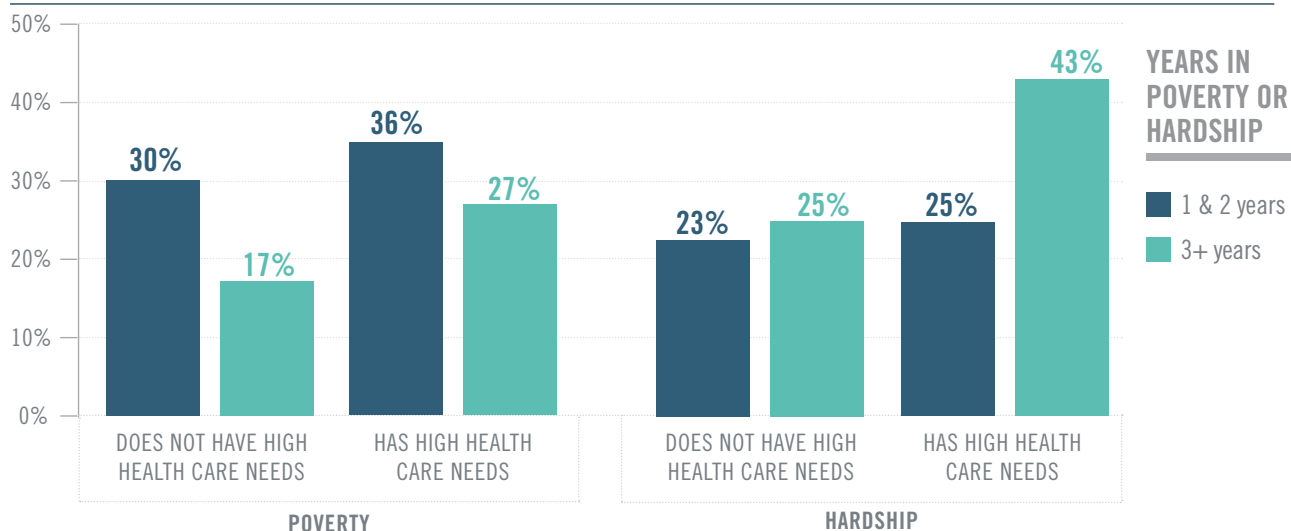
A unique feature of the Poverty Tracker is that it allows us to observe the dynamics of poverty and hardship over time. Using the Poverty Tracker cohort first sampled in 2015, we can look at experiences of poverty and hardship over a five-year period, providing detailed information into the dynamics of hardship and poverty over a longer horizon. In Figure 5, we examine the prevalence and persistence of poverty and material hardship among those with and without high health needs. We find that more than 60% of New Yorkers with high needs faced poverty at least once over a five-year period, and more than a quarter were persistently poor (living below the poverty line for three or more years). This compares to 47% of those without high needs falling below the poverty line in at least one year, and 17% who were consistently poor.

Experiences of material hardship were even more common. Nearly 70% of New Yorkers with high needs faced material hardship in at least one year over a five-year period (compared to 48% without such needs) and 43% faced persistent material hardship (compared to 25% without such needs).

These findings show that poverty and hardship are experienced by a greater number of New Yorkers than is observed when looking at a single year of data. As we have seen in other Poverty Tracker reports, when only focusing on one year of data, we underestimate the scope of the problem. When looking over longer time periods, we see that a much larger percentage of New Yorkers — both with and without high health care needs — experience poverty and hardship in at least one year. Moreover, we see that a large portion of those with high needs are persistently facing poverty and/or hardship. While most New Yorkers may not fall below the poverty line in a given year, a substantial number are low income and financially insecure, facing high risk of falling into poverty. New Yorkers with high health needs are more likely than other New Yorkers to move in and out of poverty and hardship.

Figure 5

Number of years in poverty or hardship among New Yorkers with and without high health care needs (over a five-year period)



Source: Poverty Tracker longitudinal survey data (collected between 2015 and 2019), second panel. To define high-need New Yorkers in the longitudinal data we used the respondent's most recent report of a chronic, work-limiting, or severe mental health issue (the majority of these responses were collected in 2019).

Conclusion

Two million New Yorkers, about a third of New York City adults, fall into a group we identify as having high health care needs. These are New Yorkers with multiple chronic health conditions, work-limiting health conditions, and/or severe psychological distress. While our definition of high need is broader than some use, it is important to note that many more New Yorkers live with severe health conditions and are not captured in this high need category and/or have family members, friends, and coworkers living with such conditions of their own. Policy makers should keep this in mind, understanding that the scope of who is effected is much larger than just those presented as having high health care needs (using our definition).

While the population of New Yorkers with high health care needs is diverse, we find that older New Yorkers, those with lower levels of education, those born in the U.S., and Black and Latino New Yorkers are more likely to have such needs. Knowing which New Yorkers are the most likely to face these issues and the underlying causes of such disparities should inform future research and policymaking to better understand and address disparities in health outcomes, health care access, and how such disparities can be addressed at the individual, community, and societal level. Those working to understand and improve health and health care access in New York City should also bear in mind the relationship between health and economic well-being that we have documented here.

While COVID-19 has drawn new attention to disparities in health and health care, our analysis finds that these issues pre-date the pandemic. For this reason, the Center on Poverty and Social Policy, the Helmsley Charitable Trust, and Robin Hood have partnered to produce three reports examining the state of health and health care in New York City. In addition to this report on New Yorkers with high health care needs and their economic well-being, two forthcoming reports will draw on new survey data collected in 2020 and 2022. Support from the Helmsley Charitable Trust allowed us to add a new survey module with detailed questions on New Yorker's experiences with the health care system. Combining these detailed measures of health care access and utilization with the Poverty Tracker's extensive longitudinal measures of economic disadvantage promises unusual insight into the challenges faced by high-need New Yorkers with high health care needs.

Knowing which New Yorkers are the most likely to face these issues and the underlying causes of such disparities should inform future research and policymaking to better understand and address disparities in health outcomes, health care access, and how such disparities can be addressed at the individual, community, and societal level.

Appendix A:

Survey questions used to identify New Yorkers with high health care needs.

Respondents were coded as having multiple chronic health conditions if they said yes to more than one of the following conditions: asthma, diabetes, hypertension, cancer, or heart disease. See survey questions below:

Has a doctor or other health professional ever told you that you have or had...

Asthma?	1. Yes	2. No
Diabetes?	1. Yes	2. No
Hypertension or high blood pressure?	1. Yes	2. No
Heart disease?	1. Yes	2. No
Cancer?	1. Yes	2. No
Arthritis?	1. Yes	2. No
Migranes?	1. Yes	2. No
A sleep disorder such as sleep apnea?	1. Yes	2. No
Any kind or chronic health condition, other than ones mentioned above?	1. Yes	2. No

What condition is that?

1. Enter condition:

Respondents were coded as having a work-limiting health condition if they said yes to the following question:

Do you have a health problem or disability which prevents you from working or which limits the kind or amount of work you can do?

1. Yes
2. No

Respondents were coded as having severe psychological distress if they scored a value of 13 or higher on the Kessler Psychological Distress Scale, which includes the following questions:

About how often during the past 30 days did you feel so depressed that nothing could cheer you up?

1. All of the time
2. Most of the time
3. Some of the time
4. A little of the time
5. None of the time

About how often during the past 30 days did you feel nervous?

1. All of the time
2. Most of the time
3. Some of the time
4. A little of the time
5. None of the time

About how often during the past 30 days did you feel restless or fidgety?

1. All of the time
2. Most of the time
3. Some of the time
4. A little of the time
5. None of the time

About how often during the past 30 days did you feel hopeless?

1. All of the time
2. Most of the time
3. Some of the time
4. A little of the time
5. None of the time

About how often during the past 30 days did you feel that everything was an effort?

1. All of the time
2. Most of the time
3. Some of the time
4. A little of the time
5. None of the time

About how often during the past 30 days did you feel worthless?

1. All of the time
2. Most of the time
3. Some of the time
4. A little of the time
5. None of the time

Appendix B:

Survey module on health asked to Poverty Tracker respondents in 2020 and 2021.
To be featured in future reports.

This section will ask you some questions about your health.

Would you say your health in general is excellent, very good, good, fair, or poor?

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor

In general, would you say your quality of life is...

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor

In general, how would you rate your physical health?

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor

In general, how would you rate your mental health, including your mood and your ability to think?

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor

In general, how would you rate your satisfaction with your social activities and relationships?

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor

In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor

To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

1. Completely
2. Mostly
3. Moderately
4. A little
5. Not at all

In the past 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed, or irritable?

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

In the past 7 days, how would you rate your fatigue on average?

1. None
2. Mild
3. Moderate
4. Severe
5. Very severe

In the past 7 days, how would you rate your pain on average? You can use a scale from 0 to 10 where 0 equals no pain and 10 equals the worst imaginable pain.

1. Select a number (0-10)

In the past twelve months, have you stayed overnight in a hospital because of your own health? Do not include hospital stays related to giving birth.

1. Yes
2. No

Has a doctor or other health professional ever told you that you have or had...

Asthma?	1. Yes	2. No
Diabetes?	1. Yes	2. No
Hypertension or high blood pressure?	1. Yes	2. No
Heart disease?	1. Yes	2. No
Cancer?	1. Yes	2. No
Arthritis?	1. Yes	2. No
Migranes?	1. Yes	2. No
A sleep disorder such as sleep apnea?	1. Yes	2. No
Any kind or chronic health condition, other than ones mentioned above?	1. Yes	2. No

What condition is that?

1. Enter condition:

In the past twelve months, how often did you have four or more alcoholic drinks in one day? By “alcoholic drink” we mean beer, wine, liquor or a mixed drink. Was it...

1. Every day or almost every day
2. A few times a week
3. A few times a month

-
4. About once a month, or
 5. Less than once a month
 6. Never

During the past 12 months, did you use any prescription drugs on your own, meaning without a doctor's prescription or more than recommended by a doctor? This includes sedatives, tranquilizers, amphetamines or other stimulants, and prescription painkillers.

1. Yes
2. No

During the past 12 months, did you use any other drugs on your own, such as inhalants, marijuana, cocaine or crack, LSD, heroin, or ecstasy?

1. Yes
2. No

By yourself, and without using any special equipment, how difficult is it for you to walk a quarter of a mile - about 3 city blocks? Would you say...

1. Not at all difficult
2. Only a little difficult
3. Somewhat difficult
4. Very difficult
5. Can't do at all
6. Don't do this activity

Do you use any special equipment like a wheelchair, cane, walker, or crutches to help you get around?

1. Yes
2. No

Do you have any type of disability that limits your use of city buses and subways?

1. Yes
2. No

What type of disability is that?

1. Enter disability:

As far as you know, are you eligible to use Access-A-Ride?

1. Yes
2. No

Now we have some questions about your health and health care experiences.

Do you have any health conditions or issues that require regular medical care, treatment, or appointments? This includes regularly taking medication, visiting a doctor or specialist, or having to receive treatments.

1. Yes
2. No

What condition is that?

1. Enter condition 1:
2. Enter condition 2:
3. Enter condition 3:
4. Enter condition 4:
5. Enter condition 5:

Do you CURRENTLY have any kind of health insurance coverage, including private health insurance, prepaid plans such as H-M-Os, or government plans such as Medicare or Medicaid?

1. Yes
2. No

Have you been to a doctor or other health professional for a wellness visit, physical, or general-purpose check-up in the past 12 months?

1. Yes
2. No

What kind of place do you go to most often for medical care?

1. A doctor's office or health center
2. Walk-in clinic, urgent care center, or retail clinic in pharmacy or grocery store
3. Emergency room
4. A VA medical center or VA outpatient clinic
5. Some other place
6. No usual place

Have you been to a dentist or oral physician in the past 12 months?

1. Yes
2. No

For the next set of questions, please think about the past 6 months.

During the past 6 months, how many times have you...

Gone to an urgent care center or a clinic in a drug store or grocery store about your health?	1. Enter Number of times:
Used telehealth to get medical advice or care? (Telehealth is health care received over the computer or telephone.)	1. Enter Number of times:
Gone to a hospital emergency room about your health?	1. Enter Number of times:

What brought you to the emergency room for your last visit?

1. Could not get an appointment elsewhere
2. Severe injury or other medical issue requiring immediate care
3. Psychiatric or substance use emergency
4. Other (PLEASE SPECIFY):

In the past 6 months, have you needed health care or medical treatment? Do not include care for mental health care.

1. Yes
2. No

During the past 6 months, did you delay or not get any of the medical care you felt you needed- such as seeing a doctor, a specialist, or other health professional? Do not include care for mental health.

1. Yes
2. No

What was the reason that you delayed or did not get the medical care you needed?
(Select all that apply)

1. Didn't have insurance
2. Cost to see doctor or health care professional was too high
3. Couldn't afford prescription

-
4. Didn't know where to go
 5. Lack of transportation
 6. Concerns about how you would be treated
 7. Didn't know how to make an appointment
 8. Don't have a regular doctor
 9. Haven't gotten around to it
 10. Delay related to the COVID-19 pandemic
 11. Other (PLEASE SPECIFY):

Did you get the care eventually?

1. Yes
2. No

In the past 6 months, have you needed or wanted counseling or therapy from a mental health professional?

1. Yes
2. No

During the past 6 months, did you delay or not get the counseling or therapy from a mental health professional that you needed or wanted?

1. Yes
2. No

What was the reason that you delayed or did not get the counseling or therapy? (Select all that apply)

1. Didn't have insurance
2. Cost to see doctor or health care professional was too high
3. Couldn't afford prescription
4. Didn't know where to go
5. Lack of transportation
6. Concerns about how you would be treated
7. Didn't know how to make an appointment
8. Don't have a regular doctor
9. Haven't gotten around to it
10. Delay related to the COVID-19 pandemic
11. Other (PLEASE SPECIFY):

Did you get the care eventually?

1. Yes
2. No

For the next set of questions, please think about the past 6 months.

In the past 6 months, have you...

Had a prescription for medication?	1. Yes	2. No
Skipped taking medication, taken less medication, or delayed filling a prescription because of the cost?	1. Yes	2. No

Now, please think about the last time you met with a health professional at an office, clinic, or anywhere health care is provided.

How difficult was it for you to get to this appointment? Would you say...

1. Not at all difficult
2. Only a little difficult
3. Somewhat difficult
4. Very difficult

What are some of the things that made it difficult to get to the office or clinic? (Select all that apply)

1. Visit was far away
2. Difficult transportation (subway/bus was inconvenient; Access-A-Ride was late)
3. Difficulty paying for transportation
4. You couldn't get out of work
5. You couldn't find someone to care for a child or family member
6. You were in pain and it was difficult to travel
7. Other (PLEASE SPECIFY):

During the past 6 months, have you met or spoken with a case manager or someone that coordinates your care about your health needs?

1. Yes
2. No

Have you been to a doctor or other health professional for a wellness visit, physical, or general-purpose check-up in the past 12 months?

1. Yes
2. No

During the past 6 months, has a case manager coordinated or helped you manage the logistics of getting medical care (like scheduling appointments)?

1. Yes
2. No

What did you find most helpful about having a case manager?

1. Enter Response

What did you find least helpful about having a case manager?

1. Enter response:

Thinking about your health care experiences in general, how often...

	ALWAYS	OFTEN	SOMETIMES	OCCASIONALLY	NEVER
Is it very easy to make appointments?	1	2	3	4	5
Do you receive appointment reminders?	1	2	3	4	5
Can you get care outside of standard hours (weekend or evening)?	1	2	3	4	5
Do doctors and health professionals listen to your concerns?	1	2	3	4	5
Do doctors and health professionals explain what is happening?	1	2	3	4	5
Do doctors and health professionals answer questions?	1	2	3	4	5
Do doctors not take you seriously or believe your reported symptoms?	1	2	3	4	5

How often is what is told to you about your medical condition unclear?

1. Always
2. Often
3. Sometimes
4. Occasionally
5. Never

How confident are you in filling out medical forms by yourself?

1. Not at all
2. A little bit
3. Somewhat

-
4. Quite a bit
 5. Extremely

How often are you able to make and/or change a health appointment for yourself?

1. Always
2. Often
3. Sometimes
4. Occasionally
5. Never

Thinking of your experiences trying to get health care treatment in the past, have you felt that you were judged unfairly, treated with disrespect, or discriminated against for any reason?

1. Yes
2. No

What was the reason or reasons you felt that you were judged unfairly, treated with disrespect, or discriminated against while trying to get health care treatment? (Select all that apply)

1. Race/ethnicity, or skin color
2. Age
3. Language/accents
4. Health status or disability
5. Body weight
6. Insurance status or type
7. Income level
8. Religion
9. Sexual orientation
10. Gender/sex
11. Gender identity
12. Immigration status
13. Some other reason (PLEASE SPECIFY):
14. Was not treated with lack of respect

In the past 12-months, have you avoided going to a doctor or seeking health care for you or others in your family out of concern that you would be judged unfairly, treated with disrespect, or discriminated against?

1. Yes
2. No

Some people experience health care related issues because of their housing situation. Have you faced any of the following issues in the past 12 months? (Select all that apply)

1. Difficulty storing or refrigerating prescription medications or other medical supplies
2. Not having a regular place or phone where you can be contacted by a doctor or medical professional
3. Not having a clean and comfortable place where you can recover and treat health problems
4. Unsafe living conditions such as mold, lead exposure, inadequate heat, or missing railings
5. Other health care issues related to housing situation (PLEASE SPECIFY)

Appendix C:

The Poverty Tracker identifies race and ethnicity using questions asked by the Census Bureau on various population-level surveys.³⁰

The questions read:

Are you of Hispanic, Latino, or Spanish origin?

1. Yes
2. No

What is your race? Are you...³¹

1. White
2. Black or African American
3. Asian
4. American Indian or Alaska Native
5. Native Hawaiian or Pacific Islander
6. Or something else

We combine responses to these questions into the following racial and ethnic groups:

1. Asian, non-Latino
2. Black, non-Latino
3. Hispanic, Latino, or of Spanish origin³²
4. Multiracial or another race or ethnicity, non-Latino
5. White, non-Latino

There are, however, limitations to this methodology. This type of classification is one-dimensional while one's identity is often much more robust and intersectional. In addition, our results present averages for groups of people, but averages do not reflect the experiences of all individuals. One's personal experiences may diverge significantly from the results we present. And while our questions are relatively specific, each person might interpret them differently, resulting in subjective answers. Our analyses in this report in the context of race and ethnicity are intended to help explain how disparities across groups take shape with respect to health.

³⁰ Historically, the Census asks race and origin questions to gain an understanding of the makeup of the population and to help construct civil rights protections for all. These questions have helped to reveal gaps within various social policies and to address the economic, educational, and infrastructural needs of different communities. See Brumfield, Goldvale, and Brown (2019).

³¹ Respondents could check all that apply.

³² With these groupings, New Yorkers who indicate that they are of "Hispanic, Latino, or of Spanish origin" are grouped together, regardless of their response to the question about their race. The majority of New Yorkers who identify as Hispanic, Latino, or of Spanish origin (62%) do not identify with a particular racial group (i.e., they respond "something else" when asked about their race). Roughly 25% identify as white and 13% identify as Black.

What terminology do we use when discussing race and ethnicity?

The Poverty Tracker uses the question from the Census Bureau listed above to identify if individuals are of “Hispanic, Latino, or Spanish origin.” We must use this question in order to weight the sample to Census Bureau data and to make it representative of the city’s population. When identifying New Yorkers who say yes to this question, we use the term Latino instead of Hispanic or Spanish origin. Hispanic is a term originally used in the U.S. by the Census Bureau to refer to a very diverse group of people who were linked by their history of colonization by Spain or by their Spanish origin.³³ The term is thus thought to exclude many people with origins in Latin America who do not speak Spanish — including people with origins in Brazil and/or within many indigenous groups. The term Latino, on the other hand, is more inclusive of all people with origins in Latin America.³⁴ Because the Poverty Tracker is weighted to Census Bureau data, and because the term Latino is more consistent with the Census Bureau’s question wording, we have chosen to use the term Latino in this report.

With regards to capitalizing the names of different racial groups, there has been a general consensus among organizations, publications, and news outlets that “Black” should be capitalized, as a recognition of the racial and ethnic identity that so many claim. However, such a consensus has yet to be reached regarding whether or not the same should be done for “white.” Those in favor of capitalizing white argue that designating it as a proper noun assigns accountability to the white race, and invites white people to contemplate the role that their whiteness plays in society. The main argument against capitalizing white is that white people do not have a shared culture or history, and that capitalization has been used throughout history to signify superiority and white supremacy. In this report, we leave white uncapitalized, though we note that societal and editorial discussions on this topic are ongoing and unresolved.

³³ Gershon, L. (September 2020).






³⁴ *Latino is also gendered, and many people choose to identify as Latinx to remove the gender binary implied in the term. There is also a debate around the term Latinx, with some identifying with the term and others not, or doing so only in specific settings. See Salinas Jr, C. (2019).*


Appendix D:

Supplemental analysis which highlights summary measures (multiple chronic health conditions, work-limiting health condition, severe psychological distress) among different demographic groups.

Table D1

Share of New York City adults with high health care needs and health conditions (by demographic group)

		HIGH HEALTH CARE NEED	MULTIPLE CHRONIC HEALTH CONDITIONS	WORK-LIMITING HEALTH CONDITION	SEVERE PSYCHOLOGICAL DISTRESS
	OVERALL	34%	18%	21%	9%
	RACE				
RACE 	White	32%	20%	17%	5%
	Black	37%*	19%	23%	8%
	Latino	38%**	18%†	24%	13%
	AGE				
AGE 	<35 years old	19%	3%**	8%	12%
	35-44 years old	20%	7%***	9%	9%
	45-54 years old	35%***	16%***	23%***	10%
	55-65 years old	44%***	26%***	30%***	9%
	65+ years old	60%***	44%***	28%***	4%***
	GENDER				
GENDER 	Male	32%	18%	18%	8%
	Female	36%	18%	23%	10%
	EDUCATION				
EDUCATION 	Bachelor's degree or more	24%	14%	12%	6%
	Some college or associate's degree	37%**	20%	22%**	9%
	HS graduate or less	43%***	15%	29%***	13%*
	FOREIGN BORN				
FOREIGN BORN 	No	37%	20%	22%	9%
	Yes	31%**	15%	19%*	10%

		HIGH HEALTH CARE NEED	MULTIPLE CHRONIC HEALTH CONDITIONS	WORK-LIMITING HEALTH CONDITION	SEVERE PSYCHOLOGICAL DISTRESS
BOROUGH					
 BOROUGH	Manhattan	32%	15%	21%	7%
	Brooklyn	33%	18%	24%	10%
	Bronx	39%	24%**	22%	8%
	Queens	34%	15%	17%†	12%†
	Staten Island	34%	26%*	17%	5%

Source: 2019 Annual Poverty Tracker survey data, second and third panels.

Note: The results included in this table represent the observed weighted rates among each group. Significant differences were determined using weighted logistic regressions: † $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$. Comparison groups are listed first.

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