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LATINO DATA PROJECT

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* Source for all data: IPUMS (Integrated Public Use Midrodata Series) data for 2000 and 2005 for PUMA 3603801 derived from the U.S. Census Bureau and prepared as Steven Ruggles, Matthew Sobek, Trent Alexander, Catherine A. Fitch, Ronald Goeken, Patricia Kelly Hall, Miriam King, and Chad Ronnander. Integrated Public Use Microdata Series: Version 3.0 [Machine-readable database]. Minneapolis, MN: Minnesota Population Center [producer and distributor], 2004, available at http://usa.ipums.org/usa/

Methodological note[1]: The data presented in this report are estimates with an undetermined, but small margin of error. This is because the Census Bureau data for PUMA 3603801 do not correspond precisely to the geographical contours of the NYC-designated community district of Washington Heights/Inwood. These Census Bureau data are the only data available with the precision needed to generate the comparison presented in this report for 2000-2005.

[1] See Bergad, Laird's *Washington Heights/Inwood Demographic, Economic, and Social Transformations 1990 – 2005 with a Special Focus on the Dominican Population* for a detailed description of geographical differences between U.S. Census Bureau designations and New York City community districts.

Since 2004, the NYC Department of Health and Mental Hygiene has initiated a citywide health policy called Take Care New York (TCNY) with the goal of monitoring and improving conditions that cause significant illness and death but can be improved through intervention. This report examines how well the residents of Washington Heights/Inwood (WH/IN) have fared on selected health indicators (including some monitored by TCNY) vis-à-vis the socio-economic conditions in which these individuals have lived. Whenever possible, longitudinal patterns/trends of socio-economic and/or health conditions in WH/IN as well as a comparison between data for WH/IN and NYC as a whole will be discussed.

As of 2005, 211,884 individuals were officially accounted for as making up the population of WH/IN. Latinos/Hispanics are estimated to comprise 73% of the population in WH/IN, with Dominicans as its largest national subgroup (73%), followed by Puerto Ricans (8%), Ecuadorians (6%), and Mexicans (4%)[2]. Similarly to other NYC neighborhoods, WH/IN has seen rapid growth in its foreign-born population over the last 15 years. Its population is racially and ethnically diverse, and foreign-born individuals have settled here due to a variety of circumstances and under different immigration legal status and conditions.

These newcomers and their families face a number of unique health concerns, as well as specific barriers to accessing health care services. Immigration to the United States may have meant changes in social and/or economic conditions, language, culture, and many other aspects of life that may affect their health. Yet, there is limited

[2] For a detailed description of Latino nationalities and their changes since 1990, see Bergad's *Washington Heights/Inwood Demographic, Economic, and Social Transformations 1990 – 2005 with a Special Focus on the Dominican Population.*

information available about the socio-economic factors that may affect the health of (and health care for) these individuals. This report aims at providing some insights in this area.

ECONOMIC FACTORS

Although the annual median household income in WH/IN has increased in the last 15 years (from approximately $25,000 in 1990 to over $35,000 in 2005), about 25% of all WH/IN households live on less than $15,000 per year (see Table 1). In addition, the percentage of residents living below the poverty level is higher in WH/IN (25%) than in Manhattan (20%) and NYC (21%) as a whole. This disparity is increased when we examine poverty levels among WH/IN residents with related children under 18 years old which stand at an extraordinarily high 36.4%.

Furthermore, the economic disparity between US-born households in NYC and foreign-born households in WH/IN is further highlighted when we examine the upper income brackets: only 34% of WH/IN foreign-born households have incomes of $50,000 and above as compared to 43% of all foreign-born households in NYC and 48% of US-born households.

Table 1
Median Household Income Distribution in WH/IN, 2005

WH/IN Annual Household Income (counting benefits)

Income bracket (in 2005 inflation adjusted dollars)	**Number of Households**	**Margin of Error**	**Percent of Households**
Less than $10,000	11,065	+/-1,872	15%
$10,000 to $14,999	7,954	+/-1,730	10%
$15,000 to $24,999	12,085	+/-1,798	16%
$25,000 to $34,999	10,041	+/-2,046	13%
$35,000 to $49,999	9,200	+/-1,399	12%
$50,000 to $74,999	12,499	+/-2,665	16%
$75,000 to $99,999	5,828	+/-1,545	8%
$100,000 to $149,999	4,932	+/-1,116	6%
$150,000 to $199,999	1,150	+/-670	2%
$200,000 or more	1,192	+/-780	2%
Total households	**75,946**	**+/-3,570**	**100%**

Moreover, the percent of people living below poverty level in the previous 12 months (for whom poverty status could be determined) is significantly higher in WH/IN (25%) than in NYC as a whole (13.8%). This discrepancy is even greater when we compare the percent of WH/IN children under 18 years old below poverty level in the previous 12 months (36.5%) to their peers in NYC as a whole (19.4%). Furthermore, it should also be noted that the percent of the WH/IN population that relies on public assistance has increased from 31% in 2000 to 47.6% in 2005.

LABOR FORCE CHARACTERISTICS

Of the total WH/IN population 16 years and over (N=167,099), 56% are female and 44% are males. Overall, 65% of this population (n=108,461) are in the civilian labor force (50% males and 50% females). Of those in the civilian labor force, approximately

88% (n=96,010) are employed, evenly distributed sex. Of all WH/IN parents who have children less than 6 years of age, 57% are in the civilian labor force.

It is worthwhile to notice that 50% of civilian employed individuals in WH/IN hold service or sales/office occupations as indicated in Table 2.[3] These sectors commonly offer opportunities for lower and/or uncertain wages, and rarely offer employer-sponsored health and/or retirement benefits. In comparison, only 17.9% of individuals in NYC as a whole hold service occupations.

Table 2

Occupation of WH/IN Civilian Employed Population 16 Years and Over, 2005

OCCUPATION	Number of Individuals	Margin of Error	Percent
Management, professional, and related occupations	29,974	+/-4,373	31%
Service occupations	26,858	+/-3,419	28%
Sales and office occupations	21,474	+/-3,274	22%
Farming, fishing, and forestry occupations	93	+/-157	0%
Construction, extraction, maintenance and repair occupations	4,497	+/-1,565	5%
Production, transportation, and material moving occupations	13,114	+/-2,867	14%
Total Civilian Employed	**96,010**	**+/-6,837**	**100%**

The effects of holding service and/or sales and office occupations may be somewhat compounded by the fact that the majority of the WH/IN population employed in the civilian sector works for the private sector or are self-employed workers, in all likelihood through small entrepreneurial initiatives as indicated in Table 3. Again, these

[3] NOTE. The 2005 American Community Survey data are limited to the household population and exclude the population living in institutions, college dormitories, and other group quarters.

employment arrangements do not often foster a strong safety net that would address health insurance coverage, disability benefits, and/or retirement contributions.

Table 3
Classification of WH/IN Civilian Employed Population 16 Years and Over, 2005

CLASS OF WORKER	Number of Individuals	Margin of Error	Percent
Private wage and salary workers	78,270	+/-5,892	82%
Government workers	11,714	+/-2,415	12%
Self-employed workers in own not-incorporated business	6,026	+/-1,832	6%
Unpaid family workers	0	+/-274	0%
Total Civilian Employed	**96,010**	**+/-6,837**	**100%**

This pattern of civilian sector occupation displayed by the WH/IN population seems associated with their level of educational achievement and English skills. The percent of WH/IN residents 25 years and over that have completed high school (including GED equivalency) (65%) is significantly lower than the percent of their peers in NYC as a whole (84.3%). A similar pattern is found when we examine English proficiency: 42% of WH/IN population 5 years and over speak English less than "very well," compared to 12.7% in NYC as a whole. An additional barrier to the development of English proficiency among WH/IN residents is that 70% of residents five years and over speak Spanish at home as compared to 14% in NYC.

Combined, these findings suggest the need for interventions to booster the ability of residents of WH/IN to acquire English communication skills, which could also assist them in completing a high-school education or equivalent. In a competitive society such as ours, these skills may place WH/IN residents in a better position in the job market, and ultimately help them change the conditions that affect their health and well-being.

HOUSEHOLD SIZE

Data from the American Community Survey indicate that the average household size in WH/IN (2.83 persons) is slightly higher than in NYC as a whole (2.62 persons). The percentage of households with one or more people under 18 years of age, however, is significantly higher in WH/IN (36.7%) than in NYC (33.8%). These findings are especially meaningful in light of the fact that only 26% of these households are comprised of married-couple families, as compared to 44.9% of the households in NYC.

FAMILIAL NETWORK AND CHILD CARE

Contrary to common expectations about the extended family network of Latinos, the percent of grandparents responsible for their grandchildren in WH/IN households is significantly lower (20%) than in NYC as a whole (33.6%). In addition, more than a third (38.4%) of the WH/IN women 15 years and over has never married, compared to 30.2% of their NYC peers.

In aggregate, these findings suggest that a large number of WH/IN parents, particularly single mothers, are required to cope with child care/child rearing responsibilities in addition to handling the demands of earning a living in order to support their families. These multiple responsibilities have previously been found to increase the level of stress among individual family members, having implications for mental health and well-being.

HEALTH IMPLICATIONS

The kinds of economic and social problems a community experiences offer a practical, and often accurate, measure of its quality of life and the health of its members. Studies in the U.S. and elsewhere have shown the association between wide disparities in income and social conditions, and poor health.[4]

In 1947, the newly established World Health Organization (WHO) included a brief statement in its constitution, which identified three dimensions of health:

> *Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.* (WHO, 1947)

Since its publication, the reaction among health professionals to this definition has varied considerably -- from serious concern about the ability of health professionals to contribute to "complete social well-being" of individuals and communities, to praise from those who use it as a tool for innovative change.

Ecological approaches to health and health promotion view health as a product of the interdependence of the individual and subsystems of the larger ecosystem (e.g., family, community, culture, social conditions, and economic circumstances).[5] To promote health and well-being, the ecosystem must offer conditions conducive to health and healthful lifestyles.

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[4] a) Kurnst A.E., Geurts, J.M. Van den Berg, J. (1995). International variation of socioeconomic inequalities in self-reported health. J. Epidemiology & Community Health, 49: 117-123.
b) Kennedy, B.P., Kawachi, I., Glass, R., Prothrow-Stith, D. (1998). Income distribution, socioeconomic status, and self-rated health in the United States: multilevel analysis. BMJ, 317: 917-921.

[5] Green, L.W., Potvin, L., &Ricahrd, L. (1996). Ecological foundations of health promotion. *American Journal of Health Promotion*, 10, 270-281.

The ecological or transactional perspectives of behavior assert that individual functioning is mediated by behavior-environment interactions. This has two main implications for health behavior and well-being: 1) the environment largely sets limits on the behavior that occurs in it; 2) changing environmental variables promote the modification of behavior. Considering the above discussed economic and social disparities faced by WH/IN residents, these two points lead to the recognition that health promotion in immigrant communities such as WH/IN can be most effective by exerting whatever influence it can over the economic and social conditions of residents.

HEALTH INSURANCE AND ACCESS TO CARE

Previous studies have shown that health coverage is an important predictor of access to health care. [6] As of 2005, approximately 33% of the adult population (18-64 years old) in WH/IN was uninsured or had gone without health insurance within the previous year, as compared to 22% of their peers in Manhattan and 28% in NYC as a whole (NYCDOHMH, 2006). In terms of disparities across countries of origin, low-income Dominicans younger than 65 have the highest rate of Medicaid coverage among all foreign-born (39%), with Mexicans (44%) being the immigrant group most likely to be uninsured (NYC Community Health Survey, 2003).

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[6] a) Hadley, Jack (2007). Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition, *JAMA*, 297:1073-1084.

b) Families USA. Getting Less Care: The Uninsured with Chronic Health Conditions. Washington, DC: *Families USA*; 2001.

Moreover, having an identified health care provider has been found to contribute to the quality of health care. Over 30% of WH/IN population 18 years and over was likely to be without a regular provider in 2005, as compared to about 24% of their peers in NYC as a whole. These findings are even more disturbing in light of the fact that one in every ten individuals in WH/IN utilizes emergency room services when they have a serious illness or health problem (NYCDOHMH, 2006).

DEATH RATES AND PREVENTABLE CONDITIONS

When we examine death rates, particularly for premature deaths (i.e., before the age of 75), the findings show cancer as the primary cause of death in both WH/IN and NYC as a whole. Significant differential rates, however, are apparent when we look at deaths rates by assault/homicide among adults aged 25 and older: there were 20 assault/homicide deaths per 100,000 persons in WH/IN compared with 9 for NYC. (Bureau of Vital Statistics, NYC DOHMH, 2005). This is an important indicator of health disparity because the loss of potential life among community members, particularly young adults, may impact health and well-being as well as the socioeconomic conditions of residents in new immigrant neighborhoods such as WH/IN. In these new immigrant neighborhoods many family expectations for growth and development are placed upon the potential realizations of their future generations and/or children.

Furthermore, heart disease accounts for 14% of the premature deaths in WH/IN. Although this rate is not significantly different from the rate for NYC as a whole, the overall rate of hospitalization for heart disease in WH/IN has increased by 10% in the last decade (Bureau of Vital Statistics, NYC DOHMH, 2005). It should be noted that the

incidence of high blood pressure and high cholesterol conditions (previously identified as contributors to heart disease) is significantly higher in WH/IN (27% of adults diagnosed with high blood pressure, and 27% with high cholesterol) than in NYC as a whole (22% and 26%, respectively). Similar patterns are seen for smoking -- a strong contributor to cancer, the leading cause of preventable death in WH/IN and NYC, and the cause of many illnesses, including heart disease: about 8 in 10 adult (18 years and over) smokers in WH/IN have indicated that they smoke (but intend to quit smoking), as compared to 6 in 10 for NYC as a whole (NYC Community Health Survey, 2004).

In addition to high blood pressure, high cholesterol, and smoking, other factors that increase the risk for heart disease (and illnesses such as diabetes) include obesity and lack of physical activity, which are increasingly prevalent in WH/IN as well as in NYC as a whole. More than 20% of the individuals aged 18 and over in WH/IN are obese as compared to 15% in the remainder of the City.[7] The prevalence of obesity in WH/IN is significantly associated with differential rates of diabetes – about 11% of the adults 18 years and over in WH/IN have been diagnosed with diabetes, as compared to 9% in the City. Moreover, data on patterns of physical activity (i.e., recreational exercise) indicate that about half of the WH/IN residents (48%) indicate that they do not perform any exercise at all, compared to 32% of their peers in NYC (NYC Community Health Survey, 2003). It should be noted that these health conditions can be prevented and/or managed through culturally appropriate health promotion/education and health management interventions.

[7] Obesity is defined by the Centers for Disease Control and Prevention as a body-mass index (BMI) of 30 or greater.

Overall, it should be noted that hospitalization and health care utilization data usually reflect the burden that certain illnesses place into the health care system, being used primarily for billing purposes and/or cost-benefit analysis. These data do not necessarily measure the health of a community, particularly an immigrant community. In communities such as WH/IN, health care utilization data and prevalence/incidence rates may be a better indicator of differences in access to health care than differences in the rate of certain illnesses. Despite these limitations, the information presented here suggest deep social, economic, and health disparities among the primarily immigrant population of WH/IN and their peers in the City as a whole.

LATINO HEALTH DISPARITIES IN MEDICAL EDUCATION

It is well documented that a large number of recent immigrants face language and cultural barriers when trying to access health care. Nonetheless, data on the representation of Hispanics in different health professional schools across the U.S. indicate disparities in the formation of professionals as indicated in Table 4. The existence of racial/ethnic disparities in health care represents a failure of the healthcare system to provide equal, high quality health care to all individuals, regardless of race/ethnicity or other factors. The education of health professionals is an important component of an overall strategy to eliminate health disparities.

As the U.S. becomes increasingly diverse, future generations of physicians are challenged to expand their knowledge of different population groups and develop new skills to take care of these patients effectively with cultural sensitivity. Students must learn the underlying factors contributing to health disparities to prepare themselves to care for diverse patient populations. These factors include disparities in healthcare access,

economic and social resources available to immigrant groups, language issues, understanding of cultural and folk beliefs and tradition, provider biases, and stereotyping. In addition, students must appreciate the relationship between psychosocial issues and health disparities, including the fact that a decrease in financial barriers to care among immigrant groups could reduce socioeconomic disparities in health, in order to become culturally competent physicians. This report provides a glimpse into the complexity of these issues in WH/IN, a mainly Latino immigrant neighborhood in NYC.

Table 4
Enrollment of Students in Health Professional Schools in the U.S. by Race/Ethnicity
1999-2000

Dentistry	**Number**	**%**
White	11,106	64.4
Black	808	4.7
Hispanic	**912**	**5.3**
American Indian	99	0.6
Asian	4,317	25.0
Total	17,242	100.0
Medicine (Allopathic)	**Number**	**%**
White	42,589	65.0
Black	5,051	7.7
Hispanic	**4,322**	**6.6**
American Indian	574	0.9
Asian	12,950	19.8
Total	65,486	100.0
Medicine (Osteopathic)	**Number**	**%**
White	8,019	77.2
Black	399	3.8
Hispanic	**370**	**3.6**
American Indian	65	0.6
Asian	1,535	14.8
Total	10,388	100.0
Nursing	**Number**	**%**
White	193,061	81.0
Black	23,611	9.9
Hispanic	**9,227**	**3.9**
American Indian	1,816	0.8
Asian	10,529	4.4
Total	238,244	100.0

Optometry	**Number**	**%**
White	3,619	68.1
Black	108	2.0
Hispanic	**269**	**5.1**
American Indian	30	0.6
Asian	1,287	24.2
Total	5,313	100.0
Pharmacy	**Number**	**%**
White	22,184	68.2
Black	2,697	8.3
Hispanic	**1,086**	**3.3**
American Indian	156	0.5
Asian	6,414	19.7
Total	32,537	100.0
Podiatry	**Number**	**%**
White	1,576	69.8
Black	192	8.5
Hispanic	**122**	**5.4**
American Indian	10	0.4
Asian	358	15.9
Total	2,258	100.0

SOURCES: Association of American Medical Colleges: AAMC Data Book: Statistical Information Related to Medical Education Washington, DC 2000 AAMC Student Records System, unpublished data; American Association of Colleges of Osteopathic Medicine: 2000 Annual Statistical Report Rockville, Maryland 2001; Bureau of Health Professions: Minorities and Women in the Health Fields, 1990 Edition; American Dental Association:1999-2000 Survey of pre-doctoral dental education, academic programs, enrollments, and graduates, vol. 1, Chicago 2001; Association of Schools and Colleges of Optometry: unpublished data; American Association of Colleges of Pharmacy: Profile of Pharmacy Students, Fall 1999;American Association of Colleges of Podiatric Medicine: unpublished data; National League for Nursing: Nursing Data Review, 1997; Nursing Data book New York 1982.

CONCLUSION

The health of immigrant communities such as Washington Heights/Inwood (WH/IN) increasingly reflected upon he health of NYC as a whole. Similar to other NYC neighborhoods, WH/IN has seen rapid growth in its foreign-born population (especially Dominicans, Puerto Ricans, Ecuadorians and Mexicans) since the 1980s, and immigrants have settled there due to a variety of circumstances and under different immigration statuses and conditions. As shown in this report, these newcomers and their families face various health concerns, as well as specific barriers to accessing health care services. The socioeconomic and health disparities faced by WH/IN residents lead to the recognition that health promotion and disease management in immigrant communities such as WH/IN can be most effective by way of improvements in the socioeconomic conditions of residents.

Our findings indicate severe economic and social disparities between WH/IN residents and their NYC peers. About a third of the population in WH/IN lives below the poverty level, with almost half of the residents relying on public assistance. Moreover, about half of WH/IN residents currently employed in the civilian labor force hold service or sales/office occupations, which commonly offer lower and/or uncertain wages, and few opportunities for employer-sponsored health benefits. This pattern of civilian sector occupation displayed by the WH/IN population seems associated with their level of educational achievement and English skills, which if rudimentary further hamper their ability to ensure a safety net that guarantees social and health benefits, and/or retirement assistance. In addition, a large number of WH/IN parents, particularly single mothers must cope with child care responsibilities as well as earning a living to support their

families. These multiple responsibilities increase stress among family members and affect their mental health.

These findings suggest the need for interventions to increase English skills, level of educational achievement, and child care resources among WH/IN residents, factors that may place them in a better position in the job market, and ultimately help them change conditions that affect their health and well-being.

An important challenge that many new immigrant communities such as WH/IN face is access to health care. Although health insurance coverage has been found to be an important predictor of access to health care, our findings show that WH/IN residents are less likely to have health insurance than their NYC peers, with low-income Dominicans having the highest rate of Medicaid coverage among all foreign-born and Mexicans being the immigrant group most likely to be uninsured. In addition, over a third of the adult population in WH/IN was without a regular health-care provider in 2005.

In part due to access disparities, immigrants tend to use preventive and health care services less than the general population. This pattern is certainly true for immigrants in WH/IN. Specifically, the incidence of high blood pressure and high cholesterol conditions (previously identified as contributors to heart disease) is significantly higher in WH/IN than in NYC as a whole. Similar patterns are seen for smoking, obesity, and lack of physical activity -- strong contributors to cancer and a variety of other preventable deaths in WH/IN and NYC, and the cause of many illnesses, including heart disease.

Furthermore, significant differential rates of death are apparent when we look at assault/homicide among adults aged 25 and older. This is an important indicator of health disparities because the loss of potential life among community members,

particularly young adults, may impact future health and well-being (as well as the socioeconomic conditions) of residents in new immigrant neighborhoods such as WH/IN, where expectations for growth and development are placed upon the potential realizations of future generations.

Finally, although it is well documented that a large number of recent immigrants face language and cultural barriers when trying to access health care, data on the representation of Hispanics in different health professional schools indicate disparities in the formation of professionals across the U.S. The education of health professionals is an important component of an overall strategy to eliminate health disparities.

Understanding the ecology of existing health disparities of immigrant communities such as the one in WH/IN may move NYC closer to meeting the unique needs of this growing population, both currently and in the future, and provide insights into how to address future immigrant health challenges.