

Testimony

Joint Senate and Assembly – The New York Health Act

**New York State Senate and Assembly – Committee on Health Public
Hearing**

Chair: Richard Gottfried, Assembly

Chair: Gustavo Rivera, Senate

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Introductions

Good afternoon. I wish to thank Assemblyman Richard Gottfried, Chair of the NYS Assembly Health Committee and Senator Gustavo Rivera, Chair of the NYS Senate Health Committee and the members of the committees for this opportunity to provide testimony in this hearing on the New York Health Act to establish a universal single payer health plan for all New York State residents.

Background

I am Charmaine Ruddock, the Project Director of Bronx Health REACH, a coalition of 80+ community and faith based organizations in the Bronx. This Coalition is led by the Institute for Family Health, a network of Federally Qualified Health Centers in 31 locations in the Bronx, Brooklyn, Manhattan and in Ulster and Dutchess counties in upstate New York. The Institute serves more than 115,000 patients and do nearly 600,000 patient visits each year.

Bronx Health REACH is marking its 20th year this year. Its focus, since its inception in 1999, is the elimination of racial and ethnic disparities in health outcomes in the Bronx. Much of our work in the community has focused on diabetes, and its prevention, which disproportionately affects Bronx residents for a number of reasons, including- access to health information, to healthy lifestyle choices, and to health care. By almost every health measure, the Bronx has the poorest health outcomes in New York. For the past nine years, the Robert Wood Johnson County Health Rankings Report has ranked the Bronx 62 out of the 62 counties in New York State in health outcomes and health factors. It is why Bronx Health REACH, The Bronx Health Action Center formerly the Bronx District Public Health Office, Montefiore Health System, The Bronx Borough President's Office co-founded Not62: The Campaign for a Healthy Bronx.

I. Some statistics

- a. Within New York City, the Bronx has the largest percentage of adults without health insurance (22%), and
- b. the largest percentage of adults going without needed medical care (12%).

The work of the Coalition has involved multiple focus groups with community residents to determine the obstacles they encounter in getting good health care and living long healthy lives. The academic literature documents significant racial and ethnic disparities in health. People of color get sick more often and have less access to health care services (from primary care to high tech inpatient procedures). However, although these disparities have been documented, we know little about their underlying causes and what solutions might

work. To help fill in this gap, early on in our planning year we held a series of focus groups with community residents. Our purpose was three-fold:

- To take this problem to the experts -- the people living, working and using the health care system in the South Bronx;
- To ask community residents what they think are the causes of shorter life expectancy and higher rates of illness (particularly diabetes and heart disease) in their neighborhood; and
- To solicit their recommendations for possible solutions.

We observed the following:

- People have done a remarkable job figuring out how to take care of themselves and their families in the face of what they feel is an unresponsive and uncaring health care system.
- There is a lot of passion, anger and energy in the community which is ready to be tapped.
- People had many insightful observations about how things work and why they work the way they do; they, like us, were often stymied in trying to come up with ideas about how to improve health in their community.

From the focus groups we identified the following key themes:

- Widespread distrust and fear of the health care system
- People feel undervalued and disrespected in their encounters with the system
- People experience difficulty in communicating with their doctors
- People believe that self-advocacy is important, but many find it difficult
- People have strong opinions about what constitutes “good care” -- they know it when they see it

Many felt stigmatized or mistreated because they were on Medicaid, or because people assumed that they were. “If you are black, they assume you have no insurance, once you pull out your card, you get good care”:

“So if you are on Medicaid you are stigmatized. They don’t want to accept it, for whatever reason. Maybe people on Medicaid tend to be much sicker? Because most of them haven’t

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had primary care physicians. Haven't had preventive care. Now that they decide to see a doctor they are very sick. A lot of doctors don't want to deal with that – just want to give you a pill and say go home. Don't want to have to monitor you. Less time equals more money.”

Another person recounted how the clinic receptionist's attitude changed when she found out that he and his wife weren't on Medicaid: “This lady went back to the doctor and for whatever reason, we were called second or third. And there were lots of people there. We were like very upset. We got to see the doctor, but we were very upset.”

One woman described trying to get help for her child who had become cross-eyed. “It wasn't until I got a job and I had job insurance” that she was able to get a doctor to pay attention. “Just the way I was treated with that job coverage, as opposed to Medicaid. It felt really good. I felt like I had money!”

As we examined the causes of widespread racial and ethnic health disparities in health care and health outcomes in our community and, in fact, across the state we found pervasive segregation of care based on the link between race, ethnicity and insurance status, resulting in the systematic separation of whites and people of color into different systems of care. We called it Medical Apartheid.

- We found differences in health insurance coverage by race.
- Segregation of the Poor and Uninsured into different institutions
- Segregation into Different Care Systems within Institutions
- Inequities in Payment by Public Insurance Programs
- Failure of Medicaid Managed Care to Eliminate Disparities in Care
- Institutional Subsidies for Care for the Poor and Uninsured that too often have limited mitigating effect on the cost the poor and uninsured are charged for the care they receive

The New York Health Act, if passed, will be able to have a profound impact on changing all of this. It will mean that people in the Bronx, especially in the south Bronx, will, ostensibly, be able to access the same quality of healthcare as people just a few zip codes away from them whose care now looks very different from theirs and whose outcomes, in many instances, is different from theirs. However, I would be remiss if I did not urge lawmakers to make sure that in crafting The New York Health Act they pay particular attention to eliminating the well documented disparate care that many poor black and brown people experience.