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The Health of the “Forgotten” of Washington, DC:  
An Analysis of Gentrification, Concentrated Poverty and Health

Emily Wurth

[Written for an independent study on Medicine and Society with Dr. Judith Lasker]

A black man born in Washington, DC has a life expectancy of 58, while the average life expectancy of an American man is 73. This 15-year difference illustrates the major health disparities that exist within the

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United States. While many Americans experience the most innovative and highest quality healthcare available in the world, the poorest Americans have limited access to health services and considerably higher mortality rates. As health disparities have widened, they have become a focus of study among many public health researchers. The ineffective health insurance system and the rising costs for healthcare have contributed to the inequity in the health status of Americans. However, research has revealed that the structural factors present in cities with high concentration of poverty are having a detrimental impact on the health and well-being of urban Americans. As reporter Helen Epstein states, “It makes you wonder if there is something deadly in the American experience of urban poverty itself” (Epstein, 2003).

A 2003 Brookings Institute report based on data from the 2000 census announced a nationwide decline in the concentration of poverty in metropolitan areas across the nation in the past ten years. However, Washington, DC is one of twenty-nine cities, exceptions to that national trend, whose concentration of poverty increased during that time period (Jargowsky, 2003). This trend is surprising, considering the growth and prosperity that has accompanied the widely recognized revitalization of Washington, DC over the past ten years (e.g. Fannie Mae Foundation Report, 2003). It causes one to question the social convention that urban redevelopment benefits all city residents by increasing the tax base and encouraging investment in the city, and to instead consider that the gentrifying effects associated with urban redevelopment cause disparate outcomes for residents. A possible explanation for this contradiction is that gentrification could be forcing low-income residents into neighborhoods of more highly concentrated poverty, resulting in detrimental health conditions for those dislocated. This paper is an initial examination of the evidence of this trend in Washington, DC. Available data provides some support for this correlation, but clearly suggests that more extensive research is needed to further understand the relationship between gentrification and the health of urban residents.

This paper reports on the nation’s concentration of poverty, and explores some of the factors contributing to the increased concentration of poverty in the United States since World War II. It then examines the recent increase in the concentration of poverty in Washington, DC, and investigates the impact of gentrifying forces in contributing to it. Following is a discussion on how structural social forces present in neighborhoods of high-poverty have detrimental health effects on residents, specifically examining the impact on the health of

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Washington, DC residents. Finally, some social policy and public health changes are recommended to alleviate the concentration of social and health problems in the district and nationwide.

### **Changes in the Concentration of Poverty Across the Nation**

Paul Jargowsky's report, "Stunning Progress, Hidden Problems" discusses the changes in the spatial distribution of poverty in the United States between 1990 and 2000. He defines a high-poverty neighborhood as a census tract<sup>1</sup> with 40 percent or more of the residents living below the poverty line. (Other sources define a neighborhood as high-poverty if more than 30 percent of the residents live below the poverty line, and extreme poverty if more than 40 percent of residents live below the poverty mark. Since the specific data on Washington, DC is from sources using these definitions, they will be used for the remainder of the paper). The federal poverty line is a threshold determined by the government, below which a family's total income will not allow them to afford the basic necessities for survival. The level varies depending on the number of people in a family, and is adjusted each year for inflation. The concentration of poverty is the proportion of poor residents in a city or region that live in high-poverty neighborhoods. This concentration, as Jargowsky notes, is not unrelated to the incidence of high-poverty neighborhoods. He states that "in general, the greater the number of high-poverty neighborhoods in a city or metropolitan area, the more likely poor residents of that place will be 'concentrated' in those neighborhoods" (Jargowsky, 2003). Between 1970 and 1990, cities across the nation experienced an increase in the concentration of poverty. Although the overall poverty rate did not change, the percentage of people living in high-poverty areas doubled.

However, Jargowsky's report reveals a dramatic reversal of the trend over the past ten years. From 1990 to 2000, the number of people living in high poverty areas declined by 24 percent, or 2.5 million people. Concurrently, the number of high-poverty neighborhoods decreased by one-quarter from 3, 417 in 1990 to 2, 510 in 2000. Although the nation experienced a slight decline in the overall poverty rate (.7 percent), the report shows evidence of a spatial reorganization of people living below the poverty line that has resulted in a lower concentration of poverty. The largest declines in this concentration of poverty took place in the Midwest and the South regions of the country, which decreased their rate of concentration by 45.6 percent and 34.7 percent

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<sup>1</sup> Census tracts are small, relatively homogenous areas defined by the Census bureau. The average tract contains 4, 000 people.

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respectively. Although this progress is remarkable, notable exceptions to this trend were observed in cities in the Northeast and throughout the state of California. Washington DC, was one of the major exceptions to this trend (Jargowsky, 2003). Over the same ten-year period, the number of high-poverty neighborhoods in Washington, DC doubled, as did the number of people living in high-poverty neighborhoods. As a result, 42 percent of all poor residents in the Washington, DC area live in high-poverty neighborhoods, up from 38 percent in 1990 (Fannie Mae Foundation, 52). All of these high-poverty neighborhoods are located within the city of Washington, DC.

### **What Causes Changes in the Spatial Distribution of Poverty?**

Jargowsky blames the fiscal crisis faced by the DC government during the 1990's as the cause for this increased concentration of poverty in Washington, DC. The funding problems led to the breakdown of social services, having detrimental effects on the public school systems and public safety. These cutbacks drove many middle-class families out to the suburbs of Virginia and Maryland. This explanation is similar to the one provided for the increasing concentration of poverty in inner cities around the country during the 1970's and 1980's. As the weakening economy disproportionately affected the inner cities, many residents with greater economic means fled to the new economic opportunities that were developing in the suburbs (Jargowsky, 2003).

In his book, *When Work Disappears*, William Julius Wilson asserts that this process has been occurring on a structural basis since the post World War II era. He analyzes a number of significant policy decisions that have driven this process. Following the war, the Federal Housing Authority (FHA) began selectively underwriting mortgages to encourage home ownership among Americans. Discriminatory practices excluded poor, black neighborhoods, and encouraged the establishment of middle-class whites suburbs. In addition, the government supported the development of the interstate highway system around the cities to accommodate the suburban lifestyle. The new highways frequently divided or destroyed low-income neighborhoods. This outmigration of non-poor citizens to other areas, facilitated by the roads and mortgage incentives, led to growth in poverty among the poor who remained in the inner cities.

At the same time, according to Wilson, the disappearance of blue collar, low-skill manufacturing jobs in cities, along with the suburbanization of jobs, destroyed the inner city economy and led to high levels of unemployment. The development of Federal Housing Projects by the government "has isolated families by race

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and class for decades, and therefore has also contributed to the growing concentration of jobless families in the inner city ghettos in recent years” (Wilson, 48). The New Federalism furthered by the Reagan and Bush administrations led to dramatic cuts in social spending by the government and contributed to the isolation of the poor.

### **Gentrification’s Impact on Concentrated Poverty**

One additional social factor that Wilson attributes to the increasing concentration of poverty in inner cities is the in-migration of the poor. Urban researchers are considering gentrification as a cause for the increased flow of poor people into poor neighborhoods in Washington, DC. Margery Austin Turner of the Urban Institute believes that “census numbers point to people being pushed into the city’s poorest tracts from D.C. neighborhoods closer to downtown where gentrification began pumping up housing costs in the late 1990s” (Washington Post, 2003). Although it is difficult to study the flow of people into and out of neighborhoods<sup>2</sup>, the Fannie Mae Foundation reports that the census tracts in DC with increasing poverty rates simultaneously lost and gained residents between 1990 and 2000. The tracts with poverty rates higher than 30 percent experienced a 13 percent population loss over the decade, twice the city’s overall rate of population loss for all city census tracts. However, the majority of the residents in the areas of high-poverty reported moving into their area in the past 5 years, almost exclusively from other parts of Washington, DC. The housing boom has caused investment in new housing units and rehabilitation of run-down units, driving up housing costs and causing a decline in affordable housing units.

The boom of investment in housing in Washington, DC has penetrated some areas of the city that had been experiencing decline for years. The Mount Pleasant neighborhood cluster offers an example. This economically and ethnically diverse neighborhood currently has a competitive housing market. In 2000, the average income for a household in this neighborhood was \$49,000<sup>3</sup>, a 13 percent increase since 1990; however, 57 percent of the neighborhood’s household incomes were below \$35,000 and 19 percent had incomes below \$10,000. Between 1990 and 2000, 500 rental units in Mount Pleasant became unaffordable for families earning

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<sup>2</sup> Neighborhood clusters are defined by the District of Columbia Office of Planning. There are 39 clusters in the city, composed of 3-5 neighborhoods each. For the most part, they use groupings of census tracts to define the borders. (Fannie Mae Report, Table A.2)

<sup>3</sup> Average incomes are adjusted for inflation.

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less than \$10,000. In addition, the neighborhood lost 161 federally subsidized housing units between 1998 and 2000, due to the expiration of long-term subsidy contracts. As the housing market expands in Mount Pleasant, many low-income people living in the area are being forced to find other more affordable housing options outside of the neighborhood (Fannie Mae, 49). The Howard University neighborhood cluster's housing market has also expanded in the past ten years. The number of homeowner units increased by 17 percent, primarily through the conversion of rental units into single-family homes. The homeowner median income has increased by 37 percent, and the housing costs have more than doubled. One-quarter of all homeowners moved into the neighborhood between 1999 and 2000. As a result of this vibrant housing market, the proportion of new homebuyers with low incomes has dropped 18 percent since 1995 (Fannie Mae, 26-29).

The Logan Circle neighborhood cluster near downtown has experienced the most rapid growth in the city, adding over 500 new housing units in the past four years. The typical price of a home in Logan Circle has doubled in the past eight years. However, the average family income, after being adjusted for inflation, increased by 12 percent, which is only slightly higher than the average city-wide increase of 9 percent (Fannie Mae, 28). Since Logan Circle traditionally offered a substantial number of low-cost housing units, this rapid change in the housing market has forced the displacement of many low-income residents. According to the Fannie Mae report, evidence "suggests that displacement of poor households from superheated housing markets of neighborhoods like Logan Circle might contribute to the concentration of poverty in neighborhoods like Ivy City" (Fannie Mae, 2003). Ivy City represents the areas of the city that have not reaped the same benefit from the growth in the market. Ivy City, whose poverty rate is 31 percent, gained only one housing unit in the same time that Logan Circle's market was flourishing. The gentrifying factor could explain why Washington, DC's concentration of poverty increased while other cities around the country experienced dramatic decline. Further investigation of other cities that have also experienced gentrification and increased concentration of poverty over the past ten years, such as Boston and Philadelphia, could provide further evidence of a connection between these two structural forces.

### **Residential Racial Segregation and Concentrated Poverty**

Racial segregation is present in cities across the country, as a result of the country's history of racist structural policies and individual prejudice. This concept is integral to understanding the spatial distribution of

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poverty in Washington, DC and inner cities around the country. In Washington, DC, the high poverty neighborhoods are comprised of predominantly minority populations. Since 1990, this concentration of poverty of poor blacks in DC has increased, while nationally, the concentration of poor black people has declined. This divergent trend suggests that gentrification could be playing a role in this process.

As presented in their book *American Apartheid*, Douglas Massey and Nancy Denton describe the role of racial segregation in the construction of ghettos in inner cities across the country. Massey and Denton report persistent discrimination against African Americans in urban housing markets. The government policies described by Wilson that contributed to an increase in the concentration of poverty had a disproportionate effect on poor *black* Americans. For example, the post-war FHA policy withheld mortgage capital from inner-city neighborhoods, and limited their underwriting of mortgages to white people. According to Wilson, “the manipulation of market incentives... trapped blacks in the inner cities and lured middle-class whites to the suburbs” (Wilson, 46). The subsequent construction of the Federal Housing Projects forced poor, black people into isolated communities, which gradually were cut off from social services during the 1980’s (Wilson, 1996).

The structural discrimination against blacks was compounded by individual prejudice. Massey and Denton’s surveys found that although many whites are open to living in integrated areas, they remain most comfortable in a setting where blacks constitute a small percentage of the population. Massey and Denton illustrate this through the patterns of racial segregation during the 1970’s. Cities such as Tucson, Denver and Seattle, with relatively small black populations, experienced the most rapid and pronounced desegregation, while cities with much larger black populations such as Chicago, New York, Philadelphia and Washington, DC, experienced little change in the levels of segregation in the same time period (Massey, 109-110).

The results of this racial discrimination are apparent in Washington DC, where 84 percent of residents living in high-poverty neighborhoods are black, even though only 60 percent of the city’s population is black (Fannie Mae, 53). In her report, “Poor people and Poor Neighborhoods,” Margery Austin Turner studied the spatial distribution of poor people in Washington, DC in 1990. Although she found that only 39 percent of the region’s poor residents live within the District, 60 percent of the metropolitan area’s poor blacks reside within the city. Poor blacks are four times more likely to live in the city than poor whites. The residential discrimination is more apparent in the fact that 25 percent of all poor blacks live in high-poverty areas compared

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to only one percent of poor whites. In other words, poor blacks in the DC area are twenty five times more likely than poor whites to live in high-poverty, inner-city areas. Turner's report explains that poor Hispanics and poor whites have greater access to housing in areas of less concentrated poverty in the DC metropolitan area (Turner 1997).

Some gentrified DC neighborhoods experienced a disproportionate drop in their black populations. For example, the proportion of black residents living in the Logan Circle neighborhood decreased at three times the rate of the decline in the black population citywide. Therefore, as gentrification dislocates black people from their neighborhoods, their limited alternative housing options in the DC area force them to relocate in the areas of high-poverty. Jargowsky's study confirms this trend, as he found that the concentrated poverty rate for blacks in DC increased, while nationally there was a decline in the concentration of poverty among poor blacks. Gentrification could once again explain this countering trend in Washington, DC.

### **Why does concentration of poverty matter?**

This "concentration of poor people leads to a concentration of the social ills that cause or are caused by poverty" (Jargowsky, 2003). This environment predisposes residents in high concentrations of poverty to significant disadvantages in employment, social organization, education and family structure. These social conditions perpetuate a cycle of poverty that becomes difficult to break.

High-poverty neighborhoods offer few substantial employment options and provide little information about finding jobs. As many of the most capable adults leave the neighborhood in pursuit of other opportunities, an increasing proportion of the population is comprised of children and elderly people. As a result, it becomes more difficult to maintain basic neighborhood institutions such as churches, schools, community centers, and recreational facilities, leading to a breakdown of social organization. An increase in crime, violence, drug use, and drug dealing follows, transforming the landscapes of these neighborhoods. Neighborhood deterioration reduces property values and undermines the funding base for parks, recreation centers, libraries, and the public schools, which contributes to driving out those who are able to leave. The decline of the public school systems results in high dropout rates and dampens the economic and educational opportunities for young people. As economist Robert Reich adds, "socially isolated at a time when connections count more than ever, economically segregated when career paths are blurring and manufacturing jobs disappearing, bereft of role models and social

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supports in a system that depends on both, young people in poor communities have limited means of gaining footholds in the new economy” (Reich, 239). Consequently, “drug abuse, truancy and the persistent joblessness draw young people into a long cycle of crime and incarceration” (Epstein, 2003).

“Residential segregation and poverty concentration along with childbearing trends in the black community have created neighborhood environments in which female-headed families are the primary residential and family unit” (Wilson 1996). A longitudinal study conducted in Chicago found that 31 percent of all persistently poor families (defined as families whose income have been below the poverty line for at least eight years in a ten-year period) in the United States were headed by nonelderly black women. Considering that blacks constitute only 12 percent of the U.S. population, this number is significant. Nationwide, children of single mothers are the poorest demographic group, since many single mothers are unable to earn enough to provide for the childcare and living expenses of the entire family. Furthermore children raised by single mothers are more likely to drop out of high school, earn lower wages for work, and depend on welfare. Daughters of single mothers are more likely to become single mothers themselves, perpetuating the cycle of poverty (Wilson, 91). Wilson also describes the lack of marriageable men in high-poverty areas, due to high levels of incarceration.

Washington, DC’s impoverished neighborhoods exemplify these challenges. In neighborhoods of extreme poverty (poverty level of 40% or higher), almost half of all young people drop out of high school. The unemployment rate is four times higher than the metropolitan area as a whole. Over 28 percent of the households are headed by a single parent, compared with 12 percent in the city as a whole. Finally, the high-poverty neighborhoods have only 7.8 men for every 10 women, compared to 9 men for every 10 women in the city as a whole (Fannie Mae, 53). As the concentration of poverty continues to worsen in the district, it is unlikely that any of these social problems will improve.

### **Concentrated Poverty and Health**

In addition to all the adverse social conditions facing residents in these neighborhoods, public health researchers have begun to examine the detrimental health effects of living in concentrated poverty. By isolating poor people in the most impoverished areas, their health problems are concentrated, resulting in high mortality rates. Poor urban blacks have the lowest life expectancy of all demographic groups in the U.S., aside from

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Native Americans. The superficial analysis by the sensational media causes people to mistakenly attribute these high mortality rates in many of the poorest urban areas to homicide and drug use. In reality, residents in many high-poverty areas of the country are increasingly suffering from chronic diseases, such as cancer, kidney disease, diabetes, heart disease and asthma. The structural factors associated with living in concentrated poverty have been investigated to determine their relation to health. Studies have demonstrated that neighborhood factors, environmental factors, income inequality, stress, and racial segregation contribute to the detrimental health status of people living in concentrated disadvantage.

Neighborhood conditions have become important indicators for health. The physical environment of neighborhoods with high-poverty are characterized by “bricked up abandoned buildings, vacant storefronts, broken sidewalks and empty lots with mangy grass overgrowing the ruins of old cars, machine parts, and heaps of garbage” (Epstein, 2003). This neighborhood deterioration is described by a construct labeled as “broken windows” by researcher, Deborah Cohen. Studies have shown that residents of high-poverty neighborhoods plagued with “broken windows” are less physically active than those who live in more aesthetically attractive areas. The physical disorder found in many high-poverty neighborhoods instills fear of the presence of social disorder, such as prostitution, drug dealing, violence and crime. A survey found that 31 percent of low-income people are afraid to walk in their neighborhoods, compared to 15 percent of high-income residents. This fear of going outdoors is reducing the activity levels of both parents and their children, causing additional health risks. Inactive adults are at greater risk for heart disease and diabetes. Additionally, responsible mothers trying to protect their children by keeping them inside are exposing them to the contaminants in the indoor air and increasing their risk for asthma. Decreased activity level in children is also associated with higher rates of childhood obesity (Cohen, 2003).

High-poverty neighborhoods also have features that promote unhealthy behaviors. A study conducted by Thomas LaVeist and John Wallace revealed that in Baltimore, census tracts with low socioeconomic status and predominantly black populations have a higher rate of liquor stores per capita than wealthier and predominantly white census tracts (LaVeist, 2000). Although the increased supply does not necessarily correspond with increased demand, the higher availability is indicative of the intentional marketing to low-income residents. This targeted marketing by the “manufacturers of illness” is widespread in poor communities.

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A study conducted by Caroline Schooler et al. reported that directing cigarette advertisements to low-income youth increased their use of cigarettes (Weitz, 36). Fast food, liquor stores and cigarettes are abundant and cheap in high-poverty neighborhoods.

The lack of grocery stores, and higher prices of healthy foods are additional obstacles to healthy behavior choices in poor neighborhoods. Patrice Sheppard, the executive director of a family services organization in DC says “we don’t have a grocery store in my community. We have absolutely no place to eat unless it’s fast food behind plexiglass....There are none of the amenities you find in a normal neighborhood” (Cohn, 2003). It appears that Sheppard is not alone in her struggle to find healthy food sources. The Health and Human Services Committee of the State House in Pennsylvania recently issued a report describing the shortage of supermarkets in urban areas across the state. Without access to grocery stores, people buy a few items at corner stores that offer less healthy options at higher prices. According to the report, “there is a public health epidemic of diet-related diseases in the Commonwealth. Poor nutrition among children leads to behavioral problems, developmental risks that affect their long-term health, cognitive ability and academic performance.” The committee believes the states should grant subsidies to supermarkets to develop in low-income areas (Nerl, 2003). Most people attribute poor eating habits, low levels of exercise, smoking and drinking to individual behavioral choices made by poor people, and they propose education as the solution. However “the decision and actions occur within a context of constraints and opportunities that are drastically different from those present in middle-class society” (Wilson, 55).

The social environment of a neighborhood also contributes to the health status of its residents. Collective efficacy, which describes “the willingness to help out for the social good,” (Cohen, 2003) is high in areas of high social support and is associated with greater longevity. Studies have demonstrated that people with low levels of social support have higher mortality rates. As Wilson explained, the high residential mobility and loss of the working-age population frequently results in low levels of institutional social organization in high-poverty areas. Cohen’s study identified a potential relationship between the level of “broken windows” present in a neighborhood and its “collective efficacy.” For example, if a neighbor fails to keep up his/her property, other neighbors may resent the negligent neighbor for the detrimental effect it is having on their property value.

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In addition, if fear of violence and crime in areas of high “broken windows” keeps people indoors, it is more difficult to develop social relationships with neighbors (Cohen, 2003).

A study conducted by Felicia Leclere explains the complexity of this issue. The study asserts that the social conditions in residentially segregated, high-poverty neighborhoods could contribute to the high mortality from heart disease among poor black women. Although black and white women nationwide have similar morbidity rates from heart disease, the mortality rate in 1997 for black women ages 45 to 64 was twice the rate for white women in the same age group. Leclere specifically investigated the burden that single-motherhood places on poor women, since in urban neighborhoods of extreme poverty, females head three-quarters of all black households. Although the social networks developed among black females in poor communities offer essential help in the form of childcare, income and personal support, the economic, physical and social isolation of their communities makes it difficult to provide the depth of support needed. Social support becomes an additional demand on their limited resources, and this social obligation escalates the high levels of stress in their lives. Since the etiology of heart disease has stress-linked pathways, the study found that the stress from the social responsibilities placed upon these women was contributing to their increased mortality from heart disease. The results showed that women residing in areas with more than 25 percent of the households headed by females had higher mortality rates (Leclere, 1998).

The daily stress of living in high-poverty neighborhoods, also referred to as ‘weathering,’ has been associated with other detrimental health effects. Helen Epstein cites a study conducted by Bruce McEwen, a neuroendocrinologist, who believes that the frequent release of the hormones produced by the body when people are frightened or angry, impairs the immune system and causes damage to the brain and other organs. Hormone release also inhibits the digestive process, and results in the buildup of fat around the waist. Depositing fat in the abdominal area worsens conditions such as diabetes and heart disease. Ironically, researchers at the University of California have found that abdominal fat cells, produced by eating foods high in sugar and fat, provide temporary relief from feelings of anxiety and stress. These cells inhibit the release of corticotrophin, the hormone produced by the brain that orders production of stress hormones. The researchers argue that this biological function encourages unhealthy eating habits among people exposed to constant stress, which in return magnifies their risk for obesity and the diseases associated with it (Epstein, 2003).

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The combination of all these structural forces, rather than the simple income differentiation, places residents at an increased risk for chronic diseases, and increases their rates of mortality from these diseases.

### **Health Status of DC Residents**

The detrimental health effects of living in concentrated poverty are affecting the residents of Washington DC. The city's mortality rate (number of deaths per 100,000 estimated population) is approximately 30 percent higher than the national rate. A breakdown of health indicators reveals much higher rates of death from HIV/AIDS, hypertension and diabetes in the district than the average rates for the nation. In addition, the infant mortality rate in the city of 15 deaths per 1,000 live births is over twice the national rate of 7.1. (KFF, 2001). Closer investigation of these health indicators reveals major health disparities among residents in the city. Examination of the social and demographic factors along with the corresponding mortality rates of residents demonstrates a trend of higher mortality rates in high-poverty areas. This suggests that DC's high concentration of poverty is a fundamental cause for the poor health of residents.

(The eight political wards of the city will be used for comparison. Since wards cover a much larger region than census tracts or neighborhood clusters, specific neighborhood comparisons of disease-specific mortality rates can not be made. More detailed information regarding neighborhood health indicators is needed to make specific comparisons of health status.)

The social inequality in Washington, DC is most evident in the differential between the average family incomes in the wards. According to the 2000 census, families of Ward 3 have an average annual income of \$187, 724, an increase of 13 percent since 1990, while the incomes for families in Ward 8 dropped 5 percent to \$35, 221. Racial segregation is evident in these income inequalities as 6 percent of the population of Ward 3 is black, while 93 percent of the residents are black in Ward 8. The poverty rate for Ward 3 is 7.4 percent, with only 2.9 percent of children living in poverty. In Ward 8, 36 percent of the population lives below the poverty line, including 49 percent of all children (DC Agenda, 2001). The social inequalities correlate to health disparities between residents of the wards. As mentioned previously, the overall DC infant mortality rate of 15 deaths per 1,000 live births is over twice the national rate of 7.1. The infant mortality rate for Ward 3 is 5.9, while Ward 8's rate is 27.5 (DC Vital Statistics, 1999).

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However, examination of Ward 5 makes this issue seem more complex. Ward 5, which is 88 percent black, contains many of the historically black neighborhoods in DC with varying socioeconomic characteristics. The North Michigan Park neighborhood cluster has an extremely stable housing market, with more than three-quarters of the housing units occupied by homeowners. Over half of all homeowners have lived in the same home for at least 20 years, and the median sale prices for homes in this area are up 30 percent since 1996. On the other hand, this ward contains the high-poverty neighborhood of Ivy City, which exhibits many of the social characteristics associated with concentrated poverty. Ivy City is losing population, has only 50 percent employment, and has an average family income of \$38,000. Although there is great variation among the socioeconomic status and social factors of these neighborhoods, this ward has the highest mortality rate in the city. It has twice the rate of death from cerebrovascular disease as DC as a whole. Furthermore, deaths from heart disease and hypertension are the most prevalent in this ward, and the rate of death from diabetes is the second highest. Although the poverty level is lower and median income is higher in this ward than Ward 8, the mortality rates of the residents are higher. This situation illustrates the need for more neighborhood-specific data on health to further investigate the cause for the high mortality rates in this neighborhood cluster.

The most identifiable trend from this limited health information is that the disproportionate burden of illness falls on the black residents of Washington, DC. In 2001, the mortality rate for black residents in the district was twice the rate of DC's white residents. While white residents in the district have lower mortality rates than the nationwide average for whites, black DC residents have higher mortality rates than for average black Americans, which results in the alarming racial disparities in the health of DC residents. The rate of death from diabetes is four times higher for black residents, and the rates of death from cancer and heart disease are 1.7 times the rates for white residents (Kaiser Foundation, 2001). Since 42 percent of all poor people live in high poverty areas, and 84 percent of all residents in high-poverty neighborhoods in DC are black, the detrimental health effects of living in this increasingly concentrated poverty could explain some of the racial disparities in health (Turner, 1997). As gentrification prices people out of neighborhoods of lower poverty and forces them to relocate in high-poverty areas, it could be contributing to the detrimental health of DC residents, and actually decreasing their life expectancy.

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## **Solutions through Social Policies**

Although limited information is available to study if moving from low to high-poverty neighborhoods negatively affects people's health, studies have demonstrated that the opposite trend, moving from a high to a low-poverty neighborhood has a beneficial impact on the health and well-being of the movers. The US Department of Housing and Urban Development has been conducting an experimental project called, *Moving to Opportunity*, in five major cities around the country. The goal of the initiative is to study how a change in neighborhood environment affects the life chances for low-income families. The project relocated poor urban families from areas of concentrated poverty, primarily public housing buildings, into areas of low poverty in the cities of Baltimore, Boston, New York, Chicago and Los Angeles. The experimental group for the study was given a Section 8 housing voucher that could only be used in areas with poverty rates below 10 percent. The program collaborated with local non-profit groups to assist the families in finding suitable housing. The section 8 comparison group received vouchers which could be used anywhere in the city, and received no housing counseling. The in-place control group continued to receive project-based housing assistance. The Interim evaluation of this study uses qualitative interviews of adults and children in each group to assess changes in their physical environment, social environment, economic opportunity, and educational opportunities for their children (Popkin, 2003).

Overall, this interim report found that the families who moved to areas of low poverty did experience improvement in the social conditions of their lives. They reported living in better housing and feeling considerably safer in their new surroundings. As Lola, an experimental mover in Baltimore describes, "It's totally different because there is not drug activity, no kids hanging on the corners, no kids fighting each other. It's somewhere you can call home"(Popkin, 42). Many participants commented on the peaceful and relaxing nature of their new neighborhoods. Some participants reported feeling welcomed by their new neighbors, and described an increased sense of social cohesion in their new neighborhoods, while other adults missed the social networks of the public housing, and found that cultural and language barriers made it difficult to integrate into the new community. Furthermore, many movers complained of the long distance between their new residence and their families and friends in public housing. Most participants believed that their children are safer in the new neighborhoods, and are surrounded by positive role models. The response regarding the new school

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systems was mixed. Although many participants reported that they believe the quality of schools is higher, their children struggled in adjusting to the higher academic expectations at the suburban schools. Behavioral problems were common among the children. Some parents chose to place their children, particularly older children, in schools closer to their public housing units. The economic opportunities available to MTO families were greater in their new neighborhoods

Although the evaluation of health conditions was not incorporated into the study, participants made frequent mention of their health status. Serious health problems were present in half of the adults interviewed during this study. One-quarter of the sample reported that a family member in the household lives with asthma. Participants cited physical and mental health problems as the largest barriers to employment. Chronic health conditions such as lupus, rheumatoid arthritis, strokes and cancer were mentioned among participants. Only limited information is available on how the Moving to Opportunity program influences the health status of participants. However, since their social conditions had changed, it is not surprising that their health status was also affected. Lower rates of depression were found among women in the experimental group in New York City. Additionally, many women reported improvements in their children's asthma after moving to a different neighborhood. For example, Nicolasa from Boston believes that moving away from the "dust-emitting pipes in her public housing development" improved her daughter's asthma (Popkin, 24). Although the HUD study was not originally designed to examine health, the high incidence of health issues reported in the interview initiated an expansion of their study. The final evaluation will measure the incidence of additional chronic health problems, such as obesity, blood pressure, heart disease, cancer, strokes and smoking (Epstein, 2003).

It appears that if the government of Washington, DC would react to the increasing concentration of poverty in the city, it could alleviate some of the health problems facing its residents. An easy remedy to eliminating concentrated poverty does not exist; however, recognition of some of the forces contributing to it offers a starting point to address the concentration of poverty. By understanding the impact of gentrification, measures can be taken to encourage more proportionate investment in the neighborhoods of Washington DC. The government could initiate programs modeled after *Moving to Opportunity*, which would increase access to affordable housing for low-income residents in low-poverty neighborhoods. In the sections of the city benefiting from rapid investment, such as Logan Circle, the city could use the Housing Production Trust Fund to reserve

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affordable housing for low-income residents. The government could mandate that developers include low-cost units in their construction of new housing units. Furthermore, the government could require landlords to accept Section 8 vouchers to prevent low-income residents from being forced out of their units. Incentives, such as homebuyer assistance and low-cost mortgage financing, could be used to lure investment into underdeveloped areas. Finally, by increasing public safety measures, and offering tax incentives for grocery stores, shops and restaurants, the city could demonstrate its commitment to increasing the livability in these areas (Turner, 2003).

### **Public Health Solutions**

An understating of how and why the concentration of poverty is a fundamental cause for disease and poor health in urban communities is essential for the creation of effective public health initiatives. If public health professionals do not recognize the importance of this fundamental cause for disease among the urban poor, interventions to reduce risk and improve health in these communities will be only partially successful at best.

Furthermore, the glaring racial disparities in health status of residents in Washington, DC warrants further study of racism as a factor contributing to the poor health of minority populations. Researcher Nancy Kreiger believes that further investigation of how racism influences health is critical. By explicitly naming racism and studying its detrimental health consequences, researchers are increasing the ability of public health practitioners to address it as a health issue. If the harmful physical and psychological exposure due to racism has adverse biological health effects on minority populations, public health professionals must be aware of that (Krieger, 2003). The situation present in Washington, DC supports this argument presented by Krieger.

Finally, increasing and expanding access to healthcare for the poor is imperative. Changes must be made to the medical insurance system to ensure that poor people have greater access to preventative care to moderate their risk for disease, and to the medical interventions that would decrease their mortality rates from chronic disease. The inequality in insurance coverage is contributing to the health disparities of residents across the country. This factor must be reconciled through measures such as universal health insurance to resolve the inequity in healthcare access.

## **Conclusion**

The genesis of this paper can be traced back to my experience living in Washington, DC. During the three years that I lived in the city, I observed its growth and redevelopment, and I personally benefited from the new restaurants, clubs and other attractions that the city increasingly offered. However, after I began working on the community level, I encountered some of the people whose lives were negatively affected by this process. I met the “forgotten” people who were watching “the gentry” transform their neighborhoods into places that they could no longer afford, or no longer wanted to live. I had a pivotal conversation with my co-worker, Jorge, about why he had decided to move his family out to Maryland. He explained that although he worked in the city, he could not tolerate the violence and “craziness” in his neighborhood. In his opinion, people could sense that they were going to be pushed out of their neighborhoods, and that anxiety was resulting in higher rates of violence, drug use and depression. This paper is the culmination of my conversation with Jorge (and many others, who had similar stories), the results of Jargowsky’s study on the concentration of poverty (which I heard on NPR), and my increased understanding of the detrimental health effects of living in concentrated poverty.

The construct of gentrification was created to explain the detrimental effects of urban development on certain populations. However, social convention supports the aggregate benefits of a city’s revitalization for its residents. I believe this generalization is harmful. It overlooks the residents whose homes, employment, social relations, and mental and physical health are affected by this process. In the previous section of my paper, social and public health policies are proposed to constrain the adverse effects of gentrification and the concentration of poverty. However, for those policies to be implemented, government officials and the general public must recognize and accept the adverse effects of this trend. Therefore, additional research must be conducted to analyze the complex interaction between gentrification, the concentration of poverty, residential segregation, and the resulting social and health consequences for people.

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