# HealthyNYC

## New York City's Campaign for Healthier, Longer Lives

# Contents

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## Executive Summary

The health of New Yorkers is at a major inflection point. As we emerge from the COVID-19 pandemic, the worst public health crisis in a century, New Yorkers are, on average, sicker and dying too soon. Life expectancy — the average number of years a person can expect to live from the time of their birth — dropped from 82.6 years in 2019, its highest point ever, to 78 years in 2020.[1] This represents the biggest and fastest drop in lifespan in a century; not since the 1918-1920 flu pandemic have we seen such a steep decline in life expectancy.[2]

COVID-19 put the fragility of our health into focus, showing us that our world can change in a moment, with immediate and lasting impacts on our health and well-being for years to come. Throughout the pandemic, worsening health and well-being was underpinned by loneliness and social isolation, job loss and financial instability, and trauma and grief.

COVID-19 was the major driver of this decline in life expectancy, but parallel health crises — including overdose, suicide and violence — also contributed to the sudden decline. Further, despite improvements in chronic disease outcomes continuing to contribute to overall gains in life expectancy over recent decades, heart-related disease and cancer continue to rank in the top causes of mortality (death) among all racial and ethnic groups, and extreme racial disparities[a] disproportionately affecting Black New Yorkers remain among those who die of pregnancy-associated causes.

Bouncing back is possible but will require a concerted effort on behalf of the entire city. Doing so will require a new health campaign to achieve healthier, longer lives for all New Yorkers and define the new focus for public health in the post-COVID-19-emergency era. That campaign is HealthyNYC, a comprehensive vision for how we can improve life expectancy and create a healthier city for all. HealthyNYC will:

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[a]Population-based differences in health outcomes.

1. **Establish an overall life expectancy goal for New York City (NYC) to exceed 83 years by 2030**, achieved by measurable reductions in the primary causes of death — overall death, excess death and premature death — and health inequities in our city, defined through numerical subgoals driven by our vital statistics.

2. **Highlight citywide priority strategies** that will have the greatest impact on reducing these drivers, with a focus on prevention.

3. **Monitor the major drivers** of decreased life expectancy and health inequity and progress toward goals in our city using the latest data available and a strengthened public health data system.

4. **Report annually** on the City's progress toward the goals, and reestablish goals every five years, supported by an accompanying local law.

HealthyNYC is a population health agenda for collective and strategic planning, alignment, action and accountability. Improving life expectancy in NYC will require collaboration, energy and focus from many partners, including City agencies, health care institutions, private and nonprofit businesses, community- and faith-based organizations, state and federal leadership, and everyone who calls NYC home. We must use all of our resources to support strategies that will help communities most in need, ensuring no one is left behind in our effort to increase life expectancy. Using the tools we have, we can ensure all New Yorkers are able to realize their full health potential, regardless of who they are, where they are from or where they live.

HealthyNYC will be an ongoing campaign that is used, reported on and updated regularly by current and future administrations, as data change and new conditions and needs arise. For years to come, NYC will remain focused on improving the health and life expectancy of all New Yorkers because we know New Yorkers are healthier when they live in a city that is healthier.

# The Numbers

Over the past century, NYC experienced impressive gains in life expectancy, adding approximately 30 years of life for the average New Yorker. The majority of gains were the result of effective public health and prevention strategies, in addition to health care breakthroughs and investments in public safety and housing. Since the 1980s, many of the gains in life expectancy in NYC are the result of the introduction of lifesaving HIV treatments, tobacco control measures and smoke-free policies, and efforts to curb toxins, such as trans fats, in our foods and pollutants in our air and water supply.

Life expectancy reached its highest point to date, of 82.6 years, in 2019, then decreased dramatically to 78 years in 2020.[3] This fall in life expectancy in NYC was greater than the 1.8-year decline seen across the U.S. over the same time period. Recent data[b] suggest that life expectancy in NYC has begun to improve, with 2.7 years gained back (from 78 to 80.7 years) from 2020 to 2021, largely due to declining rates of COVID-19 deaths. However, bouncing back to pre-COVID-19 life expectancy is not inevitable. Rising rates of mortality from non–COVID-19-related causes indicate that an organized and concerted effort is needed to meaningfully increase life expectancy beyond where it was prior to COVID-19.

## Health Disparities

Figure 1 shows NYC reached its highest overall life expectancy, of 82.6 years, in 2019. While overall life expectancy decreased significantly between 2019 and 2020, the largest decreases were among Black and Latino[c] New Yorkers. For Black New Yorkers, the pandemic worsened existing disparities.

### Figure 1: Overall Life Expectancy, 2015 to 2021

**Goal: Increase life expectancy to exceed 83 years by 2030**



Dotted line shows 2030 goal of increase to exceed 83 years

**Sources:** 2015 to 2020 population data are estimated based on 2010 and 2020 U.S. Census counts by linear interpolation. 2021 population data are from U.S. Census Bureau Vintage 2022 population estimates. Provisional 2021 mortality data are provided by the NYC Health Department.

[b]Data are subject to change. All 2021 data in this report are provisional.

[c]The NYC death certificate was revised in 2020 to collect data as Hispanic/Latino. As a result, NYC Health Department vital statistics data include the following categories: Latino/a, Black and White, where Black and White race categories do not include New Yorkers of Latino origin.

Figure 2 shows that life expectancy among Black New Yorkers remains the lowest among all racial and ethnic groups (76.1 years compared with 81.8 years for White New Yorkers). In 2019, life expectancy was 4.6 years shorter for Black New Yorkers.[4]

## Figure 2: Life Expectancy by Race and Ethnicity, 2015 to 2021

### Goal: Increase life expectancy to exceed 83 years by 2030

■ Latino   ■ White   ■ Black
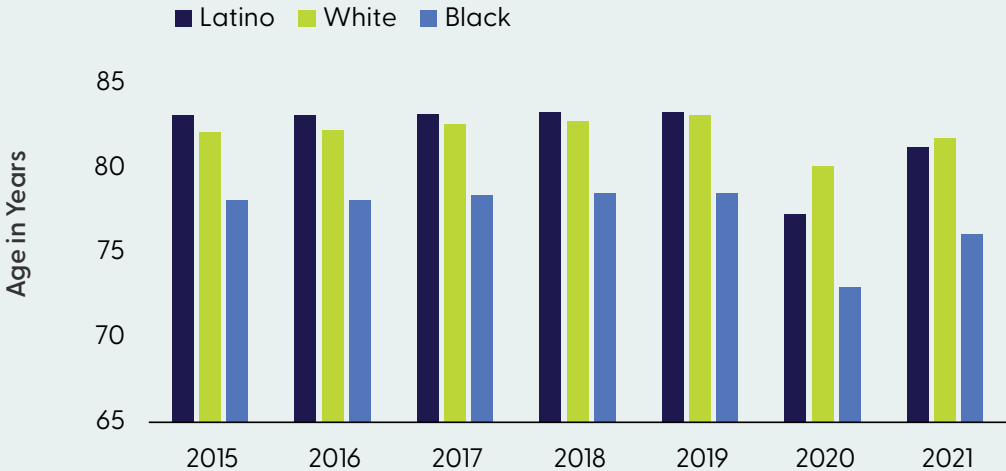


**Source:** Data are provided by the NYC Health Department. 2021 data are provisional. The number of deaths for Asian and Pacific Islander New Yorkers is too small to generate reliable life expectancies and therefore not presented in this figure.

We aim to return to the upward life expectancy trends experienced prior to 2020, which New Yorkers came to expect over the last 100 years. With improvements in key areas, we know we can get life expectancy back on track and ensure everyone has the chance to live the healthiest, longest life possible.

## Premature Death

Rates of premature death — death before age 65 — are high in NYC and have a large impact on life expectancy. In NYC, premature deaths are disproportionately experienced by people of color and people with low income. They are caused by the mental health and overdose crises, chronic diseases, and violence, which are worsened by racial and social inequities.

For example, Figure 3 shows the premature death rate in 2021 was about two times greater among Black New Yorkers than White New Yorkers. From 2015 to 2019, the age-adjusted premature death rate was relatively level. From 2020 to 2021, the rate decreased among Latino New Yorkers by 22.9%, among Black New Yorkers by 13.5%, among White New Yorkers by 10.2% and among Asian and Pacific Islander (API) New Yorkers by 16.7%.
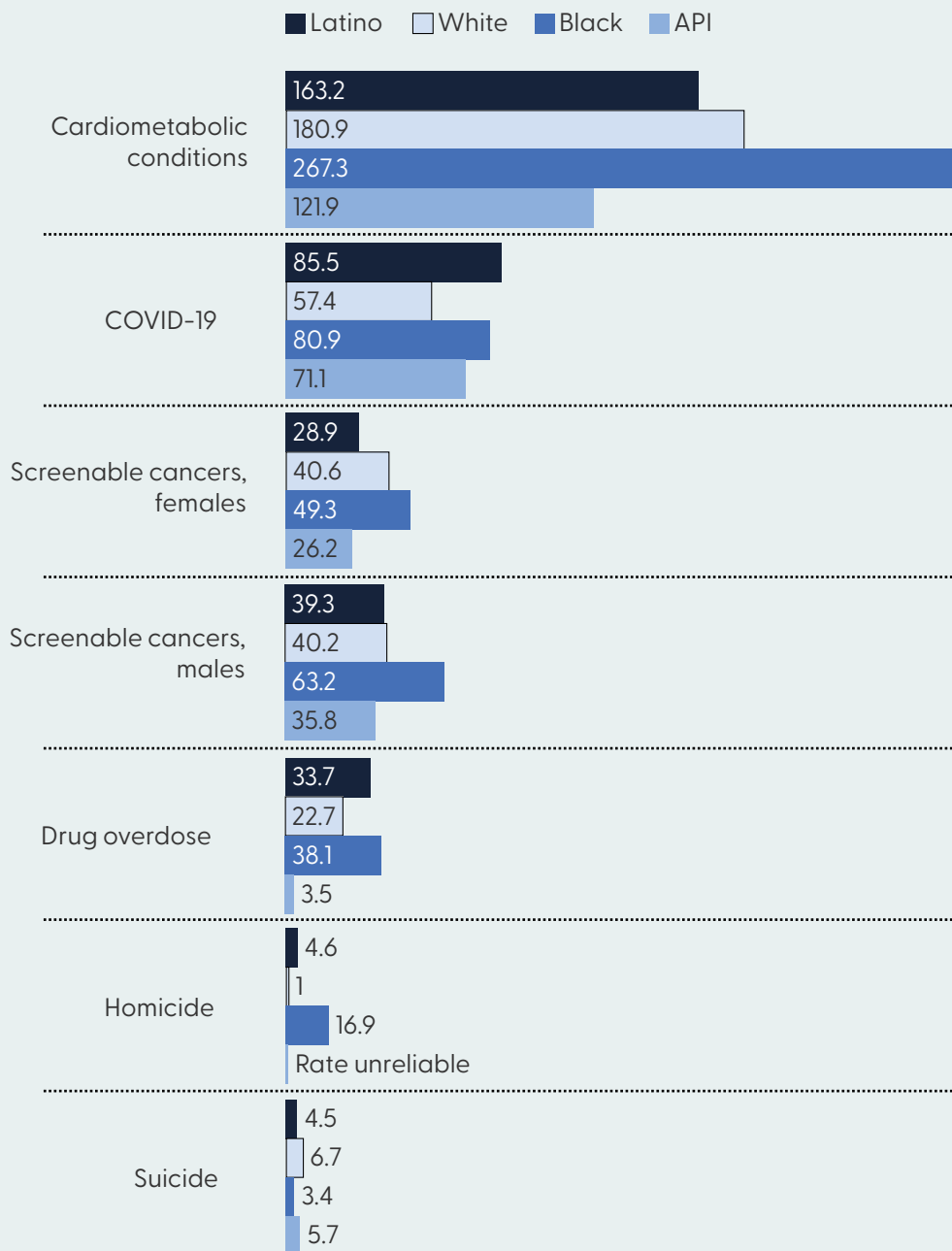
### Figure 3: Premature Death Rate, 2015 to 2021
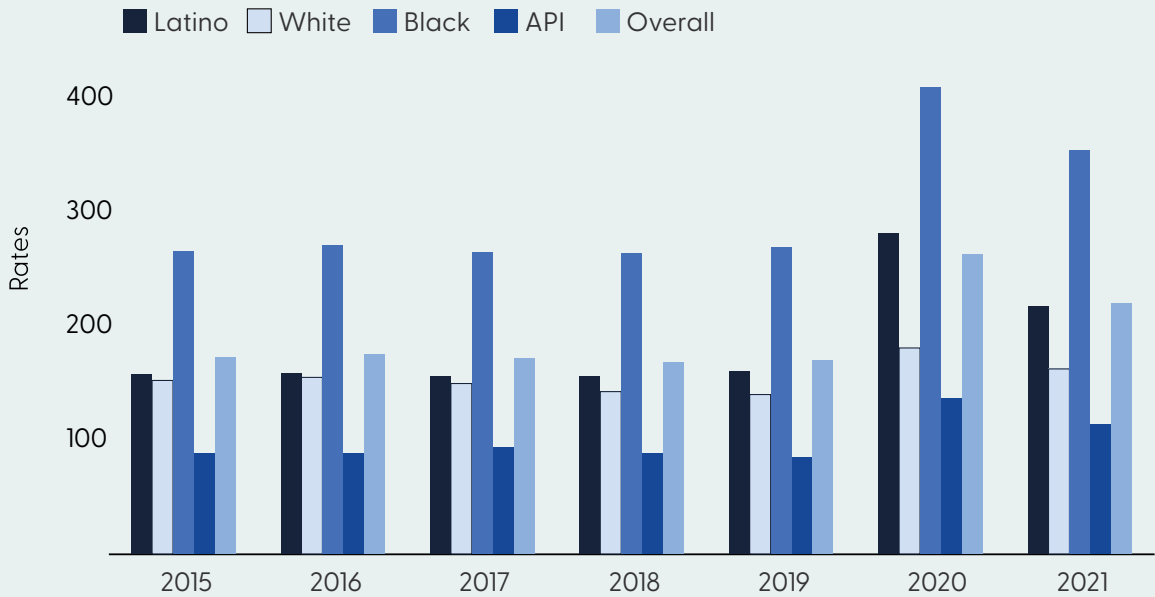


**Source:** Data are provided by the NYC Health Department. 2021 data are provisional. Premature death rate is age-adjusted per 100,000 population.

Figure 4 shows the 2021 rates for causes of death (all ages) by race and ethnicity across drivers of chronic disease, overdose, suicide, COVID-19, violence and maternal mortality.

## Figure 4: Rates of Causes of Death by Race and Ethnicity, 2021

Legend: ■ Latino □ White ■ Black ■ API

**Cardiometabolic conditions**
- 163.2
- 180.9
- 267.3
- 121.9

**COVID-19**
- 85.5
- 57.4
- 80.9
- 71.1

**Screenable cancers, females**
- 28.9
- 40.6
- 49.3
- 26.2

**Screenable cancers, males**
- 39.3
- 40.2
- 63.2
- 35.8

**Drug overdose**
- 33.7
- 22.7
- 38.1
- 3.5

**Homicide**
- 4.6
- 1
- 16.9
- Rate unreliable

**Suicide**
- 4.5
- 6.7
- 3.4
- 5.7

**Source:** Data are provided by the NYC Health Department. 2021 data are provisional. Death rate is age-adjusted per 100,000 population. **Note:** API homicide rate may not be reliable (the relative standard error [RSE] is more than 30).

# Our Vision: A Healthier NYC for All

HealthyNYC's overall goal is to increase life expectancy to exceed 83 years by 2030, with gains across racial and ethnic groups. Our vision is to set ambitious "reach" goals to change health outcomes by targeting the major drivers of overall death, excess death, premature death and extreme racial inequities.

The goals that follow have been set to address the drivers of decreased life expectancy and key racial disparities in life expectancy. We can reset the recent trends through a series of new focused, coordinated efforts across the city that call in and align many stakeholders behind these goals. These efforts will be aligned with a theory of change (see Figure 14 on Page 23) that balances prevention, care and equity for the health of all New Yorkers.

Our progress on each goal, important health outcomes, and risk factors for severe illness and death will be tracked annually by race and neighborhood. If we achieve all the HealthyNYC goals, we can avert 7,300 deaths in NYC by 2030. The following sections of this report highlight actions we will take in the next few years in collaboration with federal, State and City partners.

## Chronic and Diet-Related Diseases

Chronic and diet-related diseases, such as heart disease, stroke, diabetes and screenable cancers, continue to be leading causes of death across all racial and ethnic groups in NYC. In 2021, more than 30,000 New Yorkers died from these conditions, with one-third of these deaths due to cancer.
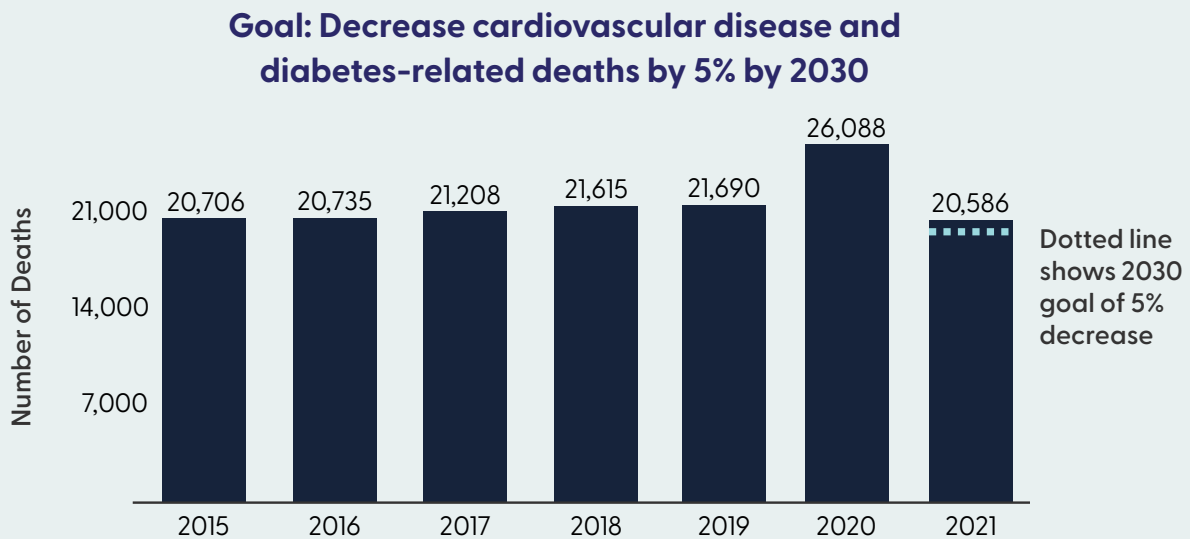
Inequitable social and economic conditions, such as lack of access to healthy foods and physical activity, and inequitable access to health care resources and opportunities mean that chronic disease has a much greater impact on some groups of New Yorkers than others. For example, in 2021, the rate of premature death from cancer was about 41% higher among Black New Yorkers compared with the citywide average, and higher than the rates among Asian, Latino and White New Yorkers. Premature deaths from diabetes and heart disease were nearly 1.9 times as common among Black New Yorkers compared with citywide. NYC is working on a coordinated strategy to address these chronic conditions and will launch future initiatives around this.

## Cardiometabolic Conditions

Figure 5 shows overall deaths from cardiometabolic conditions including cardiovascular disease and diabetes-related disease, which have stayed level, at about 21,000 per year, after a sharp rise in 2020 to 26,088. There is also a disparity in these deaths among race and ethnicity in NYC when data are shown separately across groups, with Black New Yorkers having the highest rate of deaths related to heart disease and diabetes.

**Figure 5: Number of Cardiovascular Disease and Diabetes-Related Deaths, 2015 to 2021, With 2030 Goal**

**Goal: Decrease cardiovascular disease and diabetes-related deaths by 5% by 2030**

| Year | Number of Deaths |
|------|------------------|
| 2015 | 20,706 |
| 2016 | 20,735 |
| 2017 | 21,208 |
| 2018 | 21,615 |
| 2019 | 21,690 |
| 2020 | 26,088 |
| 2021 | 20,586 |

Dotted line shows 2030 goal of 5% decrease

**Source:** Data are provided by the NYC Health Department. 2021 data are provisional. **Note:** Cardiovascular disease includes heart disease, stroke and high blood pressure. Deaths are due to these conditions as well as to diabetes and kidney disease.
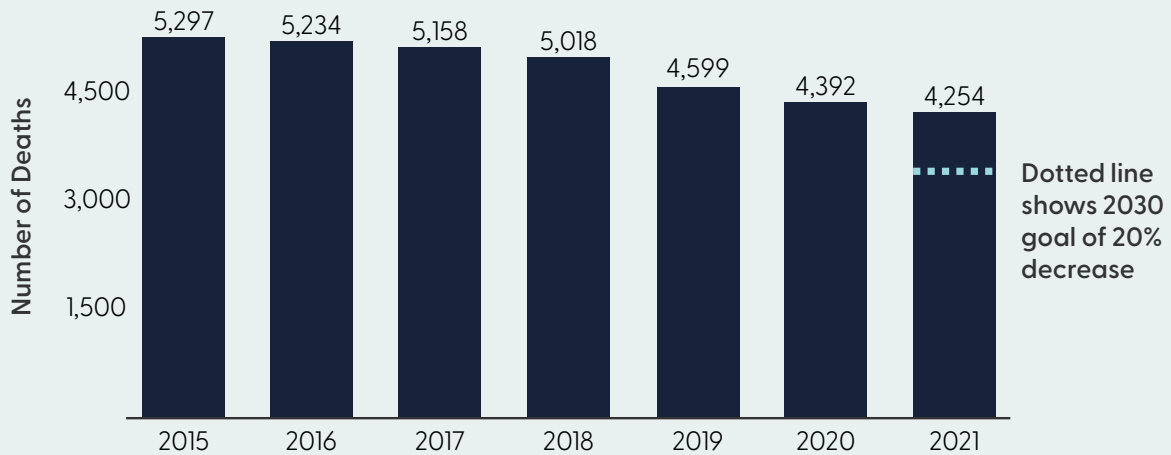
## Screenable Cancers

Figure 6 shows deaths from screenable cancers have declined by 20% since 2015. Our work will continue to build on this progress.

**Figure 6: Number of Screenable Cancer Deaths, 2015 to 2021, With 2030 Goal**

### Goal: Decrease screenable cancer deaths by 20% by 2030

| Year | Number of Deaths |
|------|------------------|
| 2015 | 5,297 |
| 2016 | 5,234 |
| 2017 | 5,158 |
| 2018 | 5,018 |
| 2019 | 4,599 |
| 2020 | 4,392 |
| 2021 | 4,254 |

Dotted line shows 2030 goal of 20% decrease

**Source:** Data are provided by the NYC Health Department. 2021 data are provisional.

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### Driver: Chronic and diet-related diseases

#### HealthyNYC Goals

Reduce deaths due to:

- Cardiovascular disease and diabetes by 5% by 2030
- Screenable cancers, including lung, breast, colon, cervical and prostate, by 20% by 2030

#### Priority Strategies

To achieve the goals:

- Increase health care access and coverage.
- Increase prevention activities and social supports.
- Increase access to healthy foods, and promote plant-forward diets.
- Reduce added sugar and salt and toxins in our food supply.
- Prevent tobacco use, and reduce smoking and alcohol consumption.

## Mental Health

Mental health and well-being are essential for living long, productive and meaningful lives. Our mental health directly impacts some causes of death and indirectly influences others, including acute and chronic causes as well as physical and behavioral causes. NYC is facing a mental health crisis following an unprecedented period of loss, isolation, trauma, economic insecurity and racial inequity during the COVID-19 pandemic, building on decades of increasing mental health needs and a history of disinvestment in and neglect of mental health systems.

Mental health contributes to decreases in life expectancy both directly through drivers such as overdose and suicide and indirectly by reducing our ability to take part in healthy activities, to make healthy dietary and lifestyle choices, to seek out health care and employment, and to connect with others. Drug-related causes, including opioid overdose, were one of the top drivers of decreased life expectancy from 2019 to 2021.

For more information, see the City's recent mental health plan titled Care, Community, Action: A Mental Health Plan for NYC, available at **nyc.gov/mentalhealthfornyc**.

## Drug Overdose

Figure 7 shows overdose deaths have increased more than 75% since 2019. By 2030, our goal is to reduce deaths by 25%.

### Figure 7: Number of Overdose Deaths, 2015 to 2021, With 2030 Goal

**Goal: Decrease overdose deaths by 25% by 2030**



Dotted line shows 2030 goal of 25% decrease
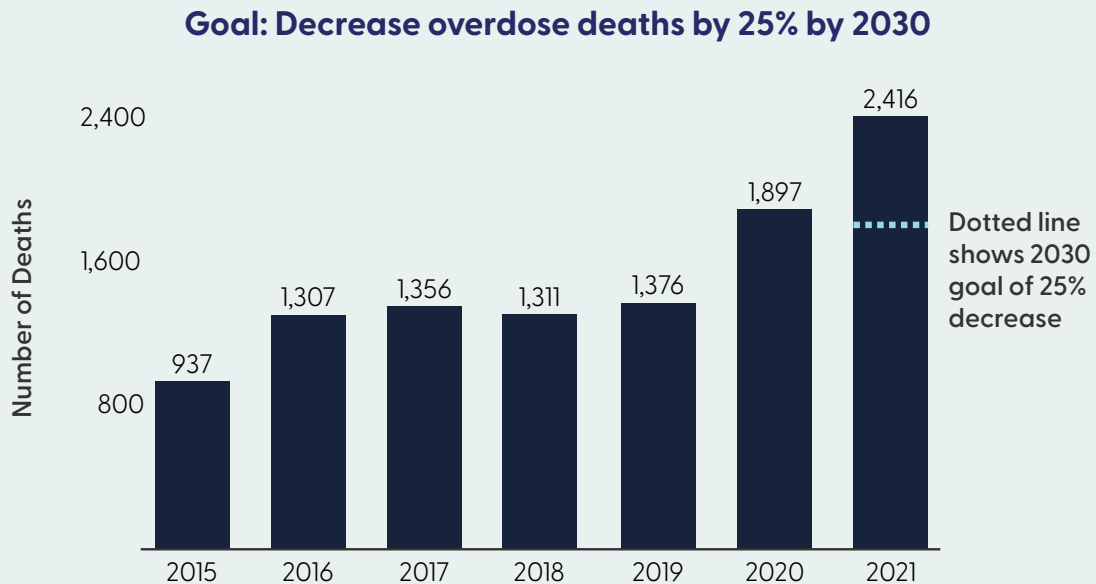
**Source:** Data are provided by the NYC Health Department. 2021 data are provisional.

**Driver: Drug overdose**

**HealthyNYC Goal**

Reduce overdose deaths by 25% by 2030.
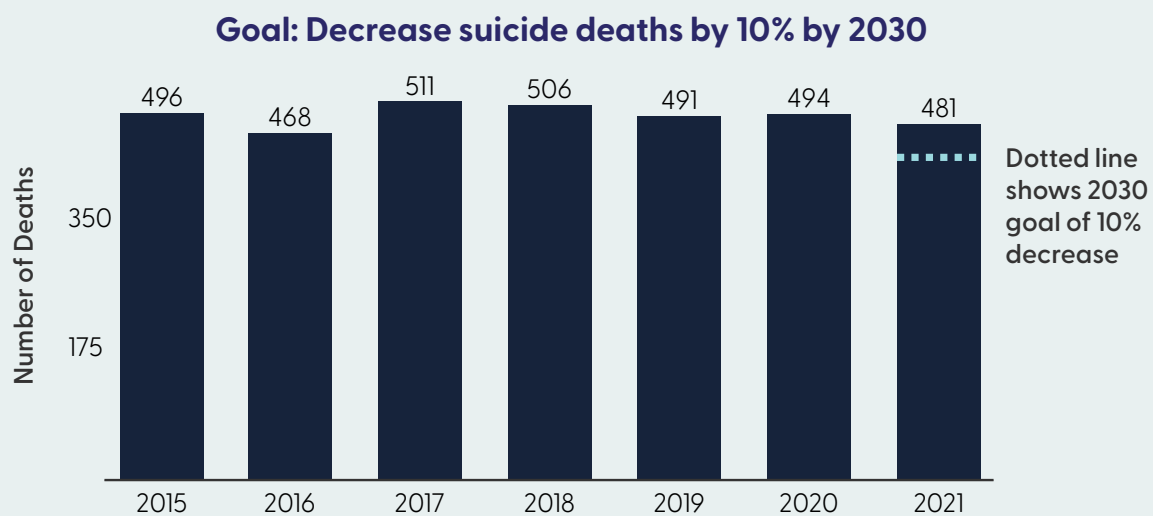
**Priority Strategies**

To achieve the goal:

- Increase access to naloxone and quality harm-reduction services, including overdose prevention centers.
- Increase access to quality treatment and recovery services, including medication-assisted treatment (MAT) and methadone.
- Reduce stigma and social isolation.
- Increase response services to nonfatal overdose.
- Increase access to drug testing services.
- Support federal policy and law enforcement efforts to reduce fentanyl in the drug supply.

## Suicide

Figure 8 shows suicide deaths have stayed level in recent years, but the high numbers per year since 2015 are not acceptable and are in contrast to natural trends. Risk of suicide is rising. Of particular concern is the increasing rate of suicidal ideation among NYC teenagers, LGBTQIA+ New Yorkers and communities of color. We can do better — our goals are to increase access to mental health care and other supports and to reduce access to lethal means of suicide in order to decrease suicide deaths by 10% by 2030.

### Figure 8: Number of Suicide Deaths, 2015 to 2021, With 2030 Goal

**Goal: Decrease suicide deaths by 10% by 2030**

| Year | Number of Deaths |
|------|------------------|
| 2015 | 496 |
| 2016 | 468 |
| 2017 | 511 |
| 2018 | 506 |
| 2019 | 491 |
| 2020 | 494 |
| 2021 | 481 |

Dotted line shows 2030 goal of 10% decrease

**Source:** Data are provided by the NYC Health Department. 2021 data are provisional.

### Driver: Suicide

#### HealthyNYC Goal
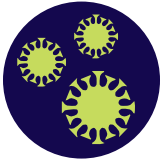Reduce suicide deaths by 10% by 2030.

#### Priority Strategies
To achieve the goal:
- Increase access to culturally responsive mental health care and social support services, including early intervention for communities of color and LGBTQIA+ youth.
- Reduce stigma and social isolation.
- Reduce access to lethal means of suicide.
- Address the impact of social media on youth mental health and suicidal ideation.

## COVID-19

More than 20,400 NYC residents died from COVID-19 in 2020, followed by more than 7,700 NYC residents in 2021.[d,5] COVID-19 was the major driver of decreased life expectancy in 2020 and 2021, with parallel health crises such as overdose, suicide and violence also contributing to the sudden decline. Age-adjusted COVID-19 death rates in 2020 were roughly twice as high among Black and Latino New Yorkers compared with White and API New Yorkers.[6] Racial disparities continued during the Omicron wave in the winter of 2021-2022, as Black New Yorkers were hospitalized at twice the rate of White New Yorkers.[7]

Deaths due to COVID-19 also disproportionately impacted older adults in NYC, with a death rate 34 times greater among people ages 65 to 84 and more than 100 times greater among people age 85 and older compared with people ages 25 to 44.[e] Of particular concern are people living in residential congregate settings (such as nursing homes, jails and prisons, and shelters), especially those where many residents may have underlying medical conditions and therefore be at increased risk for severe disease. With lifesaving science such as vaccines and antivirals, hospitalizations and deaths from COVID-19 have been reduced dramatically since the start of the pandemic, but there is still much to do to protect the health of people at the greatest risk for severe outcomes from COVID-19.
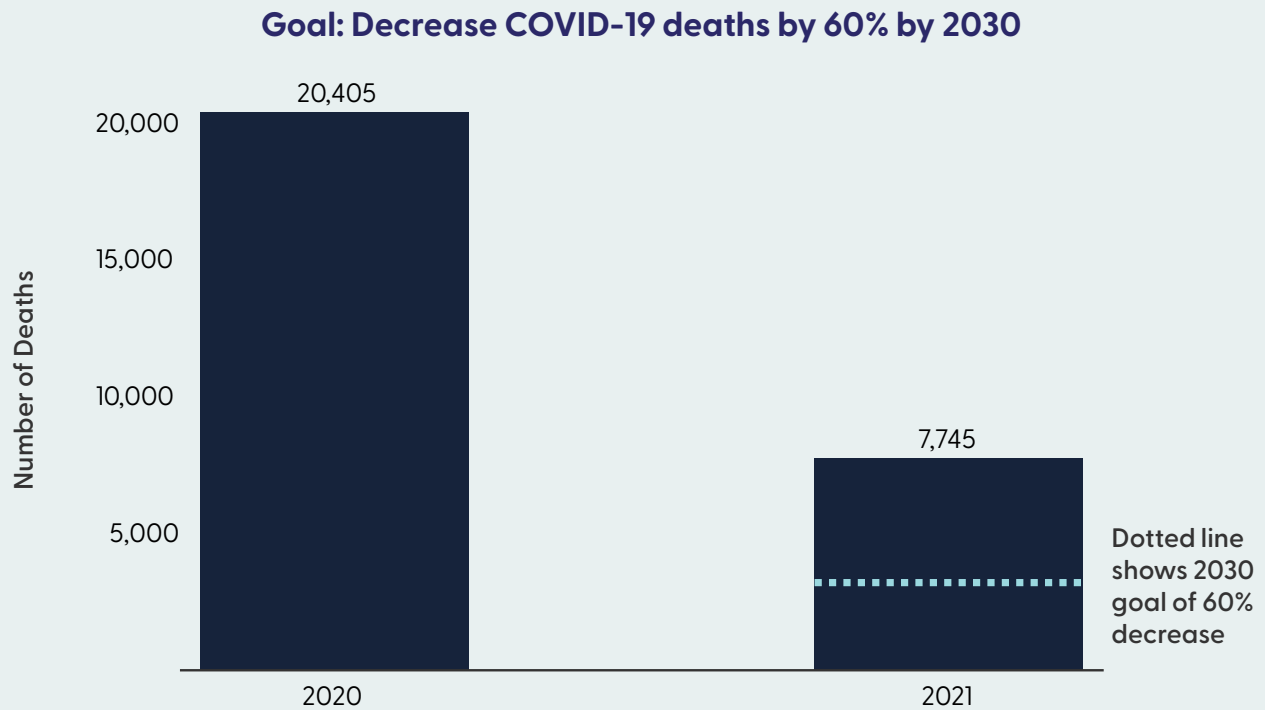
Figure 9 shows that COVID-19 deaths have declined since the pandemic began in 2020. Our goal is to continue to decrease deaths due to COVID-19, reaching a 60% reduction by 2030, which includes work to protect the health of New Yorkers at increased risk for severe outcomes from COVID-19 through access to treatment and vaccines, among other tools.

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[d]Note that COVID-19 deaths in this document are defined as those for whom COVID-19 was listed as the underlying cause of death on the death certificate. These data are different from real-time surveillance data released regularly on the NYC Health Department website. At the beginning of the COVID-19 pandemic, testing for SARS-CoV-2 was extremely limited and reporting of deaths associated with COVID-19 likely was incomplete. The NYC Health Department's disease surveillance, which involved monitoring cases and matching laboratory records of COVID-19 tests with the death registry, allowed real-time reporting of COVID-19 deaths when total deaths were increasing rapidly and reporting was incomplete.

[e]These provisional data are provided by the NYC Health Department.

## Figure 9: Number of COVID-19 Deaths, 2020 to 2021, With 2030 Goal

### Goal: Decrease COVID-19 deaths by 60% by 2030



Number of Deaths

20,405

7,745

Dotted line shows 2030 goal of 60% decrease

2020

2021

**Source:** Data are provided by the NYC Health Department and start from January 2020. 2021 data are provisional.

## Driver: COVID-19

### HealthyNYC Goal
Reduce COVID-19 deaths by 60% by 2030.

### Priority Strategies
To achieve the goal:
- Focus strategies and resources, especially those related to vaccine uptake and to availability and early utilization of treatment, on protecting New Yorkers at the highest risk of severe disease and death, which includes people who are older, are immunocompromised and/or have certain disabilities that may increase their risk for having underlying health conditions.
- Promote everyday preventive actions, such as face masks, especially when transmission increases in the community and for people with the highest risk for severe outcomes.
- Support the health care delivery system to care for patients with COVID-19, especially through free and equitable access to COVID-19 tests, vaccination and face masks.
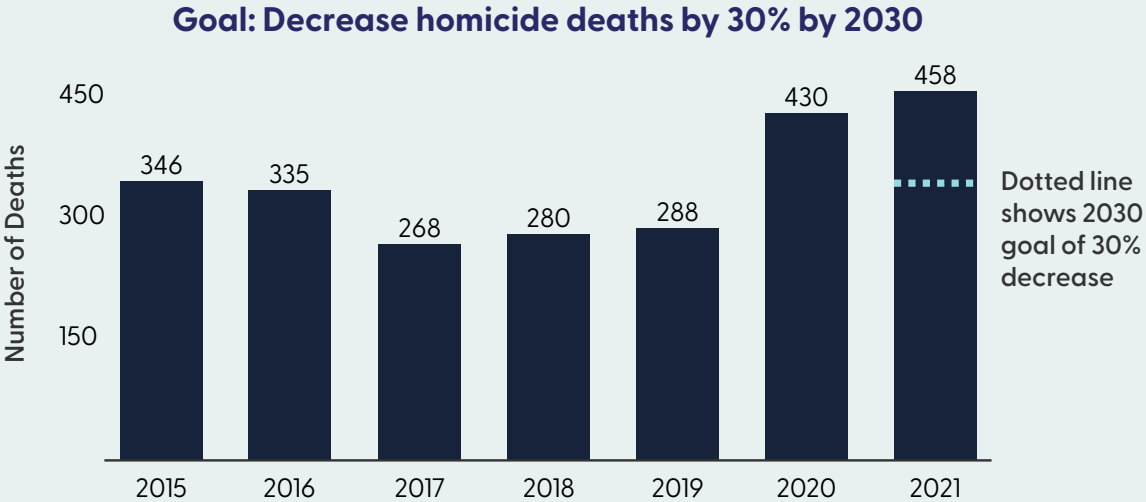
## Violence

Violence is a public health issue and impacts not only those directly involved but also the well-being of families and entire communities. Violence also predicts future negative physical and mental health outcomes. Gun violence in particular has a direct impact on premature death and can lead to stress, depression, anxiety and post-traumatic stress disorder. For example, the mental health impacts of violence include increased suicide risk and substance (alcohol and drug) use.
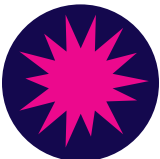
According to the NYC Health Department's **Summary of Vital Statistics, 2020**, NYC mortality data highlight homicide as the leading cause of death among people ages 15 to 24, with firearms accounting for more than 70% of these deaths. Deaths from homicide can result from any form of violence, including violence in communities between people who do not know each other, as well as intimate partner violence. For more information on the City's approach to addressing gun violence, see the City's Blueprint to End Gun Violence, available at **on.nyc.gov/gun-violence-blueprint**.

Figure 10 shows homicides have increased by more than 59% since 2019. Our goal is to decrease the current number of homicides by 30% by 2030.

### Figure 10: Number of Homicide Deaths, 2015 to 2021, With 2030 Goal

**Goal: Decrease homicide deaths by 30% by 2030**



Dotted line shows 2030 goal of 30% decrease

**Source:** Data are provided by the NYC Health Department. 2021 data are provisional.
**Note:** Homicide is defined as including multiple forms of interpersonal violence (such as violence in communities between people who do not know each other, intimate partner violence and domestic violence). Homicide data track weapon used (such as firearm, knife or physical force) and exclude suicide data, which are tracked separately in vital statistics data (see suicide reduction goal).

**Driver: Violence**

**HealthyNYC Goal**

Reduce homicide deaths by 30% by 2030.

**Priority Strategies**

To achieve the goal:

- Reduce crime and access to illegal guns.
- Invest in communities most impacted by violence to increase social connection and economic opportunities (such as youth employment and after-school activities).
- Increase access to mental health and violence-related trauma support.
- Expand community-engaged and data-driven approaches to public safety.
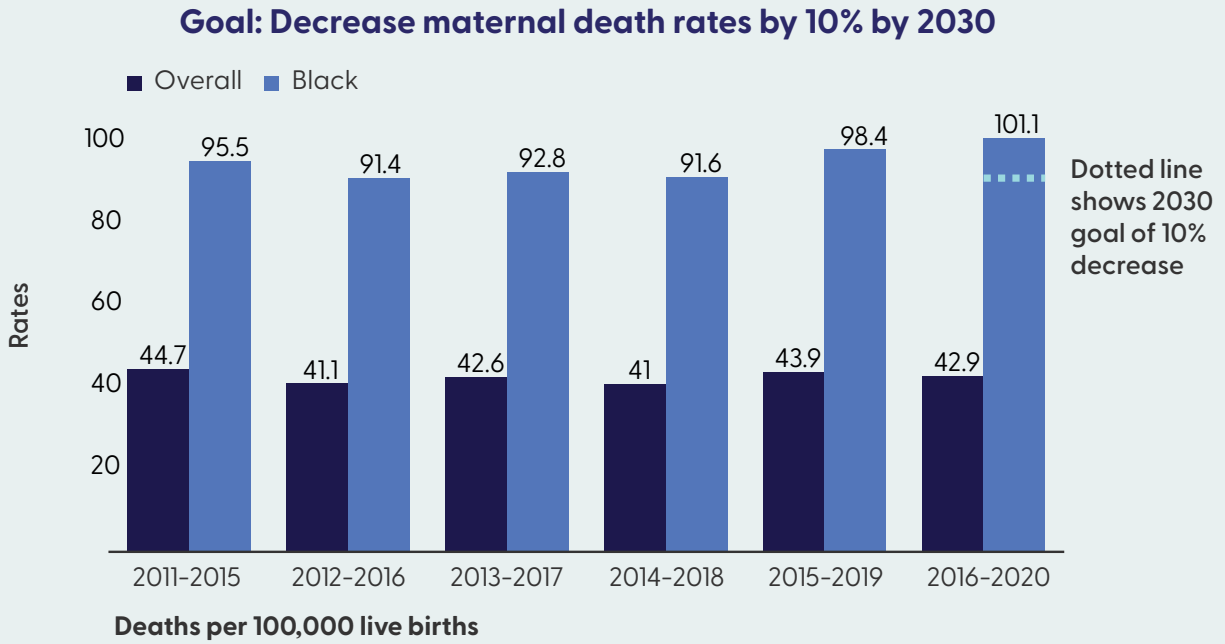
## Maternal Mortality

The overall rate of maternal mortality[f] has remained steady in NYC since 2001, and extreme disparities persist between racial groups — see Figure 11. From 2008 to 2012, approximately 2,300 to 3,100 people suffered a life-threatening complication during childbirth.[8] There was a 6% increase in the maternal mortality rate among Black women from 2011 to 2020. Between 2016 and 2020, Black women were four times more likely to die from a maternal death than White women.[9]

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[f]Maternal mortality is defined here as pregnancy-associated mortality, or death to a woman or birthing person from any cause during pregnancy or within one year of the end of pregnancy.

## Figure 11: Rate of Maternal Mortality, 2011 to 2020, With 2030 Goal

### Goal: Decrease maternal death rates by 10% by 2030

■ Overall  ■ Black

Dotted line shows 2030 goal of 10% decrease

| Period | Overall | Black |
|--------|---------|-------|
| 2011–2015 | 44.7 | 95.5 |
| 2012–2016 | 41.1 | 91.4 |
| 2013–2017 | 42.6 | 92.8 |
| 2014–2018 | 41 | 91.6 |
| 2015–2019 | 43.9 | 98.4 |
| 2016–2020 | 42.9 | 101.1 |

Rates

**Deaths per 100,000 live births**

**Source:** Data are provided by the NYC Health Department. **Notes:** The overall rates include all racial and ethnic groups, including Black, Latino, API, White and other groups. Due to instability in the pregnancy-associated maternal mortality rates from year to year, rates are presented as five-year averages to obtain more reliable ratios.[10]

Our 2030 goal of reducing maternal mortality among Black women by 10% will make significant progress toward closing this disparity.

**Driver: Maternal mortality**

**HealthyNYC Goal**

Reduce pregnancy-associated mortality among Black women by 10% by 2030.

**Priority Strategies**

To achieve the goal:

- Increase new families' access to health care and social support.
- Increase access to and quality of sexual and reproductive health care for people of color who may become pregnant, are pregnant or have recently given birth.
- Increase access to quality mental health and addiction support during and after pregnancy.
- Ensure people of color who may become pregnant, are pregnant or have recently given birth receive access to care and prevention resources for chronic and diet-related diseases.
- Improve access to and quality of obstetric health care along the whole continuum of pregnancy, childbirth and postnatal care.

# Health in the Bigger Picture

The role of public health is to protect and improve people's health. While health care focuses on treating and helping people when they are sick, public health promotes the quality of and equitable access to health care, social services and safe, healthy environments to prevent diseases before they occur. To support the physical and mental health of New Yorkers, we must focus on creating positive community, social and structural factors that influence their access to everything from education to nutritious food, while also creating a stronger bridge and improving coordination between public health and health care.
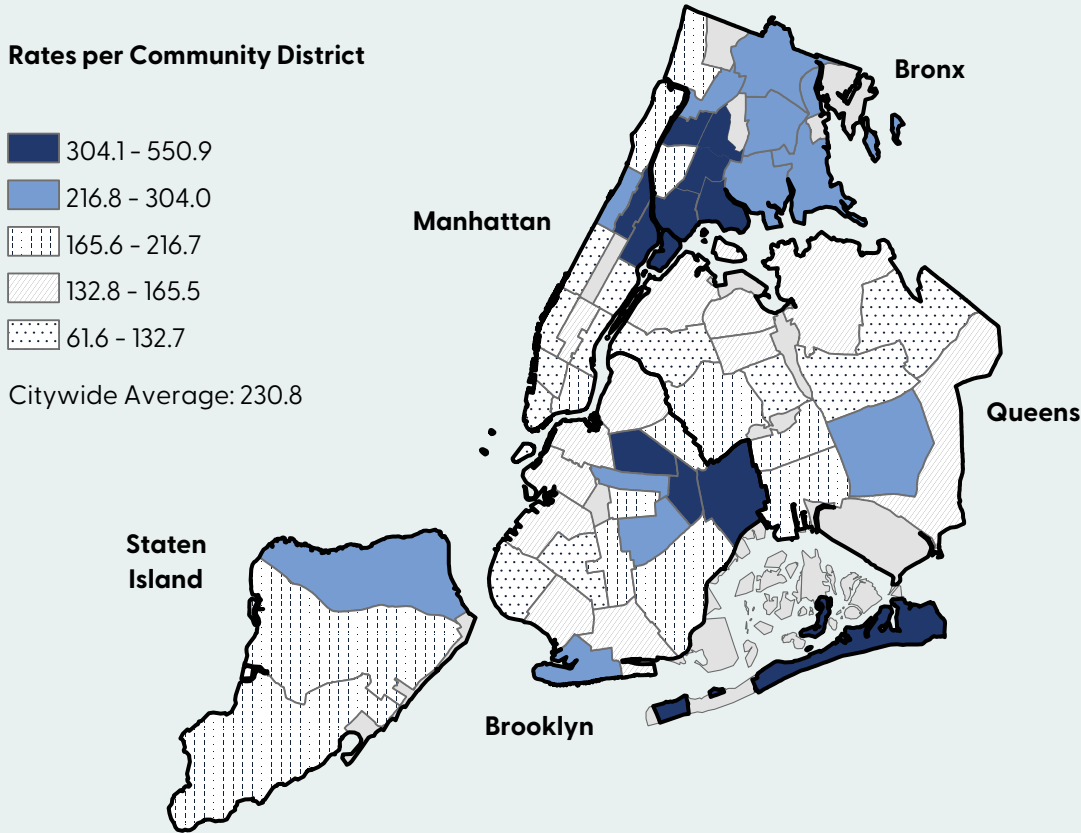
## Overlapping Community, Social and Structural Factors

Due to historical racial and economic segregation, people of color are more likely to live in neighborhoods with high poverty and experienced the highest rates of COVID-19-related deaths at the start of the pandemic. Inequities in housing, nutrition, economic opportunity and access to health care are the result of structural racism experienced across generations and discriminatory policies and practices. These systems benefit some communities while harming others, with harms compounding over time and generations, resulting in poorer health outcomes for those harmed.

Historical disinvestment in communities of color continues to result in entire neighborhoods having limited access to essential opportunities and resources, including health resources, with lower life expectancies as a result. In 2020, 19% of New Yorkers living in neighborhoods with high poverty reported they avoided seeking health care for COVID-19 symptoms due to potential costs compared with only 5% in the wealthiest neighborhoods.[11]
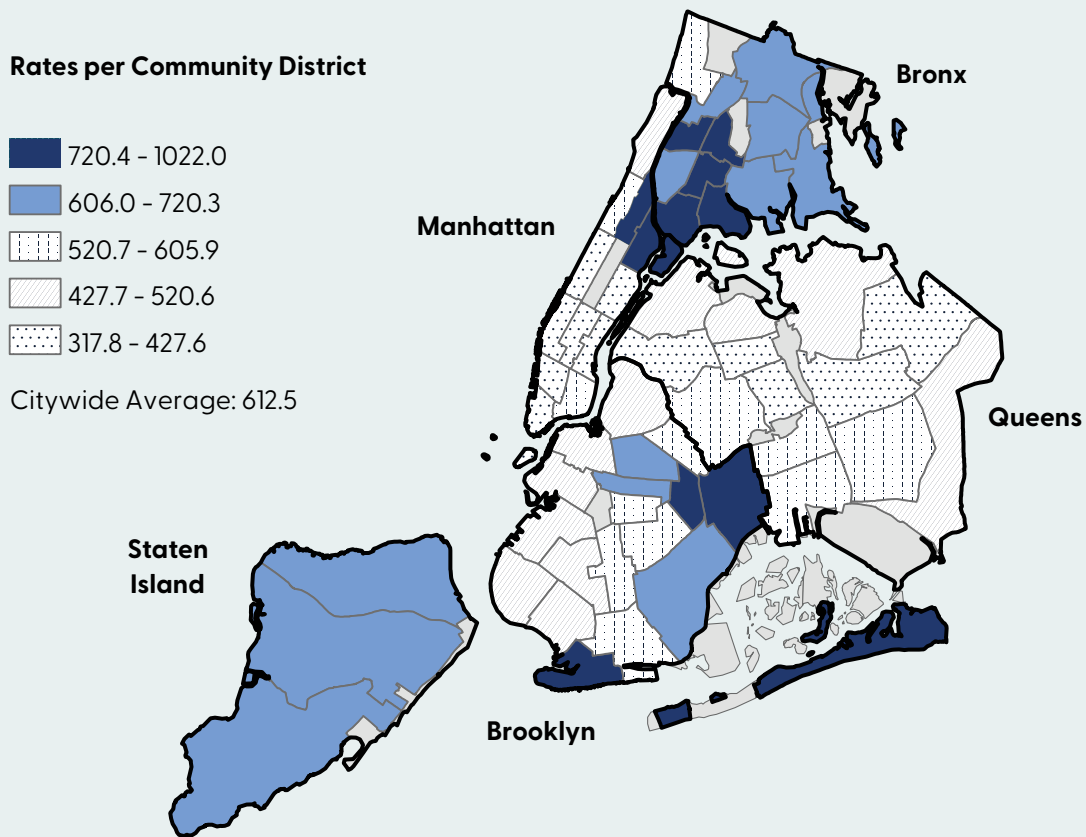
Figure 12 shows the rate for premature death by borough, and Figure 13 shows the rate for death by borough. The citywide average age-adjusted premature death rate was 230.8 per 100,000 population and the citywide average age-adjusted overall death rate was 612.5 per 100,000 population, but there are disparities across community districts throughout the city, with some areas experiencing higher premature death rates and overall death rates than others. These figures make one thing very clear: Communities of color bear the burden of higher rates of premature death than other communities.



**Figure 12: Premature Death Rate, 2021**

**Rates per Community District**

- 304.1 – 550.9
- 216.8 – 304.0
- 165.6 – 216.7
- 132.8 – 165.5
- 61.6 – 132.7

Citywide Average: 230.8

Bronx

Manhattan

Queens

Staten Island

Brooklyn

**Source:** Data are provided by the NYC Health Department. 2021 data are provisional. Premature death rate is age-adjusted per 100,000 population.

## Figure 13: Death Rate (All Ages), 2021

**Rates per Community District**

- 720.4 – 1022.0
- 606.0 – 720.3
- 520.7 – 605.9
- 427.7 – 520.6
- 317.8 – 427.6

Citywide Average: 612.5

Bronx

Manhattan

Queens

Staten Island

Brooklyn

**Source:** Data are provided by the NYC Health Department. 2021 data are provisional. Death rate is age-adjusted per 100,000 population.

### HealthyNYC Goals
Goals across all drivers

### Priority Strategies
To achieve the goals:
- Increase access to and quality of health care, mental health supports and health insurance options.
- Increase access to employment options.
- Address racial disparities in the way care is provided.
- Support community-led programming on health literacy, and increase community health worker presence in communities.
- Promote economic development.
- Improve access to affordable housing.
- Foster community investment in achieving HealthyNYC goals.

## Climate Change

Negative and inequitable health outcomes and the environmental and social factors that cause them are worsened by climate change, which is also a public health crisis. The impacts of climate change include increasing temperatures, extreme precipitation, coastal storm surge and chronic tidal flooding, which result in infrastructure failures such as power outages. A warming planet also increases the risk for infectious diseases and pandemics, especially vector-borne and zoonotic disease (disease transmitted between animals and humans) and accelerates loss of biodiversity.[12]

Each summer in NYC, on average, an estimated 350 people die prematurely due to hot weather. Heat-related deaths have been increasing over the past decade and make up about 2% of all deaths during the warm season months of May to September.

The impacts of climate change are experienced the most by New Yorkers with low income and older adults, as well as people of color because of the increased risk conferred by racism.[13] Moreover, Black New Yorkers have heat-related death rates two times higher than White New Yorkers.[14]

Climate change must be addressed to achieve healthier, longer lives. NYC is responding to the international call to combat climate change by shifting away from fossil fuels and is taking an environmental justice approach to adapt to the intensifying impacts of climate change and involve and protect New Yorkers regardless of race, ethnicity, immigration status or income. In April 2023, the Adams Administration updated the City's long-term strategic climate plan titled PlaNYC: Getting Sustainability Done, which includes health goals that are both directly and indirectly related to climate. For more information, visit **climate.cityofnewyork.us/initiatives/planyc-getting-sustainability -done**.

**HealthyNYC Goals**
Goals across all drivers

**Priority Strategies**
To achieve the goals:
- Promote strategies to improve infrastructure, climate resilience and air quality.

# Achieving Our Goals

We will improve life expectancy in NYC by taking a public health approach that uses proven, evidence-based[g] strategies and applies a health equity[h] lens to ensure that everyone enjoys the opportunity to live a healthier, longer life, leaving no one behind. To achieve our goals, we must provide our historically underserved communities (including communities of color) and most vulnerable communities (including older adults and New Yorkers with disabilities and underlying health conditions) with the support and resources they need, and they must be included in population health planning from the beginning. Prevention will be central across these strategies and investments, which acknowledges that social, economic and community factors have a significantly greater impact on health than clinical care or genetics. Often the greatest gains in healthy years lived come from intervening earlier in a person's lifespan to avoid or mitigate their later health and functional issues.

Figure 14 describes how we will achieve our goals. The three circles show three approaches to reducing mortality risk that, when combined, create areas of overlap, synergy and focus that sustain real-life, everyday change and will ensure all New Yorkers are part of the City's strategy. The three approaches include:

1.  Population-wide measures aimed at reducing overall citywide mortality risks (such as reducing added sugar and salt in foods)

2.  Providing services and connections to care for people at higher risk due to age, disability, or underlying health conditions or settings

3.  Providing services and connections to care that have an equity and place-based focus and are tailored to communities of color most impacted by structural inequities such as racism
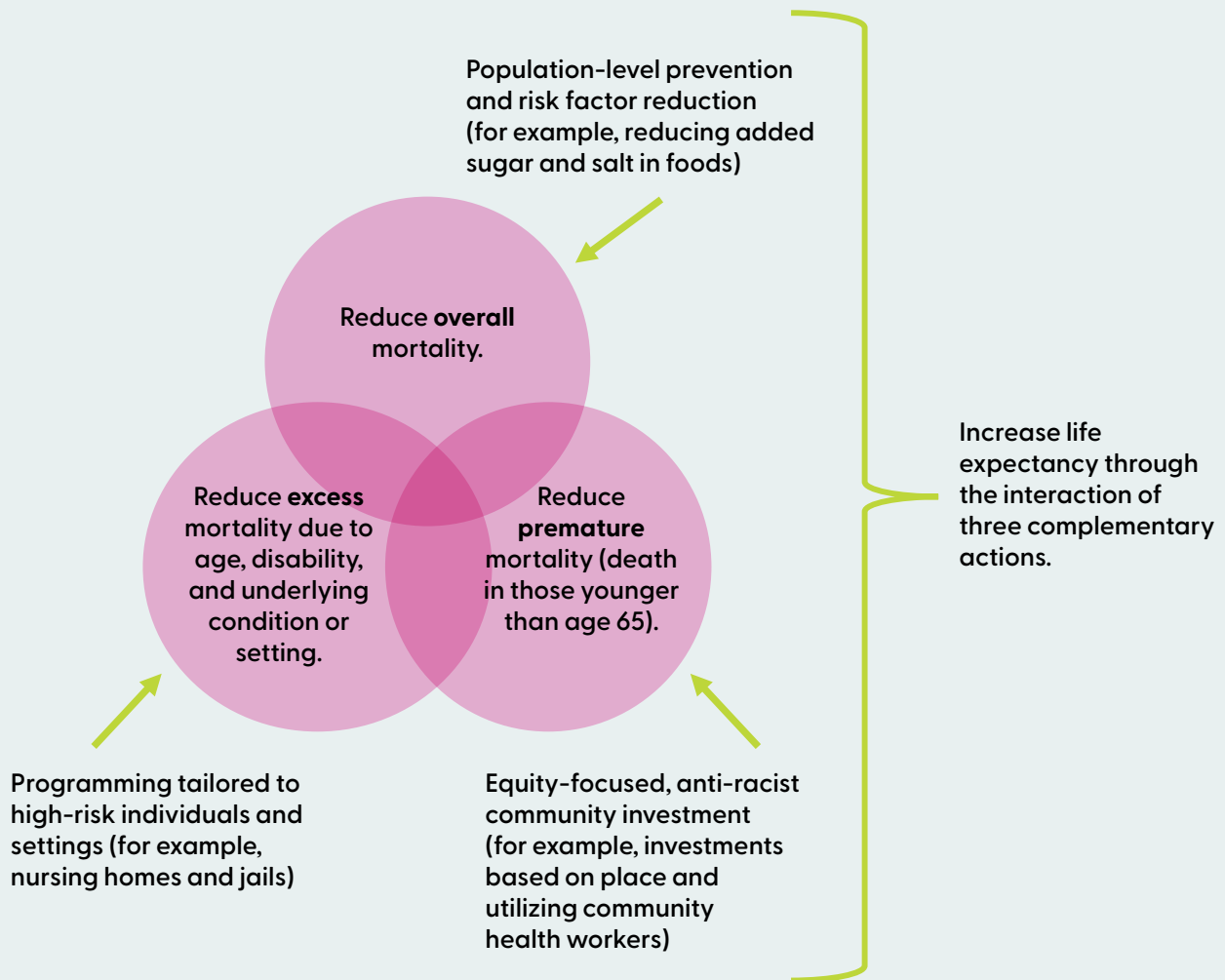
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[g]Strategies research shows are effective based on evidence.
[h]Where everyone has the opportunity to realize their full health potential.

**Figure 14: Theory of Change – How Do We Achieve Our Goals and Leave No One Behind?**

Population-level prevention and risk factor reduction (for example, reducing added sugar and salt in foods)

Reduce **overall** mortality.

Reduce **excess** mortality due to age, disability, and underlying condition or setting.

Reduce **premature** mortality (death in those younger than age 65).

Increase life expectancy through the interaction of three complementary actions.

Programming tailored to high-risk individuals and settings (for example, nursing homes and jails)

Equity-focused, anti-racist community investment (for example, investments based on place and utilizing community health workers)
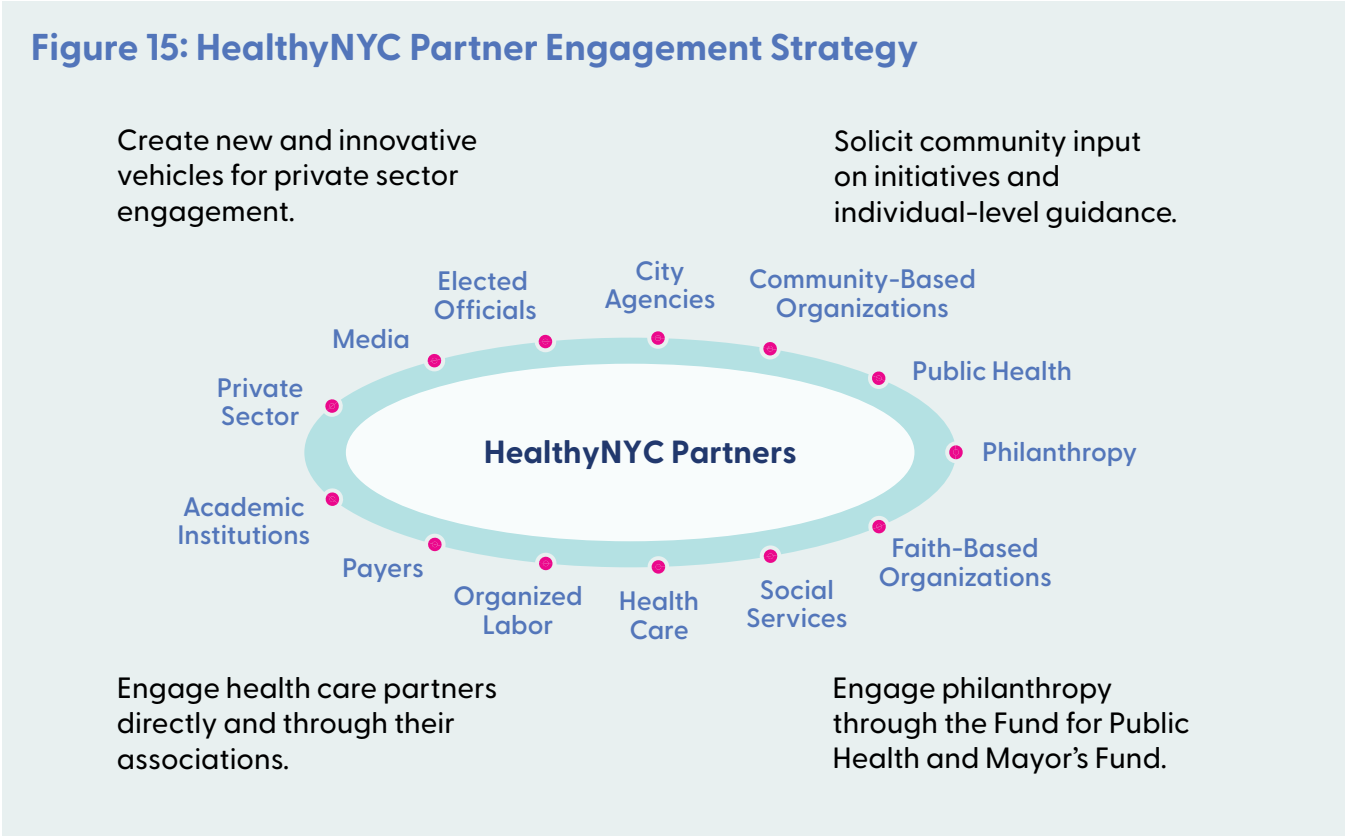
The City will continue to outline strategies and initiatives to address key challenges we face through detailed, cross-agency plans. These include our mental health plan titled Care, Community, Action as well as the City's Blueprint to End Gun Violence, plus forthcoming plans currently under development. These plans build upon the success of past and ongoing efforts to reduce preventable deaths and disparities in health outcomes, including the City's COVID-19 response efforts. This work is also underpinned by a citywide framework that treats racism as a public health crisis and the knowledge that we will not achieve gains in life expectancy without centering equity.[i]

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[i]For more information, visit **nyc.gov/health** and search for **racism as a public health crisis**.

In the coming months and years, the City will bring together partners from across private, public and nonprofit sectors, including community- and faith-based organizations, to coordinate efforts around improving prevention strategies and the structural and environmental conditions that impact health. The stakeholder engagement process — see Figure 15 — will not only involve working with a wide array of partners across the City to implement these goals but will also serve as an opportunity to gather intentional feedback on the campaign and how to best frame future aspects of it. Serving as our city's health strategist, the NYC Health Department will continue to reorganize its structures and reimagine its capabilities to meet these HealthyNYC goals, which include modernizing data systems, incorporating health equity and anti-racism into all activities, and improving processes to effectively implement health priorities.

## Figure 15: HealthyNYC Partner Engagement Strategy

Create new and innovative vehicles for private sector engagement.

Solicit community input on initiatives and individual-level guidance.

Elected Officials

City Agencies

Community-Based Organizations

Media

Public Health

Private Sector

**HealthyNYC Partners**

Philanthropy

Academic Institutions

Payers

Organized Labor

Health Care

Social Services

Faith-Based Organizations

Engage health care partners directly and through their associations.

Engage philanthropy through the Fund for Public Health and Mayor's Fund.

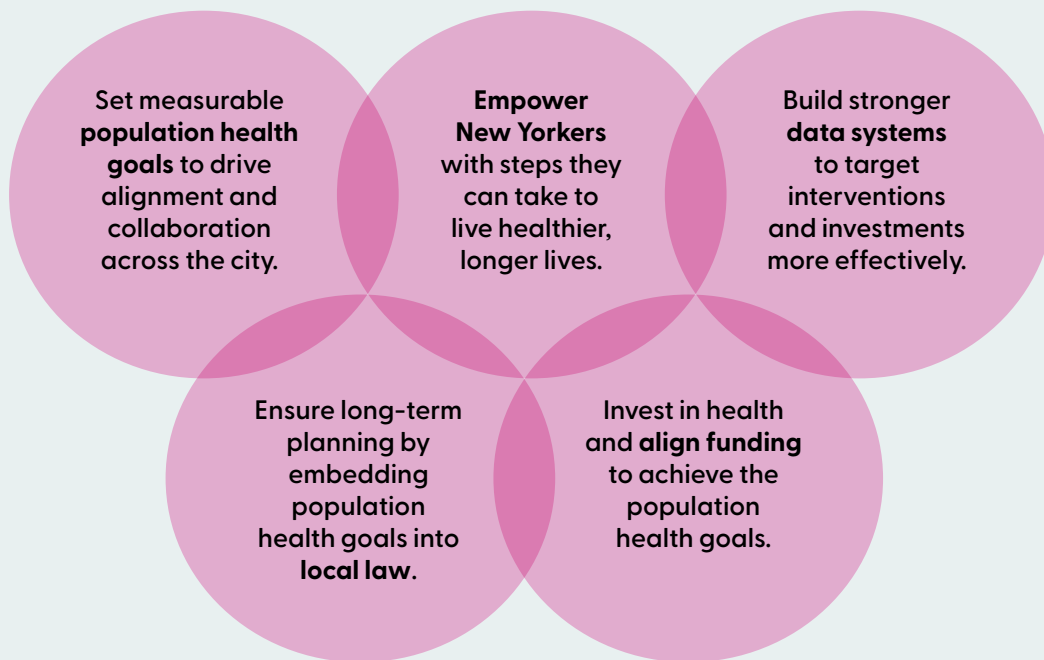## Implementing HealthyNYC

The drivers of mortality in our city can be managed and reduced using evidence-based strategies, which we have provided throughout this report as highlighted actions. To be effective, we will need to apply these strategies and actions equitably through a combination of population-level measures; programming tailored to disinvested communities; equity-focused, anti-racist community investments; and programs focused on individuals at highest risk of mortality due to age or health condition. We will also

work with City Council to embed population health goals into local law, creating a mechanism that will hold the City accountable for a population health agenda into the future. To empower all New Yorkers, we will also be launching a media campaign that will provide people with actions they can take to live healthier, longer lives.

All of this will need to be underpinned by a modernized, integrated population health surveillance system that will allow us to target interventions and investments more effectively. Finally, to ensure that our strategies achieve the scale and impact needed to reach our goals, we will also work to align spending from the City and its partners more closely with health. We will use our data and evidence to determine which investments offer the greatest returns on health across the seven leading drivers of decreased life expectancy, including those that some people may not associate with health, such as housing or food programs. We will then work to better align City and partner spending with those investments that offer the greatest returns on health to ensure the resources are in place for NYC to meet its goals. Figure 16 shows the steps, sometimes simultaneous or overlapping, through which HealthyNYC will be implemented.

## Figure 16: Putting HealthyNYC to Work



Set measurable **population health goals** to drive alignment and collaboration across the city.

**Empower New Yorkers** with steps they can take to live healthier, longer lives.

Build stronger **data systems** to target interventions and investments more effectively.

Ensure long-term planning by embedding population health goals into **local law**.

Invest in health and **align funding** to achieve the population health goals.

Together, we are focused on HealthyNYC's tangible goals for helping New Yorkers live healthier, longer lives. For updates on the City's progress toward our goals and interactive charts showing more data by race and ethnicity, visit **nyc.gov/healthynyc**.

# Complete List of Drivers, Goals and Actions

## Driver: Chronic and diet-related diseases

### HealthyNYC Goals
Reduce deaths due to:
- Cardiovascular disease and diabetes by 5% by 2030
- Screenable cancers, including lung, breast, colon, cervical and prostate, by 20% by 2030

### Priority Strategies
To achieve the goals:
- Increase health care access and coverage.
- Increase prevention activities and social supports.
- Increase access to healthy foods, and promote plant-forward diets.
- Reduce added sugar and salt and toxins in our food supply.
- Prevent tobacco use, and reduce smoking and alcohol consumption.

## Driver: Drug overdose

### HealthyNYC Goal
Reduce overdose deaths by 25% by 2030.

### Priority Strategies
To achieve the goal:
- Increase access to naloxone and quality harm-reduction services, including overdose prevention centers.
- Increase access to quality treatment and recovery services, including medication-assisted treatment (MAT) and methadone.
- Reduce stigma and social isolation.
- Increase response services to nonfatal overdose.
- Increase access to drug testing services.
- Support federal policy and law enforcement efforts to reduce fentanyl in the drug supply.

## Driver: Suicide

### HealthyNYC Goal
Reduce suicide deaths by 10% by 2030.

### Priority Strategies
To achieve the goal:
- Increase access to culturally responsive mental health care and social support services, including early intervention for communities of color and LGBTQIA+ youth.
- Reduce stigma and social isolation.
- Reduce access to lethal means of suicide.
- Address the impact of social media on youth mental health and suicidal ideation.

## Driver: COVID-19

**HealthyNYC Goal**
Reduce COVID-19 deaths by 60% by 2030.

**Priority Strategies**
To achieve the goal:
- Focus strategies and resources, especially those related to vaccine uptake and to availability and early utilization of treatment, on protecting New Yorkers at the highest risk of severe disease and death, which includes people who are older, are immunocompromised and/or have certain disabilities that may increase their risk for having underlying health conditions.
- Promote everyday preventive actions, such as face masks, especially when transmission increases in the community and for people with the highest risk for severe outcomes.
- Support the health care delivery system to care for patients with COVID-19, especially through free and equitable access to COVID-19 tests, vaccination and face masks.

## Driver: Violence

**HealthyNYC Goal**
Reduce homicide deaths by 30% by 2030.

**Priority Strategies**
To achieve the goal:
- Reduce crime and access to illegal guns.
- Invest in communities most impacted by violence to increase social connection and economic opportunities (such as youth employment and after-school activities).
- Increase access to mental health and violence-related trauma support.

## Driver: Maternal mortality

**HealthyNYC Goal**
Reduce pregnancy-associated mortality among Black women by 10% by 2030.

**Priority Strategies**
To achieve the goal:
- Increase new families' access to health care and social support.
- Increase access to and quality of sexual and reproductive health care for people of color who may become pregnant, are pregnant or have recently given birth.
- Increase access to quality mental health and addiction support during and after pregnancy.
- Ensure people of color who may become pregnant, are pregnant or have recently given birth receive access to care and prevention resources for chronic diseases.
- Improve access to and quality of obstetric health care along the whole continuum of pregnancy, childbirth and postnatal care.

# Methods

The HealthyNYC goals were developed through a data-driven process led by NYC Health Department epidemiologists. The top drivers of mortality and drivers with the greatest racial disparities were identified through vital statistics analysis. This was followed by a deeper analysis of all the drivers that focused on three key mortality indicators:

1. Overall death

2. Excess death (the difference between the observed and expected number of deaths)

3. Premature death (deaths before age 65)

These indicators, along with racial disparity data, were examined further and weighted differently depending on each of the drivers. For example, excess death dominated the overdose driver, as the current opioid crisis has driven overdose deaths to much higher levels than expected.

Program and intervention effectiveness data were also analyzed to inform how much the City thinks it can move the needle on the drivers given the tools at the City's disposal. Finally, epidemiologists and program experts took all of the above into consideration and collaborated to set the numerical goals to be both grounded in the data and aspirational enough to drive action.

All rates in this report reflect deaths among people who were both NYC residents and died in NYC, except for the life expectancy estimates. Life expectancy estimates are based on NYC residents even if they died outside of NYC. The latter depend on a file provided from the National Center for Health Statistics that lags in availability. Providing data in this way makes it possible to show the most timely information characterizing the lives and deaths of New Yorkers.

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To learn more, visit **nyc.gov/healthynyc** or scan the QR code.