Structural Inequalities in Food and Healthcare: A Sociological Comparison of Upstate and Downstate New York

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Introduction

Food and healthcare insecurity are present and persistent challenges across the United States, but factors that contribute can vary between rural and urban environments. Food insecurity, the lack of access to sufficient, nutritious, and affordable food, and health insecurity, the uncertainty about obtaining adequate healthcare, are shaped by geographic, economic, social, and structural factors. In this thesis, I examine two counties in New York: the Bronx, a densely populated borough of New York City, and Franklin County, a sparsely populated rural county bordering Canada. Despite their demographic and geographic differences, both suffer from high rates of food and health insecurity. This comparison provides an opportunity to understand how structural inequities intersect with local conditions to influence health outcomes.

I conducted a series of interviews with public health professionals and long term residents of areas such as the Bronx and North County NY. Hannah, from Keene Valley located in upstate NY, Vicky and Lisa, from the Bronx, and Mr. Smith, a Director at Adirondack Health in Franklin County. The two areas are significant because the Bronx represents an urban country with a concentrated population, while North County with counties such as Franklin and Essex are far more rural with a lower and more spread out population.

Literature Review

Food Insecurity: the condition of not having access to sufficient food, or food of an adequate quality, to meet one's basic needs.

Health Insecurity: Feeling uncertain, anxious, and vulnerable about the ability to obtain or sustain adequate health care services.

The Bronx and Franklin County differ dramatically in population identity and density, infrastructure, healthcare access, and economic activity, offering a good basis for comparison. These differences make them ideal to examine how food and health insecurity manifest across urban and rural settings, shedding light on structural, geographic, and policy-related inequities. For example, Karpyn et al. show that access isn't just about proximity but also about quality and affordability, both of which play out differently in each setting.

Bronx and Franklin county have shared challenges in their distinct contexts. Despite the stark contrasts, both regions struggle with high rates of food and health insecurity, making them comparable in their problems but different in context. In a comparative analysis it can be understood how similar problems are addressed (or exacerbated) by different social, economic, and policy structures.

Theme 1: Structural Determinants of Health and Nutrition: Food and health insecurity are deeply influenced by structural and systemic inequalities.

Giroux (2013) critiques the Framingham Heart Study for reinforcing a restrictive and individualized concept of risk factors that minimizes the role of social determinants in health outcomes. This framing has contributed to a dominant public health approach in the United States that emphasizes personal responsibility over systemic or environmental causes. Additionally, this framing has influenced insurance practices in the United States, leading an individual's risk level to determine their insurance options and cost. In contrast, Birn, Pillay, and Holtz (2017) argue for a broader understanding of health equity rooted in societal determinants

such as poverty, housing instability, and employment equity, all factors that deeply influence food and health outcomes in both urban and rural settings. Kleinman (2010) adds to this critique by introducing social theories of global health, particularly biopower which describes how states and institutions exert control over populations through health policies. Additionally social suffering theory, which highlights how structural forces and policy shape health disparities. For example, he posits that bureaucratic healthcare institutions can sometimes exacerbate suffering instead of alleviating it, as well as the notion that health problems often overlap with social problems, making integrated policy approaches needed. These theoretical frameworks are critical to a comparative study of food and health insecurity in Franklin County and the Bronx, as they provide the tools to analyze not just individual outcomes, but the broader systems of neglect, marginalization, and policy failure that underlie them.

Theme 2: National and Regional Public Health Policies

National-level data on food insecurity provide essential context for understanding how structural disparities affect households across geographic and demographic areas. The USDA Economic Research Service report by Rabbitt et al. (2024) reveals that 13.5% of U.S. households experienced food insecurity in 2023, a noticeable increase from the previous year. Particularly concerning is the rise in very low food security, affecting 5.1% of households, where members reported disrupted eating patterns and reduced intake due to financial hardship. The report also highlights that food insecurity disproportionately impacts low-income families, single-parent households, and minority communities demographics that are prominent in both the Bronx and Franklin County. While 58% of food-insecure households participated in federal nutrition assistance programs such as SNAP, WIC, or the National School Lunch Program, many still

faced significant challenges in accessing adequate food. These findings highlight the limitations of existing policy frameworks and the urgent need for more robust economic interventions and community-based solutions.

Theme 3: Environmental Influences on Food Access: Geographic and environmental factors create distinct barriers to healthy food access.

Geographic and environmental factors play a critical role in shaping access to healthy food, particularly in underserved communities. Karpyn et al. (2019) highlight the persistence of food deserts, areas with limited access to supermarkets or fresh food, despite the introduction of alternative options such as farmers markets and online grocery services. These disparities show up differently in urban and rural settings, while Franklin County struggles with geographic isolation and limited infrastructure, the Bronx faces challenges related to affordability and market saturation. For example, Kapryn states that the number of U.S. residents living in food deserts has decreased since 2010, with a 15% decline in limited-supermarket-access areas. However, racial and economic disparities remain, with non-white residents facing 30% higher rates of food inaccessibility. This is important to a comparison of Franklin and Bronx counties because of the racial differences in each population. Kapryn also states that retailers' dollar stores are increasingly present in low-income communities, offering affordable food but very processed options, raising concerns about health outcomes. Expanding on this, Cooksey-Stowers et al. (2017) introduce the concept of “food swamps,” where an overconcentration of unhealthy food outlets, particularly fast-food and convenience stores, outweighs access to nutritious options. This phenomenon is especially pronounced in urban environments like the Bronx and is shown

to be a stronger predictor of obesity than food deserts alone. Together, these studies highlight how spatial, economic, and commercial dynamics collide to create distinct but equally harmful food environments in both urban and rural communities.

Theme 4: Education, Literacy, and Empowerment

Education plays a vital role in shaping health outcomes by influencing access to knowledge, resources, and supportive social infrastructures. Ross and Wu (1995) argue that education significantly benefits health in multiple ways such as, improved economic conditions, stronger social-psychological resources, and healthier behaviors. Their analysis shows that education is not simply one component of socioeconomic status, but a foundation that enables individuals to get better employment, cope with stress, and benefit from preventive health behaviors. This perspective aligns with Velardo's (2015) framework on health, nutrition, and food literacy, which highlights the need to move beyond basic knowledge to include interactive and critical literacies. Together, these studies highlight how educational disparities shape not only what people know, but also their capacity to act on that knowledge in meaningful ways, be that navigating food systems, interpreting nutrition information, or advocating for healthier environments. In communities like Franklin County and the Bronx, where access to quality education and public health information may differ, these educational inequities have direct consequences for food and health outcomes. This shows the importance of educational interventions that are both context-specific and equatable.

Theme 5: Paradigm Shifts in Public Health NutritionL Understanding how nutrition science has evolved offers insights into current systemic limitations and opportunities.

Understanding how nutrition science has evolved offers insight into both the limitations of past approaches and the potential of new frameworks. Ridgway et al. (2019) trace the history of public health nutrition from early interventions focused on nutrient deficiencies, to concerns about dietary imbalances and chronic disease, and most recently to an ecological model that incorporates sustainability. Rather than replacing old paradigms outright, they argue that new approaches have been layered on top of outdated ones, creating a landscape where reductionist views of nutrition still exist. This layered evolution helps explain why many public health strategies remain focused on individual behavior change, despite growing recognition of the complex, interconnected systems that shape food environments and health outcomes. Acknowledging this shift is crucial for designing interventions that are responsive to contemporary challenges, including environmental sustainability, social inequality, and the structural roots of food insecurity. Giroux (2013) adds historical context to this by looking at how the Framingham Heart Study (FHS) institutionalized a restrictive concept of "risk factors" in chronic disease study. Although the FHS made significant methodological contributions, such as including both men and women and using rigorous clinical protocols, it framed risk in individualized biological terms, emphasizing traits like cholesterol and blood pressure while overlooking social and environmental determinants of health.

Together, these readings reveal how structural inequity, environmental barriers, educational disparities, and evolving policy frameworks shape food and health insecurity differently in Franklin County and the Bronx. A comparative approach would be useful in identifying both

universal challenges and place-specific solutions. This literature sets the foundation for a nuanced, intersectional analysis in the thesis

Methods

I conducted interviews with both healthcare professionals as well as long term residents of the areas who are also SUNY New paltz undergraduate students. This was a convenience sample as I already know the interviewees prior to the interview. I selected life long residents of both rural and urban areas of New York to get a broader range of experiences reflected in the interviews. I asked each resident interviewee questions about how they perceive food access in the community as well as their own food access, and asked The Director at Adirondack Health questions about how they perceived food access in the area of operation and how this may affect the health of the residents there. I analyzed this data by comparing the interviews and finding common themes.

Findings

1. Transportation and Geographic Barriers

Across both counties, transportation emerged as a key obstacle to food and healthcare access. In Franklin County, public transportation is limited or seasonal, and residents often must travel long distances in severe weather.

When I asked The Director at Adirondack Health what he viewed as the biggest challenge for people in Franklin accessing healthcare, he said

Mr Smith: “I really do think the transportation is a big challenge. You know, we have individuals who will sign up for an appointment months in advance, and then something comes up and their ride falls through on the day of, and that can happen multiple times.”

Mr. Smith: “because everything is farther away from everything else. We're also in the northern Adirondacks, the high peaks, so six to seven months out of the year, it's winter and it's snowy and the roads aren't great for travel. Again, the aging population means they may not drive as much. And, you know, I would say that overall, we're, we're not one of the more wealthy areas in the state. And so there are real problems with transportation access and even getting between those remote locations. It's just, it's harder for sure.”

This is reflected again in my interview with resident Hannah, When I asked her what she thinks may improve healthcare access in the area ashe said

Hannah: “Think healthcare access would definitely be transportation, there…is transportation (here) It's like a little bus. I think there's only, two or three, but it's only active in the summer, during the season when there's a lot of tourists around.”

When I asked her what you do if you don't have a car, she said

H annah: “Um, you have to have a car...like, you can't get by without a car.”

Similarly in the Bronx, I found that participants had a hard time accessing doctors due to the limited providers in their area and transportation difficulties.

My interviewee Lisa expressed that she did not find there to be accessible doctors directly in the Bronx, and when she needs to go she will travel into Manhattan, however this is difficult for her because she does not feel safe on the public transport that goes to the doctors outside of the Bronx that take her insurance. She also expresses that she has experienced forgoing the doctor when she felt something was wrong to avoid the hassle, and that she felt this was a very common experience among people in her community.

Vicky expressed similarly that she needs to travel to see her primary care physician, stating

Vicky: “Yeah. So… I still go to the pediatrician.....he's in Manhattan, so every time I have to go to my primary care physician, he's in Manhattan. My dentist is in Connecticut, which is like a 45 minute drive.”

Transportation is the first limiting factor when it comes to accessing Healthcare and food because if you can't get there you simply don't even have the opportunity to access it in the first place, regardless of other barriers. This spreads into both areas of food and health because of limitations in reaching grocery stores as well as doctors.

2. Economic Inequality and Food Swamps

When asking Vicky about affordability of groceries, she said

“Vicky: “a lot of things are expensive, except for, like, delis, which... is kind of like a mini grocery store. A lot of people rely on. Those are more affordable, but the grocery stores are not really.””

When I asked her if this was a sustainable way to get groceries she said

“Um, it's not really sustainable, but it's very cultural. Like, I feel like, if you're from the city...(you) know, the deli is someone's Holy Grail, and it's very easy to get quick food hot meals and stuff like that. But if you've ever been inside one, there's barely any fresh produce. A lot of the things are in cans or in packages, The only things fresh are the things you get behind the counter. But yeah, there isn't really that much fresh produce, and everything is high in sugar and fat and stuff like that. But, yeah, but a lot of people depend on it”

In Franklin, there are available grocery stores but an issue is the isolation in rural upstate NY.

When I asked my interviewee Hanna about where most people get groceries in her community, she said

Hannah: For groceries? Yeah, but it's like a 30 minute drive from Keen Valley to Lake Placid. So it's like an ordeal for the most part.”

Hannah: “It was actually a pretty big deal when Lake Placid got a Hannaford. Everyone goes to Hannaford …but for the most part, yeah, it's the big markets. We do have a local grocery store, but it's pretty expensive. So you go there if you need butter or something.”

3. Community Ties and Mutual Aid

Community ties is another similarity I'd like to address that I noticed in my interviews. Both the Bronx and Franklin county interviews revealed very strong community bonds that not only provide emotional support but also practical support. For example Vickey stated

Vicky: “"Everyone knows each other... when someone goes through something, the whole community is there to, like, help them and uplift them...If my grandma needed sugar, like she'll knock on the apartment door next door, and they'll... help her."

Hannah also stated

Hannah: “It's a really tight community, and my mom actually has a friend who's a PA [physician’s assistant]... whenever she was concerned about whether or not we should be taken to the ER... she would just ask her friend, and she would sometimes come and check us out.”

Residents of both counties expressed a lot of pride in their supportive communities and while these community ties are important, and reflect strong bonds, I believe they also reflect social networks that supply resources where the state fails.

Discussion

This research shows that while Franklin County and the Bronx are demographically and geographically different, they share common structural barriers that contribute to food and healthcare insecurity, including transportation difficulties, economic inequality, and limited access to providers. These findings align with the literature, which emphasizes the role of social determinants of health in shaping outcomes and critiques the overly individualistic framing of health risks (Giroux, 2013; Birn et al., 2017). They also reinforce how systemic factors like insufficient infrastructure and policy shortcomings exist across both rural and urban settings, as highlighted by Karpyn et al. (2019) and Cooksey-Stowers et al. (2017). What this comparison makes clear is that food and health insecurity are not only about individual access, but about larger structural neglect and inequities embedded in geography, policy, and institutions. The overlapping barriers in both counties and reliance in the form of mutual aid suggest a pattern of institutional failures where communities are left to rely on informal networks. This supports the concept of "social suffering" (Kleinman, 2010), where public health problems are tied to social systems, showing how marginalized populations often carry the burden of systemic failure.

Conclusion

This research set out to answer the question: How do food and healthcare insecurity manifest differently in rural Franklin County and urban Bronx, New York, and what structural factors shape these differences? The findings show that while the two counties are very different in demographics and geography, both face overlapping barriers like transportation challenges,

economic hardship, and limited provider access. These stem from broader structural inequalities. At the same time, distinct issues such as language barriers and urban food swamps in the Bronx, and geographic isolation in Franklin County, show how context shapes the experience of insecurity.

Sociologically, this study shows how food and health insecurity are not only the result of personal choices or isolated conditions, but instead the product of structural issues. It reinforces the relevance of theories around social determinants of health and social suffering in understanding how systemic neglect is experienced by marginalized communities. This research contributes to a broader understanding of inequality by illustrating how the same health outcomes like obesity, diabetes, and delayed care can arise from different, place-specific barriers.

From a policy perspective, these findings suggest the need for context-specific actions that address transportation infrastructure, equitable food access, and culturally sensitive healthcare delivery. In the Bronx, improving supermarket access and combating food swamps could have direct nutritional benefits. In Franklin County, investments in rural transportation and telehealth services could reduce geographic barriers. Both areas would benefit from healthcare systems that prioritize trust building, cultural competence, and multilingual outreach.

However, this research also had limitations. The sample was small and drawn from a convenience group of young, college-educated individuals, which may not represent the full spectrum of community experience. Additionally, interviews were limited to only one public health professional from Franklin County, leaving out institutional perspectives from the Bronx.

Future research should include a larger, more diverse sample. Expanding this work to include more counties or states would further explore how structural inequities shape health across different rural and urban contexts.

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Appendix

Vicky: College student and life-long resident of the Bronx

Lisa: College student and life-long resident of the Bronx

Hannah: College student and life-long resident of Keene Valley

How would you describe the general health and well-being of people in your community?

What kinds of health-related challenges do you think people in your area deal with the most?

Do you notice any general opinions about the health care systems in the Bronx

How would you describe access to healthy food in your community?

What types of places do most people in your area go to for groceries or meals?

Have you noticed any differences in food or health resources between the Bronx and somewhere more rural like New Paltz, how would you compare them?

What do you think could help improve health or access to food in your community? Price regulation riverdale

Is there anything you think people often misunderstand about your community when it comes to health or well-being?

Mr. Smith: Director at Adirondack Health in Franklin County

What are the most common health conditions you see among residents and what factors do you believe contribute to them?

Have you noticed any changes in health trends over the past decade?

Do you think more rural/urban areas face unique challenges in regards to public health?

How would you describe the most pressing public health challenges in this community?

What factors do you see play a role in these challenges?

What role do you think nutrition plays in the specific health challenges in this county?

What are the biggest barriers residents face in accessing healthcare services?

DO you believe accessibility varies across the county?

Do you notice any common social factors that make it harder for individuals to access health care? Are these unique to Franklin county?

What contribution, if any. Do you see agre, race or sex have on healthcare accessibility

Are there any local or state policies that you have noticed positively or negatively affected healthcare access in this area?

What policies or interventions do you think could be adapted successfully?