

PHANYC
Public Health Association of New York City

CITIZENS GUIDE
TO
PUBLIC HEALTH ISSUES
IN
NEW YORK CITY

July 2001

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For over sixty years, the Public Health Association of New York City has been working for improved health for the city's people. PHANYC has been a source of authoritative information about health and health care and about public health issues and has been an advocate for improved public health policy and a more responsive, equitable and affordable high-quality health care system for our city. Today, with a membership that includes physicians, nurses, educators, health administrators, researchers, students, and others concerned about the health of their neighbors, PHANYC is one of the largest affiliates of the American Public Health Association. PHANYC works with APHA, the oldest and largest public health association in the world, and its other state and local affiliates on national and international problems that affect the health of our city's population. PHANYC confronts current public health issues by informing and mobilizing its members and the general public through a wide range of forums, a diverse and extensive program of activities, and its own regular newsletter. It has become a distinctive voice of public health within New York City and has broad influence beyond its borders.

In keeping with our mission of informing our community on issues of public health, members of the Board of Directors of PHANYC have prepared this Citizens' Guide to Public Health Issues in New York City. We hope you find it informative and helpful in increasing public awareness and discussion of current public health problems and their solutions.

PHANYC is grateful to the many members of our Board for their part in the formidable task of preparing and editing material for this guide and in shepherding it to final publication. Especially important in this effort were Marvin Lieberman, the chair of the editorial committee for the Guide, and Marta Baez and Barry Skura. Andrea Glick provided helpful copy editing and other editorial advice and Joanne Landy, PHANYC's Executive Director, helped keep the effort focused and on track. Many thanks to the other original committee members who planned the guide and drafted material: David Kotelchuk, Jessica Leighton, Len Rodberg, Peter Sherman. Additional helpful advice was also received from Lawrence Bergner, Betty Wolder Levin, Katherine Lobach, Paul Meissner, Cheryl Merzel, Bob Padgug, Sidney Socolar, and Judy Wessler.

For additional copies of the guide or for information about joining PHANYC and helping in its work, please contact Ms. Landy. And please let us know if the Guide has been helpful.

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Citizens' Guide to Public Health Issues in New York City

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INTRODUCTION

The purpose of this guide is to outline public health issues facing the citizens of New York City and to pose questions that should be asked of public officials and candidates for federal, state, and local office.

We often hear statements such as:

- Many babies continue to be born at low birth weights.*
- The water supply may no longer be as safe as it once was.*
- Managed care deprives individuals of the care they need.*
- The number of uninsured residents continues to grow.*
- There is inadequate health care available to the poor.*
- The food supply may be unsafe.*
- We are in serious danger from mosquito-borne disease.*
- Air pollution is at unacceptable levels.*
- Public health services have been cut back to the danger point.*
- Some areas of our city pose greater health risks to residents than other, richer areas.*

Do we have reason for concern? What can citizens and elected officials do to correct these health problems? This guide will define public health, examine some of these health issues, and present a series of questions that persons running for elected office, public officials, and the general public need to address.

I. OVERVIEW - WHAT IS PUBLIC HEALTH?

The field of public health is committed to protecting and enhancing the health and well-being of the population. Surveys and polls consistently show that, although members of the public cannot easily define public health, they strongly support it.

The Institute of Medicine of the National Academy of Sciences defines the mission of public health as "what we, as a society, do collectively to assure the conditions in which people can be healthy." It suggests that public health consists most notably of "organized community efforts aimed at the prevention of disease and promotion of health," a concept that includes both government activities and the efforts of private voluntary organizations and individuals.

What Are the Conditions in Which People Can Be Healthy?

Our genetic characteristics and the quality of medical care we receive are important determinants of our health. But just as important are the quality of our air, water, and food; the safe disposal of waste; the prevention of accidents; the assurance of safe housing; and the control of infectious diseases and occupational hazards. All of these are among the commonly accepted areas of responsibility for public health. Social factors, such as employment status, level of income, and level and quality of education, are increasingly seen as crucial to public health, as well.

Such individual practices as smoking, excessive use of alcohol, obesity, sedentary behavior, driving at excessive speeds, domestic violence, and other behaviors known to contribute to injury or disease are often regarded as entirely within the capacity of the individual to control. But there is strong evidence that these are also the product of cultural and social factors, including poor education, poverty, unemployment, economic stress, peer pressure, and misinformation. Control of these factors is increasingly relevant to public health efforts.

What Are the Major Functions of Public Health?

The public health system is responsible for enhancing the health of the community and for preventing illness and injury. The essential public functions necessary to carry out this responsibility include:

The Assessment of Community Needs and Recognition of Threats to Health

- Collecting health data and identifying community health needs.
- Recognizing threats to health (as in the recent outbreak of mosquito-born disease)

The Assurance of a Safe Environment and Adequate and Accessible Health Services

- Assuring clean air, water, and food; pest control; lead control; public sanitation; prevention of epidemics.
- Preventing illness and injury resulting from environmental hazards and work-related conditions.
- Assuring adequate and accessible health services in the community, including hospitals, clinics, physicians, nurses, and other health workers. Important aspects of this are the financing of health services, including private insurance, Medicare, and Medicaid, and assuring the quality of health services.
- Responding to disasters and assisting communities in need.
- Assuring the development of healthy babies, children and adolescents.
- Promoting healthy individual lifestyles and behaviors.

Policy Development for the Entire Health System

- Planning, coordinating, and regulating the health system as a whole, so that it meets the present and future health needs of the entire population.

Who Is Responsible for Public Health?

A large number of public and private agencies bear responsibility for public health. Most notably, these include the city and state departments of health, mental health, hospitals, sanitation, environmental protection, housing, and welfare, as well as voluntary hospitals, community health centers, community-based agencies, and other health-related organizations in the private sector. The mayor and City Council in New York City and the governor and Legislature in Albany are responsible for providing the legislation and regulations and for supplying a large part of the funds needed to make the system operate. The federal government shares some of these responsibilities and, most importantly, provides some of the funding for them.

Public Health Funding

Most of the country's health care spending is used to treat people who are already sick. Only 3.4 percent of national health spending is for public health functions. Improving public health in an era when the principal diseases, such as heart disease and cancer, are more easily prevented than cured, may require spending more on prevention. The need for prevention is most evident when we see the effects of environmental hazards or contagious diseases, such as TB, HIV/AIDS or West Nile Virus. An emphasis on prevention is also important in less obvious ways - for example, when someone who has postponed timely care because they lack access to regular medical care is later forced to use expensive and frequently less effective emergency room services.

General Public Health Question:

What are the most important functions of the city and state health departments? How can these departments be strengthened to accomplish these functions more effectively?

II. PUBLIC HEALTH AND THE ENVIRONMENT

We all have a right to clean air, food, and water free from hazardous material and communicable diseases. This is the domain of environmental health, which traditionally has five key elements:

- Establishment and maintenance of a clean drinking water supply.
- Prevention and amelioration of air pollution.
- Prevention and control of chemical and physical hazards in the home and community.
- Maintenance of food safety and quality. (The New York City Department of Health is responsible for restaurant inspections and for responding when there is a report of suspected food poisoning.) The case study in the box below illustrates the importance of this function.
- Prevention and control of the spread of communicable diseases.

CASE STUDY: Thirteen elderly residents of a nursing home suffer from stomach aches and vomiting late one afternoon (there is only an occasional case on a regular day). Doctors strongly suspect a food poisoning outbreak and immediately call the NYC Health Department, which sends environmental epidemiologists to investigate. Investigators meet with staff in the dietary unit, take food samples from the recent lunch, and ask those who suffered symptoms and those who did not to tell them exactly what they ate earlier in the day. The culprit, they discover, was a large bowl of macaroni salad made with mayonnaise which was left unrefrigerated for almost two hours. Luckily, all the patients recover, and food-preparation procedures in the nursing home are changed to prevent future outbreaks.

EMERGING PROBLEMS

DRINKING WATER

New York City has one of the cleanest water supplies of any large city in the United States. Thanks to earlier public health movements and enlightened city leadership over the last 125 years, 1.4 billion gallons of water a day are supplied to NYC and its suburbs from a 1,969 square-mile watershed through a system of pipes, aqueducts, and reservoirs. Because the water is believed by public officials to be clean, it is not filtered, as are most city water supplies, but 10 percent of the system, the Croton Reservoir, is under court order to be filtered by 2007. The other 90 percent must conform with federal standards in order to remain unfiltered. Filtering the entire water supply would be enormously expensive. The water is fluoridated to prevent tooth decay in children and treated with chlorine to meet state and federal disinfection requirements.

In recent years, there have been potential threats to the quality of the water from the city's upstate reservoirs. These threats come from nearby housing structures, highways, and commercial development. In a landmark 1997 agreement, a pact was signed allowing the purchase of sensitive lands by the city and limiting development near the watershed, in exchange for city and state funds to upgrade upstate water systems and contribute to upstate economic development. Environmental organizations are concerned that this agreement is not being adequately monitored and enforced, threatening New Yorkers with a resurgence of bacterial and chemical pollution in our drinking water supply.

REDUCING AIR POLLUTION

In recent years, there have been major improvements in reducing air pollution. Since the enactment of the Federal Clean Air Act in 1970 and amendments in 1977 and 1990, levels of all six major pollutants regulated by National Ambient Air Quality Standards have gone down in New York City or remain well below federal limits. The six pollutants are carbon monoxide, sulfur dioxide, nitrogen oxides, ozone, dust large particulates and lead. However, the City is still not in full compliance with the standards for atmospheric ozone and for particulates (small breathable particles). For example, statewide violations of the ozone standard occur 5 to 10 days per year.

One important way to improve compliance would be to further restrict automobile and truck traffic in the City. In recent years, however, the city administration has failed to take any steps in this direction. Another approach would be to limit the emissions from buses by using cleaner-burning compressed natural gas or sulfur-free diesel fuel. Governor Pataki announced the purchase of 190 compressed natural gas buses in 1997, and more for later years; yet, by July 1999 only 34 were on the road, none in Manhattan. The MTA expects to have 1,050 compressed natural gas buses running by 2004 as well as 125 hybrid electric vehicles delivered late in 2001.

CONTROL OF CHEMICAL AND PHYSICAL HAZARDS

The NYC Department of Health plays a major role in the surveillance and control of environmentally caused diseases such as childhood lead poisoning and asthma. As a result of banning leaded gasoline, the closure of municipal incinerators, and the efforts of the New York City Departments of Health and Environmental Protection, the number of cases of childhood lead poisoning in the City dropped by more than half during the past five years, from 1,961 cases in 1994 to 896 in 1999. However, no more than 40 percent of the children who should be tested actually receive blood/lead tests (*New York Times*, 8/22/99, A1).

In 1999, the city administration, along with the City Council, agreed to overturn Local Law 1, a strict but poorly enforced law which made landlords responsible for controlling lead in homes and buildings, and replace it with Local Law 38, which places greater responsibility for initiating testing on tenants and that limits testing of homes and apartments after lead-removal efforts. This move was strongly opposed by tenant and environmental advocates as a replacement of one faulty law with an even weaker statute. A recent court decision overturning Local Law 38 leaves this issue open for legislative reconsideration.

Unlike lead poisoning, the number of cases of childhood asthma has been increasing. Tens of thousands of children each year require hospitalization for asthmatic conditions, and this epidemic continues unabated. There is a need both to identify its environmental causes and to

control those that have already been identified. Many consumer advocates believe that the city should be undertaking more stringent measures against known sources of dust pollution, control of bus and truck emissions, reduction of rodent and insect infestation, and elimination of medical incinerators in affected communities.

PREVENTING THE SPREAD OF COMMUNICABLE DISEASES

With the advent of the HIV/AIDS epidemic in the 1980's and, most recently, the West Nile Virus outbreak, the NYC Health Department's role in the prevention and control of communicable diseases has been highly visible to the public. But it is also responsible for investigating a wide range of less dramatic, but important, disease outbreaks, as well as enforcing the law that students must be fully immunized before entering school.

Funding for monitoring and controlling environmental diseases has waxed and waned, too often as a function of the latest newspaper headline or a lack of press attention. The public has recently paid a great deal of attention to the West Nile Virus and to the explosion of the rat population in some neighborhoods, but these problems have arisen in the context of past cuts in programs related to environmental health. The sudden emergence of the West Nile virus, and the subsequent pesticide spraying throughout the city, have raised questions about cutbacks in Health Department spending in these areas over the last decade. Is an ounce of prevention worth a pound of cure in these cases? Many New Yorkers have called for increases in the Health Department budget to attend to potential sources of mosquitoes in the environment, such as the shallow pools and abandoned tires, which provide haven for the *Culex pipiens* and *Culex restuans* mosquitoes that transmit the virus.

Environmental Health Questions:

1. The New York metropolitan area has been ranked among the worst in the nation in air pollution. What should the City do to reduce ozone and particulate emissions? Should auto traffic in New York City be restricted, especially in congested midtown areas in Manhattan, and how could parking at outer borough subway stations be facilitated?
2. Should new taxes or tolls be imposed on private automobiles that enter New York City, to reduce air pollution and help pay the costs of new, lower-emission buses?
3. Now that the Triborough Bridge and Tunnel Authority has instituted "congestion pricing" tolls, can the same be applied to bridge, tunnel and parking meter rates?
4. How can we get the city and state to move more quickly to introduce lower-emission buses in New York City?
5. What action should be taken by the city and state to limit known asthma triggers? What steps should be advocated?
6. How could we strengthen oversight of the 1997 NYC Watershed Agreement to assess its impact more effectively?
7. What should the city and state do to reduce chemical pollution in wastewater?

III. SURVEILLANCE

Citizens are often concerned about whether certain diseases are more prevalent in their community than in others. For example, Bedford-Stuyvesant and Bushwick in Brooklyn are known to have unusually high rates of lead poisoning, while East Harlem in Manhattan and Hunts Point in the Bronx have high rates of hospitalization for asthma. Knowing where the incidence of disease is high is the first step in trying to determine the causes of these diseases and planning interventions to reduce them.

It is government's responsibility to watch for potential threats to the public's health. Such a surveillance system includes the regular systematic collection, analysis and dissemination of health information. Data are gathered on the numbers of people subject to a variety of risk factors, including tobacco; high cholesterol levels; environmental hazards such as lead or molds; chronic diseases such as heart disease and cancer; infectious diseases such as measles or sexually transmitted disease; and tuberculosis. Using this information, public health interventions are then designed to reduce the impact of these risks to health and to determine whether the interventions were successful.

SOME FINDINGS ON ASTHMA IN NYC

Children in New York City are almost three times as likely to be hospitalized for asthma as children in the United States as a whole.

NYC asthma hospitalization rates increased 22 percent between 1988 and 1997, with a 60 percent increase among children in low-income neighborhoods.

Asthma is the major cause of hospitalization among children less than 15 years old.

The major payor for asthma hospitalizations is Medicaid.

The city, state and federal governments are responsible for planning and conducting surveillance activities. In addition, many private individuals and organizations cooperate in the effort. Private physicians must report sexually transmitted diseases and many other conditions to the local health department. Health insurance companies and managed care organizations participate by reporting specific diseases and conditions. Private citizens are occasionally also requested to answer telephone surveys about their health practices or local environment. For example, Staten Island has been shown to have higher rates of lung cancer than other boroughs in the city. Since tobacco is the major risk factor for lung cancer, a survey to be conducted next year will assess the rates of smoking among Staten Island residents. This information will be used to plan programs for Staten Island residents about prevention of tobacco use.

Public health surveillance enables city health officials to track the scope and progression of a disease or health condition. It can also be used to ensure that individuals affected by a disease or condition receive the treatment they need. AIDS surveillance, for instance, has been used by city and state officials to track the AIDS epidemic. Under a new state law, health providers will now report all patients diagnosed with HIV infection to the state and city, along

with the names of individuals who may have been exposed to HIV infection through sexual or needle-sharing contact with these patients. The health department will use that information to notify individuals of their HIV risk and encourage them to seek counseling and testing. Some community leaders have expressed concern that this new law may deter some individuals from seeking testing to determine their HIV status. Because of such concerns, the protection of patient confidentiality in all surveillance systems is critically important.

Surveillance for lead poisoning has provided important information for the last 30 years. Mandatory reporting of elevated blood lead levels has ensured that children with elevated blood lead levels receive environmental risk assessments and coordination of their care from the city Department of Health. Surveillance for lead poisoning has provided information on communities that have unusually high rates of lead poisoning, so that programs can be planned to address the problem in these communities. This surveillance has also provided the information needed to develop laws that mandated blood lead screening for all one- and two-year old children and for high-risk children until six years of age.

However, though lead poisoning is a wholly preventable disease, it creates a life-long problem for many children. The main source of lead poisoning is interior lead-based paint. It is through surveillance of children's housing and the reporting of blood lead levels that we can see where lead poisoning may be coming from, how many children are affected by it, and what communities they live in.

Surveillance Questions:

1. What should be done on the federal, state and local levels to improve surveillance of environmental hazards? Which environmental hazards should be the top priorities for improving surveillance?
2. What should be done to assure that the funding for surveillance of health hazards and diseases is spent most effectively to obtain scientifically useful information to increase public awareness?
3. What should be the role for private entities in funding of surveillance efforts?
4. Federal dollars for behavioral risk factor surveillance are primarily given to states and not localities. As a result, information on the risks facing special sub-populations is often inadequate. Should large cities, particularly those with diverse populations that include minorities and immigrants, directly receive federal funds to conduct their own risk factor surveillance?
5. Beginning two years ago, the NYC Department of Health has restricted access to certain types of small area public health data. What data should be made available to public health researchers and community organizations for the purposes of assisting in surveillance and analysis of threats to the public health?

IV. ACCESS TO MEDICAL CARE AND OTHER HEALTH SERVICES

Most people rely on health insurance to gain access to medical care, since the cost of medical care grows each year and is likely to be out of reach for most people in the absence of insurance. However, more than one in four adults in New York City have no health insurance of any kind. This is 50 percent above the average for the nation where one in six persons are without insurance. Two-thirds of the uninsured adults in this city are, in fact, working, but their jobs do not provide health insurance, and their wages are not high enough for them to afford it on their own. Rising health care costs are making it difficult for individuals and businesses to continue providing health insurance for themselves, their families, and their employees. Health insurance for a family in New York City now costs anywhere from \$5,000 per year to as much as \$12,000 with some managed care plans. Clearly, costs at these levels make insurance unaffordable to large segments of the city's population.

Many of the uninsured are children. Families without health insurance are less likely to get routine medical attention, including immunizations for their children. They are more likely to have preventable illnesses, and are more frequently hospitalized for conditions which those with insurance would have treated earlier in a doctor's office. One consequence of the growing numbers of uninsured is the increased utilization of hospital emergency rooms, where the uninsured can be confident they will be seen. Both private and public hospitals in New York City have been experiencing a continuing rise in emergency room visits, to nearly 4 million during 1999; in fact, use of the emergency room has risen 20 percent in the past decade. Today, 62 percent of all admissions take place through the ER, compared with 52 percent in 1989.

Low-income immigrants face additional hurdles. One of the additional hurdles is in finding health care providers who speak their languages and are sensitive to their cultural outlooks. In addition, many immigrants are afraid of jeopardizing their immigrant status, particularly if they are not documented. Due to this fear, many immigrants fail to request needed services -- for example, not applying for pre-natal care programs, and not getting help with paying for medicine because of being afraid to apply for Medicaid. High blood pressure can remain undetected and untreated and can lead to debilitating or deadly heart attacks and strokes. In addition, as a result of welfare reform and immigration reform, more immigrants are being denied services. As a result of these various problems, low-income immigrant communities have some of the city's worst health conditions, including continuing high rates of infant mortality, substance abuse, AIDS/HIV, hypertension, heart disease, tuberculosis, and cancer.

NEW YORK CITY IMMIGRANTS: A FEW FACTS

More than 1 million immigrants have come to New York City in the last decade.

59 percent of low-income non-citizens have no health insurance.

Only 14 percent of non-citizen immigrants use Medicaid.

Most recent immigrants are not eligible for federal assistance from Medicaid and other federal assistance programs. New York State and New York City have extended Medicaid and other programs to some recent immigrants.

MANAGED CARE

Supporters of managed care argue that when managed care is properly structured and regulated, it can provide its members with high quality preventive and curative services at reduced costs.

Seeking to reduce medical costs by avoiding the incentives to overutilization in fee-for-service programs, employers and the government have chosen to contract with managed care companies. These firms usually pay primary care providers a set rate per year, regardless of the services actually used. The plans therefore have an incentive in the other direction: to limit the services they offer. Managed care plans also use various restrictions and incentives to reduce access to specialists. These have created a widespread public backlash against managed care. One survey found that 48 percent of Americans say they personally have experienced problems with HMOs' care, or have close friends or relatives who have run into such difficulties.

As a consequence, proposals for a "patients' bill of rights" have become a popular political issue. The most extensive proposal in Congress, the Bipartisan Patient Protection Act, was passed by the Senate on June 29, and would allow patients to sue their HMO for failing to provide needed health services or for other deficiency in service. At the same time, there is little public discussion of how to control health care costs other than through managed care. Elected officials do not always comprehend the relationship between their method of controlling costs and violations of "patients' rights." On the one hand, they hope to use managed care as a method of controlling costs, particularly in the Medicaid program. When plans try to control costs through the main method at their disposal - limiting services -- the same politicians become advocates of "patients rights." Plans get criticized for doing what, in effect, they were hired to do -- control costs.

In spite of the hopes that managed care would control costs, there is actually no documented evidence that its growth - it now accounts for more than 70 per cent of all persons covered by insurance - has actually reduced expenditures. Medical cost inflation moderated during the mid-90s, probably through fear of federal cost controls in the wake of the Clinton health care proposals. But costs have begun rising again, and a number of managed care plans have either gone out of business or abandoned major sections of the country for lack of profitable opportunities.

MEDICAID MANAGED CARE

The Medicaid program - a joint federal-state-city program providing health insurance to low income families and individuals - is also experiencing rising costs. In an attempt to cut its costs, New York State has obtained federal approval to require nearly all Medicaid recipients to enroll in managed care. This program has the potential for creating a medical home for every family, with greater access to preventive care and timely care in case of illness. However, the state's Mandatory Managed Care Program may also lead to shoddy care because of a shortage of primary care providers, unrealistic productivity demands on clinicians, and inadequate compensation to health care providers. It will, for instance, be difficult to implement such a plan in a responsible manner in many areas of New York City, especially in low-income neighborhoods with a severe shortage of primary care physicians. These neighborhoods would need hundreds of additional doctors to provide the same access enjoyed by residents of more affluent communities.

Access to primary care physicians is critical for staying healthy. Families with ready access to physicians are better able to receive timely care and, as a result, are hospitalized less. The consequent reduction of complications results in reductions of other expensive medical services. New York State subsidizes medical education and thus, potentially, could influence where physicians set up their practices. However, the low Medicaid reimbursement rate of \$30 per visit discourages physicians from serving poor patients, except in hospital clinics, which are paid considerably more for Medicaid patients.

While enrollment in managed care organizations is going to be required of nearly all Medicaid recipients, there are deficiencies in the way many of these plans operate. State data show that many of the commercial managed care firms fail to meet federal guidelines for certain quality-of-care indicators such as immunizations, and they average considerably below non-profit health centers in the numbers of immunizations and cancer screenings they perform. Surveys indicate, as well, a great deal of turnover in the panel of doctors associated with each of the managed care HMOs. A patient can have little confidence that a doctor seen on one visit will still be with the organization on the next visit.

CHILDREN'S ORAL HEALTH

Proper dental care for children can do much to prevent dental disease. Fluoridation, prophylaxis, application of sealants, and instruction on diet and dental hygiene contribute to lifelong dental health. If untreated, oral diseases may cause serious general health problems, persistent pain, dental abscesses, and embarrassment caused by unsightly and missing teeth. A 1997-98 survey of the oral health of children in several New York neighborhoods revealed a higher number of decayed missing and unfilled teeth than the national average. Suggested measures to promote early and effective treatment include the following:

- Require all insurance in the state to include dental benefits.
- Educate parents about the dental needs of children and the availability of dental care for low income families.
- Provide adequate Medicaid and other federally assisted programs for low income children such as the State Children's Health Insurance Program (SCHIP) -- payments to dentists to encourage dentists to participate in these programs and supply the full range of services.
- Expand the number of school-based dental programs.

DRUG TREATMENT FACILITIES

Another area of serious concern is the lack of drug treatment facilities. For years, the State Department of Health has been reporting that there are nearly a quarter million heroin addicts in the state, but all addiction treatment programs together can accommodate no more than 15 to 20 percent of them. It is widely accepted that addiction is a disease that can be treated, and treated effectively, with substantial benefits to the individual, the family, and the community. Methadone maintenance, for instance, has consistently been found to be the most effective form of treatment by the federal government. We also know from experience in New York City in earlier periods that it is possible, given sufficient government commitment, to rapidly expand methadone treatment capacity to access tens of thousands of additional patients.

COMPETING POLITICAL POSITIONS ON UNIVERSAL HEALTH CARE

Clearly, the current system of employer-provided private health insurance is not working. Change of jobs can lead to significant change or complete loss of benefits for the workers and their families. Large numbers of New Yorkers are left out completely, with no insurance at all. There is rising dissatisfaction among consumers with the lack of choice and the difficulty of actually getting care when one has a serious, potentially expensive, illness. Many Americans - including many experts in public health - believe that the only answer is some form of universal health care, that is, health care that is available to every American, regardless of income, employment, or the community in which they live. Most models of universal health care involve some form of public financing, much like that of the Medicare system, which uses the Social Security System. The New York State Assembly (but not the New York State Senate), several years ago, passed such a "single payer" plan for this State, and other states are considering similar measures. Others advocate government subsidies to enable the uninsured to purchase commercial insurance. At the same time, the federal government has been slowly increasing the number of people, especially children, who are eligible for Medicaid. But there is, as yet, no consensus on how - or even whether - to guarantee health insurance to all Americans.

Medical Care Questions:

1. What steps can the city/state/federal government take to reduce the cost of health insurance and medical care to our residents and employers?
2. How should health insurance coverage be made available to the residents of our city and state who now have no insurance?
3. What should be done to increase the number of doctors serving low-income communities?
4. What safeguards are necessary to protect consumers against abuse by insurance and managed care companies?
5. What should be our top priorities for improving the health of children in New York City?

6. How should we improve the quality of care received by the more than one million residents of our city who rely on Medicaid coverage?
7. What should be done to ensure that managed care companies provide optimal care?
8. Do the city and state governments have a role in ensuring that everyone has health insurance? What do you think that role is? What legislative measures should be adopted to achieve that goal?
9. What steps should be taken to close the gap between the need for and availability of treatment for drug addiction? What target should be set for the expansion of treatment capacity?
10. How can enrollment and recertification for Child Health Plus be simplified?

V. THE SAFETY NET

In New York, the most important forms of government assistance are free or low-cost health insurance and public subsidies of "safety net" hospitals, clinics, and health centers. Only a portion of the people who need help are currently eligible for the various public insurance programs. And the safety net institutions are struggling to survive, because they have fewer resources but more people to serve.

The principal health insurance programs run by the state and city are Medicaid and Child Health Plus. It is not necessary to be on welfare to be eligible for Medicaid. Any family of four with an income of \$11,004 or less is eligible for free health insurance under Medicaid. Moreover, children may be eligible for assistance even when their parents are not. A family of four with an income up to \$27,213 is eligible for free health insurance for their children (and up to \$44,004 if they pay a small monthly premium) under Child Health Plus. Now that federal-state disagreements have been resolved, the state is due to begin an additional program, Family Health Plus, which will cover some additional low-income adults.

Unfortunately, Medicaid and Child Health Plus have not been enrolling all the people who are eligible for these programs. The city estimates a shortfall of 525,000 children and adults - a quarter of those who are eligible. [Source: HRA eligibility data, October 1999]. Nearly three quarters of uninsured children in New York City are eligible for, but not enrolled in, Medicaid or Child Health Plus. Welfare reform is one reason for the shortfall in the Medicaid program. Between 1995 and 1999, the city cut the public assistance rolls by 40 percent. Many of these families continue to be eligible for Medicaid, but they are often not aware of this, and the city has not encouraged them to apply. In fact, welfare advocates successfully sued the city to force it to inform applicants of their right to Medicaid and to stop the city from sending applicants away without letting them apply for Medicaid (and food stamps as well).

Another reason for the shortfall in enrollment is that it is difficult to enroll in Medicaid and stay enrolled in it. Complicated forms must be filled out, and extensive documentation is required. Medicaid enrollees must recertify their eligibility every six or twelve months; many fail to negotiate the maze of rules and documentation required to retain eligibility. As a result in any given year nearly one-half of all Medicaid Managed Care enrollees are dropped from their plans and lose their insurance coverage. However, even if these programs enrolled and kept everyone who was eligible, approximately 900,000 New Yorkers would remain uninsured, many of them immigrants who are not eligible for Medicaid and working people who can not afford even the sliding scale premiums of Medicaid.

Most hospitals, clinics, and health centers see at least some uninsured patients. However, the majority of uninsured New Yorkers are seen at a relatively small number of hospitals and clinics - the core safety net. The municipal hospital system run by the Health and Hospitals Corporation (HHC) is the largest part of the core safety net. HHC provides about 60 percent of all uninsured clinic visits. The municipal system is the only health care provider that is legally required to see everyone who needs care, regardless of ability to pay.

HHC is not the only core provider. Some private voluntary hospitals and community health centers located in low-income neighborhoods see a disproportionately large number of uninsured patients, providing another 25 percent of the uninsured clinic visits. Private hospitals only have to accept patients in an emergency and, then, only until they are stabilized and can be transferred to another hospital, typically a public hospital.

The core safety net is in danger. More people than ever before need it. The number of New Yorkers without health insurance grew by 40 percent between 1991 and 1996, and it is continuing to grow. At the same time, it is becoming harder for safety net providers to cover the cost of the uninsured. These health care providers get most of their revenue from Medicaid, and they use this revenue to cover the cost of treating those who have no insurance at all. But their Medicaid revenues are declining, both because of cuts in reimbursement rates and because of competition from private hospitals for Medicaid patients. At HHC, there were 25 percent fewer Medicaid patients hospitalized in fiscal year 1999 than in fiscal year 1995, but 36 percent more uninsured patients were admitted. Between FY 96 to FY 2000 there was a 31 percent increase in the total number of uninsured. HHC is not the only institution caught in this vise. Almost all of the core safety net is. The city and state governments have not offered a solution. For example, the City does not give HHC more money if it sees more uninsured patients. In fact, the City's tax levy support has declined from \$550 million in fiscal 1988 to \$63.6 million in FY 2001. Similarly, the state reimburses public and private hospitals - as well as some community health centers - for a portion of the cost of charity care, but not for all of this cost. Hospitals are reimbursed between 30 and 70 cents on the dollar, depending on the hospital; community health centers get even less.

As a result of these trends, in the short term, health care providers have taken the prudent business step of cutting their costs and streamlining services. For example, between FY94 and FY98, HHC took 41 percent of its beds out of operation and cut 26 percent of its workforce. Given the trend toward more outpatient care, fewer beds are needed, but it is also clear that, at some point, financial pressures can affect quality and access.

City and state officials have responded in several ways, none of them adequate. Neither the city nor the state has a public process for deciding what safety net services are needed. Much of the debate of the last few years has centered on Mayor Giuliani's proposal to privatize several of the municipal hospitals. There has been little public debate about what it will take for HHC to survive, including how HHC itself must change to adapt to the new competition for patients.

Safety Net Questions:

1. The Medicaid and Child Health Insurance programs enroll only about two-thirds of those who are eligible. Should we modify or expand these programs? How should we ensure that, once people apply, they do not encounter unreasonable barriers to enrolling?
2. When the Health and Hospitals Corporation was established in the early 1970s, the state Legislature mandated that the City fund it to provide a broad range of services for the poor and uninsured. The Legislature mandated a base funding level of \$175 million a year, adjusted for health care inflation. The city's current tax levy contribution is \$68 million a year, far below the level of earlier years. Should this be changed and, if so, by how much?

3. What steps should be taken to ensure that the City's public hospital system can continue to serve those who need its services? What should be done to help other core safety net providers survive?
4. The state pool of funds for reimbursing hospitals and clinics when they take care of uninsured patients is failing to cover costs. How should the state and federal governments deal with this shortfall of funding for safety net providers? Should we change how the money is allocated among different hospitals and clinics?
5. If it is recognized that in order to compete, HHC has to be responsive to the market forces, and needs to engage in long-term planning, how can we ensure sufficient autonomy for HHC with public accountability and avoid micro-management by the mayor's office?
6. Public and private hospitals and clinics make decisions about what services to offer based on their own individual economic (and sometimes professional) interests. They do not often coordinate their decisions with those of other providers. This can lead to a shortage of services that are needed but not profitable, and a surplus of profitable but duplicated services. Should the city and state government have a planning role in deciding what services are needed and then ensuring that these services are provided? If so how should this be implemented?

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Appendix: Questions for Discussion
Public Health Association of New York City
Citizens Guide to Public Health Issues in New York City, July 2001

General Public Health Question:

- What are the most important functions of the city and state health departments? How can these departments be strengthened to accomplish these functions more effectively?

Environmental Health Questions:

- The New York metropolitan area has been ranked among the worst in the nation in air pollution. What should the City do to reduce ozone and particulate emissions? Should auto traffic in New York City be restricted, especially in congested midtown areas in Manhattan, and how could parking at outer borough subway stations be facilitated?
- Should new taxes or tolls be imposed on private automobiles that enter New York City, to reduce air pollution and help pay the costs of new, lower-emission buses?
- Now that the Triborough Bridge and Tunnel Authority has instituted "congestion pricing" tolls can the same be applied to bridge, tunnel and parking meter rates?
- How can we get the city and state to move more quickly to introduce lower-emission buses in New York City?
- What action should be taken by the city and state to limit known asthma triggers? What steps should be advocated?
- How could we strengthen oversight of the 1997 NYC Watershed Agreement to assess its impact more effectively?
- What should the city and state do to reduce chemical pollution in wastewater?

Surveillance Questions:

- What should be done on the federal, state and local levels to improve surveillance of environmental hazards? Which environmental hazards should be the top priorities for improving surveillance?
- What should be done to assure that the funding for surveillance of health hazards and diseases is spent most effectively to obtain scientifically useful information to increase public awareness?
- What should be the role for private entities in funding of surveillance efforts?
- Federal dollars for behavioral risk factor surveillance are primarily given to states and not localities. As a result, information on the risks facing special sub-populations is often inadequate. Should large cities, particularly those with diverse populations that include minorities and immigrants, directly receive federal funds to conduct their own risk factor surveillance?
- Beginning two years ago, the NYC Department of Health has restricted access to certain types of small area public health data. What data should be made available to public health researchers and community organizations for the purposes of assisting in surveillance and analysis of threats to the public health?

Medical Care Questions:

- What steps can the city/state/federal government take to reduce the cost of health insurance and medical care to our residents and employers?
- How should health insurance coverage be made available to the residents of our city and state who now have no insurance?
- What should be done to increase the number of doctors serving low-income communities?
- What safeguards are necessary to protect consumers against abuse by insurance and managed care companies?
- What should be our top priorities for improving the health of children in New York City?
- How should we improve the quality of care received by the more than one million residents of our city who rely on Medicaid coverage?
- What should be done to ensure that managed care companies provide optimal health care?
- Do the city and state governments have a role in ensuring that everyone has health insurance? What do you think that role is? What legislative measures should be adopted to achieve that goal?
- What steps should be taken to close the gap between the need for and availability of treatment for drug addiction? What target should be set for the expansion of treatment capacity?
- How can enrollment and recertification for Child Health Plus be simplified?

Safety Net Questions:

- The Medicaid and Child Health Insurance programs enroll only about two-thirds of those who are eligible. Should we modify or expand these programs? How should we ensure that, once people apply, they do not encounter unreasonable barriers to enrolling?
- When the Health and Hospitals Corporation was established in the early 1970s, the State Legislature mandated that the City fund it to provide a broad range of services for the poor and uninsured. The Legislature mandated a base funding level of \$175 million a year, adjusted for health care inflation. The city's current tax levy contribution is \$68 million a year, far below the level of earlier years. Should this be changed and, if so, by how much?
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