

# **Public Health at a Crossroads**

**Proposals for Protecting and Strengthening  
New York City's Public Health System**

**From a Public Health Leadership Seminar**

**Convened by**

**The Public Health Association of New York City**

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## About PHANYC

The Public Health Association of New York City (PHANYC) has been working for more than sixty years to protect and promote the health of the people of our city. We are the New York City affiliate of the American Public Health Association, the oldest and largest public health association in the world.

Together with our colleagues in APHA and in its other affiliates, we strive to define and promote the conditions in which people can be healthy, including the delivery of services that are urgently needed, not only in New York City but also in New York State, in other states and in other nations. To that end, we promote dialog within the public health community, among the general public and with public officials regarding public policies and programs.

PHANYC members are engaged in practice, research, education and advocacy in public health, in related fields, and in the community. We invite the membership and support of all that value public health.

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## Contents

Preface .....	iv
Acknowledgments .....	v
Executive Summary .....	1
Serving the Public's Health .....	2
Public Health Resource Decisions in a Time of Fiscal Crisis. Critical Choices and Risks .....	3
Coordination, Communication and Joint Planning .....	4
Assessment as a Basis for Planning .....	5
Building a Popular Constituency for Public Health. Some Strategic Considerations .....	6
Appendix. Seminar Participants .....	7

## Preface

In the fall of 2001, New York City was readying itself for its quadrennial municipal elections. With the city reeling from the trauma of September 11, an anthrax scare set New Yorkers even further on edge. An economic outlook that was already negative had been plunged into deeper gloom. Implications for the municipal budget were dire.

Term limits had already ordained that this was to be no ordinary election. Not only would the city be choosing a new mayor but, in addition, fewer than a quarter of City Council incumbents would be returning.

The Public Health Association of New York City (PHANYC) had just completed a report on the first segment of its projected study of the city's public health infrastructure.<sup>1</sup> As noted in the executive summary of that report, "Because of weak political support both nationally and locally, the infrastructure for public health in [New York City] has long been neglected." Now the threat of shrinking resources and a sharpening focus on anti-bioterrorism preparedness would compound concerns about the city's health prospects and the needs of its public health infrastructure.

PHANYC decided that it might serve best by trying to assess the key public health challenges facing the city and then generate recommendations to the incoming administration and legislators. To that end, on December 12, 2001, 18 members of PHANYC's Board met in a three-hour working seminar. Joining them were seven other local public health leaders they had invited and Professor Bernard Turnock of the University of Illinois (Chicago), a noted authority on public health infrastructure. The then president of PHANYC, Professor Victor W. Sidel, presided. After an opening presentation by Professor Turnock, the participants were invited to discuss these questions:

How should the City determine the appropriate resource level for its public health infrastructure?

How can the City best strike a balance in support of the demands of surveillance and response to disaster (including terrorist acts) and every-day needs?

What other city public health models are there from which we could learn a lot about::

- a. How to engage the entire city government in healthy policy and practice
- b. Surveillance systems?

In a city as large as New York, what is an effective relationship and division of labor between central and district-level administrators?

For strengthening New York City's public health infrastructure, what should be the priorities?

Discussion ranged widely, with frequent shifts of emphasis. This report is based on both participation in the seminar and study of a transcript of the seminar. It aims to summarize the key points that emerged from the seminar. Each section includes recommendations.

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<sup>1</sup> "Strengthening New York City's Public Health Infrastructure" (September 2001). In that report, the term public health infrastructure was defined as comprising not only physical equipment and structural components but also "the set of organizations, the skilled and committed professionals, and the institutional memory that are essential pillars of an effective public health system." The term "set of organizations" should be understood to include both governmental and non-governmental organizations and the effective working relationships among them.

## **Acknowledgments**

This project was made possible by a grant from the New York Community Trust.

The productive discussion in the December 12, 2001, seminar owed much to the skillful leadership of Victor W. Sidel as moderator. Dr. Bernard Turnock's introductory presentation provided valuable background for the ensuing discussion. We are indebted to Paul Meissner for identifying sources and costs of needed support services and to Rachel Burd for handling the arrangements for the seminar and for preparing early drafts of a report. The New York City Department of Health and its staff members gave generous attention to the seminar's facility needs.

Having a complete transcript of the seminar was a great help for planning the report; Frank Goldsmith, Ellen Rautenberg and I reviewed the transcript to that end. Appreciation is due also to those who read and commented on the various drafts of the report -- Larry Bergner, Carmelita Blake, Dena Fisher, Nick Freudenberg, Frank Goldsmith, David Hansell, Jessica Leighton, Cheryl Merzel, Ellen Rautenberg, and Leonard Rodberg. They made many helpful suggestions. However, none of them is responsible for any deficiencies of the report.

Sidney J. Socolar, PhD

June 2002

## Executive Summary

To bring into perspective the task facing New York City's public health system, the Public Health Association of New York City organized a working seminar in December 2001, as the city government was about to change hands. The following are key observations and proposals that emerged.

- The combined impact of the 9/11 disaster and a depressed economy is aggravating the city's public health challenges even as the city struggles with a fiscal crisis.
- Weakened by a long succession of hiring freezes and by government that has been oriented to categorical, disease-focused funding rather than to balanced public health funding, the city's core public health capacities badly need rebuilding rather than shrinkage. Major health resource cuts during the last quarter century proved costly to the city in terms of sickness and deaths. The city cannot afford to repeat those mistakes.
- Only a public health infrastructure strong enough to meet the city's day-to-day health needs can provide a sound base on which to build the further capacity needed for preventing or coping with bioterrorism or other disasters.
- Health services alone do not determine population health. Thus, re-allocating existing municipal resources to enhance support for health services could actually harm the public's health. It is hard to escape the conclusion that protecting the city's health will require generating new municipal revenues.
- Solving a major public health problem frequently requires the efforts of more than one organization. The city has developed a model that has scored important successes in inter-agency collaboration. This model should be extended to other critical public health problems.
- The activities of virtually every municipal agency have or can have an impact on public health. Yet there is no existing mechanism to encourage consideration of public health impact as policies and programs are developed and implemented. A council of all city agency heads, chaired by a deputy mayor for health and human services, could provide the necessary mechanism.
- As a framework for building wide-ranging collaboration between the public health agencies of city government and the city's communities, the New York City Public Health Partnership could hold promise. To realize this promise will require a commitment to expand the scale of the Partnership's activities from the borough level to neighborhoods.
- As the city emerges from an era characterized by extraordinary secrecy and defensiveness on the part of city agencies, local non-governmental public health leaders are hoping that the Department of Health is ready for the openness and candor that are essential to encourage residents to participate in decisions affecting their lives and wellbeing.
- For gauging the resource needs of the city's public health system, and for appropriate resource allocation within it, the city needs a frank, expeditious assessment of the capacity of the city government to fulfill its public health responsibilities.
- Public health sorely needs a broad, committed popular constituency. The responsibility for building that constituency rests on the entire public health community in partnership with all New Yorkers that see the role of public health clearly.

## Serving the Public's Health

A helpful way to think about the public health mission in New York City is in relation to the city government's mission. Most would agree that the city government's mission is to maintain and enhance the city's capacity to function effectively. Many would emphasize its responsibility for ensuring the wellbeing of its residents. On either score, the health of the city's people and communities is clearly of central importance.

It is highly unlikely that any New Yorker would knowingly acquiesce in a shutdown of the city's public health system. Each of us relies on it daily to safeguard our air and water, prevent spread of contagious disease, assure us of sanitary conditions in the restaurants we frequent, protect us from pests such as mosquitoes carrying West Nile disease, and guard our health in numerous other ways. When preventive efforts fail and catastrophe strikes – explosion, chemical spill, or worse – public health workers are frontline responders.

The more vulnerable among us – children, adolescents, elderly, low income communities, communities of color, immigrant communities – count on the public health system in more personal ways. Among the critical services these more vulnerable New Yorkers turn to are maternal, infant and reproductive health services, lead poisoning prevention, child and school health services, STD clinics, the municipal hospital system, and others.

In meeting the health needs of these more vulnerable populations, the public health system is also protecting the health and enhancing the quality of life of all who live or work in the city. Whether the result is minimizing the number of our fellow residents carrying an untreated transmissible infection or obviating crowding in hospital emergency rooms, there is a win-win outcome.

Specifically, the job of the public health system is to protect and enhance population health – protect against injuries, illness, environmental hazards, and the spread of disease, promote healthy behaviors, respond to disasters and assist communities in recovery, and assure the accessibility and quality of personal health care services. These are often termed the *core functions* of public health.

Since the disaster of September 11, 2001, there has been an awakening of interest in the importance of the public health infrastructure, which is often seen as a prime component of an anti-bioterrorism defense. Not often acknowledged is the fact that the city's primary task in relation to its public health infrastructure is to assure an infrastructure of sufficient scope and capacity to deal with the range of problems it faces every day. Those problems can and, in some instances, do take a heavy toll in health. Unless *that* capacity is adequate, it is hard to imagine that some other set of measures will better protect the city's health.

Infusions of federal resources to strengthen the city's public health infrastructure might very well be put to good use and would be widely welcomed. Nevertheless, the national political environment is volatile, and some were concerned that, in a militarized political environment, we could find the anti-bioterrorism tail wagging the public health dog. It would be an abrogation of responsibility to permit a narrow focus on potential terrorism to sidetrack the city from dealing with its ongoing day-to-day health needs, including those of vulnerable populations. It could result in a breakdown of trusting organizational and community relationships built up over years. Only a public health infrastructure strong enough to meet the city's daily health needs can provide a sound base on which to build the further capacity needed for preventing or coping with a disaster.

## **Public Health Resource Decisions in a Time of Fiscal Crisis: Critical Choices and Risks**

In fiscal terms, New York City's current plight recalls the mid 1970s. It may be instructive to examine the public health consequences of some budget choices New York City made during that time of great fiscal stresses:

- The DOH budget and staffing were cut by 25-30 percent. The city's TB control program was decimated, a decision that undoubtedly contributed to a resurgence of tuberculosis. That and similar budget choices made by several cities during the period were later termed public health malpractice by California Congressman Henry Waxman, whose work in the area of health policy has long been highly regarded.
- During the heroin epidemic of the mid to late 1970s, the city failed to strengthen its drug treatment program, a lapse that facilitated rapid spread of HIV infection among drug users in the late '70s and early '80s. Between 1975 and the early '90s, NYC treatment capacity remained flat.
- Cutbacks in primary care access at HHC and other providers made it harder for patients with hypertension, diabetes, asthma and other maladies to manage their diseases, leading to increased morbidity and some mortality.

Although there are not yet any rigorous scientific studies assessing the impact of the 1970s fiscal crisis on public health, the available evidence suggests, in retrospect, that budget decisions made during that crisis contributed to thousands of avoidable deaths in the 1980s and early 1990s. New York City can ill afford to repeat those mistakes.

With the city once again in fiscal crisis, it must nevertheless deal with new levels of public health need. The tragedy of 9/11 and the economic decline have brought personal emotional trauma and joblessness to critical levels and have made the health of thousands more vulnerable. Health insurance coverage has been lost not only because of job loss by covered workers but also because of coverage cutbacks among those still working – although this has been offset in part by (temporary) Disaster Relief Medicaid.

The Department of Health has already been weakened by one hiring freeze after another. For example, over the past decade, each year has seen increasing numbers of vacancies and “acting” appointments in the ranks of assistant commissioners and program directors. As the familiar sports metaphor puts it, the department has “little depth on the bench.” The city's core public health capacities badly need rebuilding, surely not further resource cuts.

Can such cuts be avoided by making deeper cuts in other municipal services? A fact often overlooked when resource needs for public health are considered is that responsibility for the public's health cannot be pinned on just the health system and the public itself. The state of people's health is best understood to be the result of interplay between the individual's basic biological makeup and countless influences from the environment, the economy and the society. Virtually every activity of the city, public and private, can have an impact, either supportive of health or antagonistic to it. True, it is chiefly to the city's public health system that we must look for leadership in promoting the city's health and protecting it from both near-term and long-term threats. But population health clearly depends in major ways on housing, education, employment, nutrition, social services and other factors in which public resources are vital. Robbing Peter to pay Paul provides little assurance of better population health, which could even end up worse for the deal.

Unless health funding can be brought to an appropriate level by budget cuts elsewhere that clearly have little or no impact on the wellbeing of New Yorkers, it is hard to escape the conclusion that to protect the city's health will require generating new municipal revenues.

## Coordination, Communication and Joint Planning

The issue of inter-agency collaboration for public health is not just hypothetical. In recent months, for example, serious questions have been raised about the responsibilities of DOH and DEP in the handling of air quality problems in lower Manhattan, and about the degree of coordination between them. It has been unclear to many whether the division of responsibility between the Department of Environmental Protection and the Department of Health was working, indeed, whether each even knew what the other was doing. (A related factor is the distinct possibility that past budget decisions have left New York City without the appropriate expertise on staff.)

At the same time, the breadth of the city's public health infrastructure, extending from mayoral agencies to community-based nonprofits, can be a source of great strength. It has important implications for the surveillance function, needs assessment, the planning process, community outreach and ongoing feedback regarding the effectiveness of city health services. How to realize that potential is a major challenge.

Alongside this breadth of *capacity*, it may be useful to consider the breadth of the city government's *responsibility* stemming from the fact that virtually every one of its activities either has or can have an impact on public health. It seems obvious that, both for realizing the potential of the broader infrastructure and for fulfilling the responsibility of the governmental agencies, coordination and communication are critical.

As a framework for collaboration between the public health agencies of city government and the city's community-based organizations, the still very young New York City Public Health Partnership could hold promise, though the challenge of expanding the scale of its activities from borough level to neighborhoods can look daunting.<sup>2</sup>

As the city emerges from an era of government characterized by extraordinary secrecy and defensiveness on the part of city agencies, local non-governmental public health leaders are hoping that the Department of Health is ready for the openness and candor that are essential to encourage people to participate in public health decisions affecting their lives and wellbeing.

With respect to joint efforts by city agencies, two different kinds of agendas, both worthy, need to be considered:

- To assure interagency coordination and communication in any area of work where responsibilities of two or more agencies overlap, the mayor's office should see to it that there is a structured coordinating relationship and that it functions as required.
- A broader coordinating mechanism, a council of all city agency heads, chaired by a deputy mayor for health and human services, could serve to: (1) develop a public health foundation for the city's strategic planning and (2) encourage all city agencies to consider the public health impact of their activities and to design and implement their policies and programs in ways that would optimize their health impact.

New York City is fortunate to have successful models for joint inter-agency public health planning, models that have achieved significant improvements in health outcomes in the recent past in TB, HIV and asthma. In addition to effective inter-agency coordination under Department of Health leadership, two further features characterized these successful efforts: (1) partnerships were

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<sup>2</sup> The New York City Public Health Partnership is a public-private collaboration among more than 300 organizations in an effort to improve the health of New York City's communities by strengthening the community public health system. It includes health and social service providers, unions, faith groups and government agencies. It aims to encompass not only residents but also representation from the business, arts and technology communities. The New York City Department of Health provides administrative and technical assistance.

formed that included not only city agencies but also community organizations and university researchers; and (2) the planning process combined bottom-up and top-down approaches.

This successful model for planning should be extended to some of the city's other critical public health problems.

### **Assessment as a Basis for Planning**

As already suggested, the city's public health system has been weakened in recent years by a series of hiring freezes and by the implicit supposition, particularly in Washington, that public health is well served by funding that is heavily categorical. Categorical funding most typically represents political responses to high-profile diseases. There are certainly instances where such responses are appropriate, but inordinate reliance on categorical funding leads to resource allocation that can be far from optimal in terms of overall community health needs.

If resource needs and allocation are to be gauged reliably in the near term, planning must be based on a frank, expeditious assessment of the capacity of our city government to fulfill its public health responsibilities.

The assessment should aim to identify and characterize capacity deficits in the core public health functions – that is, in the city's capacity to promote health and prevent disease and injury. A bureau by bureau assessment, while useful, is inadequate for planning purposes. Such assessments alone cannot lead to priorities for intervention. What is required in addition is that system capabilities be considered in relation to the city's health status and needs. Of necessity, the procedure will involve strategic choices.

Appropriately, most core-function performance standards are meant to be applied not simply to a department of public health but, rather, to a wider public health system. Accordingly, while primarily the Department of Health, the city's lead public health agency, should guide the assessment, the process should be carried out in collaboration with other stakeholders as well, both governmental and non-governmental. The result should be a collective assessment of the city's public health infrastructure, including the effectiveness of communication and interaction among bureaus, among agencies and among organizations, public and private, with a pivotal role for community and neighborhood residents and organizations.

## **Building a Popular Constituency for Public Health in New York City: Some Strategic Considerations**

Public health sorely needs a broad, committed popular constituency, a constituency that has enough appreciation of the overall mission and the day-to-day role of public health that it can see beyond individual crises. The task of building that constituency still has far to go. The responsibility rests on the entire public health community in partnership with all New Yorkers that see the role of public health clearly.

It is often assumed that the only effective strategy for building support is to mobilize those people that are already part of the political system. But many of the most significant public health advances have come about when disenfranchised populations were mobilized.

As we work on building public understanding of public health, our message has to be that public health serves everyone and the most vulnerable need the most services. It was suggested that only by showing a commitment to serve everyone can we succeed in building an effective constituency.

Public health workers who participated in the initiating community forums of the Public Health Partnership rediscovered what national opinion surveys had found earlier: people thought that what public health does is provide medical services. Period. Moreover, the public participants in those meetings left no doubt that, for them, access to medical care is a need of the highest priority. The effort to develop awareness of the broader mission of public health needs to proceed with due respect and attention to the high priority that so many New Yorkers place on access to affordable health care.

There is a distinct view that the Department of Health has to become more welcoming and communicative with communities than in the past.

Ensuring the health of New York City's people and communities is a key responsibility of the city government. In large part, that responsibility is borne by the public health system, which is there to serve *all* of the city's communities – every day. Elected officials need to be clear about the breadth and depth of that responsibility. If they conceive of public health appropriations only in terms of mandated services and categorical initiatives, both the public health system and the city government risk falling far short of fulfilling their obligations to the city and its communities.

Appendix  
**Seminar Participants**

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Nicholas Freudenberg	Terry Marx
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Jessica Leighton	Bernard Turnock

Not all of the participants had an opportunity to review and comment on this report.