



Strengthening New York City's Public Health Infrastructure

A report from
The Public Health Association of New York City

ABOUT PHANYC

The Public Health Association of New York City (PHANYC) has been working for more than 60 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 world's oldest and largest public health association.

Together with our colleagues in APHA and 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 dialogue 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 who value public health.

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Cynthia K. Hosay, PhD	

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Prepared by

Sidney J. Socolar, PhD

Victor W. Sidel, MD

Annette Ramirez de Arellano, DrPH

Frank Goldsmith, DrPH

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CONTENTS

Preface	iv
Acknowledgments	v
Executive Summary	1
Introduction	3
A Framework for the Assessment	4
What is public health?	4
Defining public health	4
Necessary conditions for health	4
Core public health functions	5
The Need for a Public Health Infrastructure	5
Examining New York City’s Public Health Infrastructure	6
One function, three governments	6
The indispensable role of the public sector	7
New York City’s public health tradition: ups and downs	7
Issue One: Health System Planning in New York City	8
Dismantling of the health planning infrastructure in New York City	8
Inter-agency collaboration	9
Issue Two: Health Surveillance and Assessment in New York City	9
Purposes of surveillance	9
Surveillance and assessment activities in the City Health Department. An integration plan ...	10
A neighborhood-level agenda	11
Other problems in the gathering, analysis and dissemination of public health data	11
Public health data gathering: a shared responsibility	11
Other Issues	12
The trouble with reliance on categorical funding	12
Voluntary health agencies	12
Relation between personal health services and public health	12
The Health of the City: Its Import for the City’s Future	13
Recommendations	13
Planning for a healthy city	13
Surveillance	14
Access to data	14
The need for continued independent oversight and for wider engagement of the public	15
Appendix A. Seminar Participants	16
Appendix B. Questions Posed to the Seminars	17
Appendix C. NYC Department of Health Divisions, Bureaus and Offices – Partial List	19
Appendix D. NYC Department of Health Regulatory and Licensing Functions – Partial List	20
Appendix E. Background Papers Provided to Seminar Participants	21

PREFACE¹

In late 1997, the Public Health Association of New York City appointed a Task Force on Revitalizing the Public Health Infrastructure of New York City. A comprehensive examination of that infrastructure was long overdue. PHANYC, an independent non-governmental body of committed health professionals, seemed ideally suited to conduct it. Over a two and a half year interval, the Task Force conducted a series of seminars to analyze the infrastructure, identifying its strengths and weaknesses, considering the impact on it by changes in the health care delivery and financing systems, and formulating public policy recommendations for strengthening the city's public health systems. Funds for the project were provided by the New York Community Trust.

The Task Force held a series of six Public Health Leadership Seminars during 1998-2000 to analyze the city's public health infrastructure. The seminars, each about 2.5-3 hours long, took place on May 29, September 25 and October 30 of 1998, March 26 and April 30 of 1999, and June 7, 2000. For each seminar after the first, the typical plan was to address a specific set of related core public health functions through informal but targeted discussions. Background papers presenting an overview of pertinent topics were commissioned for each seminar from distinguished public health practitioners and were provided to seminar participants to fuel the discussions. Those papers are available on request. The sixth seminar was dedicated to discussion of a preliminary draft of this report and to proposed revisions.

Participation in each seminar was by invitation and was limited to about 25 public health professionals. The six seminars engaged a total of 54 participants (Appendix A), including several members of the New York City Department of Health.

The assignment initially undertaken by the Task Force far exceeded the time allotted to the seminars. For each seminar, the project staff developed a series of questions in an effort to frame the topic in the broadest terms. However, the focus of the seminar discussion was often modified by the interests and inclinations of the participants. This open process, while addressing many of the aspects of the assigned seminar topic, left many others either untouched or addressed more superficially. Accordingly, recommendations presented in this report include a proposal for extending the work.

Over the course of the seminar series, the discussions focused predominantly on a few local agencies, mainly official New York City municipal agencies.

Project Directorate:

Lorna McBarnette, PhD
Annette Ramirez de Arellano, DrPH
Victor W. Sidel, MD

PHANYC Committee on Public Policy
and Legislation:

Frank Goldsmith, DrPH, Co-Chair
Sidney J. Socolar, PhD, Co-Chair

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1. The report was first issued September 2000, in a limited distribution. The present edition differs mainly in that the Executive Summary has been revised and Appendix C, originally based on 1996 information, has been updated.

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

We are greatly indebted to the Task Force's two staff members for their devoted, capable efforts in organizing the seminars and helping to lay the groundwork for this report. Dr. Robert Padgug worked closely with the Task Force leadership in all aspects of the seminar planning. In addition, it was mainly he who saw to it that pertinent background papers were identified and commissioned. He and Katya Wanzer issued the invitations and made the necessary physical arrangements for the seminars. Further, especially important, Ms. Wanzer transcribed the tapes of the seminars. Their contributions are much appreciated.

Thanks to the authors of the seven commissioned background papers (listed in Appendix E) the seminars received valuable jump starts. Similarly valuable although not represented by written documents were oral presentations by two members of the New York City Department of Health: Dr. Benjamin Mojica described the current organization of the department's surveillance activities and plans for restructuring. Georgia Davidson gave an extensive review of the various periodic report series by which the department provides information on its activities and on the city's health.

When we sought information on municipal health budgets, Jonathan Cortell, Rebecca Hernandez, and Paul Lopata, all of the New York City Independent Budget Office, and Veronica McNeill of the City Council Finance Division were as prompt and generous with their help as anyone could wish.

We particularly appreciate the contributions of those who provided extensive written comments on various drafts of this report: Nancy Anderson; Drs. Lawrence Bergner, Dena Fisher, Richard Garfield, Andrew Goodman, Jessica Leighton and Katherine Lobach; Paul Meissner; and Drs. Benjamin Mojica, Gerald Oppenheimer and Elena Padilla. None of them bears any responsibility for whatever shortcomings this report has.

EXECUTIVE SUMMARY

Public health has been defined as “what we, as a society, do collectively to assure the conditions in which people can be healthy.” By current standards this includes, at a minimum, preventing the spread of disease; ensuring healthy environments – residential, occupational and recreational; preventing injuries; promoting healthy behaviors; responding to disasters; and assuring the accessibility and quality of medical care. To fulfill these functions, society needs to rely first and foremost on the set of agencies and organizations, the committed professionals and the institutional memory that make up the public health infrastructure.

Over the past quarter century, the health of New York City residents has suffered repeated assaults. In several instances these assaults have resulted in epidemics. The city has had to struggle with poverty, violence, addiction, asthma, cancer, cardiovascular disease, HIV/AIDS, homelessness and unsafe housing, unsafe and unhealthy working conditions, rodent infestations, teen pregnancy, tuberculosis, infant mortality, lead poisoning, measles, asbestos pollution, food poisoning, West Nile disease, and faltering support for public hospitals, community health centers, and child and school health clinics. The city has confronted the assaults on its health with varying degrees of commitment, and its effectiveness in dealing with them has also varied. These assaults have claimed far too many victims. Yet resources for protecting the city’s health continue to fall short. There are persistent disparities among the city’s communities in various measures of health, and some disparities have even grown. This study aims to understand New York City’s public health deficiencies in terms of its public health infrastructure.

Because of weak political support both nationally and locally, the infrastructure for public health in our city has long been neglected. Moreover, within the past decade, public health infrastructure has experienced particular stresses related to rapid changes in the medical care system. The public policy strategy of looking to market-oriented managed care to solve the country’s medical care problems as well as its public health problems has failed. Meanwhile, in practice, there has tended to be a narrow focus on the medical care strategy and all too often this has diverted attention from public health. This explains in part the weakness of state and local support of the city’s public health infrastructure.

To do its job, the public health system must be able to monitor and assess the health of the population and the potential threats to it, identify community health needs and preventive measures, plan and implement or assure measures to meet those needs and assess how well those measures are working. Both the public sector, at all three levels of government, and the private sector contribute. But it is in the public sector, free from market pressures and investor expectations, that ultimate responsibility for public health system performance rests.

This study, the first in a projected series, focuses largely on local New York City agencies and examines mainly health planning and health surveillance – the gathering, analysis and dissemination of public health data. The major findings are:

- C Although quality of life and the effective functioning of the city depend strongly on the health of its people, the study could find no evidence that New York City has a vision and a plan for the health of its people – no plan that includes goals, priorities, time frame, strategies and resource commitment. No public agency acknowledges responsibility for developing such a plan. Moreover, health promotion and protection are far too often equated simply to provision of medical care.
- C Locally, there has been a diminished political commitment to the public health infrastructure dating from the city’s fiscal crisis of the mid 1970s. Nationally, the shift of most federal public health funding to categorical disease-focused programs has tended to narrow and distort the broader public health enterprise.
- C With the demise of the New York City Health Systems Agency in 1996, the city’s health planning apparatus was largely dismantled. Even at its best it was driven mainly by institutional initiatives of private medical care institutions, thus relying on the market to identify and meet the city’s health needs, and so was far from adequate.

- C The usual responsibilities and activities of most agencies of city government can have significant impact on the health of New Yorkers. Some of the more obvious examples are the agencies dealing with transportation, housing, education and economic development. Yet there is no policy, mechanism or incentive to assure that each agency gives priority attention to the health impact of its activities and projects.
- C Surveillance to identify and assess the prevalence of health problems and their risk factors – and in some cases to give early warning of a threatening development – is chiefly the responsibility of the New York City Health Department. The responsibility is divided among various specialized subunits but these have disparate data systems. Lacking is an integrating framework that can readily generate a full picture of a community’s health status and problems. Thus public health and community leaders are severely handicapped when they try to set priorities and propose plans to protect and improve the community’s health. With sparse resources, the Department’s progress toward remedying this is disappointingly slow.
- C Although private voluntary health institutions, mainly hospitals, rely heavily on public funding, they have not been engaged systematically in coordinated health surveillance and responsible planning for the city.
- C For reasons that are largely systemic, relatively few medical practitioners see public health and preventive care as pertinent to their daily work, which is overwhelmingly treatment-oriented.

The report concludes with 14 recommendations. They aim at:

1. the development of effective health planning and integrated health surveillance, with broad participation by the relevant agencies, institutions and communities;
2. facilitation and encouragement of access to public health data by independent analysts to enable the widest use of these data in policy analysis, research and planning;
3. continued independent scrutiny of the city’s public health infrastructure; and
4. promotion of engagement of the people of New York City with public health issues.

INTRODUCTION

New York City was a leader in public health for much of the twentieth century. Its public health infrastructure is complicated and substantial. Under the City Charter, core public health functions are the responsibility of the Department of Health, but certain important health-related activities are the province of other City agencies.² In addition, the New York State Department of Health, the Insurance Department and other New York State agencies, as well as the U.S. Centers for Disease Control and Prevention and other agencies of the U.S. Department of Health and Human Services and the U.S. Public Health Service have vital roles in assuring that public health functions are carried out appropriately.

Over the past quarter century, however, New York City's ability to protect the health of its population has been threatened in several ways. Since the fiscal crisis of the mid-1970s the city's public health agencies, although they have taken on some new activities, have experienced significant cutbacks that have compromised their ability to carry out their functions. During this time, disparities in health status within the population have persisted and some have even grown; new and re-emerging infectious diseases have posed a major challenge; rats and other pests continue to affect many communities; asthma rates have risen dramatically; and cardiovascular disease, cancer, mental disorders, substance abuse and other chronic illness rates continue at high levels notwithstanding declines in some of these.

Major changes in the medical care system also affect the public health system. With penetration by competitive and profit-oriented medical care insurers and providers threatening the existence of a viable health care delivery system, government has shown far too little appreciation of the role and urgent needs of public health. The market has compelled medical care providers to compete for contracts with managed care organizations by accepting reduced reimbursement. In an effort to bolster sagging revenues, voluntary providers have vigorously recruited Medicare and Medicaid enrollees, in whom they had previously been less interested. As a result, safety net providers, mainly but not exclusively in the public sector, have sustained major losses of insured patients. Hence they have in many instances been left with a preponderance of uninsured patients and a shrinking revenue base for cross-subsidies even as the ranks of the uninsured have continued to increase relentlessly. The future of the New York City Health and Hospitals Corporation (whose support by City tax-levy revenues has virtually vanished) and of community health centers is thus uncertain. The movement toward managed care in both financing and provision of medical care confronts public health policy with critical challenges and opportunities regarding the future of the public health infrastructure.

When particular endeavors have found the requisite external support, the city has responded with significant public health achievements. When, for example, inadequate attention to public health and housing fundamentals led to an upsurge in tuberculosis and the city faced a threat of multi-drug-resistant tuberculosis, the city, with a major assist by the federal Centers for Disease Control and Prevention, rose to the occasion and responded to the threat. But the health of the city would have been served far better had public health and housing not been neglected in the first place.

2. These agencies clearly include the city's Department of Mental Health, Mental Retardation, and Alcoholism Services, the Department of Environmental Protection, the Health and Hospitals Corporation (HHC), the Human Resources Administration, the Administration for Children's Services, the Department for the Aging, the Board of Education, the Housing Authority, the Fire Department (including Emergency Medical Services), the Office of the Chief Medical Examiner, the Police Department, and the Departments of Labor, Correction, Homeless Services, Housing Preservation and Development, Sanitation, City Planning, and Transportation. However, virtually every City agency has an impact on public health.

It should be noted that for most of the twentieth century the functions currently served by HHC (a state-chartered public benefit corporation) were the responsibility of a New York City Department of Hospitals.

A FRAMEWORK FOR THE ASSESSMENT

► WHAT IS PUBLIC HEALTH?

Louis Harris Associates in December 1996 asked a random sample of approximately 1,000 people across the United States, “What is public health?” Only 3 percent of the respondents provided an answer that reflected the principles or practices of public health as its practitioners usually define it. These included partial responses, such as “health education,” “health promotion” or “immunization.” Ninety-seven percent of those questioned offered no response that described public health as it is professionally defined. Many respondents, for example, said only that public health is “health care for the indigent.”

On the other hand, the Harris Poll also provided evidence for public support for many public health programs. More than 90 percent of the same people responded affirmatively when asked, “Do you support communicable disease control?” and “Do you support immunization?” When asked about clean air, clean water, and control of toxic waste, more than 80 percent said they support efforts to achieve these goals. When asked about safer lifestyles (and, in other surveys, when asked about controlling youth access to tobacco), more than 70 percent said, “Yes, we support that.” In short, only 3 percent of the U.S. population appear to have an adequate understanding of public health services, but the vast majority appear to support the goals, values, principles and practice of public health.

The confusion on the meaning of “public health” among the general public is not surprising given the infrequency with which the mass media and other opinion-makers identify or refer to public health as a distinct and important domain of social policy and professional practice. In the minds of most residents of the U.S., many matters of public health policy and practice are not distinguished from medical matters, while others, such as violence prevention or traffic safety, are not even considered part of public health policy.

► DEFINING PUBLIC HEALTH

In 1920, C.E.A. Winslow provided a definition of public health that suggested the breadth of its concerns:

Public health is the science and the art of (1) preventing disease, (2) prolonging life, and (3) organized community efforts for (a) the sanitation of the environment, (b) the control of communicable infections, (c) the education of the individual in personal hygiene, (d) the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and (e) the development of the social machinery to ensure everyone a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birthright of health and longevity.

A more recent definition was provided by the Committee for the Study of the Future of Public Health, of the Institute of Medicine of the U.S. National Academy of Sciences. In its 1988 report, *The Future of Public Health*, the committee defined public health as “what we, as a society, do collectively to assure the conditions in which people can be healthy.” The committee elaborated:

The committee defines the *mission* of public health as fulfilling society’s interest in assuring the conditions in which people can be healthy...[T]he committee defines the *substance* of public health as: organized community efforts aimed at the prevention of disease and promotion of health. It links many disciplines and rests upon the scientific core of epidemiology...[T]he committee defines the *organizational framework* of public health to encompass both activities undertaken within the formal structure of government and the associated efforts of private and voluntary organizations and individuals.

► NECESSARY CONDITIONS FOR HEALTH

While it is clear that genetic characteristics and the quality of medical care are important factors, the determinants of health usually considered more important include air, water, and food quality, safe waste disposal, accident prevention, and the control of infectious disease agents, ionizing radiation, and occupational

hazards, all commonly accepted areas of responsibility for public health. Assurance of appropriate prenatal care has long been taken to be a key public health responsibility bearing on maternal and child health. Other determinants such as smoking prevention and violence prevention are increasingly seen as public health issues. Determinants that may be as important or even more important – such as employment status, level of income, housing adequacy and level and quality of education – are usually seen as outside the realm of public health but are also clearly relevant to the goals of public health.

A factor that has often been emphasized in discussions of determinants of health and disease is “personal habits” or “lifestyles.” Tobacco smoking, use of alcohol to excess, excess weight for height, sedentary lifestyles, driving at excessive speeds, sleep deprivation, and other factors, frequently cited as contributing to injury or disease, are often regarded as entirely within the capacity of the individual to control. But there is excellent evidence that these are often the product of socio-cultural factors and social norms, poor education, poverty, unemployment or economic stresses, racism, peer pressure, and mass disinformation. Social intervention in these factors – rather than strategies premised on the assumption that damaging personal habits stem mainly from character weakness – is increasingly being considered as a necessary part of public health efforts.

► CORE PUBLIC HEALTH FUNCTIONS

Most fundamentally, the public health system is responsible for protecting the population by preventing illness and injury. More broadly, the Essential Public Health Working Group of the Core Public Health Functions Steering Committee of the U.S. Public Health Service in 1994 listed the “functions” of public health and the services generally agreed to be “essential” to public health efforts:

- Prevents epidemics and the spread of disease
- Protects against environmental hazards
- Prevents injuries
- Promotes and encourages healthy behaviors
- Responds to disasters and assists communities in recovery
- Assures the quality and accessibility of health services.

THE NEED FOR A PUBLIC HEALTH INFRASTRUCTURE

Infrastructure is the basic framework of an enterprise or system. Those who depend on it tend to take it for granted except when it fails or breaks down. Although often thought of as physical equipment and structural components, in the sense used here it includes also the set of organizations, the skilled and committed professionals, and the institutional memory that are essential pillars of an effective public health system.

*Healthy People 2010*³ defines public health infrastructure as “the data and information systems, skilled workforce, effective public health organizations and resources necessary to assure delivery of the essential public health services...” The public health infrastructure is limited to neither a single agency nor a single level of government – nor even entirely to government, as we shall see.

3. *Healthy People 2010* is a document outlining goals and objectives for the health of the United States population. This national health promotion and disease prevention initiative is sponsored by the Healthy People Consortium, which comprises agencies from all three levels of government, nonprofits, businesses, professional organizations, communities and individuals. The initiative is coordinated by the Office of Disease Prevention and Health Promotion of the U.S. Department of Health and Human Services. *Healthy People 2010* is the Consortium’s third decennial document setting targets for population health.

Fulfilling the core functions of public health requires an infrastructure with a distinct set of capabilities:

1. To assess and monitor community health status. This includes, at a minimum:
 - a. surveillance and reporting
 - b. identification of community health needs; assessment of whether they are met or unmet
 - c. collection of data for health analyses
 - d. analysis of health care outcomes.
2. To invoke preventive measures – community-wide efforts that provide, among other services:
 - a. assurance of clean air and water
 - b. food and restaurant inspection
 - c. pest control
 - d. control of environmental hazards, including ambient and non-ambient lead, asbestos, etc.
 - e. public sanitation
 - f. safer homes and workplaces
 - g. control of infectious disease
 - h. community-level intervention in chronic illness patterns
 - i. injury prevention
 - j. promotion and encouragement of healthy behaviors
 - k. intervention in “social issues” (income distribution, jobs, housing, etc.) that produce better community-wide health outcomes.
3. To assure provision of care and access to it. This includes:
 - a. assurance of the existence of appropriate and adequate networks of hospitals and long-term care facilities, caregivers and allied health workers, clinics, ambulatory care, primary care, mental health services, specialty care of various sorts and high-tech medicine, etc., with provision through both public and private means as necessary and appropriate
 - b. assurance of access to medical care, including preventive medical care, through intervention in the third party payment system (including private insurance, Medicare and Medicaid), nurturing of community-based providers, the creation of culturally and linguistically appropriate services, and other measures.
4. To plan, coordinate and control/regulate. This encompasses a distinct health role of public bodies in providing appropriate objectives for the health system, in setting the terms, conditions, guidelines and regulations necessary for that system to function effectively and to plan for the future of the system so that it can assess public need and meet current and future health needs of the entire population.

EXAMINING NEW YORK CITY’S PUBLIC HEALTH INFRASTRUCTURE

The complexity of public health functions, their location in multiple uncoordinated agencies, the many health problems confronting the city, and the speed at which change is affecting the health care system make it imperative to examine the infrastructure devoted to public health, the resources it commands, its success or failure in carrying out its responsibilities, and the ways in which it might be improved or enhanced.

► ONE FUNCTION, THREE GOVERNMENTS

Although public health is a function of the government of New York City, the City’s powers in that area are delegated by the state and federal governments under the general welfare clause and the Tenth Amendment of the U.S. Constitution. Much of the funding of the New York City Department of Health

(DOH) is via streams of federal funds to the State, including grants-in-aid (block and categorical grants and revenue-sharing funds), some of which require state and local matching. In FY2001, 62 percent of DOH's budgeted support came from New York City tax-levy revenues.

Although Chapter 22 of the City Charter gives vast powers to the Commissioner of Health, including "jurisdiction to regulate all matters affecting the health of the city" including plans for the construction of all medical care facilities, under state law these functions are vested in the State Commissioner of Health. Thus, policy implementation is truncated by both financial and legal barriers, barriers that can be removed only by federal and/or state legislation.

► THE INDISPENSABLE ROLE OF THE PUBLIC SECTOR

The project participants recognized contributions of both the private sector and the public sector to the health of the people of New York City. Individuals and organizations in both sectors have made important contributions and both sectors will be needed if the health of New York City's population is to be maintained and strengthened. There are roles not only for public agencies but also for health providers of all kinds, community service providers, voluntary health organizations and advocacy groups, and the body politic.

Some services, such as provision of prescription drugs and over-the-counter medications and provision of extended care services to those who need them, are largely rendered by units of the private sector although they are funded collectively. Other services, such as monitoring of food, water and air safety and provision of school health services, are largely provided by the public sector. Many services, such as medical care and its associated preventive medicine, are provided by units of both sectors. Indeed, if "the conditions in which people can be healthy" are to be assured to everyone in New York City, that assurance and many of the services needed to fulfill it will have to be provided by both sectors. However, because of a variety of circumstances that are beyond the scope of this study, there is still a concern that many service providers in the private sector, in both fee-for-service and managed care units, will not provide services, or will not provide them fairly, to those in the community who are uninsured, deemed socially undesirable or set apart by race, ethnicity or other social or economic factors.

The participants attempted no extensive examination of which public health functions, under what circumstances, may be appropriately lodged in each sector. Yet it was clear that, for medical care services and even more emphatically for provision of public health services, reliance on the public sector is essential for assuring that everyone in New York City has access to equitable, high quality services.

As to the planning functions, no purely market-based system can carry these out. In an increasingly market-oriented health care system, public interventions at the level of planning and coordination are more necessary than ever.

► NEW YORK CITY'S PUBLIC HEALTH TRADITION: UPS AND DOWNS

New York City has a long tradition of humane, responsible policy and programs in public health. During several periods since the late nineteenth century, the city, and particularly the Health Department, has been a public health pioneer and innovator, earning both national and international recognition.⁴

The Board of Health, formed in 1866, was the first of its kind in the United States. In the 1890s, the City established the first municipal laboratory anywhere for routine diagnosis of disease. There have been numerous important innovations bearing on maternal and child health, child development, and school health services. DOH pioneered the application of health and safety standards to pre-school child care facilities. District health centers, themselves an innovation, became a font of innovations in public health practice. New York was the first city to have a comprehensive program for protection against radioactive materials and x-rays.

But the momentum driving such achievements has not always been sustained. There have been lulls lasting years, even decades. While the city's body of public health law and regulations has remained strong

4. See, for example, L. Baumgartner, One Hundred Years of Health: New York City, 1866-1966. *Bull. N.Y. Acad. Med.* 1969:45:555-586; and J. Duffy, A History of Public Health in New York City (Russell Sage Foundation, 1974).

for the most part, the administrative infrastructure has varied with political will and funding support. The public health infrastructure proved particularly vulnerable in times of economic stress.

The cuts in funding during the city's fiscal crisis of the mid '70s marked the start of an era of reduced political support for public health that, notwithstanding support from time to time for isolated worthy projects, persists to the present day. What impact this had on the course of subsequent epidemics in the city is difficult to assess. In the '80s, the city was unprepared to deal with the sexually transmitted disease, HIV/AIDS and crack cocaine epidemics. It has been unable to cope with the homeless mentally ill. Tuberculosis flared to serious proportions before health agencies were able to get a handle on it. Inadequate funding crippled restaurant inspection and killed the pest control program. In the summer of 1999, in the absence of adequate surveillance and a mosquito control program, the city was unprepared for the arrival of birds (and then mosquitos) carrying West Nile disease.

ISSUE ONE: HEALTH SYSTEM PLANNING IN NEW YORK CITY

There is no sign that New York City has a vision or a plan for the health of its people – a plan that extends beyond one year and includes goals, priorities, time frame, strategies and resource commitment. Aside from categorical projects, the only public health “planning” of citywide scope that takes place currently is the biennial preparation of the Municipal Public Health Services Plan that the New York City DOH is obliged to file so as to qualify for State aid.

This inadequate, narrowing approach to health planning is not new. Even when a more extensive formal planning apparatus existed, it focused only on vetting plans initiated by medical institutions and on plans to address epidemics such as HIV and tuberculosis.

► DISMANTLING OF THE HEALTH PLANNING INFRASTRUCTURE IN NEW YORK CITY

Addressing New York's public health issues requires surveillance, planning, evaluation and action. The planning function can be seen as a necessary intermediate step after data collection and analysis to help assure that effective intervention will follow.

Since 1996, however, the city's health planning apparatus has largely disappeared with the demise of the Health Systems Agency of New York City. Whatever its flaws and inadequacies as a planning entity – and it was far from perfect – the HSA served a number of useful functions. These included the vetting of capital project and service-change proposals by provider institutions and the aggregation and publication of health data. Now, such data on health status, service utilization patterns, insurance, and access to preventive services are no longer collected, collated and disseminated on a routine basis,⁵ and the policy-making process is poorer for it. This egregious example of disinvestment has seriously set back New York City's ability to fulfill its public health responsibilities.

The data stream from the Health Systems Agency imposed a badly-needed format on data collection and management, allowing areas and population segments of comparable size to be analyzed in detail. It also allowed for the computation and analysis of health indicators broken down by ethnicity, gender, age group, geography, disease category, and type of service used, among other variables. Because these data allowed the identification of disparities, they had the potential of highlighting inequities and hence provided a basis for designing strategies to address them. The distribution of funds for primary care and HIV/AIDS, for example, was largely driven by the HSA's presentations of data.

The data also created pressure to generate accurate complementary demographic (“denominator”) information that could be used by public and private health providers. Additionally, they undergirded many health care initiatives, allowing community-based groups and providers to better state their case and hence to be heard in the policy arena. This in turn energized communities and providers to ask for information, thereby fostering a constituency for accurate and timely data.

5. A New York City “Health Atlas,” published at five-year intervals by the United Hospital Fund of New York, is currently the closest approximation.

In the wake of the great national health care coverage debate (1993-94) and continuing for four or five years thereafter, some practitioners and decision-makers were convinced that much of the gap in planning data could be filled by private sources, such as the insurance, pharmaceutical and hospital industries, and some hoped that managed care organizations would provide important statistical data on the health of New Yorkers. Such overconfident assertions are rarely heard now. But the problems of relying on private entities for data aggregation and dissemination remain. Chief among these is a lack of public accountability. To correct this misdirection and to avoid conflicts of interest, the data management should be in the hands of those whose primary commitment is to the public and who have a community-wide mission. Private information systems are often used in ways that are narrowly self-serving and punitive to providers and patients. They redefine access and quality in ways that are not consonant with the public interest. Information dissemination is also seriously jeopardized and costly to users if data are in private hands. Moreover, multiple information streams emanating from different organizations will not be comparable, thereby precluding meaningful comparisons among different segments of the population and different communities.

With the passing of the Health Systems Agency, what health planning there is in New York is either categorically based and disease-driven, or takes place at the institutional or micro level. Insofar as it takes place largely in the private sector, it is aimed at maximizing profits and averting risks. Wanting is a uniform, transparent, participatory process for decisions on the allocation of resources and on the initiation and termination of services. If an effective health planning process entails the surveillance of conditions, the early detection of problems, the design of interventions, the allocation of resources in the light of public policy, and the evaluation of efforts, we can only conclude that what exists now is a significantly truncated and compartmentalized process that either stops short of the full cycle, or is limited to conditions that affect only some of the population some of the time.

Regardless of the vehicle used for health planning, it is obviously crucial that the data held by DOH be made available for this purpose. As highly sophisticated tools for data analysis have become widely available, researchers' expectations for access to data have grown apace. Efforts that appear to be underway currently within the Department to curtail public access to vital statistics and other data should be reversed. Not only should past levels of access continue, but even greater public access to community-level data should be provided, so that community health planning, under various auspices, can continue. At the same time, requirements of confidentiality must be respected.

► INTER-AGENCY COLLABORATION

As noted earlier, the activities of many New York City government agencies, not only those that are primarily health agencies, have substantial impacts on the health of New Yorkers. Yet interaction between and among City agencies on public health matters depends currently on mayoral or other executive interest and directive. No mechanism nor even policy guidance exists to ensure that serious attention to health impacts is a key concern in all such agencies, at both the planning and operational levels. Thus, when DOH identifies a problem that requires action by another City agency, that agency's response when approached may fall short because the agency does not see health as part of its mission. Moreover, even in such an obvious area as environmental health, there is no evidence of strong, effective, department-wide working relationships between DOH and the Department of Environmental Protection.

ISSUE TWO: HEALTH SURVEILLANCE AND ASSESSMENT IN NEW YORK CITY

► PURPOSES OF SURVEILLANCE

Surveillance of the state of the public's health is an ongoing process to identify problems, assess the success of interventions and guide planning and resource allocation. Surveillance aims at the early identification of problems, with a view toward guidance in allocation of resources among problems and

communities, evaluating the success of interventions, and anticipating the public health problems of 5, 10, and 20 years away. Surveillance assesses:

- incidence and prevalence of specific health problems
- hospitalization and mortality data
- risk factors for occurrence of specific health problems – factors relating, for example, to environment, occupation, work environment, housing, nutrition, education, income, social class, age, behaviors, ethnicity, country of origin
- outcomes of intervention, especially for chronic and non-reportable diseases – such as asthma, hypertension, diabetes, cancer, schizophrenia, attention deficit, etc. – and for prevention of violence and injuries.

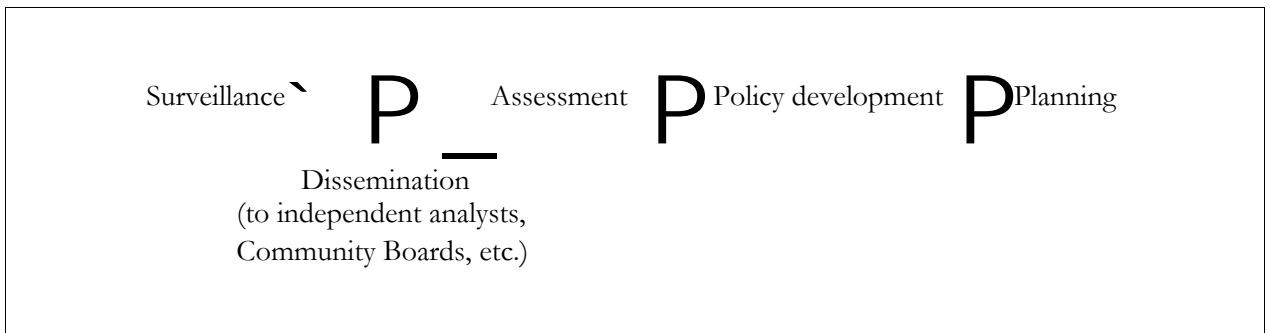
An adequate surveillance system would provide early warning of a disease outbreak irrespective of whether it arose naturally or was the work of malicious hands.

► **SURVEILLANCE AND ASSESSMENT ACTIVITIES
IN THE CITY HEALTH DEPARTMENT. AN INTEGRATION PLAN**

DOH currently maintains multiple surveillance systems, each specific to a particular disease or condition. There are, for example, systems for AIDS, sexually transmitted diseases, tuberculosis, blood lead levels, other poisonings, immunizations, vaccine-preventable diseases and many other communicable diseases. Most of these systems depend on reporting by laboratories and providers as mandated by the New York City Health Code. The systems are complex, computer-based systems that require intensive maintenance, constant upgrading, and a high level of expertise if the analyses developed and the results disseminated are to be accurate and clear. The systems have long been compartmentalized in different bureaus of DOH (Appendix C lists many of the bureaus), and the quality of the work varies from bureau to bureau.

The department sees this fragmentation as inefficient in terms of data gathering and integration and insufficiently effective in terms of assessment and response capability. A stated objective of DOH now is establishing *integrated, small-area* surveillance and assessment. As separate communicable disease surveillance systems covering reported cases are integrated, the system would provide information on co-morbidities. Another system would combine population-based surveillance systems focused on children: blood lead screening and immunization registry databases. The resulting ability to characterize each neighborhood's health status and problems with some measure of comprehensiveness could lay the ground for sound community-based planning with community participation. The time frame for realizing integrated surveillance and assessment ("Integrated Surveillance System") is, however, unclear.

Without this system, the city is effectively in the position of combating present and future epidemics and other public health problems with one hand tied behind its back. The absence of a defined time frame for implementing the critically needed Integrated Surveillance System suggests either that the city government fails to appreciate the project's importance for generating a comprehensive picture of community health status and needs or, worse, that there is no particular interest in having such a picture.



► A NEIGHBORHOOD-LEVEL AGENDA

DOH is aiming to achieve comprehensive health assessments at the neighborhood level. Only these can provide a basis for the specialized community health campaigns that DOH aims to plan and carry out in a partnership that engages both communities and businesses, an approach that is imperative if these campaigns are to succeed.

As one early step toward these ends, the department's "Turning Point Initiative" has produced community health and demographic profiles for the city's five boroughs. Analysis is at the useful but still relatively coarse level of community planning districts and HSA neighborhoods. In each borough, DOH has been trying to use the borough profile and a borough-wide public meeting to spark formation of a community health planning partnership.⁶

► OTHER PROBLEMS IN THE GATHERING, ANALYSIS AND DISSEMINATION OF PUBLIC HEALTH DATA

A range of problems that emerged in seminar discussions indicated the potential value of more systematic approaches to the gathering, management and dissemination of data.

- Often for reasons relating to differences in the category of service delivered to different patients, no reliable, uniform data link exists between health care providers and DOH. Existing reporting requirements are much too often fulfilled sloppily, even unintelligibly, by providers who are (a) overburdened and/or (b) inadequately committed to public health objectives. An effective system for communicating provider/patient encounter data to epidemiological authorities must be recognized as an essential element of an effective health system.
- Physicians with little appreciation of and commitment to public health objectives represent a problem not adequately addressed by existing DOH outreach activities.
- For those data that are collected, the infrastructure for processing, analysis and dissemination is often inadequate. Data that are made available often lack a user friendly format. Some seminar participants complained that bureaucratic rules hamper access to data by researchers and others who could use the data to develop inferences and ideas that could help guide public policy and programs. There was general agreement on the public's right to know, and also that independent analysis can contribute useful insights. (Some participants voiced concerns that liberal policies about data release might result in misinterpretation of data. Others responded that such concerns are best addressed by providing guidance on the interpretation of any data being released, not by restricting access.)
- A major investment in systems and personnel is needed, but in the current health care environment the only effective incentive for such investment is the billing needs of medical care providers.
- The city government needs to have more appreciation of the importance of surveillance data for the safety and protection of all residents, and must ensure that the needed support is forthcoming.

► PUBLIC HEALTH DATA GATHERING: A SHARED RESPONSIBILITY

It was noted that federal, New York State and New York City public health agencies all gather health data. Although ideally they should do so in mutually complementary ways, this is far from being realized in practice – seemingly a correctable inadequacy of a federal system. Although the seminars were unable to assess the thoroughness of the data gathering job overall, one problem noted is that systems are lacking that would provide New York City routinely with data on city-related events occurring outside the city – for example, births and deaths of city residents.

6. The New York City Public Health Agenda. A Plan for Action. January 1, 2000. A proposal developed by Turning Point, the New York City Public Health Partnership.

OTHER ISSUES

The seminars dealt more briefly with a number of other issues pertinent to the city's public health infrastructure.

► THE TROUBLE WITH RELIANCE ON CATEGORICAL FUNDING

Over the last two decades, as a survival strategy in an era of ideologically inspired downsizing of human services in the public sector, health agencies have relied increasingly on categorical disease-focused funding. This has severely impeded and too often altogether discouraged efforts to understand and manage community public health problems comprehensively, as well as to implement rigorously the DOH's myriad regulatory responsibilities (Appendix D).

► VOLUNTARY HEALTH AGENCIES

The city's private voluntary health agencies, mainly hospitals, the beneficiaries of major public funding, have not been systematically engaged in the city's health surveillance and planning processes, a situation that was not analyzed in the present study.

► RELATION BETWEEN PERSONAL HEALTH SERVICES AND PUBLIC HEALTH

Many of the services needed to "assure the conditions in which people can be healthy" lie in the realm of "personal health services." These services are usually performed as part of what is considered the medical care system rather than the public health system. Efforts have been made, nationally, statewide and in New York City, to introduce elements of good public health practice such as primary and secondary prevention, into the medical care system, but the structure of the medical care system in the United States and in New York City is usually not conducive to universal and equitable provision of public health services.

Many of the characteristics of the medical care system that hinder universal and equitable provision of public health services are the same as those that hinder universal and equitable provision of medical care services. They include: the nature and flow of funding of the medical care system, both fee-for-service and managed care; the fragmented nature of the medical care system in which it is extremely rare for everyone in a community, even members of the same family, to be served by the same group of medical care providers; and the recruitment and training of personnel in the medical care system.

Other important factors that underlie the inattention of medical practitioners to public health and preventive medicine include a long established, deeply ingrained culture in U.S. medicine that focuses heavily on treatment but not on prevention; the extremely strong identification of health with medicine in popular culture; and, most important, the difference in outlook of practitioners who are predominantly concerned with the health of individuals rather than the health of communities. Structural changes in the medical care system in the United States and in New York City could help reduce the barriers to universal and equitable provision of services, barriers that result from the medical care system's funding mechanisms, its fragmented nature, and the recruitment and training of its personnel. However, other factors that impede recognition of the importance of community health in medical practice would still persist.

The seminars discussed approaches for improving the coordination between the personal and public health services. The most comprehensive would be locating all personal health services within the public health system while changing the structure and financing of the medical care system so that it can support universal and equitable provision of personal health services. One recent federal proposal, the U.S. Universal Health Service Act (H.R. 3000, 106th Congress), would establish a national health service, governed locally in accord with federal guidelines, and would implement a nationwide program of comprehensive, universal health care within that framework. While that measure would place squarely on the medical care sector the responsibility to develop a public health orientation, such legislation seems unlikely to be adopted in the near future. More limited proposals for change at the federal, state or city level may help in the short run, but they are unlikely to produce the new long-term relations between personal health services and public health that are needed.

THE HEALTH OF THE CITY: ITS IMPORT FOR THE CITY'S FUTURE

The quality of life and the effective functioning of any city, anywhere in the world, are highly dependent on the health of its people. New York City is no exception. Policy makers would do well to think of the determinants of health in the broadest terms.

The diversity and density of New York City's population, many of whom are commuters, and the massive immigration into the city pose considerable, ever-changing challenges for its health services. The number of immigrants into the city annually from outside the United States is reported as being at least twice the number immigrating into any other city in this country, although the numbers of undocumented immigrants to southern border states may be underestimated. These characteristics of New York City's population that make provision of health services more difficult also make health services even more important than in many other cities.

Failure to recognize and address shortcomings in the city's public health infrastructure puts everyone's health at higher risk. It results in a reduced quality of life for all and in the loss of talented and productive people, both through the failure of the city's children to develop optimally and thrive and through the loss of residents to the suburbs and to other cities.

The quality of life in the city and the city's future, not just its health, depend on a strengthening of the city's public health infrastructure and massive new investment in public health functions, with particular attention to fostering community health and occupational health.

RECOMMENDATIONS

1. PLANNING FOR A HEALTHY CITY

For the city to generate and realize a vision for the health of its people, commitment and broad active participation by the city government are essential.

- 1.1 In recognition of the impact that the entire range of City agencies' activities can have on the health of the city, the City should establish an Interagency Council on Health, with DOH as the designated lead agency and with the deputy mayor for health and human services as chair. This Council's charge should be to assure that (1) in the development of the City's health policy and plan, and in the City's health surveillance program, each City agency recognizes the importance of its role and contributes optimally; and (2) in both planning and implementation of agency activities, full consideration is given to their impact on health, with a view to realizing each agency's optimum contribution to health.
- 1.2 The development of a three-year health plan with explicit priorities, city-wide objectives and proposed public and private programs should be a high priority for the City. The objectives should be framed in measurable terms, so that their accomplishment is easily assessed. These targets should in turn inform the allocation of resources, with areas of greater need receiving a greater intensity of resources than their healthier counterparts. The data and analyses derived from an integrated, neighborhood-level surveillance system would be an indispensable basis for this planning function.
- 1.3 Particular attention should be given to municipal funding for service needs that are underfunded because of the categorical character that predominates in the City's external funding. Both public programs and private programs with substantial public funding should receive effective oversight to ensure that the use of City resources accords with the City's priorities.
- 1.4 The plan should be developed in extensive consultation with the city's communities from the very earliest stages, and it should also be subject to community hearings. Community involvement in plan development should be a structured process that engages broadly representative structured community bodies. These bodies should be provided with staff support and full access to pertinent

information. This would help to assure that health decisions are seen politically as everyone's business, which in fact they are.

- 1.5 The mechanism and schedule for community consultation must be institutionalized in law. However, to assure development of an effective, broadly representative process, DOH should refine the methodology over two years, with participation of professional facilitators, community organizers and appropriate academic specialists. Without adequate support for developing and institutionalizing such a process, the important objective of engaging communities effectively as partners in assessment, planning and program implementation is unlikely to be realized. New York City has far too little experience in this level of government interaction with civil society (non-governmental organizations and unattached, civically active individuals) and both sides in the endeavor will need to learn on the job.
- 1.6 Health proposals should be framed within the goals of the plan, much as federal funding is based on the promotion of the national Healthy People objectives.

2. SURVEILLANCE

- 2.1 The City should give full financial and policy support to the expeditious completion of the steps needed for integrating DOH's surveillance programs and making available comprehensive community health profiles at the lowest feasible geographic level. Support should include a five-year capital plan for acquisition of the needed information systems. Funds being drawn down under categorical programs can justifiably be committed to a wide-ranging surveillance strategy.
- 2.2 Legislative mechanisms should be explored for ensuring full, mandatory engagement of the city's private health service agencies, both voluntary and proprietary, in the planning, implementation and oversight of the integrated surveillance system as a condition of continuing receipt of City funds.
- 2.3 The progressive consolidation occurring among the city's voluntary hospitals can lead to more uniform data collection and formatting within and among these hospital systems. Initiatives by DOH and HHC could promote that uniformity, yielding more consistent citywide data sets as inputs to the DOH surveillance system.
- 2.4 New York City should work toward a partnership with New York State that ensures timely, comprehensive sharing of health surveillance data pertinent to the city's health.

3. ACCESS TO DATA

- 3.1 DOH should establish a New York City Center for Health Statistics to promote and facilitate timely access – including electronic access – by City agencies, independent investigators (health care providers, academic researchers) and the public at large to public health data. Achieving a balance among conflicting concerns is not easy, but the balance must tilt toward accessibility of information. In the interest of the public's health, the City, with reasonable measures to assure confidentiality, should not only not curtail access to data, or even simply permit ready access to and independent analysis of such data; it should actively encourage it. Staffing should be available for help in clarifying how the data sources and circumstances of data collection limit plausible interpretations of the data.
- 3.2 DOH should inventory the sources of health-related information, producing a directory that details the type of data collected, the units of analysis, the source of the data (who collects and disseminates it), the frequency of gathering and publication, and the uses to which the data are put. In addition to information on vital statistics, reportable diseases, health status, and risk factors, the inventory should cover sources of information on demographics ("denominator" data), housing, employment, occupational distribution, income, environmental conditions, and patterns of health care utilization. This reference guide should be made widely available to the public at large.

4. THE NEED FOR CONTINUED INDEPENDENT OVERSIGHT AND FOR WIDER ENGAGEMENT OF THE PUBLIC

As already noted earlier, the scope of the task undertaken in this project could not be fulfilled in the 12 to 14 hours of exposition and discussion that five seminars provided. Many issues remain to be examined.

The Task Force recommends that PHANYC continue and extend the scope of the foregoing scrutiny of New York City's public health infrastructure. Such oversight by an independent public health body is itself another important level of surveillance. Among issues that could bear study are:

- The role of the New York State Department of Health. That department's full participation in future studies should be encouraged.
- The city's environmental health infrastructure. Full participation by the New York City Department of Environmental Protection in such studies is to be similarly encouraged.
- The capacity of public health infrastructure for implementing preventive measures in the city
- The capacity of the public health system to respond early to potential health crises in the city
- The capacity of the city's health systems to assure access to medical care
- The role of public health in hospital care
- Assessment of public health education and health promotion in the city
- Potential interventions to reduce and eliminate racial and ethnic disparities in health status and in access to services
- Regulatory processes in the city's public health infrastructure
- What determines whether a service best resides in the public or private sector?
- How effective is the match of federal, state and municipal health agency roles?
- Development and training of the public health work force.

Notwithstanding the vital responsibilities of public health, in a political environment where themes like government downsizing, tax-cutting and de-regulation dominate, public health agencies and their programs have a particular need for popular support if they are to remain strong. To that end, independent assessments of the public health system need to be injected effectively into popular discussion. Moreover, to understand why they should be concerned about their public health infrastructure, New Yorkers need a periodic report card that tracks a set of sentinel indicators of the city's health status. Eventually each neighborhood should get its own report card. Every effort should be made to assure that such a report card is issued regularly and that it reaches people's attention.

APPENDIX A
SEMINAR PARTICIPANTS

The following participated in one or more of the seminars on *Revitalizing the Public Health Infrastructure of New York City*.

Nancy Anderson	Jessica Leighton
Peter Arno	Betty Wolder Levin
Howard Berliner	Katherine Lobach
Anne-Emanuelle Birn	Lorna McBarnette
Cyril Brosnan	Paul Meissner
Robb Burlage	Cheryl Merzel
Eve Cagan	Bruce Mesh
Violet P. Cherry	Benjamin Mojica
June Jackson Christmas	Gerald Oppenheimer
Georgia Davidson	Robert A. Padgug
Gerry Fairbrother	Elena Padilla
Ilene Fennoy	Annette Ramirez de Arellano
Gerard Ferguson	Ellen Rautenberg
Dena Fisher	Leonard Rodberg
Nicholas Freudenberg	Sumner Rosen
Richard Garfield	David Sandman
Marthe R. Gold	Victor W. Sidel
Frank Goldsmith	Barry Skura
Andrew Goodman	Sidney J. Socolar
Carolyn Graham	Jacob J. Steinberg
Robert Gumbs	Mervyn Susser
Sally Guttmacher	Heike Thiel de Bocanegra
Dorothy Jessup	Benjamin Wainfeld
Susan Klitzman	Rodrick Wallace
David Kotelchuck	Isaac Weisfuse
Linda Landesman	David Willis

APPENDIX B
QUESTIONS POSED TO THE SEMINARS

1. What is public health? What are the special responsibilities of public health in New York City?
2. Who is responsible for public health in New York City? What are the roles of local, state, and federal government, community-based organizations, HMOs and insurers, hospitals, medicine, and schools of public health?
3. What is public health “infrastructure?” What should constitute it? What does constitute it in New York City?
4. What are the determinants of health? How do employment and personal income, occupation, housing, education, and medicine relate to public health?
5. What value do we place on public health in New York? Has this changed? What does the public think public health is?
6. Public health expenditures comprise roughly 3% of total health care expenditures (nationally). Is this an appropriate allocation for public health? What would we do with additional funding?
7. What are the health surveillance functions of government in New York City and how do they relate to state and federal functions?
8. What data are collected? What should be collected? How are they used and disseminated? Are they published on a timely basis?
9. How effective are New York City’s surveillance and monitoring of community health status and treatment outcomes, data collection and dissemination? What are appropriate indices or measures of the effectiveness of surveillance efforts?
10. What are the roles of public bodies in addressing illness and the societal conditions underlying poor health?
11. What activities does the City undertake with respect to essential public health functions in New York City, including surveillance and monitoring of community health status and treatment outcomes, data collection and dissemination? What additional activities would it like to carry out? What are appropriate indices or measures of the effectiveness of these efforts?
12. How does the City approach prevention, health education, and health promotion activities in New York? What additional activities would it like to carry out? Could managed care organizations carry out some of these functions?
13. How does the City respond to emergent, infectious, and related conditions (epidemics, catastrophe, violence, substance abuse, new pathogens)? What additional activities would it like to carry out?
14. How does the City respond to chronic disease patterns? What additional activities would it like to carry out?
15. What activities does the City undertake with regard to inspection and monitoring for pest control and pure food, air, water, asbestos, and lead? What kinds of sanctions for violations are imposed?
16. What are the functions of government in addressing problems of occupational health? What does the City do to carry out these functions?
17. How does the City publicize these public health functions among the wider public?
18. What are the roles of public agencies, in particular NYC DOH, in addressing illness and the underlying conditions that cause it?
19. Are public health agencies appropriately staffed and funded?

20. What is the City doing to respond to important public health needs:
- C prevention, health education, and health promotion? (Should managed care organizations carry out some of these functions?)
 - emergent illnesses and other health problems (epidemics, catastrophe, violence, substance abuse, new pathogens)?
 - chronic disease, including asthma?
 - inspection, monitoring, and sanctions in pest, lead, and asbestos control and the assurance of pure food, air, and water?
 - occupational health?

Which health needs most urgently require attention?

- 21. What do planning, coordination, control and regulation mean in the context of New York City public health? Who is responsible for public policy development and planning? For health needs assessment?
- 22. How do personal health services relate to public health and public health policy? What are the roles of public health agencies in assuring access to health care and its affordability to the population of the city? Is the provision of personal health services the best use of public health funds and staff?
- 23. What should be the respective roles of public and private bodies in the provision of medical care to the population?
- 24. Is new legislation or regulation needed to ensure that the health care system operates optimally in New York City?
- 25. What is the appropriate role for public hospitals, community health centers, and other publicly-funded services in the delivery of health care and in the public health system?

APPENDIX C
NYC DEPARTMENT OF HEALTH
DIVISIONS, BUREAUS AND OFFICES – PARTIAL LIST⁷

- Chief Medical Examiner
- Community Health Works
- Disease Intervention Services
 - Environmental Risk Assessment
 - Lead Poisoning Prevention
 - Environmental/Occupational Disease Epidemiology
 - Infectious and Communicable Disease Control
 - Communicable Diseases
 - HIV Services
 - STD Control
 - TB Control
 - Vaccine-Preventable Diseases
 - Surveillance and Epidemiology
 - Vital Statistics
- Family and Community Health Services
 - Child and Adolescent Health
 - Child Health Clinics
 - Day Care
 - School Health
 - Physically Handicapped Children
 - Criminal Justice Health
 - Family Health
 - Community Clinical Services
 - Maternal, Infant and Reproductive health
 - Oral Health
 - Gay and Lesbian health
 - Health Promotion and Disease Prevention
 - Chronic Disease
 - Injury Prevention
 - Tobacco
 - Minority and Immigrant Health
- Health Care Access
 - Insurance Operations
 - Compliance and Performance
 - Contract Administration, Program Development and Quality Assurance
 - Outreach, Education and Consumer Relations
 - Policy, Program Evaluation and Research
- Medical and Professional Education and Training
 - Quality Improvement
- Regulatory and Environmental Health Services
 - Environmental Sciences and Engineering
 - Environmental Investigations
 - Public Health Engineering
 - Radiological Health
 - Field Operations and Inspections
 - Veterinary and Pest Control Services

7. As of October 25, 2000

APPENDIX D
NYC DEPARTMENT OF HEALTH
REGULATORY AND LICENSING FUNCTIONS – PARTIAL LIST⁸

Abortion services
Air (compressed) for underwater breathing
Animal control
Barber shops
Bathing establishments, beaches
Buildings (commercial): lighting, ventilation, cleanliness...
Buildings (residential): heating, window guards, gas appliances...
Camps (summer)
Children’s institutions: space requirements, lavatories, beds, pest control, outdoor play, equipment
Day care institutions
Day care (family)
Diseases, reportable
Drinking water
Food, drugs and cosmetics
Food establishments, mobile vendors
Food processing
Fumigation, extermination
Hazardous substances
Laboratories (clinical)
Littering, refuse disposal
Nuisance abatement
Pathogenic organisms: handling
Pest control
Prohibited materials
Radiation control
Schools
Sewage disposal
Slaughtering of animals
Smoking
Transportation (public): sanitary standards, smoking
Water pollution control
Weight reduction groups

8. Source: New York City Health Code

APPENDIX E

BACKGROUND PAPERS PROVIDED TO SEMINAR PARTICIPANTS

COMMISSIONED PAPERS

- Fairbrother G. – Issues in Monitoring Childhood Immunization Rates
- Gumbs R. – The Role of Local Health Planning in a Market Driven Environment in New York City/New York State
- Oppenheimer G, Padgug R. – Themes in the History of Public Health in New York City, 1866 to the Present
- Padilla E. – Continuities and Discontinuities in New York City Public Health
- Padilla E. – On The Connections of Public Health and Personal Health Services in New York City
- Rodberg LS. – Infoshare – A Community Data System for Community Use
- Sidel VW, Padgug RA, Socolar, SJ. – What is Public Health?

ADDITIONAL MATERIALS

- Association of Maternal and Child Health Programs – *Maternal and Child Health Within Federal and State Agencies: Principles for Organizational Structures*
- Bickell N, Siu A, Vladeck B, Chassin M. – Reassessing Strategic Priorities for the NYC Department of Health: Final Report to the Mayor’s Office of Health Services (December 3, 1999)
- Bodenheimer T. – Disease Management: Promises and Pitfalls. *N. Engl. J. Med.* 340(15) (April 15, 1999)
- Calderon J, Flynn K, Robbins T, Sugarman R. – Asthma: The Silent Killer. Why too Many Die. *New York Daily News*, February 22-25, 1998
- Center for Studying Health System Change – Issue Brief: Managed Care Cost Pressures Threaten Access for the Uninsured (Number 19, March 1999)
- City Health Information* (New York City Department of Health) – sample issue
- Committee for the Study of the Future of Public Health, Division of Health Care Services, Institute of Medicine – *The Future of Public Health* (Washington, DC: National Academy Press, 1988), Summary and Recommendations (pp. 1-18)
- Eilbert KW et al. – Public Health Expenditures: Developing Estimates for Improved Policy Making. *J. Public Health Management Practice* 1997;3(3):1-9
- Fairchild AL, Oppenheimer GM. – Public Health Nihilism vs. Pragmatism: History, Politics, and the Control of Tuberculosis. *Am. J. Public Health*, 1998;88(7):1105-1117
- Gebbie K. – The Public Health Workforce. *Am. J. Public Health*, 1999;89(5):660-661
- Gebbie KM – Public Health Infrastructure. Northeast Public Health Leadership Institute, July 28, 1999
- Geiger HJ. – How Can the Impact of Government Budget Cuts on the Health of the People of New York Be Measured? Presented at IMPACT 97, New York City, January 14, 1997
- Harman J. – New Health Care Data – New Horizons for Public Health. *Am. J. Public Health* 1988;88(7):1019-1021
- Holloway L. – Reading, Writing, and Runny Noses. *The New York Times*, April 21, 1999
- Institute of Medicine. – Public Health and Managed Care. *Healthy Communities: New Partnerships for the Future of Public Health* (Washington, DC: National Academy Press, 1996), pp. 13-29
- Lukomnik JE, Aries N, Rodberg LS. – Mismanaged Care: the Deteriorating State of Health Care for the Poor in New York City. Presented at IMPACT 97, January 14, 1997

- Melnick A. – Clackamas County Department of Health and Human Resources: Community Health Mapping Engine (CHiME) Geographic Information Systems Project. Abstract from *Meeting the Urban Health Challenge: A Joint Public Health and Urban Planning Conference*, convened by the Hunter College Center for Occupational and Environmental Health, New York City, September, 1998
- Miringoff ML. – *1997 Index of Social Health: Monitoring the Social Well-Being of the Nation*. Fordham University
- Montague P. – Major Causes of Ill Health. *Rachel's Environment & Health Weekly* #584
- Estimated Expenditures for Essential Public Health Services – Selected States, Fiscal Year 1995. *Morbidity and Mortality Weekly Report* 46(7) (February 21, 1997)
- Public Opinion About Public Health – California and the United States, 1996. *Morbidity and Mortality Weekly Report* 47(4):69-73 (February 6, 1998)
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Public Health Association of New York City

Office Location

Mailman School of Public Health
Columbia University
722 West 168th Street, 11th Floor
New York, NY 10032

Mailing Address

2840 Broadway #297
New York, NY 10025

Telephone 212-666-4001
Fax 212-866-5847
E-mail address info@phanyc.org
Web site www.phanyc.org

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