IMPROVING URBAN HEALTH

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The New York Academy of Medicine symposium was of great interest to me personally and to the New York State Department of Health. Developing a health agenda for New Yorkers—and finding collaborative ways to implement that agenda—is something we are working on diligently.

New York State's approach to improving the health of its urban communities is based on three key premises. First, we must create a framework for identifying and addressing public health priorities in our communities, including our major metropolitan areas. Second, improving urban health requires broad-based community collaboration. For that collaboration to work, the partners in the community must look beyond their own special interests and take a holistic view of a city's health. Third, and strange as it may seem, in my travels across New York State I have found that the health problems of urban dwellers have much in common with those of rural dwellers, and that these communities can benefit from sharing strategies.

I challenge the assumption that we need to develop an urban health agenda. Rather, I believe that we need to develop a public health agenda that speaks to those in rural New York as well as in urban New York City.

A NEW YORK STATE PROFILE

New York is a very large and a very diverse state. We have a population of about 18 million, and about 40% of the state's population, or 7.5 million residents, reside in New York City. Another 23% of the population reside in the six counties closest to New York City.

When the data are compared, we find that the death rates per 1,000 population are not too dissimilar statewide when comparing New York City with the rest of the state. In fact, the death rate for New York City is just slightly higher than the rate for the rest of the state (9.4 for New York City; 9.0 for the rest of the state).

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In New York City, consistent with national trends, the top two causes of death are heart disease and cancer. The third highest cause of death is the point at which New York City diverges from the national picture: stroke is the third leading cause of death in the United States, but in New York City, acquired immunodeficiency syndrome (AIDS) has become the third leading cause of death. It is also the third highest cause of death for the state as a whole.

New York City's mortality figures change dramatically when the top five causes of death for children and teens aged 10 through 19 are considered. Shockingly, homicide is the leading cause of death in this age group. Accidents, primarily motor vehicle accidents, are the second biggest killer. Cancer, the only chronic disease in the top five, is the third highest cause of death; suicide is fourth, and AIDS is fifth. Four of the top five causes of death are preventable.

When we examine New York City residents aged 20 through 24, homicide and accidents remain the leading causes of mortality. AIDS is third; suicide remains the fourth leading cause, and cancer is fifth. Again, four of these causes are clearly preventable.

In persons aged 25 through 44, AIDS is by far the biggest killer in this age group of New York City residents. The numbers for the next four highest causes of death—homicide, cancer, heart disease, and accidents—look small in comparison. The picture changes dramatically again when we look at the next age group, those who are 45 to 64 years old. Cancer and heart disease are the top two killers, but AIDS remains a strong third. Liver disease is the fourth leading cause of death, and stroke is fifth. Among the oldest residents of New York City, those 65 and over, heart disease is the salient cause of death. Cancer is second; pneumonia is third; stroke is fourth; and chronic obstructive pulmonary diseases, such as bronchitis and emphysema, are the fifth leading cause of death.

IDENTIFYING PUBLIC HEALTH PRIORITIES

Mortality data can be useful in identifying public health priorities, but they do not identify the actual causes of poor health during the various stages of the life cycle and the means by which those root causes lead to morbidity and mortality. Late in 1995, I asked the New York State Public Health Council, an independent advisory body to the New York State Health Department, to begin identifying the highest priorities for improving health in New York's communities for the next decade. Together, we developed four principles that should guide their work. First, we agreed that communities can have the greatest impact on health by intervening in the causes of poor health rather than focusing on the health problems themselves. Second, we agreed that priority areas must address those conditions that result in the greatest morbidity, mortality, disability,

and years of productive life lost, and that reflect problems of greatest concern to local communities. Third, we agreed that the greatest improvements in health can be achieved in areas in which effective interventions involve the entire community and the individual. Fourth, we agreed that progress in addressing the priorities should be measurable through specific, quantifiable, and practical objectives.

The Public Health Council then created the 19-member Public Health Priorities Committee, to seek statewide input and to recommend health objectives for New York. The membership of this committee included representatives from the areas of public health, social services, health care providers, education, business, and industry. In May 1996, the committee held six regional workshops across the state and obtained input from more than 1,400 New Yorkers. Workshops were held in New York City, Stony Brook on Long Island, Albany, Binghamton, Syracuse, and Batavia.

On May 17, 1996, 400 people gathered at the Grand Hyatt Hotel on 42nd Street in New York City to participate in the process of identifying health priorities for New York's communities. A total of 550 people attempted to register for the workshop, illustrating the tremendous interest in this initiative in the city. Among those participating were representatives of six local health departments (including the New York City Health Department), numerous hospitals, health centers, academic centers, corporations, and community-based organizations. The groups also included members of the clergy, community-wide coalition members, and members of the public at large. The participants were divided into six smaller groups, each with their own facilitators.

After being provided with some data on causes of morbidity and mortality in the state, the groups were asked to do three things. First, they were asked to express what they felt were the most serious public health issues facing their communities. Second, they were asked to identify the underlying causes of those health problems. Third, they were asked to identify effective interventions for reducing the health problems.

In fulfilling these tasks, all participants in the workshops were asked to disregard what they do for a living or their own special health interests. Instead, we asked them to focus on the community as a whole and its most pressing health problems.

The 400 participants in the New York City workshop identified the following as the 12 greatest risk factors for poor health in their communities:

- physical inactivity
- poor nutrition

- poverty
- tobacco use
- unsafe sexual behavior
- violent and abusive behavior
- alcohol and substance abuse
- the disintegration of families and family values
- inadequate preventive services
- lack of access to health care
- lack of access to health education
- lack of adequate health insurance

The workshop participants said that those risk factors were responsible for the following 10 adverse health outcomes:

- domestic violence
- human immunodeficiency virus (HIV) and AIDS
- adolescent pregnancy
- substance abuse
- sexually transmitted diseases
- addiction
- low birth weight
- tuberculosis
- homelessness
- stress-related diseases

The input obtained from the participants at that workshop—along with input obtained at the other five workshops held across the state—was used by the Public Health Priorities Committee to identify 12 priority areas that need to be addressed in New York's communities over the next 10 years. The group generated a report, "Communities Working Together for a Healthier New York." The priority areas identified in this report are not intended to include all of the health problems facing communities, and communities with significant health problems not covered in this report are being encouraged to develop their own priorities. The report also suggests ways that communities can collaborate to address public health priorities. It includes clear objectives that can serve as the basis for performance measures to gauge progress.

HEALTH PRIORITY AREAS THAT REQUIRE ATTENTION

A dozen health priority areas were identified that require action over the next 10 years. The 12 priority areas approximate closely the causes of poor health identified at the New York City workshop. The priority areas are:

- increasing access to health care
- increasing the level of education achieved
- ensuring healthy births
- improving mental health
- improving nutrition
- increasing physical activity
- ensuring a safe and healthy work environment
- reducing unsafe sexual activity
- reducing substance abuse
- reducing tobacco use
- reducing unintentional injuries
- reducing violent and abusive behavior

The report also includes specific objectives that will be measured over time to evaluate progress. For example, one of the priority areas is ensuring healthy births. One of the objectives listed with this priority is to reduce the incidence of low-weight (less than 2,500 g) births to no more than 5.5%. This objective will be compared with a 1994 baseline of 7.7% statewide and will also be compared with the rate for individual communities and population groups. In inner-city neighborhoods in New York City, Buffalo, Rochester, and Syracuse, the incidence of low-weight births is 9% and higher; it is as high as 13% among African-Americans.

Access to Care

The report identifies a number of objectives that will be used to measure increased access to primary and preventive health care. With Governor George Pataki's leadership and support, we are working hard in New York to increase access to health care through a number of avenues. The state is providing nearly $7 million in state funding, and there is about $3.4 million in federal funding to support 152 school-based health centers in medically underserved areas of the state. Most of these centers are in New York City and other inner-city schools. Through the Primary Care Initiative, the state is providing $60 million over three years to support projects that expand access to primary care in underserved areas. The state has also earmarked $207 million to expand its subsidized health insurance program for children over the next three years.

We also plan to use an estimated $256 million from the federal government—derived as a result of the new federal child health insurance program—to supplement this program. With this funding, we will take a major step toward achieving our goal of health insurance for all New York children.

One of the objectives we have established for measuring improvement in the delivery of health care is increasing the percentage of New Yorkers who receive age-appropriate and sex-appropriate preventive health services. For our poorest residents, this is being accomplished through the state's completely restructured Medicaid program. The new managed-care-based program will provide a medical home for every Medicaid recipient, and health care providers must provide specific preventive services. The goal of this program is improved health status for Medicaid recipients. We will monitor progress in achieving improved health status by collecting data and measuring health outcomes.

Sexual Health

In the priority area of reducing unsafe sexual activity, we have established objectives that focus on reducing adolescent pregnancy and sexually transmitted diseases. In my mind, reducing teenage pregnancy is a huge priority for all of New York State, urban and rural alike. It is a major problem in all of our communities, but it is especially acute in the inner city. We set an objective of reducing the adolescent pregnancy rate to no more than 50 per 1,000 girls aged 15 to 17. The 1994 statewide pregnancy rate was 65.5 pregnancies per 1,000 girls aged 15 through 17, but the rate for New York City was 102 pregnancies per 1,000 girls, with the Bronx having the highest rate, 145.6 per 1,000.

Although unsafe sexual activity is a huge problem in urban areas, I have become increasingly aware of the magnitude of this problem in some of New York's poorest rural areas. Nothing has illustrated that point more for me personally than the activities in which I was engaged during the autumn of 1997 in Chautauqua County, New York. At that time, there was a situation that involved an HIV-positive individual who infected 10 or 11 young women in this very rural community and who then moved his activities to New York City.

The interface between the issues that we are grappling with in Chautauqua County and New York City are identical. Jamestown, in Chautauqua County, has no more than 40,000 residents, but the community has a group of teenagers who could just as easily live in Manhattan, the Bronx, or in Queens. These youngsters feel helpless, are homeless, and see no future. Unfortunately, because of the lack of adult interaction, these teens have mistaken sex and a warm body next to them for the love and the nurturing that they have missed all their lives. That can happen in rural Chautauqua County, just as it happens in New York City.

Substance Abuse and Tobacco

Reducing substance abuse, including the use of alcohol and other drugs, was cited by participants at the New York City workshop as a major public health priority. We set six objectives for reducing alcohol and drug abuse relating to

use by adults, teenagers, and pregnant women. There is a strong correlation between alcohol and drug use and unsafe sexual behavior. AIDS, the most deadly disease for young adults, is transmitted through both unsafe sex and the use of infected needles during intravenous drug use.

Another priority area is tobacco use. We established three objectives aimed at reducing the prevalence of smoking by adults, adolescents, and pregnant women. One of the objectives is to reduce the percentage of teens who smoke to no more than 10%, which is also the federal Healthy People 2000 objective.

Our baseline for this is 17%, which was determined through a survey conducted by the State Office of Alcohol and Substance Abuse. The 1996 data, obtained through our Behavioral Risk Factor Surveillance System (BRFSS), show that some 23% of all New Yorkers aged 18 and older smoke. That rate, interestingly, is the same for both New York City and the rest of the state.

Our data show that tobacco causes more disease and death in New York State than any other pathogen. The problem does not stop there because we know that, for our youth, smoking is also a gateway to drug abuse. We have recently begun the biggest initiative in the history of this state to prevent and reduce smoking by adolescents and pregnant women.

AN AGENDA FOR URBAN HEALTH IN NEW YORK STATE

In essence, our public health priorities initiative sets an agenda for communities across the state. It is a flexible agenda that communities can adapt and tailor to meet their specific needs. The report also provides ideas to communities for effective and innovative public health interventions, based on input from the workshops.

The participants at the New York City workshop cited a number of interventions they felt have been successful in hard-to-reach urban population groups. These included school-based health centers, health worker home-visiting programs, physician training in public health issues, directly observed therapy for tuberculosis patients, mobile vans for screening services, and peer outreach. All of these subsume programs that we are seeking to strengthen in New York. For example, in August 1997, the state provided $2 million in mobile mammography units and equipment to five hospitals, to expand access to breast cancer screening in underserved areas.

New York's public health priorities initiative is a call to action to our cities and communities to develop partnerships to improve health status. The report serves as a guide to community organizations that wish to develop coalitions that focus on improving health. The state has provided $700,000 in grants to local health agencies to support the development of these partnerships. A grant

of $104,000 went to the New York City Health Department to support both priority-setting activities for health and the development of a community partnership that will focus on preventing youth violence. At the same time, the New York State Health Department's New York City Regional Office is spearheading the development of a steering committee that will guide and oversee the implementation of the public health priorities initiative in the metropolitan area.

Broad-Based Collaboration

Broad-based collaborative efforts at the community level are essential to improve health status. Consider one example of how such a partnership can be used effectively to address a community public health priority.

For some time, there has been concern that certain communities in New York City are experiencing high rates of asthma. Serious health consequences are associated with the situation. To study the problem, a partnership was developed among the New York State Health Department, the New York City Health Department, the New York City public schools system, Columbia University, and the Center for Urban Epidemiological Studies at the New York Academy of Medicine. The study focused on asthma prevalence in two communities, East Harlem and South Bronx, which were chosen because of their high asthma hospitalization rates. The study included a take-home survey to be filled out by parents; in East Harlem, we had an 85% survey return rate.

The study used partnership in several ways. First, it combined traditional institutional resources from public health, academia, and the medical fields, including the use of graduate students to develop the study tool and administer the questionnaire in the schools. Second, it built partnerships with the community through interaction and feedback with Parent Teacher Associations, school principals, community organizations, and health care providers, to generate support for the study and for future interventions. Third, it involved support from the business community, to pay for classroom incentives such as tee shirts for children and educational incentives for the teachers to encourage them to support completion of the take-home questionnaire by parents.

The overall goal of this partnership initiative is to develop better tools for identifying asthma prevalence in children and to identify opportunities for educating children, parents, and teachers about the early signs of asthma and proper treatment.

SUMMARY

New York's public health priorities initiative, Communities Working Together for a Healthier New York, creates a framework for communities, including urban areas, to identify and address their most pressing public health problems. It is

both a call to action and a guide for the state's communities. The priorities identified in this initiative were the product of extensive public input across the state. Interestingly, the priorities identified by rural counties were consistent with those identified in the New York City workshop.

To a great extent, urban and rural dwellers have the same health problems, such as teenage pregnancy, substance abuse, and tobacco use, although to different degrees. Accordingly, we need to recognize that we are a global society, in which the line separating urban and rural has thinned, if not disappeared.

Improving health status in our communities, whether urban or rural, requires broad-based collaboration. It requires setting special interests aside and focusing on the good of the whole community. It requires sharing resources and expertise, as was done in the asthma study.

By developing a shared vision of what our health priorities are, by forming partnerships in our communities to address them, and by employing the use of effective and innovative interventions, we will improve health status in our communities.