
The Future of New York City's Healthcare Networks Post-Pandemic

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October 2021

SUMMARY

QUESTION: HOW CAN NEW YORK CITY REVAMP ITS HEALTHCARE NETWORKS TO BOTH EXPAND ACCESS AND OFFER ENHANCED CARE FOR CITY RESIDENTS?

WHY IMPORTANT:

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1. *Opportunity to improve equality by boosting access to health care in underserved communities*
 2. *Opportunity to reduce racial inequities*

RECOMMENDATIONS:

1. *The New York Governor and New York City Mayor should make a joint appointment of a Deputy State and City Health Commissioner. The person in this new role would be tasked with restructuring the New York health system. By 'combining the financial, regulatory, and persuasive powers' of both tiers of government, this new role should be able to bridge informational and resource divides.*
2. *Reinvest in New York City's public health infrastructure (including epidemiological surveillance, testing, and contact tracing)*
3. *Partner with trusted community and faith-based organizations to help reduce racial disparities in health*
4. *Expand health care access in underserved communities*
 - *Create a new system of localized community health capacity, distributed clinics with primary care, and digitally linked resources to other care networks*
 - *Install new regulations to set parallel standards for public and private hospitals to expand outpatient services in underserved areas (including requirements for hospital systems working alongside community service networks)*



5. *Shift health funding in New York City from hospital systems to primary and preventive care outlets (legislation has been introduced to do so)*

CONSTRAINTS:

1. *Requires state action and support, and coordination with city*
 2. *Expensive to build out health infrastructure*
 3. *Entrenched interests in hospital systems could obstruct plans to shift resources to primary and preventive care outlets, and community-based health organizations*
 4. *Certain communities still have high levels of mistrust in the government on public health issues*
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INTRODUCTION

The Covid crisis exposed the deep weaknesses in New York’s health delivery system, which were long known by health professionals but unseen and unknown by most of the general public. In a post-COVID era, they can no longer be ignored. The famous quote by Winston Churchill applies: “never waste a good crisis.” Out of the harm of the pandemic, we have an opportunity to rebuild and change our health system for the better. The City should focus on four principles:

- Partnership with the State
- Strengthening public health infrastructure
- Reducing racial inequities
- Improving access to care in underserved communities

PARTNERSHIP WITH STATE

In health care, it must be acknowledged that the State is the primary player. It is the policymaker and regulator of both providers and payors, using the authority of the Departments of Health and Financial Services. It is the principal financier of the health care system both through Medicaid and through its authority over private payors.



Refocusing, redefining and restructuring health care for New Yorkers will depend on whether the City can forge collaboration with the State government in ways that has seldom been achieved in the past. About 45 years ago, as Social Services Commissioner, I recommended that the Governor and Mayor make a joint appointment of a Deputy State and City Health Commissioner with a mandate to restructure the system by combining the financial, regulatory and persuasive powers of both levels of government to force change. Because of the State's dual role as regulator and payer, only it has the authority to drive the whole healthcare delivery system into one that provides broader access. In a complementary fashion, the City has significant control over public health. The City cannot solve the wider issue of primary and preventive care access if these agencies are allowed to operate in silos. A joint appointment from State and City can effectively bridge these informational and resource divides. Although tensions always exist between the Governor and Mayor, the current relationship between administrations has reached levels of toxicity that must be mitigated.

STRENGTHENING PUBLIC HEALTH INFRASTRUCTURE

New York City has one the largest, most sophisticated, and lauded municipal health departments in the world. Yet even it was unprepared for a major infectious disease pandemic. We lacked an adequate plan, tested and proven operational mechanisms, and command leadership that prioritized scientific and medical experts. Making it up as we went along and learning on the fly cost lives. Public health fundamentals such as epidemiological surveillance, testing, and contact tracing were woefully inadequate.

We paid a terrible price for decades of underinvestment and hollowing out our public health infrastructure. The next administration should reverse these trends so we are better prepared for the next and inevitable public health crisis.

REDUCING RACIAL INEQUALITIES

While we have decades of research that document racial disparities in health, the pandemic and the broader movement for racial justice has made them impossible to ignore. People and communities of color had disproportionately high level of COVID infections, hospitalizations, and deaths. Lower rates of insurance, less access to care, higher rates of underlying chronic illness, crowded/substandard housing, and being employed in jobs deemed to be “essential” collectively made these



communities more vulnerable. Now, it is the same low income and communities of color that are lagging behind in vaccinations.

Government can't do this alone. There is a significant association between race and levels of personal and governmental trust. We also know through research studies that Black and Hispanic people have high levels of mistrust towards governmental institutional support. Government should partner with community and faith-based organizations that are trusted messengers. This is especially important in low income, minority, and non-native speaking neighborhoods, many without digital access.

IMPROVING ACCESS TO CARE IN UNDERSERVED COMMUNITIES

Communities without sufficient doctors or in-patient clinics are limited to episodic care through emergency rooms at hospitals. Even new Urgent Care Centers have tended to bypass these communities by locating themselves in neighborhoods where residents had commercial insurance.

While the Health & Hospital (H+H) system has been trying to bridge this gap, they cannot do it alone. The Affordable Care Act significantly decreased the number of uninsured New Yorkers, but there still exists a wide gap between NYC H+H (public system) and private hospital's responsibility to the uninsured. The whole healthcare system needs to be embarked on this mission. The next City Administration must focus its efforts on creating a new system of localized community health capacity, distributed clinics providing primary care (both medical and behavioral), and digitally linked resources to the tertiary care networks in underserved communities. Past policies, such as the Delivery System Reform Incentive Payment (DSRIP) program, have illustrated how hospitals are less than ideal distributors of healthcare directly into these communities. The DSRIP experience in the City largely found that, except for a few cases, hospitals, while excellent at providing sick care, have little expertise in community delivery systems. Going forward we have to incentivize hospitals across the city to resolutely reach into communities that don't have access to healthcare. Access ultimately requires location, availability into later evening hours, and cross-training of healthcare providers to best serve the diverse health needs of communities.

Health Care is not just a right. It's a place.

Regulations should set parallel standards for both public and private hospitals to expand their outpatient services to these communities. This would be a requirement and linked to all requests for Certificate of Need (CON) approvals. A condition of this requirement would be for hospital systems to coordinate with community



service networks in order to collaborate on outreach strategies. New outpatient centers and partnerships need to be aggressively advertised to promote the extended care representative of the community's needs.

Our health care system must be rebalanced. Today primary and preventive care receive only 5-7 percent of the health care dollar. The bulk of the dollars go to hospital systems, private and public, which have enormous and expensive infrastructures, political clout (and unionized working forces) and a public image that they are "health care." Hospitals are obviously vital, but they are only part of the health care system - the 'sick care' part. Shifting even a small amount of funding to primary and preventive care would yield big gains in health status. A growing number of States are moving in this direction, and legislation has been introduced for New York to do the same.

CONCLUSION

Health is a linchpin of the City's future. A healthy population can learn, work, and contribute to a thriving metropolis. The City, in partnership, has an opportunity and an obligation to shape and create a public health and health care system that supports its residents and distributes health and opportunity on a fair basis for all. It should use all the carrots and sticks at its disposal and have the courage to create change.

