Testimony
of
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before the
New York City Council Committee on Health
on
Detecting, Preventing, and Responding to Public Health Emergencies

February 19, 2025
City Hall
New York, NY

Good morning, Chair Schulman, Chair Moya and members of the Committee and subcommittee. I am Dr. Michelle Morse, Acting Commissioner of the New York City Department of Health and Mental Hygiene. I am joined here today by my colleague Vasudha Reddy, Deputy Director of the Bureau of Communicable Diseases. Thank you all for the opportunity to testify on New York City's response to public health emergencies.

Together, New York City lived through the collective trauma of the last major public health emergency—we know the stakes are high. But the New York City Health Department has been responding to public health crises since our founding 220 years ago. Crisis response is at the heart of what we do in public health—but each emergency is different. Our city and our agency have learned many lessons since the first case of COVID-19 was confirmed nearly five years ago in New York City.

In 2022, following both the COVID-19 and mpox emergencies, the NYC Health Department committed to improving its emergency preparedness. And in light of the significant racial inequities we saw in health outcomes during the height of the pandemic, we understood that we needed to prioritize equity in our strategic planning.

We started by building a shared definition of equitable response readiness with the input of more than 1,000 Health Department staff. The next step was building a blueprint for a response that embeds equity, trust, agility, and resilience into the agency's architecture. Over the next few years, we will be implementing that blueprint across our agency.

When the next emergency hits, this blueprint will ensure we have what it takes to prioritize disproportionately impacted communities; collect, analyze, and share public health data in as close to real time as possible; and—crucially—to operate as part of a larger public health system with partners at all levels of government: local, state, national, and international.

I underscore that last point because public health is global: communicable disease is not constrained by borders. From HIV to COVID-19, we have seen time and again just how quickly local public health challenges can become global health crises.

Our Health Department has a strong system of disease surveillance**,** which is a population-level practice of data collection and analysis. Surveillance systems are used to establish and monitor patterns of disease, identify outbreaks, and inform strategies for prevention and control.

That larger system is paired with the work of disease investigation: the process of collecting information about a person or a group of people who have suspected or confirmed cases of infectious disease. Investigations can include interviews with the impacted person and their healthcare provider, reviews of medical records, and contact tracing.

Those systems, however, are reliant on national and global public health infrastructure. We need timely and accurate information from the Centers for Disease Control and Prevention. We rely on the World Health Organization for access to their comprehensive surveillance of both routine and emerging public health threats around the world. New York City is the largest hub of international travel in the United States. We cannot afford to operate in a vacuum.

Here at the Health Department, we will continue to rely on data, science, equity, and our values to guide our decisions. We have 220 years of experience deepening our public health expertise, refining our data-driven approach, and engaging the public. For as long as this agency has existed, we've protected the health and safety of our city, supported by factual information grounded in science. We remain committed to those principles.

There have been a lot of announcements and policy changes coming from the new federal administration, especially around federal funding. We are monitoring federal policy closely as it develops and planning accordingly. Approximately 20 percent of our budget is federally funded. That amounts to 600 million dollars, the majority of which go towards infectious disease control and emergency preparedness. We expect the federal government to honor the commitments that it made through grant agreements and contracts that fund vital public health services benefiting New Yorkers.

As we prepare for unknowns in federal public health funding and possible changes in federal public health guidance, we will become more reliant on state and local dollars. Right now, New York City is also operating on reduced funding from the state.

Article 6 determines the state's contribution to public health services provided by local health departments. In 2019, New York City's matching funds for Article 6 were reduced from 36 percent to 20 percent. We were the only local jurisdiction to have our public health funding cut.

In the years since, we have lost upwards of 90 million dollars a year in state public health funding. Yes, 90 million dollars. This is not just an issue of parity with the rest of the state, it's an issue of health equity. New York City has the largest population of Black, Latino, Indigenous, and people of color in the state. We are also home to the most individuals with low incomes and the largest portion of Medicaid recipients in New York. These are our neighbors, loved ones, colleagues, and friends.

Regardless of the federal context, our residents deserve equal access to New York State public health funding. Given the vulnerability of our federal funding, this issue has never been more important or timely.

To be able to meaningfully promote and protect the health of New Yorkers—as my agency is charged to do—we need consistent and sustainable funding sources. In public health, we often see a 'boom and bust' cycle of funding, where money swells during emergencies and dries up in the intervening years. We do not invest in public health prevention—we invest in our sick care system.

As I mentioned at the start of my testimony, the New York City Health Department was founded in a moment of crisis 220 years ago. The Board of Health first convened in response to a Yellow Fever outbreak in 1805. For the next 50 years or so, the city only devoted time and money to public health in moments of crisis. The organization would otherwise lie dormant.

We now know that public health works best *as* preventative health. The Health Department's work creates an invisible shield that keeps New Yorkers safe. That is life-saving work, and it extends far beyond emergency response. It has a tangible impact on the everyday health and longevity of our community. It requires, however, a sustained investment.

In 1913, then-Commissioner Hermann Biggs said: "Public health is purchasable. Within natural limitations, a community can determine its own death rate." In other words, we can literally buy ourselves more health and time. And over the course of history, we have.

When Commissioner Biggs led the Health Department, life expectancy for New Yorkers was in the late forties. Now, it's well over 80. Through investments that have created leaps forward in public health science and interventions—like clean water, vaccines, and improved sanitation—we've bought ourselves decades of more life.

Those investments fund a matrix of work happening across our city each and every day. More than 7,000 people work at the Health Department, and all of them work for more than 8 million New Yorkers in one way or another.

For example:

To prevent food-borne illness, we inspect more than 30,000 food service locations for food safety—including restaurants, school cafeterias, and food trucks.

To ensure every child in New York City has access to vaccines, we distribute more than 2.5 million doses of pediatric vaccines to more than a thousand different healthcare providers.

To prevent the spread of disease, we conduct thousands of disease investigations related to certain sexually transmitted infections, food-borne illnesses, waterborne illnesses, and other infectious diseases.

To prevent overdose deaths, we distribute more than 300,000 naloxone kits and more than 54,000 fentanyl test strips.

To meet New Yorkers where they are and build trust on the ground, we've equipped more than 5,000 community health workers to join our Public Health Corps.

To support parents who are pregnant or have young children, we've provided more than 20,000 families with nurses, doulas, and community health workers.

To support people who do not want to be pregnant, or those who cannot safely carry a baby to term, we've fielded calls from more than 8,000 people at the Abortion Access Hub.

Lastly, to celebrate the joy of a new birth or mourn the loss of a loved one, we issue more than a million birth and death certificates annually.

That's just a glimpse of our work.

No matter what lies ahead, our efforts will continue to be driven by data, science, and health equity. We will defend the health and wellbeing of every New Yorker regardless of race, gender identity, socioeconomic status, ability, or ZIP code. And we will continue to work towards longer, healthier lives for all our city's residents. When you invest in the Health Department, that's what you're investing in.

Regardless of whether we're in a period of public health emergency, our work touches every aspect of New Yorkers' lives—quite literally from birth to death. I am so proud to serve New York City, where we are committed to upholding the full spectrum of public health services and ideals, where we declared racism a public health crisis, and where we remain committed to racial equity in all facets of our work citywide. Especially in a time where trust in government may be fragile, we owe it to New Yorkers to keep doing this work.

As a practicing physician, I am inherently asking every patient I care for to trust me with their life. That trust cannot be given, it must be earned. Trust is gained in drops and lost in buckets. The NYC Health Department is committed to gaining your trust drop by drop.

For more than two centuries, we've been the pinnacle of public health in the United States. That should not change now. Thank you, Chair Schulman, Chair Moya, and members of the committee and subcommittee, for your ongoing partnership and support. I'm happy to answer any questions.