Introduction

Public Health and the American City

The names of great scientists and healers are carved on the facade of 125 Worth Street in lower Manhattan, a frieze of the familiar, the vaguely remembered, and the forgotten: Hippocrates, Pasteur, Jenner, Lister, Koch, Nightingale, Shattuck. Bronze medallions depicting allegories of health adorn the exterior walls of the imposing ten-story structure, built in art deco style with New Deal funds during the Great Depression. The building occupies an entire block on Foley Square, a short walk north of Wall Street, City Hall, and the site of the former World Trade Center. It houses the headquarters of the New York City Department of Health. Its placidly monumental appearance belies the heated clashes that have taken place over the years in front of and within its walls: a protest in 1970 at which twin rows of marchers, pro and con, faced off over health code regulations that would prevent abortion—legalized in New York State only a few months earlier—from being performed in the offices of private physicians; a public hearing five years later where, as the city collapsed into insolvency, citizens angrily demanded the ouster of the commissioner because of his proposed cutbacks to community health services; a raucous piece of street theater on the building’s front steps in 1991 where AIDS activists chanted and shook canisters of used syringes like giant maracas to protest the city’s failure to support needle exchange programs.

This book is about public health in New York City in the last decades of the twentieth century. It tells the story of how the nation’s first and in many ways preeminent local health agency sought to limit death and disease and promote the well-being of city residents. The department’s employees—several thousand professionals from diverse backgrounds serving a city of some eight million residents—are the central figures in this story. They are surrounded by a supporting cast of individuals and groups who influenced public health in the city: elected officials at the
local, state, and national levels; nongovernmental organizations devoted to health and social welfare causes; community activists; doctors in private and hospital practice; researchers and academics; business leaders; employees of other city agencies; and journalists.

New York, like most large American cities, has confronted a remarkably complex array of health threats in recent decades: new and reemerging contagions such as HIV, tuberculosis, and West Nile virus; chronic conditions such as obesity and tobacco-related illness; unhealthy consequences of the built environment such as lead poisoning and asthma; and problems symptomatic of social deprivation and inequality such as violence, homelessness, and illicit drug use. Public health professionals draw upon diverse technical bases to tackle these problems, including epidemiology, statistics, medicine, nursing, law, and the social and behavioral sciences. Good public health practice depends on the appropriate application of methods derived from these disciplines. But intervening to prevent disease also raises questions that transcend technical expertise and involves issues of ethics, values, and priorities. Whether—to take an example from later in this book—a program to identify and notify the sexual and drug-sharing partners of HIV-infected people represents an unacceptable violation of the privacy of stigmatized groups is a question that cannot be answered (adequately) by referring to an “evidence base.” Further, public health often involves moving ahead in the face of incomplete or conflicting scientific information, and the consequences of a course of action cannot always be accurately predicted when it is undertaken.

The questions that run through this book have to do with how public health programs were created and implemented in New York City during these years: What social and political factors influenced policies and practices? How were goals determined, and what forces were barriers or facilitators to meeting them? Which actors were most influential, and what strategies did they use to advance their interests? What were the major challenges to achieving a healthy city?

The answers to these questions are not as straightforward as might be assumed. A central premise of this book is that public health practices are not just the result of initiative from within the profession, nor are they solely determined by dispassionate evaluation of empirical data. To begin with, a problem must be defined as falling within the purview of public health (as opposed to being, for example, an issue of individual responsibility, the marketplace, or criminal justice). Public health professionals—influenced by the diverse constituencies described earlier—then make a series of decisions, not always explicitly acknowledged, about how resources of money, time, and effort should be allocated. Of problems thought to be appropriate targets, not all are deemed signifi-
cant or urgent; some solutions are seen as realistic and feasible, others not. Funding for city public health programs, which comes from local taxes, state and federal aid, and external grants, rises and falls from year to year. Because health is woven into so many aspects of the city’s life, the potential reactions of affected communities must be taken into account, and even relatively small-bore interventions may have unintended or unwanted consequences.

This book posits that public health issues do not have fixed or self-evident meanings. Rather, interest groups and individuals shape and define the significance of diseases and risks by selecting relevant facts to emphasize and publicize, assigning blame and accountability, and designating authority for solving the problem. Popular perceptions of threats to the public health are influenced—and often distorted—by the anxieties, misapprehensions, and psychological biases people bring to the task of assessing risks. Rare or exotic risks such as tropical illnesses seem more alarming than quotidian or banal ones such as automobile accidents, for example; risks that are involuntary are more disturbing than those willingly taken.

An additional premise of the book is that the shaping of a city’s public health agenda, like government policymaking more generally, is a fluid, manipulable process in which varied actors may be influential at different moments. The health commissioner and his or her top deputies may drive the agenda, but so may people outside the department with different priorities and goals. These actors select from an array of potential policy approaches—the public health “tool kit” ranging from persuasive measures such as mass media education and social marketing to more coercive interventions such as quarantine or regulation of property or commerce. People involved in these processes take advantage of windows of opportunity, such as a perceived state of epidemiological, fiscal, or moral crisis, to advance a particular course of action.

In sum, public health practice, while rooted in science, is an inherently and necessarily political enterprise. To be sure, views about public health do not map neatly onto liberal or conservative ideologies. But to the extent that public health entails collective rather than individual responses to illness, its activities inevitably raise questions about how government should act on behalf of citizens. The field’s nineteenth-century pioneers in the United States and Europe embraced the idea that improving the health of populations was a political, social, and economic undertaking as much as a medical one.

This account is not an institutional history, although it is concerned with internal processes of decisionmaking, program development, and implementation; nor is it an exhaustive chronicle of all the Health Department’s activities, which are far too varied and extensive to be cata-
logged in a single volume. Rather, this book highlights a series of critical episodes over four decades that illustrate the varied factors shaping public health actions and outcomes.

**Defining Local Public Health**

Local health departments play a critical—though often invisible—role in the life of American cities. They are the linchpin of the public health system in the United States, limiting disease and promoting well-being in the city or county they serve and conveying critical information to their counterparts at the state and federal levels.

Ask a cross-section of big-city residents about public health, and most will give vague expressions of approval without a precise understanding of what they are supporting. Many laypeople equate public health with free clinics for the poor. This perception is ironic, since providing clinical services represents only a small part of the field’s mission, and many within the profession have long argued that it should not be in the business of curative medicine at all. Public health is distinct from what is generally thought of as “health care” in two key respects: its focus on the prevention of illness rather than cure, and its intervention at the level of populations rather than individual patients. While government agencies play a lead role, public health also comprises various research and service activities carried out by private philanthropies, nonprofit community-based organizations, and academic institutions. “What we, as a society, do collectively to assure conditions in which people can be healthy” is how the Institute of Medicine, which published comprehensive reports on the subject in 1988 and 2003, defined the field.

Given this expansive—indeed, potentially unlimited—scope of work, it is not surprising that the profession is poorly understood and has been criticized for lacking a coherent vision. Jonathan Mann, a pioneer in linking medicine with human rights, memorably described public health as “a little bit of everything and not enough of anything.”

This diffuse mission has its roots in the mid-nineteenth century, when physicians, housing reformers, advocates for the poor, and scientists trained in new techniques of chemistry and civil engineering came together to fight problems growing out of urbanization and industrialization. The first public health crusaders, working with local and state governments, established regulations over such diverse aspects of civic life as the production and distribution of meat and milk, tenement construction, garbage collection, private and public privies, “noxious trades” like slaughterhouses and tanneries, and reservoirs and water supplies. Local health departments at the level of village, town, city, or county were first established in this country in the urban Northeast, where these problems arose most urgently. New York, Boston, Providence, Philadel-
Philadelphia, Baltimore, and New Haven developed early and activist health departments with dynamic leadership. Laws and regulations were important tools for limiting threats to the common welfare. The unlikely professional alliance that gave rise to public health soon splintered, with profound consequences for the subsequent evolution of the field. Especially significant was the break, in the early twentieth century, between doctors in private or hospital practice and those working in government. The former, represented by their increasingly powerful lobby, the American Medical Association (AMA), claimed authority over the domain of patient care and vehemently opposed any initiative to provide clinical services in the public sector. The notable exception was care for expectant mothers and their infants, an area where public health doctors had established a strong base of expertise. Local health departments were also left with responsibility for a few necessary but unglamorous categories of care that the medical profession disdained to provide: services for the indigent, treatment of sexually transmitted diseases, and control of once-epidemic but rapidly dwindling contagions such as tuberculosis and smallpox.

As preventive practices such as routine physicals became common in the 1920s, public health officials clashed with doctors in private practice over who should deliver these services. Ambitious health departments in several cities, including Milwaukee, Cincinnati, Pittsburgh, and New Haven, sought to create networks of community-based health centers that would provide government-supported care for their poor populations. Opposition from local medical societies, combined with a lack of support at the level of city government, scuttled most of these experiments in what critics labeled “socialized medicine.”

It was during these years that the dichotomies that have defined American health care ever since would take shape: curing illness was emphasized over preventing it; the individual rather than society was seen as the proper focus of intervention; and the private marketplace had primacy over the public sector. The heterogeneous public health workforce of doctors, nurses, epidemiologists, and educators claimed a more enlightened, sociologically informed view than the narrow focus of biomedicine, and some of the profession’s activist members sought to advance an environmentally focused approach that gave greater responsibility to the government. But their lack of political influence constrained their ability to shape the institutional landscape of health. Meanwhile, some of the sanitary activities for which health departments had been responsible, such as garbage collection, air pollution control, and noise abatement, were pulled under the aegis of other professions and government agencies.

In 1940 the American Public Health Association (APHA) passed a resolution codifying the standard repertoire of services that a local health
department should provide—what became known as the “basic six.” Health departments were responsible for collecting vital statistics, including birth and death rates and the incidence and prevalence of significant diseases. They were to control communicable diseases with methods such as outbreak investigations, contact tracing, partner notification, and (rarely) isolation and quarantine. They were charged with ensuring environmental sanitation in areas such as the municipal water supply (though, as noted earlier, these duties were sometimes housed in units of government other than health). They had responsibility for providing the laboratory services needed for the diagnosis of illnesses by private doctors, hospitals, and other clinicians. They were charged with providing maternal, infant, and child health services, such as education of expectant parents, prenatal checkups, immunizations, and well-baby screening. Finally, they were to provide education, through brochures, posters, pamphlets, and other mass media, to promote healthy behaviors.¹⁷

Although services were to some extent standardized along these lines, there was interstate variation—as in so many aspects of policy and politics in the United States, what local health departments actually did depended on the vagaries of state and local statutes and funding streams. Some departments offered a more limited range of programs, while others took a role in issues, such as housing, that lay outside the basic six.¹⁸ Jurisdictional arrangements varied widely, with local health departments being responsible for a single city, a county, a region, multiple cities or counties, or some combination of these. State-level authority differed as well: some state departments provided no direct services, instead delegating all such work to local units, while others had highly centralized systems largely controlled in the capital.¹⁹ On the whole, the growth of local public health was halting and uneven: as late as World War II, one-third of the U.S. population lived in an area that was not served by a full-time health official.²⁰

The primacy of local and state responsibility for public health was partly a function of the U.S. constitutional system, which delegates authority to states, and partly the result of long-standing antipathy to federal power. The U.S. Public Health Service, which originated to police the nation’s ports against imported contagions, had evolved little since the early republic, while the Surgeon General, ostensibly the nation’s chief health officer, had scant authority (though a few of those who held the position used the office’s bully pulpit effectively). The first national board of health was created in 1879 in response to an epidemic of yellow fever in the Tennessee Valley, but it proved politically unsustainable and soon fell victim to sectional power struggles.²¹ An ill-fated effort by reformers to reestablish a national board in 1913, at the height of Progressive Era faith in rational government, united in successful opposition an unlikely congeries of anti-statist activists and medical liberty groups.²²
When it was finally cobbled together in 1953 from a disparate assortment of federal agencies, the Department of Health, Education, and Welfare (DHEW) embodied political expediency more than any coherent vision of a healthy nation. The DHEW, subsequently renamed the Department of Health and Human Services (DHHS), came to play an increasingly important role in local health through grants to states and cities. So did the Center (later Centers) for Disease Control and Prevention (CDC) in Atlanta, the nation’s chief public health authority, established in 1946 as an outpost of the nation’s malaria eradication effort in the South. Nevertheless, local health departments occupied a critical niche on the front lines of the battle—as their work was often conceptualized—for healthy communities.

Eight Million Lives

The New York City Health Department, like the metropolis it serves, has always been paradoxical: it is at once prototypical and unique. On the one hand, its history encapsulates virtually all of the major epidemiological challenges faced by its peer agencies around the country. It has established pioneering programs in many areas, including health education, public health nursing, well-child care, and infectious disease control, which have served as models for other cities and states.

At the same time, New York City’s size, diversity, and status as a global crossroads set it apart. In the decades after World War II, the city’s population ranged between seven million and eight million—greater than the population of all but a handful of states. The city encompasses extremes of wealth and poverty, with some of the richest and poorest census tracts in the country. Overall it is politically liberal, but it includes swathes of relative conservatism, including largely residential areas of Queens, Brooklyn, and Staten Island, where residents often look with suspicion on the political and financial elites of Manhattan. Its racial, ethnic, linguistic, and cultural heterogeneity outstrip any other big city in the nation.

As a result of this complexity, “doing public health” in New York City has always presented exceptional challenges and opportunities. The Health Department operates with unusual autonomy from the rest of the state, enforcing a health code that supersedes state regulations in many areas; state health commissioners in Albany have often cast envious eyes down the Hudson River at the powers wielded at 125 Worth Street. Just as New York City, which holds some 40 percent of the state’s population, has always overshadowed “upstate” in the political arena, so has its Health Department been the tail that wagged the dog.

New York City’s—and the nation’s—first permanent Board of Health was created by the state legislature in 1866, largely in response to chol-
era, a recurrent scourge of nineteenth-century urban centers. The board had nine members, including the mayor, the chief health officer, and—reflecting the strong regulatory character of the era’s public health—the four police commissioners. In 1870, as part of a sweeping reform of the city charter, the Department of Health was created as one of ten new units of city government. The department’s work was divided among four bureaus: Sanitary Inspection, Street Cleaning, Records and Inspection, and Sanitary Permits. (Street Cleaning was transferred to the Police Department in 1873 and placed in a newly created Department of Sanitation in 1881.) The nine-member Board of Health remained responsible for overseeing the department’s activities and the content of the sanitary code; in a victory for home rule, the four members previously appointed by the governor were now to be mayoral choices.

While cholera provided the spur for the creation of the new agency, the problems it faced were multifarious. What had been in 1800 a town of 60,000 residents concentrated on the southern tip of Manhattan had become by the 1860s a sprawling metropolis of more than 800,000. As new arrivals jammed into slums, filth and contagion spread, resulting in the human misery famously documented by reformers such as Jacob Riis. Dead horses, human and animal excrement, and every type of refuse clogged the city’s streets. While much of the department’s sanitary work disproportionately benefited the poor, it visibly, often dramatically, improved the quality of life in the city for all classes.

These efforts were not without skeptics. Many business owners bristled at being forced to abide by sanitary regulations. Citizens who doubted the safety and efficacy of smallpox immunization often fled when the squad of vaccinators descended—with police accompaniment—on their neighborhood. Muckraking reporters charged, sometimes legitimately, that Tammany Hall was packing the department with patronage appointments. But the public and politicians alike came to accept both the new department and the broader principle it represented: that preventing illness was an acceptable rationale for government to intrude on commerce and private behavior.

During the bacteriological revolution of the late nineteenth century, the department became a national leader in translating breakthroughs in the understanding of disease etiology into interventions that benefited the people. The emblematic success story of this era was the department’s campaign to save children from diphtheria. The department’s Division of Pathology, Bacteriology, and Disinfection, newly established in 1892 with a staff of twenty-five working out of two small laboratories, gained swift renown for manufacturing the first antitoxin to treat the ravages of the disease. Department physicians then fanned out across the city to get the antitoxin from the laboratory into the arms of sick children. When city aldermen were slow to appropriate money for the cam-
paign, department leaders secured private funding and then partnered with reporters at the Herald on a series of human interest articles to dramatize the problem and its solution. The diphtheria effort was a model of the skillful deployment of science in the community.

The driving force behind that effort was Hermann Biggs, the first head of the bacteriology laboratory. Biggs went on to even greater success leading the department’s multipronged attack against the era’s greatest killer, tuberculosis. His efforts showcased the range of instruments in the public health tool kit: compulsory reporting of cases by physicians to a central registry; free bacterial diagnosis of sputum samples; hospitalization of the sick; and home visits by sanitary inspectors to ensure healthy conditions and instruct patients and their families on how to prevent the spread of the disease.

Biggs, though he never served as commissioner, was a towering figure in the department’s early history. He successfully advanced an openly paternalistic vision of public health authority, and while he preferred to achieve his goals through suasion, he had no qualms about invoking government’s coercive hand against “recalcitrant” patients or uncooperative physicians. “The government of the United States is democratic,” Biggs wrote in 1897, “but the sanitary measures adopted are sometimes autocratic, and the functions performed by sanitary authorities paternal in character. We are prepared to introduce and enforce measures which might seem radical and arbitrary, if they were not plainly designed for the public good, and evidently beneficent in their effects.”

In 1905 Biggs originated the axiom that soon became the unofficial motto of local and state health departments around the country: “Public health is purchasable. Within natural limitations a community can determine its own death rate.” Yet generations of public health professionals would discover, to their frustration, that feckless communities often preferred to spend their money on other things.

During the Progressive Era, the porous boundaries between medicine, public health, and social welfare led to protracted debates in New York City (as elsewhere) about the role of the Health Department. Healthy babies were a preoccupation of the era’s reformers, and the special value that children held in the nation’s future well-being enabled the department to carve out a niche in the care of infants, children, and expectant mothers. What began as outposts providing pure milk quickly expanded into a network of child health stations offering a range of well-baby services; in 1908 the department established the Division of Child Hygiene—the nation’s first—under the leadership of S. Josephine Baker, a formidable physician and social reformer. Baker hired a corps of dozens of nurses who made home visits to poor mothers to instruct them in proper methods of care.

Efforts to provide a broader range of clinical care for the general pop-
ulation, however, met with less success. Two commissioners during the 1910s, S. S. Goldwater and Haven Emerson, drew up far-reaching plans to establish community clinics that would bring medical and social services, housed under one roof, to the city’s poorest neighborhoods. An initial district was established on the Lower East Side, the notoriously crowded slum with some of the city’s worst health statistics; additional demonstration projects were started in other poor neighborhoods over the next two decades, often backed by support from private philanthropies. But a full-fledged expansion of publicly funded care for the poor remained blocked by the opposition of private doctors and the inertia of city government. When Mayor James J. Walker created the city’s Department of Hospitals in 1929, uniting under one umbrella eighteen public institutions that had previously been run by the Department of Health and other city agencies, including the Department of Public Welfare, the move both reflected and reinforced the growing institutional separation of prevention from treatment. It also enshrined the inpatient stay rather than ambulatory services as the dominant form of health care.

Although the well-being of many New Yorkers suffered during the financial and material hardships of the Depression, the city’s health infrastructure improved during the decade, owing to Mayor Fiorello La Guardia’s enthusiasm for public health and his skill at steering New Deal relief money into the city. Millions of dollars from federal programs such as the Public Works Administration (PWA) and the Works Progress Administration (WPA) funded expansions of programs ranging from air quality improvement to mosquito control. The Health Department’s major building program under La Guardia resulted, by 1940, in the new headquarters at 125 Worth Street (see figure I.1) along with fifteen new district health centers and nine new baby health stations.

It was during this period that plans originated years earlier by Goldwater and Emerson to create “health districts” came to partial fruition. By dividing the city into thirty areas of about 200,000 residents each, the department could tailor services to the needs of particular neighborhoods, which varied widely in the socioeconomic status and (not coincidentally) the health outcomes of residents (see figure I.2). The health centers that served each district had doctors and nurses on staff, but they were not clinics in the traditional sense: beyond treatment for tuberculosis and venereal disease, they did not provide medical care. Instead, they were centers for education, prevention, and data gathering. The staff counseled district residents about health issues, offered screening and limited diagnosis, and collected statistics about the district. The centers served as a base for nurses who made home visits in the district and for physicians who worked in the area’s schools; many of the buildings also made space available for community-based welfare and social service organizations serving the neighborhood. Anyone found to have a med-
Figure I.1  Headquarters for Health

Source: Courtesy New York City Department of Health and Mental Hygiene.

Note: The Health Department headquarters at 125 Worth Street, a few blocks north of City Hall in lower Manhattan. The building was constructed with New Deal funds during the Depression and also housed the city’s departments of hospitals and sanitation.
ical condition requiring treatment was referred elsewhere: those who were able to pay were sent to private physicians; those unable to pay were sent to the outpatient departments of the city’s public hospitals.

By midcentury, the city’s population had peaked at just under eight million, and the department’s staff had grown to some 4,800. From four divisions in 1866, it had expanded to encompass a wide range of specialized functions and technical approaches. The department’s five divisions and twenty bureaus handled everything from blood drives to restaurant inspections, from prenatal care to cardiovascular screening for the elderly. Its leadership had become far less confrontational than it had been in the era of Biggs; it accommodated powerful interests while excelling within the relatively narrow sphere of the basic six functions. It created a special ambulance service to speed premature babies to the nearest well-equipped care facility, established a poison control hotline, created the Bureau of Nutrition in recognition of the increasing importance of non-infectious sources of illness, and set up a research arm to investigate emerging epidemiological problems.

Programs such as these flourished under the dynamic leadership of Leona Baumgartner, whose savvy networking among the city’s political, medical, and business elites made her the model of a modern health commissioner. Baumgartner maintained close rapport with Mayor Robert Wagner and never missed an opportunity to remind him of the many ways in which Health Department programs benefited city residents. She had a keen eye for photo opportunities and provided good copy for the local papers, whether giving Elvis Presley a polio shot or heaving a shovel of dirt at the groundbreaking for a new health center.

By the time Baumgartner stepped down in 1962, the department had come to be known within the profession as the “gold standard” among local health agencies nationwide. Some of this vaunted reputation can be attributed to skillful mythmaking on the part of an organization that always recognized the importance of good public relations and did much to celebrate its achievements in its publications and through the local media. But this reputation cannot be dismissed as mere puffery. The department had had more than its share of commissioners and senior staffer members—Biggs, Baker, Goldwater, Emerson, Baumgartner, and many others—who were innovators of national importance; its peer agencies around the country looked to New York City for guidance and inspiration.

It is important, however, to keep the department’s very real successes and storied history in perspective. In terms of funding and prestige, public health remained a distinctly second-tier activity within the American health care system, receiving far less government support and popular recognition than clinical medicine. This was as true in New York City as anywhere else. The city had a vast and complicated health sector
Source: Courtesy New York City Municipal Archives.
Note: In the 1930s, the Health Department divided the city’s five boroughs into thirty health districts of about 200,000 residents each for purposes of data gathering and analysis, planning, and program delivery.
that included the largest public hospital system in the country, academic medical centers for research and teaching, and wealthy private institutions for patient care. In this environment, even a health department as successful and well regarded as New York’s could not help being overshadowed. The position of the department within this web of power and influence had much to do with how public health got done in the city.

From the War on Poverty to the War on Terror

The years covered in this book—the 1960s through the early 2000s—were a turbulent and difficult period for public health in the United States and in New York City in particular. Shifting patterns of disease dovetailed with transformations in society and politics to create unprecedented challenges for the city’s Department of Health.

By the 1960s, advances in vaccination and environmental sanitation had dramatically reduced many of the contagions that had been the major focus of public health work for decades. The Health Department’s 1962 annual report confidently declared that the nation was “at the end of the great era of the battle against infectious disease.” The hubris of this statement was soon evident: contagious diseases were far from banished and would return with a vengeance in forms both familiar (tuberculosis) and novel (HIV). More accurate was the department’s prediction that “we are entering the great era of cold war against chronic diseases for which we do not have biologic cures.” But as public health attempted to shift its focus to “lifestyle” conditions related to consumption—morbidity attributable to diet, exercise, and use of licit and illicit substances, among others—it would find these conditions to be far more intractable, and the methods for preventing them far less straightforward, than had been the case with controlling contagions.

At the same time, the social turmoil of this era upended traditional relationships between citizens and the elite professional and governmental institutions that were supposed to serve them. With the rise of feminism, patients’ rights, consumer activism, and the many other social movements that followed in the wake of the civil rights struggle, members of affected communities began assertively, sometimes bitterly, to contest the decisions of public health professionals. Activists mobilized around issues of race, gender, and sexuality and charged that those responsible for protecting the public’s health were complicit in a system of oppression fundamentally inimical to health. In the years during and after the Vietnam War and Watergate, public trust in institutions and authorities—the government, the military, the education system—plummeted, and the health professions were not spared.34

Coinciding with these social transformations were changes in the na-
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ontional political scene. The federal government grew dramatically beginning in the 1960s, carving out new roles in the regulation of commerce and industry and creating vast new entitlements involving health and social welfare spending. Beginning with the legislative “big bang” of the Johnson administration that brought forth Medicaid, Medicare, community mental health centers, and a host of other programs, the health care arena was transformed. While new sources of funding made possible the expansion of some public health initiatives, they were hardly an unalloyed benefit for the profession: increasing federal expenditures on hospital care and medical technologies reinforced the paradigm of curative medicine and further overshadowed the role of prevention. The accretion of power in Washington, D.C., also laid the groundwork for the backlash of the Reagan revolution and a new era of fiscal austerity and small-government ideology.

These were difficult years for local health departments around the country. In 1977 a survey found “an unevenly operative public infrastructure of community and personal health services— understaffed, underfunded, and widely ignored.” Eleven years later, when the Institute of Medicine examined the state of the nation’s public health infrastructure, its report was a grim catalog of inadequacy: “disorganization, weak and unstable leadership . . . hostility to public health concepts and approaches, outdated statutes, inadequate financial support for public health activities . . . gaps in the data gathering and analysis . . . lack of effective links between the public and private sectors.”

New York City’s Department of Health faced acute problems during these years. The city’s fiscal travails were the most notorious and paradigmatic of the “urban crisis” that gripped many large cities around the country, especially in the Rust Belt and the Northeast. Beginning in the administration of Mayor Lindsay, the city’s economic position deteriorated amid increasing social unrest and racial and ethnic polarization. These economic woes culminated in the city’s infamous insolvency in 1975. With layoffs in the thousands, the city’s public health infrastructure was especially hard hit, and the budget slashing undertaken in these years had consequences that were still being felt decades later. At the same time, the city continued to be disproportionately affected by severe and intractable health issues. Epidemiological, social, political, and economic forces—extending far beyond the walls of 125 Worth Street—created the public health challenges that are the subject of this book.

At the beginning of the twenty-first century, public health was given high priority in the city under the new mayor, Michael Bloomberg, who hired an innovative and sharp-elbowed health commissioner, Thomas Frieden. The ambitious policies and programs in recent years, coming after more than three decades in which the Health Department struggled
to overcome severe constraints, might be seen as a renewal of sorts. But casting the events in this book as a teleological narrative of “decline and rebirth” is an oversimplification that obscures as much as it explains. Rather, events since 1965 provide illuminating examples of both successes and failures—however variously these events may have been defined by the many individuals and groups concerned with public health in New York City.

This book is a work of narrative history—a story, or collection of stories, that seeks to convey the texture and detail of what it was like to address public health issues in a particular place and time and to understand why specific actors made the choices they did. Although it is informed by theoretical constructs drawn from the social sciences related to the definition of public problems and the setting of policy agendas, it remains grounded in the particularity of history. Whatever this approach may sacrifice in terms of generalizability to other jurisdictions and other eras, my hope is that a richer understanding of an individual case will compensate for this limitation.