

JAMES COLGROVE

Reform and Its Discontents: Public Health in New York City During the Great Society

The health-care system was one of the most visible and contentious battlegrounds on which the social conflicts of the 1960s unfolded. To an unprecedented extent, health status—especially the stark disadvantage in access and outcomes for racial and ethnic minorities and the poor—became an object of public and governmental concern during the Great Society era, as clinicians, community activists, politicians, and policy-makers sought to create new models of medical care that were more equitable and efficient than those of the past. The social science theories that informed the ambitious programs of Lyndon Johnson’s administration gave an imprimatur to the idea that illness was both cause and consequence of the “cycle of poverty.”¹

The ferment of this period raised fundamental questions about the place of public health in American society. For most of the twentieth century, the public health profession, concerned with prevention rather than cure and population-level analysis rather than patient care, was institutionally weak compared with organized medicine, and it struggled to advance a community-focused mission in a civic culture that privileged individualism, the free market, and limited government. In the latter half of the 1960s, grassroots mobilization, coupled with federal and state commitments to health care for the poor, opened a window of opportunity in which public health professionals could argue that their field, by virtue of its unique perspective and experience, had a special role to play in health reform. But the social and political conditions that created this opening also served as countervailing forces that limited what was possible in the new environment.

Nowhere was this landscape more unsettled than in New York City, which had a long tradition of innovative public health activities. In the mid-1960s, the city became, in the words of an economist who advised Mayor John Lindsay's administration, "one of the country's chief laboratories" for testing a "commitment to the use of the public authority to accomplish social change."² As part of an effort, now largely forgotten, to rationalize the city's massive and unwieldy health bureaucracy, the Department of Health was consolidated into an omnibus agency that linked it closely with the city's powerful medical and hospital establishment. Department employees sought to use new funding streams and a more open social climate to advance an expansive vision of public health, and forged new relationships with doctors and community members, the two constituencies that had historically bounded their mission. But their efforts at reform were caught between political and economic pressures from "above" and radical resistance from "below."

The social policy innovations of the War on Poverty and the Great Society have been the subject of extensive historical analysis.³ But this literature has given little systematic attention to the health-care arena and virtually no consideration to the role of public health.⁴ The debates over the appropriate sphere of public health provide a unique vantage from which to gain a fuller understanding of key transformations in American society in the 1960s: the shifting relationship between citizens and government; the expansion of legislative efforts to address the problems of the poor and disadvantaged; the development of a discourse of "rights," including the right to health; and the erosion of paternalistic notions of expertise, especially medical authority. This brief but pivotal chapter also sheds new light on challenges that still define the health-care system, as policymakers continue to debate the place of prevention within the country's technocratic and curatively oriented medical regime.

The Divergence of Public Health and Medicine

The professional and conceptual borders between public health and medicine were erected early in the twentieth century as clinicians in private or hospital practice diverged from sanitary reformers and laboratory-oriented bacteriologists in the public and voluntary sectors. As Allan Brandt and Martha Gardner have argued, the American health-care system was thus shaped by "the division of labor, the differences in theories and skills, and the balance of authority and politics between these two fundamentally related fields."⁵ Physicians, represented by their increasingly powerful lobby,

the American Medical Association, claimed authority over the domain of patient care and vehemently opposed moves by municipal and state health departments to provide clinical services.⁶ As preventive practices such as routine physicals became common in the 1920s, public health officials clashed with doctors in private practice over who would deliver these services. These tensions crystallized in the debates over the publicly funded maternal and child health programs of the federal Sheppard-Towner Act, which Congress passed in 1921 and AMA lobbying killed eight years later.⁷ In the decades that followed, public health became a kind of residual category: anything related to the population's physical well-being that remained outside the purview of organized medicine. Its practitioners collected statistics to map and control the spread of illness, published health-education materials, and performed a grab-bag of licensing and regulatory functions in areas such as restaurant sanitation. Their direct-care responsibilities were limited to poor charity patients who could not afford the services of a private physician, and treatment for tuberculosis and venereal diseases, stigmatized conditions for which they had historically been responsible.⁸ The profession's heterogeneous workforce of doctors, nurses, epidemiologists, and educators claimed a more enlightened, sociologically informed view of health than the narrow focus of biomedicine, but their lack of political influence constrained their ability to shape the health-care environment.⁹

In the 1930s and 1940s, argues Elizabeth Fee, debates continued within the American Public Health Association "between 'progressives' who wanted public health and medical care services to be provided in a single, unified system and 'conservatives' who wanted to leave well enough alone: to confine public health to its traditional preventive activities and categorical programs, while leaving medical care to the clinicians."¹⁰ In the postwar years, the growth in the biomedical research enterprise, exemplified by the dramatic rise in federal funding for the National Institutes of Health, reinforced the paradigm that illness was to be fought at the physiological rather than the societal level, and further eclipsed the perspective offered by the public health profession. The delivery of medical care remained firmly entrenched in a fee-for-service model, especially after the ignominious defeat of Harry Truman's proposal for national health insurance at the hands of the AMA. The association's strategy of hanging the label of "socialism" on any proposal for publicly funded health care successfully defused such initiatives through the 1950s.¹¹

The emergence of poverty as a focus of the Kennedy administration set the stage for a reexamination of the status quo that had prevailed for decades. New legislative and policy initiatives addressed a set of related empirical and philosophical questions: How do poverty and its attendant

social conditions influence health? How should medical care be linked not just with prevention but with housing, education, employment, and other aspects of welfare broadly conceived? What is the role of the state in providing some or all of these services? When Lyndon Johnson declared the War on Poverty in 1964, new health-related programs, premised on sociological and economic theories, poured money and expertise into communities around the country.¹² During Johnson's administration, Congress passed approximately fifty pieces of legislation related to health, providing funds that flowed through units of the federal government including the Office of Economic Opportunity (OEO), the Children's Bureau, and the U.S. Public Health Service. Annual federal spending on health grew from about \$3 billion in 1959-60 to about \$21 billion in 1970-71.¹³

The neighborhood health centers, funded by the OEO, were in many respects emblematic of the era. The centers were innovative demonstration projects designed to provide integrated medical screening, diagnosis, and treatment closely linked with ancillary services such as job training that would improve the life prospects of those attending. The centers' guiding principles included strong involvement of community members as advisors and lay workers; by explicitly seeking to foster the political empowerment of patients, they were intended to serve not merely as sites for care but as engines of social change.¹⁴ In 1965 and 1966 the first round of eight centers opened, followed by another thirty in 1967 and 1968.¹⁵

The neighborhood health centers did not emerge from the federal public health establishment, though they embodied the philosophy of many of the field's liberals. Jack Geiger and Count Gibson, the Tufts University physicians who were architects of the neighborhood health center model, originally asked the Public Health Service to serve as a home for the program, but the agency, long reluctant to antagonize the medical lobby, referred the two men to the Office of Economic Opportunity.¹⁶ It was unclear, moreover, whether the new federal interest and funding would strengthen the institutional position of public health, at least in its traditional bastion of state and local health departments. The OEO made most grants for neighborhood health centers to medical schools and hospitals, on the grounds that they were best positioned in terms of facilities, equipment, and clinical expertise to get up and running quickly. As a result, some public health officials saw the centers as undermining their status as the group best qualified to care for the poor.¹⁷ In addition, the availability of health-related funding to nonprofit community-based organizations and other lay providers threatened to further splinter the field of public health, and dilute its already limited political influence, by adding to the diversity of the people addressing the connections among health,

poverty, and social conditions.¹⁸ Much was in flux in the new environment, and it was far from certain what role public health professionals would play in the reforms that seemed to be taking shape.

A Window of Opportunity and a Model for Reform in New York City

The New York City Department of Health seemed ideally positioned at the start of the Johnson administration to capitalize on the new policy environment. The department, a leader in the field since its founding as the country's first permanent municipal health authority in 1866, had established pioneering programs in health education, public health nursing, well-child care, and infectious disease control, and operated a network of twenty-seven health centers throughout the five boroughs that gave it a high profile in the community. But these centers reflected a long-standing accommodation with the city's private practitioners: they provided prevention and screening, but their clinical services were narrowly confined to the traditional categories of tuberculosis and venereal disease. Any other medical problem uncovered at a municipal health center was referred elsewhere—to a private doctor or hospital outpatient department—for follow-up and treatment.

When the neighborhood health center program emerged from the OEO, its principles resonated strongly with a cadre of health department employees dissatisfied with the sharp institutional boundaries between public health and medicine and the high concentration of preventable illness in the city's poor neighborhoods compared to its wealthy areas.¹⁹ These employees were not radicals but career public servants for whom the new civil rights discourse of justice dovetailed with ideas about comprehensive care that they had formed after years on the front lines working with low-income populations. Theirs was a moderate, incremental vision of liberal reform, borne of the realism that came from working in the city's civil service. They sought mainly to broaden their traditional preventive activities to include ambulatory care, and secondarily to involve community members in the planning of services. But they did not see these changes as the gateway to radical social change or patients' political empowerment.

The department's most forceful advocate for expanding its provision of ambulatory care was Mary McLaughlin, an assistant commissioner. McLaughlin was a physician who had risen through the department ranks during two decades of service in poor neighborhoods. Her commitment and that of her like-minded colleagues grew in part from frustration at

having to refer patients elsewhere for care, knowing that follow-through was unlikely because of costs and the fragmentation of the health-care system. In the fall of 1965 McLaughlin and her cohorts first requested funds from the City Council to expand the services of the district health centers beyond what they had traditionally offered to include a full range of outpatient care. The services would be provided by contracting with nearby hospitals, which would provide the clinicians and equipment. The first two sites chosen for the expansion would be in two of the city's most economically depressed neighborhoods, Bedford and Brownsville.

The budget request that the department submitted to the City Council reflected the ideals and language of the Great Society. It argued that "health and medical care programming must become very closely involved with social and welfare activities, public assistance programs and public housing, these in recognition that socio-economic factors are major determinants of health status."²⁰ The request also reflected the influence of the nascent consumer movement, which advanced the idea that health care was a commodity with which its purchasers had a right to be satisfied: "Health prevention and promotion on the one hand and diagnostic and curative services on the other," the document declared, "must be brought together into a more comprehensive non-fragmented, easily available package for the consuming public."²¹

Finally, in explaining its proposed partnership with hospitals to provide clinical services, the department contended that there was "an awakening and growing awareness by hospitals that their programs cannot remain parochial and unresponsive to the total health needs of their surrounding communities, and that they must be equal partners with the Health Department in the shaping of comprehensive health services for local communities."²² There was little evidence of such an "awakening," and the assertion of one was rhetorical and strategic—designed to convince the City Council that the partnerships would bear fruit—rather than factual. The city's public and private hospitals (especially those in poor neighborhoods) had shown scant interest in the needs of their surrounding communities, and while they had cooperated in various health department initiatives, such as an ambulance transport service for premature newborns, they hardly viewed the health department as an "equal partner" in their work. To the extent that they were aware of the department at all, most hospital administrators viewed it as a civil service backwater far removed from the important business of patient care.

Even as this initial foray into ambulatory care was being made, the health department was facing an uncertain future. In 1965 the departure of George James, the popular commissioner, left a leadership void just as

a major reconfiguration of the city's health bureaucracy was taking shape. As new debates unfolded about the professional spheres of public health and medicine, the existence of the department as a separate entity in city government was called into question. These developments in local politics were independent of the new federal health programs, but they would powerfully shape—and ultimately constrain—the incipient reform efforts that the department was undertaking.

John Lindsay and the Health Services Administration

On December 31, 1965, John Lindsay was sworn in as New York City's 103rd mayor. A charismatic liberal Republican and rising star on the national political scene, Lindsay promised to reform what he characterized as twelve years of corruption and complacency under Robert F. Wagner Jr. and the city's Democratic machine. He brought with him a team of "good government" planners armed with the latest ideas in municipal reform.²³ Health had not been a major issue during the campaign and was not high on the list of the new administration's initial priorities—relations with powerful labor unions took center stage when a strike by transit workers crippled the city on Lindsay's first day in office—but long-simmering problems, combined with new federal initiatives, soon pushed it to the top of the policy agenda.

When Lindsay took office, a profound sociodemographic shift was remaking the city, and the delivery of health services was becoming inseparable from issues of race, class, and poverty. Between 1950 and 1970 the city's white population declined by about 1.3 million, while its population of African Americans and Puerto Ricans increased by about the same number.²⁴ Many of these new arrivals were concentrated in slum neighborhoods, and their de facto primary-care providers were the understaffed and overcrowded emergency rooms and outpatient departments of the city's hospitals. Emergency-room visits to city hospitals doubled between 1960 and 1966.²⁵ Close to a third of the city's population, about 2.5 million people, were medically indigent.²⁶

The magnitude of the city's health needs was matched by the size and complexity of its health-care sector, which accounted for about 15 percent of the city's \$4 billion annual budget. Almost one in five of the city's 42,500 employees worked in either the department of health or the department of hospitals. The latter agency, established in 1929, ran nineteen hospitals and medical centers with some 18,500 beds. The city's department of welfare also ran seven clinics especially for welfare

recipients.²⁷ Inefficiency, duplication of effort, and gaps in care were widespread. Both the health and the hospitals department operated bureaus of tuberculosis control, for example, which rarely communicated with each other. The department of welfare operated dental clinics for its clients only, while the health department ran dental clinics for children only, and the department of hospitals performed tooth extractions only.²⁸

As part of their efforts to revitalize and streamline the city's civil service bureaucracy, Lindsay's team swiftly moved to consolidate some fifty municipal departments and agencies into ten "superagencies" that would unite related functions of government such as finance, housing, and transportation.²⁹ One of these was to be a new entity called the Health Services Administration (HSA), which would join the departments of health and hospitals under the same administrative umbrella. (The new organization would also include two other health-related agencies, the Community Mental Health Board and the Office of the Chief Medical Examiner. The Department of Welfare was made part of a different superagency, the Human Resources Administration.) While government reform was the chief impulse for the creation of the new agency, the proposed consolidation was consistent with one of the ideals that underlay the OEO's neighborhood health centers: that preventive and curative health services should be linked in a more continuous and patient-friendly system of care.

It was unclear, however, whether the organizational structure of the HSA would be a barrier or facilitator for the incipient movement within the health department to create new models of care. On the one hand, administratively uniting curative and preventive services seemed a logical and necessary step toward bringing about systemic change. The commissioners of all four of the affected agencies urged the City Council to pass enabling legislation, arguing that new federal grant programs made it essential for the components of the city's health-care system to become unified so that they would be well positioned to apply for funds that became available.³⁰ Mary McLaughlin, who championed the health department's involvement in clinical services, put the matter bluntly in a letter to the City Council: "The waste, duplication and inefficiencies of the past must come to an end."³¹

On the other hand, many public health leaders feared the dilution of what made their enterprise unique. Alonzo Yerby, a leading national figure in preventive medicine who had led the city's Department of Hospitals before taking a professorship at Harvard University, described this anxiety in an address at the Johns Hopkins School of Hygiene and Public Health in the fall of 1966: "Public health people fear that their preventive programs will be lost in the daily crises of providing hospital

care for large numbers of patients. Administrators of public hospitals feel too hard-pressed by obsolete facilities, personnel shortages, strikes and work stoppages, and ever-mounting demands for services to consider the special needs of a program of prevention.”³² Said Cecil Sheps, a prominent hospital administrator and adviser to Lindsay, “When there’s blood to stop flowing, and bones to mend, public health can get lost.”³³

Some of the uncertainty about whether the new HSA structure would impede or enhance reform involved the question of whether all organizational borders would be dissolved or whether the individual departments would be retained with a new layer of bureaucracy overlaid on top to coordinate their diverse functions. Members of the Board of Health, a five-member body made up of some of the city’s medical and political elite, insisted in a letter to Lindsay that public health had to retain its independent status if the reform efforts were to succeed.³⁴ Lindsay promised the board members that reorganization legislation would specifically provide for a separate health department.³⁵

Nevertheless, many health department employees remained anxious about their influence and their future. Their unease reflected in part the precarious position in which the department had only recently found itself. The department had enjoyed a heyday under the eight-year commissionership of Leona Baumgartner (1954–62), who had assumed near-legendary status for her political savvy and tireless promotion of the department and its interests. When her widely respected successor, George James, resigned in 1965 to become dean of the Mt. Sinai School of Medicine, the department was suddenly without a strong leader to advance its interests as the merger took shape.

At the same time, pay stagnation created by a Lindsay administration salary freeze made it difficult to attract top-flight talent to the department’s middle and upper ranks. The starting annual pay for an assistant commissioner in the Department of Health, a position that required a medical degree, was \$25,000, compared to \$27,500 for a master’s level nonphysician administrator in the Department of Hospitals.³⁶ Many top managers left the health department following James’s departure, while shortages of public health nurses—the department’s “foot soldiers” against disease—left health centers understaffed and forced the cancellation of some programs, such as immunization clinics for low-income children. Working conditions in the district health centers, many of them deteriorating facilities that had not been renovated in decades, were difficult. “Years ago,” wrote one health official, “the dynamic programming of the department with opportunity to do public health research as well as the desire of physicians to live in ‘fun city’ was sufficient to attract and

keep staff. This is no longer true. Many now desire to leave the City where the problems sometimes seem insoluble and City living is no longer attractive.”³⁷

The extent of anxiety about the future was revealed by the unusual step taken by a group of health department physicians in the summer of 1966. Alarmed by the absence of a leader to serve as their advocate, they enlisted the assistance of former commissioner Leona Baumgartner, who remained an influential figure on the local health scene. “We feel that [creation of the Health Services Administration] will lead inevitably to a complete takeover of our department’s functions by voluntary hospitals whose experience, goals and capabilities do not encompass the public health field at all,” the doctors warned. “The end result of subordinating the Health Department’s functions to those of hospitals will, we believe, result in a sharp curtailment or elimination of important preventive programs, a complete breakdown of department morale, and a resultant serious threat to the public health.”³⁸

The First Health Services Administrator

To fill the post of the city’s first Health Services Administrator, who would be charged with fostering close relationships among departments that had operated with distinctly different missions and professional cultures, Lindsay’s search committee turned to Howard J. Brown. An experienced program planner and manager as well as a physician, Brown had gained a strong reputation locally and nationally by designing an innovative outpatient clinic serving low-income residents of the city’s Lower East Side that provided one of the models for the neighborhood health center program. He then went on to serve as the OEO’s chief medical adviser, and helped establish similar facilities in rural Mississippi, in Watts, California, and in several other cities around the country.³⁹

The choice of Brown thus provided a direct conceptual and practical link between New York City’s health-care system and the reform initiatives emerging at the federal level. Brown’s ideals were also consonant with those of the health department’s progressives, who had taken steps to expand their ambulatory services, and his appointment augured well for these efforts. As Brown explained to Louis Craco, the young lawyer who chaired the Mayor’s Task Force on Reorganization of the Government, shortly after accepting his new post: “There is a general consensus among modern public health and medical care professionals that the clinical, preventive and mental health services now fragmented

should be united into coherent programs.”⁴⁰ Preparing a statement that Lindsay would read in testimony before the U.S. Congress on health challenges facing the country’s large urban areas, Brown identified the two most pressing problems as rebuilding deteriorating hospitals and financing and organizing medical care for “ghetto” areas.⁴¹

Not only was Brown committed to retaining an independent Department of Health within the HSA; he foresaw that it would be *primus inter pares* among the units that made up the combined organization. Describing his long-range vision of the mission of the department to colleagues at Johns Hopkins, Brown wrote, “The major planning, coordination, surveillance and evaluation responsibility of the total health programs in New York City” would rest with public health professionals, while the other units would have “more specialized functions, major as they will be, as compared to this broad charge of the Health Department.”⁴² The Department of Hospitals, he believed, would be limited to “bricks and mortar considerations.” The health department’s charge would not be “to do all that is necessary to protect and promote the city’s health, but to make sure it is done” through standard-setting, surveillance, research, and demonstrations. Finally, he laid out a vision for the public health workforce that suggested a return to the social medicine roots of public health in the nineteenth century, when the field was guided by reformers such as Rudolph Virchow and Lemuel Shattuck. The public health leaders of the future, Brown predicted, would be “board certified public health physicians with training and skills in community medicine—medical sociologists, health urbanists—whatever they might be called . . . with one foot in the technical field of the science of medicine and the other in community dynamics.”⁴³

Brown’s vision failed to thrive within the new bureaucracy, however. Almost immediately, differing institutional cultures and priorities and conflicting personalities resulted in turf battles involving authority over fiscal and programmatic matters among the four constituent agencies that had publicly supported the merger.⁴⁴ Brown found himself at odds with members of the medical establishment because of their unwillingness to embrace his view of health services organization. His increasingly blunt public criticisms of his fellow physicians—in one speech he contended that they organized care based on “their own need for professional distinction” rather than concern for patients—cost him critical support among what should have been a core constituency.⁴⁵ After seventeen turbulent months on the job, Brown abruptly resigned in December 1967.⁴⁶ Neither of his successors would last more than two years in the position. The lack of a consistent, forceful advocate at the helm of the Health Services

Administration would prove to be a critical weakness that hampered the health department's ability to take the lead in reform.

“Ghetto Medicine”: The Health Department as Care Provider and Watchdog

In spite of Brown's departure and the uncertain environment, health department employees committed to expanding the department's clinical services pressed ahead with their plans, fashioning a proposal for capital renovations of health centers that had previously provided only preventive services.⁴⁷ Because of the stigma that clung to free clinics for the poor, the new facilities would be named neighborhood family-care centers. “The term ‘clinic’ is scrupulously avoided in speaking of this program,” Mary McLaughlin explained in a subsequent report. Each center would “operate on an appointment basis and we hope to pattern it on the type of care given in a private physician's office or a good group practice unit. The usual clinic appearance of benches, crowding, and lack of regard for patients' comfort, is a thing of the past.”⁴⁸ After Lindsay's budget director and the City Council gave the go-ahead to the budget request to partially cover the substantial capital costs, plans for neighborhood family-care centers took shape. Seven would be in entirely new facilities and nine would be in renovations of existing sites in poverty areas.

That these forays by the health department into ambulatory care did not provoke the kind of resistance from the city's medical establishment that had been seen in the past is a testament to their incremental nature and the fact that they were limited to care for the poor, which was a traditional part of public health's purview. The lack of opposition also bespoke the degree of crisis in which the city's hospitals found themselves in the latter half of the 1960s. They had long been plagued by chronic staff shortages, deteriorating physical plants, and accusations of substandard care.⁴⁹ A mayoral task force appointed when Lindsay took office found rampant administrative inefficiency, wide disparities in the quality and quantity of preventive and curative services given to people of differing socioeconomic backgrounds, an unwillingness to adapt services to the needs of a racially and ethnically diverse patient population, and lack of outpatient-care facilities.⁵⁰ The modest effort by the health department to expand its ambulatory services in poor communities was, at that moment, the least of the hospitals' concerns.

Some resistance to the new neighborhood centers did come, however, from within the health department's own rank and file. The clinical

staff of the health centers that were slated for expansion included many physicians with a more traditional orientation toward the appropriate spheres of public health and medicine. Because the new neighborhood family-care centers were to be operated in partnership with an affiliated hospital, many health department doctors feared that they would be subordinated in their work to better-trained hospital-based practitioners, or, worse, that they might be moved onto to the hospital payroll, thereby losing the seniority they had gained within the city's civil service system.⁵¹

A more serious threat to reform than resistance from within was the instability of funding. Reimbursements from Medicaid, the landmark federal-state program established in 1965 to finance care for the medically indigent, were expected to cover a major portion of the costs of the new clinical services.⁵² But New York's Medicaid program had been in disarray virtually from its inception in 1966 due to unexpectedly high costs that had blindsided even knowledgeable insiders. Bureaucratic confusion reigned amid infighting over administrative matters such as patient eligibility and physician reimbursement.⁵³ In this precarious environment it was impossible to predict what level of funding would be available even a short time in the future; McLaughlin described the program's financing as "quicksand."⁵⁴ Indeed, in 1968 the parlous state of Medicaid set off a chain reaction that would reverberate throughout the state's health-care system, most powerfully in New York City. A pivotal point in the controversy was the state aid program known as "ghetto medicine."

The state department of health originated the ghetto medicine program in response to concerns about the shortage of medical care available to the poor in rural and urban slum areas. Two bills introduced in the New York legislature in the summer of 1968 amended the state public health law to allow local health departments to provide clinical services and to receive reimbursement from the state for fifty percent of their costs, the same proportion they received for their traditional categorical programs related to tuberculosis and venereal disease. The bills slipped under the radar of the large health-care interests and passed the legislature late in the session without debate.⁵⁵ McLaughlin submitted several applications for ghetto medicine funding to support the new neighborhood family-care centers, three of which were funded.

Within a year, however, the ghetto medicine program was unexpectedly transformed by the crisis of spiraling costs that had gripped New York's Medicaid program. By 1968, New York City accounted for fully one-quarter of the nation's total Medicaid enrollment and one-fifth of the total national expenditure on the program. Some 2.5 million residents—more than 30 percent of the city's population—had enrolled.⁵⁶ In response

to the upwardly spiraling costs, the state legislature made drastic cutbacks in eligibility, resulting in close to 1.8 million adults and children being thrown off of the rolls. ("As a result of the confusion and despair regarding eligibility for medical benefits," cautioned a health department report in the summer of 1968, "we may one day very soon witness the first demonstrations for the right to health care in the United States.")⁵⁷ Although some of these individuals were subsequently re-enrolled, the overall rolls dropped by close to one million recipients, including almost three hundred thousand children.⁵⁸

Faced with a fiscal crisis because of the sudden loss of revenue they had anticipated from Medicaid, many of New York City's private hospitals were forced to take out loans at high interest. The city's powerful hospital lobby enjoyed close access to Governor Nelson Rockefeller, and in the midst of the crisis sent representatives to meet with him to say they faced ruinous losses that could force the closure of some of their outpatient services.⁵⁹ State legislators agreed to use state aid through the ghetto medicine program to keep these hospitals' ambulatory-care services from going bankrupt. Thus money that had originally been intended to allow health departments to create new outpatient services for the poor was instead diverted to propping up existing services in private hospitals.

Liberal health advocacy and civic organizations were dismayed. They dubbed the plan "Operation Bailout" and claimed that private institutions with abysmal track records in caring for the poor should not be receiving public funds.⁶⁰ But faced with a more skilled and better-connected lobby, public health had been outflanked. A highly critical analysis by a member of the Citizens Committee for Children charged that public health "did not wish to take on the voluntary hospital establishment or else did not know how to do it. . . . Public health leadership was invisible, seemingly unable or unwilling to compete in the political arena."⁶¹

The diversion of money to the voluntary hospitals did come with strings, however, which McLaughlin and another assistant commissioner, Lowell Bellin, were successfully able to manipulate. In order for the hospitals to be eligible for state aid, they had to become "public" institutions. Their ambulatory-care services were therefore "municipalized" and placed under the aegis of the city health department.⁶² McLaughlin and Bellin quickly realized that the arrangement provided them with a wedge they could use to improve the services in institutions whose practices had long remained outside their managerial purview. As Bellin explained in a subsequent report, the ghetto medicine program allowed the department to use its "newly acquired fiscal leverage to accelerate socially desirable

policies and administrative changes in voluntary hospitals historically insulated from health department dissatisfactions and restiveness.”⁶³ Among the changes in policy and practice that the department included in the contracts they negotiated with each institution were the hiring of a director specifically responsible for outpatient care, the provision of interpreters for patients, development of lists of available services, and the convening of regular public hearings on matters of hospital policy.

Bellin’s pursuit of oversight in private hospitals was consistent with a broader mission he had undertaken in 1967 to set standards and audit the quality of care provided by doctors participating in Medicaid. This watchdog role was made possible by a combination of legal and administrative authority: language in the Federal Title XIX (Medicaid) legislation, New York State’s Medicaid law, and an administrative agreement between the city and state health department.⁶⁴ Bellin was aggressive and unapologetic in his vision of the health department’s role in monitoring the provision of medical services. He drew an analogy to the department’s other, well-accepted regulatory functions. “[The health department] furnishes a restaurant a license, which confers privileges,” he explained. “It can always withdraw the license together with the privileges for due cause, that is, a cause in the interest of the public health. The analogy is obvious. The provision of foodstuffs to the public bears a potential hazard to the public health and therefore falls within the official purview of the local health department. Similarly, the provision of personal health services to the public bears potential hazard to the public health and therefore should fall within the official purview of the local health department.”⁶⁵

Unsurprisingly, Bellin experienced considerable pushback from local physicians. Typical was the complaint of the president of Queens Medical Society, who insisted that “quality medical care can no more be legislated than any Congress or Assembly or Senate can legislate honesty or integrity or tolerance.”⁶⁶ A local medical society passed a resolution declaring itself “unalterably opposed to any system of self-imposed certification of a physician’s competency by any governmental agency” and to “any governmental agency evaluating the quality of medical care.”⁶⁷

In spite of limited funding and personnel for enforcement, the health department’s auditing and standard-setting program was one of its most successful reform efforts, sustained in large measure by the sheer force of Bellin’s dogged personality. In 1969 rulings were handed down in three lawsuits challenging the department’s authority to regulate tax-supported private medical care, and in each case the department’s position was upheld. One concerned the reimbursement rate for chiropractic services; one challenged the authority to hold a hearing on allegedly

fraudulent Medicaid dental services; a third affirmed the authority to suspend or eliminate podiatrists from Medicaid eligibility because of substandard care.⁶⁸

The Perils of Community Involvement

As the health department confronted obstacles from “above”—lack of leadership in the Health Services Administration, the inadequacy of federal and state funding, and political maneuvering by the medical and hospital establishment—along with reluctance from within its own ranks, its reform efforts were simultaneously complicated by resistance from “below.” Energized by the example of civil rights mobilization and challenges to long-standing power hierarchies, community groups contended, sometimes militantly, that they, not doctors, hospital managers, or health department bureaucrats, should have final say over how the city planned and delivered its health care. Although the department had actively sought to incorporate community input in the form of advisory boards for the new neighborhood family-care centers, the involvement of these groups added a new layer of dynamics with which the health department often found itself inadequately prepared to deal.

The input of “consumers” into the planning and implementation of services was a cornerstone of the Great Society’s health programs. It was codified in federal legislation such as the Community Mental Health Centers Act of 1963, which mandated the creation of community advisory boards. This involvement was subsequently strengthened by the Office of Economic Opportunity’s requirement for “maximum feasible participation” of poor communities in the neighborhood health centers.⁶⁹ In 1966, the Partnership for Health Act further institutionalized community-planning processes.⁷⁰

Since the nineteenth century, New York City had had a well-developed voluntary sector of service organizations and civic groups concerned with health issues. Typical was the Citizens Committee for Children, which had been founded by a group of liberal social activists and philanthropists in 1946, and had a long track record of reform efforts, such as attempting to improve the conditions for African American youth in the city’s notoriously segregated child welfare system.⁷¹ In the 1960s, a new breed of community activist emerged. Unlike established organizations that grew out of a tradition of white protestant charity work by upper-class reformers, these new groups were more confrontational and less inclined to accomplish their goals by cultivating relationships with key decision-makers or engaging in

time-consuming negotiation through official channels. Many groups were made up of the intended beneficiaries of services. As one observer summarized in 1969: "Frustration, confrontation, and overt conflict are more and more becoming the modes of problem-centered action by those interested enough to get involved. In the past, service projects were not cooperative ventures; they were imposed—albeit in a charitable way—from the one side, and the clients were at least expected to be happy with what they got. Today that is impossible. The new identity and increased self-esteem of the 'other America' has rejected the supplicant's role and demands more than charity."⁷²

As the health department's neighborhood family-care centers took shape, citizens' groups subjected them to close scrutiny and, often, harsh criticism. In 1968, for example, the Citizens Committee for Children, the Lower East Side Neighborhood Association, and the Northeast Neighborhood Association wrote to Lindsay about "numerous complaints from community groups." The organizations claimed that the health department had failed to involve community members in the planning of services for centers that were being proposed for Harlem and Jamaica, Queens, and cited specifically the department's failure to clarify the standards for the services that would be offered in the new facilities and to provide ongoing information about their future plans.⁷³ The Citywide Health and Mental Health Council, another advocacy group, complained in a letter to Lindsay and the City Council that the Health Services Administration had displayed "a colossal disregard for community concern, dissent, and recommendation" and that the new organization had perpetuated "more of the same evils it was supposed to correct."⁷⁴

The responsibility in the health department for day-to-day interactions with community groups typically fell to district health officers, physicians who earned relatively low salaries and were overburdened with other duties. Most were also white, older, and very different in socioeconomic background from the communities with whom they interacted. The complicated process of diplomacy and delicate negotiations, often racially charged, required a skill set very different from what they had developed in their professional training and experience.⁷⁵

Pressure from liberal advocacy groups, including HealthPAC and the Citizens' Committee for Children, had led to a provision in the ghetto medicine legislation requiring that, in return for receiving state aid, each beneficiary hospital create an advisory board made up of fifty-one percent of its members from the community.⁷⁶ But the degree of authority these bodies would have over hospitals' decision-making, and indeed the precise nature of their mission, was ambiguous. According to the official guidelines

promulgated by the city, the groups “should neither be interpreted as having ‘community control’ nor as performing a perfunctory role. The committee should be viewed as a mechanism to facilitate both delivery and community utilization of ambulatory services.”⁷⁷ The health department was to work closely with the advisory groups, serving as a kind of mediator between their interests and perspectives and those of the hospitals. But these alliances were not uncomplicated. The committees varied widely in their knowledge of the health-care sector and their skill at dealing with the byzantine operations of hospitals. Mutual mistrust and even hostility characterized the relationships between some of the committees and the hospitals they advised; one committee filed suit against both the hospital and the health commissioner, claiming that they deliberately withheld needed information.⁷⁸

Even as the health department’s new involvement with medical care brought it into conflict with community groups, it also met resistance in its traditional domain of population-level prevention. Amid increasingly assertive grassroots activism, the department’s efforts to address illnesses related to poor living conditions encountered a minefield of potential criticism. The challenges of dealing with a health problem that was both deeply entrenched in poverty and subject of militant community action crystallized around the issue of lead poisoning. In 1967, the city recorded 642 cases of lead poisoning—mostly among African American and Puerto Rican children—and four deaths.⁷⁹ Political pressure on the Lindsay administration to address the issue began to mount as an increasing number of citizens’ groups began accusing the city of “genocide” of its poor children living in slum housing.⁸⁰ In response, the department undertook a pilot program evaluating the use of an experimental urine test that could be used in door-to-door screening to determine the extent of the problem and identify children in need of treatment. In 1969, a group of young student radicals and Puerto Rican nationalists, the Young Lords, mounted a public challenge to this effort.⁸¹

The Young Lords, in the tradition of militant activist groups such as the Black Panthers, sought to fight economic and political injustice and bring about radical social change. A New York chapter of the group, formed in 1969 after splintering from the founding organization in Chicago, first made a mark by collecting garbage from the sidewalks of East Harlem and piling it in the middle of the streets, forcing the department of sanitation to remove it so that traffic could flow. The garbage dumpings escalated over the summer of 1969 into demonstrations in which the Lords barricaded neighborhood streets and clashed with police. Soon after their formation, the group adopted the health of the

residents of *el barrio* as a primary focus of their activism.⁸² In the fall the group issued a “10-point health program” that included demands for “total self-determination of all health services in East Harlem” and “free publicly supported health care for treatment and prevention.” The plan clearly revealed the extent to which poor health was viewed as inseparable from other forms of social injustice: one of the ten points demanded “education programs for all the people to expose health problems—sanitation, rats, poor housing, malnutrition, police brutality, pollution, and other forms of oppression.” The plan also took direct aim at the city’s existing health-care bureaucracy: point 2 demanded “immediate replacement of all Lindsay and [Hospitals commissioner Joseph] Terenzio administrators by community and staff-appointed people whose practice has demonstrated their commitment to serve our poor community.”⁸³

On the morning of November 24, 1969, about thirty people, mostly members of Young Lords and their supporters, arrived at health department headquarters. They entered the office of Mary McLaughlin—whom Lindsay had recently appointed health commissioner—demanding a meeting about the issue of lead paint. McLaughlin and the assistant commissioner in charge of lead poisoning were at an all-day conference across town, but the group insisted they would not leave the premises until their demands were met. They wanted the department to turn over some forty thousand urine test kits that were being used in the pilot screening program; convinced that the failure to deploy the kits more widely was rooted in indifference to the problems of poor ethnic minorities, the group sought to take matters into their own hands and do the outreach themselves. McLaughlin’s secretary was able to reach one of her deputies, David Harris, who rushed to McLaughlin’s office to meet with the group. With the demonstrators sitting on the floor or perched on tabletops, Harris explained that the test kits were of uncertain validity and were still being evaluated. A deal was ultimately reached to allow the Young Lords to use a limited number of kits in collaboration with health department doctors who had expertise in lead screening.⁸⁴

The confrontation in the commissioner’s office epitomized the clashing perspectives of health professionals and activists. Where Harris saw the need to proceed carefully according to scientific evidence so as not to waste scarce resources on measures that might be ineffective or counterproductive, aggrieved community members saw bureaucratic stonewalling. (The urine test, it was later confirmed, was not a valid predictor of lead poisoning and was thus unsuitable for use in a screening program.)⁸⁵

In the aftermath of the occupation, the liberal weekly newspaper the *Village Voice*, which had given supportive coverage to the Young Lords’

previous efforts, took up the cause of lead poisoning among ghetto children. Muckraking *Voice* columnist Jack Newfield, a crusader for liberal political causes, repeatedly pilloried Lindsay and the health department for their inaction. He charged that mayoral aid Werner Kamarsky and McLaughlin were “cut off from the dailiness of injustice by their positions and life styles”⁸⁶ and bluntly accused McLaughlin of lying to the mayor and the press about the extent of the lead paint problem and the department’s response.⁸⁷

The following summer, the city was rocked by repeated unrest in the city’s poor African American and Puerto Rican neighborhoods. In June, angry residents of Brownsville burned garbage in the streets in protest of poor municipal services.⁸⁸ The same week, after one of the Young Lords’ leaders was arrested, hundreds of youths rioted in East Harlem, smashing store windows and burning garbage. Three days after the riot, the Young Lords mounted another assault on health department judgment around another issue that disproportionately affected the poor: tuberculosis. On June 17, a group of Young Lords “liberated” a mobile tuberculosis screening van parked at 116th Street and Lexington Avenue in East Harlem. After driving the van five blocks south and one block west, they parked it across the street from the group’s headquarters, draped a Puerto Rican flag over it, and rechristened it the Ramón Emeterio Betances Health Truck, in honor of the nineteenth-century Puerto Rican doctor and antislavery revolutionary. The X-ray technicians inside continued to perform their duties as crowds milled around outside, television crews parked at the scene, and a heavy police presence gathered, including officers stationed on the roofs of adjoining buildings.⁸⁹ After several hours of tense negotiations involving the Lords, the health officer in charge of East Harlem, and department officials downtown, an agreement was reached stipulating that the truck would be free to travel “anywhere in the metropolitan area as deemed necessary by the Young Lords party for the best health care for our poor and oppressed people.”⁹⁰

Epilogue: The Limits of Reform

During the Great Society era, moderate liberals within the New York City health department were able to advance a variety of reforms within the progressive political and social climate that prevailed nationally. They added ambulatory care to their traditional preventive activities, involved community members in the planning and implementation of services, audited the quality of care provided by physicians receiving reimbursement from public funds, and mounted new efforts to address health

problems such as lead poisoning that were rooted in socioeconomic injustice. At the same time, however, forces “below” and “above” constrained what they could accomplish. Community members newly empowered as partners in health department efforts often proved uncooperative and even hostile, while financing from federal and state legislation remained unstable. The crisis of New York State’s unforeseen and exorbitant Medicaid expenses, it was clear in retrospect, doomed the funding for the health department’s efforts. The subsequent diversion of state money from the department to private hospitals “took the heart out of the ‘Ghetto Medicine’ program,” a subsequent analysis argued, “before it could be started.”⁹¹ Just three neighborhood family-care centers were created, far short of the sixteen originally envisioned.

Even more severe fiscal retrenchment would soon put a decisive end to reform. The continued flight of the middle class to the suburbs during the early 1970s and the consequent erosion of the tax base plunged New York City into straits that culminated in its infamous collapse into insolvency in 1975. The city was taken over mid-year by a “municipal assistance corporation” (dubbed “Big Mac” by local pundits), an independent coalition of investors that kept the city solvent by assuming the most immediate of its massive debts.⁹² The staff of the Department of Health was cut by one-fourth. In a series of triage decisions, department services were categorized as “life saving” versus “life enhancing,” with the latter subject to cuts.⁹³ In this environment, the kind of expansion that had become possible in the mid-1960s was foreclosed.

At national level, backlash against the “big government” solutions of the Johnson administration had begun to set in before they had scarcely gotten under way. Typical was the fate of the neighborhood health center program. Funding for the centers remained flat during the Nixon and Ford administrations, in spite of escalating health-care costs; beginning in 1970, the program was gradually transferred from the OEO to the Department of Health, Education, and Welfare, where it “stagnated,” according to an analysis in the late 1970s.⁹⁴ As consequential as the lack of financial commitment was the disappearance of the political will to expand health and welfare services for the poor.

Even in New York City, with its tradition of liberalism and generous social provision, the public health profession’s advocates for reform were hobbled by their institutional position: most were either political appointees or civil servants subject to pressure from powerful interests and lacking a natural base of constituents to support their work. As a result, their vision of change was realistic and incremental rather than radical. To some of the field’s liberal members, this realism, placed

against the promise of the Great Society's ambitious ideals, simply provided a cover for political timidity and ineptitude. This view was given voice most eloquently by Paul Cornely, a Howard University professor of preventive medicine. Newly elected in 1969 as the first African American to head the American Public Health Association, he gave an address at the group's annual meeting in Philadelphia in which he sharply chided his colleagues for their failure to advocate more aggressively for reform. Cornely declared that the association had been "a mere bystander" on urgent social issues such as occupational health and environmental protection, and had failed to put forth any concrete proposal for a national health plan during the preceding decade when the possibility of so much change had been on the table. Public health professionals, he charged bluntly, remained "outside the power structure."⁹⁵ But as the experience of New York City reveals, the prospects for public health professionals to grasp the levers of power were always limited, even at one of the most progressive moments of the twentieth century.

*Mailman School of Public Health
Columbia University*

Notes

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