

# The Unfulfilled Promise Of Public Health: Déjà Vu All Over Again

We have not learned the lessons of our public health history.

by **Elizabeth Fee and Theodore M. Brown**

**ABSTRACT:** Many complain about public health's weak infrastructure and poor capacity to respond to threats of bioterrorism. Such complaints are but the anxiety-heightened expression of a periodic rediscovery of the deficiencies and unfulfilled promise of U.S. public health. An overview of more than two centuries suggests that where we are now with public health has been shaped by our earlier, limited, and crisis-focused responses to changing disease threats. We have failed to sustain progress in any coherent manner. If we do not wish to repeat past mistakes, we should learn lessons from the past to guide us in the future.

IN THE WAKE OF SEPTEMBER 11 many U.S. political commentators and advocates of increased funding for public health have lamented public health's weak infrastructure and poor capacity to respond to threats of bioterrorism and other potential health disasters. Far from being novel, these pronouncements represent the anxiety-heightened expressions of a common and periodic rediscovery of the deficiencies and unfulfilled promise of American public health. At such moments, recognition dawns that public health can provide an important defense against biological threats, whether natural or enemy-delivered, although its development in the United States has been consistently plagued by organizational inefficiencies, jurisdictional irrationalities, and chronic underfunding. It is apparent that public health—in addition to lacking the support it deserves—has long been subject to a social and cultural discounting, especially in comparison to high-technology medicine, which undermines its authority. This effectively and often unjustly denies it credit for past improvements in the nation's health.

One of those moments came about a decade and a half ago, after the Reagan administration had reduced funding for federal health and social welfare programs, cutting some 25 percent of the Department of Health and Human Services (HHS) budget and eliminating or crippling many public health programs.<sup>1</sup> Facing the

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AIDS epidemic and multidrug-resistant tuberculosis, many in the public health community were understandably anxious about the perilous state of their field. As the Institute of Medicine's (IOM's) Committee for the Study of the Future of Public Health put it in 1988, "This nation has lost sight of its public health goals and has allowed the system of public health activities to fall into disarray."<sup>2</sup> What the committee had witnessed, as its members were sadly aware, was not some improbable accident but a direct, determined consequence of history, the outcome of long-term disregard and of a bruising series of battles over the legitimacy, scope, professional authority, and political reach of public health. This essay presents an overview of public health in the United States as we make the case that where we are now is closely related to where we have been or have failed to go. If Americans wish to act differently in the future, we have to draw lessons from the past that will guide us as we move forward.

## Public Health's Beginnings

Public health in the United States did not begin as a systematic, rational, centrally directed activity following a coherent plan but rather as a fitful, episodic, and necessity-driven response to immediate local threats. At first, threats were most clearly identified with epidemic disease—plague, influenza, scarlet fever, measles, typhoid fever, and especially smallpox—and cities on the eastern seaboard responded by quarantining ships; isolating infected persons; and fumigating houses, goods, and belongings, to control contagion. Other measures addressed local environmental conditions as, for example, the draining of marshes, swamps, and standing water. By the later eighteenth century, as theoretical understanding began to include explicit miasmatic ideas, protective measures increasingly took the form of ordinances and interventions aimed at filth, garbage, and other typically malodorous urban nuisances.

■ **Responses to yellow fever.** From about 1793 to 1806 yellow fever posed a major threat up and down the East Coast and created a heightened consciousness of public health, then understood as the set of measures undertaken to protect the local population from epidemic disease. Philadelphia organized a Board of Health in 1794; Baltimore in 1797; Boston in 1799; Washington, D.C., in 1802; and New Orleans in 1804. These temporary municipal boards used police powers as allowed by state legislatures, where, according to the 10th Amendment to the U.S. Constitution, ultimate oversight authority resided for local public health.

New York City established a Board of Health in 1805 in response to that year's heightened threat of yellow fever. The New York board played it safe, adopting both contagionist (quarantines, disinfection) and miasmatic (garbage removal, street cleaning) measures. But as the threat of yellow fever again diminished, so did popular enthusiasm and budgetary support. This was usually how it went. Business interests lobbied against the board because the board's activities interfered with the free flow of commerce, and in 1819 their representatives success-

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fully stripped the board of its power. A similar campaign of sabotage in New Orleans succeeded in getting that Board of Health dismissed in 1825.

■ **Threat of cholera.** By the 1830s the continued growth of towns and cities; the accumulations of garbage, offal, and excrement; and the pollution of water supplies created the conditions for the further spread of epidemic diseases, especially those spread by enteric discharges. In 1832, when cholera threatened New York City, the Board of Health, now beholden to business leaders and concerned mainly with the financial vitality of the city, was reluctant to act; when the Medical Society announced that nine cases of cholera had been diagnosed in the city, the board accused the doctors of “impertinent interference” and of disrupting the economic life of the city.<sup>3</sup> As the city’s wealthier inhabitants fled to the countryside and as cholera spread through the slums and almshouses, the board was at last forced into temporary action: issuing daily reports, outfitting cholera hospitals, cleaning the streets, and warning the remaining populace to modify their intemperate behavior.

As cholera spread to other towns, boards of health were quickly formed and voluntary committees mobilized to help fight the epidemic. Once the epidemic had passed, however, the citizen committees disbanded, and the boards of health settled back into their usual lethargy. The prevailing mood in the country was “Jacksonian democracy,” an antigovernment, antiprofessional, and often anti-intellectual intensification of American individualistic and localistic values that coincided with the presidency of Andrew Jackson (1828–1836).

■ **“Sanitary” reformers.** In the 1840s and 1850s reformers tried to swim against the tide and shame city officials into taking their public health responsibilities seriously. Problems of filth, garbage, sewage, and overcrowded and dilapidated housing were clearly increasing at midcentury as cities grew rapidly, swelled with immigrants from rural America and abroad.<sup>4</sup> Health reformers, both physicians and nonphysicians, were a mixed lot with selective sympathies and a range of specific agendas, but they marshaled together under the common banner of “sanitary reform.” They held meetings, formed voluntary associations, published pamphlets, and organized conventions to advance their cause, albeit with limited success. But undaunted advocates such as John H. Griscom in New York City, a former inspector for the Board of Health, persisted in efforts to bring the horrendous living conditions of the city’s “laboring population” to public attention and redress.<sup>5</sup> Others, such as bookseller and publisher Lemuel Shattuck in Boston, managed to combine genuine pleas and plans for progressive reform with anxious warnings about the immigrant menace—that foreign horde disproportionately responsible, Shattuck claimed, for dangerously swelling the ranks of the impoverished, socially disruptive, criminal, diseased, and mentally defective dregs of society.<sup>6</sup>

■ **A turning point.** The Civil War marked a turning point for U.S. public health. Reform efforts had intensified just before the war, as may be seen by the series of national “Sanitary Conventions” held from 1857 to 1860, but it was the war itself—and the horrific disease-generating and -spreading conditions of military camps—that served as the most important spur to action. By June 1861 reformers had persuaded President Lincoln to create a Sanitary Commission to investigate conditions among the Union forces. The commission pressured both civilian and military authorities to improve sanitation and to educate officers and enlisted men about the spread of infectious diseases and the need for personal and public hygiene. The Union Army’s sanitary program was extended to certain southern cities—most notably, Memphis, Charleston, and New Orleans—with military victory and occupation, and some of these health measures continued postbellum. The most important carryover of Civil War sanitary momentum in the postwar period, however, was its effect on northern cities. New York and Chicago established the first municipal boards of health in 1866 and 1867, while Massachusetts created the first really effective state board of health in 1869.

As the sanitary momentum grew in the 1870s, most major cities instituted some form of public health organization, so that by 1879 reform leader Elisha Harris could count fifty “reasonably efficient” municipal health departments.<sup>7</sup> Several states also followed Massachusetts’s example. In 1872 Harris and nine other reform leaders met to found a new national organization, the American Public Health Association (APHA), which held its first annual meeting in Cincinnati in 1873. Some 400 members attended the 1880 annual meeting in New Orleans, and in 1881, 700 gathered in Savannah. The goal of the APHA, according to its constitution, was “the advancement of sanitary science and the promotion of organizations and measures for the practical application of public hygiene.”<sup>8</sup>

■ **Physicians’ participation.** Physicians provided strong support and leadership for the growing movement, and nearly all of the early presidents of the APHA were prominent members of the American Medical Association (AMA). Laypersons were also important within the APHA, and many broadly representative civic organizations took an active interest in public health. As John Duffy notes, the public health movement in the 1870s was now strongly supported by “responsible business leaders who recognized that a reputation for an unhealthy environment hindered community growth.”<sup>9</sup> As an 1883 journal article stated: “‘Sanitary science’...is a segment of political economy, and should receive encouragement by the State as a wealth-creating factor—riches, indeed, to the whole people far above that of any other earthly value.”<sup>10</sup>

■ **Progress at the federal level.** By 1883 the United States had already created its first National Board of Health and then, within a very short time, allowed it to lapse. This was the outcome of a complicated saga that involved reform zeal, epidemic anxiety, jurisdictional jockeying, the political maneuvering of an ambitious federal agency, and congressional reluctance to interfere with states’ rights.<sup>11</sup> Mem-

bers of the APHA had discussed the idea of creating an overarching federal health agency in the early 1870s and had promoted bills in Congress to create a national quarantine system. Congress was at first reluctant to impose federal authority on the states, but in 1878 a devastating yellow fever epidemic sweeping up the Mississippi Valley from New Orleans generated sufficient fear to prompt congressional action. A new bill gave a reorganized Marine Hospital Service—originally created in 1798 to provide hospital care for sick and disabled seamen—responsibility for administering a National Quarantine Act, although with the stipulation that no new federal regulations could interfere with existing state or municipal regulations.

After much further maneuvering, Congress in 1879 considered a new bill, backed by the APHA, to create a National Board of Health and vest it, rather than the Marine Hospital Service, with authority over the national quarantine system. The bill passed but with crippling amendments limiting its lifespan to four years and requiring the national board to follow states' regulations while prohibiting it from making any of its own. Political opposition from the Marine Hospital Service, along with direct resistance by states and municipalities, further undermined the board's authority. With no further outbreak of yellow fever to frighten Congress into stronger action, the National Board of Health was allowed to expire in 1883, and national responsibility for quarantine and public health, such as it was, reverted back to the Marine Hospital Service.

■ **Impact of immigration.** By this time, the next major public health threat was clear: Huge waves of immigrants, especially from Eastern and Southern Europe, were now entering the country while harboring (many suspected) all manner of genetic defects and infectious diseases. Attracted in large part by U.S. industrial growth and prosperity, approximately twenty-four million immigrants arrived between 1880 and 1920.<sup>12</sup> In the early 1890s this wave of immigration coincided with outbreaks of cholera in Russia and eastern Europe, and these latter were the direct inspiration for the National Quarantine Act of 1893. According to its provisions, the surgeon general and the Marine Hospital Service were responsible for preventing the admission of “idiots, insane persons,...persons likely to become a public charge [and] persons suffering from a loathsome or a dangerous contagious disease.”<sup>13</sup> To accomplish this mission, the Marine Hospital Service reviewed all state and local quarantine stations and took over many of them, most notably the recently built Ellis Island facility in New York Harbor, through which about two-thirds of all immigrants entered the country.<sup>14</sup> Reflecting its greatly expanded role in safeguarding the health of the nation and capturing the connection between perceived external threat and public health response, the Marine Hospital Service was renamed the United States Public Health Service (PHS) in 1912.

## The Birth Of Progressivism

For some public health leaders at the turn of the twentieth century, the immigrants were not so much a menace as they were vulnerable people in need of assis-



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tance. Their problems—on the filthy streets of the cities they now called their homes; in foul, dilapidated tenements; in overcrowded, disease-spreading schools; and in deplorable, unprotected, and hazardous workplaces—were but minor variants or intensified versions of problems faced by older generations of Americans as well. These problems were attacked with renewed zeal in a wave of reform generally known as “progressivism.”<sup>15</sup> Men and women, middle and upper class, professional and nonprofessional, joined in campaigns for improved housing, sanitary reform, maternal and child health, infectious disease control, occupational safety, school hygiene, and unadulterated food. They combined the new sciences of bacteriology, chemistry, sanitary engineering, and industrial toxicology with political, economic, and humanitarian principles. Their ranks included Hermann Biggs, Charles V. Chapin, Jane Addams, Alice Hamilton, and S. Josephine Baker. Politically, these reformers offered a middle ground between the cutthroat principles of entrepreneurial capitalism and the revolutionary ideas of contemporary socialists. In an era of “trust-busting,” they seemed comfortable with a role for government authority that emphasized, in a common phrase of the period, “public need over private greed.”

■ **Campaign for national health insurance.** Rising progressive reform intersected in the 1910s with a U.S. campaign to establish national health insurance. Led by the American Association for Labor Legislation—a typically eclectic Progressive Era advocacy group—the campaign for a while gained the support of major national opinion leaders, several state legislatures, and the AMA leadership. It likewise won the approval of public health leaders including, notably, Rupert Blue, surgeon general and head of the PHS, who in 1916 was also head of the AMA. Indeed, in his AMA presidential address, Blue had hailed national health insurance as “the next great step in social legislation.”<sup>16</sup> A prominent PHS surgeon, B.S. Warren, regarded the implementation of national health insurance as an opportunity to reorganize medical care. He envisioned groups of salaried physicians and nurses working under the supervision of local health departments, an arrangement that he said would encourage preventive medicine and “prove to be the greatest public health measure ever enacted.”<sup>17</sup> Controversial surgeon, former editor of the *New York State Journal of Medicine*, and outspoken “nonconformist” James P. Warbasse argued that “some day the care for the public health will be organized...as a public service...The sanitarian will be the strong man. His first business will be to keep his death rate low. This he will accomplish with the cooperation of the district hygienists, internists, surgeons, and other specialists.”<sup>18</sup>

■ **Right-wing reaction.** Political reaction to these visions for social reform was also growing. In 1915 a minister from Georgia, William Simmons, founded the Ku

Klux Klan to control minority groups and any associated social or political nonconformity. As the Russian Revolution of 1917 raised the specter of Bolshevism, America's entrance into the Great War gave a strong impetus to right-wing reaction and patriotic xenophobia. President Wilson signed the Espionage Act of 1917 and the Sedition Act of 1918, giving free rein to the persecution of anyone who criticized the U.S. government or its institutions. In 1919 Attorney General Mitchell Palmer led a national drive against "foreign-born subversives and agitators," and in 1920 his Justice Department agents rounded up more than 6,000 aliens, most of whom were summarily deported.<sup>19</sup> Quota laws and acts in 1921 and 1924 limited the immigration of each nationality to 2 percent of what it had been in 1890, thus deliberately favoring immigrants from northern and western Europe over eastern and southern Europeans. By 1929 mass immigration had perforce been ended.

■ **Assault from the medical profession.** Between 1920 and 1930 Republicans controlled the White House, the Senate, and the House of Representatives. In this conservative, resurgently free-market era, Progressivism further declined and public health itself came under suspicion. The AMA greatly increased its strength in the 1920s and, as the representative of local private practitioners, attacked federal programs as examples of "socialized medicine."<sup>20</sup> One achievement of the Progressive Era reformers had been the Sheppard-Towner Act of 1921, which provided matching funds to the states for prenatal and child health centers. Staffed by female doctors and public health nurses, these centers offered advice to mothers, with the aim of lowering infant mortality rates. In 1922 the AMA condemned Sheppard-Towner as an "imported socialistic scheme" and by 1927 was able to persuade Congress to eliminate the program.<sup>21</sup>

The attack on Sheppard-Towner was part of a much larger rear-guard assault on public health and the community provision of health services by conservative private physicians and their political allies. In 1921 Sen. Reed Smoot (R-UT) attacked the PHS, claiming that it was abusing the prerogatives of states and communities and was intending to "Russianize" the United States.<sup>22</sup> Charles-Edward A. Winslow, president of the APHA in 1926, noted in his presidential address that such attacks, while politically destructive, were intellectually "superficial and frivolous."<sup>23</sup> Moreover, the "the habit of condemning any attempt at intelligent community action by labeling it as 'socialistic' and 'bureaucratic' is...unworthy of serious-minded men." Paul Starr noted that public health in the United States suffered major political consequences from these assaults; it was "relegated to a secondary status: less prestigious than clinical medicine, less amply financed, and blocked from assuming the higher-level functions of coordination and direction."<sup>24</sup> Private practice physicians claimed credit for advances in health status they did not deserve, and the great public health surge that had crested in the Progressive Era, like the economy, crashed in the 1920s.

## Public Health's Brief Comeback

Even before the stock market crash of 1929, a privately funded commission, the Committee on the Costs of Medical Care (CCMC), had met to undertake a five-year study of the rising costs of medical care. The committee published twenty-seven research reports and, in 1932, a final report, *Medical Care for the American People*.<sup>25</sup> Although its recommendations on the reorganization of medical practice drew the most attention, the CCMC also, under the influence of Vice-Chairman Winslow, lamented the woeful state of public health. Only 3.3 cents of the “medical dollar” was spent on public health, in contrast to 29.8 cents on physicians in private practice, 23.4 cents on hospitals, and 18.4 cents on medicines.<sup>26</sup> These “niggardly appropriations” for public health, the report continued, “not only seriously limit present activities, but also hamper medical schools in their efforts to attract competent students to public health careers.”

The CCMC's ambition to expand and improve public health was limited, at least in the short run, by the economic devastation of the Great Depression. Death rates from communicable diseases increased, as did rates of infant mortality, malnutrition, mental illness, and suicide.<sup>27</sup> As banks failed, industrial production dropped, wages fell, and unemployment climbed, state and local health departments found their budgets slashed while the demand for their services soared.

■ **The New Deal.** On taking office in 1933, President Franklin D. Roosevelt began to act on his promised “New Deal” for the American people. Between 1933 and 1938 his administration created a dozen agencies that greatly strengthened the nation's public health infrastructure. Most important of these were the Federal Emergency Relief Administration (FERA), the Works Progress Administration (WPA), and the Public Works Administration (PWA). All three provided funding for state and municipal health departments, public health nursing, and municipal water and sewage systems. In 1935 Titles V and VI of the Social Security Act provided millions for maternal and child health services and for public health in general. Social Security funds were channeled through the PHS, which in turn allocated them to the states based on their population and special needs. Social Security funding, along with other agencies' money for construction of health facilities and public works, dramatically raised the level of public health services throughout the country.<sup>28</sup>

■ **Impact of World War II.** The entrance of the United States into the war in 1941 disrupted all normal civilian activities. As health departments lost personnel to wartime agencies, they also faced new challenges as military camps and war industries brought massive population shifts, new industrial hazards, and increases in infectious disease rates. The PHS began strong and effective programs against venereal diseases and malaria—the latter especially in the southern states. The Center for Controlling Malaria in the War Areas formed the nucleus of what would later become the Centers for Disease Control and Prevention (CDC) and, for the first time, eradicated malaria from the South.<sup>29</sup> Other major legacies of the war included an improved vaccine for yellow fever, a typhus vaccine, and mass production of the “mira-



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cle drug” penicillin.

With the end of the war came a brief interval of exhilaration and hope for the future. In 1944 Surgeon General Thomas Parran outlined an ambitious plan for the future of the PHS, including complete public health services, the public provision of medical care, and federal funding for health professional education and medical research: “The principle is accepted that no one in the United States should be denied access to health and medical services because of economic status, race, geographical location, or any other non-health factor or condition. It is a duty of governments—local, State, or Federal—to guarantee healthful living conditions and to enable every person to secure freedom from preventable disease.”<sup>30</sup>

## **The Cold War And McCarthyism**

These more expansive visions were not to be realized. The mood in the country soon changed dramatically with the Cold War and advent of McCarthyism. In a period of deepening conservatism from the late 1940s through the late 1950s, many of the most articulate and outspoken government officials, professors, and public health leaders came under attack, were silenced, or lost their positions and influence. Anyone advocating expanded public health services ran the risk of being denounced as a socialist or communist; even such cost-effective measures as the fluoridation of water supplies aroused public suspicion as a foreign plot and provoked “red-baiting” attacks. The most important single public health initiative of this period came from the Foundation for Infantile Paralysis, a private organization that provided funding to develop the polio vaccine when state and local health department budgets were being drained of resources. At the federal level, only the CDC grew significantly, led by chief epidemiologist Alexander Langmuir’s success in creating an “Epidemic Intelligence Service,” ostensibly to help the country prepare for the threat of Communist-initiated biological warfare.<sup>31</sup>

## **Renewed Social Activism**

■ **The War on Poverty.** In the 1960s many issues ignored or suppressed in earlier years gained renewed popular attention. The election of President Kennedy, the passage of the Civil Rights Act of 1964, and President Johnson’s “War on Poverty” all signaled a new interest in addressing social inequities at home, as revealed and brought forcibly to national attention by the civil rights movement.<sup>32</sup> The passage of Medicare and Medicaid provided more accessible health care services to the elderly and the poor. Following the traditional patterns of reimbursement set by the private insurance system, they permitted, and indeed encouraged, the further expansion of high-technology hospital care while leaving public health—increasingly defined to

include outreach to the poor and uninsured—in the shadows. As part of the War on Poverty, however, the Office of Equal Opportunity (OEO) helped to start 100 neighborhood health centers, and the Department of Health, Education, and Welfare (HEW) supported another fifty.<sup>33</sup> The aim of the most ambitious of these centers was to provide comprehensive public health and primary care services and to encourage community participation. The program allowed the brief flourishing of several exciting experiments in which poor communities helped to define their most urgent public health and medical care priorities.<sup>34</sup>

■ **The environmental movement.** The social reform and protest movements of the 1960s bore considerable resemblance to those of that earlier period of social activism, the Progressive Era. The anti-atomic testing and antinuclear movements, the anti-Vietnam War and student movements, the women's movement in its various forms, and various branches of the civil rights and poor people's movements sustained open and often visionary forms of utopian politics and social experiments.

In this generally progressive social ferment, a strong environmental movement developed around the catalyst provided by publication of Rachel Carson's *Silent Spring* in 1962.<sup>35</sup> By 1970 Earth Day attracted some twenty million Americans in demonstrations against pesticides, industrial pollution, and other threats to the natural environment. Carson's work had helped make the connections between public health, the environment, and quality of life.<sup>36</sup> Within the federal government, the environmental movement spurred the creation of the Environmental Protection Agency (EPA) and passage of the Clean Air Act of 1970. At the same time, community outrage was channeled against such hazards as substandard housing and lead-based paint, while labor mobilization and public distress over the toll taken by industrial exposures, injuries, and mining disasters prompted the creation of the Occupational Health and Safety Administration (OSHA) and the National Institute of Occupational Safety and Health (NIOSH).

■ **The ferment of the 1970s.** Scientist and physician networks such as the Medical Committee for Human Rights and the Committees on Occupational Safety and Health (COSH groups) helped push for progressive legislation and make connections between community and labor groups and federal policymakers.<sup>37</sup> Ralph Nader and his public interest research groups and Tony Mazzochi, legislative director of the Oil Chemical and Atomic Workers union, were among the more prominent working on environmental and industrial hazards. But as unemployment grew and the economy stuttered during the early 1970s, followed by the OPEC oil embargo and general recession from 1973 to 1975, many workers became anxious about losing jobs and protecting what they had and less willing to worry about the environment or the health of the poor and vulnerable. Moreover, with the proliferation of new federal agencies and multiplying constituencies pushing often conflicting agendas, the 1970s saw the growth of state and federal bureaucracy, contentious litigation, and, ultimately, the questioning of the efficacy of government intervention itself.<sup>38</sup> The resurgent progressive wave of 1968 to 1973 crashed amid the economic dif-

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 faculties and the growing political backlash of the 1970s and was followed by a period in which the ideology of a largely unregulated market economy gained new popularity as the key to public policy.<sup>39</sup>

## **Public Health In Retreat**

Already during the Carter administration, health care reform and the promotion of a broad public health agenda were in retreat, signaled most clearly by the administration’s reluctance to endorse national health insurance legislation that even Nixon had supported earlier in the decade.<sup>40</sup> The Reagan administration then swept into Washington on a wave of free-market, “supply-side economics” rhetoric. The Reagan revolution set out to dismantle regulatory agencies and social programs in an assault one author characterized as a transformation of the 1960s war on poverty into the 1980s war on welfare.<sup>41</sup> Health programs for the poor and underserved were shut down or slashed, with any surviving federal funding being bundled into “block grants” to states. Under this “new federalism,” the Reagan administration drastically cut overall allocations, generally abrogated responsibility for health and social welfare, and pushed the burdens and tough priority-setting decisions back to state and county authorities.

Within a short time, the consequences of Reagan’s policies, in creating the greatest upheaval in the American health system since World War II, were clear. What the reform politics of the 1960s and early 1970s had built up, the new politics of the late 1970s and 1980s now tore down. Health indicators worsened, and the long-term decline in infant mortality rates flattened for the first time in many decades.<sup>42</sup> The IOM’s Committee for the Study of the Future of Public Health rightly concluded that the nation had allowed its system of public health activities to fall into disarray.

This disarray occurred at the worst possible time, as the HIV/AIDS epidemic was spreading. The United States lost an early opportunity of mounting a really effective preventive program against AIDS, and, for a long time, the administration seemed determined to ignore the growing threat. As tuberculosis control programs were cut back, tuberculosis again emerged in the alarming form of drug-resistant strains. Globally, previously unknown diseases such as Ebola were appearing; old enemies such as plague and cholera were returning.<sup>43</sup> In the United States, hantavirus and West Nile virus seemed to represent a potentially unending stream of unfamiliar and potentially dangerous organisms.<sup>44</sup> In this context, the new threat of bioterrorism takes these worries to a high pitch of anxiety.

Why this awful moment and this anxious but long overdue reckoning? Because, most basically, we have not learned the lessons of our public health history. We

continue to mobilize episodically in response to particular threats and then let our interest lapse when the immediate crisis seems to be over. When will we learn to build and sustain the adequately supported institutions and personnel we need to protect the public's health in the long term? We should not allow the priorities generated at our worst moments of anxiety to displace those generated for the sustained and systematic addressing of long-standing needs, especially those of the most vulnerable of our populations. Moreover, we should not allow ideological shifts and inevitable economic cycles to deflect us from maintaining appropriate public and governmental responsibility for the health of the community. Too much is at stake, and in public health we are all legitimate "stakeholders."

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*The views and interpretations reflected in this essay are those of the authors and do not necessarily represent the positions of their institutions.*

#### NOTES

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