

Session 3327.0 – APHA: Reflections on Fourteen Decades of Public Health
Comments by Theodore Brown on Presentations by Jay H. Glasser and John Lumpkin

The presentations by Jay Glasser and John Lumpkin serve as wonderful examples of the excitement and importance of public health history. We become acquainted with past and continuing struggles for the public's health, and we learn about those who took the lead, the obstacles they faced, and, sometimes, the successes they enjoyed. As John Lumpkin has reminded us by citing George Santayana, "Those who cannot remember the past are condemned to repeat it." But as someone who earns his living as a professional historian, I'd like to suggest a few ways in which their historical explorations can be pushed a bit further, to make them even more useful for us in the present.

Let me turn first to Jay Glasser's presentation. He calls it a "flyover," and I agree that it is a great overview at about 30,000 feet. We get a sense of the struggle, courage, and heroism, but also a blur of problems and reformers, of successes and defeats, and of allies, enemies and sometimes mysterious political processes. I think we really need to come down to ground level from our flyover, to inspect the terrain at our feet in order to use history most effectively to find our way forward.

Let me take just two examples. Jay introduces us to Herman Bundeson who apparently had a stormy reign as Chicago's Health Commissioner in the 1920s. He introduced controversial measures such as setting up free venereal disease clinics and distributing condoms widely. He didn't play ball politically, so he was fired. But he was undermined as much or more by the medical profession as by politicians. He was attacked regularly in the *Illinois Medical Journal*, which called his programs "outrageous" and an "unlicensed exercise of power," and I suspect that the *Journal* targeted his infant welfare program as often – or more often – than his venereal disease program. After all, his great success in reducing Chicago's infant mortality came in the 1920s just as the national AMA (headquartered, lest we forget, in Chicago) and its state and county affiliates waged all-out war on the Sheppard-Towner Maternal and Child Health Act of 1921 and finally got it defunded and then repealed by 1929 because of its "horrible" intrusion of "state" (i.e. "socialized") medicine into private practice. This was certainly not the only instance of the bitter opposition between private practice medicine and public health, and we really need to know more about it in a fully grounded historical exploration.

Let me take another example, this from the late nineteenth century in the area of tenement house reform, sanitary inspection, and immigrant health. I strongly recommend for close reading an article

invisible and begins to lose support. Loss of support leads to insufficiency of funding – or even cutbacks – and this can lead to insurgent or resurgent public health problems because of decayed and neglected public health infrastructure. Then public health is blamed for not protecting the public against the latest health crisis. This might lead to a burst of interest and an infusion of budgetary support, but then by Catch-22, the long-term cycle continues. He seems to imply that if we want to support public health more effectively, we need to focus on *crises* or, at least, we need to take advantage of them strategically. Every crisis is a potential opportunity, and it should be seized upon.

I got a good glimpse of that strategy in action by the public health community – at least as represented by the leadership of CDC – in late 2001 in the wake of the anthrax scare to which Dr. Lumpkin referred. The journal *Health Affairs* was considering a special issue on public health policy – I believe its first ever – and scheduled a high level meeting in its editorial offices on Dupont Circle in D.C. Leaders of CDC were there, along with several Washington insiders, and Liz Fee and I were invited to attend as public health historians, probably because of our role as editors for the history sections of the *American Journal of Public Health* and also probably because in May 2001 we had published an article in *AJPH* trying to put bioterrorism and biopreparedness into historical perspective. That article went back to the CDC's efforts during the height of Cold War anxiety and paranoia in the 1950s that led to the creation of the Epidemiological Intelligence Service (EIS) that the CDC rode to substantially greater prominence and budgetary support.

At the meeting on Dupont Circle there was considerable emphasis on the need to use the “crisis” generated by the anthrax scare to greatly increase funding for public health, to build up the infrastructure, and to add capacity for surveillance and biopreparedness. How else to regain the ground that had been lost in the eighties during the Reagan Administration, that had led to a major Institute of Medicine report lamenting the poor state of the nation's public health? Focusing on bioterrorism preparedness during the Clinton Administration and turning attention to newly emerging diseases like Ebola had helped restore some budget and re-grow some infrastructure, but the CDC and its allies understood that the anthrax scare presented a tremendous new opportunity that should now be seized and fully exploited to build up or, at least, build back public health.

What did Liz and I think? How might we as historians contribute to the special issues of *Health Affairs* that would promote this agenda? As you might have guessed, as historians we were a bit skeptical and certainly unwilling to become unreflective cheerleaders for a crisis-oriented public health. We mulled over our options and came up with the suggestion that we would write an overview paper on the long-term history of public health in America, but one that expressed some

hesitation and maybe even a little skepticism about mobilizing public health around the response to crises. Our paper was published in that special issue of *Health Affairs* in November 2002 (Vol. 21, no. 6, pp. 31-43). We called it “The Unfulfilled Promise of Public Health: Déjà vu All Over Again.” This was our 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 in public health has been shaped by our earlier, limited, and crisis-focused responses to changing disease threats.”

Our basic purpose was to highlight what we had come to regard as a long-standing tension within U.S. public health between the pull towards crisis-response and “preparedness” on the one hand and a pull towards “social justice,” serving the poor, vulnerable and neglected on the other. You might consider the tension, in Chicago terms, as between mobilizing public health under Oscar De Wolfe to protect the “better sort” against the disease threat of the tenements teaming with poor and dirty immigrants *versus* mobilizing reform efforts under Jane Addams, Alice Hamilton and the others at Hull House and making *these* reform efforts the essence and focus of a social justice-driven public health. Preparedness and crisis-response can generate the political support and the budget that public health needs to survive, and the social justice approach making the needs of the most vulnerable the first priority runs the risk of offending elites and power brokers, thus leading to the underfunding or even the defunding of public health. Liz Fee and I wanted to raise these difficult questions in 2002, when it would have been easy to jump on the bandwagon and ride the anthrax scare to expanded support of public health. We’ve learned since that newly allocated “biopreparedness” funds helped the overall budgets of health departments, but often at the expense of ongoing STD and HIV/AIDS programs, sometimes draining them of budget and personnel. I’m not so sure that those issues have been resolved and that a proper balance has been restored. So I for one want to say that the strategic use of crises to support public health may come with considerable if subtle risks along with obvious advantages. History has its uses, even if its explorations don’t always reinforce our current priorities.