Accretion, Reform, and Crisis: A Theory of Public Health Politics in New York City

DANIEL M. FOX, Ph.D.

Milbank Memorial Fund, New York, New York

Received May 7, 1991

Standard interpretations of the history of public health in New York City in the twentieth century describe either the decline or the growth of the importance accorded to public health activities. To the contrary, public health has, paradoxically, both declined in salience and attracted increasing resources.

This article describes the politics of public health in New York City since the 1920s. First it describes events in the history of public health in the context of events in the economy and in city, state, and national politics. Then it proposes three descriptive models for arraying the data about public health politics: accretion, reform, and crisis. Next it describes how the politics of AIDS in New York City in the 1980s was a consequence of the history that produced these three political styles. Finally, it argues that the three political styles are generalizable to the history of public health throughout the United States in the twentieth century.

Most accounts of the history of public health in New York City between the 1920s and the 1980s describe either the decline or the growth of public health activities. Advocates of the hypothesis of decline claim that the enterprise of public health has been less prominent in the life of the city than it was between the 1880s and the First World War, the years dominated by the innovative policies of Hermann N. Biggs and his colleagues [1]. The evidence they present to demonstrate decline includes diminished priority accorded by mayors to the Department of Health in comparison with other city agencies, the tolerance by public health professionals of inefficient political appointees within the Department, and the transfer of such public health functions as hospital administration and environmental protection to newly created agencies.

The advocates of the growth hypothesis emphasize that the activities defined as public health and the resources allocated to them increased enormously during these seven decades [2]. The enterprise of public health within the city has, they claim, expanded throughout the century, in both the public and the voluntary sectors. By any measure—money spent, employees, publicity, regulation and its enforcement—public health has become more, rather than less, prominent within the city over the years.

Each of these hypotheses is incomplete. There is considerable evidence that public health was more prominent on the agenda of the city’s political leaders at the turn of the century than it has subsequently been. But there is also evidence that the enterprise of public health has continued to expand in both size and scope since then. Moreover, significant changes occurred in the politics of public health while it was, paradoxically, both declining in salience and attracting increasing resources. These
changes made it possible for public health professionals in the city to complain that they were underappreciated even as their authority and appropriations grew.

This article is an inquiry into the political history of public health in New York City. I propose a theory, less grandly a framework, for interpreting what appear to be chaotic and contradictory events. The essay is historical, but it is not strict chronological history. I begin by characterizing the politics of public health in the city since the 1920s. Then I present three political styles that have been employed by the public officials, health professionals, and leaders of voluntary organizations who have been the major participants in the enterprise of public health. I call these styles the politics of accretion, of reform, and of crisis [3]. Each of the three styles is, in the technical language of social science, a descriptive model, an abstraction that is intended to assist readers in interpreting masses of data. Finally, I will briefly explain how the politics of AIDS in New York City in the 1980s was a consequence of the history that produced these three political styles.

Throughout this article I use an empirical definition of public health: it is what the people who define its politics and policy at any time say it is. The activities people describe as public health change over time and vary among professionals and leaders of interest groups at any time. I use the phrase “the enterprise of public health” to encompass the definitions used by influential actors in the history of public health in New York City at particular times during the past seven decades. The enterprise of public health has always been broader than the mandate of the city’s Department of Health. Thus at times some readers will be tempted to say, “But that’s not public health.” Such temptations should be interpreted as warnings that the reader is imposing order retroactively on an untidy past.

The definitions of the enterprise of public health that have been used in the years described in this article do, however, have two unchanging elements. One is that public health includes whatever influences the health status of populations. The other is that it includes most preventive, many diagnostic, and some therapeutic services for the poor and the medically indigent.

**PUBLIC HEALTH IN CITY POLITICS**

The importance of public health on the political agenda of New York City government diminished gradually in the 1920s and very rapidly beginning in the early 1930s. The major cause of this diminution was the increase of public responsibility in other areas of policy. When Hermann N. Biggs began to dominate the policy and politics of public health in New York, in the mid-1880s, the city had no subways, few bridges, no massive public housing projects and hospitals built with the assistance of federal funds, and no responsibility for providing relief to the poor in their own homes. The population of the city was considerably smaller. During the first decade of Biggs’s ascendancy, the political city consisted only of Manhattan and the Bronx. The largest influx of immigrants and internal migrants occurred in the decade after 1900. During the city’s annual budget negotiating season, aggressive public health leaders competed for resources mainly with their counterparts, who administered the police, the courts, and public construction [4].

The diminished importance of public health on the political agenda of city government was evident during the first administration of Mayor Fiorello La Guardia, from 1933 to 1937. The Mayor paid attention to public health issues only when they offered an opportunity to bring money and therefore jobs to the depressed
city economy. He worked hard to obtain federal construction money in order to build two new public hospitals on what was then called Welfare (now Roosevelt) Island. He gave attention to studies and new services that were paid for with federal funds appropriated for employing the unemployed or allocated under the public health titles of the new Social Security Act. He even scheduled his photo opportunities involving public health—unlike, say, those involving police or fire services—to display his skill in obtaining federal funds [5].

The pattern of agenda-setting in city government established in the first La Guardia administration has persisted. Mayors, their aides, and other elected officials have quietly supported increased public health budgets, especially when growth was accompanied by new funds from the state or the federal government. These leaders of general politics became involved in explicit issues of public health policy only during crises, notably an epidemic or the threat of one.

Moreover, the public health enterprise has grown most rapidly outside city government in the past 70 years. This pattern of growth was evident in the 1920s, when the Milbank Memorial Fund financed an expansion of the number and mission of the health centers established a decade earlier by the city’s health department. The city’s Department of Hospitals, carved out of the Health Department in the late 1920s, distributed increasing amounts of money in order to assist voluntary hospitals and clinics to serve the poor and the medically indigent. In the early 1930s, voluntary agencies conducted pioneering studies to comprehend the magnitude of chronic disease and its implications for health services [6].

The most important public health innovation in the city during the 1930s, the founding of the Associated Hospital Service (now called Empire Blue Cross) was the work of voluntary agencies and a sympathetic state government. Blue Cross and, later, commercial health insurance relieved the city and philanthropic agencies of the cost of routine health care for many low-paid workers and the costs of catastrophic illness for many in the middle classes. When, in the third La Guardia administration, political officials and civic reformers organized a prepaid group practice alternative to fee-for-service medicine, initially to provide physicians’ services to city employees, the Health Insurance Plan, they contracted with Blue Cross to cover hospitalization for its members [7].

In sum, the salience of public health on the agenda of general politics diminished at the same time that the stakes in public health politics increased. As a result of this double shift, intense competition for resources in public health occurred outside the arenas of public debate. Health politics were not closed politics: no arena of sectoral politics can remain closed for very long in the United States. But key actors in health politics have been more frequently accountable to interest groups alone than have their counterparts in transportation, construction, zoning and urban development, public housing, landlord/tenant relationships, or the police, fire, and criminal justice systems.

The provider and professional interest groups to which key actors in public health politics accounted have not been monolithic. There has been considerable conflict among interest groups in health affairs. Within the medical profession, for example, community practitioners who were specialists had different interests from those who were generalists. Similarly, academic and community-based physicians increasingly had conflicting interests (especially after the 1960s); public health physicians have often been at odds with colleagues in other specialties, especially over the boundaries
of prevention, diagnosis, and treatment. Members of different professions frequently struggled over matters of public health policy: optometrists and ophthalmologists, for example, disagreed about who should prescribe corrective lenses for the poor and the medically indigent; nurses and social workers claimed professional territory coveted by each other and by some physicians. Voluntary hospitals had a large stake in increasing their reimbursement from public funds for the care of the poor, often at the expense of public institutions. Blue Cross insisted on discounted hospital rates in exchange for permitting its subscribers' payments to cross-subsidize treatment for the poor and for enrolling at community rates people who were self-employed or worked in small businesses. Commercial insurance companies resented the discount to Blue Cross. These examples could be multiplied many times [8].

Moreover, public health politics became so fragmented that it sometimes seemed artificial to talk of an enterprise of public health. In Biggs's time, the city's health department struggled with professional interest groups about every issue bearing on the health of populations and medical services for the poor. These struggles occurred mainly within the city, with the occasional involvement of the New York State Legislature.

Beginning in the 1930s and with increasing speed after the Second World War, there were new issues, new players, and new arenas. The most significant new issues were modern variants of older themes in public health. For instance, hospital regulation, financing medical care for the poor, and protecting against environmental hazards had once been called hospital visiting, charity care, and sanitary inspection. But debates about these traditional issues now occurred in a new, national arena. Moreover, state officials enlarged their role, making broader use of their constitutional authority to determine the institutional governance, expenditures, and tax levies of cities.

Beginning in the 1930s, the federal government replaced philanthropy and state and local government as the major source of funds to construct and renovate hospitals. The federal Hill-Burton program, named after the Act that created it in 1946, standardized the formula for distributing hospitals, especially outside major cities, and many aspects of their construction. It also strengthened the power of state agencies, whose officials prepared the plans on the basis of which the federal government allocated funds. Hill-Burton transformed public hospital politics in New York City, ending the special relationship that Mayor La Guardia had established with New Deal agencies that supplied funds for construction [9].

Hill-Burton also encouraged local advocates of expanded medical services for the poor. The federal government, as the courts later decided in response to class-action suits, chose not to enforce the standards for supplying care to the poor without charge that were contained in the Act. But the standards provided a platform for advocacy [10].

Events in the 1960s and 1970s strengthened the power of the states and the federal government in hospital affairs. Financing hospital and medical care for the poor, a public health responsibility that had earlier been shared by philanthropy and city government, became a high-stakes game with new players, beginning in the 1950s. In the early 1950s, national legislation permitted city and state agencies to purchase medical care for the poor from so-called "vendors" (private and non-profit providers), using federal welfare funds. A little more than a decade later, the Medicare and Medicaid programs made medical care for the poor a lucrative enterprise. Hospitals
and clinics that had struggled to balance their budgets with gifts from philanthropists and grants or vendor payments from government could now bill the federal government’s financial intermediaries and the state on the basis of fees and negotiated charges. Moreover, the federal government set initial Medicare reimbursement rates generously in order to mollify the medical societies and hospitals that had threatened to boycott the program. Teaching hospitals in New York and other cities realized that the patients on whom they had traditionally lost money, the elderly and the poor, now provided a greater proportion of their income than patients with Blue Cross or commercial insurance. Medical school faculty members now discovered that their teaching and research patients, whom they had recently treated without charge as a matter of enlightened self-interest, could now generate funds for their institutions and themselves. Not surprisingly, the gap between the earnings of medical faculty and the net incomes of their colleagues in the community narrowed very quickly.

In the early 1960s, the purpose of state hospital policy changed. The purpose now became regulation, especially of soaring hospital costs and payments, rather than increasing the supply of facilities. In New York, Blue Cross and the State Health Department pooled their considerable power in the early 1960s to create an official mechanism to assess requests by hospitals to build, renovate, or buy expensive equipment. The mechanism was called certificate of need. It was implemented by a newly created State Hospital Review and Planning Council. By the late 1960s, the federal government could influence hospital revenues through its power to set rates for Medicare, which accounted for a quarter to a half of the income of every hospital in the city. In 1969, New York state government began to set rates for reimbursement to hospitals from Blue Cross, as well as from Medicaid, and to certify the rates hospitals charged to commercial insurers. In this context, city government, itself a major provider of hospital care, often became indistinguishable from other interest groups that were competing to influence state and federal policy.

The politics of health care financing in the United States became extraordinarily complicated in the late 1960s. Skilled practitioners of these politics worked at every level of government, with both non-profit and commercial insurers, and with a variety of interests in the medical specialties and other health professions.

What had been a reasonably narrow set of interests as recently as the 1940s had been fragmented. Before the 1960s, city health officials, a handful of powerful philanthropists and their staffs, and leaders of a few medical societies could define a community’s responsibility for providing health care to the poor. By the 1960s, the problems of health care for the poor were beyond the reach of most local actors, even when they coalesced. Moreover, it was often beyond the comprehension of anyone except experts who devoted their professional lives to the politics of health care financing.

The new politics of race and ethnicity intensified the fragmentation of the politics of health care facilities and financing. During and after the Second World War, the black and Hispanic population of New York City increased rapidly. Public health officials and leaders of interest groups became increasingly aware of blacks and Hispanics as recipients of services and as employees, often the lowest-paid employees, of hospitals and other service agencies. The annual reports of the Health Department took little notice of the changing demography of the city until the early 1950s. Then, under a new and vigorous Commissioner, Leona Baumgartner, there was swift recognition of the significance of blacks and Hispanics for the politics of
public health. This recognition was symbolized by the annual report of the Department for 1953. For the first time, a third of the persons in public relations photographs (17 of 52) were recognizably black or Hispanic [11]. In the next several decades, the bitter politics of race and ethnicity could never be ignored in competition for the resources allocated to public health. Beginning in the 1950s, moreover, with the early organizing campaigns for Local 1199, the union that organized workers in voluntary hospitals, the politics of race and ethnicity were often expressed in strikes, demonstrations, and angry confrontations.

Similar fragmentation occurred in environmental policy. Beginning in the 1940s, new agencies became responsible for issues that had long been addressed by public health officials. The city created a new department of air pollution control in 1949. Noise abatement was delegated to the traffic authorities. The new distribution of environmental responsibilities in the city was influenced by corresponding changes at the state and federal levels. By the 1980s, many areas of environmental regulation and its politics had become almost totally separated from the politics of public health.

THE LEGACY OF POLITICAL HISTORY

The political history I have summarized had a profound influence on the enterprise of public health in New York City. During most of the past 70 years, and especially after the Second World War, most of the politics of public health has occurred outside the view of the general public, of the media, and of the elected officials who preside over general-purpose government. Public health has intersected with general politics on relatively few occasions, in comparison with other areas of civic life. These occasions have been, mainly, the financing or the opening of new and expensive hospitals and outpatient facilities, Blue Cross requests for increases in its community rates, strikes, demonstrations, scandals and lawsuits, and the threat of epidemics, notably influenza in 1947 and 1976, polio in the 1940s and early 1950s, and AIDS in the 1980s and 1990s.

Few of the instances when public health politics intersected with general politics have resulted in lasting changes in policy or institutional arrangements. Even public health crises have not precipitated institutional change, as they did in the nineteenth century. Biggs succeeded in requiring reluctant physicians to report new cases of tuberculosis because leaders of general politics perceived the high mortality from the disease as a threat to the voters who returned them to office. He was able to make permanent the temporary laboratory he established to manufacture diphtheria antitoxin in 1894 because he persuaded the leaders of general politics that the logic of the new bacteriology made it necessary for the city to provide resources that did not exist in the private sector.

In the twentieth century, however, public health crises have been occasions for visible public management rather than for fundamental changes in policies. There appear to be two reasons for this difference in the effects of crisis. The first is that, in the nineteenth century, proposals for innovation in response to public health crises appeared to have a high probability of success and relatively low costs: report a disease; isolate a contagious person; manufacture an antitoxin. The single best example is the creation of the city health department itself in response to an epidemic of cholera. In contrast, it has been much more difficult to devise low-cost permanent policies to pay or to limit the costs that result from the cumulative burden
of chronic disease (including such chronic infections as venereal disease and AIDS). Strikes and racial tensions are no more preventable or amenable to negotiation and moral principles in health care settings than anywhere else. Scandals are endemic wherever money flows as a result of public policy. Crises led to significant changes in policy only when a vaccine became available, as it did for polio, or for a condition such as retrolental fibroplasia (blindness in newborns as a result of the use of medical oxygen), for which an easy remedy was available once the cause was detected. It became difficult even to create and resolve a neighborhood crisis over an isolated victim of diphtheria or scarlet fever after 1943, when, for very good scientific reasons, the Department of Health abandoned the practice of placarding the homes of persons with these diseases [12].

A second reason that the occasional convergence of public health and general politics has not led to major changes in policy is the changing role of crises in public government. For more than half a century, issues have only received significant attention in general-purpose city government after they have been defined as crises. Creating credible crises has become the best way for officials or for interest groups to escalate an issue on a crowded city political agenda. Political leaders define their purpose in managing a crisis as making it recede with the maximum credit to themselves and the minimum memorable harm to substantial groups of voters. In a political environment in which most crises are made by clever people who are angry or upset, it is highly practical to define success in crisis management as some combination of reallocating resources and obtaining favorable attention from the media.

Since creating a crisis is at best only temporarily effective in raising the salience of issues on the agenda of city politics, leaders of the public health enterprise have devised other political styles to achieve their goals. One style I call the politics of accretion; the other, the politics of reform. Taken together, these three political styles—crisis, accretion, and reform—have provided leaders in the public health enterprise with an arsenal of political weapons.

The three styles, as I present them below, are descriptive models. In other words, they are abstractions intended to clarify masses of data. Leaders of the public health enterprise have not chosen to employ a politics of crisis or accretion or reform on any particular day. My argument is simply that most of their behavior since the 1930s can be grouped under one of the three styles, or under some combination of them.

THE POLITICS OF ACCRETION

Accretion has been the most frequent and, in many ways, the most successful, political style in the enterprise of public health in New York City. The most skillful adherents of this style have caused a great many resources to be allocated to public health and have vastly expanded the scope of public health practice.

The politics of accretion, its advocates claim, has hardly anything to do with general politics. It is primarily about the use of the best scientific knowledge to measure the illness and the health of populations and to implement those measures that reduce the former and improve the latter. A classic description of this style was the remark of one former health commissioner, Mary McLaughlin, talking about another, Leona Baumgartner. "Mayor Wagner gave Leona everything she asked for," Dr. McLaughlin claimed, "and she never had to play politics" [13].
Some advocates of the politics of accretion have believed, like Dr. McLaughlin, that the most important public health policies can be deduced from scientific knowledge; others have been more cynical, using science as a more defensible rationalization for their policy preferences than either ideology or a subjective (or partisan) concern for a particular group of people. All of them, however, insist that the enterprise of public health must expand gradually and steadily. Moreover, they have been less concerned with the organizational structure of the agencies administering the enterprise than with insisting that it is axiomatic that appointments in these agencies be made on the basis of professional criteria rather than the loyalties or demographic imperatives of partisan politics.

The politics of accretion has led to an impressive record of innovations in the enterprise of public health in New York City. Most of these innovations have taken the form of new services or outreach to new populations. Here are a few examples from the hundreds available in the records of the City's Department of Health: public health nurses assigned to domestic relations court (1929); neighborhood clinics and integrated service centers (late 1920s on); maternity and infant care (augmented with federal Social Security funds in the 1930s, with funds for armed services dependents in World War II, and with city funds after the war); diagnostic centers for cancer and other diseases (early 1950s); family planning (1940s on); diabetes control (1950s); fluoridation of the water supply (1964).

In chronic disease management, accretion occurred mainly outside the city health department until the 1950s. In the mid-1930s, the Hospital Commissioner, Sigmund S. Goldwater (a former Health Commissioner, Superintendent of Mt. Sinai Hospital, and an architect of Blue Cross), collaborating with the Rockefeller Foundation, persuaded the medical schools of Columbia and New York Universities to establish research and teaching programs at a new public hospital for patients with chronic diseases. In the 1940s, the Health Department, using federal funds, established programs for crippled children and for cancer prevention.

The politics of accretion also characterized the expansion of the governmental responsibilities for the environment. Again, here is a brief chronological summary: intervention to measure noise levels (1929); expanded sanitary services (1930s); a study of smoke hazards and other toxins (federal relief funds, 1930s), poison control (1930s and 1940s), and radiation hazard inspection and control (1940s and 1950s).

The practitioners of the politics of accretion have often complained that New York City was underspending for public health. In 1933, New York's $.63 per person was less than the $.70 to $1.45 spent by other major cities. Even in 1944, after a decade of La Guardia's reform administration, per capita expenditure for public health in the city had risen to only $.88: less than in Washington, D.C., Boston, Detroit, or Milwaukee, though more than in Philadelphia or Los Angeles.

Other practitioners of the politics of public health used such comparative data to question the effectiveness of accretion as a political style. Even under La Guardia, public health had not been a major priority of city politics. The politics of public health reform was an alternative to the politics of accretion.

THE POLITICS OF REFORM

Practitioners of the politics of reform have, for six decades, called for thoroughgoing changes in the policies that affect the health of the public. Many reformers have, over these decades, begun their advocacy by insisting that a precondition for
adequate public health policies is substantial renovation of the system by which health services are organized and paid for in the United States. Almost all of these advocates have insisted that a universal solution to financing health services, usually under a national health insurance program, is an important initial step toward improving the health of the public. In the 1930s, some leading reformers insisted that public provision of old age pensions, what became Social Security, must precede national health insurance: that adequate income made possible better nutrition and housing and thus better health. In the 1940s, reformers supported the various national health programs that were proposed in Congress. In the 1950s, some of them endorsed, as a temporary expedient, a combination of voluntary health insurance, social insurance for the elderly, and welfare benefits for the poor. A decade later, when this expedient became national policy during the Johnson administration, the reformers regarded it as the first installment of an imminent national system of comprehensive health insurance.

The practitioners of the politics of reform also made proposals for thoroughgoing change in New York City. Some of these changes would be in the structure of public agencies; others would alter methods of financing services, especially for the poor. The earliest example I have found of a reformist call for structural change was an appraisal of the City's Department of Health in 1933 by a committee of the American Public Health Association. The committee found that the Department "urgently" needed "capable leadership." The dire situation of the Department demanded "a new philosophy" as well as much more money [14]. In subsequent decades, advocates of reform called for such changes as reorganizing the city's hospitals in a separate public benefit corporation, requiring medical schools and voluntary teaching hospitals to give higher priority to health care for the poor, and creating a superagency to bring better management to the city agencies with responsibility for health and the environment.

The reformist political style was also evident in proposals to change the organization and financing of health services for significant groups of New Yorkers. Many reformers supported the Health Insurance Plan, organized initially for city workers in the third La Guardia administration. In the 1960s, many of them regarded the neighborhood health centers sponsored by the federal anti-poverty program as precursors of a future system of prepayment and group practice that was sensitive to the needs of black and Hispanic people.

Many participants in the politics of accretion also supported innovations promoted by the reformers. The three styles of public health politics have not been mutually exclusive. But the priorities of the accretors and the reformers have been different. They were sometimes different as a result of ideology; but more often as a result of who paid whose salaries. It was easier for a medical school faculty member or a labor leader than for a civil servant to be a reformer. At times, moreover, it was possible for both accretors and reformers to practice the politics of crisis, especially the variant of it that emerged in the 1960s.

THE NEW POLITICS OF CRISIS

As I described earlier, the politics of public health crises has had a venerable history in New York City. By the early 1950s, most of the practitioners of the politics of accretion and of reform believed that crises caused by epidemics would no longer occur. "Major epidemics have disappeared," declared Leona Baumgartner in 1966,
in an address commemorating “One Hundred Years of Health” in New York City [15]. During the previous decade, public health officials in the city had redefined the concept of crisis to take account of this self-evident new reality. As early as 1955, Baumgartner insisted to the mayor that the importance of the outbreaks of polio earlier in the decade had been exaggerated. She called attention to what she called new “crises” caused by the increasing burden of chronic disease and the explosion in health care costs [16]. Her successors as Commissioner of Health advanced similar arguments. Almost all of them talked of crises—but they meant crises of finance and administration that were translated into inadequate access to health services for large numbers of people.

By the late 1960s and early 1970s, that is, the leading practitioners of the politics of accretion believed that the only new crises would be those that alarmed the advocates of the politics of reform. Crises would now result from the burden of chronic illness in an aging population, from growing numbers of poor mothers and children, from the inadequacy of health care for the unemployed and the marginally employed, and from the proliferation of toxic substances in the environment. Many of the public health professionals who preferred to use the politics of accretion applauded the efforts of health officials in the Lindsay administration to gain administrative control of federally subsidized health planning and to bring the techniques of systems analysis to bear on the intractable social and health problems of the city. Their colleagues who preferred the politics of reform insisted that planning and analysis were woefully inadequate substitutes for massive governmental reorganization and the infusion of new money.

The severe fiscal crisis of the last half of the 1970s, which absorbed the attention and the resources of public officials in the city and the state, made it necessary for both accretionists and reformers to suspend temporarily action on their agendas. For a time, there was only a more rudimentary politics of personal and institutional survival. Avoiding retrenchment became the priority of employees in both agencies of the public sector and voluntary organizations dependent on public funds. For a time, the political salience of public health was lower than it had been during the severe economic depression of the early 1930s.

HAVE ACCRETION, REFORM, AND CRISIS BECOME OBSOLETE STYLES?

The AIDS crisis, first perceived in the early 1980s, initially confounded practitioners of all three of the political styles that had been employed by public health activists in New York City in this century. Accretionists had, especially until the late 1980s, very little scientific achievement on which to base their advocacy for additional resources. Reformers had a difficult time convincing themselves that far-reaching change in the organization and financing of services could be achieved with a conservative administration in Washington. Those who believed that change occurred in response to administrative and financial crises that were intensified by the political action of interest groups were confronted with a crisis caused, unexpectedly, by a virus that was transmitted as a result of human behavior.

People do not easily change political styles that have been serviceable and personally rewarding over many years. Thus it is likely that the 1990s will still be dominated by accretionists insisting that good science should be translated into policy, by reformers hoping that the national mood and therefore the majority
coalition will shift in their favor, and by strategists of crisis worrying about how many simultaneous crises general politicians can manage without diminishing the intensity of their concern. As has happened many times before in the history of public health in New York City, the shrewd use of political styles will most likely lead either to what, in retrospect, will appear to be significant changes or to the accretion of responsibilities and resources by the public health enterprise.

Two questions remain. One is whether the three styles—accretion, reform, and crisis—remain serviceable in the 1990s. That is, will they continue to provide income, allies, personal satisfaction, and even changes in public policy for their adherents? My guess is that, in New York City in 1991, adherents of each style are mainly going through the motions; repeating political behavior that has been satisfying, lucrative, and sometimes even successful in the past. I suspect that significant change in public health policy will require new styles and that these will emerge from new political coalitions that will redefine the priorities and, once again, the definition of public health. I have recently begun to write about this change, in the hope of helping it to occur [17].

The second question is whether the theory of political styles in public health that I have presented here has any relevance outside New York City. I think that it does and have limited my argument in this paper to New York City both for coherence and because, as a result of participating in several collaborative research projects, I have been immersed in data about public health in New York in recent years [18]. Many New Yorkers and a great many people outside the city insist that New York is different from the rest of the United States. It may be bigger, dirtier, and, on some streets, more dangerous than other cities. But, after living most of my adult life elsewhere, I have decided that the argument that politics, of any kind, are special in New York City is practically and conceptually wrong. It is wrong in political practice because it encourages New Yorkers to hope that they will be left alone by the state and the federal government except when subsidies are awarded, while giving officials in Albany and the federal government an excuse to be miserly with those subsidies. It is conceptually wrong because it permits New Yorkers to ignore policies “not invented here” while they busily invent the same or similar policies. I find considerable evidence that accretion, reform, and crisis have been the dominant political styles in other jurisdictions [19]. Thus I offer my models for broader discussion and, I hope, refinement.

REFERENCES

1. The definitive statement of the hypothesis of decline is Duffy J: A History of Public Health in New York City 1866–1966. New York, Russell Sage Foundation, 1974, Chapters 11–12. Duffy claims (p. 297) that the City Department of Health went “steadily downhill” after 1918. Duffy, moreover, equates the enterprise of public health in New York with the fortunes of the Department throughout his book. Thus the decline of the Department was emblematic of the decline of the enterprise.

2. A vigorous and often-quoted statement of the growth hypothesis is Baumgartner L: One Hundred Years of Health: New York City, 1866–1966. Bull NY Acad Med (Second Series) 45 (June): 555–586, 1989. She writes (pp 555–556): “Without the ups and downs of [the Board and Department of Health] . . . their eternal vigilance and their willingness to change has meant that millions of persons have continued to live more safely in the potentially hazardous environment of this unique city.”

3. Some readers familiar with historiographic debate may wonder why I use the unfamiliar word “accretion” rather than the conventional “increment.” The reason is that it is wrong to juxtapose “incrementalists” and “reformers” in the history of health politics in New York. Both the accretionist and the reform styles that I describe below were incrementalist. New York had a high population of
revolutionaries compared to elsewhere in the United States, but they appeared only occasionally in health politics. The dispute between the accretionist and the reform styles was not over whether change should occur in increments or in sudden, revolutionary jumps. It was, as I describe below, over whether change should occur by adding services or by changing the structure and financing of public health activities.

4. Duffy, [1]; see also Fox DM: Social policy and city politics: Compulsory notification for tuberculosis in New York, 1889–1900. Bull Hist Med 49 (Summer): 169–195, 1975

5. On La Guardia’s priorities and tactics, see Kessner T; Fiorello H. La Guardia and the Making of Modern New York. New York, McGraw-Hill Publishing Company, 1989. My assessment of the Mayor’s photo opportunities is an unquantified result of examining published and archival photographs.

6. The voluntary sector was, of course, a major actor in public health politics before 1920—especially in matters of hospital care, tuberculosis control, and housing. My point here is simply that the size and therefore the political salience of the voluntary sector increased after the late 1920s because it absorbed more public funds allocated for health and social services.

7. Fox DM, Rosner D; Stevens R: Between public and private: A half century of Blue Cross and Blue Shield in New York; and Fox DM: Sharing government authority: Blue Cross and health planning in New York. Journal of Health Politics, Policy and Law, in press

8. There is vast documentation for these points, as there is for the other examples of the effects of events in public health politics in New York City in the years described in this essay. To avoid ponderous notes, I cite sources only for direct quotations or claims that are based on specific documents.

9. For Hill-Burton and health politics in general in these years, see Fox DM: Health Policies, Health Politics: The Experience of Britain and America, 1911–1965. Princeton, Princeton University Press, 1986. On La Guardia’s special relationship with New Deal agencies, see [5], Chapter 9.

10. On hospitals and the poor and hospital politics in general during these years, see Stevens R: In Sickness and in Wealth. New York, Basic Books, 1989.

11. Report of the Department of Health, City of New York, for the year 1953. Municipal Reference Library

12. The change in Section 89 of the Sanitary Code of the City of New York, which removed the last placarding requirements, is described in correspondence between Commissioner Ernest L. Stebbins and Dr. Arthur Freeborn Chase, President of the New York Academy of Medicine, in November 1943. Papers of the Committee on Public Health Relations, New York Academy of Medicine

13. Mary McLaughlin to the author in conversation, Stony Brook, New York, sometime in mid-1976; see also Imperato PJ: The Administration of a Public Health Agency. New York, Human Sciences Press, 1983 for an excellent overview, especially for the years after 1960

14. American Public Health Association: The Public Health Program in New York City: An Appraisal of the Activities of the Department for 1933. No publisher, processed, copy available in the Library of the New York Academy of Medicine

15. Baumgartner, [2], p 585

16. The Commissioner Reports. In Report of the Department of Health, City of New York for the Years 1955–1956, pp 9–15, for Baumgartner’s statement that polio “was never a major cause of disease in New York City” and for her use of crisis rhetoric. Correspondence bearing on these issues is in the Baumgartner papers, Countway Library, Harvard Medical School, Boston, MA. Her successors expanded on the rhetoric of administrative crisis. A notable example, in the Department’s Report for 1963–64 is Commissioner John R. Philip’s statement that “The Health Department is now in crisis, which means that holding the line on the health of the City is in crisis. It is largely a financial matter” (p 7).

17. Fox DM: Health Policy and the New Disability Policy: The Potential for Convergence. Presented to the National Academy of Social Insurance, annual meeting, January 25, 1991, and forthcoming in the proceedings of that meeting

18. In particular, the Blue Cross History Project and a project on epidemics in New York City sponsored by the Museum of the City of New York. On the former, see Fox DM: Sharing governmental authority: Health planning in New York. Journal of Health Politics, Policy and Law, in press

19. For example, Fox DM, Leichter H: Rationing in Oregon: The new accountability. Health Affairs 9 (Summer) 7–27, 1991