Commentary

Big City Urban Health Departments: Catalysts in the Crucible of Population-Based Health

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Big City Health Departments: Leadership Perspectives is a collection of articles and commentaries documenting the powerful influence of public health organizations on improving the health of populations within their jurisdictions. Assembled by James Sprague and colleagues from the de Beaumont Foundation, an array of examples are provided from the largest cities in the nation.¹ A list of these 20 health departments and the criteria for inclusion in the Big Cities Health Coalition can be found in the article by Leider and colleagues.² Indeed, large cities are at the forefront in extending public health and social policy to realize changes in our environment abetting population health.

Carried through the 7 commentaries from big city health departments is the theme of promoting health in the urban context above and beyond the traditional prescribed functions of local health departments. Those traditional functions include vital records, food and water sanitation, maternal and child health, and infectious disease control and surveillance. Larger population size is associated with the availability of not only more local resources but also access to increased federal funds. While the Affordable Care Act is largely viewed by the public in terms of its impact on health insurance and access to health services, this act has many public health provisions including the Prevention and Public Health Fund, Community Transformation Grants, opportunities to increase integration with organizations providing clinical services, and mandated coverage for clinical preventive services.³ Large urban areas have received the largest Community Transformation awards. In California, for example, the most populous jurisdictions receive greater resources to implement enhancements that facilitate population health: \$497 076 to the 65 000 residents of Lake County to improve nutrition and physical activity; \$3 517 360 to the 488 000 residents

of Sonoma County to address smoking in multiunit housing; and \$7 883 885 to 479 000 residents in Los Angeles to improve nutrition and physical activity and reduce tobacco use.⁴

Ample evidence exists that the availability and quality of essential public health services vary by community. Mays et al⁵ showed that performance measures with respect to delivering public health programs and services were associated with the size, financial resources, and organizational structure of local health departments. The focus of this issue on *Big City Health Departments* in no way diminishes the innovative work accomplished by other health departments throughout the nation. Examples are regularly published in this Journal. What this focus does provide is a look at initiatives currently being tested in urban areas that may have relevance to advance the health of the nation.

Considering the historical context and political realities, it is not surprising that big city health departments lead the way in establishing our public health agenda. Medieval cities had councils responsible for not only community administration but also disease prevention, infection control prevention, food inspection, waste disposal, and quarantine presaging the later formation of boards of health.^{6(pp50-79)} The development of public health in Britain and the United States can be directly traced to the contributions of Edwin Chadwick.^{6(pp207-211)} In 1842, he published the General Report on the Sanitary Condition of the Laboring Population of Great Britain. This classic report showing that the poor

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exhibited a preponderance of disease stimulated social reform and sanitary reform in Britain and the United States. Chadwick was also the chief architect of the 1848 Public Health Act that created a general board of health and empowered the establishment of local boards of health and appointment of a health officer. Although later repealed, this spurred population-based preventive efforts in England and the United States. The first boards of health were established in the United States in the 1700s.⁷ Various cities contend for the honor of establishing the first board of health: Baltimore, Charleston, Philadelphia, and New York City. New York City established a board of health in 1796 that consisted of 3 commissioners and a health officer. The term *health officer* designated the responsibilities of a quarantine officer.⁸

The New York City Department of Health (NYCDOH) is deserving of attention in that its past and recent history is emblematic in extending boundaries of public health action. While many of these initiatives have been started or adapted by other municipalities, examination of New York City is important in this commentary because it reveals overall factors that facilitate changes that enhance population health—the *realpolitik* of public health. Under 2 recent New York City Commissioners of Health, Tom Frieden (now Director of the Centers for Disease Control and Prevention) and Thomas Farley, we have witnessed initiatives to reduce tobacco use in public places, eliminate trans fats in restaurants, strategies to reduce dietary salt, and improve chronic disease surveillance.

Pioneering advances in public health is not a new event for NYCDOH. In 1908, an NYCDOH physician, Josephine Baker, established a landmark for public health by setting up newborn visits by a public health nurse in the lower eastside of Manhattan. This activity reduced infant deaths by 1200 compared with the previous summer. Following this in 1910, she established baby health stations that combined sale of bottled pasteurized milk with teaching in the care of infants, a practice that was replicated by other states and the federal government.^{6(pp357-360)}

One of the particular factors empowering NYCDOH is the statutory power of its Board of Health. A bill passed by the state legislature established the Metropolitan Board of Health, which later evolved into the Board for NYCDOH.^{6(pp245-248)} Of note, the board was provided with extensive power to create ordinances, to execute them, and to judge the acts it had implemented. Tom Frieden writing about confronting epidemics in the modern era, referring to tobacco, trans fat, and other policy-based initiatives, comments that New York City is unique with 8 million inhabitants and having as much regulatory and implementation authority as a state public health agency.

When the NYC Health Department was established in 1866, it was given broad executive powers to enact and enforce a wide range of regulations to promote the public's health under oversight by the Board of Health. This policy-making and enforcement authority has long been recognized as crucial to controlling communicable disease; we have seen that this authority can be equally effective in promoting healthy behaviors and preventing chronic diseases.^{9(p8)}

In the early 1970s, another dynamic NYC Commissioner of Public Health, the late Lowell Bellin, using the authority of the Board of Health, established the “Children Can’t Fly” campaign to counter the high rates of death and injury among children who fall from windows. The program involved a law, enacted by the Board of Health, requiring the installation of window guards in high-rise apartments where children lived. This was implemented to the consternation of the NYC Housing Authority, which became responsible for the expense of window guard installation in public housing. As a result of the program, a significant reduction in the incidence of falls occurred, especially in the Bronx, where a reduction of 50% was recorded. Many other cities throughout the world have replicated this program.¹⁰

Other factors enabling progress of health departments in large cities include political support, public health infrastructure, and systems for collecting and analyzing health data. Public support for public health measures, particularly those affecting personal lifestyle behaviors and avoidance of health risks, is another essential element that may distinguish residents of New York City and other large cities. Frieden et al comment that a “small but vocal minority of residents often strongly opposes public health programs even when the majority favours them.”⁹ Yet, to the extent this is true, it may differentially apply to large urban areas and not elsewhere. The author serving as a health officer in Arizona and upstate New York regularly encountered antipathy or outright antagonism from elected representatives to measures interpreted as limiting their personal freedom. Contentious discussions with county legislators in upstate New York, some 200 miles from New York City, occurred when they vehemently contended that indoor smoking prohibitions were harbingers of “telling us what to eat at fast food restaurants.” The dominant political language of American political discourse, Beauchamp¹¹ observes, has long been individualism and does not support benevolent restriction of voluntary conduct.

For this reason, political support, when available in large urban centers, is key to progress on population-based prevention measures. Fielding,¹² in his commentary about Los Angeles, emphasizes the importance of working with elected officials and being cognizant of their priorities. In New York City, there was

extraordinary support for various public health campaigns championed by the health department from then-Mayor Michael Bloomberg. Mayor Bloomberg made reducing smoking one of his signature issues. Headlines on health issues identified these as Bloomberg initiatives: “Bloomberg calls for residential smoking rules”¹³; “NYC’s Bloomberg led the way on trans fat ban.”¹⁴ Finally, size limits on sugary drinks, another Bloomberg initiative, and passed by the Board of Health, encountered considerable public controversy and was overturned by the Court of Appeals. Significantly, in a far-reaching decision with implications for the future, the Court of Appeals ruled that the city Board of Health had overstepped its bounds by setting a 16-oz limit on sugary beverages sold in restaurants and other public venues. “By choosing among competing policy goals, without legislative delegation or guidance, the board engaged in lawmaking,” the court declared in a majority opinion, “... its choices raise difficult, intricate and controversial issues of social policy.”¹⁵

Notwithstanding this limitation by the courts, public health agencies are increasingly involved in addressing environmental and social determinants so important to community health. Important here, and captured in this special supplement of the *Journal of Public Health Management and Practice*, are the successes of large urban health departments including those in the Big Cities Health Coalition in leading the nation in advancing population health. In the 19th century, public health officials addressed poor sanitation, crowding, and poor ventilation to reduce infectious disease. As Krieger and Higgins¹⁶ of the Seattle/King County Health Department describe in the 21st century, the concern with housing is now expanded to include asthma, lead poisoning, injuries, and mental health. We are now witnessing an even broader, expanded agenda for urban public health, illustrated in this issue: health in all policies; collaboration with a network of community players; and engagement with reform of health care services.

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