Public
Health Then and Now

A Window on the Past: The Position of the Client in Twentieth Century Public Health Thought and Practice

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Introduction

The influence of events and social values on the propositions accepted as scientific knowledge is well recognized. The cultural processes through which events and values work include childhood socialization, peer pressure, organizational incentives, and even legal sanctions. Social values and issues influence the way subjects of inquiry are chosen, how research questions are framed, the data considered germane for testing a hypothesis, and the interpretation of results. Some propositions, considered so self-evident that they are not tested, are used as assumptions in research that is done. Opposing views may be voiced but do not prevail.

Social and cultural equilibrium is disturbed when groups express unmet needs and previously unacknowledged identities, when social and economic conditions change, and when scientific discoveries lead to paradigm shifts. Changes in social values and in accepted causal relations result. Since the public health movement has always been embedded in the social milieu when defining its obligations and selecting its means, it is to be expected that its history will reflect the foregoing processes.

This paper uses materials published in the *American Journal of Public Health* supplemented by other selected manuscripts as a window to look at professional thought and practice concerning the position of clients in the public health system during the twentieth century. By reviewing the middle year of each decade, a cross-sectional set of observations is obtained from which historical changes in public health ideas can be identified. Assumptions that were taken for granted in some periods were worked into program decisions and sometimes formed the centerpieces of public health programs.

The position of the client is viewed in relation to the following elements:

- Inheritance versus environment (nature vs nurture) particularly as related to racial characteristics;
- Poverty as a cause of ill health and a determinant of personal interaction with health systems.

Some ideas must be imputed retrospectively to a given period because nothing was said about them—only later is a counterposition articulated, and the past is seen through new eyes.

Often the record shows that what would now be regarded as more scientific and enlightened views coexisted with and directly conflicted with older views. There was disappointment as well as progress in replacing error and prejudice with more soundly based views about the implication of various forms of deprivation for inter-group differences in health. While a theory of simple linear evolution of ideas cannot be sustained, we have nevertheless witnessed change as the historical actors struggled to reconcile received opinions with the experience and environment of their times.

Race and Public Health: South and North (the early days)

A paper by Dr. C. E. Terry, presented in 1912 at a meeting of the municipal health officers during the annual meeting of the American Public Health Association (APHA), reveals how accepted norms of Southern public health professionals regarding race and health served as a filter through which statistics and direct observations were processed in defining problems and deciding policies.[1] Speaking as the health officer of Jacksonville, Florida, Terry postulated that the health problems of Southern cities were "created" by Blacks*; the difficulties, he said, are in direct proportion to the per cent of Blacks in the population; the influence of the Black holds back the progress of any community in public health, gives a false impression of the sanitary standing of cities, and, by preventing their growth, has financial consequences. But far more important, he asserted, is the direct influence of the Black race "as a menace to our own" through infection. Even though the Black mortality rate in Jacksonville was 23.2 per 1,000 compared to 15.2 per 1,000 for Whites, and Blacks had an excess of deaths from tuberculosis and respiratory disease, venereal disease, and congenital debility, Terry said, the overall White race of mortality is higher than it should be owing to "a race infection" occurring as the Blacks "mingle with us in a hundred intimate ways" while rendering services.[1]

Terry charged that the midwives who attended nearly all Black deliveries had twice as high a stillbirth rate as physicians. The causes of the problem, said Terry, included: 1) the nature of the midwives, who usually "belong to the most ignorant type of Negroes—too lazy and incapable to support themselves in any other way"; 2) the income level of patients, who could not afford other types of birth attendant; and 3) the fact that physician care was offered only to paying patients, free care by physicians being too much to ask or

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*The term "Negro" is retained only in direct quotations; "Black" is used in all other text in accordance with usage of this Journal.

expect. Moreover, he maintained that the midwife forced her way to the bedside and prevented the use of physicians, adding that the Blacks who did use physicians were attended by "ignorant" Black or "less well-equipped" White physicians.[1]

Yet Terry believed that Black mortality from preventable causes could be attacked by community programs, and reported that a Colored Health Improvement Association had been formed, through which a "colored" nurse provided direct care for patients with communicable diseases and instructed the Blacks in healthful practices.

Terry accused misguided philanthropy of having spent its money on "adding to the literary accomplishments" of Blacks rather than on better housing, hospital facilities, and medical "inspection and attendance."

> "If we condemn every house that is unfit for habitation in Jacksonville we will condemn 33 percent of all of our houses and . . . 90 percent of these are occupied by Negroes."[1]

In the discussion that followed Terry's presentation, other physicians at the meeting added their own views on race, housing, and midwifery. A Public Health Service physician from Washington, DC, for example, observing that there were homes in that city that were of too little value to justify connecting them with city sewer lines, proposed as an alternative to White investment in improving conditions a strong building ordinance that would cause Blacks to move, asserting that actually they would be "better off" in rural areas and the Whites would be "better off" if the Blacks moved away.[1]

A different attitude was expressed by a New York doctor who pointed out that White property owners in the South not only were satisfied to allow their properties to remain unimproved because the investment was slight and the rent high, but also opposed public spending to improve streets and lay sewers. Moreover, he asserted, it was not only respecting property more than human life that caused the problem, but racism: Blacks were barred from the more desirable parts of town even if they had money to purchase homes there.[1]

Another Northern physician pointed out that Italian and Russian immigrants were also badly housed and in need of nurses and midwives who could speak their language. He disagreed with Dr. Terry's characterization of Black midwives, saying that Black women were capable of being educated as midwives and Black women "will gladly avail themselves of the services" of educated attendants. The speaker, from Kansas City, told how two "colored" nurses and two physicians went into a section occupied by 5,000 Blacks to "instruct the parents and the people how to live."[1]

Terry's paper and the ensuing discussion show a recognition of the interplay of economic forces in the housing market and the medical care market, and how Black poverty and low educational levels created an environment that was conducive to communicable disease and to poor birth outcomes. Although some of the other discussants feared the effects of the ill health of Blacks in fostering contagion and a diminished labor supply, they were reluctant to urge investment in bettering the health of Blacks; furthermore, they felt, improving the education of Blacks might reduce their willingness to occupy servant roles even though it would increase economic opportunity and raise the level of health practices. The setting of rational priorities was affected both by stereotyping and by the need to maintain a subordinate class.

Stereotypical attitudes toward race were shared by many other Southern physicians. Curtice Rosser[2] wrote in the *Journal of the American Medical Association* in 1925:

> "The physician of the South inherits the health problem of the Southern Negro as he does his religion and his Democratic affiliation. The obligation to concern himself constantly with the question of disease in the more or less indolent, often dependent race, which makes up one tenth of our population and crowds our dispensaries, is mandatory—humanity impels and the safety of the adjacent Caucasian race demands."[2]

Heredity and Health (the 1920s)

The contents of *American Journal of Public Health* in the 1920s reflect the popularity of hereditary theories of illness, embracing not only race but "the unfit" in general.

The ideology of the hereditary position included the equation of morality with the advancement of social evolution, which in turn was identified with the biological perfection of the human race and with the ascendancy of the fittest nation. Mental, psychological, and behavioral traits and capacity were assumed to be inherited in the same manner as physical characteristics; economic achievement was the mark of competence. The competent and cultured classes, by restricting their own births, deprived the nation of its stock of talents and left the future to the incompetent. This was made worse by all social welfare measures that protected the unfit against natural selection.

The environmentalist response questioned the poor quality of the genetic research based on genealogies, mental institution records, prison data, and the like that led to claimed association of inherited traits with ethnic group membership and with observed behavior, and questioned the tests used to measure intelligence. Environmentalists challenged both the practicality of expecting marriage decisions to be prompted by and to advance genetic considerations, and the undemocratic nature of state interference with marriage and procreation. Impressed by the relationship between adverse economic conditions and human growth and functioning, they sought human betterment through improved opportunities for nutrition, education, and employment, and other social changes.

Scientific and enlightened views often coexisted with and directly conflicted with older views.

Adherence to hereditary views logically limited interest in prevention and treatment programs that would interfere with the dying out of the unfit. This issue is addressed in C. A. Kofoid's review of the book by Abraham Myerson, Professor of Neurology at Tufts College Medical School, *The Inheritance of Mental Diseases*. Kofoid remarked that the dominent influence "today" (1925) in the mental illness field is belief in heredity.[3] Myerson's book, however, by arguing that transmissible mental diseases may be caused by unknown agents whose effects persist over several generations, is able to defend mental hygiene efforts as not "dysgenic and injurious to the race."

The "health" program to which hereditary theories did lead was eugenics. Arthur Dandy, author of a widely used book called *Outlines of Evolutionary Biology* that ran into several editions, also wrote *The Biological Foundations of*

Society, that strongly advocated limiting the propagation of the unfit. Kofoid, the reviewer, described this book as having "strong social leanings . . . conditions created by modern life tend to the establishment of one vast mongrel population . . . the humanitarian but wholly unscientific doctrine that all men are equal leads to a general and permanent deterioration of mankind."[4]

Mazÿck P. Ravenel, editor-in-chief of the Journal, reviewing the book, *The Education of Handicapped Children,* approved of the author's attribution of criminality, pauperism, and vagrancy to inheritance of feeble-mindedness.[5] The book was part of the Riverside Textbooks in Education; its author, J. E. Wallace Wallin, was director of the Bureau of Special Education and Psycho-Educational Clinic, and Professor of Clinical Psychology at Miami University.

An Idaho law permitting sterilization of the "feebleminded, insane, epileptics, habitual criminals, moral degenerates, and sexual perverts" was described in a Journal section on Law and Legislation[6] by James A. Tobey, LLB. Candidates were selected by a state board of eugenics; if they refused, court action was taken. This procedure was praised by Tobey as "an admirable instance of due process of law." At that time, 18 of the 48 states had a sterilization law "of some sort" in effect, according to the Committee on Mental Hygiene, but the Montana Commissioner of Health questioned if the law had not done more harm than good.[7]**

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At the same time that heredity was being stressed as the cause of ill health, the *Journal of the American Medical Association* in January 1925 commented editorially that rickets is seen to be non-hereditary (the importance of lack of sunshine during a period of rapid growth having been observed since the 18th century) and that environment is all-important for tuberculosis; heredity was blamed when a disease was hard to investigate.[9]

Yet in 1935, according to two officials of the Memphis City Health Department, statistical differences in mortality from typhoid fever and infant mortality between Whites and Blacks could be explained by race[10]; a similar explanation was used by J.H.M. Knox, Chief of the Maryland Bureau of Child Hygiene, in analyzing maternal and infant mortality.[11] For some phenomena recorded in health statistics, it was difficult to ignore environmental factors even if there was a predisposition to racial/hereditary explanations. Thus, when Edward N. Chapman examined the contamination of irrigation water by sewage and the resulting Colorado death rates from "filth diseases," he puzzled about why the rates were higher than those in California even though the level of intelligence in Colorado was higher and the per cent of Mexicans and foreign-born lower than in California.[12]

In that same period, an article on tuberculosis control in the industrial health insurance program of the Southern Pacific Railway described the problems of dealing with Blacks and immigrants.[13] As the company would be held liable if tuberculosis was contracted on the job, causal attribution was economically important. According to Philip King Brown, of the Southern Pacific Hospital in San Francisco, it had been necessary to employ foreigners and Blacks without physical examination at times of peak labor demand. He attributed their health complaints not to their working conditions, which "are better than where they come from," but to disease they brought with them. As the disease is more common in cooks, waiters, and porters, "all of whom are Negroes," than in train and engine men, the highest-paid employees except for executives, he said, it seems that "good pay and intelligence" keep the rate down even where there is exposure to considerable dust.[13]

Merrill E. Champion, reviewing a report on maternal mortality in Philadelphia, asserted that as maternal mortality is undiminished in the face of improved medical care and public education, the "racial factor and the effect of civilization on childbearing need to be considered."[14]

In an editorial published by the Journal in 1935 discussing marriage counseling as a public health function, German statistics were quoted on the "socially eugenic" effects of services offered at marriage counseling bureaus. The birth rate per 1,000 in Bremen for the poor and the laboring classes fell 60 per cent and 53 per cent, respectively, between 1901 and 1925, whereas the birth rate "among families of the well-to-do" increased by 15 per cent. "It would appear," commented the unsigned editorial, "that the less competent but usually more prolific fraction of the population reduces its birth rate more than do the economically more favored groups." Data for France showed a similar trend, while the United States had "disproportionally high birth rates among the less competent part of our population."[15]

A book pleading for sterilization of mental defectives was favorably reviewed; such persons were said to be unfit for parenthood and unable to employ either medicinal or mechanical contraception.[16]

Infant mortality was a major focus of interest in developing a connection between social conditions and health.

An extended expression of enthusiasm for "race hygiene" was included in a report of a visit to the Berlin Health Exposition of 1935, two years after the ascendancy of the German National Socialist Party. Appearing under the title, "New Germany Teaches Her People," the report was written by H. E. Kleinschmidt, director of health education of the National Tuberculosis Association, who traveled to Germany as a fellow of the Carl Schurz Foundation. As he described the exposition, the vast vestibule had a display showing a nation being led upward by a giant eagle; "Without being told, [the viewer] 'feels' rather than learns, that what he is about to see is of vital concern to the nation." A great hall exhibits material on "race hygiene" in which "the anti-Semitic policy is meticulously explained." Galleries of unfortunate biological misfits "drive home the logic back of the new sterilization laws."[17]

But in the same volume of the Journal, Myerson, reviewing a book on heredity and disease by Otto L. Mohr, attacked "geneticists of the type called eugenists" for build-

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**Although such laws often encountered executive refusal to enforce and court opposition, the US Supreme Court upheld a revised Virginia law in *Buck v. Bell* in 1927 (Court opinion written by Justice Oliver Wendell Holmes).[8]

ing up "an aristocratic ideal of life which is entirely unwarranted in so far as biology itself is concerned." Environment should be recognized as a genetic factor. Mohr had referred to "the classic and revolutionary work of Müller showing that mutation can be increased by environmental events."[18]***

While intergroup differences in health were still attributed by this reasoning to inheritance, the mutability of inheritance became the mode by which social environment might be influential. But heredity as a causal factor receded as the direct effect of the environment of different groups on their current health, and the stability of adverse environments as an explanation of persistent intergroup differences, were asserted.

Some ten years later, poverty was seen as a cause of mental illness, as well as a possible result, and both causal propositions were used to justify public action. Every child had a right to be born into an environment that is congenial to mental, moral, and social development, while prevention of social maladjustments that would lead individuals to become wards of the state and a burden to near relations was to be the objective of mental hygiene in public health.[20]

Social Conditions and Ill Health: The Impact of the Depression

Infant mortality was a major focus of interest in developing a connection between social conditions and health. Work of the Children's Bureau in the 1920s linked infant mortality to prematurity and showed the death rate to be affected by birth order and interval, artificial feeding, mortality of mothers, and occurrence of tuberculosis and convulsions in mothers, as well as father's earnings.[21] Selwyn Collins emphasized that the association of infant mortality with father's earnings, a measure of low economic status, was independent of such factors as birth order and interval, with which economic status might be correlated. The relationship applied to both native-born and foreign-born mothers, and was in line with English statistics.[22]

The impact of the Great Depression of the 1930s on health and ability to pay for care was gradually acknowledged and became an important stimulus to fresh thinking about effects of social conditions and the case for public responsibility. Although a nutritional survey of 4,500 children on public relief decried "hysteria and even panic created by well-meaning but uninformed self-styled nutritionists" and found conditions satisfactory,[23] reports from the field began by 1935 to form a coherent picture of need. The effect of chronic illness on the economic capacity of patients and their families was demonstrated and, conversely, economic conditions were cited as a contributing factor in ill health.[24] A study in *Public Health Reports* documented relative changes in height and weight of children whose family income had fallen to a low level in the depression.[25] A national study of maternal deaths showed that four-fifth of them followed poor or no prenatal care.[26] Josephine Roche, Assistant Secretary of the Treasury in charge of Public Health, stated that the disabling illness rate was 56 per cent higher in families worst hit by the depression, and yet they received only half of the care received by the most comfortable group.[27]

Rev. A. Clayton Powell, Jr., a Black minister, was quoted on the cellar housing conditions of 10,000 of the Harlem population—which he described as "dark, damp, cold dungeons, in squalor worse than that of the Arkansas sharecroppers." US Senator Robert F. Wagner, sponsor of housing and labor legislation of The New Deal, voiced the right of all to decent shelter, sun, air, and recreation, "which the slums deny."[28] A 1955 report from Hawaii[29] provided statistical evidence of the relationship of housing to health. The relationship was stronger for venereal disease and tuberculosis than for infant mortality and suicide. Overcrowding was more important than dilapidation for raising the overall mortality rate in a given census tract.

Race remained a powerful divider in regard to health services during the 1930s.

The effects of unemployment (along with housing, nutrition, and occupation) on the health and well-being of Philadelphia Blacks were recognized during the depression: a survey of 3,616 persons of employable age attending a clinic found that 60 per cent were unemployed.[30] Likewise, Perrott and Collins reported on the effect of unemployment on morbidity rates[31]; in San Francisco the relative mortality of unemployed and employed wage earners was studied in a joint effort of the California Relief Administration, the Public Health Service, and the Milbank Fund.[32] Support was urged for a federal census of unemployment through the Federal Emergency Relief Administration.[33] At another stage of the depression's effects, the spread of meningitis in a Civilian Conservation Corps (CCC) camp, a federal work program for unemployed men, was found to be related to serious overcrowding.[34]

Race as a Divider in Service Provision (the 1940s)

Recognition of environmental factors in health did not automatically end racial/ethnic stereotyping or guarantee equal progress in terms of services. Ten years after its passage, the Social Security Act had helped raise from 762 to 1,800 the number of counties with full-time health officers, 90 per cent of whom were physicians, an expansion that might affect favorably public health services in rural areas. The Committee on Professional Education of the American Public Health Association, concerned about the preparation of health officers for their larger roles, developed proposed educational qualifications for health officers.[35]

Nevertheless race remained a powerful divider in regard to service. Paul Cornely, MD, then Associate Professor in Preventive Medicine and Public Health at Howard University College of Medicine, reported in 1942 on a survey that compared the segregated health services available for Black and White residents in 96 southern counties in the decade of the 1930s.[36] His report showed that Blacks had fewer services as measured by tuberculosis clinic hours, prenatal clinic hours, the per cent of babies delivered in hospitals, dental services, and even public health fellowships. The only services showing improved availability to Blacks between 1930 and 1939 were those for venereal disease, but even here the ratio of services by race was not in proportion to the ratio of incidence. It would appear that reluctance of local authorities to spend money on the health needs of Blacks was in conflict with fear of contagion.

***Herman Müller's demonstration that genetic mutations could be induced in fruit flies by x-rays won him the Nobel Prize in Physiology of Medicine in 1946; it was first fully reported at the Fifth International Congress of Genetics in Berlin in 1927.[19]

Fear of contagion from "the other" was indicated in a 1945 report by D. M. Gould on a mass x-ray survey in San Antonio, summarized by Raymond S. Patterson. Patterson wrote that the report touched on the "excessively high prevalence of tuberculosis among the Latin-Americans (which) was shown to have an unfavorable influence upon the Anglo-Americans."[37]

In the same year, L. M. Graves and F. H. Cole, writing from the Memphis and Shelby County, Tennessee tuberculosis control program, said:

> "We have recently required x-ray examinations for health cards. These cards are used principally by domestic servants, and are required by the housewives before the servants are employed. We will gradually cover a large proportion of the Negro females in the community by this program."[38]

Developing Recognition of Disadvantaged Groups (the 1950s and 1960s)

After World War II, the language of the public health movement reflected universalist ideals. Health was construed to include self-actualization, and the right to health was considered part of the democratic ideal. The responsiveness of health to social forces was more widely accepted.

The relation of the rate of fetal and infant mortality to residential segregation in New York City was described to a 1949 meeting of the APHA by Alfred Yankauer, MD. He reported that the infant mortality rate of both Whites and non-Whites rose sharply as the proportion of Blacks in a residential district increased. He pointed out that population density and high rents due to segregation, poor housing, limited food shopping choices—and overloading of neighborhood medical facilities—were detrimental to the health of all residents.[39]

In 1955, John J. Hanlon, medical director of the Public Health Service, and chief, Public Health Division of the International Cooperation Administration, welcomed the effects that he attributed to generally available public health benefits—namely, the increased numbers of formerly underprivileged racial, national, and social groups, which meant that the population as a whole was better nourished, healthier, able to live longer, and able to interact with improved educational and economic opportunities. Hanlon rejected neo-Malthusian pessimism because of the vast potential of solar energy as the basis of the world food supply. But spatial changes in population immigration, suburbanization, decentralization, and domestic travel including movements of migrant workers called for adaptation of practitioner supply, health facilities, and the legal framework of pensions and fringe benefits. Social betterment for all in a growth economy was seen as a natural evolution.[40]

Social and economic class became more evident in the 1950s than in earlier periods in analysis of needs and planning for service. A health department was to consider as necessary data for planning of social services the economic, national, and racial groups in its locality and where families turn in times of financial stress.[41] Class and ethnic barriers to community efforts to conduct self-surveys and health planning were observed.[42] The link between respiratory cancer mortality and social class was reported by the Metropolitan Life Insurance Company *Bulletin*.[43] Home care for cardiac patients was recommended to include service to families, since a very deprived population was encountered.[44] Thus class was not interpreted as a sign of personal failure or incapacity but indicated an "at-risk" category for damage to health. Neuropsychiatric disorders in infancy—other than retardation—were attributed to pregnancy complications and prematurity,[45] factors that began to be traced to availability of prenatal care.[46] Only 9.7 per cent of Black women had low birthweight babies if they had first trimester care, but the rate rose to 23.5 per cent if they had no care at all. A search for specific causes of reproductive failure was said to be replacing "curiosity and superstition."[47] Unbearable economic difficulties were recognized as the context of the impaired functioning of mothers found in the study of underweight children, even though there were many who were "excellent and resourceful managers" under the circumstances.[48]

Recognition of class factors in sickness and in use of medical services was mounting by 1965, and was often linked to the disadvantages of ethnic minorities in society and the health care system. Economic hardships were found to limit both the variety of foods and the quality of diet for crippled children in rural counties.[49] Infectious hepatitis had a higher incidence in areas of low socioeconomic status and was correlated with the level of sanitary facilities and housing. The fact that the disease spread from poor areas to surrounding rich areas was noted, a reminder of times when the entrenched fears of the more affluent were a source of support for communicable disease control measures.[50] The poor condition of the public's teeth was attributed to income limitations, reinforced by an inadequate supply of dentists compared to need (which would be expected as a response to low effective demand).[51] Data from The Bureau of Old Age and Survivors Insurance of the Social Security Administration documented a relation between having less work in a base year and higher death rates in four subsequent years.[52]

Not only was the prevalence of mental retardation among children affected by socioeconomic status, according to Poole, but a poor home environment was felt to reduce school adjustment and learning among those with a mental retardation diagnosis.[53] The suicide risk was higher for older White males at both extremes of the socioeconomic scale.[54] Children using outpatient psychiatric facilities were noted to have different paths of referral and type of clinic, depending on social class: low-income children were more often referred through law enforcement agencies, and this led to resistance to therapy. Conversely, voluntary clinics serving high-income areas reported more interviews per child and a better success rate.[55]

Entrenched fears of the more affluent over disease spreading from poor areas generated support for communicable disease control measures.

Low income was found to correlate with numerous measures of illness, need for care, and inadequate utilization.[56] One major factor was ethnocentrism, associated with low socioeconomic status, and a cause of lower expectations and motivation regarding health and medical care, and thus of a condition of "medical deprivation." System complexity was seen as a barrier to use by low-income groups.[57] The poor showed resentment and apathy toward health professionals, and the offer of fragmented and incomplete services (such as diagnosis without treatment) alienated the poor.[58]

Ethnic minorities had poorer health status, with improvement in their health lagging behind the nation as a whole.[59]

Class differences in the prevalence of mental illness were discomfiting to health reformers because of the issues of stigma and unresolved causality. Class differences in care-seeking behavior offered an explanation: one author, analyzing the behavior of the poor with neurotic symptoms, found that they were less likely than the rich to come early for care not only because they did not realize that symptoms warrant treatment, but also because of restricted treatment opportunities. Hence when seen, they presented with more advanced symptoms and were "sicker" than upper-class patients.[60]

Documentation of class differences in general illness rates provided support for social and health reformers. Whether illness was a *cause* of poverty as well as a *result*, proposals to improve access to care fit into a multifaceted effort to wipe out poverty in which health care was a vital component.

Race as a Proxy for Social Disadvantage (the 1970s)

In the public health parlance of 1975, non-White race was a powerful indicator of unmet health needs because it was a proxy for disadvantaged environment and poor health status resulting from poverty. A report by John Coulihan, of the University of Pittsburgh Department of Community Medicine, described a battery of screening tests in a low-income, mostly Black neighborhood. Of those screened, 18 per cent had untreated disease requiring treatment.[61] Previous evidence showing race per se to be a cause of difference in health was reevaluated. A study by researchers from the Department of Psychiatry of the University of Pennsylvania and Manchester University reported that race appeared to produce neurotic symptoms but the effect disappeared when controlled for social class.[60] An earlier study by nutrition experts at Chapel Hill, NC concluded that level of educational attainment largely explained the Black-White differences in the rate of inadequate diets that remained after accounting for income.[49]

Social malaise interferes with public adherence to democratic ideas.

Since poor health observed among Blacks could reflect not only inequality in the general economy, schools, and housing—i.e., environmental factors in health—but also the absence of treatment opportunities, the relation of minority races to the health care system became a public health concern. A position paper adopted by APHA's Governing Council in 1974 referred to racism as an established characteristic of the health care delivery system.[62] Lorin E. Kerr, MD, occupational health chief for the United Mine Workers of America and past president of APHA, commented that national rhetoric that "Health is a Right" had had little or no effect on either attitudes, social concepts, or laws. In his view, health personnel lacked commitment to the total well-being of all, regardless of class, color, or ethnicity.[63]

James G. Haughton, MD, executive director of the Cook County (Illinois) public hospital system, decried the two-tier system in which poor Blacks and Hispanics were obliged to use emergency room and wards of public hospitals, while patients with ability to pay received care in private offices and hospitals. He cited Cook County Hospital's disease detection and prevention activities as examples of what hospitals could do for community health if they undertook the task.[64]

Conclusions

The perceived position of the client in public health practice, comprising both the path by which a state of need was reached and the appropriate features of the client-system relationship, has responded over a half-century to shifts in social values and the experience of living in an industrial society. The weight of science in producing these shifts has been crucial (epidemiology provides examples), but part of the drive toward exploring scientifically the associations between socioeconomic factors (including the health care system itself) and health has come from altered perceptions of possible causes—a paradigm shift. Observation of the daily life and health of the disadvantaged, and of the risks encountered under industrialism, over the human life cycle and the business cycle, must have influenced many practitioners and investigators. Not only did efforts of the powerless to find a voice in society impinge on health systems, health facilities themselves were often a significant arena, as in hospital worker organization and the elimination of segregation by the civil rights movement.

The painstaking and imaginative work of many committed individuals helped build a body of knowledge and shape new ideas concerning client vulnerabilities, client needs, and client rights in a democratic society. Competing legacies in American life—individualism, which pointed social policy toward support of entrepreneurialism and market forces, and belief in government as the vehicle of mutual aid needed to deal with the human distress that flowed from certain features of a market economy—were mirrored in debates over the causes of illness and the possibilities of improving health. A depreciated image of the abilities and personalities of clients of public programs accompanied the division of the population into the economically healthy and the economically sick, with the former being a market for private medicine and the latter a residual group for whom horizons were limited in every way. The appreciation of environmental factors in disease and in inability to meet costs of illness was influential in changing this image of the client.

That resource availability influences social attitudes is shown in studies of racial prejudice. Social malaise also interferes with public adherence to democratic ideas. A replay of past controversies is not only imaginable but in some ways already manifest in current emphasis on individual responsibility for health, reduced public commitment to control of environmental risks, and narrowing of reproductive choice for the poor. However incompletely respect for the client has evolved both as an ideal and in practice, lengthy and persistent effort was necessary to cause this evolution. Views of the mid-1970s represent adaptation to social change and no doubt will be re-examined and adapted to a continually changing society. In this process, however, vigilance is needed because of actual and proposed revision of public systems. Consequences of program reorganizations and budget cuts, changes in financing, misuse of ethical issues to affect access to service, and incentives to providers to serve the well and affluent may prove hazardous to the most vulnerable.

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