Public Health, the APHA, and Urban Renewal

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Joint efforts by fields of public health in the last decade have advocated use of the built environment to protect health. Past involvement by public health advocates in urban policy, however, has had mixed results. Although public health has significantly contributed to health improvements, its participation in urban renewal activities was problematic. Health advocates and the American Public Health Association produced guidelines that were widely used to declare inner-city areas blighted and provided a scientific justification for demolishing neighborhoods and displacing mostly poor and minority people. Furthermore, health departments failed to uphold their legal responsibility to ensure that relocated families received safe, affordable housing alternatives. These failures have important implications for future health-related work on the built environment and other core public health activities. (*Am J Public Health*. 2009; 99:1603–1611. doi:10.2105/AJPH.2008.150136)

THE PAST DECADE HAS SEEN a reemergence of efforts to connect public health and urban planning. Focusing on the health effects of the built environment, new research has shed light on the association between urban sprawl and obesity, the association between the physical form of neighborhoods and the physical activity levels of its inhabitants, and the role of housing in asthma. On the basis of this research, new programs are being developed, new building and design standards have been proposed, and there is new willingness to manipulate the built environment to promote and protect health. During this process, it will be important to remember the lessons of 20th-century program failures as public health seeks to intervene again in the built environment in this new century.

EARLY HOUSING EFFORTS BY PUBLIC HEALTH

Ideas about what constitutes a healthy city have changed over the past 150 years. Today, attention focuses on various sources of pollution, but at one time, pollution produced by urban industry was secondary to issues arising from poor sanitation. However, even the association between sanitation and disease has gone through varying periods of conceptualization.[1,2] At the beginning of the 19th century, it was thought that miasmas caused disease, but by the end of that century it became understood that diseases were transmitted by bacteria and viruses. Today, we understand that diseases are the result of a complex series of interactions between human factors, including genetics and health behavior, and the ecosystems in which humans live.[3] The environmental improvement of cities is thus a moving target.[4]

A central concern of Edwin Chadwick, the author of an early influential report on sanitary conditions in England, and other founders of the public health movement, was the housing conditions in the rapidly growing cities of Europe and the United States.[5] These 19th-century health advocates included in their sanitary surveys graphic descriptions of tenements, but had a limited set of tools for addressing housing conditions. Despite these limitations, their work, along with other initiatives including clean water supplies, were responsible for substantial improvements in public health.[6,7]

Efforts to improve cities first centered on alleviating the worst 19th-century housing problems with reforms that included the

passage of laws reining in property rights and a legal strategy that shifted housing responsibility from tenants to property owners.[8] At the beginning of the 20th century, housing laws were passed to further broaden the power of government to regulate housing. By the end of World War II, however, the public had lost faith in this incremental effort to improve tenements and turned toward massive slum clearance. The solution was to condemn tenement districts in their entirety and start over.

Another effort by early advocates was building model tenements that limited economic returns in order to reduce rents (popularly referred to at the time as "philanthropy at 5%") and "Octavia Hill tenements"—developments that combined new construction with social services and enlightened rent collection.[9] By the early 20th century, however, it was clear that philanthropists had limited ability to build housing; the need was far greater than their capital could provide. Early building codes, enforced by building departments, improved new housing, but most of this new construction was for the middle classes or the wealthy and most codes exempted existing buildings. Vast areas of substandard housing existed in cities.

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Furthermore, some of the first efforts to enact housing codes created as many problems as they solved. The "dumb-bell tenement," for example, a late-19th-century housing form that featured small side air shafts, 2 to 4 apartments per floor, and rooms smaller than 100 square feet, was born out of a competition meant to encourage better housing designs for New York City. The resulting housing featured cramped rooms requiring passage through one room to get to another and windows that provided neither light nor ventilation.

To remedy this situation, housing advocates led by Lawrence Veiller convinced the New York State legislature to pass the Tenement Law of 1901 (or Veiller's Law, as it is sometimes called), which created the model for housing codes for the entire United States.[10(pp216–220)] Veiller grounded his concern about housing quality in public health, stating

> There is not very much use in taking people from a hospital, apparently restored to health," he wrote, "and sending them back to some slum, putting them into a dark room, where they never see daylight, or letting them live over an open sewer; we all know that in two or three weeks we shall have them back in the hospital, in as bad a condition physically as they were before.[11(p330)]

In a move that was to have important consequences during the urban renewal era, Veiller's Law made the city's health department the primary enforcer of housing codes. He counted on the professional expertise of health inspectors, visiting nurses, and others to provide the vigilance and impartial rigor he saw as necessary for promoting healthy housing. Veiller drafted a model tenement house law and traveled around the United States lobbying for its adoption by states and local municipalities.[12] In city after city, health departments were given the legal authority for housing inspections.

By the 1920s, however, the tenement law movement had lost energy. This was partly due to its successes; most large cities had housing laws modeled along Veiller's guidelines. But it was also because housing advocates had seen the limits of the model tenement laws. Given weak enforcement and the exemptions for existing tenements, there was still a high percentage of substandard housing. Then, two new housing advocates appeared on the scene. Edith Elmer Wood, who eventually served as a consultant to the US Housing Authority, and Catherine Bauer, who would be active in housing policy until her untimely death in 1964, both promoted the idea that the federal government should be involved in constructing housing for the poor. Wood based her arguments on the economics of housing production, demonstrating that it was impossible for low-wage workers to afford decent housing.[13]

Bauer was heavily influenced by the mid–20th-century architecture critic Lewis Mumford. At his suggestion, she had toured Europe to study how governments there were responding to housing shortages. On the basis of this experience she published *Modern Housing*, a book proposing new minimum housing standards, in 1934.[14] She stressed that minimum housing quality must include well-designed units and buildings, peace and quiet for family domesticity, designs supportive of family life,

aesthetics, and accessible amenities. She cautioned that just bulldozing slums without providing large amounts of replacement housing would not work and warned that displacing the poor from one district to another would just move blight rather than eliminate it.[14(pp245–247)]

As the decades passed, public health drifted away from urban planning in favor of building medical laboratories and concentrating on the identification and tracking of individual disease cases.[15] The American Public Health Association (APHA), however, continued to be highly involved in housing. It organized the Committee on the Hygiene of Housing (APHA-CHH) in 1937, and its president, Charles-Edward Winslow, periodically reported on its progress and activities in the *American Journal of Public Health*. In 1938, the APHA-CHH published guidelines for healthy housing that represented the "fundamental minima of physical, mental, and social health."[16(p354)] Housing and health advocates stressed the connections between tenement living and disease. Because housing was responsible for poor health, it became a goal of the reformers to advocate for demolition of the worst units and for a comprehensive national program of housing construction that would build as many as 13 million units from 1937 to 1945.[17]

URBAN RENEWAL

After World War II, there was a growing consensus that US cities were troubled. Postwar suburbanization created fears that inner cities could not compete with suburbs. Most troubling, according to the Federal Housing Administration, was that

> For many years urban slums and blighted areas have been spreading, becoming more intensified, and breaking out in new spots. Collectively they have reached startling proportions. This has been a long process of degeneration and neglect, bringing grave financial and economic difficulties.[18(p1)]

Because housing was often substandard, White residents tended to move out and—worst of all, in the opinion of the time—their were taken by African Americans moving to cities to escape the prejudice and poverty of the rural South. By this time, public health concerns about the built environment were changing: whereas before the house was considered to be the locus of problems, now the neighborhood was viewed as the source of social and physical pathology. Partly in response, the APHA-CHH published neighborhood health standards in 1947.[19]

In 1954, the US Congress passed the Housing Act, creating a federal program of urban renewal that had the support of a consensus of the nation's mayors, business interests, social welfare activists, housing advocates, and public health professionals. Many states passed similar legislation. A report on urban renewal by the United Auto Workers used a health metaphor to describe the problem:

> The spread of blight will be just as fatal to the city as the spread of cancer is to the individual and the treatment must be just as thorough.[20(p12),21]

The coalitions supporting urban renewal had more than sufficient power to overrule and outmaneuver any local or neighborhood opposition, and public health advocates would have not been able to defeat the urban renewal program if they had tried.[22,23]

In addition, urban renewal took place in the context of a society that relied on capitalism to provide urban housing and amenities as well as for urban growth itself.[24] The ultimate responsibility for urban renewal therefore resided in a system that limited the policy tools necessary for mayors to meet the challenges they faced.[25] In general, the steps for an urban renewal project were to authorize an urban renewal authority, declare an area blighted, plan new development, acquire properties and condemn buildings, relocate residents, clear sites, and sell the land to a new developer at a reduced price or use the land for a public purpose such as a cultural facility or sports arena. Federal and state dollars were used to advance the costs of development and to subsidize new development.[19] The funds were used by local governments and cities to set in motion large scale programs that hired planners, architects, surveyors, marketers, and others.

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This does not mean, however, that the actions of public health professionals at the time should not be scrutinized. Many public health departments were heavily

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involved in urban renewal projects. These departments carried out the house-to-house inspections that documented the extent of blight and the range of substandard housing. Health departments had great expertise in health inspections, from decades of door-to-door surveys of tuberculosis, diphtheria, and other diseases and from inspections of occupied housing as set forth in Veiller's Law. A survey of municipal housing departments in 1911 found that housing inspections were the responsibility of the health department in 59 of 88 cities.[26] Only the health department had the authority or expertise to inspect housing for the blight surveys.

In 1948, the APHA-CHH developed guidelines for inspecting housing and neighborhoods. With the passage of the 1954 Housing Act and its statutory mandate that blight be documented, these guidelines began to be used as legal justification for urban renewal areas. The methodology included detailed inspection forms, checklists, and procedures for tabulating results. In general, the guidelines outlined a standard of housing that idealized suburban single-family homes rather than inner-city multifamily or small one- and two-family buildings—nearly identical to the Federal Housing Administration standards of the time. Minimum lot size was 6000 square feet for a single-family home, something that rarely existed in the older neighborhoods of a city. The guidelines discouraged families from living in apartment buildings and declared that buildings with both commercial and residential uses were inferior. Although the guidelines did encourage access to public transportation, jobs, parks, and public services, they were biased against traditional urban neighborhoods. Significantly, the standards did not condemn racial segregation in housing, only acknowledging that some evidence suggested that segregation was bad for health and that there was a need for additional study before the APHA could develop a position on the issue.[27]

The guidelines' criteria did not consider the positive aspects of urban neighborhoods, such as the human element that made city living tolerable. They did not incorporate scales indicating that residents' families were nearby or that children's playmates were next door. They did not consider that the grocer extended credit to regular customers or that residents attached decades of memories to buildings. The guidelines attempted only to measure independent objective aspects of healthy housing and neighborhoods and did not and could not measure emotional qualitative aspect of healthy homes and communities.

The public health community and the APHA were particularly involved in the necessary early step of declaring neighborhoods blighted. Blight was an ambiguous term and government officials could manipulate its meaning at will. By establishing its guidelines, the APHA supplied a scientific and seemingly impartial justification for declaring a neighborhood blighted.[28] These guidelines were widely adopted, and eventually about one third of US cities used either the full APHA survey methodology or a modified version of it (the primary reason more cities did not use the guidelines was that they were expensive and time consuming to follow). The US Public Health Service provided free training to cities that wanted to use the APHA's methodology.[29(pp52–72)] Armed with this housing hygiene survey instrument, the local health department could identify areas with large numbers of blighted housing units and slum neighborhoods. They produced wall-sized maps that indicated where there should be urban renewal projects.[30] Cities now had a procedure for targeting neighborhoods for destruction.

DISPLACEMENT AND RELOCATION

Many health departments were also supposed to certify that replacement housing for displaced residents was of a certain minimum standard. In theory, a displaced family would go to the urban renewal project relocation office and be offered a new home at a rent or price comparable to that of their current home; the new home would then be inspected by the health department and, if approved, the family would move in. The scope of displacement from urban renewal and the clearing of land for new public housing construction and urban highway construction was massive and racially biased. In 1962, it was estimated that about 80% of those displaced by urban renewal were African Americans, ranging from 60% in New York City to 100% in Baltimore, Maryland.[31]

In practice, the relocation of residents from urban renewal

areas contributed one of the most tragic episodes in US history. Until the World Trade Center attacks of September 11, 2001, US cities had not been touched by war since the burning of Atlanta, Georgia, during the Civil War. Major US cities were spared any large-scale disaster for nearly 100 years, from the 1906 earthquake in San Francisco, California, to Hurricane Katrina in New Orleans, Louisiana, in 2005. From roughly 1950 to 1980, however, major cities were decimated by urban renewal, highway building, and other factors. The scale of destruction of affordable housing in the name of urban renewal and public housing efforts was striking. According to housing historian Roger Bile's analysis,

> Between 1949 and 1968, the program razed 425,000 units of housing but constructed only 122,000 units nationwide (the majority of which were luxury apartments).[32(p153)]

The city of Gary, Indiana, planned to relocate 40 000 residents over a 10-year period beginning in the late 1950s,[33(p135)] at a time when the city's total population was 178 000 and falling.[34] New York City's plans called for displacing over 500 000 families, a greater number than those displaced by Haussmann's renovation of Paris, France, in the 1860s.[35] Housing was torn down for highways, urban malls, and arenas and stadiums. Where there was once vibrant, if low-income, commercial activity, there were now office blocks connected to expressways for easy access. Urban residents were treated as clutter by urban renewal authorities, obstructing the effort to get people in from the suburbs. By the end of 1962, 636 cities had federal urban renewal projects. These were not limited to large cities; 52% of cities with populations of 50 000 to 100 000 had ongoing projects. The country was on track to displace 4 000 000 people by 1972.

The urban renewal phases of demolition and relocation moved slowly, and conditions deteriorated for those still left in areas to be cleared. Robert Caro described the Manhattanville urban renewal area of New York:

> And in the buildings—the ruins of buildings, the shells of buildings—people still lived. Visiting those people—entering those shells of buildings, shrinking perhaps past the huddled wreckage of a man that lay in the doorway, stepping into a dim hallway filled with the stench of urine and vomit and, in the shadows, a vague menace, stumbling up unlit flights of stairs that had steps missing, grasping for a banister that wasn't there—was an unnerving experience.[37(p970)]

Worse, the supply of replacement housing was severely limited. Urban renewal was not a housing production program; on the contrary, the stated goal of the 1954 Housing Act was to reduce the amount of low-income housing in a city. But only 5 years earlier, Congress had justified passage of legislation authorizing the US public housing program (the Housing Act of 1949) by declaring a shortage of affordable healthy housing. Both acts, however, only allowed new public housing construction to the extent that existing housing was eliminated, and neither came close to full replacement levels. Together, these acts guaranteed increased shortages of low-income housing.

Adding to the problem was the pervasive racial discrimination in housing at the time. African American victims of urban renewal had particular problems finding replacement housing but received no assistance. Only 0.5% of total federal expenditures for urban renewal were spent on relocation services. Health departments, which in most cities had the legal responsibility for certifying that alternative housing was safe and healthy, apparently did not notice that there were no families being referred to them and that they were not being called to inspect replacement housing. There is no health literature calling out this injustice.

Even when health departments attempted to become involved in relocation, the lack of adequate alternative housing stymied their work. It was only in 1966 that, frustrated by the increasingly negative effects of urban renewal, public health professionals began to protest. A Massachusetts housing advocate, Lowell Bellin, wrote in the *American Journal of Public Health*,

> Objectively speaking, health departments in many cities have found themselves in the hideous role of persecuting and harassing the poor. A health department that vigorously enforces housing and sanitary code regulations frequently compels an identical family to move, and then move, and then move again, sometimes within a few months of each move, and the poor family repeatedly and successively takes refuge in substandard housing.[38(p778)]

Finally, many public health advocates, along with medical officials, welcomed urban renewal as opportunities for building new hospitals, laboratories, and research facilities in inner-city neighborhoods. A. J. Harmon, executive director of the Kansas City redevelopment authority, boasted,

> In Kansas City, we will make a site available near the center of the city for a great medical and health complex, including a

> medical school, hospitals, research facilities, libraries, laboratories and other related activities. It promises to be one of the finest medical centers in the nation.[39(p701)]

These new facilities were built at the cost of the homes of people who were displaced.

HEALTH AND COMMUNITY EFFECTS

The effects on the mostly poor African American victims of urban renewal were severe. Mindy Fullilove, surveying urban renewal projects in Pittsburgh's, Pennsylvania, coined the term "root shock" to portray the alienation, estrangement, and isolation of former residents.[40] Herbert Gans, in his work on the mostly Italian and Jewish residents displaced from the West End in Boston, Massachusetts, portrayed the sad habit of former residents wandering around the sidewalks and cold "superblocks" (a multiacre block without through streets and with limited connections with surrounding blocks) of the replacement development (which few original residents wanted or could afford to live in), seeking solace in the memory of what once was. Marc Fried, a psychologist, described the effects thusly:

> But for the majority it seems quite precise to speak of their reactions as grief. These are manifest in the feelings of painful loss, the continued longing, the general depressive tone, frequent symptoms of psychological or social or somatic distress, the active work required in adapting to the altered situation, the sense of helplessness, the occasional expressions of both direct and displaced anger, and tendencies to idealize the lost place.[41(pp159–160)]

Fifty years after San Francisco's Western Addition project commenced, the ill feelings continued. In July 2008, the San Francisco Redevelopment Authority finally called an end to the project. What had once been the city's largest African American community, with a thriving mix of stores, entertainment venues, and other African American–oriented establishments at the beginning of the process in 1948, emerged from the project as "an area that has become known for its violence and is home to a number of fast-food restaurants and empty storefronts."[41] In total, 883 businesses were closed, 4729 households were displaced (almost none were given new replacement units), and 2500 Victorian homes were demolished. "They wiped out our community, weakened our institutional base and never carried out their promise to bring people back," said Reverend Amos Brown of the San Francisco National Association for the Advancement of Colored People.[42 (pB-1)]

The urban forms that replaced these neighborhoods were problematic. The precedent for the large-scale redevelopment of cities had been established by the Swiss architect Le Corbusier in his Plan Voisin for Paris.[43] In that massive proposal, he called for the almost complete destruction of Paris's Right Bank. In its place was to be a series of high-rises set in parks, connected to the hinterlands by wide highways. Inspired by this plan, redevelopment in the United States produced superblocks, large skyscrapers set back from streets, strong highway connections between new downtown projects and distant suburbs, and limited-access retail areas,[44] all features that are now known to be associated with decreased physical activity, increased reliance on cars, social isolation, and crime.

There were and are alternatives to postwar US urban renewal. Urban renewal, combined with the destruction from World War II, also drastically altered the landscape of European cities. But in the context of a longstanding history of government action to finance and build housing for the poor and working-class populations, physical changes to cities there were very different. In Paris, despite Le Corbusier's plan, urban revitalization efforts concentrated on preserving the city's high-density, six-story urban fabric; consequently, the poor were relocated to massive high-rise developments on the periphery. These developments, or *banlieues*, that erupted in violence in 2006 after police officers shot and killed two teenagers. In London, redevelopment produced some urban displacement (gentrification produced more) that resulted in the poor being relocated into high-rise developments but also being moved to peripheral "housing estates" that had better connections to public transport, jobs, and open space than their US counterparts.

Today, the continuation of renewal efforts reflects the political realities in France, Great Britain, and the United States. In France, redevelopment is still heavily administered by the central government, in keeping with France's strong socialist welfare state tradition. Great Britain has opted for a public–private partnership approach, government working with business to revitalize inner cities. The United States, in a political age that values deregulation and a government retreat from virtually all social services, has vastly decreased any federal or state funding for redevelop beyond limited dollars for

cleaning up brownfields (contaminated former industrial sites), enterprise zones (a new revitalization program that stresses job training and other services to residents along with assistance to local businesses), and tax credits to encourage new development in low income areas. Historically, the United States was also unique in that it combined the destruction of African American neighborhoods with pervasive housing discrimination that tried to prevent alternative housing for African Americans, concentrating and magnifying the negative effects of urban renewal.

THE OBLIGATIONS OF PUBLIC HEALTH PROFESSIONALS

Public health advocates played a central role in the development of new housing codes and can share part of the credit for the great improvement in health and mortality that began in the late 19th century, a time well before the advent of modern antibiotics, diagnostics, and prevention. Furthermore, healthy housing advocates and the APHA should be applauded for their championship of the right to healthy housing at time when most other segments of society did not see a role for government in the provision of safe, affordable housing. However, healthy housing advocates and the APHA created housing and neighborhood standards that downgraded urban living, provided a scientific basis for condemning low-income housing and urban neighborhoods, and developed a detailed inspection procedure that was easily adapted to declare a community blighted, establishing the necessary legal conditions for vast areas of cities to be bulldozed. And once urban renewal displacement began, housing departments failed to live up to their legal responsibilities to ensure that adequate replacement housing was provided. Health departments did not speak up on behalf of the constituencies they were morally responsible for protecting.

The ultimate accountability for urban renewal lies far beyond the administrative and legal responsibilities of mid–20th-century health departments. Mayors and redevelopment authorities are ultimately responsible for urban renewal. Public health's involvement in the redevelopment process was limited to the early step of identifying blight and the later step of housing relocation. But why did public health participate in this process at all? Certainly, since health departments reported to city administrations, they most likely had little choice but to help carry out city policy. Given the lack of power that health departments would have had to challenge strong city governments determined to bulldoze their slums, the cooperation of health departments in urban renewal is not surprising. If public health officials had resisted, they could have placed their jobs in jeopardy. But the fact that they displayed no public discontent over their role in urban renewal suggests that they were willing participants in the process. Why?

Public health workers may have believed that the standards developed by the APHA truly reflected conditions that needed to be eradicated and that they were objectively applying these standards to the blight in their cities—despite the fact that these regulations were selectively employed to destroy African American communities. Perhaps because two generations of public health practitioners, confronted by a disconnect between a day-to-day responsibility for housing inspections as mandated by Veiller's Law and a professional focus that now saw disease as an individual responsibility—a shift that began soon after Louis Pasteur and Robert Koch convincingly proved that microorganisms caused disease—felt themselves in conflict with slum and tenement dwellers. With engineers successfully taking on public sanitation through water supplies, sewers, and campaigns for connecting indoor plumbing with sewers, public health professionals turned to "personal hygiene," hand washing, vaccination, and the identification of sick individuals.[45] As pubic health became more closely allied with the increasingly professional field of medicine, with many public health schools founded as offshoots of schools of medicine, it became less concerned about the environmental conditions in the slums.[46(p88)] Forced contact with a population they now believed to be a problem (the poor were more likely to be ill, less likely to live in sanitary conditions, and less likely to have their children vaccinated) could have led to a lack of sympathy. The connection to social reform slipped.

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Public health practitioners therefore became less able to

address the underlying causes of poverty. The lack of people of color in the public health workforce may have resulted in a shortage of advocates for at-risk neighborhoods, and the professionalization of the field alienated practitioners from their natural constituents, the poor. In Chicago, Illinois, for example, tuberculosis was made a reportable disease in 1908. When the health department received a case report, a nurse was dispatched to the house of the victim, who was told to not spit, to sleep outdoors, and to avoid alcohol. The health department, however, did not seem to notice how these measures would do little to stop the progression of either an individual's case or the epidemic itself, and was frustrated by the lack of cooperation it received in the tenements. Stepping up its enforcement efforts, the department took uncooperative patients to municipal sanitariums for education.[47] This most likely disrupted families, and put them at economic risk.

IMPLICATIONS FOR THE FUTURE

Today, large-scale bulldozing of communities is rare. Neighborhood revitalization now tends to focus on loans for housing improvements, redevelopment of abandoned industrial sites, code enforcement, and targeted infill development (programs that seek to use empty or underused parcels inside built-up areas rather than open land at urban peripheries), all policies with less negative impact than traditional urban renewal. Public health has played a more positive role in these programs, including its key role in the remediation of brownfield sites,[48,49] lead cleanup programs,[50] and healthy housing initiatives.[51] These programs have cast public health professionals as advocates for the poor and at-risk neighborhoods; perhaps they have also conditioned them to have a greater appreciation for distressed communities and made them comfortable speaking out for disadvantaged people whose interests are threatened. Together, these programs make it less likely that public health will function in the future as it did during the urban renewal era.

It is too late to remedy the consequences of urban renewal, but there is an obligation to remember the lessons from that time. There are a number of policies and programs that should be adopted. First and foremost, public health professionals must be advocates for the disenfranchised. The failure during the urban renewal era began when public health did not rise to defend the poor. Today, public health is involved with at least one major program of potential impact on disenfranchised, at-risk people: disaster planning and relocations during emergencies. The US Immigration and Naturalization Service has sometimes used mass evacuations during hurricanes as opportunities for screening for illegal immigrants.[52] The question arises whether public health can be a participant in such actions without compromising its fundamental moral commitment to help those least advantaged. At a minimum, the situation calls for a strong public health response. Who else has the scientific authority to speak out against potentially destructive government policies? Public health must work in partnership with its constituents if it is to be effective.

Second, there must be an acknowledgment of the role that public health played in these destructive policies. The urban planning profession went through a self-evaluation and produced books such as *The Federal Bulldozer* and *After the Planners* that took the entire profession to task.[35,53] The public health profession needs a similar assessment. Urban planning practitioners also established new programs, such as the community development corporation and brownfields programs, that rely heavily on community-based boards of directors and community-based processes to protect poor neighborhoods from public policies that may have a negative impact on these communities. The public health equivalent, the community health center, does tremendous work to bring medical services to underserved communities. Until recently, however, they have tended not to be involved in community redevelopment and planning activities. Only a few health centers have committed themselves to working on addressing the overall problems of urban neighborhoods. Because of their close relationship with at-risk communities, they should take a lead in protecting communities from new threats.

In addition, with the new attention to the built environment among health professionals, the record of the past must be incorporated into curricula, guidelines, books, and study guides to promote healthy design. Only by remembering the past can these mistakes be avoided in the future. If the lack of minority health workers did contribute to this failure of policy, public health must increase its efforts to expand the diversity of its workforce. These workers can play a vital role in identifying and guarding against potentially destructive policies. Finally, the APHA might consider establishing a new committee, charged, as was the APHA-CHH, with examining its archives and reporting back to the APHA membership on its past role and recommendations for future actions.

The urban renewal program was developed and implemented without any input from the people who were the objects of these programs: the poor, often non-White populations of so-called blighted neighborhoods. Today, we have accepted ways of undertaking cooperative ventures between government, public health professionals, and affected communities. From community-based participatory research and neighborhood-based planning to health impact assessment and institutional review boards, there are a number of mechanisms that incorporate community perspectives into health programming. These ways of working with diverse communities must be fully integrated into research and practice. The lessons of public health, the APHA, and urban renewal must be remembered as we move forward. ■

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References

1. Tarr J. 1996. *The search for the ultimate sink: Urban pollution in historical perspective.* Akron, OH: University of Akron Press.

2. Tarr J. 2005. Some thoughts about the Pittsburgh environment. Introd. to *Devastation and renewal: An environmental history of Pittsburgh and its region*, ed. J. Tarr, 1–10. Pittsburgh, PA: University of Pittsburgh Press.

3. Melosi M. 2001. *Effluent America: Cities, industry, energy, and the environment.* Pittsburgh, PA: University of Pittsburgh Press.

4. Melosi M. 2008. *The sanitary city: Environmental services in urban America from colonial times to the present.* Pittsburgh, PA: University of Pittsburgh Press.

5. Winslow C.-E. 1949. The message of Lemuel Shattuck for 1948. *Am J Public Health.* 39(2):156–162.

6. Kermack W.O., A.G. McKendrick, and P.L. McKinley. 1934. Death-rates in Great Britain and Sweden: expression of specific mortality rates as products of two factors and some consequences thereof. *J Hyg (Lond).* 34(4):433–457.

7. Preston, S. and E. van der Walle. 1978. Urban French mortality in the nineteenth century. *Popul Stud (Camb).* 32(2):275–297.

8. Blackmar E. 1995. Accountability for Public Health: Regulating the Housing Market in Nineteenth-Century New York City. In *Hives of sickness*, ed. D. Rosner, 42–64. New Brunswick, NJ: Rutgers University Press.

9. Dreier, P. 1997. Philanthropy and the housing crisis: the dilemmas of private charity and public policy. *Housing Policy Debate.* 8(1):235–294.

10. Ford, J. 1936. *Slums and housing.* Westport, CT: Negro Universities Press.

11. Veiller, L. 1911. The National Housing Authority and its relation to public health. *Am J Public Health.* 1(5):330–333.

12. Veiller, L. 1914. *A model housing law.* New York, NY: Russell Sage Foundation.

13. Wood, E.E. 1919. *The housing of the unskilled wage earner.* New York, NY: Macmillan.

14. Bauer, C. 1934. *Modern housing.* Boston, MA: Houghton Mifflin.

15. Corburn, J. 2004. Confronting the challenges in reconnecting urban planning and public health. *Am J Public Health.* 94(4):541–546.

16. Committee on the Hygiene of Housing. 1938. *Am J Public Health.* 28(3): 351–372.

17. Winslow, C.-E. 1937. Housing as a public health problem. *Am J Public Health.* 27(1):56–61.

18. *A handbook on urban redevelopment for cites in the United States.* 1941. Washington, DC: Federal Housing Administration.

19. Winslow, C.-E. 1947. Health goals for housing. *Am J Public Health.* 37(6): 653–662.

20. *Memorandum on post war urban housing.* 1944. International Union, United Automobile, Aircraft and Agricultural Implement Workers of America (UAW-CIO).

21. *Plan for New York City. A proposal.* 1969. New York, NY: New York City Planning Commission.

22. Davies, J. 2002. Urban regime theory: a normative-empirical critique. *J Urban Aff.* 24(1):1–17.

23. Imbroscio, D.L. 1997. *Reconstructing city politics: Alternative economic development and urban regimes.* Thousand Oaks, CA: Sage.

24. Harvey, D. 1981. The urban process under capitalism: A framework for analysis. In *Urbanization and urban planning in capitalist society*, ed. Dear, M., and A. Scott, 91–122. New York, NY: Taylor and Francis.

25. Dowding, K. 202. Explaining urban regimes. *Int J Urban Reg Res.* 25(1):7–19.

26. Organization of municipal health departments. 1912. *Am J Public Health.* 2(5):366–383.

27. Twitchell, A. 1943. A new method for measuring quality in housing. *Am J Public Health.* 33(6):729–740.

28. Tiboni, E. 1949. Appraisal of substandard housing. *Am J Public Health.* 39(4):459–461.

29. Hemdahl, R. 1959. *Urban renewal.* New York, NY: Scarecrow Press.

30. Senn, C. 1951. Hygiene of housing: contribution of the American Public Housing Association to housing evaluation. *Am J Public Health.* 41(5 pt 1): 511–515.

31. Markis, P. 1962. The social implications of urban redevelopment. *J Am Inst Plann.* 27(3):180–186.

32. Biles, R. 2000. Public Housing and the Postwar Urban Renaissance. In From tenements to the taylor homes: In search of an urban Housing policy in twentieth-century America, ed. Bauman, J., R. Biles, and K. Szylvian, 143–162. University Park: University of Pennsylvania Press.

33. Catlin, R. 1999. Gary, Indiana: Planning, Race and Ethnicity. In *Urban planning and the African American community: In the shadows*, ed. Thomas, J.M., and M. Ritzdorf, 126–142. Thousand Oaks, CA: Sage Publications.

34. Gibson, C. 1998. *Population of the 100 largest cities and other urban places in the United States: 1790–1990.* Washington, DC: US Bureau of the Census.

35. Leach, R. 1960. The federal urban renewal program: a ten-year critique. *Law Contemp Probl.* 25(4):777–792.

36. Anderson, M. 1964. *The federal bulldozer.* Cambridge, MA: MIT Press.

37. Caro, R. 1975. *The power broker: Robert Moses and the fall of New York.* New York, NY: Vintage Press.

38. Bellin, L. 1966. Obligatory alliance—the urban renewal authority and the city. *Am J Public Health Nations Health.* 56(5):776–784.

39. Harmon, A.J. 1964. Health and urban development, I: the trend and probable future of cities in relation to health. *Am J Public Health Nations Health.* 54(5):699–703.

40. Fullilove, M. 2005. *Root shock: How tearing up city neighborhoods hurts America, and what we can do about it.* New York, NY: Random House.

41. Fried, M. 1966. Grieving for a Lost Home: Psychological Costs of Relocation. In *Urban renewal: The record and the controversy,* ed. J.Q Wilson, 359–379. Cambridge, MA: MIT Press.

42. Fullbright, L. 2008. Sad chapter in Western Addition history ending. *San Francisco Chronicle*, July 21, 2008. http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2008/07/20/BA6511Q4G0.DTL&tsp=1 (accessed July 21, 2008).

43. Le Corbusier. 1929. *The city of tomorrow.* Cambridge, MA: MIT Press.

44. Scully, V. 1969. *American architecture and urbanism.* New York, NY: Henry Holt and Company.

45. Wolman, A. 1925. Values in the control of environment. *Am J Public Health.* 15(3):189–194.

46. Lubove, R. 1962. *The progressives and the slums: Tenement house reform in New York City, 1890–1917.* Westport, CT: Greenwood Press.

47. Robertson, J.D. 1918. Chicago's tuberculosis problem. *Am J Public Health.* 8(3):227–237.

48. Wedding, G., and D. Crawford-Brown. 2007. Measuring site-level success in brownfield redevelopments: a focus on sustainability and green building. *J Environ Manage.* 85(2):483–495.

49. Greenberg, M. 2003. Reversing urban decay: brownfield redevelopment and environmental health. *Environ Health Perspect.* 111(2):A74–A75.

50. Hynes, H., R. Mayfield, P. Carroll, and R. Hillger. 2001. Dorchester Lead-Safe Yard project: a pilot program to demonstrate low-cost, on-site techniques to reduce exposure to lead-contaminated soil. *J Urban Health.* 78(1):199–211.

51. Jacobs, D., T. Kelly, and J. Sobolewski. 2007. Linking public health, housing, and indoor environmental policy: successes and challenges at local and federal agencies in the United States. *Environ Health Perspect.* 115(6): 976–982.

52. Roebuck, J. 2008. Groups seek clarification on evacuation policies. *Christian Science Monitor*, July 9, 2008. http://www.themonitor.com/articles/hurricane_14287___article.html/evacuation_people.html (accessed August 10, 2009).

53. Goodman, R. 1972. *After the planners.* New York, NY: Simon and Schuster.