Health Commissioner Leona Baumgartener (1954–1962), right, assisting Dr. Harold Fuerst in administering Elvis's polio vaccine, October 28, 1956

PUBLIC HEALTH'S UNPOPULARITY

The most invisible essential job of all

Jessie Cacciola, May 16, 2020

"If we do it well, you'll see nothing, and you'll just have to take my word that it would've been bad." A close friend of mine has worked in public health all her life, now for the CDC's COVID-19 task force, and she's a magician — driven by data, preventative measures, actions that are invisible to everyone else, until something pops out behind the curtain.

When we were in college, she was the one getting you back into your dorm after you locked yourself out. She secured my roommates and I a place to live when we were looking to move off campus, told us what shots we'd *really* need for our first trips out of the country, and twelve years later, she's still the first person I call when I need to hear the truth. For years, friends of hers — myself, excluded — told her she'd be better off working for the private sector, but she and I both know she'd rather play offense.

The pillar, and unfortunate unpopularity, of public health rests on the invisible. We have to believe in it first. It is seemingly unwise to pay for what isn't happening, no matter the uncertainty of when it will. Early alerts are generally not the most effective. A warning, no matter its severity, must go through a filter of personal doubt, peer review, and ultimately a decision to fight, flight, or do nothing until a threat exists out front where you can see it.

The job of the NYC Department of Health and Mental Hygiene (DOHMH) sounds simple but has gotten complicated over time. Its founding mission — to prevent, track, and cure — would soon be pulled apart.

In 1965, president Johnson's "Great Society" shifted funds from preventative agencies to medical technologies. No doubt, we needed efficiency in drug development, but we wouldn't need as many if our preventative resources remained as strong. But since medicine is sold on the private market, there's greater incentive to need it. Just as U.S. Secretary of Agriculture at the time, Earl Butz (1971-1976), could not foresee what would happen when he made it easier to grow corn, Johnson set into motion a shift in the way we view public health and the perception of what it costs. Their intentions were noble at a time when we desperately needed life to be more livable, but that doesn't mean we don't have a chance to fine-tune their approach.

We were left with a system that costs less upfront, but for the individual, a much higher price later. Public health agencies, chopped at the knee, began to bleed, leaving the public to abate risk as best it could. No longer able to fulfill their role as primary caretakers, as educators, departments of health reinvented themselves. As expert trackers and record keepers — which began with death and birth certificates — they became inspectors of the private sector and would soon fear the sight of room temperature butter in every restaurant in town.

Before 2017, I didn't know much about the DOH. We generally don't, until we have to. That was the year my favorite bar decided to stop serving my favorite meal. That loss now pales in comparison to the losses we're experiencing now, but at the time, fueled by anger and no answer, I started to write a book. I'm a food operator by trade. I've worked mostly in the middle of the supply chain, sold bread, cheese, and seafood to restaurants, and have written about food politics for most of my career, though never as it related to restaurant inspections. But when you feel the singe of a crossed wire, you stand up. These things are all connected.

I was ready to add to a pile of unread complaints to the DOH, along with so many cooks over the years — about how inspectors seem painfully unknowledgeable about the very things they

inspect (yes, bread starter is rife with bacteria but the good kind); how fines might as well be taxes for the city ($53.6 million at its peak in 2012, shortly after letter grades began); how the Department seems bent on a gotcha model of enforcement, and does very little to support those looking to serve good, clean food — but none of these failures are the Department's fault. It's taken me three years to come to this sobering (truly, deflating) conclusion. Like air out of a worn tire, I needed to let go. The bike was old. It wasn't going to get me anywhere.

Halfway through March 2020, when it became abundantly clear that restaurants would need to close their "non-essential" doors, and by doing so, risk never opening them again, these punitive inspections continued. You might have wondered, doesn't the DOH have anything better to do? At one time, it did. I promise you'll be consoled by the story of how the DOH formed, and how our relationship became so estranged.

In 1866, New York founded the nation's very first health department, then the Metropolitan Board of Health. Until 1965, the department had more padding than the city's private hospitals. Health stations were set up all across our five boroughs and offered free screenings and treatment. You could say this is because there was far more loss at the time, far more filth, poverty, and death, but imagine, if you can, how much more there would have been if the needs weren't validated. Major mountains needed moving for us to overcome the days when wild pigs were our only trash collectors. This was before the city's garbage was deferred to Bedloe's Island, now Floyd Bennett Field, off Jamaica Bay.

For its first century, the DOH did just that. It wasn't easy. But during these years, it was more financially stable for a doctor to work for the Department than it was to open a private practice, or even work for a hospital, so most did. Public nurses, too, made more than their hospital peers. I imagine it was also more meaningful. Appointed doctors could focus on research projects and preventative education for the public — through lectures, pamphlets, and even motion picture shows — rather than rely on the business of treating the public when it got sick.

Beyond the limitations of our current administration, the system now is not built for foresight; rather it's built to play catchup to a crisis that demands an immediate cure. A necessary shift in mindset will require us to put on our bifocals.

To understand policy, it's helpful to know your local government's fiscal year, the time at which new budgets are proposed and adopted. Our federal fiscal year is October 1st through September 30th; New York State's is April 1st through March 31st, and the city's is July 1st through June

30th. Grants and fines are the bulk of what they run on. They have something much better to offer, but no one's been buying it for the last fifty years. When the city needs to attend to a crisis, or rebuild as it did after 9/11 and after Sandy, it must pull from an existing budget, and the only way to do that is cut programs and make new money. Is it any wonder, then, why letter grades began in July of 2010?

Departments of health are not the enemy. The enemy lies in how we value them, not in times of crises but every day. When yellow fever threatened to cross over into New York from Philadelphia in 1793, a group of leading doctors got together to prepare the city for the inevitable. By 1819, the city's wealthiest had moved to the country — what is now Greenwich Village, but was then a small town outside city limits — leaving the poor to weather what was thought to be a poor person's problem. But the wealthy soon learned that their health was linked to the health of all residents, and would require an "everybody in" approach.

In the early 1900s, there were public health districts throughout the city, so that in 1906**,** the Department had 318 diphtheria antitoxin stations in all five boroughs, and $104,000 in free antitoxin could be distributed per year — the equivalent of about $3.2M today. This was the first time the Department effectively fought an epidemic. It was accomplished only by making an effective treatment available, and free, to everyone.

The Department's first century was a brutal achievement, a model for the rest of the nation. By 1962, Dr. Leona Baumgartner had ended a legacy term as Commissioner, and it was high times. I'd like to think she basked in the warmth of support as she posed for pictures while unveiling new health stations and giving Elvis his polio shot. With major epidemics thought to be at bay — polio, tuberculosis (twice), cholera, and yellow fever — the Department had begun funding research on chronic and infectious diseases.

Then in 1965, under president Johnson's Great Society, the U.S. funneled money into medical technologies and depleted funding from city and state agencies, and the bottom fell out. Of course, the public sector would still need to approve anything that was used in the private sector, and people would have to be able to afford it. (By contrast, F.D.R.'s New Deal of the 1930s and 1940s had funded the expansion of public works projects, which led to more health centers for the NYC DOH and a bureau completely dedicated to the eradication of tuberculosis.)

NYC Health Commissioner Leona Baumgartener (1954–1962), right, playing air-guitar with Elvis as she administers his polio vaccine, October 28, 1956

So the private sector began to grow. The three decades that followed saw continued budget slashing for the public sector. The NYC DOH neared insolvency by the 1970s and again in the ‘90s, which left it primely unprepared for the HIV/AIDS epidemic as it waited for a national response. Mitch McConnell’s suggestion that states turn to bankruptcy will sound harshly similar to Gerald Ford when he effectively told the city to drop dead in 1975. Local police precincts then began distributing flyers outside Port Authority that displayed the grim reaper, titled “Fear City”, in an effort to keep people away, or at least keep them from staying out late. It was an effort to prolong the inevitable, abate risk, flatten a curve at a time when resources were dangerously limited.

The need for a public health department is kind of like the worst imaginable chicken-or-egg scenario. We can create an environment where the chicken is least likely to catch salmonella, or we can spend the rest of our days warning people about the dangers of raw yolk, no matter where the chicken comes from. Where we lack in prevention, treatment takes over, but there isn't always a cure. Tracking is only as effective as its timing. The longer you wait, and the further your sources travel, the harder it becomes.

There hasn't been a time like this in some time. Because of this, the first thing the DOHMH needs to do is convince local officials that it needs to hire more staff, but with fixed budgets, that's unlikely to happen beyond grants through the CDC, until the city is able to move things around.

In the meantime, agencies that are now tasked with treating the public directly, such as NYC Health + Hospitals, are generally far more staffed (all of the time, because we always need them) and can shift priorities more easily. You could also argue that we always need them because our preventative measures are muted. In other words, we always need both. While the DOHMH was once tasked with executing all three parts of public health (preventing, tracking, curing), that last part broke off into the private sector, and now there are attempts to take part two away as well.

Public health agencies are first and foremost educators focused on prevention. That's where they really shine. Before we start panicking about how many times we should be washing our hands, they should already be there with the answer. Without continuous support, even during times deemed off-season, they're forced to play defense. On the rare, unpredictable but crucial times we need them, they must fight to be louder than the loudest voices.

Maybe a few months from now, by July or September, one day, the public will go back outside. Maybe in a year or two, we'll forget how to wash our hands like surgeons, to live and cook and work from home, to see what a dog looks like wrapped in the same protective plastic as its owner. We can hope to return to something resembling normal, but normal is completely inadequate for what we know to be true: it won't stop us from being here again.

An egg is only a risk after we've made it porous. It is painfully clear now, if not before, that the people who've chosen to work in public health, chose so not for the fame, but to serve the public in whatever way we'll let them. What can we do? Understand why inefficiencies exist, and persist. Listen to the people who have nothing to gain but the satisfaction of knowing they kept you safe.

This can come in many forms: cooks you trust to feed you, friends who vow to wear a mask with you in public, and if we can manage to keep our health departments above water, from fumbling in our basements, they'll be able to speak their truths just as easily. We won't have to fight them on things that don't matter, or wait to hear it from a friend.

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Jessie Cacciola is at work on a book about the history of restaurant inspections, titled Recipes to Confuse the DOH. *She is a food operator in New York who has sold seafood, bread, and cheese to restaurants, and is currently working from home for a hotel where people used to gather. She has written for The Atlantic, GQ, Edible, Time Out, and New York.*

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