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COMMENTARY

The War On Poverty's Health Legacy: What It Was And Why It Matters

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ABSTRACT The movement to promote a culture of health bears many similarities to another large-scale and ambitious effort from more than fifty years ago: President Lyndon Johnson's War on Poverty. Long a target of critics of all ideological persuasions, the War on Poverty, through its heritage, offers an instructive precedent for champions of the culture of health movement. This essay examines two regional-level War on Poverty health endeavors, one each in New York City and Los Angeles. They show the influence the War on Poverty had on the ground in widening the health care safety net, implementing holistic models of care, and facilitating community involvement in the leadership of larger health care institutions.

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Imagine an ambitious program for population health improvement that facilitates partnerships linking the government, universities, and other non-profit organizations. It builds bridges from health to other critical sectors of society. It cultivates leadership, particularly among those unaccustomed to leadership roles. It creates an enduring health care delivery system that takes into account the social context of patients' lives outside of clinical settings. And it provides meaningful employment to thousands of people taking part in bold and experimental programs.

You'd be right to think that the above sounds a lot like the culture of health, as embodied in the Robert Wood Johnson Foundation's Culture of Health Action Framework. But it's also describing something initiated more than fifty years ago. In his 1964 State of the Union Address, President Lyndon Johnson declared an "unconditional war on poverty," one to be waged at all levels of American society. "Poverty is a national problem, requiring improved national organization and support," Johnson declared. "But this attack, to be effective, must also be organized at the State and the local level and must be supported and directed by State and local efforts."

Johnson argued that "our chief weapons in a more pinpointed attack will be better schools, and better health, and better homes, and better training, and better job opportunities to help more Americans."¹ He envisioned something that would reach widely, cross into many sectors, and—in contemporary parlance—not be stove-piped by bureaucratic walls.

As the historian Julian Zelizer has noted, Johnson's political timing could not have been better. His first full term as president began with the Democrats in control of both chambers of Congress, and the next two years saw the largest expansion of domestic social welfare legislation and policy since President Franklin Roosevelt's New Deal in the 1930s. There were programs centered on early childhood intervention (Head Start), aid to resource-poor rural and urban areas (Model Cities), youth civic engagement (VISTA and AmeriCorps), and increasing access to legal services (Legal Aid) and health care (Medicare and Medicaid).²

But the War on Poverty soon saw its fortunes fall. The performance of many programs was uneven, while the Vietnam War siphoned off many economic resources.³ Richard Nixon's inauguration as president in 1969 closed the polit-

ical opening that had allowed the War on Poverty to be launched so quickly. And finally, a recession from 1973 to 1975 prompted a new era of budgetary austerity. The War on Poverty, born amid optimism and abundance, faced a new climate a decade later—one characterized by anxiety and stringency.

The War on Poverty also came under attack in the world of letters. Some critics accused it of aiding out-of-control activists who misappropriated resources.⁴ From the left came analyses that characterized the programs as overly individualistic and focused on building human capital instead of transforming repressive social structures.⁵ And radical critics argued that the War on Poverty bureaucracy had absorbed and co-opted, sometimes through patronage networks, activist energy that might otherwise have had a larger impact elsewhere.⁶ The mounting criticisms, along with the decline of Johnson's reputation due to Vietnam, have diminished the War on Poverty's place in the collective memory of American social policy. Too often, individual programs from this time period, such as Head Start or Medicare and Medicaid, are discussed in isolation, instead of being seen as part of a larger multifront policy heritage. Exploring that heritage, however, can guide analogous efforts in the culture of health. It can help those efforts, in turn, avoid some of the same errors and transcend the shortcomings of their predecessors.

In this essay I focus on where the War on Poverty's health programs had the most impact: at the regional and on-the-ground level. I explore three major War on Poverty achievements: increasing access to care in resource-deprived areas, implementing holistic models of health care, and fostering community inclusion in medical administration. New York City and Los Angeles make two ideal cases. The New York City example was pioneering novel health care delivery even before the War on Poverty and its health program began. Los Angeles, meanwhile, became a site for concerted policy response in the wake of the 1965 Watts riots and demonstrates how the War on Poverty addressed injustices brought to the fore by social unrest of the time. Though they hardly occurred without complications, the achievements in these two cities can help us see the War on Poverty in a new and constructive light.

New York City: Social Determinants Of Health Before 'Social Determinants Of Health'

Each day in Lower Manhattan, hundreds of patients use Gouverneur Health. It's an outpatient clinic in an area that has repeatedly undergone

rapid demographic transformation, serving as host to waves of immigrants—among them European Jews, Puerto Ricans, and Chinese. Many of its first-generation clients have low incomes and speak no or limited English. For them, Gouverneur, like many facilities of its kind, is a key component of a health care safety net. Few of these patients know, however, of the facility's role in the War on Poverty's health program.

With roots in settlement house reform efforts, for decades into the twentieth century Gouverneur served as a hospital for the Lower East Side.⁷ By the 1950s Gouverneur's physical plant had begun to crumble.⁸ In 1961 word came down that the city might close Gouverneur altogether. But in an eleventh-hour move, Mayor Robert Wagner intervened. He ordered that New York City close only Gouverneur's inpatient services and that it expand the outpatient department, turning it into an experimental ambulatory clinic that would be administered by Beth Israel Medical Center and led by Howard J. Brown, a former physician for the United Auto Workers and Health Insurance Plan of New York.⁹

Brown and his team got busy, articulating a vision that, in their words, focused on "comprehensive medical care of high quality" that would "meet the total needs of the Lower East Side" by using "all the presently available medical and related community resources in rendering such care" [emphasis added].⁹ This vision of health sought to integrate Gouverneur into its wider socioecological context. Three major reforms were immediately implemented. First, Gouverneur cultivated relationships with the network of surrounding social service agencies, encouraging them to inform patients about the facility and to learn about the social context of potential patients. Second, it hired employees directly from the Lower East Side and with language ability appropriate for the ethnically diverse population (29.0 percent Puerto Rican, 8.2 percent African American, and 3.2 percent Chinese).¹⁰ And lastly, Gouverneur became one of the first American medical facilities to implement continuity-of-care clinics, where a patient saw the same physician on repeat visits.⁹

Early success caught the eye of the federal government. In 1966 a grant followed from the Office of Economic Opportunity (OEO), a new federal agency created to administer many of the War on Poverty programs. The grant was part of the office's fledgling neighborhood health centers program, which included—among others—two famous facilities overseen by Jack Geiger and Count Gibson in Mound Bayou, Mississippi, and Boston, Massachusetts.

With new resources, Gouverneur continued to

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innovate. In 1967 Brown and his associate director, Harold L. Light, published a list of twenty-five ambitious “basic operating principles.” One read: “The patient functioned as part of a larger milieu—in his own home and in the broader community—and these forces, therefore, must be taken into account if the service rendered was to be meaningful.” It was the fourth principle, though, that stood out above the rest. It read, simply: “The community at large was entitled to a voice in the program and should share in the decision making process wherever possible.”¹¹ Beneath the simple statement was a bold idea: that voices in American health care, formerly limited to those of the insulated medical elite, would now include those from the community. The statement suggested a reordering of the traditional medical hierarchy.

The community plank coincided with what would become the War on Poverty’s most controversial administrative requirement. Buried in the 1964 Economic Opportunity Act, which had created OEO and appropriated funding for programs run out of it, was a requirement that programs receiving federal War on Poverty funds devise mechanisms to include the “maximum feasible participation” of constituents in the programs’ operation.¹² For Gouverneur, that meant the creation of a health council, dubbed the Lower East Side Health Council–South (hereafter, the Council), to serve as an official conduit between Gouverneur’s constituency and the facility’s administrators.

Day to day, the Council also carried out some remarkable activities. With the help of ten youth “health aides” from the Lower East Side, it commissioned a survey and study on the usage of services, which had increased since Gouverneur’s reorganization.¹³ The Council also reported on alarming conditions outside the formal health care system. A typical report came from “Mr. and Mrs. C.,” who lived in an apartment described as “unsanitary. The building is filled with rats and they have been robbed twice.... Toilet in hallway outside.... Mrs. C. is

expecting a child any day. She was given help in filling out housing applications for the Projects. She was also sent to Gouverneur Prenatal Clinic.”

Isolation, poor housing, and economic deprivation, as cases like this showed, could not be detached from bodily ills. The study’s authors stated the links even more explicitly when they concluded: “The target neighborhood has one unifying factor—*poverty!*” It went on, “Improved mental, physical, and environmental health is as much tied to improving the conditions of housing and welfare as it is to building new and better medical and health structures.”¹⁴ This was an organic formulation of a “social determinants of health” perspective, formed from day-to-day encounters and conversations with residents.

The work continued. The Council regularly pointed patients toward useful neighborhood resources. In the process, it employed people from the neighborhood, cultivated leadership potential through programs such as the youth-driven survey, and reported facts from the ground back to Gouverneur higher-ups. As late as the summer of 1967, mandatory community participation appeared to be thriving.

But “maximum feasible participation” soon caused problems. The Council’s experience in the late 1960s illustrates the phrase’s ambiguity. Part of the tension was rooted in the bureaucratic structure of War on Poverty grants. Federal funds were typically not disbursed directly to watchdog community boards. Rather, they went to the institutions for which community boards provided a community check and balance. It was up to the institution in question, then, to adhere to the “maximum feasible participation” guideline. In Gouverneur’s case, the institution was Beth Israel, which had helped the city by formally shepherding the Gouverneur project from its early days.

The first conflict between the Council and Beth Israel came when the Council concluded that it required a full-time staffer. But Beth Israel rejected both the Council’s pick for a staffer and a request for hiring funds. Only after a 1968 visit from officials of the federal OEO did Beth Israel reverse its decision.^{15,16} There were other conflicts, both major and minor. A final explosive turning point came in December 1969, when the Council received a sympathetic letter from Harvey Karkus, a Gouverneur doctor who deplored the conduct of Beth Israel’s higher-ups. A month later, Karkus lost his job, and 150 people confronted the head of Beth Israel in protest.^{17,18}

The conflicts became heated enough to require more mediation from the OEO. An operative of the office, sent from Washington, pinned much of the problem on nebulous legislative

language—“maximum feasible participation”—that either side could invoke in its favor. In the OEO’s view, Beth Israel saw community participation as “a process wherein non-professional people are given education by hospital professional...and then serve as a public relations and information source.” For Beth Israel, community participation meant outreach. For the Council, it meant that, plus shared governance. In the words of the OEO, the Council saw “itself as a lay board of directors which understands the health needs of the community and is qualified to have a policy making voice.”¹⁹ Who rightfully spoke for the community, and in what capacity could they act?

The office ultimately reversed many of Beth Israel’s decisions, but to prevent future conflict, it required the Council to draft a “work plan” that mandated “a more formal communications system” between the Council and Beth Israel.²⁰ Although the OEO’s arbitration was favorable to the Council, two years of rancor over community participation may have extracted a toll on the quality of service. A 1969 Council survey of patients revealed that complaints about personnel included “carelessness and indifference” and “insensitive treatment of patients, particularly non-English speaking patients.”²¹ This underscored how a seemingly clear and laudable goal—the involvement of the very people who would benefit from a program—was hard to realize in the world of day-to-day practice and could result in conflict that unexpectedly compromised other parts of Gouverneur.

Los Angeles: Race, Riots, And Community Health

Throughout the mid-twentieth century, pervasive housing discrimination had concentrated 90 percent of LA’s black population into two adjoining neighborhoods, Watts and Willowbrook (collectively referred to hereafter as Watts).²² In August 1965 Watts exploded, and residents rioted for almost a week over police brutality and lack of social services. An official riot commission endorsed the construction of more health care infrastructure as a component of the city’s response.²³ It also researched resource deprivation and found a medical desert in Watts, where the physician-to-population ratio was less than half the countywide figure. In one of the area’s few small for-profit hospitals, an inspection had “ordered the kitchen to be cleaned, mice-droppings to be removed, infected dressings to be incinerated.” Watts residents willing to go to the county general hospital had to travel eight to ten miles from an area with poor public transportation and low automobile

ownership.²⁴

The riot and these conditions attracted the attention of the Office of Economic Opportunity, which selected Watts as a site for a neighborhood health center. Dubbed the South Central Multi-Purpose Health Service Center (hereafter the Center), the facility opened in 1967. The program was always about more than filling gaps in health care services. Like Gouverneur, it also attempted to connect health services with the social environment where delivery took place. The Center hired local residents to inform other residents about the center’s services. These employees helped residents navigate other social service agencies for job training and housing assistance, and they briefed the Center’s staff about surrounding conditions. Employment at the Center was also tied to on-the-job training, part of a national movement to nurture paraprofessionals.²⁵

Early optimism was soon dashed by governance battles. In a situation analogous to the relationship and funding arrangement between Beth Israel and Gouverneur, the University of Southern California (USC) received federal funds for the Center. In the previous couple of decades, USC had been rapidly expanding several miles directly north of Watts, displacing many black residents in the process. For James Bates, a community organizer hired for the Watts health project, USC’s involvement aroused justifiable suspicion. A black alumnus of USC, Bates was uniquely situated to observe Watts residents’ impressions of the university. He summarized their sentiments bluntly, “We just don’t want the University of Southern California in Watts under any circumstances.”²⁶

USC felt the suspicion. All three of the administrators at the Watts center initially selected by USC were white. A concessionary move of USC, however, was to hire a local black physician, Sol White, for a co-administrative role. Interpersonal clashes between him and the white physicians promptly ensued. In Bates’s view, these tensions were a microcosmic version of the larger animosity of independent black physicians in Watts toward the new project, which they saw as a threat.²⁶

Intraracial economic differences of this sort fed into a second governance struggle around “maximum feasible participation.” As the Center’s paid organizer, Bates had the thankless task of forming a Community Health Council (CHC) to facilitate the required lay participation. Theoretically, the CHC was to have a say in personnel and other major administrative decisions. But Bates struggled to even put the CHC together. Watts’s racial composition masked tremendous heterogeneity within the neighborhood, and as-

The ambition to achieve intersectoral coordination was implicit in the War on Poverty's many different targets.

sembling a group of people to work together proved challenging.

In the end, Bates came up with a blunt tool (what he called a “Membership Determining Funnel”) to shape the CHC’s composition.²⁶ The funnel’s formula scored prospective members’ responses in interviews, then whittled the group down by where people lived in Watts and how old they were—a crude but ultimately necessary step toward creating something representative. The first Council assembled consisted of seventeen blacks (nine women and eight men), six of whom had had some higher education.

Surprisingly, community governance in Watts then proceeded with far less conflict. And to the credit of Bates and the Center, after the initial growing pains, the Center had considerable success, being able to function autonomously after USC phased itself out of the project. Credit for the harmony went to the early work of Bates and the extraordinary talents of Rodney Powell, a black physician from Philadelphia who had spent part of the decade in the Peace Corps before eventually coming on board as the Center’s associate project director–center director. Despite the “somewhat hostile milieu” that greeted him, Powell worked with the CHC on a new division of labor to clarify power sharing.²⁷ He proposed streamlining the structure of the Center and having the CHC operate as a board of directors, setting broad goals for the Center and having the final say on major “program operations” while leaving daily operations to others.²⁷

The CHC agreed to Powell’s suggestions, partly because of his good-faith efforts to reach out to the CHC, and proposed multiple meetings—what Powell later called “sustained, in-depth and even sensitivity-type sessions between the CHC and myself as well as, between the key program staff and the CHC.”²⁷ His efforts at cooperation and clear statement of overall deference to the CHC were a sharp contrast from the tension of the early days with USC.

A key indication of developing harmony appeared in the summer of 1969, when members of the Los Angeles Police Department swarmed the Watts Festival after a “minor civil disturbance.”²⁷ Powell recalled “the spectacle of heavily armed police, four and five to a car with shot guns and riot guns displayed in the car windows, patrolling the community in convoys of 4–5 cars,”²⁷ which left Watts residents worried about another possible uprising. Into the night, the Center’s staff members prepared an impromptu disaster plan in case events escalated. Although no such disaster occurred, the events led to feelings of solidarity among those working at the center: They had “special knowledge,” in Powell’s words, “that a team had been born.”²⁷

In September 1969, shortly before Powell’s departure, the Center earned a positive federal review. Its success after initial rancor pointed to one underappreciated aspect of the War on Poverty: the importance of talented community organizers and administrators like Bates and Powell, whose interpersonal skills and sensitivity allowed projects like the Center to navigate fraught political territory.

Reclaiming The War On Poverty’s Health Legacy

In a recent essay, the late historian Michael B. Katz noted that too many analysts had become wedded to “narratives of failure,” leaving them pessimistic about the prospects for positive social change. Katz added that “bits and pieces of other stories can be fit together to support a counter-narrative of limited successes, less dramatic but no less important and ripe with implications for the future.”²⁸

The War on Poverty’s health legacy offers such “bits and pieces.” Gouverneur and the Watts Center are but two examples. They and other health programs confound a common critique of the War on Poverty that focuses on its individualistic thrust—which, according to one scholar, “addressed poverty as a problem of individual development and the social disorganization of poor communities rather than as a function of the distribution of existing jobs or employment segregation.”²⁹ In some respects, the neighborhood health center experiences fit into this tradition. The centers’ founding advocates, particularly in Watts, portrayed them as job training opportunities and entry paths to health careers.

But unlike many War on Poverty experiments in the same locales, neighborhood health centers were not mere training facilities but actual creators of jobs, by virtue of their very existence. They were part of a nationwide investment in infrastructure and a political response to perva-

sive maldistribution in medical care.

Today, fifty years later, the federally qualified health center program directly funds more than a thousand similar centers across the country, and as the political scientist Robert Mickey has noted, it has recently attracted quiet bipartisan support.³⁰ These centers work alongside others modeled after them and funded through different streams, private and public. Both Gouverneur and the Watts health center are still standing, despite having weathered many budgetary and political storms. This achievement represents no less than an enduring alteration of health infrastructure, not just tweaks to individuals' human capital. That said, human development was not something to be dismissed, either. As Crystal Sanders argued in her analysis of Head Start in Mississippi, War on Poverty programs were training grounds for people who would go on to play critical roles in other social movements and social service endeavors.³¹

It is not hard to point out these programs' limits, of course. The most obvious concerns budget and scale. Even with the replication of the neighborhood health center model, there remains a fragmented, patchwork quality to decentralized health care services that renders the coordination of common goals a challenge. In the trying fiscal climate of the past few decades, health centers have also sometimes been forced to rely on unpredictable combinations of governmental and philanthropic funding. This raises the question of what happens after piecemeal grants expire. The question is not a new one and was raised in a trenchant 1966 article on grantsmanship and social services, titled "Social Action on the Installment Plan," by the urban studies scholars Martin Rein and S. M. Miller. In it, the authors noted that ephemeral local demonstration projects here and there ultimately failed to cascade into long-term and society-wide change.³² Current efforts to establish and scale up a culture of health also have their origins in philanthropy with support for projects through grants. Mindful of the history of the War on Poverty and OEO grants, present-day efforts must confront the dilemma of how to convert the piecemeal and experimental to systemic and permanent change.

A more ambiguous legacy of the War on Poverty is the primacy placed on community governance. *Community* was a deceptively simple organizing concept for collective governance. While community could serve as a unifying concept, it could just as easily be contested or appropriated by certain parties in fights for administrative power. In both the Gouverneur and Watts cases, this proved a constant undercurrent and, at times, a distraction. Elsewhere, contests

The programs discussed here, and the values that inspired and sustained them, left a significant legacy.

over community could derail a project entirely. In 1971 *Science* published a lengthy article on battles over community governance in Floyd County, Kentucky, where local elites had hijacked a health center's community governance structure and began misallocating funds.³³ Commitment to inclusive administration—and responsiveness to the particular needs of local patients who frequent facilities—remains easier as a rhetorical statement than something implementable in practice. This points again to the need for skilled facilitators with superb interpersonal skills to serve as conduits between health institutions and their constituencies when stakeholders attempt to enact the community ideal.

Intersectoral collaboration was also a major opportunity that was not entirely realized. Such limits were poignantly expressed by the Watts health center's Rodney Powell at a Harvard University conference on "Medicine in the Ghetto." He urged his fellow participants to adopt a "pluralistic approach" that would "integrate practitioners, public institutions, and consumers into a system that relates to medical, social, and environmental needs, including education, employment, housing, transportation, recreation, communications, and so on."³⁴ The ambition to achieve intersectoral coordination was implicit in the War on Poverty's many different targets: occupational mobility, housing, nutrition, early childhood education, and health care access, among others. And sometimes, as in Gouverneur's and the Watts health center's outreach to social agencies around them, it was instantiated. But a more systematic version of interagency coordination at all levels of governance was lacking. There are parallels to the present, as various entities in the health sector attempt to move guidelines for health in all policies from an ideal to a more widespread reality.

Despite these shortcomings, the War on Poverty's health legacy should not be dismissed. The programs discussed here, and the values that

inspired and sustained them, left a significant legacy. During the current era of enormous political turbulence, this legacy should be seized—indeed, embraced—by all of those involved in contemporary efforts such as building a culture of health. ■

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NOTES

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