"A Right to Be Safely Born":

The Quest for Health Justice for American Mothers and Children, 1890-1965

by

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ABSTRACT

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Abstract

Between 1890 and 1965, the ideology of government responsibility for maternal and child health represented a continuous and central goal that fueled programs and institutional networks of progressive and liberal social policy advocates. Beginning in the settlement houses of the 1890s, a cadre of female bureaucrats, social reformers, and their political allies developed an array of federally based programs. Conservative stakeholders—among them anti-feminists, representatives of the medical industry, anti-communists, and white supremacists—strenuously opposed this vision of health justice, arguing that health was a personal responsibility in which government should play no part. Despite the achievements of government-based progressive reformers in instituting their vision in urban settlement houses, under the Sheppard-Towner Act of the mid-1920s and during the years of the New Deal and World War II, the Cold War's approach to domestic social policy after 1947 clamped down on their vision. After this conservative turn against social democratic solutions to welfare needs, these progressive advocates shifted their attention to the international health rights movement and to community-based maternal and child health activities.

My dissertation introduces the concept of health justice as an interpretive lens to trace the history of health policy progressives and their institutional networks. On the one hand, health justice reflects the communitarian premise that the health of all members of society is essential for the common good. On the other hand, health justice implies that health and health care are individual rights that government ought to protect. While communitarian arguments were often on the tip of the tongues of social reformers, a passionate belief in citizenship-based rights and redistributive and

humanitarian ideas of social justice undergirded their policy ideas and became a more explicitly stated position during the New Deal and World War II. This justice-based approach to maternal and child health policy was consistently undermined by the prevailing counter-ideologies of individual responsibility for health, local control of public services, racial segregation in health services, and the commodification of health care.

My work relies on primary evidence collected from the personal papers of key protagonists, the administrative records of the Children's Bureau housed at the National Archives, oral histories, and the presidential papers of Harry S. Truman. Published primary materials have been culled from memoirs, professional public health and medical journals, as well as the popular press. I also draw from a body of historical and political science scholarship of the past twenty-five years to contextualize the narrative.

Dedication

Dedicated to my sons, Benjamin, Eliav, and Judah Goldman.

Contents

Acknowledgements

I am fortunate to have so many people and institutions to thank for their help in completing this dissertation. Bill Chafe has been a kind and astute mentor and committee chair. He has been with me at every stage of this dissertation. I admire his own prolific scholarship and his devotion to his students. Throughout my time in graduate school, Ed Balleisen has gently pushed me to think more analytically and made my work much better through his extensive insights. Sherman James has inspired me to read outside of my field, to learn other disciplines' methodologies, and to approach the study of inequality and poverty head-on. Since I was nineteen, David Rosner has modeled for me the kind of scholar I hope to be, one who combines political passion and intellectual rigor. Jeff Baker's willingness to participate in this committee has given me the resource of someone well-versed in my subject, and his involvement has helped me to understand the complex politics of pediatrics. Bob Korstad has supported me during my years at Duke and encouraged me to use the lens of health politics to understand modern American history. All of my committee members have been, without a moment's exception, generous, kind, and supportive. This warmth, their brilliance, and their interest in understanding the issues of our time, have helped me to love this project, and to finish it.

Many senior scholars have refined my skills, asked me helpful questions, honed my subject, and found relevant materials. My first marvelous history teachers were Ann Norton Green and John Wood. More recently, I have received guidance and encouragement from John Dittmer, Eric Foner, Janet Golden, Malachi Hacohen, Margaret Humphreys, Kriste Lindenmeyer, Nicole Sackley, Pete Sigal (my department's Director of Graduate Studies), Karin Shapiro, Karen Kruse Thomas, and Eric Yellin.

Introduction:

In 1948, the American Public Health Association chose Dr. Martha May Eliot as its new president. She was the professional organization's first female president, chosen in large part for her success in running the largest single-payer health insurance system the nation had ever seen. In her acceptance speech, Eliot insisted that the most urgent priority facing the public health professional community after World War II was the improvement of American children's health. "What we do for the child," she declared, "can be taken as a fair measure of social progress."[1]

According to Eliot, she and her colleagues had failed the children of the nation. During the war, "three babies died for every two soldiers killed in action." Eliot explained the irony of the situation: Although Americans believed that their "standard of living is high enough to provide not only food, shelter, clothing, education, recreation for families, but also health and medical care" to all Americans," the statistics on the nation's children showed quite the opposite. Eliot believed that the only way out of this dilemma was to "provide a medical care program" available to all, regardless of income level, one that would be "as freely available to mothers and children as is our public education system."[2]

Although medical care was Eliot's first priority, her ideas about how to resolve the health crisis of America's children went far beyond a comprehensive, federally funded health care system. She believed that the improvement of children's health

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[1] Martha May Eliot, "Cultivating Our Human Resources for Health in Tomorrow's World," *American Journal of Public Health and the Nations Health* 38, no. 11 (1948): 1500-2.
[2] For statistics of child deaths during World War II, see Committee for the Improvement of Child Health of the American Academy of Pediatrics, "Road Ahead for Better Child Health," (1948), accessed online through digital archives of Georgetown University's Maternal and Child Health Library on January 26, 2014, http://www.mchlibrary.info/history/chbu/20320.pdf; for Eliot's interpretation and recommendations, see Eliot, "Cultivating Our Human Resources for Health in Tomorrow's World," 1500-2.

required policies that would "control . . . employment practices," supervise the "production and distribution of food, clothing, [and] housing," and ensure improvements in public education. Her list of suggestions ended with the need for "development and protection of our social institutions of freedom and justice."[3]

This last point was hardly an off-hand remark. For sixty years, a group of social reformers had insisted that improving children's health, along with that of women, could only be accomplished by increasing justice in society. Beginning in the settlement houses of the late nineteenth century, an ideology of health justice for women and children, and a set of strategies for pursuing it, began to coalesce.

This dissertation tells the tale of those who believed in the idea of health justice. Beginning in the 1890s and running through the Progressive era, the New Deal, World War II, and the early Cold War, this history uncovers the moral foundations, the ideological paradoxes, and the political strategies involved in the pursuit of health justice for women and children. Throughout a seventy-five-year period, from 1890 through 1965, federal programs to create justice in maternal and child health provoked a strident backlash. This dissertation tracks two sets of protagonists: the advocates and practitioners of health justice, as well as their forceful opponents, for whom the capacious and flexible vision of justice in health was profoundly threatening and in conflict with their idea of how American policy should respond to the health needs of American women and children.

This dissertation relies on the concept of "health justice" to interpret how America's political economy has moved to include the idea that the health of Americans

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[3] Ibid.

is a matter of public responsibility. Before setting up the primary arguments that this dissertation asserts, it is useful to briefly define the concept of health justice.

In 1946, the World Health Organization inscribed in its constitution that health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." For the purposes of this study, "health" can be thought of as a state of being: to live in circumstances that, in the words of economist Amartya Sen, have the potential to be "free from escapable illness, avoidable afflictions and premature mortality." For women of childbearing age, health includes healthy pregnancy and delivery, and for infants and children it means routine preventive health care, adequate nutrition, sanitation, and housing. This dissertation is, in part, a history of how this broad concept of health played out over time. As the settlement-house movement's social reformers became aware of the dangers that industrial laborers faced, and of the perils that confronted working women and children in particular, health came to encompass the circumstances of work as well. In this dissertation, health represents the outcome of a complex network of living and working conditions that reflect an individual's social, political, and economic circumstances.[4]

As Eliot's presidential address proclaimed, the health of pregnant women and infants is a particularly important component of overall individual and social health. Healthy pregnancy and early childhood have always correlated with healthy adulthood, and the specific statistic of maternal and infant mortality has long been one of the strongest measures of a population's overall health. The social reformers in my study insisted that a nation's or city's health was connected to its ability to make sure that

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[4] For World Health Organization Constitution, see Constitution of the World Health Organization, July 22, 1946, 14 United Nations Treaties Series 185, http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1; for Amartya Sen's paraphrased definition, see Amartya Sen, "Why Health Equity," *Health Economics* 11 (2002): 660.

women survive pregnancy, and that babies live past their first year of life. For generations, the health of pregnant and postpartum women and their infants has served as a yardstick for measuring a society's health.[5]

Advocates of health justice assert that government bears the primary political and economic burdens of protecting the health of its constituents. Health justice encompasses two distinct justifications for this belief. On the one hand, health justice reflects the communitarian premise that ensuring the health of all members of society is essential for the common good. On the other hand, health justice implies that health is an individual human right. The social reformers who emerged from the settlement houses and worked toward health justice over the course of the first sixty-five years of the twentieth century held fast to both of these axioms. Rather than finding these arguments for communal wellbeing and individual rights to be in conflict, social reformers saw them as interlocked. At different times and for different reasons, advocates of health justice invoked both sides of these philosophical claims.

Maternal and child health experts from the late nineteenth century hearkened back frequently to a utilitarian concept of a just society, which had justified public health interventions for over a century. The belief that the government should ensure the "greatest happiness" for "the greatest number" originated with the Enlightenment British philosophy of Jeremy Bentham. Government's role was to enhance the "people's welfare." At times this meant undermining the rights of private property owners. This ideology drove the panoply of mid-nineteenth century and Progressive-era expansions

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[5] For the history of efforts to reduce infant mortality rates, see Richard Meckel, *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850-1929* (Ann Arbor: University of Michigan Press, 1998); for the significance of infant and maternal mortality statistics in interpretations of social wellbeing, see Jeffrey P. Brosco, "The Early History of the Infant Mortality Rate in America: A Reflection Upon the Past and a Prophecy of the Future," *Pediatrics* 103, no. 2 (1999): 478-9.

in public provision of benefits and services, including universal education, the
expansion of urban sanitation systems, the growth of police power, and the authority of
fire squads to enter private homes and businesses to extinguish fires. Municipal public
health departments and public health officers prioritized the common good over
individual protection. As historian Charles Rosenberg has written, "There could be no
public virtue without public health." This morally-based justification for communitarian
public interventions was a steady refrain in the settlement-house movement's calls for
health justice.[6]

The individual-rights claim for health justice is, by comparison, younger, but it
became louder over the course of the Progressive era. As the political and economic
inequality of industrial society became evident, social reformers emphasized that they
could help to ensure disadvantaged people's access to health services. Decades before
the New Deal, women of the settlement house era dabbled with radical political
viewpoints and started to formulate a set of rights for working people in particular to
fair and safe labor environments, adequate living conditions, and health services. For
these progressives, the role of government was to counterbalance the power of private
capital. During Franklin Roosevelt's presidency, the federal government's commitment
to social welfare needs reached its pinnacle, thanks in large part to Eleanor Roosevelt's
passionate advocacy. Between 1933 and 1946, while social reformers continued to draw

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[6] For Bentham's "greatest happiness" philosophy, see Jeremy Bentham, *A Fragment on Government*, Oxford:
Clarendon Press, 1891, accessed on January 27, 2014,
https://archive.org/details/afragmentongove00bentgoog. First published in 1776 as a critical,
anonymously written introduction to William Blackstone, *Commentaries on the Laws of England*. For the way
that communitarian political thinking pervaded law and policy in the creation of the nineteenth-century
regulatory state, see William J. Novak, *The People's Welfare: Law and Regulation in Nineteenth-Century America*
(Chapel Hill: University of North Carolina Press, 1996). For Charles Rosenberg's application of this premise
to public health intervention in the cholera epidemics of the 1800s, see Charles E. Rosenberg, *The Cholera
Years: The United States in 1832, 1849, and 1866* (Chicago: University of Chicago Press, 1987), 5.

upon both sides of this concept of health justice, they increasingly highlighted the premise of individual rights, which would, for the rest of the twentieth century, become a central approach to assert government involvement in social policy.[7]

This dissertation traces both strains of thinking. It asks why social reformers framed their calls for justice in maternal and child health in the ways that they did, and to what ends. I will show that, while communitarian arguments were often on the tip of the tongues of social reformers, a passionate belief in citizenship-based rights also undergirded their policy ideas. Time and again, health-justice advocates figured out strategies to target not only the sickest Americans, but, more importantly, the sickest Americans who were also the most politically disadvantaged, "rights-less" people. They insisted that the recipients of their services were not to be labeled as objects of charity or as the "undeserving poor," but rather as mothers and children, who, as citizens and human beings, were entitled to health. These maternal and child health advocates were preoccupied with health inequality as an evil in itself, not just as an incidental blemish

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[7] For an example of individual-rights-based thinking during the Progressive era, see David A. Moss, *When All Else Fails : Government as the Ultimate Risk Manager* (Cambridge, MA: Harvard University Press, 2002), 228, where he cites an American legal scholar who in 1905 argued that American liability law needed to prevent the "wholesale sacrifice of individual rights at the altar of commercial greed." For an even earlier iteration of a rights claim to fulfill an individual claim, namely for freed slaves to obtain land rights, see Claude F. Oubre, *Forty Acres and a Mule: The Freedmen's Bureau and Black Land Ownership* (Baton Rouge: Louisiana State University Press, 1978). For the role of rights politics in the New Deal and post-New Deal state, see Jennifer Klein, *For All These Rights: Business, Labor, and the Shaping of America's Public-Private Welfare State,* (Princeton, NJ: Princeton University Press, 2003). During the New Deal and in the post-war era, individual rights-based claims for government protection flourished especially during the civil rights era. For just a few studies of this historical phenomenon, see Felicia Ann Kornbluh, *The Battle for Welfare Rights: Politics and Poverty in Modern America* (Philadelphia: University of Pennsylvania Press, 2007); Michael J. Klarman, *From Jim Crow to Civil Rights: The Supreme Court and the Struggle for Racial Equality* (Oxford ; New York: Oxford University Press, 2004); Zaragosa Vargas, *Labor Rights Are Civil Rights: Mexican American Workers in Twentieth-Century America* (Princeton, N.J.: Princeton University Press, 2005); and Ruth O'Brien, *Crippled Justice : The History of Modern Disability Policy in the Workplace* (Chicago: The University of Chicago Press, 2001). Interestingly, none of these histories deal specifically with a right to health or health care. For that contribution, see Beatrix Rebecca Hoffman, *Health Care for Some: Rights and Rationing in the United States since 1930* (Chicago: University of Chicago Press, 2012).

on the face of communal wellbeing. Health needed to be a public responsibility on moral

and rights-based grounds, not just because sick people cost society too much.[8]

While developing this timeline of how health justice concerns evolved among

American social reformers, this dissertation also reveals several other key findings,

which shed new light on the transformations in health policy and the welfare state

during this time period. I argue that maternal and child health was a continuous and

central goal that brought together progressive and liberal social policy advocates. Those

who aimed to improve the lives of the industrial working class, to expand the welfare

state, and to create a system of national health care saw improvement in the health of

pregnant women and children as a crucial starting point—an achievable first step in a

broader political agenda. These social reformers believed that improvement of American

infant and maternal mortality statistics could serve as a politically palatable and popular

rationale for expanding government involvement in health services, as well as other

welfare needs.[9]

The development of maternal and child health programs represented a crucial

site where the rubber hit the road. These endeavors took progressive health policy

ideology and turned it into a bureaucratic and programmatic reality on a nationwide

level. Between 1890 and 1965, the reach of federal maternal and child health programs

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[8] For the concept and predicament of rights-less people, see Joel Feinberg, "The Nature and Value of Rights," in *Rights, Justice, and the Bounds of Liberty: Essays in Social Philosophy* (Princeton: Princeton University Press, 1980). This is a reprint. It was originally presented as the Isenberg Memorial Lecture at Michigan State University, January 10, 1969, and first published in *The Journal of Value Inquiry* 4 (1970): 243-257. For the "undeserving poor," see Michael B. Katz, *The Undeserving Poor: From the War on Poverty to the War on Welfare*, 1st ed. (New York: Pantheon Books, 1989). For the role of gender in determining deservingness, see Linda Gordon, *Pitied but Not Entitled: Single Mothers and the History of Welfare, 1890-1935* (Cambridge, MA: Harvard University Press, 1995).

[9] My work builds on earlier contributions in the history of health policy which look specifically at maternal and child health. See Colin Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth-Century America* (Princeton, NJ: Princeton University Press, 2003), 129-131; Hoffman, *Health Care for Some*, 47-53; and Jonathan Engel, *Doctors and Reformers: Discussion and Debate over Health Policy, 1925-1950* (Columbia, SC: University of South Carolina Press, 2002), 234-236.

vastly expanded, in both urban and rural areas, making women and children a test group for those who envisioned a comprehensive, federally developed system of health services for all Americans.

This dissertation details how progressive policy advocates entered the growing bureaucratic machinery of the Progressive era and New Deal to institute programs for women and children founded on a health justice ideology. Over the course of the seventy-five years of this study, social reformers in maternal and child health refined institutional and political strategies that originated in the settlement houses and that remained relatively stable through the middle of the twentieth century. Even as the federal state became increasingly fractured, these bureaucrats created networks across the branches of government, including Congressional committees, executive agencies, and military departments. The successes of reformers hinged on these institutional alliances. They also doggedly pursued professional and political connections across multiple jurisdictions, which in the sphere of public health had a long history of jockeying for authority. Finally, health justice advocates built alliances that cut across public and private organizations. Maternal and child health bureaucratic innovators were far from cut-off public servants. Rather, they constantly connected with an array of private institutions, among them philanthropic foundations, professional groups, women's political and voluntary groups, academic research institutions, and private political lobbies.[10]

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[10] My approach to studying the capacity of bureaucratic institutions and their leaders, and their reliance on other sources of political power, including private voluntary organizations, professional representative organizations, and philanthropies, relies on the interdisciplinary historiographies of "the new institutional history" and American political development. For an example of the new institutional history approach to studying a federal bureaucracy, see Daniel P. Carpenter, *Reputation and Power: Organizational Image and Pharmaceutical Regulation at the FDA* (Princeton, NJ: Princeton University Press, 2010). For the foundational American political development monograph, see Stephen Skowronek, *Building a New American State: The*

In several distinct ways, issues of gender were central to the development of maternal and child health policy. Advocates of maternal and child health justice were relatively segregated along gender lines. One group, overwhelmingly female, emerged directly from the settlement houses of the late nineteenth century. They were a cadre of college-educated women, among them pediatricians, communist sympathizers, public health nurses, and leaders of the movement for industrial health and safety. Another group, mostly male, emerged from the public health professions' commitment to improve sanitation and infectious disease control. This group saw rural development, health improvement, and expanded medical care access for black people as primary features of building social democracy. Members of these two groups pursued different careers. They built separate professional and personal networks, were housed in different bureaucratic agencies, and had differing political strategies and predilections. Furthermore, while maintaining a veneer of respectful collaboration, they nevertheless competed over status, authority, and funding.[11]

Expansion of National Administrative Capacities, 1877-1920 (Cambridge, UK: Cambridge University Press, 1982). For a more recent overview of American political development, see Karen Orren and Stephen Skowronek, *The Search for American Political Development* (Cambridge, UK: Cambridge University Press, 2004).

[11] This dissertation aims to intervene in the historiography of these two groups of public health reformers, because this historiography has been bifurcated, with scholars focusing mostly on one group or the other. For the study of female social reform work, see Gordon, *Pitied but Not Entitled;* Robyn Muncy, *Creating a Female Dominion in American Reform, 1890-1935* (New York: Oxford University Press, 1991); Kriste Lindenmeyer, *"A Right to Childhood": The U.S. Children's Bureau and Child Welfare, 1912-46* (Urbana: University of Illinois Press, 1997); and Molly Ladd-Taylor, "Federal Help for Mothers: The Rise and Fall of the Sheppard-Towner Act in the 1920s," in *Gendered Domains: Rethinking Public and Private in Women's History: Essays from the Seventh Berkshire Conference on the History of Women,* ed. Dorothy O. Helly and Susan Reverby (Ithaca: Cornell University Press, 1992), 217-227. For studies that focus on the nineteenth century male-dominated public health profession, see C. E. A. Winslow, *The Evolution and Significance of the Modern Public Health Campaign* (New Haven: Yale University Press, 1923); Rosenberg, *The Cholera Years*; Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, Inc., 1982), 180-197; and John Duffy, *The Sanitarians: A History of American Public Health* (Urbana: University of Illinois Press, 1990).

Despite these divisions, these groups of social reformers shared a gender-based ideology about women and children as deserving recipients of federal health services and policy activism. Theirs was, at the end of the day, a quite traditional plea: that women -- as mothers of children, and infants, as the most defenseless members of society -- deserved and needed government protection to maintain health. This ideology pervaded all aspects of maternal and child health justice work, from protections for women in the workplace, to the expansion of federally-run health care facilities. In spite of their traditionalist assumptions, health justice advocates developed new institutions, careers, and opportunities that transformed the role of women in modern American political life. Even as social reformers toed a traditionalist line to justify their efforts, their work elevated politically engaged women to an unprecedented level of professional status and political power.[12]

Finally, while this dissertation foregrounds the narrative of social policy progressives, it also studies the tactics and gender ideology of those who opposed health justice for women and children. The conservative struggle against socially progressive reform activities at times represented a struggle against female political engagement writ large. Antagonists relied repeatedly on the powerful message of anti-Communism. They cast female social reformers as unfeminine radicals who wanted to push

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[12] For a historiographic review of the literature on maternalism's female ideologues, see Patrick Wilkinson, "The Selfless and the Helpless: Maternalist Origins of the U.S. Welfare State, *Feminist Studies* 25, No. 3 (Autumn, 1999): 571-597. This literature includes: Seth Koven and Sonya Michel, eds., *Mothers of a New World: Maternalist Politics and the Origins of Welfare States* (New York: Routledge, 1993); Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge: Harvard University Press, 1992); Kathryn Kish Sklar, *Florence Kelley and the Nation's Work: The Rise of Women's Political Culture, 1830-1900* (New Haven: Yale University Press, 1995); Vivien Hart, *Bound by Our Constitution: Women, Workers, and the Minimum Wage* (Princeton: Princeton University Press, 1994); Gwendolyn Mink, *The Wages of Motherhood: Inequality in the Welfare State, 1917-1942* (Ithaca: Cornell University Press, 1995); Eileen Boris, *Home to Work: Motherhood and the Politics of Industrial Homework in the United States* (Cambridge, UK: Cambridge University Press, 1994); and Molly Ladd-Taylor, *Mother-Work: Women, Child Welfare, and the State, 1890-1930* (Urbana: University of Illinois Press, 1994).

bureaucracy down the throats of individualist, free market-reliant Americans. Although coordinated by the private medical industry, this backlash built a vast network of conservative stakeholders, among them white supremacists and anti-feminists, who saw government as not ultimately responsible the well-being of all American mothers and children.[13]

What follows is organized into three time periods: 1890 to 1929, 1929 to 1946, and 1946 to 1965. For each of these periods, I frame the broad political, economic, and social trends of the era. I then describe in detail the efforts of social reformers for maternal and child health justice. Finally, I explore the sources and consequences of opposition to these social reformers.

Part I, spanning 1890 to 1929, begins with chapter 1, where I introduce the two major historical phenomena that started the settlement-house movement. These were, on the one hand, the rise of the industrial working class, and on the other, the expansion of a cadre of educated, middle-class women who sought a way to use their education for the public good, rather than accept being confined to the domestic sphere.

In chapter 2, these two strands are woven together in four emblematic biographies of settlement-house women who articulated this movement's response to the health problems of industrial working women and their children. In the personal lives, political commitments, and professional trajectories of Jane Addams, Florence Kelley, Lillian Wald, and Alice Hamilton, the ideology of health justice began to take shape.

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[13] For a study of the alliance of anti-feminists and medical conservatives in the 1910s and 1920s, see J. Stanley Lemons, "The Sheppard-Towner Act: Progressivism in the 1920s," *Journal of American History* 55, no. 4 (1969): 776-786. For the medical establishment's role in conservative politics later in the 1930s and 1940s, see Gordon, *Dead on Arrival*, 224-226.

Chapter 3 discusses the creation of the Children's Bureau. Founded in 1912, the Bureau became the movement's federal home. From this base, the women of the settlement houses strove to reduce infant and maternal mortality rates and to obtain woman suffrage. They also designed and oversaw the biggest federal project in health service provision: the Sheppard-Towner Act programs in maternal and child health education. Between 1912 and 1925, health justice became a central feature of the female-led political agenda.

In Chapter 4, I relate how the demise of female political engagement after the achievement of woman suffrage, combined with anti-Bolshevism and Southern Democratic conservatism, undermined the accomplishment of the Children's Bureau women during the Sheppard-Towner years. Thanks to this perfect storm of countervailing forces, the Sheppard-Towner programs lost their funding, and the settlement-house movement's vision for maternal and child health justice lapsed. Conservatives asserted that, although healthy children were good for social wellbeing, their welfare was not the business of government nor the responsibility of the public.

Part II of the dissertation looks at efforts for maternal and child health justice from 1929 to 1946. In Chapter 5, I frame this period's social reform endeavors in light of the Great Depression, which vividly revealed the connection between poverty and sickness and yielded the most pivotal social policy legislation of the period: the Social Security Act. The Act created the modern welfare state, but lacked a national health program, leaving much to be done to make good on the promise of heath justice reform. In Chapter 6, I relate the New Deal's attempt to respond to this gaping hole, looking at how Secretary of Labor Frances Perkins, Surgeon General Thomas Parran, and an array of mostly male public health officials within the Farm Security Administration used

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their newfound bureaucratic authority to promote health insecurity through health cooperatives, experiments in income redistribution, and federally administered health services. In Chapter 7, I explore the efforts of the female-led Children's Bureau during World War II to respond in their own way to the lack of national health insurance. The Bureau's Emergency Maternity and Infant Care Program was designed for the pregnant wives and infants of military servicemen and became the nation's largest experiment in single-payer health insurance. Chapter 8 details how private practice pediatricians undermined EMIC and parted ways with the justice-oriented approach to health policy advocated by their female colleagues at the Children's Bureau. The New Deal and wartime experiments in maternal and child health justice suffered defeats as the medical industry and its conservative allies sought to curtail the bureaucratic growth in federal government and to stymie the vision for social democracy in health.

In Chapter 9, I conclude my study by exploring what happened when the Cold War quashed the possibility of federally guaranteed health services. After a brief moment of indecision regarding the post-war direction of social policy, domestic policy conservatism arose in 1947 as the domestic corollary to the Cold War foreign policy agenda. In these years, people like Eliot, and her male counterparts in the Farm Security Administration shifted toward international health justice work, as well as local community health endeavors, rooting themselves in the progressive institutions of the international rights regime and the public health academy. Although the settlement-house movement's ideology of health rights for women and children lost its base in Washington, these women found new ways and places to foster rights-based thinking about maternal and child health.

This dissertation uses the concept of health justice as its central analytic idea. In doing so, I aim to give modern-day public health professionals, inheritors of female social reform aspirations in social work and public health nursing, as well as philosophers of health rights, historians of the modern welfare state, and scholars of health policy a history of a transformative, inspiring, and morally charged principle.

In 1948, Martha May Eliot declared that "mothers and children have a better chance to survive in one part of the country than in another," and that "mothers and babies are also better off if they are born into white rather than Negro families." That this continues to be true should not be taken as a sign of the failure of those who worked toward justice in maternal and child health, but rather as an indication of how strenuously they have fought against a tide of American political ambivalence, at times even hostility, about remediating health inequality. As today we face a time of widening health disparities, I hope that readers will think about what has worked and what has not, understand and appreciate the entrenched qualities of heath justice's opponents, and find a reason to continue working toward "health justice."[14]

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[14] Martha May Eliot, Statement on Title V of the Social Security Act, May 8, 1946, Folder 329, Eliot Papers.

Chapter 1. The Social Crisis of Industrial Society and the Rise of Educated Middle-Class Women

The idea that government had a responsibility to preserve health and expand access to health care began with the settlement-house movement. Between 1890 and 1920, a cadre of middle and upper-middle-class women observed with moral concern the dire humanitarian needs that grew out of industrialization, growing income inequality, and economic volatility. Even before they could vote, female settlement-house reformers invented the political arena of social welfare policy. They also created new careers that specifically aimed to intervene in social problems and to agitate politically for the welfare of vulnerable, impoverished, and disfranchised people.

From the outset, the problem of ill health proved a centerpiece for these women's understanding of the problems of newly industrialized America. They saw the improvement of health and the creation of health justice as a central goal. Under the roofs of the settlement houses in the late 1890s and early 1900s, and subsequently in the halls of the Children's Bureau in Washington, DC, the engagement of these women in health policy would become clearly articulated, bureaucratically viable, and politically compelling.

Chapters 1 through 4 explore how the idea of health justice germinated in the settlement-house movement. This ideology, as articulated specifically by these social welfare reformers at the turn of the century, had several features. For one, women of the settlement houses saw the dangerous conditions of working and living in industrialized society as an environmental and structural problem that injured people's health. Among their central missions was ensuring that all American children were raised in conditions

that could realistically lead to healthy adult lives. They also saw access to health services—including medical and nursing care, health education, and the infrastructure of modern sanitation—as essential to improve individual wellbeing and social justice. They saw the health of individuals and of society as a whole as fundamentally linked. Personal health had to be enhanced in order to ensure the overall well-being of society. Likewise, social and political problems like petty crime, truancy, alcoholism, prostitution, unsafe housing, and political corruption undermined the health of individuals. The women of the settlement houses formulated their calls for social justice most often in communitarian terms, while at the same time implying the deservingness of all individuals of the same opportunity to live a healthy life. The settlement-house movement was the bridge that linked the politics of economic and social justice with problems of health and health care.

The subsequent four chapters narrate the story of how this early generation of female social reformers engaged in the politics of health justice between 1890 and 1929. Chapter 1 outlines trends in both the industrial working class and the educated middle class at the turn of the twentieth century. Chapter 2 relates the stories of four women who played leading roles in inserting concerns about health into the settlement-house movement's wide-ranging agenda. In their own ways, Jane Addams, Florence Kelley, Lillian Wald, and Alice Hamilton incorporated health concerns as seminal features of the progressive movement's social welfare agenda. Chapter 3 details the 1912 creation of the Children's Bureau as the settlement-house movement's institutional home in Washington, DC. From its earliest years, the Bureau became involved in federal maternal and child health policy, and between 1921 and 1929, the Bureau designed and led the most far-reaching federal program to date to expand access to health services

and health education for American mothers and children. Chapter 4 explores the long-term forces of opposition between 1890 and 1929 that ran parallel to the settlement-house movement's gradual ascendance in social policy. In the late 1920s, as the women's movement became increasingly fractured in the wake of woman suffrage, these antagonistic forces would achieve the upperhand, eroding the Bureau's bureaucratic status and temporarily foreclosing the settlement-house movement's power in the domain of health policy. Their persistent calls for health justice were temporarily muffled as American political life in the 1920s turned away from the progressive political agenda of social welfare reform.[1]

The settlement-house movement arose as a response to the developments in society, politics, and the economy that occurred between 1870 and 1920. In the fifty years after the Civil War, an array of technological innovations transformed the American economy from a predominantly agricultural system to an increasingly industrialized one. From Chicago to Pittsburgh, from New York to Syracuse, factories arose, producing mountains of steel and refined coal, bolts of cloth and vats of dye, telegraph wires and light bulbs. Raw materials were manufactured into usable wares—garments and

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[1] Throughout this section, I will refer to the "progressive movement" and the "Progressive era." The "small-p" progressive movement encompassed a vast set of expert-led reformist responses to the social and economic tumult of the late nineteenth century. This small-p progressivism, which the women of the settlement-house movement helped to lead, was distinct from the formal, mostly male, Progressive political activity, which instituted its own answers to the new complexities of the enlarged economy, most significantly trust regulation, banking reform, and industrial rationalization. For the difference between small-p and large-P progressivism, see William H. Chafe, "Women's History and Political History: Some Thoughts on Progressivism and the New Deal," in Nancy A. Hewitt and Suzanne Lebsock, eds., *Visible Women: New Essays on American Activism*, (Urbana: University of Illinois Press, 1993), 101-118. For key historiographic treatments of the p/Progressive era and its political and social movements, see Daniel T. Rodgers, "In Search of Progressivism," *Reviews in American History* 10, no. 4 (1982): 113-132; Peter Filene, "An Obituary For 'The Progressive Movement'," *American Quarterly* 22, no. 1 (1970): 20-34; Gabriel Kolko, *The Triumph of Conservatism: A Re-Interpretation of American History, 1900-1916* (Chicago: Quadrangle Books, 1967); Richard Hofstadter, *The Age of Reform; from Bryan to F. D. R* (New York: Random House, 1955); and Robert H. Wiebe, Robert H, *The Search for Order, 1877-1920* (New York: Hill and Wang, 1967).

typewriters, electric motors and steam engines, sewing machines and railroad ties. The rapid expansion of the railroad system drove this industrial growth, as the products of urban factories could be transported, bought, and sold throughout the country.[2]

As industrial production expanded, wage laborers flocked to American cities to work in the new factories. Between 1880 and 1920, the total number of Americans living in urban areas tripled. Within fifty years, the number of urban areas with over twenty-five thousand residents went from six hundred in 1870 to 2700 in 1920. The urban population included many native-born Americans who migrated from rural regions. With the revolutionary sanitation measure of water supply protection undertaken by many municipalities in the wake of cholera epidemics, urban dwellers as early as the 1850s began to live longer, again contributing to the expansion of the urban population. The percentage of foreign-born Americans exploded at the same time, as waves of European immigrants—more than one million a year—arrived in American cities, displaced by political and economic unrest in their countries of origin and lured by the availability of low-skilled work in American factories.[3]

Cities teeming with low-wage migrants and immigrants began to burst beyond their infrastructural capacities. Urban slums were born. With "household garbage and

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[2] For scope, causes and effects of industrialization in late nineteenth century and early twentieth century United States, see Richard Franklin Bensel, *The Political Economy of American Industrialization, 1877-1900* (Cambridge, UK: Cambridge University Press, 2000); Melvyn Dubofsky, *Industrialism and the American Worker, 1865-1920* (Arlington Heights, IL: AHM Publishing Corp., 1975); and Glen Porter, "Industrialization and the Rise of Big Business," in Charles Calhoun, ed., *The Gilded Age: Perspectives on the Origins of Modern America*, 2nd ed. (Lanham, MD: Rowman and Littlefield, 2007): 11-28.
[3] For expansion of urban population between 1880 and 1920, see Michael R. Haines, "Population, by Race, Sex, and Urban-Rural Residence: 1880-1990," Table Aa716-775, and "Urban and Rural Territory – Number of Places, by Size of Place: 1790–1990." Table Aa684-698, *Historical Statistics of the United States, Earliest Times to the Present: Millennial Edition*, eds., Susan B. Carter, Scott Sigmund Gartner, Michael R. Haines, Alan L. Olmstead, Richard Sutch, and Gavin Wright (New York: Cambridge University Press, 2006), accessed online January 28, 2014, http://dx.doi.org/10.1017/ISBN-9780511132971.Aa684-1895, and http://dx.doi.org.proxy.lib.duke.edu/10.1017/ISBN-9780511132971.Aa684-1895. For revolution in municipal sanitation measures over the course of the nineteenth century, see Charles Rosenberg, Rosenberg, Charles E, *The Cholera Years: The United States in 1832, 1849, and 1866* (Chicago: University of Chicago Press, 1987).

debris" disposed directly into streets, animals freely roaming to scavenge, and garbage collection haphazard, cities were "filthy beyond the most fertile imagination." Poorly-ventilated, fire-prone tenement housing, often reliant on privies, arose to accommodate urban families. A new danger arose from the vast expansion of the railway system that transported consumer and industrial goods. Heavy railway traffic led to hideous railway disasters in cities. In 1871, in the north end of Boston, two trains collided, killing twenty-nine people, exposing the degree to which cities were unprepared to protect their inhabitants.[4]

Working conditions for industrial laborers further compromised their health and welfare. As manufacturers aimed for speedy production to maximize profits, little attention was paid to worker safety or the environmental impact of manufacturing. Factory workers were susceptible to electrical fires; respiratory illnesses spread among tightly packed workers in poorly ventilated, steamy shop floors. The new sweatshops cranked out products for a vastly expanding industrial economy, often at the expense of the bodies that worked the machines. The infamous 1915 Triangle Shirtwaist Fire in New York killed 146 women who were trapped in a garment-making tenement sweatshop. Jacob Riis's 1890 photodocumentary work, How the Other Half Lives, exposed the crisis conditions of the urban poor through vivid and lurid images of slum dwellers and child laborers in New York's Lower East Side. Petty crime, alcoholism, prostitution, domestic violence, and workplace injuries were rampant. To the Victorian, pastoral sensibility of America's middle and upper classes, the structures of traditional

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[4] For the extent of urban squalor in Chicago, see David N. Pellow, *Garbage Wars: The Struggle for Environmental Justice in Chicago* (Cambridge, MA.: MIT Press, 2002), 24. For dangers of railway traffic, see Thomas K. McCraw, *Prophets of Regulation: Charles Francis Adams, Louis D. Brandeis, James M. Landis, Alfred E. Kahn* (Cambridge, MA: Belknap Press of Harvard University Press, 1984), 26-27; and Daniel P. Carpenter, *The Forging of Bureaucratic Autonomy: Reputations, Networks, and Policy Innovation in Executive Agencies, 1862-1928* (Princeton, NJ: Princeton University Press, 2001), 79-80.

moral life were decaying. Men were becoming alcoholics, women were forced to work outside the home, and slum children had lost the possibility of an idyllic childhood. Municipal and state governments were evidently failing to ensure that urban life could sustain safe, let alone dignified, living conditions for their inhabitants.[5]

The health consequences of urban industrial life were dire, despite the mid- and late-nineteenth century innovations in bacteriology and public health. As historian Richard Meckel has shown, infant mortality began to decrease as early as 1850, as public health reformers began to win the fight against water-born epidemic diseases. Nevertheless, between fifteen and twenty percent of infants born in the second half of the nineteenth century still died before turning one year old. Diseases like tuberculosis, syphilis, typhoid, and scarlet fever loomed large, and childbirth represented one of the biggest risks to women's health. Before 1930 one in every thirty women could anticipate dying during her fertile years. After tuberculosis, childbirth was the leading cause of death for women aged fifteen to forty-four. Many babies lacked clean milk, and malnutrition was rampant among the urban poor. Predictably, the lowest income groups had the highest infant mortality. Likewise, black Americans were far more likely to die prematurely than whites. Although the industrial economy increased per capita wealth and the average life expectancy lengthened in the second half of the nineteenth century, the gap between the health of the middle and upper-middle classes and that of the lower classes grew.[6]

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[5] Jacob A. Riis, Percival Goodman, and Seymour B. Durst. *How the Other Half Lives: Studies among the Tenements of New York* (New York: Charles Scribner's Sons, 1890).

[6] For the seminal study of the changes in infant mortality in the late nineteenth and early twentieth centuries, see Richard A. Meckel, *Save the Babies : American Public Health Reform and the Prevention of Infant Mortality, 1850-1929* (Ann Arbor: University of Michigan Press, 1998). For statistics on infant death rate in the late nineteenth century, see Meckel, 1. For maternal death rate before 1930, see Judith Walzer Leavitt, "Under the Shadow of Maternity: American Women's Responses to Death and Debility Fears in Nineteenth-

At the same time that unfettered industrialization introduced a new level of disadvantage and risk for the American working class, another set of developments was transforming the lives of middle and upper class women. When the Civil War ended, the Victorian cult of domesticity yoked financially stable women to their homes. According to this gender code, a respectable woman's vocation was to bear, rear, and nurse children; to keep a clean and efficient home; and to support her husband's career and political engagements. Women lived within a tightly defined "sphere" of domesticity where they devoted themselves to "nurturant activities, focused on children, husbands and family dependents."[7]

For the duration of the nineteenth century, white middle-class women remained outside the formal world of white male politics. Nevertheless, women's opportunities for informal, voluntary engagement in public life steadily grew after 1840. A women's wing of the abolition movement emerged in the mid-1840s in both northeastern and Southern cities. In 1848, the Seneca Falls Convention built the first institutional base for the woman suffrage movement. After the Civil War ended, urban women's activities in the public sphere accelerated. In 1873, the Women's Christian Temperance Union was

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Century Childbirth," in Leavitt, ed.,*Women and Health in America*, 2nd ed. (Madison: University of Wisconsin Press, 1999), 33. For maternal and infant health issues before 1915, see Molly Ladd-Taylor, *Mother-Work: Women, Child Welfare, and the State, 1890-1930* (Urbana: University of Illinois Press, 1994), 19, 25-26. For changes in life expectancy by race, see Michael R. Haines, " Vital Statistics," in chapter Ab of *Historical Statistics of the United States, Earliest Times to the Present: Millennial Edition*, eds., Susan B. Carter, Scott Sigmund Gartner, Michael R. Haines, Alan L. Olmstead, Richard Sutch, and Gavin Wright (New York: Cambridge University Press, 2006), accessed online February 1, 2014, http://dx.doi.org/10.1017/ISBN-9780511132971.Ab.ESS.01. See also Herbert S. Klein, *A Population History of the United States* (Cambridge, UK: Cambridge University Press, 2004), 95-128. For the concept of the "epidemiological transition" and its particular influence on infant and maternal death rates, and of this period as the "Age of Receding Pandemics" in Western industrialized nations, see Abdel R. Omran, "The Epidemiologic Transition: A Theory of the Epidemiology of Population Change," *The Milbank Memorial Fund Quarterly* 49, no. 4 (1971): 509-538.
[7] Linda Kerber, "Separate Spheres, Female Worlds, Woman's Place: The Rhetoric of Women's History," *The Journal of American History* 75, no. 1 (1988): 10.

founded to create in America a "sober and pure world" through moral purity, evangelical Christianity, and abstinence from alcohol. In the 1880s, women participated in the missionary campaign against the foot binding of women in China. In 1890, with the founding of the General Federation of Women's Clubs, women's club activities became organized into an international movement whose main goals were to undertake community service and to assert a role for women in American political life despite the lack of woman suffrage. These political engagements generally were restricted to genteel, voluntary activities for women with means and avoided conflict with middle-class women's primary domestic duties and identities.[8]

While these new women's political ventures flowered, a revolution in women's education liberated many middle-class women from total domestic confinement. The rise of women's higher education was the essential first step in the creation of a set of female-dominated careers that would permanently transform social policy in America. Before 1870, it was widely believed that intellectualism defied innate femininity and could even inhibit a woman's health and reproductive capability. But by the l880s, these views had become outmoded, and a woman with an active mind and worldly knowledge became more the norm. Increasingly, a college education came to be seen as an acceptable and even favorable experience before marriage for a young, middle-class woman. At least until she was married, a woman could use her higher education to pursue a career in teaching or nursing.[9]

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[8] For the Women's Christian Temperance Union, see Ian R. Tyrrell, *Woman's World/Woman's Empire: The Woman's Christian Temperance Union in International Perspective, 1880-1930* (Chapel Hill: University of North Carolina Press, 1991), 2; For the anti-footbinding campaign, see Margaret E. Keck and Kathryn Sikkink, *Activists Beyond Borders: Advocacy Networks in International Politics* (Ithaca, NY: Cornell University Press, 1998), 59-66.

[9] Geraldine Jonçich Clifford, *Lone Voyagers : Academic Women in Coeducational Universities, 1870-1937* (New York: Feminist Press at the City University of New York , 1989), 15-16.

By the turn of the twentieth century, higher educational opportunities for women increased nation-wide. An array of all-women's higher educational institutions, including the "Seven Sisters" colleges (Barnard, Bryn Mawr, Mount Holyoke, Radcliffe, Smith, Vassar, and Wellesley) dramatically expanded the availability of higher education for women able to pay for their schooling. In the South, schools such as Spelman and Barber-Scotia gave post-secondary degrees to black women, and all-white women's colleges, such as Sweet Briar and Goucher, did the same for white women. In 1870, Hunter College in New York became the first public university for women. Women also gained entry to religious, mainly Protestant, seminaries. Schools such as Rockford Women's Seminary and Boston University's School of Theology inculcated their female students with a Protestant social gospel theology. This theology was heavily reformist and insisted that social activism was a key part of a life of feminine Christian virtue.[10]

As the boundary between male public life and female domestic confinement broke down, coeducation also became socially acceptable. By the turn of the twentieth century, more than half of American universities had become coeducational. Boston University, founded in 1862, and the University of Chicago, founded in 1893, were coeducational from the start. The 1862 Morrill Land Grant Act spurred the creation of more state universities, and those whose taxes funded these schools insisted that the schools provide educations to not just their sons, but also their daughters. Though this legislation made hardly any impact on southern public education, it drove large

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[10] For history of higher education institutions for women, see Joan Marie Johnson, *Southern Women at the Seven Sister Colleges: Feminist Values and Social Activism, 1875-1915* (Athens: University of Georgia Press, 2008); and Linda Eisenmann, ed., *Historical Dictionary of Women's Education in the United States* (Westport, CT: Greenwood Press, 1998).

Midwestern schools, such as the University of Michigan and the University of Wisconsin, to accept women.[11]

The women who graduated from these colleges in the last decades of the nineteenth century soon faced a dilemma that seemed impossible to resolve. How could they be educated to develop their intellect, just like men, and then be cast back, without an alternative, to the roles of full-time mothers and housewives? What did an education mean if it could not be used? How could they observe the dire social problems of industrialized society and remain content to labor solely in their own homes? Was there a way for women, without the vote, to assert a role in public life despite total male control of party politics and government bureaucracy at the federal, state, and municipal level? For these women, unpaid domestic labor became an inadequate life pursuit. The traditional careers of bedside nursing and elementary-level teaching seemed almost quaint in light of the dire social problems that newly industrialized America faced. The opportunities available to these women fell short of the professional ambitions that their college degrees inspired.

By the turn of the twentieth century, it became clear that many middle-class, college-educated American women did not see marriage as an inevitable next step. One 1885 survey revealed that only 27.8 percent of college-educated women in America were married. In the face of traditionalists alarmed by this life choice, women with higher degrees defended their lifestyle, explaining that a life of celibacy and professionalism was a worthy and moral choice. To some, the decision of some female college graduates not to marry signaled the creation of a movement for women's "economic

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[11] Mariam K. Chamberlain, *Women in Academe: Progress and Prospects* (New York: Russell Sage Foundation, 1988); and Barbara Miller Solomon, *In the Company of Educated Women : A History of Women and Higher Education in America* (New Haven, CT: Yale University Press, 1985).

emancipation." An ever-growing cohort of unmarried, college-educated young adult women sought not only meaningful professions, but also a new type of female domesticity, one that allowed for political engagement and did not revolve around a male spouse or the rearing of children.[12]

In 1893, a cadre of women created their own solution for professional and personal fulfillment through the invention of urban settlement houses. These reform-minded women merged their personal and professional ambitions, their intellect, and their moral sensibilities to develop a new style of social and political engagement, and one that fit into traditional ideas of women's domestic skillfulness. The settlement house became the social and political extension of the domestic home, a place where these educated women would live and become "public mothers" in spite of the personal unwillingness of these women to conform to the traditional roles of wife and mother. Through socially and politically engaged activities in urban centers beset with the fallout of industrialization, college-educated women paved a road out of Victorian female confinement and into politics. These women created the new careers of social work, public health nursing, and industrial medicine, and with them a social movement that would permanently insert social welfare issues into the terrain of American political life. Through an array of strategies, from service to activism, they pushed their goals—to make newly industrialized society more moral, healthful, peaceful, and just. Under the roofs of Hull-House, the Henry Street Settlement, and an array of other urban settlement houses around the nation, these women brought their education and their Christian theology together with the Victorian assumption that women—as women—were

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[12] Patricia Ann Palmieri, *In Adamless Eden: The Community of Women Faculty at Wellesley* (New Haven, CT: Yale University Press, 1995), 219-221.

inherently and uniquely capable of uplifting the moral and spiritual wellbeing of their fellow human beings. These women imagined—or at least publicly portrayed—these careers as domestic, and hence consistent with a feminine role in society. They planned to become the "charwomen" of industrial society. In this new kind of social, yet domestic, home, the settlement worker nursed society, just as mothers nursed their children. They swept the streets, just as Victorian wives swept the floors. They placed themselves in needy communities to do just what Victorian women were expected to do in their own homes: to teach and encourage people to live a moral, hygienic, productive, and God-fearing existence, and to create an environment where such a life could be led.[13]

The story of how these women inserted an ideology of health justice into American social welfare policy can best be understood through the biographies of four women who became leaders in the settlement-house movement. Their interlocking professional and personal lives reveal that from the earliest years of women's settlement-house-based engagement in social welfare, concerns about justice in health and health care permeated their interpretation of the problems of industrial life. These women began to develop interventions and a strategy of research, activism, and bureaucratic institution-building that aimed to improve health and increase access to health care. For personal, ideological and professional reasons, Jane Addams, Florence Kelley, Lillian Wald, and Alice Hamilton incorporated concerns about health and health care into the settlement-house movement's political agenda. Although rarely articulating it explicitly, they espoused a political ideology for health justice that grew out of their

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[13] For concept of "public mothers," see Carroll Smith-Rosenberg, *Disorderly Conduct: Visions of Gender in Victorian America*, 1st ed. (New York: A.A. Knopf, 1985), 263; see also Mary P. Ryan, *Womanhood in America, from Colonial Times to the Present* (New York: New Viewpoints, 1975), 233; Elizabeth Fee and Barbara Greene, "Science and Social Reform: Women in Public Health," *Journal of Public Health Policy* 10, no. 2 (1989): 161-163.

concerns for the welfare of working-class families and the rights of industrial laborers. Health justice required not just access to health services, but an overall living and working environment that was conducive to health. In this way, they anticipated later international human rights ideas of a right to health and health care. In the settlement houses, the politics of the working class became connected to the politics of health and health care in America.

Chapter 2: The Work for Health Justice of Four Settlement-house women

Jane Addams could hardly have believed the Victorian myth that home was a healthful and serene environment where a woman obtained fulfillment. Her own childhood was filled with loss, illness, and trauma. Before Addams's birth in 1860, three of her siblings had died as infants. Three years after she was born, Addams' mother died while delivering a stillborn infant. When Addams was four, she contracted Potts's disease, a form of tuberculosis that curved her spine, required surgical intervention in her teenage years, and affected her health throughout her life. When she was six, her older sister Martha died, and when she was twenty, her father died of appendicitis. After this series of losses and other encounters with violence and mental illness among family friends, Jane and her sister Anna suffered major episodes of mental illness. Both sisters were diagnosed with the newly invented women's mental disease of "neurasthenia," characterized by depression and self-absorption.[1]

By the time she was a young woman, Addams aimed to recover and to escape the confines and crises of her childhood home. After graduating in 1881 from Rockford Women's Seminary in Illinois, Addams had no interest in marrying. At first, she hoped to mimic her brother and embark on a career as a physician. But these plans shifted after she returned from her European "grand tour," which had become a right-of-passage for many upper-middle-class American women. While most young women spent these trips absorbing art and culture, Addams became transfixed with the "misery and wretchedness" of European working-class life. She toured London's Toynbee Hall, a

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[1] Louise W. Knight, *Citizen: Jane Addams and the Struggle for Democracy* (Chicago: University of Chicago Press, 2005), 19, 114, and 143.

house in London's East End where middle-class women were serving the urban poor. In her memoir, *Twenty Years at Hull-House*, Addams wrote that after visiting Toynbee Hall, she arrived at a plan for her life's work: to "rent a house in a part of the city where many primitive and actual needs are found" and to invite "young women who had been given over too exclusively to study" to live there and "learn of life from life itself." In 1893, she and her friend Ellen Gates Starr founded Hull-House in Chicago's impoverished eleventh ward. From the outset, Hull-House aimed to "alleviate the lot of the poor."[2]

From the beginning, Addams saw the settlement houses as a means to improve the health of the women who lived in them, along with the health of their neighbors. Addams wrote that, after disease and poverty, nothing was as "fatal to health and to life itself as the want of a proper outlet for active faculties." Besides providing outlets for the vital intellectual energy of the settlement workers, Hull-House would also uplift and educate its neighbors, most of whom were working-class Russian-Jewish, Italian, Greek, and Bohemian immigrants. Addams and Starr believed that middle-class culture and education would trickle down to the working class. Hull-House residents taught classes in English and instructed immigrant mothers in American styles of parenting and education. Maternal education on how to care for babies lay at the heart of the settlement-house movement's idea of how to improve infant health.[3]

In spite of her movement's classist and, not incidentally, racist efforts to teach immigrant mothers how to be more like white, middle-class, American-born women, Addams nevertheless knew that inundating industrial workers with middle-class

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[2] For Addams's plans after college, see Knight, *Citizen*, 103-104; for Addams' response to European cities, see Jane Addams to John Weber Addams, Oct 29, 1883, in Jane Addams, Mary Lynn McCree Bryan, Barbara Bair, and Maree De Angury, *The Selected Papers of Jane Addams, Vol. 2, Venturing into Usefulness, 1881-88* (Urbana: University of Illinois Press, 2009), 270. For the idea for Hull-House, see Jane Addams, *Twenty Years at Hull-House* (New York: New American Library, 1961), 187. This book was first published in 1910. For Hull-House's goal of alleviating poverty, see Herma Clark, "When Chicago Was Young," in Addams, Bryan, Bair and Angury, *The Selected Papers of Jane Addams, Vol. 2*, 226.
[3] Jane Addams, "The Subjective Necessity for Social Settlements," 1893, in Jane Addams and Jean Bethke Elshtain, *The Jane Addams Reader* (New York: Basic Books, 2002), 20.

culture and values could hardly fix the array of social problems that working-class people faced. Driven by her hope for a "renaissance of the early Christian humanitarianism," Addams saw settlement house work as a way to create a more socially just and righteous world. Though they were born to privilege and intellectual opportunity, she and her colleagues stood "ready to perform the humblest of neighborhood services. We were asked to wash the new-born babies, and to prepare the dead for burial, to nurse the sick, and to mind the children." Under Addams' leadership, Hull-House created a kindergarten and nursery for children whose mothers worked and women's clubs and classes for families, organized a purchasing cooperative to help reduce the cost of living, and distributed food to sick children through a public dispensary.[4]

For the women of Hull-House, working toward health justice meant breaching the boundaries of social privilege for the good of those less fortunate. She and her friends were making society healthier and more just by nursing the sickest victims of industrial society. An infant "born with a cleft palate" whose mother refused to care for him lived at Hull-House for six weeks. The infant "died of neglect a week after he was returned to his home." In another instance, "we ministered at the deathbed of a young man, who during a long illness of tuberculosis had received so many bottles of whisky through the mistaken kindness of his friends, that the cumulative effect produced wild periods of exultation, in one of which he died." Despite these failures, the women of Hull-House believed that their ministrations, informed as they were by modern American expertise, were in general superior to those of immigrants themselves. This

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[4] For the settlements' contribution to a Christian renaissance, see Jane Addams, "The Subjective Necessity for Social Settlements," 20. For the settlement-house women's willingness to serve the sick, see Addams, *Twenty Years at Hull-House,* 100; for the array of Hull-House's social justice-oriented programs, see Michael E. McGerr, *A Fierce Discontent: The Rise and Fall of the Progressive Movement in America, 1870-1920* (New York: Free Press, 2003), 65.

overtone of expert superiority pervaded the settlement-house movements' interventions in health and health care for the subsequent fifty years.[5]

In her first year at Hull-House, Jane Addams and her middle-class colleagues came to appreciate that the world that they aimed to improve was not merely ailing, but in fact was riven with social and class conflicts. In the summer of 1894, George Pullman, the owner of the nation's largest railway sleeping car manufacturing company based in Chicago, cut his workers' wages. He was also the landlord for many of his thirty-five hundred workers, whose rents he maintained at the same level after cutting their wages. Beginning in Chicago and spreading across the nation, Pullman workers decided to unionize, and their supporters rallied an organized labor campaign and industry-wide workers' strike. Pullman refused to negotiate with the union and its controversial socialist leader, Eugene V. Debs. By the summer's end, Pullman workers had burnt hundreds of train cars and thirteen people had died in clashes between unions and police. The strike ended when the US Army intervened on Pullman's side.[6]

In the strike and its tragic climax, Addams saw the "distinct cleavage of society" and the "class bitterness" between vulnerable working people and the owners of large corporations. Addams had tried and failed to serve as a local peacemaker during the strike. She criticized Pullman for his selfishness and for not understanding the responsibility a wealthy man had for those who depended on him. The strike gave Addams a new certainty that "the present industrial system is in a state of profound disorder." She saw now that this disorder could yield to violence. She resolved that the settlement house's role was to ameliorate social conflict, and to do so by improving social wellbeing overall. No longer could she or her colleagues be content to intervene in

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[5] Addams, *Twenty Years at Hull-House,* 112.
[6] Richard Schneirov, Shelton Stromquist, and Nick Salvatore, *The Pullman Strike and the Crisis of the 1890s: Essays on Labor and Politics* (Urbana: University of Illinois Press, 1999), 1-9.

individual problems. Now the work of the settlement-house women was to ensure social health, and by doing so, to prevent tragic social conflict. The strike also revealed that the corporate owners' concern for their own profits outweighed any moral concern for the welfare of their dependent workers. Addams became increasingly aware that in these circumstances, the Victorian ideology that the disadvantaged were largely responsible for their own misfortune no longer made sense. She became one of the key Progressive-era reformers who emphasized the structural problems—from corporate power to limited governmental concern—that placed the welfare of the disadvantaged at the whim of the wealthy. [7]

In the wake of the Pullman strike and thanks to her immersion in the structural problems of urban working-class life, Addams quickly realized that to uplift and purify the decaying lives of working-class industrial people required more than ad hoc charitable activities and the performance of domestic labor for society. Using the "house" as a culturally acceptable site for women's activities, the settlement-house movement began to connect its direct service work to serious political engagement. In the period before woman suffrage, the settlement-house movement's strategists noticed an opportunity. Addams saw that traditional, elite, male political life was in no way responding to the social ills that were arising in industrialized society, and that her settlement house was located—physically and morally—at the center of these problems. The settlement house could serve as a "backdoor" into American political life for her and her colleagues.

Hull-House's endeavors filled a vacuum in the structural responses of the political system to the problems of industrialized society, and included concerns about public health in their initiatives. Without elected office and with only minimal personal

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[7] McGerr, *A Fierce Discontent*, 56-58.

compensation, these women were willing to take up problems in which the institutions of formal male politics had no interest. Even Addams' most politically explicit work—for woman suffrage and her activism for international peace during the years preceding World War I—situated women as uniquely responsible for ensuring morality in public life. Throughout her wide-ranging activities and engagements, Addams situated herself and her colleagues as the ones who would not only provide care to the victims of industrial life, but also as a new cadre of political agents who would create solutions. These women believed that the environments of life and work were the cause of working-class people's ill health and resolved to intervene in these problems at their source.[8]

Addams's political ideals hearkened to both communitarian and rights-oriented features of justice. In her 1910 essay entitled "Charity and Social Justice," Addams declared that the crisis of industrial society had led to "gradual coming together" of two once disparate groups: the "Charitable" who were "moved to action by 'pity for the poor,'" and the "Radicals," whose work was "always fired by a 'hatred of injustice.'" Addams believed that new problems posed by industrial labor and urban disorder were breaking down this old divide. A child brought to Hull-House had gone deaf from a serious case of the measles; her mother had neglected the child's symptoms, merely because she "could not stop work to care for her." Such stories revealed that "maladjustment" and "individual poverty" were overcoming the capacity of traditional, charitable organizations. They had not yet done enough to "eradicate dark tenements, unclean milk, disease-breeding food, and many another evil." A set of structural changes was required, one that would link private philanthropists, local governments, and industrial owners. The goal of these changes would be to create a society where

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[8] Amy L. Faichild et al., "The Exodus of Public Health: What History Can Tell Us about Its Future," *American Journal of Public Health* 100, no. 1 (2010): 54-63.

vulnerable individuals faced fewer dangers to their health. The aim was not just to improve the lot of these individuals, but rather to create a society where such deeply rooted social problems would no longer compromise its moral and economic wellbeing.[9]

The settlement-house movement insisted that every problem faced by the industrial working class required a coordinated political reaction, for the good of individuals and of society as a whole. Addams and her Hull-House colleagues invented creative, spontaneous, and entrepreneurial strategies for policy change. These ranged from pressing local politicians for policy solutions to taking on new investigatory and civil service tasks within the settlement house. They engaged in public outreach campaigns and pushed the local press to expose the worst abuses of workers in factories and the worst dangers of life in the urban slums. Addams believed that the settlement house could intervene in just about any social ill. The rampant issues of domestic violence, truancy, and delinquent youth led Addams to advocate for a new system of family courts. This advocacy culminated in Chicago's municipal Court of Domestic Relations, which served as a model for cities around the nation to create local, specialized courts with jurisdiction over wrongs involving women and children. Hull-House workers sponsored federal legislation to make public education compulsory. Concern about the unmet needs of non-English speaking immigrants led Hull-House residents Sophonisba Breckenridge and Grace Abbott in 1907 to found the Immigrants' Protective League, where settlement-house women served the interests of the foreign-born working class. This organization created waiting rooms in heavily used railway stations and investigated fraudulent practices by loan and employment agencies that pretended to provide services to immigrants.[10]

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[9] Jane Addams, "Charity and Social Justice," *The North American Review* 192, no. 656 (1910): 68-81.
[10] For Addams's creation of specialized municipal court systems, see Michael Willrich, *City of Courts: Socializing Justice in Progressive Era Chicago* (Cambridge, UK: Cambridge University Press, 2003), 133-134; for

Interventions in the structural causes of public health problems were central to Hull-House pursuits. This work relied on calls to remediate the individual health risks posed by the untreated waste problem in the house's neighborhoods, and also to communitarian ideals about an efficient and safe society. The water in Hull-House's slum neighborhood was a breeding ground for disease-bearing bacteria. Addams attacked the issue of unsafe drinking water and sewage mismanagement with a preliminary educational campaign, teaching the ward's residents about the importance of proper refuse management. Though Addams certainly believed immigrants lacked the knowledge of modern methods of keeping house and needed to be acculturated to modern American ways of community health improvement and family domesticity, she also saw the need for structural change. She pleaded with Chicago officials to make good on their promise of sound sanitation policies. She installed a waste incinerator on Hull-House's property and requested a city contract to manage the neighborhood's garbage. When city officials refused, she successfully petitioned the mayor of Chicago to become the eleventh ward's garbage inspector, thus obtaining the authority to enforce sanitation requirements. Addams's efforts around this primary urban public health problem exemplify the interest that settlement house workers had in improving public health.[11]

Addams believed that social science needed to guide and legitimate policy change, although she always insisted that the mission of Hull-House was to serve, not to study. Nevertheless, *The Hull-House Maps and Papers*, published in 1895, depicted, pictorially and qualitatively, the difficulties faced by the residents of Chicago's eleventh

the Immigrant Protective League, see Lela B. Costin, *Two Sisters for Social Justice: A Biography of Grace and Edith Abbott* (Urbana: University of Illinois Press, 1983), 68-78.
[11] Addams, *Twenty years at Hull-House, 185, 315.*

ward, from the safety problem in Chicago's ghetto to the cruelty inherent in child labor and the "sweating system" of industrial production. At Hull-House, sociologists Edith Abbott and Sophonisba Breckenridge authored an array of empirically researched texts on social welfare issues, including industrial labor conditions, the problems in urban jails, and the causes of truancy, prostitution, and domestic violence. By the early 1900s, Addams's settlement house had become the feeder institution for the University of Chicago's School of Social Service Administration. At Hull-House, Jane Addams and her colleagues invented social work, a career that applied social scientific research to improve the lives of industrial workers and their families.[12]

Addams encountered resistance for many of her social policy innovations from local politicians. She found municipal machine politics intransigent and local bosses often uninterested in the structural problems endemic in working-class people's housing and living conditions. Consequently, Hull-House became a hub of protest against political machines and their corrupt practices, and Addams battled the local bosses in Hull-House's neighborhood. In this campaign she was unsuccessful. In others, such as the establishment of Prohibition, the push to combat prostitution, and the creation of citizenship schools to help acculturate new immigrants, she was brilliantly effective.

Addams avoided radical political ideology, but she believed that industrial cities were revealing the cracks in the social contract. While cities in the past were "the cradles of liberty," in 1905 Addams declared that they had become the "centers of radicalism." In light of this transformation, Addams recommended that urban reformers and municipal public servants in large cities bear the responsibility of working toward "Aristotle's ideal of the city, where men live a common life for a noble end." Her hope

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[12] See, for example, Edith Abbott, *Women in Industry: A Study in American Economic History* (New York and London,: D. Appleton and Co., 1910); and Edith Abbott and Sophonisba Preston Breckinridge, *Truancy and Non-Attendance in the Chicago Schools : A Study of the Social Aspects of the Compulsory Education and Child Labor Legislation of Illinois* (Chicago, Ill.: University of Chicago Press, 1917).

was that class conflict and inequality would not overcome the social goal of communal wellbeing.[13]

The activities of Hull-House's urban residents consistently linked community needs with an ideology of political empowerment, redistributive justice, and social and political change. Despite Addams' public hostility toward socialism and communism, and while Hull-House's service work certainly aimed to broker peace among classes, Addams' views about social change consistently reflected a vision of a just society with a government that would intervene not merely to ensure communal order, but to protect basic rights to those whose personal wealth could not guarantee their family's welfare. Government regulation, therefore, was needed to bolster the political power of less advantaged people. She insisted that the power of the wealthy, the corporate manufacturer, and the political boss needed to be countered by "the emancipation of the wage-worker" through enforced labor protections and labor unions that could accomplish collective bargaining for better working conditions, wages, and other labor rights. She believed that "life's best goods" were the "the common inheritance" of all children, regardless of their wealth or nation of origin. Her demands for female suffrage aimed not just to make the male electorate more moral, but also to give political voice to the disempowered. She attacked prostitution as a system of "sexual subordination," explaining that:

> Women with political power . . . would not brook that men should live
> upon the wages of captured victims, should openly hire youth to ruin
> and debase young girls, should be permitted to infect unborn children—if
> political rights were given women, if the situation were theirs to deal
> with as a matter of civic responsibility, one cannot imagine that the
> existence of the social evil would remain unchallenged in its semi-legal
> protection.

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[13] Jane Addams, "Problems of Municipal Administration," *American Journal of Sociology* 10, no. 4 (1905): 444.

Although she concealed her radicalism and publicized the settlement-house movement

as an effort to civilize industrial society, Addams saw the protection of individual rights

as crucial for social change, and she created a social movement to effect such change.[14]

In 1927, the head of the National Consumer's League, Florence Kelley, reviewed

a book about the history of socialism in England. She remarked at the outset:

> It is an old joke that every transitional step toward Socialism the world
> over is derided and opposed by reactionaries as socialist, anarchist,
> communist (or bolshevik), until it is accomplished and found useful, after
> which it is treated as democratic or as an item in the long program of
> social reform.

Kelley was willing to call a spade a spade. To her, every accomplishment on behalf of

working-class people should be seen as an accomplishment of the "Socialist

movement."[15]

Unlike her Hull-House colleague and friend, Jane Addams, Kelley openly

espoused communist ideology. She used this political perspective to understand the

problems of industrial safety and health and brought her ideological background into

play through her career in industrial factory regulation and consumer and labor

advocacy. For her, progressive campaigns for labor rights and healthful living

conditions were a matter of social justice. Kelley's Communist Party affiliation helps

historians appreciate just how key this political vision was for this cohort of female

American social reformers. While Jane Addams and others shied away from publicly

affiliating with radical movements of the period, Kelley embraced these political groups,

showing how deeply these ideas penetrated the settlement-house movement.

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[14] For emancipation of the wage worker, see Addams, "The Modern Lear," in Addams and Elshtain, *The Jane Addams Reader*, 173; for idea of "common inheritance," see Addams, "The Thirst for Righteousness" in *Jane Addams Reader*, 143; for Addams's views on prostitution, see Ruth Rosen, *The Lost Sisterhood: Prostitution in America, 1900-1918* (Baltimore: Johns Hopkins University Press, 1982), 58.
[15] Florence Kelley, review of *Rise and Decline of Socialism in Great Britain, 1884-1924*, by Joseph Clayton, *Social Service Review* 1, no. 2 (1927): 334-335.

Kelley came from a politically active but not radical background. Born in Philadelphia in 1859 to a middle-class Quaker family, Florence Kelley was exposed at an early age to abolitionism. Her family shared a personal friendship with Lucretia Mott, a leader in the women's rights and suffrage movements. Kelley's father was an advocate of labor in the new steel industries, although his politics remained within the framework of capitalist class relations.[16]

Kelley's concerns about physical health and the vulnerability of women and children may have emerged during her own childhood. All five of her sisters died as children, two of them in the first six months of life. Their deaths were probably caused by the common summertime diarrheal infections that proliferated in the tainted water, milk, and food supplies of nineteenth-century American cities. Kelley herself contracted diphtheria in her twenties.[17]

Kelley rose to adulthood during the revolution in higher education for women. She attended Cornell University, where she became immersed in the methods and findings of the social sciences, which aimed to "study people 'as they exist'" and to obtain both statistics and interpretations of social life. After her graduation in 1882, Kelley traveled to Europe and became entranced with socialism. She and her husband were active members of the Communist Party in Zurich and New York. Kelley's friendship with Friedrich Engels culminated in her English translation of the *Conditions of the Working Class in England*, as well as essays by Karl Marx. In the late 1880s, Kelley's marriage began to fail, and in 1891 she moved with her children to Hull-House.[18]

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[16] Kathryn Kish Sklar, *Florence Kelley and the Nation's Work: The Rise of Women's Political Culture, 1830-1900* (New Haven: Yale University Press, 1995), 16, 19-20.
[17] Sklar, *Florence Kelley and the Nation's Work*, 27-49.
[18] Ibid., 69; and Florence Kelley, *Notes of Sixty Years: The Autobiography of Florence Kelley* (Chicago: C.H. Kerr Publishing Company, 1876), 81; for translation of Engels' work, see Friedrich Engels and Florence Kelley, *The Condition of the Working Class in England in 1844, with Appendix Written 1886, and Preface 1887* (New York,: J. W. Lovell Company, 1887).

At Hull-House Kelley began to pursue research on the dangers of sweatshops. With the support of the Illinois state government, she began to investigate garment workers' labor conditions. In 1893, Illinois's Governor John Peter Altgeld appointed Kelley Chief Factory Inspector, which gave her regulatory authority over factory safety in all of Illinois's factories. Workplace safety had declined as factory owners aimed to produce greater quantities of products with fewer labor costs. Kelley insisted that factory owners comply with the new Illinois statute limiting industrial work to an eight-hour day. Frustrated by difficulties pursuing legal action against factory owners who violated these laws, Kelley obtained a law degree from Northwestern University and joined the Illinois Bar in 1895.[19]

Kelley used the problem of public health, not just of workers, but also of consumers, to pursue her regulatory aims. The year of her appointment, a smallpox epidemic broke out in Chicago's working-class districts, where tenements were being used as sweatshops. Kelley used this outbreak to launch a political and legal battle against sweatshop owners. To prevent garments from spreading the disease, Kelley insisted that clothes produced in locations where smallpox was found should be "immediately destroyed." She created a press campaign that informed the consumer public of the risks of purchasing sweatshop-produced garments during the outbreak. She threatened Chicago's somnolent public health office with intervention by state and federal authorities if sweatshops were not abolished on these public health grounds.[20]

After obtaining credentials as the first government-paid factory inspector, in 1899 Kelley moved to the Henry Street Settlement in New York and founded the National Consumers League. There, through activism on the consumer side of capitalist relations,

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[19] For research on sweating system, see Florence Kelley, "The Sweating System" in Jane Addams, *Hull-House Maps and Papers* (New York: Thomas Y. Crowell & Co., 1895), 27-45; for Kelley's legal career, see Sklar, *Florence Kelley*, 237-248.
[20] Sklar, *Florence Kelley,* 265-8.

she extended her mission to improve labor conditions, her ideas about how to expand justice for workers hearkened to a deeply communitarian ethos, namely that the welfare of the nation's consumers was linked to labor rights. Her appeal was largely on moral grounds. The National Consumers League's founding principles declared that "the responsibility for some of the worst evils from which producers suffer rests with the consumers who seek the cheapest markets, regardless how cheapness is brought about." As a way to remediate this problem, the League identified and encouraged the purchase of products produced in safe working conditions and without child labor.[21]

In another instance of communitarian ideological thinking, Kelley harnessed the period's Victorian beliefs about female physiology to achieve safety reforms for female workers. In the landmark 1908 Supreme Court case *Muller vs. Oregon* chief litigator Louis Brandeis hired Kelley and a colleague to prepare a brief on the health and safety issues relevant to the arguments that women's workdays should be limited to eight hours. The brief insisted that a limited workday was essential to protect the "physical organization" and tendency toward "nervousness" of women in particular, and that a longer workday compromised women's health. Similar to her smallpox-based campaign against sweatshops, Kelley used issues of physical health to justify top-down government oversight. In this instance, she was successful, as the case gave legal sanction to the first groundbreaking federal regulation for workday length. Again, this progressive reformer realized the efficacy of health-based claims for creating law and regulating industrial power holders for the sake of improving the conditions of working-class people.[22]

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[21] See National Consumers League Constitution, cited in Josephine Goldmark et al., "The Work of the National Consumers League During the Year Ending March 1, 1910," *Annals of the American Academy of Political and Social Science* 36, Supplement (1910): 7; and Florence Kelley, "The Responsibility of the Consumer," *Annals of the American Academy of Political and Social Science* 32, Supplement (1908): 108-112.

[22] The Brandeis Brief," published by University of Louisville Brandeis School of Law, accessed on February 17, 2014, http://www.law.louisville.edu/library/collections/brandeis/sites/www.law.louisville.edu.library.collections.brandeis/files/brief3.pdf, 18-19.

Claims about worker health and a morally driven set of beliefs about individual deservingness and social wellbeing pervaded Kelley's advocacy for the Eighteenth Amendment, which instituted a federal prohibition against alcohol production and consumption. She argued that the amendment would encourage employers as a matter of course to replace alcoholic beverages with "refreshing substitute drinks" for laborers who are "exposed to excessively high temperatures." She believed that Prohibition brought into focus the "elementary human right" of laborers—"the right to replace, as needed, the fluid which they exhaust at their work."[23]

Like Jane Addams, Kelley considered the communitarian and individual-rights based rationales for social reform and government regulation to be complementary. She promoted factory inspection, industrial safety reform, consumer regulation, and even bans on alcoholic beverages as ways to make society better and safer, but also as a way to protect the rights of working people, whom the system of industrial production had turned into mere cogs in the wheel of a vastly-expanded economy. Through her work as an advocate for labor and consumer rights, Kelley pushed forward the settlement-house movement's articulation of human physical health as a central feature of the moral framework that should govern the relationship among industry owners, laborers, and consumers.

More than Kelley, Lillian Wald explicitly applied the settlement-house movement's progressive political ideology to remediate the physical health problems of working-class families. Like Addams from Chicago and Kelley in Philadelphia, Lillian Wald was raised in a city that was being transformed by the rise of industrial manufacturing. Like them, she earned a college degree and created a new career path—

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[23] Florence Kelley, "Laborers in Heat and in Heavy Industries," *Annals of the American Academy of Political and Social Science* 109 (1923): 175.

in her case, public health nursing—for women concerned about social welfare for the industrial laboring classes.

Born in Cincinnati in 1867, Wald moved to Rochester when she was eighteen. Her youth in the 1870s occurred while Rochester was being transformed into a booming industrial town that relied on the labor of low-skilled, low-wage workers. Wald was the daughter of German-Jewish immigrants who arrived in the mid-nineteenth century and quickly became members of the manufacturing elite. The family strove to assimilate with their Protestant, white, upper-middle-class counterparts, and also adopted their share of social obligation and charitable uplift. The Wald family was affluent, and Lillian's mother responded to the presence of low-wage, needy people through charity, giving money to unemployed men when they stopped by the house. Rochester's large working-class population was predominantly Jewish, like her family, although the Eastern-European garment workers who toiled in the factories had little in common with her German-Jewish relatives. Rochester's working class was at the vanguard of labor organization, particularly with the Knights of Labor. Conflicts between Rochester's business owners and laborers in the shoemaking and garment industries escalated in the late 1880s, causing worker lockouts and arrests. Growing up in a city of industrial growth and simmering social conflict, Wald learned of the complex industrial society that her once provincial hometown had become.[24]

After completing her secondary education at an English-French boarding school, Wald, like Addams, realized that a life filled with "days devoted to society, study, and housekeeping" would not suffice. Her ambition for "serious, definite work" led her toward a career in nursing, which by this time had become an easily accessible profession for young women. She enrolled at New York Hospital's nursing school, and

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[24] Marjorie N. Feld, *Lillian Wald: A Biography* (Chapel Hill: University of North Carolina Press, 2008), 28-31.

began her career nursing immigrant orphans in Manhattan's Lower East Side. Although

she had been trained in an urban hospital, she was nevertheless overcome by the scenes

of poverty that she first saw through the windows of a tenement house upon paying a

home visit.[25]

Like other young women training as nurses in the 1890s, Wald shunned the

traditional nurse's role as "the physician's hand" and the "ideology of discipline" that

expected nurses to respond docilely to doctors' requests. Nurses had long served as

doctors' subordinates in clinics, private practices, and hospitals. Other nurses obtained

work as bedside caregivers for families with means. With hospitals becoming profit-

making institutions in the late nineteenth century, and thanks in large part to the rise of

antiseptic practices among doctors, the sheer volume of surgery increased. Hospitals

demanded more nurses to assist in medical procedures and provide post-operative

care.[26]

Wald found these career options insufficient and resolved to change nursing

from a quiescent women's pursuit to a politically motivated and ambitious social reform

venture. Her exposure to poverty among the "proletariats" of New York's Lower East

Side inspired in her a belief that "as a citizen" she had to respond to the problems of

poverty in the city that as a young adult had become her home. A communitarian

political ideal can be seen in her explanation of her career decisions. She believed that

she and her friends had a "responsibility and privilege" to do "our share in speeding the

realization of the unity of society, the brotherhood of man." Founded in 1893, Wald's

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[25] Ibid., 22, 27-29; and Lillian Wald, "The Nurses' Settlement in New York," *American Journal of Nursing* 20, no. 8 (1902): 567-8.

[26] For antisepsis and the expansion of surgery, see Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, Inc., 1982), 156-160; For the ideology of discipline in the nursing profession and the role of nurses as the "physician's hand," see Barbara Melosh, *"The Physician's Hand": Work Culture and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982); and Susan Reverby, *Ordered to Care : The Dilemma of American Nursing, 1850-1945*, Cambridge History of Medicine (Cambridge, UK: Cambridge University Press, 1987), 39-59.

Henry Street Settlement became the institutional foundation where she would respond to the health needs of New York's working class as her contribution to this broader task of social improvement.[27]

Henry Street residents aimed to use their training to respond to the conditions of New York's most vulnerable working people. Wald's vision politicized nursing and drew socially concerned young women into a movement to make nursing services available across socioeconomic classes. She insisted that "a humanitarian civilization" would allow for all people, not just the well-off, to receive nursing attention in their homes. Wald's concept of the "public health nurse," a career that she is widely credited with inventing, made an implicit claim for redistributive justice in health care. Wald believed that nurses should have the option "to set out and act on their own sense of nursing's sphere and mission," and that this freedom could create an opportunity for nurses to assert the same independence as women social workers and reformers. For Wald, nursing patients who were unable to pay for their own care became a way to help society in a broader sense.[28]

Wald began to pursue this goal by reinvigorating the Visiting Nurse Service of New York with the help of its wealthy patrons. In realizing her vision for this institution, Wald demonstrated a communitarian ethos. She believed that those with wealth were obligated, not merely to perform haphazard acts of charity, but rather to use their status and wealth to create large and powerful institutions that would improve the health of society as a whole. With private philanthropic support, Wald expanded the size and reach of the Visiting Nurse Service so that the organization could provide home-based bedside care to anyone who needed it and not restrict services only to the most

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[27] Wald, "The Nurses' Settlement in New York," 567-8, 573; and Robyn Muncy, *Creating a Female Dominion in American Reform, 1890-1935* (New York: Oxford University Press, 1991), 19.
[28] Melosh, "More than the Physicians' Hand" in *Women and Health in America*, 486.

desperately sick or poor patients. Although willing to provide completely free care, Wald decided that visiting nurses could collect sliding-scale fees from patients who could pay, and thereby lift the care of those in need out of the realm of charitable offerings. Wald believed a community like New York's Lower East Side needed a nurse-led organization that would transform access to health care and serve as proof that all New Yorkers deserved the ministrations of a nurse at their bedside.[29]

Henry Street's public health nurses saw their role as improving the health of society as a whole, through individual case work. Individuals deserved care, but Wald's larger vision was a society with less disease. Henry Street's nurses were not merely treating individuals; rather, they were "seeking out the deep-lying basic causes of illness and misery, [so] that in the future there may be less sickness to nurse and to cure." This new career untethered nurses from the institution of the hospital, allowing them to intervene in an array of individual and community-health problems. Concerned about malnutrition and the spotty availability of vaccination, Wald initiated the school nursing system. She placed nurses in public schools, which allowed for a far more systematically distributed oversight of children's pediatric care and monitoring. New York City public health nurses were in the vanguard of establishing a universal, school-vaccination program. Besides ensuring that children sick with infectious diseases were kept home to prevent the spread of contagious disease, school nurses provided the first free system of routine, publicly available preventive health services. School nurses conducted weight and height measurements and created free school-lunch programs. Wald believed that "the school is the most efficient agency" in reaching parents to educate them on the most

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[29] See Feld, 61l; and Lillian D. Wald, *The House on Henry Street* (New York: H. Holt and Company, 1915), 29.

up-to-date recommendations for in-home child nutrition, basic preventive health, and parenting education.[30]

The Henry Street Settlement's community health center was Wald's most explicit attempt to create a justice-based health care program. With its array of both health and community-building services, this primary care health clinic created a model for subsequent American formulations of community-based health care. In the settlement house's "First Aid Room," as early as 1902 nurses were treating basic health needs, mostly for children. Possibly the first instance of well child care, this small project grew rapidly, and by 1911 the community health center's interdisciplinary team of doctors, nurses, and social workers were prescribing infant formula, training parents in preparing formula, and coordinating weekly visits for newborns to supervise infant growth and thriving. Henry Street's clinic was on the front end of a rapidly growing movement to create interdisciplinary urban "infant welfare stations" that delivered a range of health and education services and went beyond the milk distribution efforts of older "milk stations." By 1915, there were 539 infant welfare clinics like Henry Street's, doing in 142 cities what Wald had begun doing in her settlement house in the first years of the century. Soon after the settlement's health center was established, a philanthropist donated a "charming home in the country" where Henry Street's site-based health care

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[30] For Wald's expansive vision of social improvement through public health nursing, see Wald, *House on Henry Street*, 16; for school nursing program, see Lillian Wald, "Medical Inspection of Public Schools," *Annals of the American Academy of Political and Social Science*, 25 (1905): 88-96. Much of the literature about these undertakings situates them within the troubling paternalist Progressive-era agenda of training, supervising, and disciplining poor and working class women in their domestic practices. In this way, public health nurses "encroached upon the traditionally private realm of the domestic sphere." For this nuanced historiographic treatment, see Sarah Elise Abrams, "Seeking Jurisdiction: A Sociological Perspective on Rockefeller Foundation Activities in the 1920s" in Anne Marie Rafferty, Jane Robinson, and Ruth Elkan, eds., *Nursing History and the Politics of Welfare* (London: Routledge, 1996), 217; and Amy L. Fairchild, *Science at the Borders: Immigrant Medical Inspection and the Shaping of the Modern Industrial Labor Force* (Baltimore: Johns Hopkins University Press, 2003), 77.

services expanded to respite and rehabilitative care for "convalescents and tired-out people who need rest."[31]

Lillian Wald believed that for the good of society, working-class families needed access to primary care, not just in the schools where their children were educated and the neighborhoods where they resided, but also in the factories where they toiled. She advocated that industrial workplaces employ health care professionals, either doctors or nurses, to provide basic medical services. Wald explained this idea in pragmatic and paternalistic terms. Just as her school nurses could curtail infectious disease outbreak and make sure parents were adequately feeding, clothing, and bathing their children, on-site health services made sense as a way to limit the spread of disease, decrease worker absenteeism and increase productivity.

But Wald's agenda went deeper, pointing to a justice-based ethos about the deservingness of working-class people to obtain health care and to live and work in circumstances that could lead to healthy lives. She believed that factory-based health professionals could protect workers, investigate occupational disease, and minimize the factors of industrial life that threatened laborers' physical wellbeing. Further, she argued that the state had a legitimate authority over industrial factories with regard to healthy working conditions. To Wald, "the medical inspection of industries would seem to be a logical extension of the police powers of the state." Public health nurses and factory health officers were needed to enhance the common good, and in this way counter the rights of property owners to do what they would to their laborers.[32]

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[31] For Henry Street's "first aid room" and convalescent home, see Wald, "The Nurses Settlement in New York," 570-571; for the infant welfare station on Henry Street, see "Infant Welfare Work at the Henry Street Settlement," *The American Journal of Nursing*, 11, no. 7 (1911): 550; for growth of infant welfare clinics around the country, see Meckel, *Save the Babies*, 125.
[32] Lillian Wald, "The Doctor and the Nurse in Industrial Establishments," *American Journal of Nursing* 12, no. 5 (1912): 403-408.

For Wald, the absence of widely available health care for working-class people where they lived and worked represented a moral blight. In the days before the settlement-house movement in New York City, the Lower East Side "reflected popular indifference—it almost reflected contempt—for the living conditions of a huge population." Wald believed that the welfare of this "vast, crowded area, a foreign city within our own," required the concern not just of progressive-minded social reformers, but of New York City's political and economic powers. Like her colleagues at Hull-House, Wald argued that people in working-class neighborhoods deserved primary health care, and giving the laboring classes access to health services would enrich the nation as a whole. This perspective on communitarian justice shaped the work of the public health nurses who came out of the settlement-house movement. They insisted that illness and disease were the fallout of urban social problems and maintained that improving public health required structural change.[33]

At the same time that Wald innovated a politicized, community-based, and justice-oriented approach to preventive health services, Alice Hamilton—another leading figure of the settlement-house movement—demonstrated that a career in medicine and bacteriology could likewise intervene in the politically and morally charged problems of working-class people's physical health. Over the span of her professional life, Hamilton came to understand and expose the specific, causal relationship between industrial labor conditions and the dire health problems of the working class. In this work, she used medical and epidemiological methodologies to further the settlement-house movement's aims of ameliorating the health of industrial laborers.

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[33] Wald, *House on Henry Street*, 2.

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Born in 1869 and raised in Indiana, Hamilton obtained her medical degree from the University of Michigan. She pursued further training in Europe in the late 1890s before returning to the United States to complete internships in Minneapolis, Boston, and Baltimore. Hamilton began her medical practice in Chicago. As a woman physician who had once considered a career as a medical missionary, she regarded Hull-House as the logical place for a professional woman with social reform aspirations to reside. Although Hamilton initially rebuffed Hull-House's focus on social welfare, over time her exposure to working-class people's health problems prompted "an intense and humane concern for people, especially for those who had [a] small chance in this world." Blending her medical expertise with her exposure to industrial working conditions, Hamilton developed an "interest in industrial diseases." She explained that "living in a working-class quarter, coming in contact with laborers and their wives," she would listed to "tales of dangers that workingmen faced, of cases of carbon-monoxide gassing in the great steel mills, of painters disabled by palsy, of pneumonia and rheumatism among the men in the stockyards." Ten years after moving into Hull-House, Hamilton became the "founding mother" of industrial medicine in the United States.[34]

Like her colleagues in social work, sociology, and public health, Hamilton believed that meticulous research on the specific health hazards in industrial workplaces was necessary to justify activist campaigns to impose regulations on industries. In 1908 she completed the first major study on industrial safety in Europe and the United States. In 1909, Hamilton became the US's "federal investigator for industrial diseases." Over the next fifteen years, her research exposed the dangers in the production of lead paint,

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[34] For Hamilton's early biography, and her decision to live at Hull-House, see Muncy, *Creating a Female Dominion in American Reform*, 23; and Elizabeth Shepley Sergeant, "Alice Hamilton, M.D., Crusader for Health in Industry," *Harper's Monthly Magazine*, May 1926: 767, cited in William T. Moye, "BLS [Bureau of Labor Standards] and Alice Hamilton: Pioneers in Industrial Health," *Monthly Labor Review* (June 1986): 24-27; for Hamilton's interest in industrial disease, see Alice Hamilton, *Exploring the Dangerous Trades: the Autobiography of Alice Hamilton, M.D.* (Boston: Little, Brown and Company, 1943), 114.

rubber, matches, explosives, pottery, and synthetic dyes, as well as the hazards endemic to copper mining and manufacture of army munitions and airplane wings. She became aware that laborers were getting sick and dying to create weapons designed to kill others. Hamilton employed an array of research techniques to build the first body of epidemiological data linking industrial labor to health outcomes. She first educated herself in the technical aspects of a certain industry, then thoroughly investigated factories engaged in that industry, before correlating instances of individual health problems with particular industrial activities and exposures. She interviewed laborers at home, at union meetings, and even at saloons, to build her pool of data.[35]

Industrial owners' reactions to Hamilton's research and published exposures were varied. Some, who had already faced employee lawsuits for damages, responded with "secrecy." Other companies insisted that employees had "assumed the risks" of working in a particular trade or maintained that symptoms of industrial poisoning were actually attributable to workers' alcoholism. Some vigorously denied allegations, covering their tracks or launching their own research endeavors to assert alternative explanations for the health problems of laborers. Workers were often at the mercy of these corporate employers, and industries were slow to change and often successful in rebutting Hamilton's assertions. Hamilton nevertheless rose to great stature as the world expert in industrial health. She was the first to bring female voices into international projects to address population health. In 1924, she became the only woman on the League of Nations' Health Committee.[36]

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[35] For Hamilton's early career and studies on industrial disease in 1908 and 1909, see Muncy, *Creating a Female Dominion in American Reform*, 24; for Hamilton's willingness to interview laborers where they were, see Moye, "BLS and Alice Hamilton," 24-27.

[36] For owners' responses to her research findings, see Hamilton, *Exploring the Dangerous Trades*, 3-6; for Hamilton's overall influence, see David Rosner and Gerald Markowitz, "The Early Movement for Occupational Safety and Health, 1900-1917," in Judith Walzer Leavitt and Ronald L. Numbers, eds, *Sickness and Health in America*, 2nd ed., rev. (Madison: University of Wisconsin Press, 1985), 507-521; David Rosner and Gerald Markowitz, *Dying for Work: Workers' Safety and Health in Twentieth-Century America*

Hamilton's activities while living at Hull-House illustrate how far-reaching and assertive the settlement-house movement had become. The women of this social movement insisted that their higher education earned them a place in the process of political and social change. Even Hamilton, among the more reticent participants in explicitly reformist endeavors, brought her career and her own identity as a medical expert into the service of social reform. Florence Kelley's communist predilections, and Hamilton's readiness to spurn gendered ideas of where women belonged, revealed that at least part of the settlement-house movement's political goals were indeed radical.

Hamilton's copious reports about the sources and consequences of industrial toxins exposure were not explicitly political. She knew that certain toxins, as well as excessive heat, humidity, and exhaustion, were deadly, and she hoped to build a body of evidence that could empirically demonstrate "the strain of each occupation on the human system" to be used for "the protection of working people." She explained that some workplace problems were particularly dangerous for women and children: exposure to lead, for instance, because lead poisoning compromised a woman's ability to birth healthy, or even living, children. Hamilton's writings were eminently pragmatic recommendations to create regulatory oversight of dangerous trades.[37]

Despite Hamilton's focus on concrete facts and avoidance of political diatribes, it is nevertheless possible to catch a glimpse of her position on health justice and to understand where her sympathies lay. In a presentation on her profession's efforts to

(Bloomington: Indiana University Press, 1987); and Barbara Sicherman and Alice Hamilton, *Alice Hamilton: A Life in Letters* (Cambridge, MA: Harvard University Press, 1984), 1-10.

[37] See, for example, Alice Hamilton, "Occupational Disease Clinic of New York City Health Department, *Monthly Review of the U.S. Bureau of Labor Statistics* 1, no. 5 (1915): 8; and Alice Hamilton, "New Scientific Standards for Protection of Workers," *Proceedings of the Academy of Political Science in the City of New York* 8, no. 2, (1919), pp. 23-28

develop scientific standards to protect workers from excessive exposure to toxins, she wrote:

> For every man who is gassed with carbon monoxide in the great steel-rolling mills, there are hundreds of tailors and bakers and laundry workers and linotypers and electrotypers who are slowly poisoned by the minute quantities of carbon monoxide in the air that comes from naked gas jets; and for every man who is gassed by going into a benzol still to repair it, there are probably hundreds who lose their health gradually by working with rubber cement, and by working in varnishing establishments, getting a little benzol every day.

Although Hamilton believed researchers needed to learn "just where the danger point in chronic poisoning begins," she appeared to be suggesting that locating this exact point would hardly fix the fundamental moral crisis created by the industrial economy. Industrial work was killing its laborers while industry owners were reaping the profits. For women, whom she and her contemporaries saw as particularly vulnerable, the moral stakes were even higher. Industrial health researchers had not yet established a "standard for the weight that a woman ought to be able to lift," and, Hamilton wryly remarked, "I do not know how we shall ever arrive at such a standard."[38]

Buried among her elaborate explanations of the physiological effects of mercury, lead, and other chemicals on the human body was Hamilton's controversial, humanitarian claim, that people have a right to make a living without being poisoned in the process and that "working people have a right to work in a clean and fairly comfortable and decent place." Hamilton insisted that government regulations needed to do a better job to protect workers and to oversee industrial practices to improve worker safety. She believed that profits reaped at the expense of wage laborers' health were ill-gotten and that laborers needed to be compensated for sicknesses and injuries that originated at work.[39]

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[38] Alice Hamilton, "New Scientific Standards for Protection of Workers," 25, 27-28
[39] Ibid., 28

Addams, Kelley, Wald, and Hamilton, along with others in the settlement-house movement, asserted that industrial life was harming the health of laborers and their families. Arguments about individual health and physical danger drove many of their activist campaigns, and through these undertakings a plea for health justice began to emerge. These women envisioned a society where the potential for all citizens to live a healthy life was a right protected by public powers. These social reformers frequently hearkened to communitarian principles. They believed that a good, upright democratic society was one where poverty and illness did not run rampant. From installing neighborhood waste incinerators to encouraging consumer protections, from building infant welfare clinics to researching industrial poisons, these social reformers envisioned a more just environment, where individuals' health did not hinge on their financial fortunes. These women created the settlement houses as the physical places where health justice seemed a palpable possibility. The educated, privileged women who worked there believed that they had no greater right to a healthy life than their neighbors. In the first two decades of the twentieth century, these female-led institutions would become the seedbed for social democratic federal policy that explicitly addressed the health needs of American women and children.

Chapter 3: The Children's Bureau and the Sheppard-Towner Act

In the first fifteen years of the twentieth century, the settlement-house movement became a force in the politics of social reform on Capitol Hill. With the founding of the federal Children's Bureau in 1912, the movement won an institutional and bureaucratic home in Washington, DC, where it would pursue an array of research and regulatory programs on social welfare issues. Two events in the Bureau's first ten years revealed the newfound political power of these women and their plan to place issues of maternal and child health at the forefront of their agenda. In 1919, with the passage of the Nineteenth Amendment, female social reformers achieved their primary goal: woman suffrage. Two years later, Congress passed the Maternity and Infancy Protection Act, which would become know as the Sheppard-Towner Act, a policy that represented the high-water mark for the settlement-house movement's involvement in federal health-care politics. At least for the time being, the women of Hull-House, Henry Street, and other settlement houses around the nation had achieved a "female dominion." These women would play a major role in the federal politics of social welfare. With a foothold in Washington, the women of the settlement-house movement engaged in nationwide research on infant and maternal mortality and in "baby saving" campaigns, showing that federal involvement in the health of women and children would be among their primary agendas.[1]

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[1] For the concept of "female dominion" in social policy, see Muncy, *Creating a Female Dominion in American Reform*. A major historiographic debate pervades the secondary literature on Children's Bureau's first twenty years. With the term "dominion," Robin Muncy asserts the authority the Bureau had over child-welfare policy, and the directorial role played by the settlement-house movement's leaders. She also appreciates how this authority was consistently restricted by higher powers, particularly those in the male-dominated domains of legislatures, courts, and cabinets. Muncy, *Creating a Female Dominion*, xii. Other scholars, among them Molly Ladd-Taylor and Linda Gordon similarly emphasize the historic influence of the settlement-house movement in creating a federal welfare state concerned with maternalist protection of

During its first fifteen years, the Children's Bureau built an institutional framework for realizing its goal of expanding access to maternal and child health services and reducing infant and maternal mortality. The Sheppard-Towner Act sanctioned this program, officially placing the women of the Bureau at the helm of a nationwide project to expand government-administered health services for women and children. This endeavor was no small feat, considering the medical sector's fierce insistence that health care remain completely within the purview of medical practitioners.

By the mid-1920s, opposition to the Bureau's role in federal maternal and child health issues had gained the upper hand. Perceiving the Bureau's ambition to develop policies to expand access to federally-supported primary health care, opponents fought tooth and nail against the Bureau's efforts. The most strenuous opposition came from the American Medical Association and its affiliated local medical societies. Representatives of these organizations, almost all of them male private medical

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women and children. Theda Skocpol's work counters that, rather than being essentially directed by the settlement-house movement's leaders, maternalist social policies arose and were influential because of broader trends in the American "polity," among them the weakening of political parties, the overall bureaucratization of political life, and the increasing power of local and state women's voluntary organizations. To Skocpol, the Children's Bureau's power drew from the broader shifts in American political life during the first two decades of the twentieth century, as opposed to the settlement-house movement's dominion in social welfare policy. In this chapter, I do not try to prove either of these claims. I accept the validity of both sides; the settlement-house women rose to unprecedented power in these years and helped create a welfare state concerned with the protection of women and children, but other changes in political institutional life in both male and female political spheres served the interest of locally-led social welfare programs. As this chapter shows, the Bureau harnessed this local political power and created a top-down structure for social welfare policy, especially in the area of maternal and child health care. This debate influences my study on the origins of federal maternal and child health care policy, both in terms of its leadership and its institutional structure. See Muncy, *Creating a Female Dominion*, *xii*; Ladd-Taylor, *Mother-Work;* Ladd-Taylor, "Federal Help for Mothers: The Rise and Fall of the Sheppard-Towner Act in the 1920s," in Dorothy O. Helly and Susan Reverby *Gendered Domains: Rethinking Public and Private in Women's History: Essays from the Seventh Berkshire Conference on the History of Women* (Ithaca: Cornell University Press, 1992), 217-227; Linda Gordon, *Pitied but Not Entitled: Single Mothers and the History of Welfare, 1890-1935* (Cambridge, MA: Harvard University Press, 1995); Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge, MA: Belknap Press of Harvard University Press, 1992); and Linda Gordon, "Gender, State and Society: A Debate with Theda Skocpol," *Contention* 2, no. 3 (1993).

practitioners, believed that the Bureau was using the Sheppard-Towner Act to advance a socialized, federally regulated and financed alternative to fee-for-service, commodified health care in America. By the late 1920s, this opposition successfully undercut the Bureau's political leverage until the New Deal years. The rapid rise and fall of the settlement-house movement's power in the realm of maternal and child health care between 1912 and 1929 revealed just how tenuous was the Bureau's foothold in the area of health care policy, just how vulnerable female-driven political engagement was, and just how controversial the idea of public responsibility for maternal and child health would remain for decades to come.

According to popular lore, in 1903 Florence Kelley and Lillian Wald dreamed up the Children's Bureau as a federal agency that would be as concerned with American children's health as the government had already become with the health of American pigs, horses, and cotton. As the story goes, while eating breakfast the women discussed a newspaper article about federal agents from the Department of Agriculture who were investigating the impact of the boll weevil on Southern cotton production. Kelley remarked to Wald that if the federal government's growing bureaucracy included "a department to look after the Nation's farm crops" then it ought to have "a department to look after the Nation's child crop." President William Howard Taft concurred, remarking in 1909 that the government was spending over fourteen million dollars to do research and provide recommendations to farmers on "how they ought to treat the cattle and the horses, with a view to having good hogs and good cattle and good horses." He suggested that "it does not seem to be a long step or stretch of logic to say we have the power to spend the money on a Bureau of Research to tell how we may develop good

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men and women." Three years later, Congress created such a bureaucracy and placed it in the hands of the settlement-house movement's leaders.[2]

Kelley and Wald's idea, and Taft's enthusiasm for it, reflected not just a justice-oriented concern about the welfare of women and children, but also the influence of eugenics and Social Darwinist thinking in the formulation of infant welfare work in the first decade of the twentieth century. "Fitter families" and "better babies" became refrains in progressives' local activities in training mothers about child rearing. Julia Lathrop, who would become the Bureau's first director, was sympathetic with eugenic beliefs. While living at the Henry Street Settlement and working as a visiting nurse on the Lower East Side, Margaret Sanger invented the controversial idea of birth control in 1914 partly as a way to improve the human race. Although Jane Addams and other settlement-house movement activists virulently opposed the idea of birth control, fears that social problems could pass through heredity and the assertion that lowering immigrant birth rates could nip problems like truancy, crime, and mental disease in the bud fueled support for a federal bureaucracy designed to improve the future "crop" of American children.[3]

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[2] For story of the origins of the Bureau and Taft's remarks in support, see Dorothy E. Bradbury, *Four Decades of Action for Children: A Short History of the Children's Bureau* (Washington, DC: U.S. Government Printing Office, 1956), 1, 3; and Dorothy Bradbury, "The Children's Advocate: The Story of the Children's Bureau, 1900-1946," cited in Muncy, *Creating a Female Dominion in American Reform*, 39.

[3] For the influence of eugenics on progressive social policy reformers, see Michael Willrich, "The Two Percent Solution: Eugenic Jurisprudence and the Socialization of American Law, 1900-1930," *Law and History Review* 16, no. 1 (1998): 63-111; Laura Lovett, "'Fitter Families for Future Firesides': Florence Sherbon and Popular Eugenics," *The Public Historian* 29, no. 3 (2007): 69-85; and Alexandra Minna Stern, "Better Babies Contests at the Indiana State Fair: Child Health, Scientific Motherhood, and Eugenics, 1920-35," in *Formative Years: Children's Health in the United States, 1880-2000,* Alexandra Minna Stern and Howard Markel, eds. (Ann Arbor: University of Michigan Press, 2002), 121-152; for Margaret Sanger's invention of the notion of "birth control," see Matthew James Connelly, *Fatal Misconception: The Struggle to Control World Population* (Cambridge, MA: Belknap Press of Harvard University Press, 2008), 50-51; for Sanger's time at Henry Street, see Jean H. Baker, *Margaret Sanger: A Life of Passion* (New York: Hill and Wang, 2011), 48-49; for Jane Addams' objection to birth control, see Peter Engelman, *A History of the Birth Control Movement in America* (Westport, CT: Greenwood Publishing Group, 2011), 60. Though the birth control movement grew out of the same Progressive-era milieu, by the mid-1920s "birth controllers" would adopt a very different, adversarial attitude toward the state from mainstream Children's Bureau-led maternalist social reform efforts. See Robyn L. Rosen, "Federal Expansion, Fertility Control, and Physicians in the United States: The Politics of Maternal Welfare in the Interwar Years," *Journal of Women's History* 10, no. 3 (1998): 53-73.

A federal bureau to protect children also fit squarely into the broader Progressive-era expansion of the bureaucratic state with a parallel increase in the regulatory authority of government. The ideological rationale for this state expansion was communitarian. Americans needed their government to protect them from the overweening, self-serving power of private corporate power. A Children's Bureau to protect children was, in this view, no different from contemporary laws that created safety standards for railroad crossings, protected working-class people's right to organize, and defended small business owners from price fixing or monopolies. Like Harvey Wiley's campaign to create federal regulations over the food and milk supply and over pharmaceutical products, the women of the settlement house asserted federal leadership over all matters of child welfare.[4]

The connections between settlement-house reformers and other policy innovators grew not just from the Progressive era's growing ideological consensus about the dangers of unregulated corporate wealth, but also from individual personal connections. Many of these women were personally connected to politically powerful individuals in Washington, DC—mainly men—who played leading roles in Progressive political work, including establishing oversight in the domains of banking and railroads and in reining in "bossism" in local government. The fathers of four prominent women of the settlement house reform movement—Sophonisba Breckinridge, Florence Kelley, Julia Lathrop, and Katharine Lenroot—served as senators or congressmen, giving these women access to formal political power, even without the franchise. Furthermore, organized women's groups around the nation in the first decade of the century were becoming more and more engaged in campaigns for federal regulation of industry, notably the development of a Food and Drug Administration. The women of the

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[4] Daniel P. Carpenter, *Reputation and Power: Organizational Image and Pharmaceutical Regulation at the FDA* (Princeton, NJ: Princeton University Press, 2010), 74-5.

settlement-house movement saw in the first years of the twentieth century that the time

was ripe to incorporate social welfare issues in the top-down bureaucratic expansion

that was already emerging in American political life and linking female political

engagement to national policymaking.[5]

Between 1900 and 1909, settlement-house movement leaders developed an array

of proposals for a federal children's agency, led by women, that would take a "whole-

child" view of the problems of social welfare. According to this model, the agency

would address the full array of problems that settlement-house movement workers had

identified as the causes of disease and poverty among American children, among them

child labor, truancy, domestic violence, poor housing, unclean water and milk supplies,

and nutritional deficiencies. Settlement women envisioned the Bureau as a "great moral

force for the protection of children" in all facets of their lives. The problem of access to

maternity and pediatric health care was initially just one of the many issues that these

social reformers hoped to address from Capitol Hill.[6]

When Congress created the Children's Bureau in 1912, it tasked it with the broad

mission "to investigate and report" upon "all matters pertaining to the welfare of

children and child life among all classes of our people." In the eyes of its advocates, the

creation of the Children's Bureau had great symbolic importance. It marked the first step

in a hoped-for "revolution in the prevailing assumptions about public responsibility for

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[5] For instance, Florence Kelley had become close with Louis Brandeis while writing the "Brandeis Brief" for the landmark labor rights case Muller v. Oregon (1908), see Melvin I. Urofsky, *Louis D. Brandeis: A Life* (New York: Pantheon Books, 2009), 220-225. The Bureau's first director, Julia Lathrop, was connected to politics through her father, who served as an Illinois Congressman, and worked to control local boss politics in Illinois. See Jane, Addams, *My Friend, Julia Lathrop* (Urbana: University of Illinois Press, 2004), 22. This is a reprint of Jane Addams, *My Friend, Julia Lathrop* (New York,: Macmillan, 1935); for other family connections between settlement-house women and formal politics, see Linda Gordon, "Black and White Visions of Welfare: Women's Welfare Activism, 1890-1945, *The Journal of American History* 78, no. 2 (1991), 577; for role of progressive women in formation of FDA, see Carpenter, *Reputation and Power*, 80-83; for general pattern of expert-led bureaucratic expansion during the Progressive era, see Robert H. Wiebe, *The Search for Order, 1877-1920.* (New York,: Hill and Wang, 1967).
[6] Kriste Lindenmeyer, *"A Right to Childhood": The U.S. Children's Bureau and Child Welfare, 1912-46* (Urbana: University of Illinois Press, 1997), 17, 26-27.

child welfare." It suggested that the federal government would indeed take on the regulatory and administrative responsibilities necessary to maintain the social welfare of women and children. As Julia Lathrop, the Bureau's first director and the first woman to run a federal bureau, explained, "The Children's Bureau is an expression of the nation's sense of justice, and the justice of today is born of yesterday's pity." This remark exemplified the optimism of Children's Bureau leaders. They believed that the creation of the agency meant a seal of approval on their movement's ideology of social justice and the role of maternal and child health in communitarian wellbeing. Taking care of vulnerable children would no longer be construed as a charitable endeavor but would represent a recognition that the state was fundamentally responsible for its citizens' welfare. According to Taft's Secretary of Commerce and Labor, who supported the Bureau's establishment, the Bureau's existence embodied the belief that "protection of the child is protection of the state." Children who were healthy and responsible citizens would be "a source of progress and substance to the state and nation." Just as significant was the selection of women who, in spite of not being able to vote in federal elections, were nevertheless handed the keys to control social policy.[7]

In spite of these proclamations and thanks in large part to male chauvinism in federal politics, the scope of this women-led Bureau was in fact quite limited. Congress expressly curtailed the new agency's regulatory authority. With its initial budget minimal, the Bureau was tasked only with researching and reporting. It was not given license to intervene in any concrete way.

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[7] For the text of the statutory law creating the Bureau, see Establishment of the Children's Bureau, Stat. L. 79 (April 8, 1912); for hopes of the settlement-house women after the Bureau's establishment, see Anne Firor Scott, introduction to *My Friend, Julia Lathrop*, by Jane Addams (Urbana: University of Illinois Press, 2004), xxii; for Lathrop's declaration about the Bureau's expression of the nation's sense of justice, see Julia Lathrop, "The Children's Bureau, Proceedings of the National Conference on Charities and Correction" 1912, cited in Paul Theerman, "Julia Lathrop and the Children's Bureau," *American Journal of Public Health* 100, no. 9 (2010): 1589-1590; for the views of Taft's Secretary of Commerce and Labor, see "Bureau to Look After Children: President Will Probably Sign the Measure in a Few Days," *The Atlanta Constitution (*April 8, 1912).

For various reasons, the problem of infant mortality—measuring it, researching its regional, racial and socioeconomic prevalence, and reducing it—represented the Children's Bureau's primary focus. In the text of the legislation that brought the Bureau into existence, "investigations into the problem of infant mortality" and "birth rates" were placed at the top of the list of subjects for the Bureau's attention. Indeed, President Taft had hoped for an even more clearly mandated health focus for this new social welfare agency, as he had initially aimed to create not a children's welfare administration, but rather a Department of Health. In spite of political disagreements about the extent of the Bureau's regulatory authority, the goal of "saving . . . human life" represented the key point of political agreement.[8]

Though officially limited to investigating rather than intervening, the Bureau rapidly built a set of professional, political, and organizational alliances that allowed it to contribute actively to the reduction of infant morality. It commissioned research projects and published the findings of social workers, public health nurses, and pediatricians. Its goal was to build a wealth of statistical data on infant mortality in terms of specific causes, regional problems, and effective interventions. Like their counterparts in the non-governmental national "baby saving" organization, the American Association for the Prevention of Infant Mortality, the Bureau's leaders understood that merely researching the scope of infant mortality was not enough and that measures should be taken to decrease these rates.[9]

As historian Richard Meckel has shown, maternal education represented the Children's Bureau's main strategy for reducing infant morality. Five years after the Bureau was created, one newspaper explained that the women of the Children's Bureau

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[8] See Stat. L. 79; Lindenmeyer, *"A Right to Childhood"*, 25-26; and Kriste Lindenmeyer, "The U.S. Children's Bureau and Infant Mortality in the Progressive Era," *Journal of Education* 177, no. 3 (1995): 57-69.
[9] Meckel, *Save the Babies*, 109-122.

were the commanders of a "brigade" of women trained in home education who were "invading homes having babies, teaching mothers to make and use" new technology, such as "outdoor cribs, fireless cookers, and iceless ice boxes." The Bureau believed that by teaching mothers, technological advances such as the advent of refrigeration could be brought into the service of nourishing babies. Though the women of the Bureau saw themselves as the professional leaders in these activities, the great majority of the foot soldiers in this campaign, especially outside of urban centers, were working voluntarily, with the occasional support of health department representatives, but without direct involvement on the part of federal Children's Bureau officials.[10]

Although maternal education was at the forefront of its endeavors, the Children's Bureau also saw a place for itself in educating public health and medical professionals around the nation about effective methods for reducing infant mortality. In 1914, the Bureau solicited information from 109 mayors that detailed their municipalities' "baby-saving" efforts, particularly during the dangerous summer months, when infants often died of water-born infectious diseases. The Bureau published educational materials directed toward professionals, such as the pamphlet "How to Conduct a Children's Health Conference." Expert advice was laid out on how to set up a clinic for routine pediatric care, with details on how to maintain hygienic conditions and efficient administrative procedures in the waiting areas, as well as recommendations on the equipment and procedures for routine well-child health supervision such as weighing and checking for mental development. Other Bureau activities included working with local "Baby Week" campaign groups in the field to run programs to teach public health officials the best ways to educate mothers about infant

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[10] For quotation on the "brigade" of women, see "War Will Kill Our Men; Don't Let Sun Kill Our Babies!" clipping from *Gazette* (1917), cited in Muncy, *Creating a Female Dominion in American Reform*, 93; for nationwide efforts, both before and after the creation of the Children's Bureau, that saw maternal education as the primary intervention to reduce infant mortality, see Meckel, *Save the Babies,* 124-158.

care and to encourage their state health departments to establish infant hygiene programs. These programs were essential forerunners for the well-baby clinics and conferences that the Bureau developed throughout the nation.[11]

In these early years, this women-led agency obtained bureaucratic status and autonomy not only through its meticulous research publications, but also through its role as a source of expert guidance for the nation's mothers. The Bureau published booklets for mothers with titles like "What Do Growing Children Need?" and "Bottle Feeding: Consult Your Doctor Before Weaning the Baby." Many American mothers relied on the Bureau's widely disseminated texts on "Infant Care," "Prenatal Care," and "The Child from 2 to 6" as manuals for advice. The women of the Bureau cast themselves as public servants who were extending their role as mothers outside the private home. Their job in Washington was to nurse and nurture society's children, and to help mothers do this work with the best and most modern methods. Describing her role in guiding this institution, Grace Abbott characterized the Bureau as a "baby carriage" and her task as being to "wheel it into the traffic" of executive agencies on Capitol Hill. She explained that many other federal bureaucrats, who drove far sturdier and more powerful vehicles, "think it does not belong there at all" because they do not understand that the carriage is "the symbol of the home and the future of America." For the women of the Bureau, this metaphor of the Bureau was utterly concrete. The Bureau

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[11] For 1914 mayor survey, see Julia Lathrop, letter of transmittal, US Children's Bureau, "Baby-Saving Campaigns; A Preliminary Report on What American Cities Are Doing to Prevent Infant Mortality," (Washington, DC: Government Printing Office, 1914), accessed online February 3, 2014, http://www.mchlibrary.info/history/chbu/20388.pdf; for Bureau's advice on running a children's health conference, see Frances Sage Bradley and Florence Brown Sherbon, "How to Conduct a Children's Health Conference," (Washington, DC: Government Printing Office, 1917); for Baby Week campaign work, see Janet Golden and Howard Markel, "A Historically Based Thought Experiment: Meeting New Challenges for Children's Health and Well-Being," *Health Affairs* 26, no. 2 (2007): 445-449.

was a federal home for the young, and a place where the nation's mothers could obtain support and guidance to become better and more modern mothers.[12]

The leaders of the Children's Bureau did more than advise American women on how to raise their young. Rather, these activist social reformers used their place in Washington to guide women's voluntary work. They developed collaborative relationships with local women and their voluntary organizations, especially the General Federation of Women's Clubs and the Congress of Mothers. These features—an almost all-female leadership and a total reliance on networks between federal female bureaucrats and local women's organizations—would prove to be the defining characteristics of the Bureau and the qualities that decisively contributed to its political and logistical ability to achieve its ambitious projects in maternal and child health.

While earnestly building their expertise and reputation as social mothers, the women of the settlement-house movement were simultaneously hard at work agitating for woman suffrage. This activist movement flourished in the settlement houses, and by 1920, the suffragist cause had largely woven together the disparate strands of women's political endeavors. While some female activists emphasized equal-rights arguments for suffrage, social reformers in the settlement-house movement generally argued that women's inherent differences—their moral sensibility and innate drive to nurture— made them necessary for a healthy political process. They believed that once women could vote, "the entire political system would be transformed" to become purer, less corrupt, and more concerned with the day-to-day needs of Americans. Communitarian

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[12] For Bureau publications, see, for example "What Do Growing Children Need?" accessed online, February 3, 2014, http://www.mchlibrary.info/history/chbu/20944.PDF; "Bottle Feeding: Consult Your Doctor Before Weaning," accessed, February 3, 2014,http://www.mchlibrary.info/history/chbu/20939.PDF; and Lindenmeyer, *Right to Childhood*, 67; for Abbott's metaphor, see "Excerpt from Miss Abbot's Speech..." 1931, Folder 331, Eliot Papers.

ideals drove the political thinking of the settlement-house women's approach to suffrage activism.[13]

Even without woman suffrage, the women of the settlement-house movement had achieved a public presence in the Children's Bureau, but they saw this institutional home as just the first step. In 1917, Julia Lathrop explained that the Bureau's efforts showed "what enfranchised women could do for the government and their communities" and that as mothers, women should be "concerned with the matters which the suffrage decides" and "take their share in the responsibility which can only be expressed by voting." Similarly, Lillian Wald insisted that, while women had previously managed to "gain their wishes by influence, using their power over some man or men," the time had come for women to participate in politics "directly and openly." Just as she and her colleagues in settlement houses and in the Children's Bureau were taking concrete steps toward public engagement, women throughout the nation needed to make their way out of the home and into the voting booth. In doing so, the nation's women could address the issues that most affected them. The women of the settlement house expected that these issues would be the health and welfare of American women and children.[14]

For social reform women, suffrage and Progressive-era social reform efforts were inextricable from one another. For instance, in Oregon the political effort for woman suffrage emerged in tandem with the progressive women's campaign to purify the state's milk supply. Among the primary rationales for women's enfranchisement, at

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[13] For the array of political rationales for suffrage in the women's movement, see William H. Chafe, *The Paradox of Change: American Women in the Twentieth Century* (New York: Oxford University Press, 1991), 45-47; and Nancy F. Cott, *The Grounding of Modern Feminism* (New Haven: Yale University Press, 1987), 7; for expectation that political life would be transformed after woman suffrage, see Chafe, *Paradox of Change*, 25.
[14] For Lathrop's views on suffrage, see Julia Lathrop, "Suffrage and the Home," cited in Lindemeyer, "*Right to Childhood*", 32; for Wald's remarks about female political participation, see Lillian Wald, "Suffrage 1914," in Clare Coss and Lillian D. Wald, *Lillian D. Wald, Progressive Activist* (New York: Feminist Press at the City University of New York, 1989), 75.

least for social reform suffragists, was the hope that once women could vote, they would insist on greater public spending, especially in the arena of public health. They hoped that this infusion of government money would expand child hygiene activities and thereby give more American children access to the medical and public health improvements and the methods of limiting infectious diseases that the nineteenth-century bacteriological revolution had made possible. For the women who emerged from the settlement-house movement, the communal needs of Progressive-era society demanded a voting female constituency led by social reformers.[15]

In 1919 Congress passed the Nineteenth Amendment, ensuring universal suffrage for women, at least for white women. This political achievement represented the culmination of sixty years of female activism that had unified the women's movement even when gender ideologies split them apart. For the women of the Children's Bureau and the majority of politicians on Capitol Hill, this success signaled a political mandate for federal work in child welfare and public health. Thanks in large part to this achievement, the Bureau quickly initiated its most expansive policy program to date: a federally funded grants-in-aid program that brought federal funds to support maternal and child health service work around the nation.[16]

In 1921, Congress approved the Sheppard-Towner Maternity and Infant Protection Act just two years after women got the vote. The timing was hardly a coincidence. The majority of politicians who supported the law's vast expansion of the

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[15] For the campaigns for suffrage and pure milk supply in Oregon, see Kimberly Jensen, *Oregon's Doctor to the World: Esther Pohl Lovejoy and a Life in Activism* (Seattle: University of Washington Press, 2012); for the argument that woman suffrage actually improved child survival rates through public health improvements, see Grant Miller, "Women's Suffrage, Political Responsiveness, and Child Survival in American History," *Quarterly Journal of Economics* 123, no.3 (2008): 1287-1321.
[16] For the ways that this movement and the achievement of woman suffrage omitted the political goals of black women, see Paula Giddings, *When and Where I Enter: The Impact of Black Women on Race and Sex in America* (New York: William Morrow, 1984), 119-134.

Children's Bureau's authority did so not because they had a particular interest in the social welfare issues that the Act addressed; rather they hoped to salvage their political careers. The Women's Joint Congressional Committee, which led lobbying activities around "women's issues," convinced politicians that newly enfranchised women would vote as a bloc and use their political power to advance social welfare policies geared toward women and children. Unfortunately for these ardent female activists, by the mid-1920s it became clear that the "woman vote" was not a monolithic political entity. In the end, as soon as suffrage was achieved, organized female political activism, which grew out of progressivism, began to languish in the face of internal movement divisions and overpowering forces of opposition.[17]

The Sheppard-Towner Act tested political willingness to allow women, both those who led the Children's Bureau and those who institutionalized its objectives on the local level, to play a major role in maternal and child health care. The legislation also tested the institutional capabilities of the Bureau to affect significant change in infant and maternal mortality rates. Although federal funding lasted less than a decade, the Sheppard-Towner programs revealed that the women of the Children's Bureau were ready to fight their most strident opponents on the issue which would provoke the greatest controversy: the involvement of federal, female bureaucrats in medical care. These women believed that, to be considered serious players in the federal politics of social welfare and public health, they needed to assert themselves as participants in health care politics. Between 1921 and 1929, social reformers of the settlement-house movement did so for the first time, and in these years the Children's Bureau laid the foundation for long-standing federal involvement in maternal and child health activities. The political language, both in support of and in opposition to this piece of legislation,

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[17] For politicians' fear of the "woman vote," see Chafe, *Paradox of Change*, 26-29; Ladd-Taylor, "Federal help for Mothers," 218; and Ladd-Taylor, *Mother-Work,* 169.

and the institutional strategies used to enact it, would serve as models for subsequent episodes in federal intervention in maternal and child health services during the New Deal and World War II.

The experiences of World War I contributed to the Children's Bureau's post-war push to expand its involvement in federal maternal and infant health care. During World War I, the Children's Bureau described its efforts to maximize family health as an act of patriotism. During the war, the Bureau helped create a woman's division within the larger Council of National Defense, an organization that Woodrow Wilson formed in 1916 to prepare the American economy, civilian population, and infrastructure for wartime. Julia Lathrop believed that this "Women's Committee" would expand the public's support for policy reform around child welfare and strengthen the connection between popular support and the Children's Bureau. Through the popular press, the Bureau explained that "saving babies is a vital part of fighting the war" and that, besides caring for servicemen, there was "no more patriotic duty than that of protecting the children, who constitute one-third of our population." The Bureau made health recommendations about caring for infants. Bureau pamphlets advised mothers to keep their babies in the shade, noting "War will kill our men; don't let sun kill our babies!" Even the Bureau's recommendations to women about how to care for their infants were framed in the language of wartime patriotism.[18]

The findings of physical examinations performed upon enlistment also proved useful in the Bureau's efforts to expose a crisis in American health that required government intervention. All military conscripts and enlistees were subject to a physical examination. Between 1917 and 1918, a full third of enlistees were deferred for health

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[18] For women's division of Council on National Defense, see William J. Breen, *Uncle Sam at Home: Civilian Mobilization, Wartime Federalism, and the Council of National Defense, 1917-1919* (Westport, CT: Greenwood Press, 1984); For "saving babies" as patriotic war effort, see Muncy, *Creating a Female Dominion in American Reform, 97.*

reasons. The Bureau used this new awareness of the poor physical health of many potential young soldiers to garner support for its efforts to improve the health of American children. Lathrop argued that "nothing was more necessary to the country at war, especially in view of the poor health of so many young men summoned by draft boards, than a program to improve children's health." This language was persuasive, and contributed to the Bureau's establishment of 1918 as the "Year of the Child." The war helped Lathrop and her colleagues in Washington begin "a revolution in the prevailing assumptions about public responsibility for child welfare." Twenty years later, World War II would similarly prove to be key for the Children's Bureau's efforts to create and maintain maternal and child health programs.[19]

In the wake of this newly vigorous post-war interest in the health of American young people, a Democratic Senator from Texas, Morris Sheppard and Iowa Republican Congressman Horace Mann Towner proposed a law that would dramatically expand the Bureau's ability to create new programs for women's and children's health throughout the nation. The bill encountered opposition but, thanks in large part to lobbying by a subcommittee of the Women's Joint Congressional Committee, led by Florence Kelley, it passed in a landslide in Congress. The achievement proved that the women of the settlement-house movement, once involved in federal institutional power, could successfully assert themselves as leaders in federal health care policy. The Bureau's leaders knew that the passage of this law would be a watershed moment in the role of settlement-house women in federal public health policy: it would make the Children's Bureau the first federal agency to administer federal health care funding. The

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[19] For statistics on health problems among World War I enlistees, see Colin Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth-Century America* (Princeton, NJ: Princeton University Press, 2003), 137-138; for Lathrop's views about necessity of child health program in light of health needs of servicemen, see Anne Firor Scott, introduction to *My Friend, Julia Lathrop*, xxii.

legislation was also a direct product of politicians' view that they needed to appease a female reform-minded constituency.[20]

The Sheppard-Towner Act established the approach that federal legislation would take in addressing the welfare needs of women and children for the subsequent forty years. While advocating for its passage, responding to its antagonists, and instituting its policy, the Children's Bureau developed a set of strategies that would pervade its bureaucratic methods into the years of the New Deal and World War II. In certain respects, both of these factors—Washington's approach to maternal and child health policy and the Bureau's methods of instituting these policies—would both embolden and in other respects hamstring the leaders of the Children's Bureau for decades to come.

Although the Act's four million dollars of funding was modest and its mandate vague, it nonetheless "expressed, consolidated, and broadened" the "dominion" of settlement-house women in federal social policymaking. Essentially an expansion of health-related settlement-house activities of the prior twenty years, the Act supported programs that "encompassed the thinking of the Hull-House circle about child welfare and federal-state cooperation" and "embodied what the Children's Bureau had learned in the first decade of its existence about mothers and children's pressing needs for health care." The Sheppard-Towner Act "funded 183,252 health conferences for mothers and babies, 2,978 permanent child health or diagnostic clinics (or both), 19,723 classes, and the distribution of twenty-one million pieces of literature." State-based health services paid for through Sheppard-Towner funds provided care to over four million babies and preschool age children and seven hundred thousand pregnant women. Although it is

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[20] For text of the Act, see "Sheppard-Towner Maternity and Infant Protection Act of 1921," 42 Stat. 224 (1921); for the Act as a direct result of woman suffrage, see Jeffrey Baker, "Women and the Invention of Well Child Care," *Pediatrics* 94, no. 4 (1994): 528; and Lindemeyer, *Right to Childhood*, 79-83.

difficult to evaluate the program's impact, it is likely that it contributed to the substantial

drop in infant mortality rates during the 1920s.[21]

As important as these measurable accomplishments was the law's invention of a

matching system for social policy programs, which would become a permanent feature

of federal welfare legislation in the United States. Under the Sheppard-Towner Act,

every state received five thousand dollars outright for health programs for pregnant

women and infants. A further incentive was built in for states that created their own

laws to develop maternal and child health or hygiene divisions within their state health

departments. After having their plans approved by a federal committee, states could

receive another five thousand dollars in matching funds for each year of the legislation's

duration. The Act "paid to the several States" funds intended "for the purpose of

cooperating . . . in promoting the welfare and hygiene of maternity and infancy." The

legislation gave no clear prescription for what state maternal and child health

departments should do once they had been established, but instead explained that the

primary aim was federal-state cooperation around these issues. This structural linking of

federal maternal and child health policies to state political will and bureaucratic

capabilities would continue for the rest of the century.[22]

While the Sheppard-Towner Act placed power in state legislatures and health

departments to ratify and administer the details of the program, it substantially elevated

the Children's Bureau's status. As a result, the Bureau became one of the primary federal

bodies in the area of health care policy. It also marked a turning point in the Children's

Bureau's decision to approach health care as a specific, targeted issue in their agenda of

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[21] For the Act's expansion of "female dominion," see Muncy, *Creating a Female Dominion in American Reform*, 93; for the Act's embodiment of the settlement-house women's thinking about cooperation and the pressing need for maternal and child health care, see Anne Firor Scott, introduction to Jane Addams, *My Friend, Julia Lathrop*, xxvi; for summary of what the act funded and its likely effect on infant mortality rates, see Golden and Markel, "A Historically Based Thought Experiment," 447.
[22] Sheppard-Towner Act of 1921, 42 Stat. 224 (1921)

women'a and children's social welfare. The Sheppard-Towner Act established a Board of Maternity and Infant Hygiene, which elevated Julia Lathrop as the Chief of the Children's Bureau to the same authoritative footing as the Surgeon General of the United States Public Health Service. The Bureau had long maintained that it sought a broad-based, whole-child response to the array of health and welfare problems that faced young Americans. Now, with the passage of the Sheppard-Towner Act, the Bureau accepted the reality that, if it was to assert authority in the area of women's and children's physical health, it would need to focus on this particular issue. This willingness can be seen in Julia Lathrop's stark question to Congress in the months before the bill's passage: "why does Congress wish women and children to die?" Implied was the Bureau's new claim that "every child has a right to be well born." With Sheppard-Towner, the Bureau asserted that government had a role to play in protecting life and ensuring health for Americans during pregnancy and infancy.[23]

While the Children's Bureau obtained unprecedented authority and funds with the 1921 passage of this Act, the law also restricted the Bureau in certain respects. The Sheppard-Towner Act explicitly stated that the Children's Bureau was permitted to access no more than five percent of each year's funds for its own administrative costs. Hence its growth was impeded. In addition, the legislation was time limited, and after its initial six-year time window, it would require additional legislation to continue. This time-limit meant that the Bureau could expect a political struggle six years down the road, during which time it would have to prove its success and counter further opposition. Finally, although the Act was a piece of federal legislation, it empowered each state to administer and regulate its own maternal and child health activities. States could opt out if the political support for publicly funded maternal and child health was

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[23] For Lathrop's challenge to Congress, see Lindemeyer, *Right to Childhood*, 82; for the "right to be well born,"see Children's Bureau pamphlet, "Minimum Standards of Prenatal Care," (1923), cited in ibid., 99.

lacking. Indeed, to obtain Sheppard-Towner funds, states had to "pass special qualifying legislation, vote matching funds, provide a plan for implementation, and create a special bureau for administering the program." While allowing each community to design programs tailored to its needs, these requirements also "made maternity work vulnerable to political opposition and incompetent administration" on the state and local level. The Sheppard-Towner Act represented a template for how future pieces of federal social policy, especially in the area of maternal and child health care, would funnel bureaucratic power to states.[24]

Perhaps the most important feature of the Sheppard-Towner Act was its explicit exclusion of a means test: Anyone who wanted to obtain services through these federally funded programs could do so, without being asked about his or her personal finances. This absence of a system for determining socioeconomic eligibility meant that, as a matter of course, access to federally supported maternal and child health care should remain separate from poor-relief programs. The Bureau's appreciation of this ideological point would become among the most politically provocative features of the Bureau's approach to health care policy during the New Deal and World War II. [25]

The Sheppard-Towner Act gave a federal stamp of approval to the system of public-private institutional alliances that female social reformers had long cultivated. The settlement-house movement leaders who were based in Washington organized a political force to rally for the Act, bringing together other progressive and women's voluntary organizations, including the General Federation of Women's Clubs, the National Consumers League, the National Council of Jewish Women, the National Congress of Mothers, the League of Women Voters, and the Parent-Teachers

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[24] Ladd-Taylor, "Federal Help for Mothers: The Rise and Fall of the Sheppard-Towner Act in the 1920s," 221-222.
[25] Gordon, *Pitied but Not Entitled*, 94-95.

Association, along with women's professional organizations such as the American Association of University Women and the National Federation of Business and Women's Clubs joining as well.[26]

The Bureau's reliance on female volunteers was hardly new. From the early days of the Bureau, settlement-house women in Washington, DC understood that their programs would be instituted by people in communities. But the Sheppard-Towner Act brought unprecedented funds and official approval to this pattern. Sheppard-Towner activities' success depended on a strong "alliance" between "working class and farm mothers" with "middle-class maternalists and reformers." In rural areas, where permanent maternity and infant health clinics rarely existed, health services were delivered at health conferences, organized by local women's clubs who rallied civic leaders, local businesses, and physicians to lend support. With schools often closed for these occasions, the Sheppard-Towner conferences had a "carnival atmosphere." Children got prizes and received physical examinations while parents attended educational programs. Women of the Bureau "headed the whole operation and supervised the activities of two lower echelons of authority: the analogous public agencies [that the Bureau] helped to create in the states, and the women's organizations, which continued throughout the 1920s to help implement programs at the local level." Although the Bureau from its earliest days had relied on these networks of women's organizations, the Sheppard-Towner Act solidified and formalized these institutional connections and brought a federal stamp of approval to this system of collaboration

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[26] For network of women's political organization during early twentieth century, see Muncy, *Creating a Female Dominion in American Social Reform,* 104; and Skocpol, *Protecting Soldiers and Mothers,* 56.

between a federal bureaucracy and private women's voluntary organizations. These women's alliances would prove to be a durable feature of 1920s social policy.[27]

While alliances with women's organizations would remain solid for decades to come, the Sheppard-Towner years represented a brief moment of collaboration and collegiality among maternal and child health bureaucrats and their pediatrician colleagues. The ability of these two groups to work together reflected this period's powerful communitarian ethos about the need to protect the health of American mothers and children. Collaboration also arose as female social reformers proved themselves to be the primary movers in changing how American mothers sought support and education for themselves and health care for their children.

The Sheppard-Towner Act became a bridge between social-reform-oriented female doctors, who mainly worked out of philanthropies and public health departments, and their male colleagues based in private practice and academic hospital positions. Beginning in the late 1880s, a cadre of female doctors had been achieving prominence in preventive child-health work, leading the movement for milk and infant welfare stations and relying mainly on private philanthropic funding. These women found themselves working for philanthropies or in bureaucratic roles because, as women, they had difficulty building successful private practices. S. Josephine Baker exemplified this trend. After a brief, unsuccessful attempt to establish a private practice, she went on to create over thirty well-child clinics in New York City with philanthropic funding. In 1908 she convinced the City of New York to create a Bureau of Hygiene, a public health agency specifically focused on preventive child health care. At the same

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[27] For cross-class women's collaboration, see Ladd-Taylor, *Mother-Work*, 168; for rural well-child conferences as carnivals and health fairs, see Baker, "Women and the Invention of Well Child Care," 529; and Ladd-Taylor, "Federal help for Mothers: The Rise and Fall of the Sheppard-Towner Act in the 1920s," 223; for federal social reform bureaucrats' authority over activities of public agencies and women's volunteer groups, see Muncy, *Creating a Female Dominion in American Reform*, 121.

time that women like Baker were rising in the ranks of local public health bureaucracies, the Children's Bureau hired several female physicians, among them Dorothy Reed Mendenhall and Frances Sage Bradley.[28]

With health clinics and well-baby conferences expanding thanks to Sheppard-Towner funds, pediatricians saw an opportunity to expand their specialty's reach. Public demand for routine well-child health care was growing rapidly. Whereas in the past, pediatricians had been confined to hospital-based academic research on childhood diseases, under Sheppard-Towner, they became actively involving in preventive pediatric care, staffing health clinics and doing demonstrations at well baby conferences. As historian Sydney Halpern explains, exposure to Sheppard-Towner-funded projects familiarized the public with the doctor-administered physical examination and by the end of the decade contributed to "a perceived need for scientific child-rearing advice" among middle-class parents. For these reasons the American Pediatric Society supported the Sheppard-Towner programs during the 1920s.[29]

The involvement of both public servants and private practitioners in standardizing and disseminating parenting and well child rearing expertise paralleled similar trends in other areas of American life. Just as public-private institutional partnerships were crucial for the expansion of maternal education and preventive health services for children, the federal government worked collaboratively with private institutions in other day-to-day economic and social issues. Other Progressive-era federal endeavors—such as truth-in-lending guidelines formulated by the Federal Trade Commission and Federal Reserve Board, the system of grain grading established under the 1916 Grain Standards Act, and early "anti-quackery" campaigns led by the Food and

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[28] See Jeffrey Baker, "Women and the Invention of Well Child Care," 528.
[29] See Sydney A. Halpern, *American Pediatrics: The Social Dynamics of Professionalism, 1880-1980* (Berkeley: University of California Press, 1988), 91, and, for the general trend toward doctor-supervised pediatric care, 87-100

Drug Administration—all relied on private professionals and researchers for knowledge, regulatory strategies, and public outreach. The belief was that by pooling knowledge and authority, modern society could become better organized and more able to address community needs. The Bureau's reliance on private professional and voluntary organizations to formulate well-child care standards and build popular enthusiasm for maternal and child health services fit into a broad Progressive-era trend that linked public and private experts as a way to improve the lives of regular Americans.[30]

The specific set of institutional connections that arose in the US Department of Agricultural Extension Service serves as a useful comparative case. By the mid-1910s, the USDA's agricultural modernization mission relied on four interconnected groups: federal administrators based in Washington, DC: federally-employed agricultural extension agents in local areas; land-grant college agricultural researchers; and finally, the recipients of these interventions—the farmers themselves, along with their wives and children. This system was strikingly similar to the social welfare system that was based out of the settlement houses, and then out of the Children's Bureau. The Smith-Lever Act of 1914 provided federal matching funds to states to support efforts in modern agricultural production. These funds formalized and funded a system that USDA bureaucrats had in fact already been in place for ten years. Like Smith-Lever, the Sheppard-Towner Act created a grants-in-aid matching program that formalized an institutional arrangement that was already up and running. Thanks to this federal legislation, the collaborations among the main players in social welfare and maternal

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[30] For public-private collaboration in federal lending regulation, see Thomas K. McCraw, *Prophets of Regulation: Charles Francis Adams, Louis D. Brandeis, James M. Landis, Alfred E. Kahn* (Cambridge, MA: Belknap Press of Harvard University Press, 1984), 167; for FDA's collaborative work against "quack" and patent medicines, see Carpenter, *Reputation and Power*; for grain grading standardization, see M. Elizabeth Sanders, *Roots of Reform: Farmers, Workers, and the American State, 1877-1917* (Chicago: University of Chicago Press, 1999), 303-304.

and child health—federal Children's Bureau leaders, university and settlement-house-based researchers in social work and sociology, local and municipal health departments, and private health care practitioners—became well-funded and officially sanctioned. And just as the USDA aimed to modernize agricultural practices, these interconnected social reformers, doctors, and researchers shared the goal of disseminating innovations in hygiene, nutrition, public health, and health care services during pregnancy, delivery, and infancy.[31]

While the Children's Bureau relied on local women to organize and staff "baby weeks" and well-child clinics, the extension service similarly depended on farmers' wives to disseminate modern farming ideas. The Agricultural Extension helped build farm women's clubs, 4H groups for children, and farm-business alliances. Similarly, the Bureau "mobilized grassroots organizations to support its work, uniting with volunteer organizations as well as local agencies in their baby-saving work." This federal-local institutional partnership structure and the reliance on volunteer women distinguished these two projects from other regulatory activities of the 1910s and 1920s, which were in general more top-down programs. Both the Bureau and the extension were unprecedented attempts to use federal money and bureaucratic expertise to achieve lasting change among regular Americans. These efforts to modernize and expand access to maternal and child health services would remain the Children's Bureau's goals for the next forty years, and the institutional structure that hinged on local participation would remain significant throughout the 1930s and into the years of World War II.[32]

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[31] I am grateful to Elizabeth Brake for these insights on how under Smith-Lever, the USDA continued and expanded activities that linked the federal extension service and local institutions. See also Lindemeyer, "*A Right to Childhood*", 78.

[32] For mobilization of grassroots efforts under Sheppard-Towner, see Golden and Markel, "A Historically Based Thought Experiment," 446.

This strategy of network building among federal social-welfare bureaucrats and voluntary organizations helped this maternal and child health justice agenda flourish despite the ascendance of government-corporate alliances in most other departments of the federal government. While Children's Bureau women were working to join government bureaucrats with female "citizen volunteers," Secretary of Commerce Herbert Hoover was empowering a very different type of public-private cooperation over the course of the 1920s. The Hooverite system of "associative government" encouraged private industry participation in regulatory oversight. Hoover's business-government alliances aimed to decrease social conflict, ease tension between labor and corporate bosses, and encourage market growth. At its most extreme, pro-business, associative government would "promote and regulate the cartelization of private industries so as to reduce destructive competition and maintain prices." The Department of Commerce led the process of bringing private business representatives into co-regulatory partnerships with the federal government. It served as "a clearinghouse of information for and an organizer of associations in the private sector as well as a publicity agent for expert advice," much as the Children's Bureau was for local women's organizations, state maternal and child health programs, and individual families.[33]

This distinction between the Bureau's network of alliances and the Hoover administration's associative approach revealed deeply rooted differences between social welfare advocates and bureaucratic leaders in other areas of government. First and

[33] For Hoover's cartelization plans, see Alan Brinkley, "The New Deal and the Idea of the State" in Steve Fraser and Gary Gerstle, *The Rise and Fall of the New Deal Order, 1930-1980* (Princeton, NJ: Princeton University Press, 1989), 88; for the Department of Commerce's role in Hooverite associative government, see Muncy, *Creating a Female Dominion in American Reform*, 102; for trend toward co-regulation, see Edward J. Balleisen, "The Prospects for Effective Co-Regulation in the United States: A Historian's View from the Early Twenty-First Century," in Edward J. Balleisen and David A. Moss, *Government and Markets : Toward a New Theory of Regulation* (Cambridge, UK: Cambridge University Press, 2010), 443-81; and Edward J. Balleisen and Marc Eisner, "The Promise and Pitfalls of Co-Regulation: How Governments Can Draw on Private Governance for Public Purpose," in *New Perspectives on Regulation,* David Moss and John Cisternino, eds. (Cambridge, MA: The Tobin Project, 2009), 127-150.

foremost was the matter of gender. The women leaders of the Children's Bureau pursued different alliances and achieved success through the efforts of local women's organizations because of the impermeable professional gender segregation of the early twentieth century. Whereas businessmen and their male representatives collaborated with other, male-dominated bureaucracies, the Bureau's leaders relied especially on connections with women.

Even if these gender divisions had been more fluid, the Bureau's leaders still might have spurned cooperation with private industries, even though such alliances might have been useful. Rooted in the settlement-house movement's conviction that industrialists were responsible for producing the poor conditions of living and working among the nation's urban working classes, the Bureau's leaders believed the federal government needed to wield power over, and not give in to the self-interest and authority of private capital. To these leaders, creating a just society meant counterbalancing the power and unfair advantages of the wealthy. This communitarian undertaking meant defending the rights of laborers, educating mothers on how to raise their children, and equitably distributing free well-child health services. By contrast, associative government embodied a faith that private individuals would make decisions that were in the interest of all of society.[34]

Ultimately, the Bureau sought a stronger, more heavy-handed state than many other 1920s bureaucrats. In this way they were out of step with the pro-business political ideology of these years. Although willing to collaborate with like-minded pediatricians, the Children's Bureau women were unwilling and perhaps even unable to form alliances with male-dominated private industry. The statist political ideology that underlay the Bureau's strategy, and the communitarian idea of a just society built and protected by

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[34] Muncy, *Creating a Female Dominion in American Reform,* 102, 108.

beneficent federal bureaucrats, would remain in place for decades to come. This dearly held social reformist approach set the terms for subsequent proposals for federally supported maternal and child health work and also for the major conflicts over whether public institutions should be held accountable for the health of women and children.

Chapter 4: Opposition to Progressive-Era Female Social Reform Engagement in Maternal and Child Health Policy

In 1926, when the Sheppard-Towner Act was due for renewal in Congress, opponents convinced federal politicians that arguments against the law far outweighed its benefits. Within two years, Sheppard-Towner funds were liquidated, and the federal government withdrew from its active involvement in local programs to improve maternal and child health. The defeat of Sheppard-Towner represented the death knell for female reformers' vision during the Progressive era of the Children's Bureau at the helm of an expansive, nationwide network of social welfare professionals, local voluntary organizations, and public health bureaucrats that would improve maternal and child health from the ground up.

Between 1912, when the Bureau was created, and 1926, when the Sheppard-Towner Act failed to obtain renewal, conservative groups evolved into a unified chorus of antagonism to woman-led political efforts. During these years, a coalition grew among anti-suffragists, red-baiters, Southern white supremacists, and the private medical sector. Together, these voices decried the attempt by social reformers to make the health of mothers and children a federal responsibility. Though unable to staunch the tide of national female political engagement around suffrage in 1920, by 1926, this coalition convinced Congress to curtail the Children's Bureau's work in health services, and to foreclose the agency's capacious vision of itself as an interventionist federal bureaucracy that would end child labor and defend women's and children's access to health services.

Early attacks on settlement-house women, the Children's Bureau, and the suffrage movement hearkened back to a set of longstanding refrains about how social reformers' professional and political lives violated traditional ideas about gender, sexuality, and domesticity. While Jane Addams, Julia Lathrop, Alice Hamilton, Grace Abbott and many others insisted that unmarried and childless women could participate in social and political issues as "municipal mothers" or the "charwomen of society," antifeminists saw their work as a threat to the "cult of true motherhood." For traditionalists, everything about the "New Woman"—her higher education, her political interests in suffrage and social problems, her careerism, and her personal fulfillment outside of the roles of wife and mother—violated nature. Despite the strenuous efforts of groups like the National Association Opposed to Woman Suffrage and the wide dissemination of anti-suffrage diatribes in *The Woman Patriot*, over the course of the 1910s the woman-led movement for suffrage gradually overcame Victorian opposition to women's involvement in political life, first on a state level and eventually in federal elections. The suffrage movement united advocates of equal rights with social reformers' arguments that women had a role to play in purifying political life. Communitarian arguments about the particular female capacity to improve society through political participation merged with feminist arguments that the vote was a right of citizenship, regardless of gender.[35]

In 1912, as suffragist political activism was expanding, the proposal for a federal Children's Bureau, which would serve as a federal base for settlement-house movement

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[35] For the concept of the New Woman and her role in early twentieth century women's political work, see Martha H. Patterson, *The American New Woman Revisited: A Reader, 1894-1930* (New Brunswick, NJ: Rutgers University Press, 2008); for anti-suffrage opposition to the Children's Bureau's infant and maternal health work, see Richard A. Meckel, *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850-1929* (Ann Arbor: University of Michigan Press, 1998), 207-209; for the success of the suffrage movement and the way that it merged disparate parts of the women's movement, see William Chafe, *The Paradox of Change: American Women in the 20th Century* (New York: Oxford University Press, 1991), 22-25; and Nancy F. Cott, *The Grounding of Modern Feminism* (New Haven, CT: Yale University Press, 1987), 23-33.

activity, provoked concerns about a collapsing division between public and private life. In congressional hearings about the proposed creation of a Children's Bureau, conservative congressmen worried that the Bureau's "agents," perhaps with the good intentions of improving individual welfare, "in their zeal, would overstep the bounds, enter dwellings, and interrogate members of families who would not understand their right to privacy." Leaders of private child welfare organizations similarly saw the proposed Bureau as an attempt by the federal government to centralize power, step on the toes of private philanthropic activity, and spend tax money on issues better left to charities. Elbridge Gerry, the leader of the New York Society for the Prevention of Cruelty to Children, anticipated that the Bureau would "utilize the prevention of cruelty for political patronage and personal capital" and would thereby "lower the whole moral tone of the Nation." These concerns about personal privacy led to the insertion of an amendment in the Children's Bureau's initial proposed legislation that would prohibit Bureau agents from forcibly entering private homes. Despite social reformers' view that ameliorating maternal and child welfare would at times require a natural extension of police power, opponents to this communitarian vision of enhanced public authority worked to curtail this power.[36]

Opponents to social reformers' vision of an active federal bureaucracy also hoisted the banner of "states rights." These arguments reflected fundamental political disputes about how Progressive-era policy changes would effect the balance of power between national and state jurisdictions. Even before the Children's Bureau was created,

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[36] For concerns about excess zeal of Bureau's agents, see "The Children's Bureau Bill," *The Baltimore Sun,* February 5, 1912, 6; for Gerry's views, see "Opposed to Federal Children's Bureau: Proposed New Government Department Not Needed, *New York Times,* January 28, 1912, pg. 14; for prohibition on forcible entry, see Kriste Lindenmeyer, *"A Right to Childhood": The U.S. Children's Bureau and Child Welfare, 1912-46* (Urbana: University of Illinois Press, 1997), 26.

opponents to the idea of a settlement house in Washington, DC alleged that such an institution would tread on individual states' self-governance.

In the wake of Reconstruction, the Southern political elite in the early twentieth century held firmly to states' rights arguments. For political purposes, states' rights served as shorthand for the larger set of white elites' concerns about maintaining white supremacy, black disfranchisement, and agricultural production based on exploitable sources of labor. Southern Democrats believed that endowing a progressive-minded federal bureaucracy with the power to enforce child labor regulations, provide health services, and oversee welfare conditions would undermine the white elite's control over the working conditions of black laborers in particular. Outside of the white supremacist South, politicians nationwide feared that the Bureau's goal of protecting the rights of workers and disfranchised people might come at the expense of the rights of property holders. In spite of these objections, the Bureau was nevertheless created in 1912 as part of the "Progressive reform crescendo" of the early 1910s, but Southern Democrats' concerns about federal overreaching, and their diffidence about offering federally supervised welfare services to black people, led to the Bureau's minimal budget and constrained authority. These sources of antagonism would continue to hamper the Bureau's engagement in policy issues for decades to come.[37]

After the 1920 passage of the Nineteenth Amendment, the political agenda of social reformers became viable in a new way. Federal politicians were now concerned that, to obtain the "woman vote," they needed to support the social reform agenda forwarded by the women of the Children's Bureau. The Sheppard-Towner Act was the first major social policy proposals that these social reformers advanced after achieving suffrage. As historian Molly Ladd-Taylor notes, conservative antagonists understood

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[37] Lindemeyer, "*A Right to Childhood*," 26.

that the "political objective of the Sheppard-Towner Act was to educate women with an eye toward mobilizing them to demand more extensive welfare services." For those who objected to an enhanced federal bureaucracy with settlement-house women at its helm, the stakes were high.

Missouri Democratic Senator James Reed led the charge against the Sheppard-Towner bill, using much of the same logic that he had summoned in his push against suffrage. A prominent member of Missouri's Democratic Party and a stalwart Jeffersonian conservative, Reed objected to the Progressive-era expansion of federal bureaucracy, and the role that female social reformers were playing in it. Reed believed that the achievement of woman suffrage nationwide was the first event in what could become a parade of female-led political activity and aimed to staunch the tide. He caricatured the suffragists' belief that women had a role to play in the "purification" of the "man-governed world," which they considered "a seething cesspool of inquity." He urged his colleagues to prevent the women who had led this movement from gaining greater federal authority. The women of the Children's Bureau were merely "a band of devoted spinsters" who erroneously believed that "the only people capable of caring for babies and the mothers of babies are ladies who never had babies." Reed's efforts to quash the Sheppard-Towner bill reflected the anxieties of anti-feminists and gender traditionalists, who saw female political engagement, professionalism, non-normative sexual identity, and unmarried lifestyles as distinct threats to family life and Republican democracy. Early opposition to the Sheppard-Towner Act reflected a keen awareness that the passage of woman suffrage had "politicized motherhood" and placed the

nation's mothers in the position of revolutionizing the federal government's attitude toward humanitarian need.[38]

Opposition to the Bureau also thrived from the era's Red Scare. In her testimony during the 1921 Senate committee hearings, one "Mrs. Gibbs" called the Sheppard-Towner proposal "a hydra-headed monster" designed to "coerce the Government and force sovietism, bolshevism, socialism or something else upon us." Reed characterized the Sheppard-Towner Bill's "fundamental doctrines" as "drawn chiefly from the radical, socialist, and bolshevistic philosophy of Germany and Russia." These remarks reflected how fearful conservatives were about the socialist overtones of the settlement-house movement's communitarian approach to social policy.[39]

Although unsuccessful in preventing the passage of the Sheppard-Towner Act, Reed and his fellow conservatives successfully slashed the law's funding and dramatically diminished its scope. Initially the Bill's proponents requested an annual appropriation of four million dollars, yet the final version provided for only one and a quarter million dollars per year. In addition, states were permitted to opt out of Sheppard-Towner funding, and the Bureau's total authority over the program was compromised by the creation of an oversight committee, which included the Public Health Service's Surgeon General and the Federal Commissioner of Education. Last but certainly not least, the bill gave the Children's Bureau the authority to enhance public educational and outreach activities for mothers, but prohibited it from paying medical

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[38] For Reed's political views, see James Reed, "The Pestilence of Fanaticism" *The American Mercury* (May 1925): 4; and Meckel, *Save the Babies*, 208-209; for politicized motherhood, see Molly Ladd-Taylor, *Mother-Work: Women, Child Welfare, and the State, 1890-1930*, (Urbana: University of Illinois Press, 1994), 169
[39] For "hydra-headed monster" remark, see "Mrs. Gibbs Hits Maternity Bill at Washington," *The Baltimore Sun*, August 29, 1921; for ultimate political goal of the Act's female supporters, see Ladd-Taylor, *Mother-Work*, 169.

expenses for individual pregnant women or their babies. In the end, the Sheppard-Towner Act did not upend the system of fee-for-service medicine in America.[40]

A lot changed between 1921, when Congress passed Sheppard-Towner, and 1926, when the law was up for renewal. Most important was the certainty that newly franchised women did not represent a serious political force in favor of social reform programs. Low female voter turnout in 1922 and an inconsistent connection between gender and support for social welfare-related policies allowed powerful Secretary of Commerce Herbert Hoover and like-minded conservative congressmen, who previously had feared a women's voting bloc, to express their disinterest in social reform programs. In addition, in the wake of success in passing woman suffrage, the women's movement succumbed to internal disputes. By 1922, "first wave" feminism's success in harnessing nationwide female political engagement, once united by the woman suffrage struggle, had largely dissipated.[41]

In a general way, political winds had shifted rightward. With the 1924 restriction on immigration and the post-war clamping down on leftist radicalism, the Children's Bureau increasingly seemed like an unnecessary concession. During the 1920s, the rise of pro-business, "Hooverite" associative government turned the political tide against statist progressive endeavors like the Sheppard-Towner Act. Conservatives at the same time were pummeling the Children's Bureau's other major policy endeavor—a federal ban on child labor. In his campaign against the child labor prohibition, Senator Reed decried that "a farmer could be sent to jail for sending out his seventeen-year-old boy to milk a cow" or a mother for "asking her daughter to assist in the family sewing." Southern political stakeholders, among them cotton farmers and textile owners, appreciated that the Southern agricultural economy relied on children and women as exploitable

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[40] Meckel, *Save the Babies*, 211, 219
[41] Chafe, *Paradox of Change*, 28-33.

agricultural laborers. With support from religious groups, representatives of agricultural capital launched a powerful and successful campaign against the Bureau's proposed federal ban on child labor. Reed explained that, like the Sheppard-Towner Act, a federal prohibition on child labor would further compromise "individual privacy," exacerbate "the problems of centralized federal power" and "undermine . . . free private industry."[42]

The fight over the longevity of Sheppard-Towner, like the debates over the federal child labor ban, revealed the fundamental political philosophical standoff that was taking place in the waning years of the Progressive era. Social reformers had long held that communitarian concerns about the disadvantages faced by the working class justified government curtailment of capitalist property rights. By the middle of the 1920s, the tables were turning away from this political philosophy and toward the exaltation of property rights above all else. Federal, tax-funded programs like Sheppard-Towner were increasingly castigated as in direct conflict with the "myth of the weak American state" whose main role was to protect individual liberties. In 1926, the Act came up for renewal before "a Congress [that was as] committed to budget-cutting and an administration as devoted to the interests and values of business as any administration in US history." Despite the Bureau's successes in improving health for pregnant women and infants under Sheppard-Towner and the still-powerful ideology of maternalism, conservative political trends doomed the law by the second half of the 1920s.[43]

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[42] Jan Dolittle Wilson, *The Women's Joint Congressional Committee and the Politics of Maternalism, 1920-1930*, (University of Illinois, 2007), 85; and Lindemeyer, *"Right to Childhood"*, 108-138.

[43] For the idea that this hands-off state was in fact a myth, see William J. Novack, "The Myth of the 'Weak' American State*," The American Historical Review* 113, no. 3 (2008): 752-772. For the pro-business Congress of 1926, see Robyn Muncy, *Creating a Female Dominion in American Reform, 1890-1935* (New York: Oxford University Press, 1991), 125.

By 1924, a new virulence appeared in attacks against social reformers' activities and against female, and especially feminist, political engagement. As post-war conservatism took hold nationwide, social reformers' goals were cast as part of an alien, Moscow-led infiltration of bolshevist politics. The fury of anti-feminist (and indeed, anti-female) politics could be seen in the War Department's development of the "spider web conspiracy theory," which asserted that over twenty women's political groups were part of a Russian-Communist radical scheme. The women of the Children's Bureau became caught up in these outlandish allegations, with antagonists calling the agency the epitome of "Bureaucratic Autocracy" in Washington, that "hotbed of Bolshevism."[44]

Conservative congressmen were ready to roll back an array of Progressive-era federal laws. They castigated the Sheppard-Towner Act, along with the Smith-Lever Act that funded the agricultural extension, for relying on the "50-50 system of fiscal reciprocity" wherein the federal government matched state dollars. Fiscal schemes of this sort were, to their mind, "encroachments" against state controls of their own coffers, which resulted in "a corrupting spendthrift system" that compromised efficiency, state power, and privacy. These antagonists emphasized the "dangers of bureaucracy" in "placing gigantic power in the hands of bureau chiefs." The inevitable fallout of such authority was "the deprivation of certain liberties." The era of Sheppard-Towner communitarian-bureaucratic experiment for resolving maternal and infant health needs was on the wane.[45]

Shortly after the Sheppard-Towner Act appeared on the books, the American Medical Association's House of Delegates circled the wagons, declaring in 1922 that the

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[44] See Lemons, "The Sheppard-Towner Act: Progressivism in the 1920s," *Journal of American History* 55 (1969): 780; and Chafe, *Paradox of Change*, 28; The proposals for peace-time alien and sedition laws and the increased authority of the FBI serve as further evidence of this period's fierce anti-socialist currents. See William H. Thomas, *Unsafe for Democracy: World War I and the US Justice Department's Covert Campaign to Suppress Dissent* (University of Wisconsin Press, 2007).
[45] "States Challenge Rise of Federal Powers," *New York Times*, April 11 1926, xx-3.

law represented an incursion by "state medicine." They expected their members to fall in line, but some would not. The pediatricians who made up the AMA's Committee on the Diseases of Children supported the Sheppard-Towner Act. Whereas the more conservative members of the American Pediatric Society toed the AMA's antagonistic line, these more liberal doctors stood by their female bureaucratic colleagues and saw their activities as an effective way to improve child health. When the AMA's top leadership came down against Sheppard-Towner, these more liberal-minded pediatric specialists were cast out of the nation's most powerful medical lobby. In 1931, these doctors formed a new body—the American Academy of Pediatrics—to represent their interests and politics. In the Sheppard-Towner years, doctors were divided amongst themselves about whether the government had a legitimate role to play in maternal and child health activities. These internal professional disputes revealed that social reformist politics, communitarian political ideology, and the public health work of female pediatricians had affected the political thinking of many pediatric doctors. During these years, many of them stood by the Children Bureau's health justice approach, risking their professional reputations and the camaraderie of their private practitioner colleagues.[46]

For pediatricians, then, Sheppard-Towner programs proved to be a double-edged sword. Although they showed the efficacy of public programs in improving child health, Sheppard-Towner health clinics and well-child conferences also expanded the market for privately rendered preventive pediatric care for new babies. Thanks to Sheppard-Towner-funded preventive health presentations and well-baby clinics, middle-class people saw and wanted doctor-supervised health care for their infants. In the 1920s, with the profit-making potential of preventive well baby care only just

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[46] Jeffrey Baker, "Women and the Invention of Well Child Care," *Pediatrics* 94, no. 4 (1994): 527-532; and Meckel, *Save the Babies*, 215-219.

emerging, pediatricians still supported the Children's Bureau's top-down, public efforts in the sphere of preventive child-health services and maternal education.[47]

Despite this alliance between maternal and child health bureaucrats and pediatricians, by 1926 the American Medical Association's campaign against the Bureau's involvement in maternal and child health won out. The AMA had grown savvy about cultivating allies, including various Catholic organizations and the Daughters of the American Revolution, which in 1921 had supported the Children's Bureau's efforts. Strange bedfellows in this movement against Sheppard-Towner also included "medical libertarians," who opposed any regulatory impositions in the field of health care, including forced vaccination, quarantines, licensure laws for medical professionals and institutions, and of course the attempts at standardization of maternal and infant health care under the Sheppard-Towner Act.[48]

While some Congressmen opposed wholesale the idea of any federal health service program for women and children, others opposed the law's extension because it would maintain the power of this increasingly unpopular woman-led agency. Indeed, President Hoover supported proposals that maintained the Sheppard-Towner activities but shifted the law's funding and authority to the United States Public Health Service. Not incidentally, the USPHS was run by men and aligned with the AMA.[49]

The struggle over the Sheppard-Towner Act was in fact a skirmish in a much larger war over the gender and ideological underpinnings of the public welfare state. The battle between the mostly male private practitioners of the AMA and the mostly female child welfare reformers of the Children's Bureau was an iteration of a much

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[47] Sydney Halpern, *American Pediatrics: The Social Dynamics of Professionalism, 1880-1980* (Berkeley: University of California Press, 1988), 91-95.

[48] J. Stanley Lemons, "The Sheppard-Towner Act: Progressivism in the 1920s," 779-780.

[49] Molly Ladd-Taylor, "Federal Help for Mothers: The Rise and Fall of the Sheppard-Towner Act in the 1920s," in *Gendered Domains: Rethinking Public and Private in Women's History: Essays from the Seventh Berkshire Conference on the History of Women*, ed. Dorothy O. Helly and Susan Reverby (Ithaca: Cornell University Press, 1992), 221.

larger battle of the sexes in the professions. The bill's opponents depicted the women of the Bureau as spinsters who sought to control the parenting practices of other women because they lacked their own children and were not themselves fulfilled as mothers. In this formulation, these bureaucrats' desire to participate in political life was cast as a mere sublimation of their thwarted urge to be wives and mothers.

The debates over the Sheppard-Towner Act contributed to the Bureau's decision to dig its heels in on the issue of maternal and child health care and to move away from the diversity of environmental, structural, and poverty-based concerns that had enlivened the settlement-house movement. Established under the Sheppard-Towner Act, the Bureau's "Child Hygiene Division" pushed the Bureau away "from strictly social and environmental factors to a consideration of medical causes for infant death and morbidity." This shift, toward concerns about access to and standardization of maternal education and child health services, and away from environmental and structural issues, reflected the struggle of Bureau women to assert their professional expertise and legitimate authority in an era that consistently linked "masculinity and public power." The women of the Bureau became more focused on scientific and medical issues to assert their abilities in these domains, which were typically associated with masculinity. Bureau doctors, especially, aimed to join the ranks of experts, previously the exclusive domain of male physicians and scientists. The Progressive era valorized the expertise of the white, professional middle classes, and with the Sheppard-Towner Act, women social reformers in the Bureau found an opportunity to participate more actively in this "political hegemony." This desire to obtain power as medical

experts came at the expense of a more expansive vision of public health and structural change, which would prove to be a lost legacy from the settlement-house movement.[50]

The final fight over the Sheppard-Towner Act showed the catch-22 in which women in political life found themselves in the wake of woman suffrage. Once it became clear that women did not vote as a bloc, politically active women realized that their devotion to a "women's agenda" could create a political cage, preventing them from being taken seriously as political actors in the larger ideological struggles over bureaucratization and regulation. The women of the Children's Bureau would continue to face this dilemma in coming decades. While asserting themselves as sympathetic representatives of women's needs and pursuing a women's agenda on the one hand curried sympathy and support, on the other it separated these female political actors from "rough and tumble" political life. In the course of the New Deal and World War II, the women of the Bureau would continue to face questions of gender politics over their role in the political arena of maternal and child health care.

The demise of the Sheppard-Towner Act demonstrated that the Bureau's vision for public responsibility for maternal and child health simply did not square with the political consensus that rose to the fore in the 1920s. The Sheppard-Towner Act's liquidation demonstrated that, in the years after the surge of women's political engagement around suffrage and before the New Deal, the welfare of American children

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[50] For Child Hygiene Division, see Lindemeyer, *"Right to Childhood"*, 89; for masculine power in science and medicine, and Bureau women's efforts to assert their professional expertise, see Camilla Stivers, *Bureau Men, Settlement Women: Constructing Public Administration in the Progressive Era*, (Lawrence: University Press of Kansas, 2000), 8, 10-11; for efforts of women to participate in male "political hegemony," see Muncy, *Creating a Female Dominion in American Reform*, 109, 110-115. For more on the Bureau's own chauvinism, in the larger context to male chauvinism, see Kristin Barker, "Birthing and Bureaucratic Women: Needs Talk and the Definitional Legacy of the Sheppard-Towner Act, *Feminist Sudies*, 29:2 (2003); and Linda Gordon, *Pitied but Not Entitled : Single Mothers and the History of Welfare, 1890-1935* (Cambridge, MA: Harvard University Press, 1995), 95. For the public health profession's problematic turn away from structural understandings of public health problems and toward bacteriology, see Amy L. Faichild, et al., "The Exodus of Public Health: What History Can Tell Us about its Future," *American Journal of Public Health* 100, no. 1 (2010): 54-63.

went back to being "the responsibility of individual mothers, not society." For the rest of the 1920s, the rights of property owners trumped communitarian concerns, as well as the idea that citizens had a right to health opportunity during pregnancy, infancy, and childhood.[51]

The Sheppard-Towner Act's remaining appropriations dwindled just months before the stock market crash of 1929. This economically crippling event, and the nationwide crisis of social welfare that it set off, exposed how a government designed around these principles of private responsibility was neglecting the human needs of its citizens, including the health needs of women and children.

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[51] For individual mothers' responsibility for their children's health, see Molly Ladd-Taylor, "Federal Help for Mothers: The Rise and Fall of the Sheppard-Towner Act in the 1920s," 227.

Chapter 5: The Political and Economic Context of New Deal and Wartime Health Justice Work

A new era in the pursuit of health justice for women and children arose after the stock market crashed in 1929. Between the onset of the Great Depression and the end of World War II, federal regulatory authority, funding, and public support for maternal and child health justice work rose to new heights. After laying out the political and economic context of the New Deal era in this chapter, the subsequent chapters (Chapters 6 and 7) will detail the array of health policy experiments that originated in Washington. In Chapter 8, I will address the backlash against this New Deal and wartime experimentation.

These four chapters on the New Deal and war years detail the programs that emerged between 1933 and 1946, under the auspices of the Farm Security Administration (FSA), the US Public Health Service (USPHS) and the Children's Bureau. These experiments were the next steps that grew logically out of the vision and achievements of the Sheppard-Towner years. The programs that took off during the New Deal and World War II represented the high-water mark of endeavors on the part of female social activists and federal bureaucrats to frame health and health care as a public responsibility and not just a private problem.

In some ways, these health experiments were quite different from one another. At first, the federal government simply threw federal funds at emergency health needs, providing public health nursing and other preventive health care services to the most desperately poor and the sickest victims of the Depression. Later, New Dealers developed more bureaucratically sophisticated programs. The FSA designed, operated, and subsidized health-care cooperatives that gave small farmers, tenant farmers, and

former sharecroppers their first reliable and sustained access to health care. During the New Deal, the federal government also employed physicians, public health nurses, and sanitation engineers who expanded the public health infrastructure in rural regions and staffed health centers and mobile health clinics in urban slums, migrant labor camps, and homestead communities. These clinics provided basic medical services directly, providing a model for health care delivery that fundamentally challenged the private, fee-for-service model of medical care. Most importantly, during the war years, the Emergency Maternity and Infant Care Program (EMIC) paid for maternity care and pediatric services for over a million women and babies.

When examined as a group and in the context of other developments and controversies during the New Deal, World War II, and the early Cold War welfare state, these experiments reveal several new insights into the struggle for publicly funded health services. First, they show that the female social reformers of the settlement-house movement, who had gained a seat at the table during the Progressive era, continued to expand their ambitions, their professional expertise, and their network of supporters. During the early 1930s, this cadre of mostly female social reformers became linked in purpose with a cohort of mostly male progressive political actors who directed the push for the Social Security system. Together, these groups generated health care experiments whose scope was broad enough to become widely known among public health and medical professionals. These experiments served as pilot programs for a potential revolution in how medical care was distributed and how public health was maintained. This second generation of female reformers and public health bureaucrats, who had come of age during the Progressive era, played a leading role in moving American political will toward the inclusion of health care by the mid-1940s into the social safety net.

Two separate but linked groups of federal bureaucrats directed the health policy experiments of the 1930s and 1940s. Run mainly by men, the USPHS and FSA pursued public health interventions and medical care programs for farmers and other agricultural workers. Directed primarily by women, the Children's Bureau focused on expanding maternal education, preventive health services and health care access for mothers, crippled children, and infants. Although operating out of separate Capitol Hill institutions, both groups espoused a set of shared beliefs the federal government should take responsibility for improving American health.

Administrators in the PHS, FSA and Children's Bureau espoused a top-down regulatory approach and a belief that the federal government should guide state and local efforts. Both groups saw the 1930s as a new era of federal policymaking opportunity. Having undertaken some small-scale, nationwide policy experimentation during the 1910s and 1920s, by the 1930s, federal bureaucrats saw their chance to "scale up" their projects. With the onset of a nationwide economic depression, the time was ripe for an activist public-policy response to social welfare needs.

With the increasing sophistication and efficacy of medical interventions, medically trained bureaucrats in Washington were certain that access to the expertise of health care professionals would improve American health. These bureaucrats across the FSA, the PHS and the Children's Bureau refused to curtail their involvement in federal health care innovation, despite the Social Security Act's omission of a national health plan.

Federal advocates of expanded health justice continued to hearken to communitarian premises, but increasingly summoned an individual rights-based logic for public funding of maternal and child health care services. In the years of the New Deal and World War II, a consensus began to build that citizens had a right to be

protected by their government from financial ruin caused by injury or illness. Progressives articulated that Americans were entitled to such protection, not just as a way of making society more efficient and healthy, but also as a matter of individual rights. Health justice advocates relied on both of these rationales in their pleas for federal funding and regulatory authority for their programs and in their responses to their opponents.

The next four chapters of this dissertation explore how advocates of federal health service work kept their nose to the grindstone not just in developing popular and political support for the ideology of maternal and child health justice, but also in bureaucratic terms, trying out in real time the kinds of government-supervised and funded public health initiatives that they hoped would transform the health care experiences of all Americans. This study of social democratic health care experiments deepens our historical understanding of progressive health care politics during the 1930s and 1940s. Those who envisioned health care as a public responsibility did not just engage in fiery debates on Capitol Hill over the inclusion of a health insurance program in the Social Security Act. These advocates sought to forge institutional alliances and bureaucratic experiences that would help realize a health care system premised on federal funding and regulation. They were committed to health and health care as part of the promise of social democracy.

Just as the settlement-house movement's reform and public health innovations were born from the social, economic, and political circumstances of industrialization, the social change and health care innovations of the 1930s and 1940s arose from vast social and economic changes, as well as a new set of political ideas about how government should respond to problems of human welfare.

The 1920s had been a period of political conservatism and renewed confidence in American power and vitality in the wake of the First World War. The decade's limits on immigration, isolationist foreign policy, and a public health focus on racial purity and quarantine reflected the belief that the United States could insulate itself from risk and cordon off the political power and social needs of immigrants and non-white Americans. Corporate interests were consistently defended in courts, while labor activism was suppressed. Settlement-house activism as a countervailing power against corporate abuse was no longer the powerhouse that it had once been.[1]

The stock market crash of 1929, however, and the subsequent decade of spiking unemployment, rapidly growing poverty, and volatile markets debunked the confidence of the 1920s. With over thirteen million Americans unemployed by 1932, middle-class Americans were exposed to a level of financial risk that had been unknown to the previous generation, and working-class people teetered on the brink of malnutrition and pauperism.[2]

The economic crisis exposed the extreme poverty and dire health disadvantages that had long existed in large pockets of both rural and urban America, especially among black, native, and immigrant Americans. Images of migrants from the Dust Bowl South showed how vulnerable Americans were to the vagaries of the market. Through the FSA's Works Progress Administration, photographers brought the faces and bodies of downcast people into the light, much as Jacob Riis's *How the Other Half Lives* had done in 1890. The iconic novel of the Depression years, John Steinbeck's *Grapes of Wrath*,

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[1] For conservatism in 1920s immigration policy, see John Higham, *Strangers in the Land; Patterns of American Nativism, 1860-1925* (New Brunswick, NJ,: Rutgers University Press, 1955); and
Roger Daniels, *Guarding the Golden Door: American Immigration Policy and Immigrants since 1882* (New York: Hill and Wang, 2004), 27-58; for the rise of conservative racial politics in the 1920s, and the relationships among racial, gender, and class conservatism, see Nancy MacLean, *Behind the Mask of Chivalry: The Making of the Second Ku Klux Klan* (New York: Oxford University Press, 1994.)
[2] William E. Leuchtenburg, *Franklin D. Roosevelt and the New Deal, 1932-1940* (New York: Harper & Row, 1963), 2.

concludes with the birth of a stillborn child whose mourning mother nurses a half-starved man whom she finds along the road. With the Depression, the "correlation between poverty and sickness" became indisputably true.[3]

The social welfare crisis brought on by the Depression made the public more generally aware of the health disadvantages faced by the most indigent Americans and of the differential in health and health care access that had long existed in large pockets of the United States. As President Franklin Roosevelt famously explained in his second inaugural address in 1937, a third of Americans were "ill-housed, ill-clad, ill-fed,"and in 1940, Roosevelt maintained that over a half of American children still "live in families that do not have enough money to provide fully adequate shelter, food, clothing, medical care, and educational opportunity." With regard to medical services, many Americans were simply too poor to pay for primary care, and health care services were unevenly distributed, with poorer, rural regions with limited or totally without local resources for care. As Children's Bureau reports revealed in meticulous detail, the health of black mothers and infants, in both cities and rural regions, was, in terms of infectious disease morbidity, infant and maternal mortality, and access to health services, appallingly worse than what existed among their white counterparts. Besides being poorer, rural children suffered disproportionally from preventable infectious diseases and parasitic conditions.[4]

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[3] John Steinbeck, *The Grapes of Wrath* (New York: Viking Press, 1939); for correlations between poverty and sickness, see Beatrix Rebecca Hoffman, *Health Care for Some: Rights and Rationing in the United States since 1930* (Chicago: University of Chicago Press, 2012), 6.

[4] For Roosevelt's remarks, see Franklin D. Roosevelt, Inaugural Address, January 20, 1937, accessed online February 12, 2014, http://historymatters.gmu.edu/d/5105/; and Franklin Roosevelt, remarks before White House Conference on Children in a Democracy, cited in Robert Cohen and Eleanor Roosevelt, *Dear Mrs. Roosevelt: Letters from Children of the Great Depression* (Chapel Hill: University of North Carolina Press, 2002), 35; for American health during Great Depression, see Jose A. Tapia Granados and Ana V. Diez Roux, "Life and Death during the Great Depression," *Proceedings of the National Academy of Sciences* 106, no. 42 (2009): 17290-17295; and Hoffman, *Healthcare for Some*, 6-7; for the uneven distribution of medical services, see Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, Inc., 1982), 125-126; for Children's Bureau reports revealing race-based and regional health disparities, see, for example, "Maternal Mortality in Fifteen States," 1934, accessed February 12, 2014,

Shortly before her appointment in 1934 as the director of the Children's Bureau, Katharine Lenroot explained that in the previous twelve months, twelve thousand women died in childbirth, leaving in their wake an immeasurable level of "social and economic loss" not to mention the "insecurity for the children left behind." The problems of industrial disease and injury that Progressive-era reformers had begun to expose among poor and working-class people persisted. The average American laborer and his or her family had little or no insurance against the financial disasters brought on by injury or death. Centered in major industrial hubs, Progressive-era reform work had done practically nothing to protect agricultural workers from disease or injury, not to mention the predatory employment arrangements of tenant farming and sharecropping.[5]

These vivid humanitarian needs made middle-class people more politically open than ever before to government-based solutions to social welfare needs. Personal or moral failings had long been considered the causes of poverty, joblessness, and ill health, but the Depression caused a shift in this way of explaining—and understanding—social welfare needs. In the wake of revelations about the role of corporate capital in generating the economic disaster, the predicaments faced by the Depression's victims no longer seemed like their fault. After 1933, newly empowered New Deal liberals turned away from an insistent focus on individual responsibility and liberty and instead promised to create a federal government that served as a protector and a beneficent force, stabilizing the economy and ensuring security against personal

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http://www.mchlibrary.info/history/chbu/20624.pdf; Maternal Deaths: A Brief Report of a Study Made in Fifteen States," 1933, accessed February 12, 2014, http://www.mchlibrary.info/history/chbu/20612.PDF; and "Infant and Maternal Mortality Among Negroes," 1937, accessed February 12, 2014, http://www.mchlibrary.info/history/chbu/20860.PDF.
[5] For Lenroot remark, see "Security for Children" 1934, Box 1, Folder 5, Lenroot Papers; for laborers' lack of insurance, see Hoffman, Health Care for Some, 4-7.

risk at the hands of greedy employers and unpredictable economic crises. At its most idealistic, the New Deal advanced the idea that risk should be shared and that the government should provide a safety net when misfortune occurred.[6]

In merely five years, between 1933 and 1938 the New Deal transformed the terrain of social policy. The first two years of this period, known as the "First New Deal," focused on economic stabilization, with expanded regulatory powers in banking and securities industries and top-down price stabilization for cash crops. Relief programs began to provide cash benefits to unemployed people, and new funds were pumped into public works projects with the goal of putting Americans "back to work."[7]

By 1935, Americans were accustomed to Roosevelt's proactive policymaking. Whereas the First New Deal focused on stabilizing banks, large industry, and the agricultural economy, the "Second New Deal" put into place institutions designed to develop a more socially democratic welfare state. Between 1935 and 1938, Roosevelt's policy agenda aimed to curtail the dominance of private capital and to allow Washington bureaucrats to create solutions for mass unemployment and poverty in order to improve working and living conditions for the industrial and agricultural underclasses. Manifestations of this activist agenda abounded. Under the National Labor Relations Act, commonly referred to as the Wagner Act, federal law protected the right to organize for laborers working in private firms, allowing workers to form trade unions, engage in collective bargaining, and strike when necessary. In 1935, Congress created the Works Progress Administration, through which New Dealers channeled money to states and municipalities for public works projects. The WPA allowed public

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[6] For history of moral failing as root of illness, see Charles Rosenberg, "Banishing Risk; Continuity and Change in the Moral Management of Disease," in *Morality and Health*, ed. Allan M. Brandt and Paul Rozin (New York: Routledge, 1997); for the beneficent and protective New Deal state, see Jennifer Klein, *For All These Rights: Business, Labor, and the Shaping of America's Public-Private Welfare State* (Princeton, N.J.: Princeton University Press, 2003), 6-7; Ira Katznelson, *Fear Itself : The New Deal and the Origins of Our Time* (New York: W.W. Norton, 2013).
[7] Arthur M. Schlesinger, *The Coming of the New Deal, 1933-1935* (Boston: Houghton Mifflin, 2003), 179-194.

institutions not merely to disburse welfare benefits to the indigent and unemployed, but also to become employers for a huge number of middle-class people, among them skilled tradesmen, engineers, artists, photographers, librarians, and teachers. At its height in 1938, the WPA employed over three million people.[8]

The 1935 Social Security Act was the watershed piece of New Deal social policy. The law created a universal, federally-funded and regulated insurance system for the aged, unemployed and disabled. Roosevelt's most durable social policy provision, the Act was funded through employer and employee contributions but controlled by the federal government. It encoded the political ideology that protection against economic risk was a responsibility of the nation-state.

The Social Security Act omitted one major feature for which its authors had ardently fought: a national health plan. The next chapter (Chapter 6) begins with the struggle to incorporate health insurance into the Social Security Act. The efforts of those ardent advocates of a national health plan shaped subsequent New Deal programs in health services. Despite the failure to create a right to health care through the Social Security Act, bureaucrats in the Farm Security Administration and the Public Health Service continued to design and administer federal projects that engendered their ideology of health justice: the belief that the state was responsible to develop and ensure access to health services, not only to treat serious illness but to provide adequate nutrition, preventive services, and health education during pregnancy, delivery, and childhood. Chapter 7 explores the parallel undertakings of social reform women in the Children's Bureau, who aimed to apply the settlement-house movement's health justice ethos to maternal and child health services run by the federal government. The dire economic and health crises wrought by the Depression, the spirit of policy innovation

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[8] Arthur M. Schlesinger, *The Politics of Upheaval: 1935-1936, the Age of Roosevelt, Volume V*, (Boston: Houghton Mifflin, 2003): 385-423.

during the New Deal, and the subsequent exigencies of wartime preparedness allowed these bureaucrats to keep the federal government "in the game" of health policy innovation until 1948.

While the 1930s and 1940s witnessed a surge in social policy innovation designed to pool risk, regulate industry, ensure labor rights, and promote social democracy— including health care programs—a countervailing conservatism opposed this vision and truncated the scope of these programs. The federal politicians who drove this conservative push against the New Deal were Southern Democrats in Congress. White supremacist local politics and the powerful organized medical lobby buttressed their antagonism toward any federal social policy that encoded basic political and economic rights for all Americans. Chapter 8 examines the ascendancy of these political forces as World War II came to a close.

Bolstered by Cold War anti-socialist rhetoric, these forces effectively foreclosed the social democratic vision of the New Deal, including universal health care and a vast system of federally overseen health service projects. The health service programs of the New Deal and the World War II era allowed Americans to glimpse the possibility that health could become a right in America, parallel to that of free speech or universal education. This period saw widespread public support for both the communitarian and the rights-based logic of health justice. While political efforts to revive a national health program persisted and programs to support the health and welfare of American women and children limped along after World War II, the Cold War effectively snuffed out the possibility that the United States would use federal power to institute health justice for all.

Chapter 6: The Great Depression, the Struggle for a National Health Plan, and the FSA's New Deal Health Service Programs

One of the first questions that President Franklin Delano Roosevelt faced upon entering the White House in 1933 was how his New Deal recovery plan would address the problem of American health needs. "Talk of the right to health care was everywhere," and Roosevelt included physicians in his rapidly formed circle of social policy experts. How to respond to the health predicament of people whom the Depression had hit hardest became a central feature of the New Deal. The question of how to include health services as part of the New Deal cut to the core of the challenge faced by social policy planners. The Great Depression imposed an unprecedented economic crisis on Americans and their government, but, in historian Alan Brinkley's words, the crisis was "doubly intimidating," as "Americans had as yet made few decisions about what their government should do and how it should do it." Americans and their political representatives were also divided about political ideology, and the degree to which communitarian and rights-based principles should inform the recovery policies intended to bring the nation out of economic and humanitarian crisis. In the area of health policy, as elsewhere, the New Deal was not just a period of solving specific new problems but also "a process of building government institutions where none existed, of choosing among various prescriptions for an expanded American state." New Deal policy experimentation represented an unprecedented contestation of the prevailing grip of capitalist thinking over the field of medical care. [9]

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[9] For the ubiquitous talk of health care rights during the New Deal period, see Beatrix Rebecca Hoffman, *Health Care for Some: Rights and Rationing in the United States since 1930* (Chicago: University of Chicago Press, 2012), 24. For the "doubly intimidating" crisis, see Alan Brinkley, "The New Deal and the Idea of the State"

Thanks partly to the visionary humanitarian politics of Eleanor Roosevelt and her personal network of socialist-minded, mostly female reformers, the possibility that the ideology of health justice could prevail in American health service provision seemed to be on the horizon. While communitarian arguments remained crucial political language for health justice advocates, the New Deal's innovators increasingly incorporated rights arguments to justify and popularize their requests for federal funding and bureaucratic authority. During this heady period, many progressives believed that they might soon attain their goal of having the federal government take responsibility for Americans' health needs, as a way to improve society *and* to make good on an American right to health.[10]

The public servants working toward this goal were housed under several executive agencies. Their programmatic responses to the dire conditions of American health needs fell into three general categories: direct service, coordination of health care cooperatives, and public health projects to improve sanitation and housing. This chapter focuses on programs geared toward health and healthcare in the longer timeline of the New Deal and reveals several key issues. First, progressive health policy planners during the New Deal held what would, in today's parlance, be termed a "fundamental causes of disease" theoretical assumption. Drawing on the settlement-house movement's prior ideology, New Deal bureaucrats who built the period's federal health service programs believed that the causes of physical illness were to be found in an array of structurally based social, economic, and environmental factors. Although often prioritizing access to medical care in their interventions, these bureaucrats understood

in Steve Fraser and Gary Gerstle, *The Rise and Fall of the New Deal Order, 1930-1980* (Princeton, NJ: Princeton University Press, 1989), 86.
[10] For Eleanor Roosevelt's politics and the reform network that she cultivated, see Blanche Wiesen Cook, *Eleanor Roosevelt Volume 2: The Defining Years* (New York, NY: Penguin Books, 1999), 52-69.

that health care was just one feature of improving American health. Second, even though the pinnacle piece of New Deal social policy legislation—the Social Security Act—omitted a universal plan for health insurance, New Deal bureaucrats continued to insist that the federal government should play a substantial role in delivering health services to those who needed them most, explicitly arguing for a redistribution of the risk of illness and injury. Third, the health programs that grew out of the New Deal relied on institutions that already existed on the state, municipal and regional level. Because of these locally-based institutional frameworks, the health service programs that the New Deal helped create preserved and in some cases further encoded longstanding tendencies toward racial discrimination in health services.[11]

New Deal health programs definitively solved neither the health disparities nor the problems of access and quality that pervaded health care distribution, but these programs did break new ground in developing community-based, cooperatively designed institutions upon which future, publicly based health delivery programs would be modeled for the rest of the twentieth century. In this way, these New Deal innovations, while relatively limited in scope, were transformative in the history of public healthcare policy and in the effort to institute health justice.

Only three months elapsed between Roosevelt's inauguration, in March of 1933, and the establishment of federal bureaucracies that would respond directly to the health crisis in America. During Roosevelt's first one hundred days in office, the Committee on Economic Security (CES)—the administration's inner circle for domestic policy design led by economist Edwin Witte—rapidly envisioned a set of federal institutions that would address health needs as part of their mandate. Witte and his colleagues on the

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[11] For the theory of the fundamental causes of disease, see Bruce Link and Jo Phelan, "Social Conditions as Fundamental Causes of Disease," *Journal of Health and Social Behavior* 35, extra issue (1995): 80-94.

CES focused on "employment assurance," and aimed at "increasing government control in economic life." The CES quickly began drawing up federal policies to protect Americans from economic insecurity over the long-term.[12]

Roosevelt's inner circle also rapidly accelerated and expanded short-term relief programs, placing the federal government at the helm of relief operations nationwide. As Roosevelt's Secretary of Labor, Frances Perkins, later explained, while policymakers favored programs to put Americans back to work, they believed that "there must be direct relief of some sort soon . . . or the country won't hold." Planners knew that Roosevelt had no objections to "a true dole of giving bread at the door," including cash benefits and direct services.[13]

In May, President Roosevelt created the Federal Emergency Relief Administration (FERA), which became the institutional home for the New Deal's first modest medical care funding activities. This executive bureaucracy absorbed President Herbert Hoover's prior Emergency Relief Agency (ERA). Whereas Hoover's relief agency had allowed state and localities to completely determine the nature and scope of their response to emergency needs, and even to opt out of any serious relief efforts, FERA's new director, Harry Hopkins, insisted that the federal authorities would oversee all relief operations and indeed would force states to address humanitarian needs. Hopkins' experiences in large-scale relief administration included efforts in maternal and child welfare as well as public health. As a young man, he had helped run New York City's Bureau of Child Welfare, where he delivered relief services to poor mothers. After World War I, he worked as a Red Cross administrator, running operations for

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[12] Edwin E. Witte, "Features of the Economic Security Program," *Annals of the American Academy of Political and Social Science* 178, Increasing Government Control in Economic Life (1935): 88.
[13] Reminiscences of Frances Perkins (1951-1955), in the Oral History Research Office Collection of the Columbia University Libraries, transcripts accessed February 22, 2014, http://www.columbia.edu/cu/lweb/digital/collections/nny/perkinsf/introduction.html, Part IV, 469-473.

seven Southern states. In the 1920s, he took the helm of the New York Tuberculosis Association and expanded that organization to tackle more health issues, including heart disease. When Roosevelt appointed him to run FERA, Hopkins was already attuned to individual and public health issues as key features of humanitarian welfare response.[14]

FERA took an activist approach to relief work. The agency gave out grants to states, rather than loans, and took on oversight of all state-based relief operations. Aware that some kind of auditing system was necessary to ensure the parity of responses across states, FERA created minimum standards and developed a centralized information base for relief programs, problems, and procedures. Although states' programs continued to differ in scope, the federal government assumed a directorial role to ensure the creation of humanitarian services and cash benefits for the poor, as well as work relief and worker education programs. Under FERA, an array of employment sectors took root through the influx of federal investment in private industry, including construction, highway building, artistic and theatrical work, and consumer goods production.[15]

FERA provided the PHS with one million dollars to grant to states, earmarked specifically for rural health needs. These funds initiated a period that would continue into the years of World War II, when the PHS's influence was vastly enhanced. Already in 1933, states began building new public health endeavors and supplementing already-existing health services, including medical clinics and hospital services, which had been difficult to maintain with only state-based funding,. As historian Karen Kruse Thomas

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[14] For Hopkins's background at Red Cross and other public health-related professional work, see Adam Cohen, *Nothing to Fear: FDR's Inner Circle and the Hundred Days That Created Modern America* (New York: Penguin Press, 2009), 259-260.
[15] For the difference between the ERA's more hands-off approach and FERA's activist approach to emergency response management, see Cohen, *Nothing to Fear*, 10, 270-272.

explains, PHS funds under the New Deal vastly expanded health care access, especially for rural black people, but did so within the system of Jim Crow segregation in health care that had long existed in the rural South. Although New Dealers intended for these PHS funds to increase black people's access to health services in particular and to raise the overall quality of medical services that served black people, they nevertheless further institutionalized the divide between white and black people's health care.[16]

FERA also used its federal works division to undertake vast public health and sanitation campaigns. Thirty-two thousand men were paid to do rural sanitation work, building privies and waste incinerators, improving housing in slums, and sealing mines. Another thirty thousand men "were put to work draining and cleaning up breeding places" of malaria-spreading mosquitoes. According to one administrator, thanks to FERA, "in a few months (136 days) more has been accomplished for the control of malaria than has been possible in twenty-five years" under the PHS alone.[17]

These programs demonstrated that New Dealers understood crisis relief in much the same way that settlement-house women had approached urban reform. Just as in the early part of the century, the settlement-house movement had aimed to improve health by attacking the structural disadvantages faced by the industrial working class, during the Depression New Dealers developed an elaborate set of policy innovations to combat the interlocking problems of poverty, malnutrition, unemployment, poor sanitation, and infectious disease. New Deal civil servants hoped that the health of citizens would improve as federal works and relief programs took hold, and as people had enough money in their pockets to pay for food and housing.

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[16] Karen Kruse Thomas, *Deluxe Jim Crow: Civil Rights and American Health Policy, 1935-1954* (Athens: University of Georgia Press, 2011), 49. One million dollars in 1933 would be the equivalent of 17.7 million in 2012 dollars.
[17] "Federal Emergency Relief and Public Health," *American Journal of Public Health and the Nations Health* 24, no. 6, Part 1 (1934): 642-643.

Besides putting these public health endeavors in motion, in 1933 FERA distributed an astounding five hundred million dollars as grants-in-aid to states, to be used for direct relief not only for the indigent but for "all needy unemployed persons" as well as their dependents. As a proportion of the overall American economy, FERA's initial expenditure was the equivalent of 142 billion dollars in 2012. FERA also began a federal voucher program to allow non-cash payments for food, shelter, clothing, and fuel.[18]

Reluctant to generate conflicts with the powerful medical industry lobby, which insisted that private fee-for-service was the only acceptable method for paying medical practitioners, FERA did not issue vouchers for health care. It did, however, set up a cash allotment program available for those who applied to their state or local relief office specifically for help "to make good on their unpaid doctor bills." As of September 1933, if a doctor was willing to reduce fees to the "prevailing minimum charge," FERA would provide cash to cover these costs.[19]

FERA's array of large-scale public health projects was in accord with the longstanding political willingness to provide public funds to do broad-based public health improvement work. But with the medical care payment program, the Roosevelt administration showed its willingness to go further to intervene in the system of healthcare delivery and payment. In spite of the opposition of medical societies, FERA administrators established a reduced fee schedule for those using federal cash allotments to pay for their medical expenses. According to this schedule, benefit recipients paid half of what doctors usually charged. FERA's medical care payment

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[18] For FERA, see Frances Fox Piven, "Economic Collapse, Mass Unemployment, and the Rise of Disorder," in Frances Fox Piven, *Who's Afraid of Frances Fox Piven?: The Essential Writings of the Professor Glenn Beck Loves to Hate* (New York: New Press, 2011), 1896-1897. For translation of 1933 FERA expenditures to recent dollar values, see the "calculator" section of the website "Measuring Worth," accessed February 16, 2014, http://www.measuringworth.com/index.php.
[19] For FERA medical bill cash program, see Michael R. Grey, *New Deal Medicine: The Rural Health Programs of the Farm Security Administration* (Baltimore, MD: Johns Hopkins University Press, 1999), 33.

program inserted the federal government as a participant in the domain of health care services, not just for the indigent but also for out-of-work middle-class people.

FERA's public health activities fell in line with the communitarian goal of a cleaner, more sanitary environment, but the medical payment program would prove to be an opening gambit in progressives' campaign positing health as a "basic right." Federal administrators avoided explicit rights-based political language in the early 1930s, but in five short years, they would become bolder in expressing their plan to create a "larger movement toward greater public benefits for all citizens," and to include health within that vision.[20]

At the same time as FERA and other agencies were taking on immediate crisis relief projects, progressive health policy advocates were conducting research and positing political justifications for federal health-policy reform. Advocates of a federal single-payer health insurance program believed that the crisis in American health demanded a structural response through a system of medical service delivery and financing. They knew that they had a short window during which to advise Roosevelt's Committee on Economic Security (CES), the central policy advisory team that designed the full swath of New Deal responses to the 1930s economic crisis.[21]

The Committee on the Costs of Medical Care (CCMC), an interdisciplinary panel of forty-eight of the nation's most esteemed health economists, philanthropists, and policymakers, began building a case for a national health plan after conducting extensive research on the health problems of Americans. The CCMC included Alice

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[20] Rosemary Stevens, *American Medicine and the Public Interest* (New Haven: Yale University Press, 1971), 178-9.

[21] For the effort to create a national health plan under Roosevelt, see Jonathan Engel, *Doctors and Reformers: Discussion and Debate over Health Policy, 1925-1950* (Columbia, SC: University of South Carolina Press, 2002); and Colin Gordon, *Dead on Arrival; the Politics of Health Care in Twentieth Century America* (Princeton, NJ: Princeton University Press, 2003), 92-93, 110-111.

Hamilton among its experts in industrial health, as well as University of Chicago public health professor, Isidore Falk, and the Milbank Memorial Fund's lead researcher, Edgar Sydenstricker.[22]

Committee members insisted on the necessity of a national health plan and began to do so not only with tried-and-true communitarian logic but also with explicitly rights-based arguments. In the words of one CCMC member, "the expectant mother in a two-room cabin has an inalienable right to medical care," and the guarantee of medical care access needed to be blind to an individual's state of residence, race, and class. The committee's final report shied from such direct political talk, but moral consternation about inequitable access could be read between the lines. Despite the reality that "sickness falls alike on the rich and the poor," health care facilities were "not distributed according to needs, but rather according to real or supposed ability of patients to pay for service." Advocates of health policy change insisted that their proposals for national health insurance were justified not just by a left-leaning political ideology but with concrete empirical evidence showing that poor health was disabling the American people and its economy. A PHS research study, funded in part with FERA money, concurred, showing that in 1933 almost half of those on relief had acute illnesses, and that a full third of those families on relief with "disabling" medical problems had no medical care whatsoever. In light of these findings, reform-minded experts believed that the nation needed a revamped system of federal health financing and delivery.[23]

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[22] For members of the CCMC, see Jennifer Klein, *For All These Rights: Business, Labor, and the Shaping of America's Public-Private Welfare State* (Princeton, NJ: Princeton University Press, 2003), 120-121.
[23] For expectant mother remark, see Stewart Roberts, "Social Trends," *New England Journal of Medicine* (1935), cited in Beatrix Hoffman, *Health Care for Some: Rights and Rationing in the United States since 1930* (Chicago: University of Chicago Press, 2012), 23. For problem of inequitable distribution and CCMC's policy recommendations, see "The Committee on the Costs of Medical Care Presents Its Final Report," *Milbank Memorial Fund Quarterly Bulletin* 11, no 1. (1933): 23; for corroborating 1933 PHS report, see Grey, *New Deal Medicine*, 33.

Between 1933 and 1935, the debate over whether Roosevelt's social policy legislation should include a national health plan came to a head, with New Dealers split on the matter. While the CCMC and its allies in Washington insisted that a national health plan was crucial to improve American health, other Roosevelt advisors felt that the political implications of a national health plan went too far. The CES was conflicted about whether a federally guaranteed right to health care should be a feature in the system of social benefits that it was tasked to create.

Two of Roosevelt's most intimate policy advisors, both members of the CES—Frances Perkins, of the Department of Labor, and Thomas Parran, of the Public Health Service—were at the forefront of health policy debates. With ideological dispositions that grew out of the Progressive-era approach to social reform work, Perkins and Parran hoped that Roosevelt's social policy legislation would include a national health plan. Even though they did not achieve their pinnacle goal—a comprehensive national health plan—they continued to develop programs that would enhance health justice. Over the course of the 1930s, their calls for progressive policies became more politically explicit as they articulated how workers' rights, along with the rights of citizenship, justified federal involvement in health services.

Frances Perkins came of age politically and professionally during the settlement-house movement. Born in 1880 to a family of Protestant Bostonians, she attended Mount Holyoke and the University of Pennsylvania's Wharton School, studying first chemistry, then sociology and economics. In her twenties and thirties, she volunteered at Hull-House and then resided in a social settlement in Greenwich Village where she worked on labor protection and social welfare issues that affected industrial female laborers and prostitutes. She rose in stature steadily. After serving as the head of the New York Consumers League and witnessing the Triangle Shirtwaist Fire of 1911, she decided it

was time to become a civil servant, believing that ultimately, government needed to protect workers against the dangers of industrial labor. After serving on New York City's Committee on Safety, in 1919, New York's Governor Al Smith appointed her to the Industrial Committee of New York State.[24]

By 1929, when Roosevelt was elected as governor of New York, Perkins was an obvious choice to lead the state's planning for economic recovery in the wake of the stock market crash. Four years later, shortly after his inauguration to the presidency, Roosevelt appointed her as his Secretary of Labor, where, serving as the first female Cabinet member, she would help write the New Deal's social policy legislation. As biographer Kristin Downey writes, Perkins became the president's "moral conscience," determining how federal policy would respond to the urgent crises of human welfare wrought by the Great Depression.[25]

In 1934, Perkins established the federal Division of Labor Standards, and it was there that she instituted a settlement-house style approach to bureaucratic regulation and articulated the view that health issues were among workers' rights worthy of federal protection. Her Division aimed to improve conditions for industrial workers, with a focus on curtailing excessive hours, instituting a minimum wage, eradicating child labor, and ameliorating workplace-based health risks. Her staff led trainings to teach laborers about the risks they encountered at work. The Division also "defined its role as advocate for labor, both organized and unorganized." Finally, the agency went beyond what historians Gerald Markowitz and David Rosner term "narrow economism," seeking rather "to include a safe and healthy work place as legitimate worker demands in collective bargaining." Perkins' Division was among the most

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[24] See Reminiscences of Frances Perkins; for Triangle Shirtwaist Fire, see Part I, 38-174; for New York City Committee on Safety and appointment to Industrial Commission , see Part I ,385-444.

[25] Kirstin Downey, *The Woman Behind the New Deal: The Life of Frances Perkins, FDR's Secretary of Labor and His Moral Conscience* (New York: Doubleday, 2009), 11-14, 21-23, 96-101.

activist New Deal agencies, boldly crossing into state jurisdictions and appearing in factories unannounced to investigate health and safety violations and to support unions.[26]

Perkins asserted that those with financial and political power were responsible for protecting the health of Americans, especially those with substantially less financial and political leverage. To her, protective labor policy grew naturally from a "growing sense of justness" in American society. When those who owned factories shirked their responsibility to protect workers' health, it fell on the government to police them. Federal labor policy aimed, above all, to protect the "free right of labor to organize without interference by employers." The ability to organize and negotiate with employers would counterbalance the potential for substandard working conditions. Like her colleagues in industrial health and safety, Perkins believed that many of the worst health problems among Americans stemmed from abusive working conditions, and that only federal labor laws could effectively push employers to comply with basic safety and health standards and provide workman's compensation in the event of job-related injury or illness. Perkins espoused a maximalist view of federal engagement in health policy, one that took matters of health out of the private domain and into the public sphere.[27]

Perkins's expansive belief in the national government's responsibility to improve health was matched by that of Roosevelt's Surgeon General, Dr. Thomas Parran. Parran served on the Medical Advisory Committee, which was tasked with advising Roosevelt's CES on matters of health policy. The heads of this medical committee—

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[26] Gerald Markowitz and David Rosner, "More than Economism: The Politics of Workers' Safety and Health, 1932-1947," *The Milbank Quarterly* 64, no. 3 (1986), 336.
[27] Frances Perkins, "A National Labor Policy," *Annals of the American Academy of Political and Social Science* 184, Issue on the Problems of Organized Labor (1936): 1-3.

White House physician Ross McIntire and the renowned neurosurgeon Harvey Cushing—were more conservative in their views on health policy. In light of organized medicine's history of denouncing any federal involvement in health care financing, McIntire and Cushing feared retaliation by colleagues in private medical circles if the social security legislation, which they were helping to design, included a national health plan. Parran, however, did not shrink from controversy and pushed for a national health plan. This willingness to provoke his colleagues in medicine pointed to an iconoclasm that pervaded much of his career as the nation's most powerful public health bureaucrat.[28]

Like Perkins, Parran came of age during the Progressive-era period of social policy innovation and inherited an experimental approach to public health reform. Parran's communitarian politics of health justice originated in his nationwide campaign against venereal disease, during which Parran asserted that government should actively intervene to address this taboo health problem. The PHS's syphilis control campaign of the 1920s and 1930s challenged Victorian-era prudishness about sexuality. Parran insisted that federal public health officials needed to battle syphilis head-on, treating individuals and launching education campaigns on ways to curtail sexual transmission of the disease. Upon his death in 1968, he was remembered by a colleague as "the man who had the guts to bring the word syphilis into the sitting rooms and parlors of the homes of people in the United States." Parran insisted that it was the federal government, rather than merely private philanthropic groups that should wage this campaign. His iconoclasm in bringing the problem of venereal disease into the light matched that of the settlement-house women; both insisted that, for communitarian

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[28] For McIntire and Cushing's position on national health plan, see Hoffman, *Health Care for Some*, 25.

wellbeing government needed to expose social and health problems, rather than turn a blind eye to what had long been considered the most private of health problems.[29]

Parran saw the battle against syphilis as an entry point for health services in regions and communities that had long suffered from lack of access to health care of any kind. Despite the gross ethical violations of the Tuskegee Syphilis Study, which was paid for through Parran's anti-syphilis funds, staffed by PHS doctors and nurses, and led to the unnecessary deaths of hundreds of black men from untreated syphilis, Parran's venereal disease campaign nevertheless revolutionized the availability of medical services for poor Southerners during the 1920s and 1930s. Under Parran's leadership, the federal public health monies for fighting syphilis became a funding stream to create new health care facilities, thereby bringing services to populations that had never before had access to health care. In this way, Parran's anti-syphilis work represented a wedge to insert the federal government in a project of health improvement and medical care expansion for poor Southerners, many of them black. Even as the public health profession's Progressive-era commitments to anti-poverty and sanitation work diminished during these decades, the anti-syphilis campaign indirectly asserted that poor, black, and rural populations deserved federally supervised access to health services.[30]

In light of Parran's record of directing a nationwide public health program that transformed health services in the rural South, Roosevelt saw him as a visionary expert able to rescue emaciated public health activities in the wake of the Great Depression. In 1932, then-Governor Roosevelt brought this ambitious, forty-year old midlevel

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[29] "Thomas Parran (1892-1968)," *American Journal of Public Health* 58, no. 4 (1968): 615; and Allan Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880* (New York: Oxford University Press, 1985), 122-160.

[30] For the classic text on the Tuskegee study, see Jim Jones, *Bad Blood: The Tuskegee Syphilis Experiment* (New York: Free Press, 1981); for the ways that the experiment paradoxically enhanced health care access, even for some of its subjects, see Susan Reverby, *Examining Tuskegee: The Infamous Syphilis Study and Its Legacy* (Chapel Hill: University of North Carolina Press, 2009), 178-182; and Thomas, *Deluxe Jim Crow*, 64-67.

bureaucrat to Albany to reinvigorate his state's public health services, which had become stretched beyond capacity by the Great Depression's economic disaster.

In these years, Parran began to articulate a rights-based vision of health justice, which went beyond the standard communitarian arguments for public health intervention. He insisted that the Depression would touch off a fundamental conflict between the system of commodified medical care and the premise that a social democratic, humanitarian government needed to enhance the health of all citizens. Parran declared that leaders in organized medicine "must recognize as a basic premise the right of every person to the maximum opportunity to secure and regain health co-equal with the rights to liberty and the pursuit of happiness." Shortly after he became president, Roosevelt appointed Parran as Surgeon General, and assigned him to the CES, where, with Perkins, he argued for the inclusion of national health insurance in the social security legislation. Parran framed his views in terms of rights, arguing that "every citizen, North and South, colored and white, rich and poor, has an inalienable right to his citizen's share of health protection." Already, a high-level Washington civil servant was going beyond communitarian principles for health policy change and prioritizing individual citizenship rights as the fundamental rationale for federal involvement in health services.[31]

Perkins, Parran and their allies lost the struggle to include national health insurance as part of Roosevelt's New Deal. When Roosevelt signed the Social Security Act of 1935, there was no mention of national health care. Many believed that Roosevelt had conceded this feature of the Act in order to obtain the support of doctors and their

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[31] For conflict between commodified health care and new rights-based system, see "Parran Predicts State Medicine: Doom of Individualist Doctor Near," *New York Times*, June 8, 1934, 14; for Parran's remarks regarding "inalienable right" to health protection, see Parran, quoted in Thomas, *Deluxe Jim Crow*, 67.

allies for the larger package of federal workmen's compensation and old age insurance. By other accounts, Roosevelt's support for national health insurance had been only tepid, and his devotion to political consensus and other features of the New Deal agenda far outweighed his enthusiasm for universal, federal health insurance. In the end, the goal of getting Americans back to work was more politically pressing than creating a right to health care.[32]

The other key force that spelled defeat for a national health plan in 1935 was the gradual shift toward employer provision of health care, which had begun in the course of the 1920s. In 1933, Roosevelt brought an "ideology of security" with him to the White House. Americans deserved protection against the risks of old age, unemployment, and workplace injury. In this political context, the large insurance companies saw an opportunity to capitalize on Americans' growing desire for risk protection. As historian Jennifer Klein has documented, by 1934 the giants of the insurance industry, among them John Hancock Mutual and Metropolitan Life, vastly expanded their markets, selling an array of insurance products to individuals and companies, including old age pension policies and health care annuities. The president of Equitable Insurance explained to other industry leaders his belief that "social insurance agitation will result in renewed appreciation and great stimulation of life insurance activities, both individual and group." By the time the scope of social security benefits was on the table for debate, the rise of welfare capitalism was well underway, and Roosevelt became

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[32] Colin Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth-Century America*, (Princeton, N.J.: Princeton University Press, 2003), 269-70; and Jill S. Quadagno, *One Nation, Uninsured : Why the U.S. Has No National Health Insurance* (New York: Oxford University Press, 2005), 23.

convinced that perhaps private, employer-based health benefits could adequately address this social welfare need.[33]

This shift toward welfare capitalist solutions for health benefits undermined social reformers' capacious vision of health justice. Since the settlement house years, progressive policy advocates had linked illness to structural inequalities and to broader social welfare issues of inadequate housing, poor sanitation, and unsafe working conditions. By contrast, employer-based health insurance programs cast illness as primarily a medical problem. Employers could take on the burden of helping to cover medical costs for workers, thus avoiding more elaborate and costlier interventions to improve working conditions. In the context of the humanitarian needs of the Depression, welfare capitalist health programs also undercut the political power of labor unions, by providing an attractive alternative to union-based voluntary benefit programs and by tempting workers to seek out employment in companies with benefits that would help with their health care costs. After the Social Security Act passed without a national health plan, private workers compensation programs became "the only recourse for many to seek restitution for the diseases and disabilities created by the industrial workplace."[34]

Despite this tremendous setback to their vision of health as a problem for public institutional intervention, health justice advocates like Parran and Perkins refused to "roll over and play dead" when it came to federal engagement in health services. Ironically, it was after this major defeat that the New Deal's most ambitious health care

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[33] For politics of security, see Klein, *For All These Rights*, 78-80; for Equitable Insurance president's remark on the opportunity before him and his colleagues, see Thomas Parkinson, 1934, cited in Klein, *For All These Rights*, 85. For definition of welfare capitalism, see Klein, *For All These Rights*, 2.
[34] For influence of Depression on organized laborers' eventual acceptance of employer-based solutions to their welfare needs, see Lizabeth Cohen, *Making a New Deal: Industrial Workers in Chicago, 1919-1939* (Cambridge, UK: Cambridge University Press, 1990), 314-316; for private workers' compensation programs' role in making illness a medical problem, and as sole recourse for coverage, see David Rosner and Gerald Markowitz, "The Struggle over Employee Benefits: The Role of Labor in Influencing Modern Health Policy," *Milbank Quarterly* 81, no.1 (2003): 58-59.

programs took root. The capacity and urgency for bureaucratic innovation in health policy accelerated after this political defeat, thanks in part to the movement that reformers' had built in their efforts to bring about a compulsory national health plan. This policy goal solidified the alliance of like-minded federal civil servants and researchers in the spheres of social reform and public health. It brought together Perkins and her settlement-house-movement friends at the Children's Bureau with the mostly male circle of leaders in Parran's public health bureaucracy.

After 1935, these reformers—among them liberal pediatricians and general medical practitioners, public health officers, and social welfare advocates—continued to travel in tight circles, connected to the PHS and several philanthropic foundations including the Rosenwald and Commonwealth Funds. They published papers in the *American Journal of Public Health*, *Survey Graphic*, and other reform-minded journals. Among these health policymakers was Michael Davis, a health economist who played a lead role in the Committee on the Costs of Medical Care and was renowned as one of the nation's leading progressive thinkers in matters of health care policy. While Davis and other leaders in the Social Security efforts, such as Edgar Sydenstricker, worked at private philanthropies (Davis at the Rosenwald Fund and Sydenstricker at the Milbank Memorial Fund) others were based in public health academic programs. Among these academic public health experts were Nathan Sinai of the University of Michigan and Henry Siegerist of John Hopkins. Although thwarted in creating a national health plan, this cohort of health care progressives preserved their vision of health as a right, and began to work more closely with female colleagues in the Department of Labor and the Children's Bureau. Individuals across these government institutions became united in their hope that the failure of the national health plan would not doom all federal experiments in health services. In a sense, the loss of the health plan as a part of the

Social Security Act motivated these reformers to continue to create programs that would chip away at health inequality for the remainder of the New Deal period and into the years of World War II.[35]

Under the New Deal, experts in public heath joined forces with the New Deal's lead economists and welfare administrators, thereby placing health services firmly within the administration's vision of economic and social recovery. Already in 1933, under Surgeon General Parran's leadership, the PHS "loaned" Michael Davis to the Resettlement Administration (RA) as that agency formulated health programs for disadvantaged agricultural families. This loan arrangement would expand over the next ten years to include other key public health experts, among them Milton Roemer, Frederick Mott, and Ralph C. Williams. Through these New Deal agencies, public health experts, who had lost the prize of a national health plan, nevertheless gained access to federal funds and administrative power, through which they worked toward their goal of inserting the federal government into the provision of health services. The RA, and later the Farm Security Administration (FSA) would serve as a "bully pulpit" for those who envisioned a broad new system for health care delivery even though they had not achieved success in the passage of the Social Security Act. As historian Thomas Clark explains, "the role of Michael Davis and the FSA medical officers on loan from the USPHS demonstrates the critical role that a rather small and insular group of policy intellectuals and 'experts' can play in the development of social policy." This role of expertise played out not only in the sphere of social policy, but also in other spheres of the enhanced bureaucratic administrative state of the New Deal.[36]

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[35] For institutional affiliations of New Deal health program designers, see Thomas Clark, "The Limits of State Autonomy: the Medical Cooperatives of the Farm Security Administration, 1935-1946," *Journal of Policy History* 11, no. 3 (1999): 257-282; and Grey, *New Deal Medicine*, 145.
[36] For personnel loan arrangements and Michael Davis and other experts' influence, see Clark, "The Limits of State Autonomy," 263; for FSA as "bully pulpit" for health policy progressives, see Thomas, *Deluxe Jim*

The informal loan arrangements of personnel from the PHS to New Deal

recovery agencies was not out of the ordinary in the 1930s. New Deal programs

maintained the fluidity of institutional bureaucratic arrangements. Just as the CCMC

and Roosevelt's CES had brought together private doctors, academic public health

scholars, settlement-house-based social reformers, and government bureaucrats, the

RA/FSA-based health projects continued to allow people from private philanthropies,

federal institutions, and municipal and state agencies to work together in ways that

deemphasized the divisions among private and public funds and institutions. In a way,

these endeavors resembled the public-private partnerships established in the 1910s and

1920s through the Sheppard-Towner maternal and infant health programs and the Smith

Lever Act agricultural exchange projects. The permeable boundary that persisted into

the 1930s between private and public life contributed to the speed of social change and

certainly to the capacity to innovate major bureaucratic programs, like the New Deal

health programs, during the first three decades of 20th century. [37]

The leaders of the PHS retained a provision in the Social Security package that

would keep them in the game of health policy. Relatively uncontroversial compared

with the national health plan proposals, Title VI appropriated eight million dollars a

year to the Public Health Service for the purpose of "establishing and maintaining

adequate public-health services, including the training of personnel for state and local

health work." While Parran had long worked to put "public health on the map of

national priorities" it was Title VI that "made this explicit." These funds were "the first

Crow, 50; or the enhancement of bureaucratic administrative state under the direction of experts, see Joanna Grisinger, *The Unwieldy American State: Administrative Politics Since the New Deal*, (Cambridge, UK: Cambridge University Press, 2012), 1-9.

[37] For interconnectedness of between private philanthropic staffing and funding and public bureaucracies during the 1920s and 1930s, see Judith Sealander, *Private Wealth and Public Life: Foundation Philanthropy and the Reshaping of American Social Policy from the Progressive Era to the New Deal* (Baltimore, MD: Johns Hopkins University Press, 1997), 27.

money the state boards of health had received from the federal government since the years immediately after World War I." This section of the Social Security Act represented a turning point in federal commitment to the public health needs of the rural South. For Parran and his associates, Title VI funds proved crucial for their efforts through the remainder of the New Deal. Added to various other pots of New Deal relief funds through FERA and the Public Works Administration, and working through these more flexible New Deal agencies, PHS bureaucrats were able to pursue Parran's mission to make the federal government a key player in improving American health. As Karen Kruse Thomas argues, though meager in size, the Social Security Act's provisions for health service improvement proved crucial for "salvaging and securing the health of many thousands of . . . poor, white and black" Southerners. In its focus on the public health needs of the agricultural South, Title VI proved that Roosevelt and the New Dealers had their sights set on improving the health and welfare of rural agricultural Americans.[38]

Fueled by Title VI funds and the political commitment to rural health that these funds implied, New Deal plans to remediate the health problems in the agricultural South became more ambitious. To Parran, the rural South represented "the Nation's No. 1 health problem." The problems of ill health among rural Americans dwarfed those of urban dwellers. Preventable diseases such as malaria, hookworm, and pellagra remained real risks. The sources of the health crisis in the rural South were both old and new. The region had long been less developed and more disease-stricken than the industrializing North, and its public health infrastructure remained spotty in spite of the

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[38] "Social Security Act of 1935," 49 Stat. 620 (act of Aug. 14, 1935), Sections 501 and 601; for the significance of Title VI for Parran's PHS endeavors, see Brandt, *No Magic Bullet*, 142; for the role of Title VI in improving Southern health, even as it further encoded racial segregation in health care facilities, see Thomas, *Deluxe Jim Crow*, 59-60.

Rockefeller Foundation's anti-hookworm campaign and other scattershot philanthropic and municipal endeavors. An already dire situation became even worse with the onset of the Great Depression's economic disaster. According to R.C. Williams, who became the FSA's health programs coordinator, by the mid-1930s, three million farming families lived "on the brink of disaster" because of flood, drought, economic crisis, absence of credit and low crop prices.[39]

With the Depression, crop prices plummeted, which devastated the financial security of farm owners and drove more people into tenancy, sharecropping, and agricultural day labor. Intending to stabilize the Southern economy, Roosevelt's Agricultural Adjustment Act (AAA) provided subsidies to farm owners for voluntarily decreasing their production. Land owners pragmatically decided to leave their least productive lands to lie fallow. But it was these lands that had long been farmed by tenant farmers and sharecroppers, many of whom were descended from slaves and who already occupied the bottom rung on the Southern agricultural economic ladder. AAA policies therefore pushed sharecroppers and tenant farmers into even greater destitution. The great drought of the early 1930s along with the general move toward mechanized farming techniques, left another population of agricultural workers— migrant laborers—unable to obtain day work or pushed into laboring at wages too low to put food on their families' tables. All of these interlinked problems reached a critical point in the early 1930s, making Southerners uniquely vulnerable to malnourishment,

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[39] Parran, cited in Thomas, *Deluxe Jim Crow*, 31-32; for health problems in the South, see Jack Temple Kirby, *Rural Worlds Lost: The American South, 1920-1960* (Baton Rouge: Louisiana State University Press, 1987), 186-188; for "brink of disaster" remark, see R.C. Williams, "Development of Medical Care Plans for Low Income Farm Families; Three Years Experience," *American Journal of Public Health* 30, no. 7 (1940): 725; for history of Southern health, see Margaret Humphreys, *Yellow Fever and the South* (New Brunswick: Rutgers University Press, 1992); and John Ettling, *The Germ of Laziness: Rockefeller Philanthropy and Public Health in the New South* (Cambridge, MA: Harvard, 1981).

unsanitary living conditions, and inadequate income to pay for even the most basic medical care.[40]

As the first two years of Roosevelt's initial response to the Depression waned, tenant farmers organized to become a powerful political force. Through the interracial Southern Tenant Farmers Union, poor farmers voiced their anger at how early New Deal agricultural policy had left them landless. Among this group's demands was the improvement of rural public health facilities. In response, Roosevelt's social policy designers as well as state governors not only created Title VI to fund public health improvement as part of the Social Security Act, but also focused agricultural policy to respond to the needs of this newly vocal agricultural constituency. In 1935, Congress folded the FERA into the Resettlement Administration, reflecting the administration's new focus on resettlement as a means of improving the welfare of evicted tenant farmers and other migrant rural laborers. [41]

Under the RA, New Dealers undertook bold social experiments to improve the circumstances of "dispossessed farm people," whom many considered the most extreme casualties of the Depression and drought. The RA initiated the enormous and controversial project of agricultural resettlement, attempting to move poor agricultural people off of infertile lands and into federally supervised camps. The RA also developed experimental planned communities with cooperatively owned credit unions, retail services, and farms. Backlash against these socialist-style endeavors was intense. Opponents accused the RA of forcing population migration, economic nationalization,

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[40] For social fallout of the Agricultural Adjustment Act, see Adam D. Sheingate, *The Rise of the Agricultural Welfare State: Institutions and Interest Group Power in the United States, France, and Japan* (Princeton, NJ: Princeton University Press, 2001), 113-115; and Donald H. Grubbs, *Cry from the Cotton: the Southern Tenant Farmers' Union and the New Deal* (Chapel Hill,: University of North Carolina Press, 1971), 7-26.
[41] For SFTU, see Grubbs, *Cry from the Cotton*, 123; Marc D. Naison, "The Southern Tenant Farmers Union and the CIO," in *We Are All Leaders: The Alternative Unionism of the Early 1930s*, ed. Staughton Lynd (Urbana: University of Illinois, 1995), 102-116; and Robert Rodgers Korstad, *Civil Rights Unionism: Tobacco Workers and the Struggle for Democracy in the Mid-Twentieth-Century South* (Chapel Hill: University of North Carolina Press, 2003), 148.

and excessive governmental oversight of day-to-day life and private industry. In reaction to the firestorm of anti-Communist attacks on the homesteads and other resettlement projects, in 1937 Roosevelt signed the Bankhead-Jones Farm Tenancy Act, replacing the RA with the Farm Security Administration. The FSA was tasked with creating relief measures for tenant farmers, but removed the concept of "resettlement" as the key method in resolving rural landlessness and poverty.[42]

The FSA's biggest program under Bankhead-Jones was the provision of what in modern parlance would be dubbed "microloans." These loans enabled former tenants and sharecroppers to purchase land and equipment and become small landowners who would be "self-supporting and self-reliant." In some respects, this federal loan program replaced farm owners with the federal government as the de facto landlord for thousands of farmers and sharecroppers. In spite of this assertion of state control, the federal government aimed to give these vulnerable agricultural citizens a modicum of stability and a stake in agricultural growth. Federally-provided loans were designed to help farmers become independent, to purchase grain and basic equipment, and to regain a foothold in the South's agricultural production system. By encouraging group purchase of large equipment and seed, the FSA retained some socialist-style endeavors while overall encouraging independent farm ownership. [43]

Shortly after the RA/FSA loan program began, the New Deal health care cooperatives also started. R.C. Williams, the PHS civil servant who led the FSA's health care arm, insisted that the cooperatives were a specific response to the health needs of borrowers. The official rationale for the health care cooperatives was pragmatic and

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[42] For "dispossessed farm people," see Frederick Mott, "Health Services for Migrant Farm Families," *American Journal of Public Health* 35, no. 4 (1945), 308; for Bankhead-Jones Tenancy Act, see J. I. Hayes, *South Carolina and the New Deal* (Columbia: University of South Carolina Press, 2001), 134.
[43] For farms' desire for self-sufficiency, see R.C. Williams, "The Medical Care Program for Farm Security Administration Borrowers," *Law and Contemporary Problems* 6, no. 4 (1939): 584; for critical historiography of the FSA, see Jane Adams and D. Gorton, "This Land Ain't My Land: The Eviction of Sharecroppers by the Farm Security Administration," *Agricultural History* 83, no. 3 (2009): 323-51.

fiscally based. As soon as the small loan efforts began to grow in the late 1930s, it became clear that the most significant obstacle to repayment was health care needs. The FSA's field agents, who maintained close contact with borrowers, realized that the federal loan project had a "serious gap." Farmers were defaulting on loans "as chickens, hogs, or calves were sold to pay for medical bills." A 1940 survey of FSA borrowers revealed that half of loan failures "were directly traced to 'bad health.'" The specific health problems that FSA fund recipients faced included "acute illness, abscessed teeth, hernias, malaria, and other conditions." A health care project for borrowers made sense, not only in response to the "wanton waste of human life and curtailment of borrowers' usefulness to themselves" but also from "a purely economic point of view."[44]

The medical cooperative programs, which began under the RA in 1935, grew in the late 1930s under the FSA and peaked in 1942, bringing federally subsidized health care to 625,000 people in forty-one states. The structure of these programs varied, but certain features were standard across states. All were essentially voluntary medical care cooperatives, where members paid in to obtain coverage. The health care economics underlying them were the same as the health insurance programs that had been developed in the course of the 1920s and 1930s under the auspices of labor unions, fraternal aid societies, and employers themselves. Like the private plans sold by Blue Cross and Metropolitan Insurance, the medical care cooperatives for rural borrowers similarly aimed to "pool the risks and costs of sickness and injury." FSA loan recipients paid dues to participate. These annual membership fees were usually two to three dollars per month, with additional premiums for each additional family member. These membership fees were often withdrawn directly from loan checks, much as employer-based health programs deducted premiums directly from employees' earnings and

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[44] R.C. Williams, "Development of Medical Care Plans for Low Income Farm Families," 727.

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labor-based programs would pull participation fees directly from laborers' union dues. The pooled funds were used to pay the doctors' bills for members and their families, including basic medical care, emergency hospitalizations, and usually some amount of dental and drug benefits. These programs became "the nation's most extensive experience in voluntary group prepayment for health services among rural people."[45]

The role of the federal government in supervising and subsidizing these health care cooperatives distinguished them from private voluntary programs. Because participants were federal borrowers, the funds that were paying the dues originated as federal loans. FSA bureaucrats assisted with administrative matters and set payment ceilings for particular services. Federal employees were at times appointed as the "bonded trustee" for the cooperative, overseeing the premium accounts and paying out funds to participating doctors at the end of each month. Most importantly, the FSA contributed substantially to the accounts of medical cooperatives, and this additional grant funding allowed these programs to cover far more medical care than the membership dues alone could have covered.[46]

The rural medical care cooperatives of the New Deal broke new ground in federal regulation of medical care. By establishing a system whereby publicly managed funds were used to compensate private medical practitioners, the cooperatives positioned federal bureaucrats to regulate an array of features of these programs,

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[45] For Blue Cross and Metropolitan Insurance plans' pooling of risk, see Jennifer Klein, "The Politics of Economic Security: Employee Benefits and the Privatization of New Deal Liberalism" *Journal of Policy History* 16, no. 1 (2004): 36; for details on FSA plans, see Thomas Clark, "The Limits of State Autonomy," 257-282. Pooled group plans were the most common and had the most longevity, but some states briefly developed "individual contract plans." In these states, individual families paid into medical expense accounts. If the family remained in good health, these funds would go unused, while in others, the family's medical expenses would exceed what remained in their individual account. In those situations, doctors would be asked to provide services without payment; for individual contract plans, see R.C. Williams, "Development of Medical Care Plans for Low Income Farm Families," 725-735; for summary of FSA health cooperatives as unprecedented national experience with voluntary group prepayment, see Mark Ziegler, E. Richard Weinerman, and Milton I. Roemer, "Rural Prepayment Medical Care Plans and Public Health Agencies," *American Journal of Public Health* 37, December 1947: 1578.
[46] Thomas Clark, "The Limits of State Autonomy," 257-282; and Michael Grey, *New Deal Medicine*, 48-77.

including fee schedules. Federal public health officers asserted standards of care, particularly in the domain of maternal and child health care. These features made the RA/FSA health care cooperatives "an unusually explicit government effort to monitor and modify medical practice" in the 1930s.[47]

In some states, the medical cooperatives used their funds to hire salaried physicians and nurses to render services to members. In other locales, funds were collected at the beginning of the term and were spent down monthly to pay the bills of private practitioners. Federal bureaucrats made decisions about what to do when funds ran dry, as was often the case: when the costs of submitted physicians' bills exceeded available funds, the cooperative's fund paid what it could on a prorated basis. Although some medical practitioners complained about the adjusted fee schedules and these prorated arrangements, many were glad that the federal programs ensured them some reimbursement for their services, even if it was less than they had previously garnered. The health plans meant that these doctors, whose incomes were diminished because local people lacked the funds to pay for their care, now had a partner, albeit a government one, that would pay them for their services. For the most part, local physicians in destitute rural communities and their representative medical societies willingly cooperated.[48]

The FSA health care cooperatives boldly insinuated the federal government into the arena of health insurance, which was still in its infancy. In this way, they were "making good" on the hope for federal involvement in national health care coverage that had been thwarted in the Social Security Act's omission of a comprehensive health plan. With the rural health care cooperatives, the federal government entered into the

[47] Grey, *New Deal Medicine*, 86.
[48] For various methods of paying doctors' bills and prorating, see R.C. Williams, "Development of Medical Care Plans for Low Income Farm Families, 725-735; for local physicians' support, see Grey, *New Deal Medicine,* 65-66.

actuarially unpredictable market of health insurance. Other types of individual insurance, in particular fire and property insurance, had become widely known and available. With the help of local boards and actuarial bureaus, insurance providers in these markets had developed reliable actuarial information that assessed risk and determined premiums. By comparison, health insurance was a new and particularly complicated product. In the 1930s, the health industry's dominant experts—medical doctors—were loathe to accept voluntary insurance as payment, let alone to welcome the insurance industry's imposition of standards of care, that would do for medicine what fire insurance standard setting had done to limit liability and decrease individual risk.[49]

During the 1930s, the availability and complexity of medical procedures and technologies grew, and the advent of antibiotics revolutionized the medical and pharmaceutical economy. As medical specialties grew and technologies such as the x-ray and vaccination became increasingly available, health care costs rose rapidly. Led by people who had wrestled with these challenges during the debates over including a national health insurance plan in the Social Security Act, the FSA's health care initiatives showed that the federal government continued to be interested in grappling with these new complexities in health insurance, rather than in passively handing the issue of health care insurance to private insurance companies and their partners in industry and labor unions.

The rationale for the New Deal health cooperatives had a communitarian undercurrent. As R.C. Williams explained, while life, fire, and theft insurance were "old

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[49] For gathering of actuarial information in fire and property insurance, see Edward Balleisen, "Rights of Way, Red Flags, and Safety Valves: Business Self-Regulation and State-Building in the US, 1850-1940," unpublished manuscript in author's possession, 8; and Marc Schneiberg, "Combining New Institutionalisms: Explaining Institutional Change in American Property Insurance," *Sociological Forum* 20 (2005): 93-137.

stories to the American public, the banding together of a group of people for mutual protection against the incidence of illness was new to the public and viewed with misgivings." Williams and his colleagues in the FSA insisted that health care needed to be provided as part of a social obligation to protect low-income Americans from the potential risks of illnesses. The leaders of the FSA health care cooperatives insisted that these programs were limited in both their reach and their mission. The bureaucrats at the FSA were not angling to develop a de facto health social security system for all. Rather, they explained, FSA health programs "grew out of economic necessity" and were "an incidental by-product of a Depression-born program of farm loans which were made exclusively to families unable to obtain credit from any non-governmental source." According to this official position, these health cooperatives were driven not by political ideology but by a pragmatic logic: "When families had no money to pay for physicians' services, avoidable deaths occurred and the Government lost the money it had invested." In this formulation, the New Deal impulse for experimentation grew out of the practical goals of increasing efficiency, reducing risk, and enhancing Southerners' communal wellbeing.[50]

While the mid-level civil servants running the health cooperative program readily declared this communitarian ideology, the nation's highest level public health bureaucrat, Surgeon General Thomas Parran, believed something else was going on. Pointing to the potentially revolutionary significance of publicly administered health services, Parran wondered:

> having accepted free and, in about a third of the states, moderately adequate medical care—in many instances more freely available than in their whole previous experience, and of better quality than provided by the quacks and

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[50] For "old story" of life, fire, and theft insurance, and newness of group health insurance, see R.C. Williams, "Development of Medical Care Plans for Low Income Farm Families," 728; for pragmatic, economic rationale for health cooperatives, see R.C. Williams, "The Medical Care Program for Farm Security Administration Borrowers," 584.

> shysters so often patronized by those in the lower classes—will [recipients], having experienced such care, continue to insist upon it?

At a national conference in 1938 on how to resolve the health crisis in America, Parran predicted that public opinion about a right to health care was indeed changing. He believed that, even more openly and quickly than public health experts or New Deal lawmakers, Americans were "beginning to take it for granted that an equal opportunity for health is a basic American right." In Parran's view, FERA efforts to pay medical bills, Title VI public health projects, and federally subsidized FSA health cooperatives constituted efforts to enact this rights-based political ideology for health justice.[51]

The FSA's health care projects in migrant worker camps went even further than any of these other programs in suggesting that all Americans had a right to health services. Transient agricultural laborers and displaced low-income farmers and sharecroppers, who in 1935 numbered approximately seven hundred thousand, were perhaps the hardest hit by the economic Depression. They suffered from long-term health conditions as well as malnutrition, "exposure," and specific medical conditions that arose from their living conditions during migration. Beginning in 1938, the FSA declared that this group of Americans would best be served through permanent, federally funded labor camps. Washington took responsibility for serving this population in large part because their movement across state borders provoked questions about which state was responsible for serving their welfare needs. Considering the reticence of state governments to take responsibility, the FSA was able

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[51] For future insistence on medical care, see Thomas Parran, Jr., "Health Services of Tomorrow," *Public Health Reports* 49, no. 15 (Apr. 13, 1934): 483; for Parran's remark about heath as a basic American right, see Reginald M. Atwater, "National Health Conference: A Review," *American Journal of Public Health and the Nations Health* 28, no. 9 (1938): 1112.

to step in, without much controversy, to test experimental social policy programs as part of its effort to reduce the number of the poor migrant laborers.[52]

Besides creating permanent camps where migrants received shelter, food, and welfare relief, the FSA created the Agricultural Workers Health and Medical Association (AWHMA). This government-organized and subsidized nonprofit corporation provided medical care to agricultural wage laborers. It was similar to the FSA's state-based medical care cooperatives for small farm loan recipients, but with one key distinction: migrant workers in federal camps paid no membership dues. This FSA program constituted the first single-payer, fully federally funded health insurance program available to an able-bodied population. The AWHMA rendered services by paying local doctors, nurses, and hospitals directly, as well as by establishing on-site health centers for camp residents and comprehensive mobile health clinics moving among camps. The funds also supported the work of USPHS physicians, dentists and public health nurses who ran child hygiene and nutrition education programs, and engineers who undertook sanitation improvement projects within the federal camps. The AWHMA efforts, both in paying medical expenses and in bolstering public health projects, demonstrated how eager New Deal civil servants were to bring health justice to the agricultural South.[53]

The FSA also established health services in what would prove to be their most experimental and controversial projects: greenbelt towns and rural homesteads. These programs were planned communities, with cooperative ownership of basic services, such as credit sources, retail services, public land, and farming equipment. In addition, homestead community funds paid the salaries of full-time physicians and nurses who

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[52] R.G. Leland, "Medical Care for Migratory Workers," *Journal of the American Medical Association* 114, no. 1 (Jan. 6, 1940): 45-48.
[53] US Department of Agriculture Committee on Post-War Programs, "Better Health for Rural America; Plans of Action for Rural Communities" (Washington, DC: US Government Printing Office, 1945), 12-13; Grey, *New Deal Medicine*, 80-85; R.G. Leland, "Medical Care for Migratory Workers," 48-50; and Frederick Mott, "Health Services for Migrant Farm Families," 309-310.

staffed health centers. By 1940, over fifty resettlement communities had either on-site

medical services or an extensive system of cooperation with local doctors, paid for by

the community's government-funded health plan. As with other New Deal endeavors,

private philanthropies supplemented federal funds and recipient dues to create more

funds to bring health professionals to serve needy agricultural communities.[54]

The New Deal's political ideology of health justice—the notion that the federal

government was essentially responsible for the health of Americans—comes sharply

into focus in the images of failing physical health, especially that of women and

children, taken by the photographers of the Works Progress Administration. While the

FSA created resettlement camps, homesteads, and the system of small farming loans, it

simultaneously launched what would perhaps become its most famous and enduring

program: the photodocumentary project of the Works Progress Administration. The

WPA aimed to put not only unskilled laborers but also artists, writers, and skilled

craftspeople back to work through government-funded projects. The WPA's

photodocumentarians were tasked with creating a body of evidence on the crisis of

American welfare, as well as a propagandistic record of the success of New Deal

programs in amelioriating these humanitarian needs. The FSA's photographers'

representation of physical health and health care services for the rural poor was a visual,

visceral indictment of America's ability to ensure the welfare of its people.

The FSA's photographers took pictures and recorded details of their subjects'

circumstances to create a comprehensive depiction of the poor physical health of the

victims of the Great Depression, their lack of healthcare access, and, when health care

was obtained, their exposure to grossly inadequate and even unsanitary services. WPA

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[54] Grey, *New Deal Medicine*, 63-65; and Carol Squiers, *The Body at Risk : Photography of Disorder, Illness, and Healing* (New York: International Center of Photography, 2005), 48-50.

photographers focused particularly on the vulnerability and innocence of sick children, the youngest victims of poverty, migration, malnourishment, and ill health. Importantly, New Deal photographers' focus on physical health substantially predated the FSA's loan programs.[55]

Though relatively little-known and apparently never published, images of illness abound in the FSA archive. A 1937 series of photographs by Walker Evans depicts the haggard faces and languid bodies of "sick flood victims" on the beds of an ill-equipped Red Cross infirmary in Arkansas. Dorothea Lange noted the health conditions of her migrant labor subjects in images from 1936. A young woman and her newborn are identified as "Wife and sick child of a tubercular itinerant, stranded in New Mexico." The title of another Lange photograph from 1936 highlighted the causal role of poor health in its subjects' overall fate. The image, of two young blonde children and a parent looking away from the camera, portrays

> [p]art of an impoverished family of nine on a New Mexico highway. Depression refugees from Iowa. Left Iowa in 1932 because of father's ill health. Father an auto mechanic laborer, painter by trade, tubercular. Family has been on relief in Arizona but refused entry on relief roles in Iowa to which state they wish to return. Nine children including a sick four-month-old baby. No money at all. About to sell their belongings and trailer for money to buy food. 'We don't want to go where we'll be a nuisance to anybody.'

The title of a 1938 photograph by Marion Post Wolcott explains that the subject, the mother of seven and wife of a coal miner, was "usually sick with a bad bronchial condition." Comments such as these, highlighting the poor health, inadequate health care facilities, and connections among illness, malnutrition, dangerous work and poverty, pervade the body of FSA photographs.[56]

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[55] See, for example, Russell Lee, US Farm Security Administration/Office of War Information, "Sick, Undernourished Baby of Sherman Ritchie...," May1937 (Near Iron River, MI), accessed February 17, 2014, http://www.loc.gov/pictures/collection/fsa/item/fsa1998022666/PP/.
[56] All digital photographs accessed February 16, 2014. Walker Evans, US FSA/OWI, Three photographs titled "Sick Flood Refugee...," February 1937 (Forrest River, AK),

At the same time as they recorded the humanitarian health needs of rural

Depression victims, WPA photographers publicized the model programs that the New

Deal was bringing into agricultural areas. One image depicts community members

building modern privies under the supervision of public health workers. Others show

people encountering modern medical care, perhaps for the first time: public health

nurses weighing infants and kindly doctors conducting physical exams on docile

children. These photographs served as a foil to the pictures of malnourishment, illness,

and underdevelopment. They were intended to show how successful New Deal social

policy innovations could be in improving individual health.[57]

As these images demonstrated, the problems of physical health and the health

policy innovations of the New Deal were central features of the Roosevelt

administration's anti-poverty efforts. Rather than being *ad hoc* services, the health care

cooperatives, migrant health clinics, and newly subsidized programs of public health

service workers fit into a larger New Deal effort toward health justice. By the second half

of the 1930s, New Deal civil servants in the PHS and FSA were hearkening not only to

communitarian ideas, but also to rights-based principles in their insistence that the

federal government needed to help improve the health and wellbeing of the sickest

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http://www.loc.gov/pictures/item/fsa1998020992/PP/;
http://www.loc.gov/pictures/collection/fsa/item/fsa1998020993/PP/; and
http://www.loc.gov/pictures/item/fsa1998020994/PP/; Dorothea Lange, US FSA/OWI, "Wife and sick child..." (NM), August 1936, http://www.loc.gov/pictures/collection/fsa/item/fsa1998021798/PP/;
Lange, US FSA/OWI, "Part of an impoverished family...," (NM), August 1936,
http://www.loc.gov/pictures/collection/fsa/item/fsa1998021800/PP/; Marion Post Wolcott, "Coal miner, six of his seven children..." (Chaplin, WV), September 1938,
http://www.loc.gov/pictures/item/fsa2000030767/PP/. Additional examples of photographs of ill Depression victims include: Russell Lee, "Mexican father and child..." (San Antonio, TX), March 1939,
http://www.loc.gov/pictures/collection/fsa/item/fsa2000013685/PP/; and John Vachon, "Sick child," (Aliquippa, PA), January 1941, http://www.loc.gov/pictures/collection/fsa/item/fsa2000042828/PP/.
[57] Marjory Collins, "Mothers waiting...," (Greenbelt, MD), 1942; Marion Post Wolcott, "Nurse Shamburg weighing..." (Gee's Bend, AL), 1939; Dorothea Lange, "FSA Camp..." (Tulare County, CA), 1939; John Vachon, Inoculation for typhoid..." (Irwinville Farms, GA), 1938; John Collier, three photograph titled "FSA agricultural workers camp...," (Bridgeton, NJ), 1942; and Russell Lee, "Unloading a privy house..." (Southeast MO), 1938, all reproduced in Squiers, *The Body at Risk*, 51-64.

victims of the Depression. This array of federal health projects showed that even though the Social Security Act failed to create national health insurance, many New Dealers insisted that improving American health was a key feature of their humanitarian agenda. The WPA photographs bolstered the FSA's efforts to react to the health needs of Americans, but they would hardly render these federal bureaucrats impervious to the criticisms launched by both stridently conservative and more moderate voices who believed that the federal government had no business in the provision of health care.

Chapter 7: Title V and the Emergency Maternity and Infant Care Program

In the aftermath of the Social Security Act's failure to include health care, the Farm Security Administration (FSA) created new ways for federal bureaucrats in the Department of Agriculture and the Social Security Administration to respond to health needs. At the same time, the Children's Bureau also rushed to respond to the health needs of American families. Their respective interventions helped create the framework for what would become America's first experiment with federally-sponsored, nationwide health care.

The Children's Bureau's health care activities grew out of the New Deal's expansion of federal government, although the leaders of the Children's Bureau saw their 1930s and 1940s health initiatives as a continuation of the work that had been started in the mid-1920s under the Sheppard-Towner Act. The Children's Bureau's "dominion" in the area of social policy had contracted over the course of the late 1920s under President Herbert Hoover's presidency and during the first years of the Depression. In 1933, President Franklin Roosevelt's New Deal leveraged the women of the settlement-house movement into a new position of institutional authority. Thanks in large part to First Lady Eleanor Roosevelt and her close relationship with the president's Secretary of Labor, Frances Perkins, these women became crucial players in the federal government's relief operations. [1]

With Perkins at the helm of the New Deal's social policy planning, the Children's

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[1] Robyn Muncy argues that although the years of Sheppard-Towner represented the high-water mark of the "female dominion" in social reform, she appreciates that despite the 1920s decline of the female dominion, child welfare institutions nevertheless "remained intact" and reemerged during New Deal. See Robyn Muncy, *Creating a Female Dominion in American Reform, 1890-1935* (New York: Oxford University Press, 1991),125.

Bureau once again assumed the role of Washington's moral conscience, consistently framing women's and children's health as among the most pressing humanitarian issues. The Depression had left over seven million children under sixteen—"one sixth of the total child population"—reliant on emergency relief. Hinting at a political ideology oriented toward redistributive justice, the newly appointed Bureau director Katharine Lenroot explained, "The children of 1935 have a right to expect a Nation in which progress is being made toward widely diffused prosperity." As a matter of policy, the administration of the Social Security Act worked toward this goal. The key provisions of New Deal social policy legislation brought to fruition some of the most dearly held items of the social welfare movement's agenda: the protection of the industrial workforce against the financial risks of unemployment, injury, and old age, and the long-term funding of the Aid to Families with Dependent Children system of welfare.[2]

While the system of unemployment relief, old age compensation, and welfare for poor families embodied key policy goals of the settlement-house movement, the Children's Bureau did not administer these programs, and they did nothing to enhance the Bureau's power or status. Moreover, the absence of health care as a feature of the Social Security Act left a gaping hole in the social safety net that the women of the Children's Bureau hoped to fill, at least partially. Having gained a seat at the table on social welfare issues, these women insisted that they still had a role to play. Thanks to their accomplishments under the Sheppard-Towner Act and their concerns about the absence of a national health program in the final version of the Social Security Act, the Bureau's New Deal role would be played on the stage of health services for women and children.

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[2] For Lenroot's remark, see Katharine Lenroot, "What Children Have a Right to Expect of Us in 1935," National Conference on Needs of Children, New York, January 4, 1935, Box 1, Folder 9, Lenroot Papers; for history of Aid to Families with Dependent Children, see Linda Gordon, *Pitied but Not Entitled: Single Mothers and the History of Welfare, 1890-1935* (Cambridge, MA: Harvard University Press, 1995), 4-6.

The Bureau's endeavors to direct, regulate, and administer health services for women and children between 1935 and 1947 occurred in two distinct but overlapping phases. The first phase began in 1935 and arose out of the funding and authority of the Social Security Act's Title V. The second phase of the Bureau's maternal and child welfare work was a civilian preparedness measure created to protect military servicemen from unexpected financial burdens. When America entered the war in 1941, the Bureau had already created the groundwork for the Emergency Maternity and Infant Care Program (EMIC). This program would become the nation's most expansive single-payer health insurance program to date, bringing government-paid prenatal and infant health care to the pregnant wives and infant children of low-paid military servicemen.

Taken together, the Bureau's Title V work and EMIC demonstrated these social reformers' hope to push toward their aim of health justice for American women and children, and their belief that the Great Depression and war had opened the window for a renewed undertaking. For those who insisted that health care remain firmly within the domain of private medical practice and private insurance schemes, these programs would represent the Bureau's most aggressive and threatening efforts to date, leading to the strident opposition that ultimately eviscerated the Bureau's political power for the remainder of the twentieth century.

When Roosevelt began to forge his sweeping legislative response to the humanitarian needs wrought by the Great Depression, the leaders of the Children's Bureau regarded the moment as their opportunity to regain and even surpass the authority and funding that had waned since the lapsing of the Sheppard-Towner programs in the late 1920s. When Roosevelt asked the Committee on Economic Security (CES) to make sure that the Social Security Act would take into account the welfare

needs of American women and children, the CES's leaders—Secretary of Labor Frances

Perkins and Executive Director Edwin Witte—turned to the women of the Children's

Bureau. Led by the Bureau's new director, Katharine Lenroot, a small circle of women

who had come of age during the settlement-house movement wrote the Social Security

Act's provisions concerning women and children. Together, Grace Abbott, Lenroot, and

Martha May Eliot drafted these measures and helped push them through Congress.

These three women knew that the stakes were high: with the passage of the Social

Security Act, Congress would vest potentially unprecedented authority in the Bureau,

thereby allowing it to regain its foothold in federal social policy provision.

The professional lives of Abbott, Lenroot, and Eliot embodied how the

settlement-house movement and its array of concerns about social welfare had taken up

residence at the Children's Bureau. The elder statesperson of the group, Grace Abbott,

was a veteran of the first generation of settlement-house women. Born in 1878 into a

family of Nebraska Quakers, Abbott, with her sister Edith, moved as a young woman to

Hull-House, where she lived with Jane Addams while studying social work and

conducting research on immigration and child labor. She moved in 1917 to Washington,

DC and became the Children's Bureau's second chief in 1921. She led an unsuccessful

push to create a constitutional amendment prohibiting child labor and guided the

Bureau effectively during its period of ascendancy through the maternal and child

health work funded by the Sheppard-Towner Act.[3]

When Grace Abbott retired in 1934, Washington insider Katharine Lenroot was

chosen as her successor. Born in 1891, Lenroot came of age in a powerful political family

in Wisconsin. Entering a world where women had new professional opportunities,

Lenroot accompanied her father to Washington during his career in Congress and

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[3] For biography of Grace and Edith Abbott, see Lela B. Costin, *Two Sisters for Social Justice: A Biography of Grace and Edith Abbott* (Urbana: University of Illinois Press, 1983).

became fully bilingual in Spanish. After attending college at the University of Wisconsin, she became a leading figure in labor regulation bureaucracy. During Abbott's tenure, Lenroot was appointed as the Bureau's assistant chief, where her expertise grew to encompass juvenile courts and the social problems faced by unwed mothers and their children. She also used her bilingual abilities to present American social policy approaches to Latin American policy leaders. Lenroot was appointed because she was seen as someone with national and international connections, who, in the context of Roosevelt's larger vision for social welfare reform, could carry the program to new heights.[4]

Perkins's appointment of Lenroot to lead the Bureau in 1934 was also a decision to pass over Martha May Eliot, a pediatrician and Lenroot's contemporary, whom many saw as a candidate for director. Whereas Lenroot's career touched many of the diverse interests of the settlement-house movement, Eliot's expertise was specifically in children's physical health. Like Lenroot, Eliot came of age shortly after the women of the settlement-house movement had carved out new professional niches and demonstrated that college-educated women had an array of options. Like her role models, Eliot grew up in a middle-class family that was attuned politically and religiously to the social gospel and its message demanding humanitarian responses to the needs of the poor and the working class. Raised in Boston's West End, Eliot assisted her father in running an orphan placement organization, where she first learned of "broken families and homeless babies." Educated in the "fashionable" Back Bay area, she also became exposed to the privilege of members of Boston's elite, and "found out that I wasn't especially interested in it for myself." Like other middle-class women of her generation,

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[4] For Lenroot's qualifications, see Grace Abbott to Grover Powers, 24 November 1934, Folder 152, Eliot Papers; for Lenroot's expertise in Latin American maternal and child health issues, see Pan American Child Congress Reports and Bulletins, 1924, 1926-27, Box 20, Folders 11 and 12, Lenroot Papers.

Eliot used her college degree to pursue an independent professional life. She attended medical school at Johns Hopkins and specialized in pediatrics through a residency at Yale. Whereas Lenroot had connections to political power, Eliot was personally linked to the local religious elite, as her brother Frederick May Eliot became the head of the Unitarian church, a powerful presence in Boston.[5]

Martha May Eliot's career as a physician exemplified the "social medicine" professional ideal, which was emerging at Johns Hopkins during her matriculation as a medical student. Originating in 1850s Germany as a way to link politics and medicine, the social medicine doctrine evolved in the course of the early twentieth century in American academic medical centers as a belief that doctors' highest duty was to respond to community-wide health needs rather than to pursue technological expertise, scientific specialization, or a wealth-building private practice.

Eliot fit squarely within this new professional ideal. In Boston, she served in free baby clinics. While pursuing her pediatric specialty at Yale, she conducted a community-wide study of rickets. Her research blended the subspecialty of children's medicine with public health, as she proved that simple interventions like dietary supplementation with cod liver oil and exposure to sunlight had epidemiologically significant effects in controlling this common childhood ailment. Explaining her decision not to pursue a career in private practice, she stated, "I never felt comfortable . . . asking for my fees." While working at the Yale Medical School Department of Pediatrics in the 1920s, Eliot began to divide her time between academic medical research and a career as a federal administrator, becoming the director of the Bureau's Division of Child and Maternal

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[5] For Eliot's childhood and early career, see Dorothy Barclay, "Godmother to the Nation's Youngsters," *New York Times*, Apr 6, 1952, pg. SM17; Martha May Eliot, interview by Jeannette Bailey Cheek, Cambridge, MA, November 1973-May 1974, Schlesinger-Radcliffe Oral History Project, tapes and transcript, 14-40; for Eliot's brother's Unitarian church leadership, see Cynthia Grant Tucker, *No Silent Witness: The Eliot Parsonage Women and Their Unitarian World* (Oxford, UK: Oxford University Press, 2010).

Health.[6]

When Abbott retired in 1934, colleagues in public health floated Eliot's name as Abbott's successor. Her pediatrician colleagues insisted that her background as a doctor made her especially appropriate for the role, considering that the Children's Bureau had become a key player in the provision of maternal and child healthcare during the Sheppard-Towner years. Although passed over for the position, Eliot's stature grew at the Bureau during the years of the New Deal and World War II. Appreciating Eliot's seniority and her particular expertise, Lenroot created a new position—Assistant Director—for Eliot, where she would direct the Bureau's health-related activities.[7]

In 1935, Abbott, Lenroot, and Eliot, along with Labor Secretary Frances Perkins, were the doyennes of the child welfare movement. When Perkins gave her friends free rein to design the maternal and child health features of Roosevelt's social policy legislation, they seized the moment to expand the Bureau's authority and funding for maternal and child health work. The section of the act that they authored—Title V— included two key provisions to be administered through the Children's Bureau: a grants-in-aid program to finance maternal and child health projects like those built during the Sheppard-Towner years; and a program to support medical treatment for "crippled children." In different ways, these two programs allowed these inheritors of the settlement-house movement to reassert their agenda for health justice for women

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[6] For social medicine's doctrine and origins, see Victor W. Sidel, "What Is Social Medicine?," *Monthly Review* 56, no. 8 (2005), accessed February 18, 2014, http://monthlyreview.org/2005/01/01/what-is-social-medicine; and Erwin Heinz Ackerknecht, *Rudolf Virchow: Doctor, Statesman, Anthropologist* (Madison: University of Wisconsin Press, 1953), 165; for rickets study, see Martha May Eliot, "The Control of Rickets -- Preliminary Discussion of the Demonstration in New Haven," *Journal of the American Medical Association* 85 (1925): 656-63; and Eliot et al., "The Value of Salmon Oil in the Treatment of Infantile Rickets," *Journal of the American Medical Association* 99 (1932): 1075-82; for Eliot's decision not to pursue private practice, see Barclay, "Godmother to the Nation's Youngsters."

[7] For support of Eliot's candidacy, see Chairman to Secretary of Labor, 16 June 1934; Perkins to Powers, 21 June, 1934; "t" to Powers, 14 August 1934; Powers to Dewson, 25 July 1934; and Grace Abbott to Powers, 1 October 1934, all letters in Folder 152, Eliot Papers; for Eliot's job as assistant director, see Press Release, Department of Labor, 4 December 1934, Folder 154, Eliot Papers.

and children.[8]

The women of the Children's Bureau aimed high in their proposals for Title V, with an eye toward expanding the Bureau's coffers and its degree of authority in the domain of health service provision. Abbott recommended that the Bureau propose at least to "double the amount that we had in those days [the years of the Sheppard-Towner law] and give the states larger amounts of money and see whether we can't get further than we did." Eliot suggested that their proposal should not be restricted to maternity and infant care projects; rather, she proposed that Title V health programs be available not only to mothers and infants, but to all children up to the age of eighteen or even twenty-one.[9]

Eliot, Lenroot and Abbott also took the opportunity to design what would turn out, ironically, to be one of the least controversial but also the most ambitious regulatory programs of the entire Social Security legislation. Section Two of Title V authorized the Bureau to oversee medical care for all "crippled children" in the United States. The program grew out of Abbott's suggestion that she and her colleagues determine "which groups in the entire population would be accepted as a group [that] should have their medical care aided through federal funds" and to propose such a program as part of the Social Security Act. The decision to include medical care for children with disabilities specifically was a conscious political maneuver, as "it was obvious to all of us that the opposition to giving care to crippled children would be less than the opposition had been to maternity care" under the Sheppard-Towner programs.[10]

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[8] For summary of Title V programs, see Suzanne Mettler, *Dividing Citizens: Gender and Federalism in New Deal Public Policy*. Ithaca, N.Y.: Cornell University Press, 1998), 129; Kriste Lindenmeyer, *"A Right to Childhood": The U.S. Children's Bureau and Child Welfare, 1912-46* (Urbana: University of Illinois Press, 1997), 193-4.
[9] Martha May Eliot, interview by Peter A Corning, 21 June 1966, New York, Columbia Oral History Project, transcripts and tapes, 46-48.
[10] Ibid.

In spite of its small appropriation of under three million dollars, the Bureau's crippled children's program symbolically enhanced the Bureau's power in the domain of health policy. Even the Public Health Service was not tasked with a direct payment medical care program, much to the consternation of Surgeon General Thomas Parran. Parran believed that the Social Security Act's expansion of the Bureau's role in health care policy was a mistake, voicing an objection that echoed the PHS's objection to the Bureau's Sheppard-Towner programs a decade earlier.

During the debates over the Social Security Act, it became clear that the Bureau and the PHS would continue to vie for authority and status under the New Deal. Both bureaucracies feared a major government overhaul and wondered which agency's authority would be attenuated. Parran firmly believed that the Bureau belonged under the authority of the PHS. Early in her time as Bureau director, Lenroot wondered whether she and Parran would be in an "open fight" or instead would work the issue of bureaucratic authority out "behind the scenes." In spite of this competition, Parran and Eliot "found a way of working together during the Depression days." They addressed each other as "Tom" and "Martha" in letters. And when the Bureau obtained authority over the Title V funds, Parran grudgingly accepted the Bureau's continued role. He explained, "Now you know, Martha, I just don't agree with the Congress on what they have done but after all, it's the law of the land and the Children's Bureau has the responsibility for administering this program, and I do not intend to get in your way at all."[11]

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[11] For "open fight" or "behind the scenes" struggle between Bureau and PHS, see Lenroot to Eliot, 14 December 1936, Box 17, Folder 10, Lenroot Papers; for evidence that Eliot and Parran were on a first name basis, see "Tom" to Eliot, 21 November 1946, Folder 472, Eliot Papers; for Parran and Eliot's working relationship, and Parran's remarks about the Bureau's authority over Title V, see Eliot, interview by Corning, 52.

While the Bureau benefited from the Social Security Act's maternal and child health provisions, its leaders nonetheless were critical of other features of this legislation. In essence, they felt it did not go far enough. It provided too limited benefits, neglected the neediest, and "failed to redistribute income." This remark indicated how deep were their commitments to more egalitarian politics and a vision of redistributive justice for social welfare benefits. The law left many working people—many of them women and agricultural laborers—outside the system of contributory social benefits. And the social security system relied not on general tax-revenue financing, but rather on a system of matched, employee and employer contributions. In the words of Eliot's deputy, Harry Becker, Eliot and he "wanted to move toward a tax-supported health care program from general revenue." They opposed the "payroll tax approach" to social policy financing. This opposition was in keeping with the generally progressive and even radical political viewpoints that emerged from the settlement-house movement.[12]

The Bureau's concerns about this employment-based structure for the social safety net reflected the gap between these female veterans of the settlement-house movement and the men who led the Social Security Administration. The basic conflict was between the Bureau and the "insurance boys." The "insurance boys"—the male designers of the social security system, led by Arthur Altmeyer, Isidore Falk, and Edgar Sydenstricker—saw social security as a way to increase individuals' purchasing power through a government-supervised contributory insurance system. For them, increasing overall wealth and protecting people against poverty during unemployment and old age made fiscal sense and fit within an ethos of communitarian social betterment. By contrast, the female child welfare advocates at the Bureau maintained that federal social

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[12] For the Bureau leadership's concerns about the Social Security Act's limitations, see Muncy, *Creating a Female Dominion in American Social Reform*, 153; for Becker and Eliot's objections, see Harry Becker, interview by Peter A. Corning, New York, 6 December 1966, Columbia Oral History Project, transcript and tapes, 4.

policy needed to create a system of justly distributed, government regulated benefits available to all Americans and separate from wage earning. They also aimed to make revenue-supported, grants-in-aid activities the norm, rather than the exception for the structure of the welfare state. Their unrealized vision for social security pointed toward a more radical, rights-based notion that the federal government should take responsibility for the basic needs of all citizens, regardless of one's wage earning status.[13]

Title V exemplified the Bureau's approach to social welfare activity. Funded through general revenue, Title V maternal and child health funds were disbursed as grants-in-aid to states. Under Title V, Congress funneled 3.8 million dollars to the Bureau to provide states with grants for maternal and child health programs. Although less than half as big as the PHS's New Deal-enhanced budget, Title V greatly surpassed the Bureau's prior funding under the Sheppard-Towner Act. With more than half of these block grants contingent on states providing dollar-for-dollar matching monies, the total amount of government money being spent on maternal and child health service activities reached a new peak. Title V surpassed the Sheppard-Towner Act's activities not just fiscally but substantively, as children up to age eighteen could obtain services from facilities with Title V funding. Title V also explicitly funneled money to the families with the least access to health care in rural areas and in areas of economic distress.[14]

While Title V's maternal and child health programs were the largest beneficiaries in terms of funding, the crippled children program was the most expansive regulatory feature not just of Title V but of the Social Security Act as a whole. Under Part Two of Title V, the Children's Bureau distributed 2.85 million dollars to states to pay for the medical needs of physically disabled children. This policy surpassed every prior federal-

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[13] For "insurance boys" and their approach to social security versus child welfare advocates' vision, see Harry Becker, interview by Corning, 19.
[14] Martha M. Eliot and Jessie M. Bierman, "Accomplishments in Maternal and Child Health and Crippled Children Services under the Social Security Act," *Journal of Pediatrics* 13, no. 5 (1938): 678-691.

state program in health services, as it specifically authorized the provision of medical care for a special group. Through these funds, the Bureau paid the bills for surgical, medical and in-hospital services for these children.

Eliot believed that the crippled children's program foretold a gradual revolution in health justice. She predicted that in ten years, health care for children with any "special problems and handicaps growing out of conditions in the home or problems of personality and handicaps" would be "generally recognized as a public responsibility." The transfer of health care needs of disabled children from a private matter to a public responsibility represented a pivotal starting point, at least symbolically. Eliot hoped that ever larger portions of the population would find their health care needs met through public resources, and that the federal government would take on an ever-increasing responsibility for individual Americans' health care needs.[15]

Taken as a whole, Title V allowed the Bureau to further its longstanding goals of increased general access to medical services, expanded opportunities for professionals in maternal and child welfare work, and enhanced government authority over women's and children's health care. Through this funding, the Bureau put in place a system of organized cooperation with local physicians to extend state and local health facilities. The funds created new services through "local health units" where services were not yet available. Social Security funds helped the Bureau oversee the creation of new well-baby conferences and prenatal clinics and pay for the services of in-home nurses, infant care educators, public health nurses, dentists, and nutritionists. Each of these programs furthered the Children's Bureau's mission—and indeed the settlement-house

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[15] Martha May Eliot, "Statement on Title V of the Social Security Act," 12, 8 May 1946, Folder 329, Eliot Papers.

movement's agenda—on maternal and child health.[16]

For the women who supervised these programs, Title V's *raison d'etre* originated in the connection between poverty, racial inequality, and maternal and child health outcomes. Over the course of the 1930s and early 1940s, the Children's Bureau undertook and disseminated exhaustive statistical research to prove the powerful link between poverty, race, and maternal and child health. Like the research undertaken by sociologists dwelling in urban settlement houses in the first decades of the twentieth century, these studies aimed to bolster a specific social welfare agenda. In laying out the background for Title V of the Social Security Act, Eliot emphasized the role of social and racial inequality as a determining factor for maternal and infant health outcomes. According to Eliot's logic, the crippled children's program intended to shift the burden of caring for very sick and handicapped children from the shoulders of beleaguered, poor, and disproportionately black families to the public tax base. For Eliot and her colleagues, policies like Title V were driven by the goal of health justice for all American children. Poor, black families simply did not deserve what they were experiencing, and federal support of disabled children's health care needs would not only lighten this burden but improve their health outcomes.[17]

The women of the Children's Bureau believed that Title V, along with Title VI, had paradoxically benefited from the raucous debates over the inclusion of a national health system within the Social Security Act. As Lenroot explained:

> There was no opposition to the maternal and child health, crippled

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[16] Eliot and Bierman, "Accomplishments in Maternal and Child Health and Crippled Children Services under the Social Security Act," 679-681.

[17] For examples of the Bureau's statistical research studies, see "Maternal Deaths: A Brief Report of a Study Made in 15 States," 1933, 3, accessed February 12, 2014, http://www.mchlibrary.info/history/chbu/20612.PDFhttp://www.mchlibrary.info/history/childrensbureau.html#10; and "Births, Infant Mortality, Maternal Mortality: Graphic Presentation 1940-1942,1943-1945," accessed February 18, 2014, http://www.mchlibrary.info/history/childrensbureau.html; for impact of socioeconomic and racial inequality on health outcomes, see Eliot, "Statement on Title V of the Social Security Act," Eliot Papers.

children and public health titles of the Social Security Act. Probably if
there hadn't been this health insurance controversy, if all that had been
proposed was the public health provisions and the children's provisions,
they [the American Medical Association] would have risen up in arms
and said "Well, this is a toe in the door," you know.

The Children's Bureau's leadership indeed saw Title V as a "toe in the door" to a large

scale social welfare system, with just distribution and standardized provision for women

and children's medical care at its core.[18]

Seven years after the Social Security Act became law, as the nation was gearing

up to enter the war, the Children's Bureau saw a new opportunity to bring its radical

politics of health justice to bear on federal health policy. In 1942 the exigencies of civilian

war preparedness and the politics of patriotism enabled the Bureau to design and

administer the Emergency Maternity and Infant Care (EMIC) Program, which

guaranteed federally-regulated and financed health care coverage to pregnant wives and

infants of low-paid military servicemen. Although limited in its patient population,

EMIC would become the largest single-payer health insurance program the nation had

yet seen, and the most ambitious attempt to provide federal health insurance and

regulation of medical care for an able-bodied segment of the American populace. EMIC

represented the apex of post-New Deal attempts to thoroughly rework the federal

government's role in health-care financing and regulation for American women and

children.

The private medical industry immediately lashed out against EMIC and its

mostly female bureaucratic leaders. By the mid-1940s, the stakes were clear, both for

doctors and for the insurance companies that had gained a powerful and profitable role

as middle men between patients and medical providers. Although relatively small in

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[18] Katharine Lenroot, interview by Peter A. Corning, Princeton University, NJ, 22 February 1965, Columbia
Oral History Project, transcript and tapes, 115.

scale and justified by the ideology of patriotism, EMIC blew the lid open on longstanding disputes between federal maternal and child health bureaucrats and private practice pediatricians, obstetricians, and gynecologists. EMIC grew out of the progressive political movement that tried to insert a national health program into the New Deal agenda. The struggle over EMIC exposed not just the sheer power of those private stakeholders who rejected any hint of federal interference in the system of American medicine, but also the built-in weakness of those bureaucratic institutions that were attempting to develop viable, large scale federal regulation of segments of the health care market. The fight over this small but symbolic program would be the first major test of the New Deal's political will to distribute health care to a part of the American populace, and to expect the federal government to bear the moral burden and fiscal costs of creating a right to health care.

According to EMIC's leaders, the idea of using Children's Bureau funds to cover the medical costs of the pregnant wives and infants of military servicemen arose as a spontaneous response to a specific problem. In 1941, the military doctors at Fort Lewis in Washington State found themselves overwhelmed by the medical needs of the wives of the young men who had arrived at this military installations in preparation for deployment to the war theater in the Pacific. These men's pregnant wives "had followed their men to camp with the hope that they might be with their husbands for a little while before they were sent overseas." Finding themselves in a "strange community" near their husbands' military installations, these "army wives" could not rely on county-based programs which restricted coverage to permanent state residents. The Red Cross was also unable to meet the increased demand. As early as 1940, the War Department had already ascertained that it would not provide or pay for medical care for military personnel families. Faced with these barriers, commanding officers, first at Fort Lewis,

and eventually others around the country, began requesting assistance from their local and state health departments, who turned to the Children's Bureau. [19]

At first, in response to these demands for help, the Bureau encouraged state health departments to use their Social Security Title V allotments to pay the bills for these women's prenatal care. But by December of 1942, the Bureau had received so many similar requests that it approached Congress for help, as it became fearful that their 1943 Title V funds would not last through the full fiscal year. The Bureau's leaders initially requested 1.8 million dollars specifically to be used to pay for the medical needs of servicemen's pregnant wives and infants during the 1943 fiscal year. In their testimony, they defined EMIC as an emergency program and as a necessary response to the war's impact on civilians. They also framed it as a natural extension of Title V activities, but one that, in providing medical care funding to a new population, required a new congressional mandate. With little hesitation, Congress gave the Bureau almost all of what was requested by its director, Katharine Lenroot, and its medical director, Martha Eliot, and wrote EMIC into the wartime budgetary appropriations laws. With their foot in the door in 1943, Lenroot and Eliot quickly sought to expand funding for the program, and "less than a week after EMIC became law the Children's Bureau expressed a need for six million dollars to cover the program for the next fiscal year." For the next five years, the Bureau returned frequently to Congress to request more and more funds

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[19] For EMIC as a spontaneous response, see Harry Becker, interview by Peter A Corning, December 6 1966, 18-19; for problem at Ft. Lewis in 1941, see *First Deficiency Appropriation Bill for 1943, March 3, 1943, Before the US Senate, Committee on Appropriations*, 78th Cong. (1943) (statement of Katharine Lenroot, Chief, Children's Bureau), 129-133; for wives following their men to camp, see Dorothy Edith Bradbury and Martha M. Eliot, "Four Decades of Action for Children; a Short History of the Children's Bureau," (Washington, DC: Government Printing Office, 1956), 58; for army wives' difficulty getting care, see Nathan Sinai and Odin Anderson, *EMIC (Emergency Maternity and Infant Care): A Study of Administrative Experience*, (Ann Arbor: University of Michigan, 1948), 21-22; for Red Cross's difficulties, see Livingston L. Blair, "Letter Recognizing Katharine Lenroot," 1951, Box 24, Folder 1, Lenroot Papers; and also Sinai, *EMIC*, 22; for War Department's certainty that it cannot take on these women's care, see Major General Adjutant to Commanding Generals, 18 December, 1940, Box 213, File 13-2-2-1(0), Correspondence with Unofficial Agencies re. EMIC, Records of the US Children's Bureau (RG102), National Archives, Washington, DC.

to pay for EMIC.[20]

Eliot and Lenroot obtained widespread congressional support by downplaying the ways that EMIC diverged from the Social Security Act's maternal and child health funding. In their testimony before Congress's appropriations subcommittees, the Bureau's leaders expressed that they were merely seeking permission to shift how the Bureau channeled Social Security funds for the duration of the war emergency. Whereas in the past the Bureau had sent grants-in-aid to states to bolster health programs, under EMIC the Bureau's Social Security funds would be directed to state health departments with the understanding that they were to be used to pay private providers and hospitals for the prenatal and pediatric care of servicemen's wives. These arguments demonstrated that the Social Security Act's crippled children's program was the clear precedent for EMIC, as it was the only previous social benefits program that funneled federal dollars to pay medical bills outright. In addition, Lenroot and Eliot convinced Congress to release new federal funds, without the stipulation that states match them. This plan represented a shift from the funding system of both the Sheppard-Towner and the Social Security Act's maternal and child health programs. With EMIC, the federal government would be preeminent, both in terms of regulatory authority and financing. States had no financial obligations to fund EMIC except through the "administrative machinery" necessary to put the program in motion.[21]

Congress's First Deficiency Appropriation Bill of 1943 placed new power and funds in the hands of federal agencies in the name of war preparedness projects. At the same time, wartime tax policies—especially the opportunity for employers to write off the cost of employees' insurance premiums—motivated private corporations to expand

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[20] Sinai and Anderson, *EMIC*, 18-23, 29, appendix vii-x.
[21] Ibid., 29; and Gloria Auerhan and Jeannette Loring, "A Study of Forty Mothers Who Received Maternity Care Under the Emergency Maternity and Infant Care Plan at Sloane Hospital for Women," Master's Essay in Social Work, Columbia University, 1945, 2.

their employee benefits. EMIC serves as evidence of two, divergent federal policy approaches to social benefits during the years of World War II. Between 1941 and 1946, the federal government was bolstering incentives for private corporations to provide social benefits. At the same time, Capitol Hill experimented with programs like EMIC, to see how wide the federally woven social safety net could stretch. Even as the federal tax code enhanced private welfare state solutions, Congress decided "maternity and infant care," at least for the families of servicemen, "were problems of the war to be solved by organized action."[22]

Through EMIC, the Children's Bureau's leaders played a major role in civilian preparedness, and set out to include child health as a key feature of the nation's war preparedness policies. Their efforts to make child health and welfare programs a part of the war effort resembled those of their settlement house forebears twenty-five years earlier during World War I. At the outset of American engagement in that war, former Children's Bureau Director Julia Lathrop had convinced Woodrow Wilson to greatly expand his wartime budget for child welfare work. Lathrop asserted that "nothing was more necessary to the country at war, especially in view of the poor health of so many young men summoned by draft boards, than a program to improve children's health." The leaders of the Bureau in the early 1940s hoped that the Bureau would play an even larger role in civilian preparedness and that war would again motivate political concern for child welfare. As in World War I, the health of draftees revealed a problem in American health more generally. In 1941, Katharine Lenroot sent a statement to state health departments to urge the expansion of health services for children, especially in

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[22] For the role of the tax code during World War II in enhancing private corporations' motivation to provide health benefits to employees, by making premiums tax deductible, see Nancy Jecker, "Can an Employer-Based Insurance System be Just?" in *The Politics of Health Care Reform: Lessons from the Past, Prospects for the Future*, ed. James A. Morone and Gary S. Belkin (Durham: Duke University Press, 1994) 261-262; for EMIC as solution to wartime need, see Sinai and Anderson, EMIC, 181.

regions with military installations. The rationale for her recommendations lay in "the high proportion of young men examined under the Selective Service Act who have been found to be physically unfit for general military service." Lenroot urged that "protection of the health of the children of the nation is essential to the present morale and future defense of our democracy." The Selective Service Board claimed that as many as forty percent of drafted military servicemen were turned away because of "physical or mental impairments." The logic for EMIC's creation repeated the same refrain as the Bureau's efforts during World War I. Once again, the welfare of pregnant women and infants was seen as crucial for the health of a nation at war.[23]

The Children's Bureau saw the protection of children during wartime emergency to be a pressing problem. With Surgeon General Thomas Parran, Martha Eliot journeyed to Britain with a War Department committee to investigate Britain's civilian defenses. The trip's goal was "anticipating an emergency and prescribing an orderly manner for the handling of public needs during it." Eliot's role was to "focus on children, how to get them out of danger zones" and "how to insure [sic] their health and education under emergency conditions." While Office of Civil Defense director Fiorello Laguardia would later call "nonprotective programming" civilian preparedness "sissy stuff," women like Lenroot and Eliot saw the protection of pregnant women and soldiers' children as an integral part of the war effort. The Children's Bureau believed it had a clear role to play

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[23] For Lathrop's assertion to Wilson, see Anne Firor Scott, Introduction, in *Jane Addams, My Friend*, by Julia Lathrop, (Urbana: University of Illinois Press, 2004), xxii; for Lenroot's 1941 statement, see "To State Health Officers from Children's Bureau," 30 April 1941, Box 212, File 13-1-0-5-6 State and Territorial Health Officers Jan. 1941-, Records of the US Children's Bureau; for forty percent estimate of men turned away from enlistment, see Thomas Clark, "The Limits of State Autonomy: The Medical Cooperatives of the Farm Security Administration, 1935-1946," *Journal of Policy History* 11, no. 3 (1999): 266; for health of women and children as part of war effort, see Rosemary Stevens, *American Medicine and the Public Interest* (New Haven, CT: Yale University Press, 1971),132; and Colin Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth-Century America* (Princeton, NJ: Princeton University Press, 2003), 137-139.

in coordinating the state and local efforts for wartime preparedness.[24.]

EMIC's chief administrators framed EMIC as a benefit for soldiers. The federal government became a kind of symbolic stand-in for the serviceman, who was giving his labor and potentially his life to the nation. The program aimed to "improve the morale both at the fighting front and on the home front." It did so "by relieving [servicemen] of concern over the uncertainty of the availability of maternity care for their wives and medical and hospital care of their infants, and of anxiety as to how the cost of this care would be met." Children's Bureau publications, such as an insert that was placed in servicemen's monthly paychecks to advise their wives of the new program, explained that it was "the service of your husband to our country [that] gives you and your baby the right to this care wherever it can be provided." Brochures announced that "Uncle Sam" would be "footing the Stork Bill" and would serve as "the godfather to these 'EMIC babies.'" Women who received EMIC assistance, when asked about the rationale for the assistance, expressed the belief that "war mothers need [help] most," and while they would have preferred to pay for their own care, their identity as wives of servicemen justified the government's help. In 1946, to the great surprise of several skeptical Congressmen, Lenroot went to Capitol Hill to give back money that she had requested earlier in the year because the war's resolution rapidly decreased EMIC caseloads around the country.[25]

[24] For Eliot and Parran's trip to Britain, see "Mission Develops U.S. Civil Defense," *New York Times*, 13 February 1941; for civil preparedness as "sissy stuff," see Laura McEnaney, *Civil Defense Begins at Home: Militarization Meets Everyday Life in the Fifties* (Princeton, NJ: Princeton University Press, 2000), 17; for Children's Bureau having a role to play, see Katharine Lenroot to Hecht, 16 October 1942, Folder 159, Eliot Papers.

[25] For EMIC's morale-boosting goal, see Martha M. Eliot, "Experience with the Administration of a Medical Care Program for Wives and Infants of Enlisted Men," *American Journal of Public Health and the Nations Health* 34, no. 1 (1944): 34; for relieving servicemen of concern, see Martha M. Eliot and Lillian R. Freedman, "Four Years of the EMIC Program," *Yale Journal of Biology and Medicine* 19, no. 4 (1947): 621; for insert text, and argument that war mothers need the help most, see Gloria Auerhan and Jeannette Loring, "A Study of 40 Mothers," 1, 29; for "Uncle Sam footing the bill," see Mead to Eliot, 21 March,1945, with Clipping "US Is Godfather to One Baby in 6" [no date], Box 200, File 13-2-2-1(0) Correspondence regarding EMIC Program April 1945, Records of the Children's Bureau; and Press release, "Uncle Sam Still Footing Stork Bill for

Alhough EMIC was a response to the wartime situation, it was far more than a slapdash solution to unexpected health needs. Through EMIC, the Children's Bureau rapidly built a sophisticated bureaucratic apparatus that imposed federal regulation on obstetric and pediatric care for a significant segment of the American populace. With the help of field workers and local health officers, Children's Bureau administrators wrestled with and resolved a plethora of issues about requirements for coverage for both hospitals and individual practitioners, standards of care, fee structures for participating doctors and hospitals, and auditing expectations. The Bureau's speed and confidence in responding to these issues demonstrated its readiness to oversee a national health program. Its deft administrative capacities reveal that this federal bureaucracy had in fact long been prepared to administer such a program and to develop a top-down, nationwide program to regulate maternal and child health care, which at the close of the war it would seek to make permanent.

The question of whose health care needs EMIC covered was a contested subject, and one whose answer revealed the program's long-term ideological underpinnings. EMIC covered the pregnant wives and infants of the four lowest pay grades of servicemen. Coverage for this group did not depend on a test for indigence—commonly known as a "means test." Eliot explained this feature of EMIC at length to colleagues in professional journals, as it was this absence of a means test that distinguished the program from welfare benefits. Eliot insisted that EMIC needed to be framed as a benefit program for servicemen's wives, rather than as a charity offering. To readers of the nation's most important medical journal, she explained that a means test would, *de facto*,

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30,000 Servicemen's Babies Monthly," 6 March 1946, Box 199, File 13-2-2-1(0) March 1945-April 1946, Records of the US Children's Bureau; for Lenroot returning money in 1946, see Sinai and Anderson, *EMIC*, 47-48.

"put hospitals and physicians in position to evaluate patients ability to pay, and to interrogate all EMIC patients to determine if they have extra means in order to pay more" than the state health department was offering as payment. A means test would also "result in uncertainty as to whether or not care would be paid for" and thereby "nullify the primary purpose of the program and shake the confidence of the enlisted men in the safety of their wives and infants." While Eliot successfully fended off attempts to insert a means test, even without one the program's coverage of only the lowest four paygrades of servicemen ensured that officers' wives and children were excluded from coverage and that the income level of participants was low vis-à-vis other military personnel. In spite of this built-in limitation, the number of eligible women and infants was impressive. With eleven percent of the American population called up to military service, and eighty-seven percent of those called up in low-paid servicemen positions, the pool of potential participants was sizable.[26]

Additional eligibility questions arose with regard to marital status and the correspondence of the moment of conception with a serviceman's tenure of active duty. Children's Bureau administrators decided that as long as a serviceman was married during the period of service and conception, the infant and wife could obtain EMIC coverage. If a couple was unmarried, the mother was not eligible for EMIC-paid obstetrical care, but the servicemen's infant was, so long as the serviceman acknowledged his paternity. Female military service people who were themselves pregnant, such as Woman Air Cadets or "WACS," were not covered. A set of values lay beneath these decisions. EMIC was intended to help married women whose husbands

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[26] For EMIC as benefit, not charity, see Eliot and Freedman, "4 Years of the EMIC Program," 621; for the problems with a means test and the percentage of servicemen in the lowest four pay grades, see Martha M. Eliot, "Emergency Maternity and Infant Care Program -- for the Wives and Infants of Men in the Armed Forces," *Journal of the American Medical Association* 124, (1944): 837; and Eliot, "Experience with the Administration of a Medical Care Program for Wives and Infants of Enlisted Men," 36; for EMIC not covering officers' wives, see Lucille Marsh to Mrs. Ownby, 27 September, 1948, Box 201, File 13-2-4(0) Appeals for Help, General Jan 1945, Records of the US Children's Bureau.

were giving their service to the nation. EMIC fit into the prevailing social policy framework that encouraged marriage and the family wage earning system.[27]

As with Sheppard-Towner and Title V programs, EMIC vested great authority in local and state health officers. States feared "future federal domination" of maternal and child health programs, and Congress insisted that for a direct medical bill payment program like EMIC to remain on the books, the states should continue to maintain ultimate authority over disbursement and service regulation. The Bureau eagerly dispelled these fears, and insisted that, as with all prior Bureau-directed maternal and child health programs, state and local health departments were seeing to EMIC's day-to-day operations and making case-by-case decisions about coverage and care. On the array of specific questions about covered services and provider requirements, the Bureau demurred to the standards of local hospitals and providers and encouraged the use of state standards as guidelines. States were permitted to evaluate independently whether additional medical treatments would be covered, including serums and biologics, endocrines, oxygen therapy, plasma, and x-ray therapy. States could decide whether to pay specialists with training in obstetrics or pediatrics more than general practitioners for EMIC-covered care. Federal EMIC funds became available after states had established and obtained approval for their individual EMIC program. At the war's conclusion, as Congress downsized and eventually liquidated EMIC, each state was responsible for terminating its EMIC cases.[28]

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[27] For coverage if father married at the time of conception, see Frank Kropf to Gentlemen, 28 June 1946; Lesser to Kropf, 15 July 1946, Box 201, File 13-2-4(0) Appeals for Help, General Jan 1945; for coverage of infant, but not mother, if unwed, see Seibert (American Legion) to Lenroot, 1 May 1946, Box 199, File 13-2-2-1(0) Correspondence Re EMIC, July 1946; Caviness to Dept of Labor, 6 July, 1946, Box 201, File 13-2-4(0) Appeals for Help, General Jan 1945; Daily to Caviness, 22 July, 1946, Box 201, File 13-2-4(0) Appeals for Help, General Jan 1945; for EMIC not covering WACS, see Meissner to Dept. of Labor, 1 May 1945, Box 200, File 13-2-2-1(0) Correspondence regarding EMIC Program April 1945; all from Records of the US Children's Bureau.

[28] For state authority in running EMIC, see Sinai and Anderson, *EMIC*, 177; for state-based decision-making about medical treatments, see Meeting on Hospital Cost Accounting, San Francisco, California, 15 July 1943,

The Bureau's insistence that EMIC be run on a local and state level was politically essential. In order to maintain support from Southern Democrats, wartime social programs reified state authority. This assertion of state dominance over the program's logistics allowed the Bureau to curry favor with local health departments. It also allowed the Bureau in the early 1940s to build support among congressmen who only three years earlier had rejected those New Deal activities that they believed excessively enhanced federal power and spending.

EMIC case rolls rapidly grew, and administrative issues arose as local health departments struggled to keep up with bills and manage the array of logistical issues and procedural questions. In New York City, the number of infant cases in the summer of 1945 had become so great that the Visiting Nurse Service felt the need to streamline recordkeeping. It asked the Bureau for permission to give the Department of Health a case list of sick "EMIC babies," to ensure that all these infants receiving home care would have their bills paid. By the close of the year, this system was in place and working smoothly. Federal bureaucrats knew that demand for EMIC was growing quickly and worked deftly to help local health departments to keep up.[29]

Difficulties arose when doctors and hospitals accepted—or in some cases,

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Box 210, File 13-4-4-2 Regional Conferences Jan 1942, Records of the US Children's Bureau; for state decisions regarding different rates to pay specialists versus general practitioners, see Memorandum from Eliot to State Health Officers and State Maternal and Child Health Directors, 7 July 1944, Box 212, File 13-1-0-5-6 State and Territorial Health Officers April/1944, Records of the US Children's Bureau; for state-based liquidation procedures, see Daily to Kerby, 7 January 1946, Box 198, File 13-2-2-1(0) Correspondence Re. EMIC September 1947-March 1948; Memorandum From Regional Medical Director to Executive Officers of State Agencies Administering Maternal and Child Health, 19 December 1947, with attachment "EMIC Maternity Care Will End This Spring; Medical Aid for Babies Continues into 1949" 30 December 1947, Box 198, File 13-2-2-1(0) Correspondence Re. EMIC September 1947-March 1948, Records of the US Children's Bureau.

[29] For Visiting Nurse Service request, see correspondence among Leona Baumgartner (NYC Department of Health), Helen Wallace (Director of New York's Department of Public Health EMIC program), Elizabeth Phillips (Assistant Director of Visiting Nurse Service of New York) and Marian Randall (Executive Director of Visitng Nurse Service of New York), 25 July, 13 August, 19 September, 4 October, and 28 December 1945, Box 43, Folder 1, Records of the Visiting Nurse Service of New York.

demanded— payment at the time of service from EMIC-eligible patients. State health officers complained to EMIC's Washington office that some doctors had demanded payment from patients directly because they were frustrated by the wait time between submitting their claims and receiving EMIC reimbursements. Federal administrators saw complaints like these arising around the nation, in Oregon, the Midwest and urban centers like Philadelphia. EMIC's statutes required that health department payments be issued only to physicians and hospitals, not to patients to reimburse them for out-of-pocket payments. Besides creating frustration among patients and doctors, cases like these revealed that while EMIC aimed to cover health care costs for pregnant wives and infants of servicemen, misinformation and old traditional patterns of fee-for-service patient payment were clogging the bureaucratic works. Beginning in 1943, federal administrators attempted to stem the tide of local health department complaints and to provide support and information as EMIC's growth outpaced the bureaucratic competency of local health programs nationwide.[30]

In operating as a state-administered program, EMIC stayed inside the gender-based institutional confines that had long existed for public benefits affecting women and children. During the New Deal, a trend solidified, wherein men become subjects of federal social policies—most importantly, the Social Security system—while women and children remained subjects of state authorities. EMIC exemplified this New Deal model of a gender-divided experience of citizenship, with male citizens part of an essentially federal sovereignty while women and minorities were subjects of individual states.

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[30] For Oregon's Department of Health problems with impatient doctors, see Belz to Luvaas, 6 June 1945, John Luvaas to Oregan State Board of Health, 26 March 1946, and Erickson to Luvaas, 4 April 1946, Box 199, File 13-2-2-1(0) Correspondence Re EMIC, July 1946, Records of the US Children's Bureau; for cases in Philadelphia where patients were paying out of pocket, see Miss Crawford and Ruth Tartakoff, "Philadelphia Enquirer Item on EMIC," 13 September 1945, Box 199, File 13-2-2-1(0) Correspondence Regarding EMIC Program, Sept 1945; for similar problems in Midwest, see Dr. Curtis and Ruth Olson, Meeting with Janet Neel, 12 May 1945, Box 200, File 13-2-2-1(0) Correspondence regarding EMIC Program April 1945; for federal bureaucrats' meetings with local and state health departments, see Frances Rothert to David E. Brown, 6 August 1943, Box 209, file 13-0-4-2, Records of the US Children's Bureau.

While the Social Security Act made all wage earning men entitled as US citizens to workmen's compensation, unemployment, and old age benefits, Title V and EMIC reified the power of states over social programs for women and children. In this way, EMIC further encoded the gender norms of New Deal social policy, which not only enlarged federal authority but also aggrandized individual state powers. EMIC's federal designers saw the program as a step toward a federally protected right to a safe birth and infancy, but states' authority over the program, as well as hospitals' and doctors' ability to opt out of EMIC altogether, concealed this political ideology.[31]

While leaving much in the states' hands, the Children's Bureau's leaders nevertheless aimed to standardize medical care for pregnant women and infants nationwide. Eliot believed the program needed to set a "pattern of minimum services to be provided by all states to every wife and infant accepted for Care under the EMIC program." Through its regular "circulars," the Bureau delineated its expectations for facilities to obtain EMIC payments. Maternity wards and nurseries needed screens to "give protection against flies and mosquitoes." Hospitals were required to establish wards or rooms devoted to maternity and infant patients. "A reliable method of identifying each infant" needed to be in place. Bedpans were to be sterilized between uses, and maternity beds located with "at least 60 square feet per patient." Each room needed to have running water and each infant was to have his or her own basinet spaced at least six inches apart from the next.[32]

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[31] Mettler, *Dividing Citizens*, 15-20; for doctors and hospitals option not to participate, see Bauer to Eliot, 7 August 1944, Box 213, File 13-2-2-1(0) Correspondence with Unofficial Agencies re EMIC; and Van Horn to Devereaux, 10 October 1944, Box 199, File 13-2-2-1(0) March 1945-April 1946, Records of the US Children's Bureau.

[32] For "pattern of minimum services, see Eliot to John T Mason, July 10 1944, Box 210, File 13-0-4-4, Conference State MCH Directors, Box 198, File 13-2-2-1(0) Correspondence Re. EMIC September 1947-March 1948, Records of the US Children's Bureau; for standards regarding screens, maternity wards, methods to identify infants, bed pans, bed spacing, running water, and bassinet spacing, see Administrative Policies, Emergency Maternity and Infant Care Program, EMIC Information Circular No. 1, US Department of Labor, Children's Bureau, , Box 116, Folder 3, Records of the Maternity Center Association.

Although states were empowered to decide the necessary qualifications for EMIC-paid health care providers, the Bureau's Washington bureaucrats nonetheless exerted control over these individual providers through EMIC's reimbursement mechanisms. To rein in the wide disparities in healthcare costs, and in order to provide care for servicemen's wives and infants in a fair way across the nation, the Children's Bureau established fee ceilings for which EMIC would pay providers for typical prenatal care, hospital deliveries, and infant care, as well as a cap on the cost for hospital-based services and ward care. States had some discretion to pay doctors and hospitals at higher rates than these Bureau-imposed ceilings, but these additional payments would be the responsibility of state health departments. As important, the program disallowed patients from paying—and doctors from accepting—additional fees for "luxury" inpatient or outpatient service. [33]

In the *Journal of the American Medical Association*, Eliot explained one of EMIC's most controversial federal policies: doctors were to be paid for EMIC patient work on a case-based system, rather than as fee-for-service. The Bureau believed that this payment scheme would limit variations across states for how much prenatal, delivery, postpartum and infant care would cost, as well as what services would be included as part of routine care. A doctor could file bills for EMIC payment for prenatal care immediately after the birth, and for early infant care, after the child reached fourteen days. In order to receive payment, a provider was obliged to provide a specific minimum amount of care. "Complete maternity care" included seven prenatal examinations, one postpartum examination, and "other services recognized as part of

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[33] For example of state authority, in this case over minimum qualifications for providers to obtain reimbursement, see Memorandum from Chief of the CB to State Health Agencies, 13 July 1943, Box 212, File 12-2-0-3; for federally set fee ceilings, see Memorandum, Establishment of a maximum ward rate, 16 July 1943, Box 210, File 13-0-4-2 Regional Conferences Jan 1942, Records of the US Children's Bureau; for prohibition against accepting additional fees for luxuries, see Eliot, "Experience with the Administration of a Medical Care Program for Wives and Infants of Enlisted Men," 36.

routine complete maternity care." In the event that physicians did not perform these basic requirements, their payments would be reduced to cover the "services actually rendered." Additional services were compensated above this standard rate, but the Bureau again had the authority to decide what services qualified as non-standard and therefore paid as fee-for-service. The Children's Bureau set these case rates based on national averages. Infant care, defined as routine preventive care for the first year of a child's life, was divided into two periods: the first two weeks of life, and the remainder of the first year of life. Routine care of a healthy infant was reimbursed at one rate for the first two weeks of life, after which the remainder of the first year of care would be paid as an additional case. Reimbursement rates for infants and babies with illnesses were negotiable, but the Bureau made final decisions about compensation. These standardization provisions demonstrated the Bureau's continued devotion to its longstanding objectives: medicalizing childbirth and expanding access to well-child health care as a way to improve maternal and infant mortality rates.[34]

EMIC's policies on circumcision epitomized the Bureau's use of reimbursement decisions to assert its authority over standards of care, as well as its power in defining

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[34] For logic of case basis payment system, see Eliot, "Emergency Maternity and Infant Care Program -- for the Wives and Infants of Men in the Armed Forces," 835; in response to objections to this system, in the summer of 1945 the Bureau revised this policy so that if 80% of patients in a state had received "complete maternity care," the state health department would pay out the full rate of case-based compensation for 100% of EMIC cases. See Thomas Gamble to Martha Eliot, 26 February 1945 and 8 July 1945, Eliot to Gamble, 9 1945, 3 August 1945, Box 199, File 13-2-2-1(0) Correspondence regarding EMIC program, August 1945, Records of the US Children's Bureau; guidelines for infant care were established through "Circulars," which the Bureau sent to state health departments; see US Department of Labor, Children's Bureau "Administrative Policies, Emergency Maternity and Infant Care Program, EMIC Information Circular No. 1," Box 116, Folder 3, Records of the Maternity Center Association; and "EMIC Informational Circular No 17," 30 March 1945, Box 200, File 13-2-2-I(0) Correspondence Re EMIC Program Mar 1945, Records of the US Children's Bureau; for EMIC's contribution to bringing birth into hospitals, and reducing infant mortality rates, see Schwartz to Taylor with attached note, Clara J. Schiffer, "Large Percentage of EMIC Births in Hospitals and Attended by Physicians," unpublished report, 26 July 1948, Records of the US Children's Bureau; US Children's Bureau, Department of Labor, "Standards and Recommendations for Hospital Care of Newborn Infants, Full-Term and Premature," Box 116, Folder 3, Records of the Maternity Center Association Papers; for pre-EMIC commitment to medicalizing childbirth, see Martha M. Eliot, "What is the need today?" presented at Conference on Better Care for Mothers and Babies, January 17-18, 1938, 32-38, Box 117, Folder 4, Papers of the Maternity Center Association Papers; and Muncy, *Creating a Female Dominion in American Reform*, 98.

infancy and early childhood and the necessary health services required during this period of life. According to the Bureau, EMIC funds were not to be "expended for circumcision of infants" during the first nine days of life. EMIC circulars explained that in-hospital circumcisions were not part of the case reimbursement for labor, delivery, and newborn care, and would therefore not be approved as an additional necessary procedure. But circumcision would be paid for after an infant's fourteen day of life as part of the covered, routine newborn services. One New York state obstetrician asked, "What logic inspired the ruling the Bureau made that it would approve payment for fifteen or sixteen day, and not eight or nine day, circumcisions?" Eliot explained that this EMIC policy was in keeping with the agency's definition of infancy as "the first two weeks of life" and circumcision was not an essential service for the health of newborns. However, in the event that the same physician continued to provide pediatric care after this two-week period, the doctor could apply for a new authorization for continued, post-newborn infant care. Once approved, this care would include circumcision as a standard practice. This policy implicitly motivated pediatricians to continue their care of infants after the first two weeks of life, as opposed to ending care after the neonatal period for families who lacked the means to pay out of pocket for ongoing pediatric care. Through these kinds of regulations, the Children's Bureau asserted itself as an institution engaged in defining the parameters of specialist care for women and children's health services.[35]

When the war ended, EMIC's mandate withered. EMIC remained in place for servicemen until June 30, 1947, at which point the liquidation process began. Any maternity cases approved before that date were seen through until delivery. EMIC

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[35] Gamble (NY State obstetrician) to Eliot, 26 February, 1945, and Eliot to Gamble, 9 March, 1945, Box 199, File 13-2-2-1(0) Correspondence regarding EMIC program, August 1945, Records of the US Children's Bureau.

would pay medical bills for infants conceived before June 1947 until they reached their first birthdays, thereby ensuring that the Bureau would continue to make grants to states for EMIC expenditures through the spring of 1949. As the caseloads dwindled, the Children's Bureau returned excess funds to Congress, and in the summer of 1949 the books were closed. As the program wound down, it appeared, by all accounts, to have been successful. At its height in 1946, EMIC funds paid for one in every seven American births. In total, 1.2 million pregnant women and 230,000 infants received federally funded medical services under EMIC. EMIC "reached eighty-five percent" of the women and infants eligible to use it.[36]

EMIC enhanced the reputation of the Children's Bureau's leaders among public health experts, who lauded the program and its director. In a personal letter to Martha May Eliot, bacteriologist and public health icon C.E.A. Winslow wrote:

> May I say how my admiration for your accomplishments grows? Your undaunted courage, your wisdom, your patience, your unruffled balance are rare qualities in Washington (or anywhere else). And your conduct of the program for wives and children of the soldiers is the most important milestone of the past decade.

The editorial board of the *American Journal of Public Health* congratulated the Children's Bureau for having successfully responded to the problem of transient military families, and for the remarkable administrative cooperation between the Washington federal

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[36] For liquidation of EMIC, see FSA, SSA, CB, "Press Release," 23 July 1947, Box 198, File 13-2-2-1(0) Correspondence Re: EMIC May 1947; Memorandum, Regional Medical Director to Executive Officers of State Agencies Administering Maternal and Child Health, 19 December 1947, with attachment "EMIC Maternity Care Will End This Spring; Medical Aid for Babies Continues into 1949," 30 December 1947, Box 198, File 13-2-2-1(0) Correspondence Re. EMIC September 1947-March 1948; Federal Security Agency, Children's Bureau, form letter re. liquidation of CB, filed 6 August 1948, Box 198, File 13-2-2-1(0) Correspondence re. EMIC April 1948; and Memorandum, Lenroot to State Health Officers, 1 August 1949, "Subject: Liquidation of Emergency Maternity and Infant Care Program," Box 483, Foder13-2-2-1(0) Correspondence re EMIC 1949-1952 (file 3 of 4 in box), Records of the US Children's Bureau; for EMIC paying for one in seven births at its peak, see Eliot and Freedman, "Four Years of the EMIC Program," 634; for total number of EMIC cases, see Sinai and Anderson, *EMIC*, 175; for EMIC reaching eighty-five percent of eligible women and children, see Katharine Lenroot , interview by Peter A Corning, February 22 1965, Princeton University, NJ, Columbia Oral History Project, transcripts and tapes, 146.

oversight and local and state health departments. In their analysis of the program

supported by the Milbank Memorial Foundation, Nathan Sinai and Odin Anderson

called EMIC "a striking demonstration of joint effort and of administrative resiliency."

In January 1947, Eliot was elected to become the next president of the American Public

Health Association, the first woman to fill this eminent position. Her colleagues selected

her for this prestigious position thanks to "her courageous and statesmanlike

personality," and in recognition of the Bureau's contributions to public health, which

had become especially vivid through the EMIC program.[37]

EMIC allowed Washington's bureaucratic experts in maternal and child health to

implement the kind of health services that they and their academic colleagues agreed

was state-of-the-art. This implementation involved attempting to push midwives and

osteopaths out of the practice of maternal and child health, a task that women of the

Bureau had been working toward gradually for twenty-five years. Although the Bureau

was restricted from setting minimum qualification standards for prenatal care providers,

Congress maintained the agency's authority to set these qualification standards for those

who cared for children. Through this authority, the Bureau refused to pay osteopaths for

pediatric care. Moreover, the Bureau used EMIC to insist that childbirth's rightful place

was in a hospital. Most midwife-attended births occurred at home. EMIC did not

compensate midwife-supervised home deliveries, though it did pay for doctor-attended

home-births in communities where no EMIC-approved or EMIC-accepting hospitals

existed.[38]

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[37] For CEA Winslow's accolades, see CEA Winslow to Eliot, 23 October, 1943, Folder 49, Eliot Papers; for AJPH's compliment, see "Close of the EMIC Program" *American Journal of Public Health* 39, no. 12 (1949): 1580; for Sinai and Anderson's support, see Sinai and Anderson, *EMIC*, 181; for Eliot's appointment as APHA president, see "The Cleveland Meeting," *American Journal of Public Health* 37, no.1 (January 1947): 70-71.
[38] For Bureau standards for infant health services, see William S. Tyson to Swope, 14 June, 1946, Box 199, File 13-2-2-1(0) Correspondence Re EMIC, July 1946; and Memorandum from Chief of the Children's Bureau to State Health Agencies, 13 July 1943, Box 212, File 12-2-0-3; for earlier efforts to push midwives and

Public health supporters considered the move toward traditional medical care and toward hospital-based labor and delivery one of EMIC's most significant accomplishments, and one that was only achieved because of the Bureau's federal oversight. They observed that of the 1.1 million "EMIC babies" born around the country, ninety-three percent were born in hospitals, and most of the remaining percentage were "attended by a physician." In praising EMIC's accomplishments, the national public health community highlighted the dramatic increase in the overall "proportion of births occurring in hospitals." Their statistics showed that hospital births "reached a new high of 84.8 per cent" in 1947, which stood in great contrast to the "72.1 per cent in 1943, an increase of almost one-fifth." This shift occurred "in spite of the great post-war rise in the birth rate and the shortage of new hospital facilities." The causal vector between the medicalization of birth and the improvement in infant and maternal mortality nationwide was difficult to prove, but supporters insisted that the increase of access to medical care during pregnancy and infancy explained the lower rate of maternal and infant mortality among servicemen compared to the civilian population.[39]

Besides obtaining the support of public health colleagues, the Children's Bureau relied on the support of the military and its advocate organizations. Long concerned with the military's inability to care for the families of servicemen, representatives of the

osteopaths out of service provision for women and children, see Martha M. Eliot, "What Is The Need Today?" presented at Conference on Better Care for Mothers and Babies, 17-18 January 1938, 32-38, Box 117, Folder 4, Records of the Maternity Center Association; for EMIC's strategies to limit care by midwives, see "Meeting on Hospital Accounting," San Francisco, 15 July 1943, 6, Box 210, File 13-0-4-2 Regional Conferences - Jan 1942, Records of the US Children's Bureau.
[39] For percentage of doctor-attended EMIC births, see Schwartz to Taylor, 26 July, 1948 with attachment, Clara J. Schiffer, "Large Percentage of EMIC Births in Hospitals and Attended by Physicians," unpublished report, Box 198, File 13-2-2-1(0) Correspondence re. EMIC April 1948, Records of the US Children's Bureau; for achievement despite increased birthrate, see "Close of the EMIC Program," *American Journal of Public Health* 39, no. 12 (December 1949): 15580; for argument that more medical care led to better birth outcomes, see Fowler, Secretary Treasurer of the Congress of Women's Auxiliaries of the CIO, to Elliott (sic), 8 November, 1946, Box 199, Folder 13-2-2-1(0) Correspondence re. EMIC, November 1945, Records of the US Children's Bureau.

armed forces expressed vociferous support for the Bureau's taking responsibility for the

care of this military population. Army officers conveyed their particular support for a

program that assisted lower-paid servicemn. Although the PHS's Surgeon General's

office had for decades opposed the Bureau's involvement in matters of public health and

health care, military representatives in that office conveyed to Eliot:

> what an excellent morale factor this program has been . . . . Soldiers going
> to our many overseas Theaters of Operations go with a knowledge that
> their wives are being cared for during childbirth, thus relieving them of
> weeks or months of worry over the uncertainty of what is taking place
> back home.

Similarly, the American Legion, the political advocacy group for servicemen and

veterans, appreciated that the lack of such a program during World War I had been a

problem, and praised the Bureau for creating the program during this war in Europe

and the Pacific.[40]

EMIC helped the Bureau garner powerful political allies in the first lady's office

and in the labor movement. Already sympathetic to the concerns of settlement-house

movement women, Eleanor Roosevelt expressed in her syndicated "My Day"

newspaper column how "very glad" she was to learn of EMIC, which "will be of great

help" to servicemen and their wives. President of the American Federation of Labor

William Green likewise supported EMIC and hoped the program would continue even

after the war's end. Likewise the "women's auxiliaries" of the Congress of Industrial

Organizations expressed their staunch support of EMIC in a newsletter disseminated to

all union members, explaining that EMIC had made hospital care widely available to

both white and "Negro" mothers, which in their view translated to "far fewer deaths

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[40] For army officer support for EMIC, see Munson to Eliot, 25 March, 1944 , Box 213, File 13-2-2-1(0) Correspondence with Unofficial Agencies re. EMIC; for Surgeon General's office support, see Norman T. Kirk to Eliot, 25 February, 1944, Box 213, File 13-2-2-1(0) Correspondence with Unofficial Agencies re. EMIC; for American Legion support for EMIC, see Sinai to Eliot, 10 December, 1946, Box 198, File13-2-0-1 (0); and Emma Puschner to Eliot, 13 November 1944, Box 213, File 13-2-2-1(0) Correspondence with Unofficial Agencies re. EMIC, Records of the US Children's Bureau

and a better start to life" for those children.[41]

The Children's Bureau's administrative deftness, its cultivation of progressive political allies, and its conscientious linking of federal oversight with state and local health services represented a continuation of the agency's thirty-year-old strategy in the sphere of maternal and child health. After the Sheppard-Towner programs and Title V Social Security endeavors, EMIC stood as the third major milestone in the Bureau's path to expand maternal and child health services to ever larger segments of the American population. Growing out of the settlement-house movement's innovative and incremental approach, with EMIC the Bureau seized on a newly sympathetic segment of the American population and proved its capabilities in overseeing and regulating a large-scale health service program.[42]

Although framed by its designers, advocates, and politicians as a war emergency program, EMIC was in fact evidence that the women of the Children's Bureau saw the program as the next step in the settlement-house movement's vision of health justice for American women and children. In a 1944 article in *Parents Magazine*, Eliot expressed EMIC's significance as the first step toward her agency's agenda of creating a system of publicly funded, universal maternal and child health care. She wrote:

> The start of this program marks a red-letter day for the United States for it is truly a program of public maternity care. It is a small beginning to be sure, but its significance is great. It marks a major break from our present makeshift system . . . why shouldn't we as citizens dream a dream of public maternity care for expectant mothers and their babies.

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[41] For First Lady's support, see Eleanor Roosevelt, "My Day; Maternity and Infant Care Available to Soldiers' Families," *The Washington Daily News*, clipping in Box 216, File 13-2-2-1(0) Correspondence Unofficial Agencies re EMIC program, Records of the US Children's Bureau; for William Green's support, see Green to Senator Murray, 13 October, 1945, Folder 330, Eliot Papers; and Green to President, 14 January, 1952, Box 577, File 103-G, Harry S. Truman Papers: Official File; for CIO women's support, see Fowler (Secretary Treasurer of Congress of Women's Auxiliaries of the CIO) to Eliot, 8 November 1945, Box 199, Folder 13-2-2-1(0) Correspondence re. EMIC, November 1945, Records of the US Children's Bureau.
[42] For this narrative of continuity in the Bureau's efforts in maternal and child health care, see Sinai and Anderson, *EMIC*, 10-12.

Eliot explained the logistics of bringing such a dream to fruition. Instead of the current system, wherein Americans were "paying the bill for a considerable portion of this out of our individual pockets," she recommended that the cost of all women's prenatal and infant health care should be divided across the total population, "in the form of general taxes collected by the state and federal government annually." She predicted that the program could be funded by "an average of $2.00 to $2.50 per taxpayer." Eliot knew that many Americans were not in a position to pay out of pocket for prenatal and infant healthcare, and that such a system would give these Americans a right to health care that was, under the current commodified system, available only to those with the means to pay for it. To Eliot, EMIC represented the first step toward the Children's Bureau's goal: "a free-to-all service with full-time salaried physicians, paid for directly from general taxes and controlled and directed by a federal bureau."[43]

This article, and the radical agenda that it revealed, provoked a strident backlash. The ferocity of EMIC's opponents would show just how radical Eliot's dreams were. Just four years after she wrote this article, it became clear that this vision of a right to health care for American women and children would not come to fruition. By 1948, the communitarian and rights-based ideology of health justice for American mothers and children, toward which Eliot and her forebears had toiled for over fifty years, would begin to seem like a pipedream. Antagonism toward federal government involvement in health services showed that, in spite of EMIC's popularity and success, the ideology that it espoused conflicted with the most powerful, conservative stakeholders in the system of American health services.

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[43] Martha M. Eliot, "Baby Care: Today and Tomorrow," *Parents Magazine* 19, no. 1 (January 1944): 24-25, 61-62.

Chapter 8: The Backlash against New Deal and Wartime Experiments in Federal Health Services

Thanks to the popularity of the Public Health Service's rural health improvement work, the Farm Security Administration (FSA) health cooperatives, and the Children's Bureau efforts with the Emergency Maternity and Infant Health Care program (EMIC), conservatives who objected to federal involvement in health policy realized that their battles were hardly over. Much to the chagrin of those who had successfully excluded a national health plan from the 1935 Social Security Act, these programs showed that those who hoped to create federal health services, especially for women and children, still had a toehold among federal policymakers. Even more concerning to conservative leaders was the eagerness of many doctors to participate in these federally directed programs. Like other Americans, many doctors acknowledged that federally financed and regulated health programs during the New Deal and World War II increased the quality and quantity of health services and facilities nationwide and led to improvement in individuals' health. Ultimately, despite their strident criticisms of the health cooperatives and EMIC, the top leadership of the American Medical Association (AMA) and their conservative political allies in Congress grudgingly agreed to cooperate with the programs, at least for the duration of the Depression and war.

Titles V and VI of the Social Security Act, along with the FSA health cooperatives, mobile health centers for migrant workers, and EMIC were part of a trend during the 1930s and early 1940s to experiment with federal funding of health services. The 1938 Venereal Disease Control Act committed three million dollars in federal funds to the fight against syphilis. With these funds, the Public Health Service delivered "free antisyphilitic drugs" for the indigent and allowed for expansion of state and local

facilities where individuals could obtain serological testing and treatment. The law was the culmination of Surgeon General Thomas Parran's decades-long campaign against venereal disease and served as a prominent example of the "shift in notions of federal responsibility for ameliorating social problems." By June 1944, with the end of the war in sight and the expectation that ten percent of the total American population would be veterans, Congress passed the GI Bill, the period's "massive government outlay to house, educate, employ, and mend returning soldiers." Taken as a whole, these Depression-era and wartime social policies pointed to the federal government's growing commitment to include health as an issue of federal concern. Government engagement in health justice issues was particularly evident for those subsections of the population that were deemed particularly deserving, such as servicemen's wives, displaced and unemployed victims of the Great Depression, and returning veterans.[1]

Despite this openness to government involvement in the health and welfare needs of many Americans, a longstanding, countervailing trend aimed to exclude government from social policy, especially health-care policy. Just as conservative groups had railed against the Sheppard-Towner programs of the 1920s, so too did they object to programs like the New Deal health cooperatives, migrant health clinics, and EMIC. The top brass of the AMA marched at the forefront of this struggle against federal health policy endeavors, and this time they were joined by America's pediatricians. In 1938, these conservative forces in the medical community gained the upper hand, bolstered by

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[1] For National Venereal Disease Act, see Henry Morgenthau, "Annual Report of the Surgeon General of the Public Health Service of the United States for the Fiscal Year 1939," January 3, 1940, 124-125, accessed February 19, 2014, HTTP://congressional.proquest.com.proxy.lib.duke.edu/congressional/docview/t47.d48.10407_h.doc.497?accountid=10598; for the Act as a sign of shift toward federal responsibility for social problems, see Allan M. Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880* (New York: Oxford University Press, 1985), 144; for GI Bill, see Laura McEnaney, "Veterans' Welfare, the GI Bill and American Demobilization," *Journal of Law, Medicine, and Ethics* 39, no. 1 (Spring 2011): 27.

a coalition of Southern Democrats rising to power on Capitol Hill. Despite the economic

devastation of the 1938 economic recession and continuing environmental and social

crises in agricultural regions, these right-wing forces aimed to curb what they saw as

"the excesses of New Deal liberalism." These opponents feared that the social

democratic programs of the New Deal foretold an American acceptance of the premises

of Britain's 1942 Beveridge Report, which recommended nationalization of the health

care system as a whole.[2]

The first targets of conservative critical attention were the New Deal's most

radical agricultural programs, among them the federally subsidized health cooperatives

for FSA borrowers. The AMA faced internal divisions with regard to these health plans,

particularly between urban private practitioners and rural physicians. The Great

Depression had taken a toll on rural doctors' incomes, and many physicians in

struggling areas supported any program that would pay them for services that they had

been rendering, sometimes for free. In a 1941 AMA-administered survey of physicians

who were paid through medical care cooperative plans, four of every five respondents

approved of these New Deal projects. Thus, the AMA shied away from outright

opposition, adopting instead what historian Michael Grey has called a policy of

"studious neutrality." Although it avoided outright confrontation with rural colleagues,

as early as 1937 the national medical professional association expressed its fears that the

FSA programs would, for the long-term, introduce "regimentation, regulation, red-tape,

limitation of choice, compensation by salary, and administration by nonmedical

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[2] For "excesses of New Deal liberalism," see Thomas Clark, "The Limits of State Autonomy: The Medical Cooperatives of the Farm Security Administration, 1935-1946," *Journal of Policy History* 11, no. 3 (1999): 268; for the Beveridge Report, and American political resistance to this British model, see Colin Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth-Century America* (Princeton, NJ: Princeton University Press, 2003), 149-151.

personnel." The organization's leaders advised members to be wary of participating in such schemes.[3]

Despite local medical support for health cooperatives, conservative leaders of the AMA got their way when, in 1942, Congress dramatically cut the FSA's budget and pressed the agency to liquidate its cooperative projects. In committee hearings, the FSA's cooperative farms were denounced as comparable to "Stalin's forced collectivization of Soviet agriculture." The FSA health cooperatives succumbed to the AMA's lobbying tactics. When the FSA was replaced by the far less radical Farm Home Administration in 1946, this federal bureaucracy was "explicitly prohibited [from] further participating in health care or health insurance programs."[4]

Like the battle against the health cooperatives, the campaign against EMIC also suffered from internal divisions. The lack of unanimity among doctors kept ajar the window of opportunity that had opened during the mid-1930s. With many rank-and-file doctors willing to participate in programs like EMIC, federal bureaucrats were able to continue to pursue social democratic experiments in health care. The attacks by conservatives on EMIC took two forms: criticism of the full swath of the program and its socialist implications, and piecemeal efforts to chip away at the program's most radical features. Neither was successful in defeating EMIC entirely, nor materially undermining EMIC during the years of the war. In spite of these attacks, EMIC garnered broad participation. In the end, the program terminated, as its leaders had promised it would, when the war emergency came to a close.

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[3] For rural doctors' economic difficulties, for 1941 study of rural doctors, and for AMA's position, see *Journal of the American Medical Association* 120, no. 16 (1942): 1315-1324; and *Journal of the American Medical Association* 108, no. 18 (1937): 1524-1526. Both cited in Michael R. Grey, *New Deal Medicine: The Rural Health Programs of the Farm Security Administration* (Baltimore: Johns Hopkins University Press, 1999), 139.
[4] Clark, "The Limits of State Autonomy," 267-9.

Less than ten years earlier, in support for the Children's Bureau's endeavors under the Sheppard-Towner Act, a group of liberal pediatricians had broken from their more conservative medical colleagues at the AMA. They even formed their own professional representative organization, the American Academy of Pediatrics, as the older, more traditional American Pediatric Society had joined the AMA leadership in castigating the Bureau's efforts. But by the years of World War II, the terrain of collegial support had fundamentally changed, and pediatrics had become a lucrative specialty, with well-child health care a crucial source of income for fee-for-service pediatricians. With these changes, many pediatricians' support for the Bureau fell away, and in the mid-1940s, it was the leaders of the American Academy of Pediatrics who orchestrated the medical opposition to EMIC.

Dr. Joseph Wall, a private pediatrician from Washington, DC, led the charge. In spite of Congressional approval of EMIC, Wall alleged that the program was an insidious assertion of federal bureaucratic control. The women of the Children's Bureau, he charged, were seeking to surreptitiously and "arbitrarily control medical practice." Having read Eliot's expansive letter in *Parents Magazine,* Wall believed that the women of the Bureau saw EMIC as a first step toward nationalized health care. Accordingly, he launched an assault on EMIC, and everything it stood for. Likeminded physicians at the helms of their state medical societies joined in, explaining to constituents that EMIC would "open the door to government medical service for ALL, without economic distinction or determination of need." The program was "definitely SOCIALIZED MEDICINE." In light of these objections, in 1944 Wall used the platform of the AAP's professional journal to explain to colleagues "that the time has arrived when serious consideration must be given to the relationship existing between the Academy and the Pediatricians of the United States on the one hand and the Children's Bureau of the

Department of Labor on the other." With the battle lines drawn over whether doctors

would participate in health justice-oriented federal efforts, a political chasm opened

within the once tight-knit world of pediatric medicine and public health.[5]

The AAP's published assault on EMIC provoked outrage among progressive-

minded pediatricians, especially Martha May Eliot's friends and colleagues, who saw

her as an altruistic and skilled bureaucrat focused on improving the health and welfare

of pregnant American women and infants. Physicians like Edwards Park, Eliot's mentor

at Yale, described Wall's position as "terribly shortsighted and stupid." Even before

EMIC had grown to its eventual size, Park described it as "an extraordinarily popular

success." He marveled that "the Advisory Committee of the Academy has chosen to

make this popular tremendous accomplishment of the Children's Bureau the issue. I can

scarcely think of any act more shortsighted." Park predicted that, thanks to Wall and his

collaborators, "in the public mind the pediatrician would at once be charged with

making the preservation of their own way of doing things take precedence over the

welfare of the mothers and children of the soldiers." Parks believed that "the stupidity

of the [the AAP's statement], if it goes unchecked, would be equal to any act of Fishbien

[sic] in the way of alienation of public sentiment, which is saying a great deal." Here,

Parks was referring to Dr. Morris Fishbein, the famously outspoken conservative editor

of the *Journal of the American Medical Association*. Parks believed that the arch-

conservative, self-interested politics of powerful professional leaders like Wall and

Fishbein was turning the American public against American doctors. EMIC's

supporters, led by the Yale pediatric public health expert, Grover Powers, wrote to the

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[5] For AAP's attacks on EMIC and Wall's statement regarding the long-term relationship between the AAP and the Children's Bureau, see "The EMIC Program," *The Journal of Pediatrics* 25, no. 1 (1944): 88-91; for an example of regional support for the position that EMIC was socialized medicine, with capitalizations preserved from the cited text, see Fernal Foster to Michigan State Medical Society Membership, 28 July 1943, Box 209, file 13-0-4-2 (2) of 2, Records of the US Children's Bureau.

Journal of Pediatrics to express their side of the story, explaining the importance of EMIC and the diligence of its lead administrators. As this intra-professional controversy mounted, the AAP retracted its position, choosing instead a tactic of grudging, temporary support for the Bureau and its wartime efforts. With congressional support and clear professional dissension on the issue, representatives of the AMA and the AAP tempered their tone, agreeing to "wholeheartedly cooperate with the program for servicemen's families for the duration [of the war] but not beyond."[6]

Though Wall and his cadre at the AAP withdrew their refusal to support EMIC during the war years, they nevertheless continued to express vociferous opposition to many of its most radical features. They asserted that EMIC's use of a direct payment system was unnecessary, and attempted to convince Congress to make EMIC a cash benefit, given to servicemen's wives, just "as cash allotments are made to the wives and children of servicemen for other necessities of life." According to the AMA's House of Delegates, a government body paying a physician or hospital directly was "needless and undesirable because it is not in accord with the American system of medical practice." EMIC's opponents also tried to convince Congress to include a means test for EMIC, thereby ensuring that EMIC recipients were in fact too poor to pay for their care out of pocket. Antagonists also bridled against the imposition of fee ceilings and the prohibition against EMIC's participating doctors requesting or accepting any additional payments for services. Adding insult to injury, opponents found that some EMIC patients carried insurance policies as well, and these physicians were maddened to learn that, although individual supplementation to fee ceilings was not allowed, EMIC funds

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[6] For Parks' reaction to AAP statement, see Edwards A. Park, MD to Rustin McIntosh, 10 August 1944, Box 5, McIntosh Papers; for Powers' support for EMIC, see Grover F. Powers, "Comment the American Academy of Pediatrics and the Children's Bureau," *The Journal of Pediatrics* 25, no. 3 (1944): 275-78; for AAP and AMA retraction, see "Reports of Officers," *Journal of the American Medical Association* 124, no. 18 (April 29, 1944): 1273.

could be used to supplement these policies' coverage. Until this practice was curtailed,

physicians were forced to accept not one, but two forms of third party payment. In the

view of antagonists, EMIC exposed just how far medical care had strayed from the

simple, fee-for-service system that had long prevailed.[7]

Like EMIC's opponents, Eliot and her colleagues saw how great the stakes were

for EMIC's policies around the issues of direct payment, means testing, and

supplemental payments. She insisted that direct payment was the only effective way to

assure medical care for servicemen's wives. In response to one adamant opponent of

direct payments, Eliot remarked:

> It is hard for me to see how physicians who are purportedly seeking ways
> to provide care of the highest quality can believe that today when medical
> care in this country is so poorly distributed that handing a mother X
> number of dollars would in any way improve the quality of care that she
> or her infant will get."

To the national readership of the *Journal of the American Medical Association*, Eliot

explained that a means test was "contrary to the democratic principles under which

their husbands have been drafted for service in the armed forces." With each of these

provisions, Eliot's vision triumphed. Through 1946, she and her colleagues at the

Children's Bureau remained in a position to determine the method by which maternal

and child health care could be justly distributed to this subset of the population, which

politicians deemed utterly deserving. Despite the late 1930s conservative turn away

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[7] For cash benefit proposal to avoid direct payment, see "Reports of Officers," *Journal of the American Medical Association* 124, no. 18 (April 29, 1944): 1273; for one doctor's frustration regarding patient's using EMIC to supplement other insurance coverages, and Eliot's response, see Gamble to Eliot, July 1945 and Eliot to Gamble, 3 August 1945, Box 199, File 13-2-2-1(0) Correspondence regarding EMIC program, August 1945, Records of the US Children's Bureau; for objections to direct payment scheme, see Nathan Sinai and Odin Anderson, *EMIC (Emergency Maternity and Infant Care): A Study of Administrative Experience*, (Ann Arbor: University of Michigan, 1948), 33.

from the most liberal, income-redistributing features of the New Deal, Congress continued to protect EMIC from the onslaughts of its conservative antagonists.[8]

The struggles over the New Deal health cooperatives and EMIC revealed that, for the duration of the 1930s and through World War II, the federal government's long-term role in health policy was up for grabs. Bureaucrats at the Public Health Service, the Farm Security Administration, and the Children's Bureau held firm to a justice-based vision for federal involvement in health services. Drawing from both communitarian and rights-based discourses, the designers and administrators of he New Deal health cooperatives and EMIC argued that to resolve the social crisis of the Great Depression and to make good on President Roosevelt's statement of economic rights, federal agencies needed to stay in the game of health service financing and delivery. Just as their opponents asserted, these progressive federal employees indeed saw EMIC—like other federal health experiments during the war years—as a "possible trial balloon, bridgehead, or entering wedge" for a durable system to create health justice in America. Their opponents in the medical profession were keenly critical of this plan, and aimed, just as they had in the 1920s, to stymie social reformers' progressive agenda and convince Americans that the federal government had no rightful place in health service financing and delivery. The exigencies of the Depression and war staved off these opponents. But in peacetime, all bets were off.[9]

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[8] For Eliot's remark regarding "X number of dollars" as inadequate, see Eliot to Veeder, 18 December 1943, Box 214, File 13-2-2-1(0) Correspondence with Unofficial Agencies re EMIC, Nov 1944, Records of the US Children's Bureau; for means test as contrary to democratic principles, see Martha M. Eliot, "Emergency Maternity and Infant Care Program -- for the Wives and Infants of Men in the Armed Forces," *Journal of the American Medical Association* 124, no. 13 (1944): 837.

[9] For "possible trial balloon" remark, see "Reports of Officers," *Journal of the American Medical Association*, 1275.

Chapter 9: The Cold War and the Legacy of Health Justice at Home and Abroad

In the late 1940s, Martha May Eliot and Katharine Lenroot were investigated by the FBI. Like other progressive federal officials who had risen in stature during the heady New Deal years, they were scrutinized for potentially radical proclivities. Both were cleared of allegations of disloyalty. Borden Veeder, a pediatrician who had vocally objected to EMIC's socialistic overtones, later recalled that he had been summoned to report on the Bureau's leaders by "one of those witchcraft Congressional committees for Communist leanings." When asked if Eliot was disloyal, Veeder recalled saying that thought he was in "violent disagreement with the President over a lot of his social and economic views," he hardly considered Roosevelt "'disloyal'." He explained, "I feel exactly the same as regards Dr. Eliot. I have known her many years and believe her to be as loyal as anyone I know." Though these women were cleared of disloyalty charges, the the Red Scare irrevocably changed the political climate for progressive health policy innovators.[1]

By 1948 the writing was on the wall. The New Deal was ending, and the war-era's progressive script for federal social welfare policy was fading quickly. Between 1933 and 1946, the socially democratic health-care programs, designed and led by Lenroot, Eliot, and many other federal civil servants, were a politically viable approach

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[1] For investigation of Lenroot, see FBI, "Katharine Lenroot; Report of Special Agent Thomas A Simpson," (reference number 121-10991), in author's possession; Memo J Edgar Hoover (Director of FBI) to Seth Richardson (Chairman of Loyalty Review Board, US Civil Service Commission), May 6 1949, (File: IRB:CFN: jcd), in author's possession, released by US Office of Personnel Management; for investigation of Eliot, see "Report on Dr. Martha May Eliot," 21 March 1968, enclosure in memorandum from Mildred Stegall to DeLoach, in author's possession. Their original locations are unknown. All of these documents were obtained by mail subsequent to author's FOIA request to the FBI for all records for Katharine Lenroot and Martha May Eliot. For Veeder's response to Eliot's investigators, see Veeder to Eliot, 5 February 1960, Folder 50, Eliot Papers.

to social policy. But by the last three years of the decade and through the 1950s, programs like EMIC and the New Deal health cooperatives collapsed, becoming artifacts of a bygone liberal era.

What happened between 1945, when powerful political support held EMIC's opponents at bay, and 1950, when everything left of center became out of bounds? What happened to the careers and political aspirations of women like Eliot and Lenroot, along with their male counterparts in the FSA? This final section answers these questions, first through analysis of the macro-level transformations that took place between 1944 and 1950 in federal politics, national tax policy, and the rise of the private welfare state. I then turn to the biographies of Lenroot and Eliot, the inheritors of a settlement house-based ethos of health justice work, to discuss where the most ardent advocates of health justice for women and children fit themselves into both domestic and international efforts in the fields of public health and social welfare activities during the Cold War and through the 1965 return of a liberal approach to federal social policy.

Between 1944 and 1947, it was unclear which way domestic politics would turn. There were two contradictory and parallel developments during this period. On the one hand, federal commitment to Americans' day-to-day needs and to social democratic values grew substantially. On the other, conservative political views, corporate power, and market-based solutions to social welfare needs grew increasingly strong. To make matters even more complicated, some major federal policies of the era rested decidedly in the middle, with their consequences uncertain as far as which direction—left or right—they would pull domestic politics.

The women of the Children's Bureau hoped that the surge of participation in and support for EMIC in 1946 signaled the continuation of the New Deal and wartime gains

in social democracy. Empowered by the New Deal and wartime social programs, liberal stakeholders and policymakers had gained serious traction in redistributing political power, expanding the purchasing power of lower-income Americans, increasing the access of minority Americans to civic life, and countering the conservative forces of corporate capital and white supremacist politics.

Still, the first months of Harry Truman's presidency left many in President Roosevelt's inner circle anxious about the durability of the New Deal's social welfare commitments. Inaugurated in April of 1945, Truman quickly dismantled Roosevelt's cabinet, replacing most of its members with more centrist advisors, many of them Southern Democrats and all of them male. Truman's newly appointed Secretary of State, James Byrnes, privately told Secretary of Labor, Frances Perkins, "There won't be any place in this administration for people like you." The New Deal, he declared, "has come to an end." Indeed, Perkins, the cabinet's most reliable friend to the women of the Children's Bureau, was replaced by the far less progressive and less ambitious Lewis Shwellenbach. In the 1946 mid-term elections, Republicans gained control of both houses of Congress, thereby buttressing Truman's conservative shift. Successful conservative candidates for Congress, such as Richard Nixon and Joseph McCarthy, made the specter of Communist subversion and the rejection of the New Dealist regulatory state prominent and publicly appealing campaign messages.[2]

Despite of the ascendence of this conservative political viewpoint, New Deal liberals nevertheless retained the hope that Truman would remain committed to at least some of the New Deal's ideals of social democracy. Significantly, Truman kept

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[2] For Byrnes remark, see Downey, *The Woman Behind the New Deal*, p. 349. For Truman's Cabinet, see Michael J. Hogan, *A Cross of Iron: Harry S. Truman and the Origins of the National Security State, 1945-1954* (Cambridge, U.K.: Cambridge University Press, 1998), 253. For the success of Richard Nixon and other conservatives in the 1946 elections, see Jonathan Bell, *California Crucible: The Forging of Modern American Liberalism* (Philadelphia: University of Pennsylvania Press, 2012), 19-20; and Chafe, *Unfinished Journey*, 76-77.

Roosevelt's most progressive Cabinet member, Henry Wallace, in the post of Secretary of Commerce. In his first year in office, Truman established a Civil Rights commission, and in 1947 he became the first president to ever address the national convention of the National Association for the Advancement of Colored People, the largest and most politically influential African-American political lobby. "Every man should have the right to a decent home," he declared, "the right to an education, the right to adequate medical care, the right to a worthwhile job, the right to an equal share in the making of public decisions through the ballot, and the right to a fair trial in a fair court." Even as conservatism appeared to be gaining traction, Truman nevertheless appeared to espouse a Rooseveltian devotion to basic political and economic rights as part of the entitlements of US citizenship.[3]

In a 1945 speech to Congress, Truman unveiled his national health plan, stating that "the health of American children, like their education, should be recognized as a definite public responsibility." Truman may well have offered these remarks to curry favor with his progressive base and with black Democratic voters in the North, whom he knew to be crucial for his political longevity. Nevertheless, such statements led many advocates of federally designed health-care programs to believe that Truman would be a great advocate for health justice. Bolstering this faith was the fact that Capitol Hill still swarmed with New Deal officials, who had cut their teeth creating social welfare and health service policies. They had yet to be swept out of town.[4]

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[3] For Henry Wallace as Secretary of Commerce, see Chafe, *Unfinished Journey*, 76. Truman's speech before the NAACP, see Harry Truman, Fourth draft, speech to NAACP, with corrections by Harry S. Truman, 28 June 1947, Papers of Harry S. Truman: President's Secretary's File, digital transcript accessed January 22, 2014, http://www.trumanlibrary.org/flip_books/index.php?pagenumber=1&titleid=252&tldate=1947-06-28&collectionid=ihow&PageID=-1&groupid=3723; for Roosevelt's advocacy of a right to homeownership, and the political philosophical implications of that position, see Ronald Tobey, Charles Wetherel, and Jay Brigham, "Moving Out and Settling In: Residential Mobility, Home Owning, and the Public Framing of Citizenship, 1921-1950," *American Historical Review* 95, no. 5 (1990): 1395-1422.
[4] For Truman's speech unveiling his health plan, see Harry Truman, Special Message to the Congress Recommending a Comprehensive Health Program, 19 November 1945, accessed January 22, 2014,

Senator Claude Pepper of Florida was the politician who most embodied this optimism about Truman's commitment to federal responses to social welfare needs. Pepper devoted himself to partnerships with progressive Children's Bureau leaders throughout the war years and shortly thereafter. Even as "Florida turned toward the right" and as the state's powerful white-supremacist businessmen flexed their muscles against his political career, Pepper became an activist for New Deal political ideology, as well as early civil rights engagement. Pepper's little-known campaign to create a right to maternal and child health care epitomized the way that wartime experiments in social democracy fueled progressives' visions of a peacetime continuation of the New Deal. In spite of the gathering tide of conservatism at the war's end, some politicians maintained their passion for social democratic programs even when such endeavors were at cross purposes with those of their constituencies.[5]

In the fall of 1945, Pepper proposed S.1318 to Congress, a bill to create the Maternity and Infancy Care Act. The "Pepper Bill" envisioned a comprehensive

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http://www.trumanlibrary.org/publicpapers/index.php?pid=483&st=&st1=. For the faith held by liberal policy advocates that Truman was committed to their approach, see Frothingham to Truman, 21 March 1946, Truman Papers: President's Personal File, Box 552, File 2506. There is a historiographic debate on the extent of Truman's commitment to a progressive health policy agenda and to FDR's New Deal political agenda as a whole. For those who argue that Truman was passionately committed to the New Deal's social democratic plans, albeit within the system of capitalism, see Alonzo L. Hamby, *Man of the People: A Life of Harry S. Truman* (New York: Oxford University Press, 1995). For Truman as committed in earnest to a national health plan, and his willingness to take political risks in order to see this plan to fruition, see Beatrix Rebecca Hoffman, *Health Care for Some: Rights and Rationing in the United States since 1930* (Chicago: University of Chicago Press, 2012), 58-61; Monte M. Poen, *Harry S. Truman Versus the Medical Lobby: The Genesis of Medicare* (Columbia: University of Missouri Press, 1979); and Karen Kruse Thomas, *Deluxe Jim Crow: Civil Rights and American Health Policy, 1935-1954* (Athens: University of Georgia Press, 2011), 149. On the other side of the debate, Colin Gordon argues that Truman's 1948 support for a liberal and capacious health care agenda relied on his knowing full well "that it would be shredded in Congress." See Colin Gordon, *Dead on Arrival : The Politics of Health Care in Twentieth-Century America*, (Princeton, NJ: Princeton University Press, 2003), 270. David Blumenthal and James Morone argue that not only did Truman merely inherit his position on a national health plan from FDR, but "he did little to lobby it through Congress, he never took it to the American people (though his allies begged him to do so), and he never came close to winning." See David Blumenthal and James A. Morone, *The Heart of Power: Health and Politics in the Oval Office* (Berkeley: University of California Press, 2009), 58. For the perspective that Truman's devotion to centrist political consensus far outweighed him commitment to Roosevelt's vision for social democracy, see Chafe, *Unfinished Journey*, 76-77.
5 For Florida's rightward turn, see Claude Denson Pepper with Hays Gorey, *Pepper: Eyewitness to a Century* (San Diego: Harcourt Brace Jovanovich, 1987), 120 and 199.

maternal and child health system, run by the Children's Bureau. It would be modeled on

EMIC and the Social Security Act's Crippled Children's Program. The program defied

the trend of the post-war years to make government benefits available only to the most

indigent. Pepper's health care plan for women and children would have no means test,

would be funded through general revenue, and would guarantee "comprehensive

preventive, diagnostic, and curative services for all mothers and children who elected to

participate." Pepper believed that the women of the Children's Bureau should oversee

this nationwide endeavor. Initial political maneuvering for the Pepper Bill began as

early as 1944, when Martha May Eliot approached Pepper, the Chairman of the Senate

Subcommittee on Wartime Health and Education, to urge his support of the Bureau's

federal wartime preparedness activities in child welfare. With EMIC in full swing, Eliot

understood that her successful leadership of EMIC was linked to the fate of Pepper's

proposed extension of EMIC during peacetime.[6]

In the summer of 1946, with EMIC enrollment at its all-time high, Pepper's

proposals were brought before congressional committees. Before the Senate Committee

on Education and Labor, representatives of the Congress of Industrial Organizations

(CIO) expressed their support for S. 1318, as did progressives in the public health field.

Dr. Paul Cornely, the medical director of Howard University's hospital, believed that the

Pepper Bill would create a long-term federal program to ameliorate the infant and

maternal mortality rates which, though gradually decreasing during the years of EMIC,

nevertheless remained "alarmingly high for a civilized nation such as ours," especially

among black Southerners and "Mexicans." Hazel Corbin, a friend of Eliot and the

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[6] For full text of S.1318, and Pepper's summary of the proposed law, see *Maternal and Child Welfare Act of 1946: Hearings on S. 1318, Before the Committee on Education and Labor, United States Senate,* 79th Cong., 2nd. Sess., June 21 and 22, 1946 (statement of Claude Pepper, Democratic Senator from Florida), 10. Henceforward "MCW Act Hearings, 1945." For Eliot's lobbying for Pepper's support, see "Memo of Interview with Feltus," 22 March 1944, Folder 159, Eliot Papers.

director of the Maternity Center Association, a New York-based training institution for professional midwives and public health nurses, believed that the Pepper Bill would engender a just system of health care. Pepper's proposal would refute the notion that in America "there are two kinds of [health] care for two kinds of people—one kind for free patients, another for those who pay their way." As in the past, some progressive-minded physicians, such as Henry Helmholz of the Mayo Clinic, remained devoted to the Bureau's mission. Helmholz appreciated that Pepper's bill would reframe health care as a basic right. In a telegram sent to Pepper and read before the Senate committee deliberating over the bill, "Just as every American child has a right to an education so S. 1318 states for the first time that every American child has a right to health." Statements like these cut to the heart of the bill's political implication. In the words of American Federation of Labor (AFL) leader William Green, "every American citizen has the right to be safely born." Green predicted that "S.1318 will do much to make good that right."[7]

Thanks to remarks like these, Eliot realized that, if made into law, Pepper's bill would indeed upend health care nationwide and position the Bureau to lead this revolution toward comprehensive maternal and child health services. As "people who are living in areas without modern facilities and services" became aware of their entitlement to health services, they would "press their right to receive the kind of care we know how to give today." Eliot saw that the Bureau, as well as every health facility that served women and children, had their work cut out for them. Thanks to EMIC's success and the widely held faith in Eliot's superior competence, Pepper believed that

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[7] For Cornely, Corbin and Helmholz statements before the Senate Committee, see Senate Committee Hearings on S. 1318, June 1945, 218, 273, and 92; for William Green's remark on S. 1318, see Green to Senator Murray, 31 October 1945, Folder 330, Eliot Papers.

the women of the Children's Bureau were the designated leaders for such a visionary project.[8]

Predictably, the bill encountered fierce antagonism. Opponents insisted that, while EMIC was acceptable in wartime, the Pepper Bill was utterly unacceptable as a peacetime extension of an EMIC-style program. EMIC's great foe, pediatrician Joseph Wall, called the program a "socialistic endeavor" that violated the rights of states to establish their "constitutional prerogatives." He feared that Pepper's proposals would impose "assembly line methods" in health care and "trespass upon the civil liberties of the American people."[9]

Opposition to the Pepper Bill tapped into the longstanding antagonism toward female-led political and professional endeavor. In the 1920s, the Sheppard-Towner Act, coupled with the suffragists' recent success, had provoked anti-feminists to characterize the politically engaged women of the Children's Bureau as angry, degendered activists whose lack of personal fulfillment in the domestic sphere fed their political rambunctiousness and their professional ambition. Similarly, though more tempered in their language, the Pepper Bill's opponents bridled against the Children's Bureau's postwar aspirations in health policy administration. Conservative male doctors caricatured the female directors of the Bureau as driven by "sentimental feeling" and called their endeavors a motherly imposition of "what is good for you not only on the medical profession but on the public." Antagonism to female leadership in maternal and child health policy in the years after the war also reflected the marginalization of female physicians in the medical profession. In the late 1930s and through the war years, women had far fewer options for medical residencies and were mostly absent from the

[8] Eliot to Wilson, 19 December 1945, folder 330, Eliot Papers
[9] letter Wall to Mayo, 17 September 1945, Folder 330, Eliot Papers; and MCW Act Hearings, 1945 (Statement by Dr. Joseph Wall, Chairman of the Committee on Legislation of the American Academy of Pediatrics, representing the American Medical Association), 59.

AMA's leadership. The Pepper Bill revived an old question: would the nation's political leaders, along with the dominant members of the medical lobby, allow a female-led bureaucracy to design and direct a national health program, whose goal was to address the specific health rights of pregnant women and children?[10]

In the end, the answer was a resounding no. Pepper's proposals for expanding maternal and child health services, for creating a universal health system for children politically comparable to the system of universal education, and for empowering female New Deal bureaucrats to run it went farther than the Truman administration was prepared to go. The Pepper Bill fell by the wayside when Truman threw his support behind the national health plan developed by Senator Robert Wagner. Known as the Wagner-Murray-Dingell Bill, S.1606 aimed to expand the Social Security Act to include a national health plan that would be funded through employer and employee contributions and run by the Social Security Administration. New Deal liberals unified in support of S.1606 as the bill that would bring health care into the system of social security benefits that protected the welfare of wage laborers and their families. Although S. 1606 would do little to improve health care access for black Americans in the agricultural work force, left-wing political organizations, like the Physicians Forum, nevertheless joined the effort to pass the Wagner-Murray-Dingell program, seeing it as the most politically viable health reform bill on the table. Like victory gardens and federally subsidized child care centers, EMIC would not live beyond the years of the war.[11]

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[10] For gender-based remarks about the Bureau's female directors, see Marshall Carleton Pease, "The Children's Bureau. Chapter in American Academy of Pediatrics: June 1930 to June 1951" (Evanston, IL: American Academy of Pediatrics, 1952), 160; for the limited opportunities of female doctors in the 1940s, see Regina Markell Morantz-Sanchez, *Sympathy and Science: Women Physicians in American Medicine* (New York: Oxford University Press, 1985): 340-341.

[11] For Truman's support of Wagner-Murray-Dingell bill instead of Pepper bill, see Memorandum "HAK" 19 March 1946, Box 105, File Health, Truman Papers: President's Secretary's File; for the Truman administration's relative disinterest in women's issues, see Cynthia Harrison, *On Account of Sex: The Politics*

Despite EMIC's success and the support of politicians like Pepper, in 1946 the

Children's Bureau was dealt its biggest blow yet. That year, Truman initiated a thorough

reorganization of the federal government, aiming to streamline the chaos of New Deal

agencies that had arisen on Capitol Hill under his predecessor. New Deal insiders

considered Truman's reorganization plan to be driven by "anti-labor sentiment," as the

plan's most substantial consequence was a weakening of the Department of Labor,

which, thanks to the Children's Bureau and the Division of Labor standards housed

within it, had been in the vanguard of left-wing policymaking for labor rights. Federal

Reorganization Plan 2 went into effect in July. The Bureau was demoted to a sub-agency

within the FSA, and both were subsumed within the larger Social Security

Administration.[12]

For the women of the Bureau and their allies, reorganization represented a long-

anticipated blow. Supporters of the Bureau had worked tirelessly against "previous

attempts to dismember" it, fully aware that a shift to a lower bureaucratic rung would

spell defeat for its vision. The AMA had lobbied for the agency's demotion as early as

1937, aware that such a move would undermine these women's ability to push forward

their health-justice agenda to place federal government at the helm of health service

regulation. After reorganization, the Bureau's worst fears were confirmed. The male-led

FSA treated the Bureau's staff as a "huge corps of clerical workers" rather than as the

of Women's Issues, 1945-1968 (Los Angeles: University of California-Los Angeles Press, 1988)*,* 62-64; for Physicians Forum support of Wagner-Murray-Dingell Bill, see Physicians Forum Pamphlet, [no date], Box 196, File Health and Medical Program, Truman Papers: President's Secretary's Files. For wartime child care centers funded through Lanham Act during WWII, see Kaspar Bucher, "A Social History of Ideas Pertaining to Childcare in France and in the United States," *Journal of Social History* 45, no. 4 (2012): 1005-1025; and Abby J. Cohen, "A Brief History of Federal Financing for Child Care in the United States," *The Future of Children* 6, no. 2 (1996): 26-40; for victory gardens, see Char Miller, "In the Sweat of Our Brow: Citizenship in American Domestic Practice During WWII—Victory Gardens," *Journal of American Culture* 26, no. 3 (Sept 2003): 395-409.
[12] Kriste Lindenmeyer, *"A Right to Childhood": The U.S. Children's Bureau and Child Welfare, 1912-46* (Urbana: University of Illinois Press, 1997): 252-3.

medical, nursing, and social welfare professionals that made up forty percent of their staff. The Bureau's health policy endeavors were "swallowed up by the Public Health Service," which directed the Social Security Administration's health initiatives. With the withering of the Pepper bill and the demotion of the Children's Bureau, it appeared that the women of the settlement-house movement had lost their campaign to play a part in federal health policy.[13]

The withering of the Pepper Bill highlighted the increasing force of underlying conservative currents in American political life. During the World War II era, conservatives had been chipping away at the social democratic aspirations of both the organized labor movement and the federal bureaucracy. Though the turn toward conservatism was not a foregone conclusion at the war's end, two interconnected developments on the home front fueled the conservative trend in domestic politics: the increasing viability of private voluntary benefit programs, and the triumph of business unionism.

During the war years, American wage earners and their families increasingly came to believe that their social welfare needs could be met through what historian Jennifer Klein has called "the public-private welfare state." Even as they contributed to the public Social Security system, wage earners also voluntarily contributed to private health and annuity programs put in place by their employers. Whereas private benefit programs and health clinics had once been run by fraternal societies and unions during World War II, voluntary health insurance organizations now took control of these

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[13] For prior attempts to move Children's Bureau, see US Department of Labor, Children's Bureau organizational chart, attached to "Memorandum: in relation to proposals for reorganizing or transfer of functions," 3 August 1944, Folder 255, Eliot Papers; for letters from Bureau allies seeking to prevent reorganization, see, Hassett to the Director of the Bureau of the Budget, 21 March 1946, Box 114, File Children's Bureau, Truman Papers: Official File; and Powers to McMahon, 22 May 1946, Folder 331, Eliot Papers; for the specter of reorganizing in 1937, see Lenroot to Eliot, 14 January 1937, Box 17, Folder 10, Lenroot Papers; for the PHS's "swallowing" the Bureau, as an outcome of reorganization, see Martha May Eliot, interviewed by Peter A Corning, June 21, 1966, Columbia Center for Oral History.

functions. Some union representatives were wary of these schemes, unsure about whether these private "welfare programs were 'a legitimate trade union activity or a form of collaboration with welfare capitalism.'" According to historians David Rosner and Gerald Markowitz, however, labor willingly supported their members' participation in voluntary insurance programs. The labor movement saw the insurance industry as a "community service institution." During the war, "health insurance—a method for *paying* for health care—began to displace the *provision* of health care as a primary goal for organized labor." During World War II, the labor movement had paradoxically supported two very different methods for Americans to obtain health benefits. Even as the AFL and CIO's leadership promoted programs like EMIC and advocated for national health insurance proposals, union members themselves increasingly participated in voluntary benefit programs whose reins were firmly in the hands of private industry.[14]

Employers drove the vast increase in voluntary benefit program participation. This support grew out of wartime economic and labor policy. The federal government's wartime wage freeze made it impossible for employers to increase monetary compensation as a way to retain badly needed workers. In the context of labor shortages, voluntary benefit programs became a means to expand compensation offers and attract workers. Even more important was the wartime tax code, which allowed businesses to deduct the cost of benefit premiums from their taxable income. At the same time, workers were permitted to exclude these benefits from their taxable income. These wartime policies helped explain employers' enthusiasm to make voluntary benefit

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[14] For public-private welfare state, see Jennifer Klein, *For All These Rights : Business, Labor, and the Shaping of America's Public-Private Welfare State* (Princeton, NJ: Princeton University Press, 2003), 6-10; for voluntary insurance, see Marie Gottschalk, "The Elusive Goal of Universal Health Care in America," *Journal of Policy History* 11, no. 4 (1999): 367-398, 371; and David Rosner and Gerald Markowitz, "The Struggle over Employee Benefits: The Role of Labor in Influencing Modern Health Policy," *Milbank Quarterly* 81, no 1. (2003): 60-61.

programs available to their workforce. They also made working-class people aware of the possible advantages of having their social welfare needs met through privately owned commercial and voluntary health insurance programs based at their jobs.[15]

The medical lobby threw its political weight behind these private solutions to health care financing, convincing businesses that this approach was preferable to public national health proposals. Although in the 1920s and 1930s organized medicine had bridled against any form of third-party reimbursement, including union-run health benefit programs and mutual benefit societies, by the mid-1940s the leadership of the AMA came to see privately-run voluntary health benefits as preferable to public, government-run activities like the New Deal health cooperatives, EMIC, and Truman's national health plan. Though still preferring a system in which all medical bills were paid by patients themselves as fee-for-service, the medical lobby by the 1940s supported private insurance schemes like Blue Cross/Blue Shield. The leadership of the AMA saw these options as the lesser of two evils. The Pepper Bill and the Wagner-Murray-Dingell proposal were, in the words of the President of the Utah Medical Society, "a definite step by Government bureaus to interfere between the doctor and his patient." A federally directed health coverage program remained, as far as private practice physicians were concerned, the worst-case scenario. [16]

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[15] For wartime tax policy and its influence on private benefits, see Beth Stevens, "Blurring the Boundaries: How the Federal Government Has Influenced Welfare Benefits in the Private Sector," in Margaret Weir, Ann Shola Orloff, and Theda Skocpol, eds., *The Politics of Social Policy in the United States* (Princeton. NJ: Princeton University Press, 1988), 132-133. Jennifer Klein deals at length with the growth of the insurance industry, and with labor and management's eventual acceptance of the industry's private welfare solutions during the war years. She links this process of change also to the growth of the group medical practice, most notably the Kaiser model. See Jennifer Klein, *For All These Rights*, 177-203.

[16] For AMA's eventual embrace of voluntary and then commercial health insurance plans, see Christy Ford Chapin, "The American Medical Association, Health Insurance Association of America, and the Creation of the Corporate Health Care System," *Studies in American Political Development* 24, no. 2 (2010): 143-167; and Christy Ford Chapin, "Ensuring America's Health: Publicly Constructing the Private Health Insurance Industry, 1945–1970," *Enterprise and Society* 13, no. 4 (2012): 729-743. For the Utah Medical Society's reaction to the national health plan proposals of the late 1940s, see MCW Act Hearings, 1945 (Exhibit 18, Statement submitted by Ray T. Woolsey, Utah State Medical Association), 223.

At the war's end, the direction of post-war politics still hung in the balance, despite these signs of growing conservatism. In 1944, FDR vastly expanded the Public Health Service's coffers, creating a nationwide anti-tuberculosis campaign, a grants-in-aid program for public and private institutional research in public health, and expanded PHS-supported public health nursing services. Thanks in part to the federal government's economic recovery during the war years, in 1946 Congress further increased federal spending in health policy. The National Mental Health Act of 1946 created the National Institute of Mental Health as a response to the mental health needs of returning veterans. Despite the conservative current against the New Deal interventionist state, by the time the war ended the federal government was spending more than it ever had to increase the scope of public health research and to expand access to basic health services.[17]

Dwarfing these programs was the GI Bill of 1944, the most wide-ranging social program the United States had ever seen. Besides paying for thousands of returning veterans to attend college and purchase their first homes, the GI Bill pumped 8.4 billion dollars into the Veterans Administration (VA) hospital system by 1947. This federal spending made the total expenditures on federal health programs like the New Deal health cooperatives and EMIC look like small change.[18]

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[17] For 1944 expansion of the PHS, see Franklin D. Roosevelt, "Statement of the President on Signing the Public Health Service Act," July 1, 1944, from Gerhard Peter and John T. Woolley, *The American Presidency Project,* accessed online January 24, 2014, http://www.presidency.ucsb.edu/ws/index.php?pid=16528; for the National Mental Health Act, see National Mental Health Act, 1946, Pub. L. No. 79-487, 79th Cong., 2nd. Sess. (July 3, 1946). David Rosner and Gerald Markowitz argue that these wartime changes in public health policy pointed to an overall conservative trend within the field of public health, which emphasized research over structural change. See Gerald E. Markowitz and David Rosner, *Lead Wars: The Politics of Science and the Fate of America's Children* (Berkeley: University of California Press, 2013), 3-4. While acknowledging this overall political trend and the moderate political impact of this spending, my emphasis here is merely on the unprecedented federal support for health policy programs.

[18] See Servicemen's Readjustment Act of 1944, Pub. L. No. 78-346, 58 Stat. 284m (1944). See also Christine Scott, "Veterans Affairs: Historical Budget Authority, FY1940-FY2012," prepared for Congressional Research Service, June 2012, accessed January 26, 2014, http://www.fas.org/sgp/crs/misc/RS22897.pdf. For the GI Bill generally, see Glenn Altschuler and Stuart Blumin, *The GI Bill: A New Deal for Veterans* (Oxford: Oxford University Press, 2009).

Despite the dramatic contrast in terms of its scope, the GI Bill's commitment to universally available, government supervised health services for returning servicemen and their families reaffirmed the logic of EMIC—that those who served in the nation's armed forces were entitled to government-paid health care, as were their wives and children. Progressive health reformers hoped that the popularity of the GI Bill and the VA health system would induce a larger public outcry for a universal health insurance system for all Americans in subsequent years. VA officials used the law to test innovative methods of linking federal funding and oversight with private medical practice. This endeavor led the politically conservative VA medical director, Dr. Paul Magnuson, to fear that, with the GI Bill, his agency had "given aid and comfort to those who wanted to bring all medicine under government control."[19]

Irrespective of whether or not veterans' benefits could be generalized to the entire American population, the GI Bill profoundly expanded federal involvement in health services. According to sociologist Alex Campbell, the law made ten percent of the American population potential "beneficiaries of a fully funded national health care system with facilities in nearly every state." The VA not only opened new health facilities around the nation and repaired old ones, but also linked these facilities to medical schools, thereby providing veteran patients with access to doctors outside of the civil service system. This move increased the quality and availability of care that the government could provide to its returning soldiers and their families. Even as conservative ideologues in Congress and at the AMA pushed against New Deal and wartime initiatives, the GI Bill, like other wartime federal programs, garnered

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[19] Colin Gordon, *Dead on Arrival*, 133.

widespread political support, based on its patriotic justification and its effects in strengthening the fortunes of the middle class.[20]

The mixed direction of health policy after the war was reflected again in the 1946 Hill-Burton Act. Advocates for this law, which funneled seventy-five million federal dollars per year into hospital facility repair and construction, came from both sides of the political aisle. Conservatives who had opposed Truman's national health plan nevertheless supported Hill-Burton "because it tackled health care shortages without inviting government intervention," and asserted no government regulation of individual hospitals' policies. Hill-Burton supporters from the left were pleased by the law's declaration that Hill-Burton-funded facilities had to deliver a "'reasonable level' of care to the poor." Surgeon General Thomas Parran believed in Hill-Burton, seeing increased hospital access as a key feature of health policy reform and as a means for making health care universally available. Like many other progressives, Parran believed that the law would do more than any of the 1930s PHS or Children's Bureau programs, to transform health care for black Americans. As Karen Kruse Thomas argues, the law did in fact dramatically expand health care access for black Southerners.[21]

Despite Hill Burton's stipulation to increase health care access for the indigent, its impact was far less progressive than some of its advocates had hoped. Most disappointing to the National Medical Association, the national medical society for black

[20] Alec Cambell, "The Invisible Welfare State: Establishing the Phenomenon of Twentieth Century Welfare Benefits," *Journal of Political and Military Sociology 32*, no 2 (2004): 249-267; and Mark D. Van Ells, *To Hear Only Thunder Again: America's World War II Veterans Come Home* (Lanham, Md.: Lexington Books, 2001), 121-123; for the rise of veterans as a political bloc beginning after World War I, see Stephen Ortiz, *Beyond the Bonus March and GI Bill: How Veteran Politics Shaped the New Deal Era* (New York: New York University Press, 2009).

[21] See Hill-Burton Act, formally Title VI of the Public Health Service Act, Pub. L. No. 79-725, 60 Stat. 1040 (1946). For conservative as well as progressive rationales supporting Hill-Burton, see Hoffman, *Health Care for Some*, 69, 146; Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, Inc., 1982), 349; and Karen Kruse Thomas, *Deluxe Jim Crow : Civil Rights and American Health Policy, 1935-1954* (Athens: University of Georgia Press, 2011), 190-191; for Parran's perspective, see "Thomas Parran, 1892-1968," *American Journal of Public Health* 58, no. 4 (1968): 617.

doctors, Hill-Burton allowed "separate but equal" facilities for black patients. Hill-Burton fit in with what historian Colin Gordon refers to as the "political strategy of placating reformers by opening the federal purse and placating opponents by relinquishing control to local or private interests." As indicated by the law's powerful support from the American Hospital Association, Hill-Burton legitimized the belief, advanced by the biomedical industry, that access to medical technology was the key to improved health. Hill-Burton gave a federal legislative stamp of approval to the hospital industry's argument that hospital access equaled health. While hospital beds became more available under Hill-Burton, many patients nevertheless could still not afford them.[22]

Some skeptics of this hospital-based focus for post-war health intervention understood that the seemingly generous federal health policies of the 1940s, which equated health facility expansion with health reform, were political gambits to obtain liberal supporters, and would do little to improve the health of disadvantaged Americans. Among these skeptics were the women whose political roots lay in the settlement-house movement. In 1940, Children's Bureau stalwart Edith Abbott already saw that the political strategy of hospital construction was inadequate for improving the health of American women and children. When Roosevelt proposed a much more limited hospital construction program during the course of the New Deal, Abbott declared that policies like these would create "not a health program but a series of

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[22] Karen Kruse Thomas dubs this trend in health service funding in the South "Deluxe Jim Crow," arguing that even as funding for Southern public health grew, these institutions further cemented the systematic racial segregation of medical facilities. Kruse Thomas, *Deluxe Jim Crow,* 73-75. See also Gordon, *Dead on Arrival,* 93. For a local case study on the role of Hill-Burton in black people's quest to obtain for health services and in the increased entrenchment of medical segregation in Memphis, see Keith Wailoo, *Dying in the City of the Blues: Sickle Cell Anemia and the Politics of Race and Health* (Chapel Hill: University of North Carolina Press, 2001), 95-103. In the late 1950s, in the wake of Brown v. Board of Education, black medical activists, such as Montague Cobb, grasped onto the Hill-Burton Act as the first piece of federal legislation that could serve as a wedge against medical segregation; see David Barton Smith, *Health Care Divided: Race and Healing a Nation* (Ann Arbor: University of Michigan Press, 1999), 46-47.

hospital shells." By the time that Hill-Burton was on the table, liberal Democratic Senator James Murray of Montana saw things Abbott's way, explaining that the law would be "of only 'limited value' without a comprehensive plan for paying hospital and medical costs." In this way, Hill-Burton epitomized the complex politics of health care during the mid-1940s. Even as controversial programs like EMIC and proposals like the Pepper Bill advanced deeply progressive solutions for structural inequities in health care, more moderate programs, like Hill-Burton, expanded federal involvement in health policy while simultaneously shoring up the health care industry's devotion to commodification, segregation, and expanded facilities, as opposed to structural interventions in public health.[23]

If the first two years of Truman's presidency represented a brief moment of uncertainty as to which way national politics would turn, by 1947 the Taft-Hartley Act and the labor movement's capitulation to the premises of business unionism had settled the question. One year later, by 1948, when Harry Truman ran for reelection, anything left-of-center had become politically untenable. The one major exception to this overall conservatism was civil rights. Despite Truman's durable commitment to expanding racial equality, in the last two years of the 1940s, the surge of conservatism had fundamentally altered the domestic political terrain. This shift rightward made Truman's declaration of a "Fair Deal" expansion of the New Deal into, at best, an unlikely possibility.

It was the demise of the industrial labor force's political power that created the worst blow to the prospects for health justice in America. In 1945 and 1946, the largest strike wave in American history had spread across the nation, encompassing laborers in

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[23] For Edith Abbott's views, see Hoffman, *Health Care for Some*, 69-70. For the 1950s and 1960s iteration of this viewpoint that hospitals would not equal health, see Starr, *Social Transformation of American Medicine*, 364-5.

oil fields and auto plants, meatpackers, steel workers, and coal miners. War-time wage freezes, combined with fast-growing costs of consumer goods, angered workers. While companies were reaping new profits, workers were not. They demanded better wages, job security, pensions, employer-paid insurance benefits, and safer working conditions. But organized laborers in Detroit's auto industry wanted something more than these gains. They envisioned a system of "industrial democracy," in which labor would play a powerful role in political life. In the context of labor-employer relations, unions would actively participate in management decisions and would use strikes and work slowdowns to assert their power. In the 1945 Detroit standoff between General Motors and Walter Reuther's United Auto Workers, the union demanded that the automaker's Chief Executive Officer Alfred Sloan open the company's books to its workers and the public. Meanwhile, strikes expanded across the steel, railroad, and mining industries.[24]

Truman was not happy. He threatened laborers with military conscription and became, in the words of the leader of New York's transportation workers' union, "the number one strike breaker of the American bankers and railroads." In the fall of 1946, Truman kicked Henry Wallace, the most pro-labor member of his Cabinet, out of his inner circle. Driven by the exigencies of foreign policy, anti-labor politicians, Ohio Republican Senator Robert Taft and New Jersey Republican Fred Hartley, Jr., proposed severe legislation to control labor. Under the Taft-Hartley proposals, the government could obtain injunctions against strikers, unions were required to participate in an eighty-day cooling-off period before walking out of the workplace, and states could pass legislation enabling business owners to maintain "open shops" where laborers had the

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[24] For the demise of labor's political power and the silencing of 1930s radicalism and civil rights activism, see Robert Korstad and Nelson Lichtenstein, "Opportunities Found and Lost: Labor, Radicals and the Early Civil Rights Movement*," Journal of American History* 75, no. 3 (1988): 786-811. For 1945 labor dispute in Detroit, see Chafe, *Unfinished Journey*, 89; and Nelson Lichtenstein, *The Most Dangerous Man in Detroit : Walter Reuther and the Fate of American Labor* (New York: Basic Books, 1995).

option not to join the local union. Unions could no longer directly fund political campaigns, and union officials had to foreswear communist affiliations. This last feature was particularly problematic for numerous CIO unions where Communists played a major role. While Truman wavered on how assertively he would counter labor's political power, conservatives aimed to roll back the gains that labor had made during the New Deal, to silence the radical and civil rights activism that had been brewing in the 1940s, and keep the work stoppages of the fall of 1945 from ever happening again. Organized labor understood the stakes, and dubbed the law "a 'slave labor' bill." Truman vetoed Taft-Harley to maintain the labor movement's waning favor, but Congress overrode his veto.[25]

Under the Taft-Hartley Act, the labor movement's political muscle atrophied and its leaders shifted toward the tactics of business unionism, where organized labor accepted management's offers of benefits and incremental negotiations at the expense of playing a role in management decision-making. This conservative approach pushed industrial laborers to participate en masse in the system of employer-based health benefits, which employers had already come to accept as a necessary part of appeasing organized labor. With this shift, the labor movement ceased to throw its weight behind a publicly funded health care system. With the capitulation toward business unionism, the labor movement's radical flank in America gave way.[26]

Truman's approach to the domestic political exigencies of the Cold War represented the nail in the coffin to New Deal social and industrial democracy. On March 12, 1947, Truman spoke to Congress about the political crisis in Greece and

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[25] For Truman as number one strike breaker, see Chafe, *Unfinished Journey*, 90; Marc Allan Eisner, *The American Political Economy: Institutional Evolution of Market and State*, (New York: Routledge, 2011), 95-97; and Lawrence Friedman, *American Law in the 20th Century* (New Haven: Yale University Press, 2002), 190-191.
[26] For the rise of business unionism, see Kim Moody, *An Injury to All: The Decline of American Unionism*, (London: Verso, 1988), 40-48.

Turkey and America's role in the matter. In light of Soviet involvement in this region and elsewhere, US foreign policy needed to support nations that were falling prey to "terrorist activities . . . led by Communists." With the Truman Doctrine's commitment to contain communism abroad, the Cold War definitively began. Alongside Truman's activist foreign policy agenda came a domestic political corollary: the rousting of communist sympathizers from American bureaucratic power. Less than two weeks after his speech on Greece and Turkey, Truman signed Executive Order 9835, creating the Federal Employee Loyalty Program. This order suggested that an insidious network of Communist sympathizers had infiltrated American government and allowed any "suspicion of disloyalty" to serve as grounds for immediate dismissal from federal office. Truman's logic was simple: a Red Scare at home would provide the political fuel to further his fight against Communism the world over. The world had become divided between the forces of good and evil, and, in the words of Michigan's Republican Senator, Arthur Vandenberg, Truman needed to "scare the hell out of the American people."[27]

By the end of the decade, the House Un-American Affairs Committee (HUAC), working with J. Edgar Hoover's Federal Bureau of Investigation, began to conduct investigations of people like Eliot and Lenroot. HUAC paraded bureaucrats and politicians through their meeting room, vividly illustrating the specter of Soviet infiltration in the federal government. Mississippi's Democratic Representative John Rankin, who in the 1920s had fought against the Children's Bureau's progressive health service work, became a stalwart supporter of the government's hunt for subversives.

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[27] Harry S. Truman: "Special Message to the Congress on Greece and Turkey: The Truman Doctrine," March 12, 1947, online by Gerhard Peters and John T. Woolley, *The American Presidency Project*, accessed January 26, 2014, http://www.presidency.ucsb.edu/ws/?pid=12846; and Harry S. Truman, Executive Order 9535, accessed January 26, 2014, http://trumanlibrary.org/executiveorders/index.php?pid=502; for Vandenberg's remarks, see Chafe, *Unfinished Journey*, 93.

Meanwhile, Claude Pepper's political nemesis in Florida launched a campaign against him, dubbing him "Red Pepper." As historian Landon Storrs has copiously documented, under HUAC a multitude of mid-level New Deal bureaucrats withdrew from public life, hiding their affiliations with leftist politics and turning away from federal bureaucratic life to avoid further professional ruin and personal humiliation.[28]

Anti-communist rhetoric lay at the heart of Truman's 1948 reelection campaign against Henry Wallace. The president castigated the politics of "Henry Wallace and his Communists." Fearful that an even-more conservative political agenda would arise if Thomas Dewey—the Republican Party candidate—were elected, the CIO supported Truman, hopeful that he would work to undermine the Taft-Hartley Act. After his narrow second-term victory, Truman made some headway on racial issues, but he distanced himself from social democratic proposals like the Pepper bill.[29]

Truman's efforts to create a national health plan in 1948 represented the New Deal's last gasp on health care reform. Truman's plan was far from radical. He aimed to extend the Social Security system to include health care benefits, thereby making it possible for all American wage earners and their families to obtain health care coverage. This employer-employee-funded proposal was a far cry from the Pepper Bill, and its underlying goal was to create a health care system for individual Americans, rather than to address the full swath of structural problems that affected American health outcomes. Nevertheless, the plan would have significantly undermined the private medical industry's control over health care in America, and for this reason, it was opposed by all of the same stakeholders who had objected to 1920s public health work, New Deal health projects, and wartime programs like EMIC. Despite Truman's effort to rally the

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[28] For HUAC and John Rankin, see Chafe, *Unfinished Journey,* 93-94; for the Second Red Scare generally, see Landon R. Y. Storrs, *The Second Red Scare and the Unmaking of the New Deal Left* (Princeton, NJ: Princeton University Press, 2012); for "Red Pepper," see Pepper and Gorey, *Pepper,* 202.
[29] Chafe, *Unfinished Journey*, 95-97.

same forces that had participated in the 1935 struggle to include health care in the Social Security Act, his efforts failed. With the labor movement's acceptance of business unionism and the overall climate of anti-radicalism, Truman's proposal withered. Health care reform did not stand a chance in the climate of conservatism that had risen to the fore in domestic politics by the close of the 1940s.[30]

In this climate of anti-radicalism, the federal officials at the Children's Bureau and the FSA who had inherited the settlement house movement's social democratic approach to women and children's health care no longer had comfortable institutional homes on Capitol Hill. By 1948, it was clear that opponents to health justice had achieved what they had tried to do for over two decades: muffle the most progressive voice in Washington, burying health policy radicals within the bureaucratic social welfare apparatus.

The FBI dug up evidence of Katharine Lenroot's radical predilections. In the 1930s, she had sponsored the Committee of Women of the National Council of American-Soviet Friendship and had been involved in the United American Spanish Aid Committee. Nevertheless, Lenroot was cleared of charges of disloyalty and retained her post as Director of the Children's Bureau through the end of the 1940s. But the years of scrutiny of Lenroot's political proclivities, including FBI interviews of her friends, family, and even her real estate agent, had taken a toll. In 1951, Katherine Lenroot retired, and asked Martha Eliot to assume the mantle of leadership of the Children's Bureau. Eliot accepted, despite an attractive opportunity that awaited her at Yale as a professor in the School of Public Health with the chance to develop a new Department of

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[30] For Truman's 1948 effort to pass the Wagner-Murray-Dingell Bill and opposition to this plan, see Monte M. Poen, *Harry S. Truman Versus the Medical Lobby: The Genesis of Medicare* (Columbia: University of Missouri Press, 1979); and Gordon, *Dead on Arrival*, 18-20, 143-144, 155-156.

Maternal and Child Health. Overcoming the "dread" about life in the Capitol, Eliot took the post, largely because Lenroot as well as Eleanor Roosevelt urged her to do so. In doing so, she carried on a tradition, begun by her forebears in the settlement house years, of accepting public posts out of a sense of civic duty, and the hope that this institution could continue to push forward the goal of health justice for women and children.[31]

The career paths that Eliot and Lenroot pursued during the 1950s and 1960s reveal a final chapter in the stories of those who hoped to create a system of health justice for women and children in America. In these years, women like Eliot appear to have gradually realized that the era of ambitious, politically charged engagement around federal health justice work had ended. They felt a sense of foreboding, as the settlement-house movement's institutional approach and political ideology became increasingly marginalized. What was the source of that foreboding? And how did they respond to the realization that their political agenda had been squeezed out? Finally, what activities and institutions did they turn to, so that their skepticism might be replaced by camaraderie and a sense of renewed opportunity?

Eliot's apprehension about serving as the Bureau's new director was in part the result of the political climate created by the Red Scare. She herself had been investigated, and her colleagues had been given the chance to denounce her. In all likelihood, her dread also grew from the reality that not only her politics but also her personal lifestyle were objectionable in a 1950s characterized by the resurgence of traditionalist gender

[31] For FBI findings on Lenroot, see "Katharine Lenroot; Report of Special Agent Thomas A. Simpson," (reference number 121-10991), original location unknown, in author's possession. This document was obtained by author through FOIA request to FBI for all records re. Katharine Lenroot, and it was released by the FBI; and "Memorandum: J Edgar Hoover (Director of FBI) to Seth Richardson (Chairman of Loyalty Review Board, US Civil Service Commission), 6 May 1949, (File: IRB:CFN: jcd), original location unknown, in author's possession. These documents were obtained by author through FOIA request to FBI for all records on Katharine Lenroot. It was released by the US Office of Personnel Management. For Lenroot's invitation to Eliot to become new Bureau director, see Lenroot to Eliot, 8 August 1951, Folder 155, Eliot Papers; for Eliot's other employment opportunity, see Eliot to Sinai, 28 April 1951, Folder 155, Eliot Papers.

roles for women. Like the women of the settlement house, Eliot and Lenroot lived most

of their adult lives in monogamous, same-sex relationships. Eliot maintained a long-

term, exclusive, and probably romantic relationship with pediatrician Ethel Dunham.

During the FBI's 1948 investigation of Eliot, an unnamed informant alleged that "an

individual with whom Dr. Eliot had resided over a ten-year period possessed

communist tendencies and instilled some of those principles in Dr. Eliot." Eliot's

affiliation with Dunham was, in itself, suspect. Like Eliot, Lenroot too spent her adult

life in a long-term personal and professional partnership with another social reformer,

Emma Lundberg. By the early 1950s, women like Eliot and Lenroot no longer fit as

comfortably into Washington's bureaucratic life as they had during the New Deal, with

its network of female social reformers led by Eleanor Roosevelt and Frances Perkins.

College-educated, independent women who rose to professional expertise while living

personal lives in the company of other women were yet again seen as deviants. As in the

earlier iterations of anti-radical public opinion, feminists and unmarried professional

women during the Red Scare of the 1950s were branded "foreign agents" and deemed

part of a bolshevist infiltration into American public life.[32]

  If this anti-lesbian and red-baiting climate were not enough to make Washington

an inhospitable place, by the early 1950s, proponents of commodified health care in

America had damaged the Children's Bureau's vision of publicly directed health

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[32] For Eliot's relationship with Dunham and a hagiographic treatment of Eliot as an influential lesbian doctor, see Lillian Faderman, *To Believe in Women: What Lesbians Have Done for America--A History* (Boston: Houghton Mifflin, 1999), 291-305; and Bert Hansen, "Public Careers and Private Sexuality: Some Gay and Lesbian Lives in the History of Medicine and Public Health," *American Journal of Public Health* 92, no. 1 (2002):36–44. For FBI investigation, see "Report on Dr. Martha May Eliot," 12 March 1968, enclosure in Memorandum from Mildred Stegall to DeLoach, original record location unknown, in author's possession. This document was obtained by author through FOIA request to FBI for all records re. Martha May Eliot, released by FBI. For material on Lenroot and Lundberg's personal relationship, see photograph of Lenroot and Eliot, Box 9, Folder 29, and Lundberg Will, Box 8, Folder 30, both in Lundberg Papers. Lenroot was the executor. For presumed connections between lesbianism and bolshevism, see Donna Penn, "The Sexualized Woman: The Lesbian, the Prostitute, and the Containment of Female Sexuality," in *Not June Cleaver: Women and Gender in Postwar America, 1945-1960*, ed. Joanne J. Meyerowitz, (Philadelphia: Temple University Press, 1994), 358-381.

services for women and children. In the wake of Truman's failed efforts to create a national health plan, a coalition of private stakeholders—among them group and individual medical practitioners, for-profit hospitals, and commercial health insurance companies—reclaimed the reins of the health care economy. The surge in medical costs, the resulting potential for profit-making in medicine, and the increasing emphasis on technological advancement in biomedical research trumped the public health agenda that social reformers had been pursuing for the past sixty years. Thanks to these conservative forces, the Children's Bureau women's aspirations for a rights-based approach to maternal and child health work became a shout in the dark.[33]

Accordingly, during the 1940s and 1950s, the public health profession backed away from the explicitly justice-oriented focus of an earlier generation of public health reformers. Many public health advocates accommodated to the new political climate, focusing their energies on the less controversial project of encouraging bipartisan federal support to fund health research. Public health lobbyists easily convinced federal legislators to support their proposed expansion of the National Institutes of Health. Such research-based public health endeavors allowed politicians to appear concerned with the nation's health without having to make controversial commitments to publicly funded, federally guided health service projects. In the course of the 1950s, NIH grew to become a hub for research grants that gave scientists and doctors relative freedom. Through this expansion, academic public health experts could garner funds and status for research projects in an era when large scale public health interventions were no longer politically viable. This carrot of research funding lured public health practitioners and researchers away from politically focused structural change and toward scientific

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[33] For changes in medical and insurance industries during the 1950s, see Starr, *Social Transformation of American Medicine*, 327-363; and Christy Ford Chapin, "Ensuring America's Health: Publicly Constructing the Private Health Insurance Industry," PhD dissertation, University of Virginia, 2012.

inquiry. With these changes in the fields of medicine and public health, female

pediatricians like Eliot became relics of a bygone era.[34]

Despite these inhospitable circumstances and the turning of the tide away from

the Bureau's approach to maternal and child health services, Eliot remained in

Washington and attempted to maintain and expand a justice-based program for

maternal and child health services. She held fast to her belief that being a public servant

is "one of the highest callings any citizen of the United States can have" and was

devoted to the Bureau as "the conscience of the American people toward its children."

Finally a doctor had become the director of the Children's Bureau, and Eliot hoped,

perhaps naively, that her appointment might allow the Bureau to maintain a role in

health care administration.[35]

During her early years as the director of the Children's Bureau, Eliot persisted in

her calls for the public to take responsibility for the health of American women and

children. She served on Truman's Presidential Commission on the Health Needs of the

Nation (PCHNN), a federally supported study panel that persevered in spite of the

failure of Truman's national health proposal. In her summary report to this body, she

emphasized the problem of poor access to adequate medical, dental, occupational, and

mental health services, especially for poor and rural children. Eliot insisted that this was

not mainly a problem of health manpower shortages, but rather one of inequality.

Access to "children's health services" remained inextricably linked to "economic well-

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[34] Rosner, Starr, and Robert Cook-Deegan and Michael McGeary, "The Jewel in the Federal Crown? History, Politics, and the National Institutes of Health," in Rosemary Stevens, Charles E. Rosenberg, and Lawton R. Burns, *History and Health Policy in the United States: Putting the Past Back In* (New Brunswick, NJ: Rutgers University Press, 2006), 177- 218; for growth of research during World War II and 1950s, see Starr, *Social Transformation of American Medicine*, 338-347.

[35] For Eliot's views on civic leadership, see Dorothy Barclay, "Godmother to the Nation's Youngsters," *New York Times,* April 6, 1952, p.SM17

being," and it was still the case that children with less money had far less access to decent care.[36]

Eliot's understanding of the problem of maternal and child health went beyond the issue of health care access. In her keynote address to Truman's panel of experts in June of 1952, Eliot expressed her belief that the "grave danger" to American children's health lay in the fact that medical care was "too little and too late" for many poor children. A family's poverty more than anything else determined their ill health. The children who suffered most were those living in single parent homes whose average income was a mere thirty dollars per week. Eliot remained the moral conscience on this problem, insisting that government was responsible not just to expand health care but to improve the health of America's poorest and sickest children. Exposing the problem of health injustice endured as an essential feature of Eliot's role as the Bureau's director, even as the terrain for justice-oriented health policy became inhospitable for her and her colleagues.[37]

The most convincing proof of Eliot's unflagging devotion to her agency's approach to maternal and child health work can be seen in her attempt, in the months after becoming the Bureau's leader, to reignite EMIC. As American engagement in Korea reached an apex, Eliot wondered if "as the armed forces grow and families start moving around the country, the need for an EMIC program will arise." It was a rhetorical question. Eliot already knew that New York Democratic Senator Herbert Lehman had developed a bill to fund a new EMIC-style plan to cover the costs of pregnancy and early childhood for families of servicemen in the lowest seven pay grades. Eliot

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[36] "Health of Mothers and Children" July 8, 1952, 5, Box 9, File Study Panel on Health of Mothers & Children, July 8 1952, Records of the President's Commission on the Health Needs of the Nation, Record Group 220 (henceforth "PCHNN – RG 220).
[37] "Keynote Address of Martha M. Eliot" to PCHNN, June 18 1952, p. 5014-5015, Box 10, File Study Panel on Health of Mothers & Children, July 8, 1952, PCHNN – RG 220.

considered the proposal to be a "basically good EMIC bill." The Bureau's old allies

agreed. AFL President William Green wrote to Harry Truman, explaining the need for a

"quick provision of funds to activate without delay the operation of the Emergency

Maternity and Infant Care Programs in the centers of defense activity throughout the

nation." However, with labor's political influence significantly reduced, and with the

AMA and Blue Cross opposing new federal involvement in health financing, the

proposal gained little traction. Already practiced in castigating the Bureau for EMIC and

for its efforts to pass the Pepper Bill, opponents flexed their muscles again. One

California physician explained that he and his colleagues had already been "burned up"

by the Bureau's "attempt to foist [EMIC] upon the country" and would refuse to tolerate

another program like it. This doctor ended his letter to Edwin Daily, Lenroot's deputy,

by congratulating him on his departure from the Bureau just in time to avoid the

controversy that this new EMIC proposal would incur. As Eliot had predicted, with

Cold War foreign policy issues dominating American political conversations in the

1950s, it was "of course, very difficult to get financial support for programs not regarded

as basically defense programs." By the spring of 1952, the proposal was dead. [38]

It became clear during the first two years of Eliot's leadership that the Bureau's

voice on maternal and child health policy had been muffled. The demotion of the

Children's Bureau and the disempowerment of its leaders also made it nearly impossible

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[38] For Eliot's remarks at swearing-in ceremony, see clipping, *JAMA*, 15 September 1951, Folder 162, Eliot Papers. For Lehman's EMIC-style proposal, see "Senate Committee Staff Studies EMIC and Military Dependents' Problems," Box 36 File: *Capitol Clinic* (Folder 1), PCHNN – RG 220. For Green's remarks on Lehman's proposal, see William Green to President, 14 January 1952, Box 577, File 103-G, Truman Papers: Official File; for support and opposition to Lehman's proposal, see "Senate Health Subcommittee Action on EMIC Bills Promised 'Fairly Soon' March 18, 1952, Box 36, File: *Capitol Clinic* (Folder 1); "Budget Bureau Won't Recommend Passage of EMIC Bills" March 25, 1952, Box 36 File: *Capitol Clinic* (Folder 1); April 15, 1952, "Blue Cross Spokesman Opposes Separate Maternity Contracts for GI Dependents", PCHNN, Box 36 File: *Capitol Clinic* (Folder 1), all in PCHNN – RG 220; for California's doctor's correspondence to Edwin Daily, see Thompson to Daily, May 14 1951, Box 482, File13-2-2-1(0) Correspondence Re. EMIC 1949-1952 [folder 3 in box], Records of the US Children's Bureau. For Eliot's view on the challenge in getting the bill passed, see Lenroot to Eliot, 27 April 1951 Folder 155, Eliot Papers.

for women like Lenroot and Eliot to mentor a new generation of similarly driven female social reformers within this agency. Whereas a continuous line of female-led political engagement in redistributive, justice-oriented health service programs had existed from the first years of the settlement houses in the 1890s, through the 1920s and 1930s, and into the years of World War II, the political shift that occurred after 1947 broke this chain of continuity. The Bureau lost the funds and the reputation to remain a compelling institution for liberal-minded women social reformers. In the context of Cold War conservatism and the "June Cleaver" domestic ideal, the archetype of altruistic, unmarried, and politically engaged women like Jane Addams, Florence Kelley, and Lillian Wald lost traction. The Children's Bureau ceased to be the federal home where college educated women could build careers and implement their political ideology through bureaucratic innovations. Although settlement houses continued to function around the nation, by the years following World War II, many of these institutions were depoliticized, becoming sites for service provision and sociological research. Just as the Bureau became a quiescent federal agency, the settlement houses ceased to be the source for innovative, liberal, and even radical social reform planning.[39]

Because of these forces that severed the line of social reform efforts, many histories of the women of the Children's Bureau and of the settlement-house movement terminate with the New Deal. These histories leave scholars to wonder: what happened

[39] For the "June Cleaver"-style domination of normative female gender identity during the 1950s, see Elaine Tyler May, *Homeward Bound*. Other historians point to a more complex role for women in post-war America, which enabled many pathways out of this "conservatism and constraints" model. See, for example, William Chafe, *Paradox of Change: American Women in the 20th Century* (New York: Oxford University Press, 1991). For a summary of this literature, see Joanne Meyerowitz, "Introduction: Women and Gender in Postwar America, 1945-1960, in *Not June Cleaver,* 1-18. For the de-politicization of New York's settlement houses in the face of anti-radical forces of the 1950s, see Michael Fabricant and Robert Fisher, *Settlement Houses under Siege: The Struggle to Sustain Community Organizations in New York City* (New York: Columbia University Press, 2002): 48-50.

to these women in the wake of the conservative turn away from their social reform agenda? Where did they turn their attention in the 1950s and 1960s?

In truth, these women's rights-based approach to maternal and child health services persisted through subsequent decades. Even as these women-led institutions withered and their ability to foster a new generation of social reformers diminished, the women who had led the Children's Bureau during the EMIC years retained their fundamental politics. They sought out new institutions where they could pursue their vision of equitably distributed and high quality maternal and child health care, as well as their understanding of the structural forces behind women and children's health.[40]

A similar problem of "where to go next" faced the men who had led the Farm Security Agency and Public Health Service's health care activities during the New Deal and war years. In April 1946, Truman signed the Farmers Home Administration Act. This law replaced the FSA with the Farm Home Administration (FHA), an agency to which Congress gave far less authority than to its predecessor. The writing was already on the wall. In 1947, the FSA's controversial rural rehabilitation project, with its health cooperatives, migrant health programs, and experimental health plans, was terminated. According to Frederick Mott, by 1947 the Health Services Branch of the FSA/FHA had become "the immediate point of attack." In the words of historian Michael Grey, its "already skeletal staff had been purged." Functionally, at least, the FSA had suffered a fate similar to that of the Children's Bureau: its bureaucratic capacity was eviscerated, with its health-related policy advocates either dismissed or effectively muzzled.[41]

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[40] For histories of female social reform work, and of the Children's Bureau that end between the New Deal and the late 1940s, see Robyn Muncy, *Creating a Female Dominion in American Reform, 1890-1935* (New York: Oxford University Press, 1991); and Kriste Lindenmeyer, *"A Right to Childhood": The U.S. Children's Bureau and Child Welfare, 1912-46* (Urbana: University of Illinois Press, 1997).

[41] For the conversion of the FSA to the FHA, see Michael R. Grey, *New Deal Medicine: The Rural Health Programs of the Farm Security Administration* (Baltimore: Johns Hopkins University Press, 1999): 10; for the dismantling of the FSA's medical endeavors, see Grey, *New Deal Medicine*, 164-166.

The Red Scare of the early 1950s punished the FSA and PHS leaders who had been in the forefront of New Deal experimentation in health care policy. HUAC scrutinized two of the FSA health services division's lead staff, Milton Roemer and Fred Mott. Even Surgeon General Thomas Parran was brought before HUAC. By providing names and serving as witnesses, the leaders of the AMA helped HUAC target those medical doctors who were considered the ring leaders behind progressive health care ideals. In light of this harassment and the systematic dismantling of the FSA and the Children's Bureau, the questions facing progressives were where they would turn their attentions, and how they would foster a new generation of progressive health policy advocates.[42]

As the window closed in the early 1950s for a justice-based approach to federal health policy, Children's Bureau and New Deal agency officials pursued the next chapter of their careers in international, local and labor-based institutions. The women of the Children's Bureau and the men of the FSA and Public Health Service went to different organizations. Female social reformers like Lenroot and Eliot participated most actively in the international health rights movement and local community health endeavors. Meanwhile, key male public health bureaucrats turned to helping other, more progressive-minded nations develop national health systems. They also contributed their energies to one of the post-war period's most ambitious health system innovations: the comprehensive health service system built by and for the United Mine Workers of America (UMWA). In this spectrum of international, local, and labor-movement based engagements, people like Eliot, Lenroot, and many others found new programs to which they could contribute their energies, expand their professional

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[42] Grey, *New Deal Medicine,* 164.

expertise, and create a new hub for justice-based approaches to health policy. Their biographies reveal not only the doggedness of their endeavors, but also the durability of their ideology, which has persisted to the present day.

Despite their agency's focus on domestic health needs, the leaders of the Children's Bureau had long dedicated themselves to serving women's and children's health needs around the world. In Eliot's case, her transnational perspective on maternal and child health services began when she was in medical school at Johns Hopkins during the years of World War I. She and Ethel Dunham, already a close friend, had hoped to go to France to serve at a base hospital during World War I. They were denied the opportunity, as no women were invited on this mission. By the beginning of the next war in Europe, Eliot's stature had increased, and women now had a role to play. In the winter of 1941, Eliot toured Europe with Surgeon General Thomas Parran, among others, in order to become familiar with the Allies' civilian preparedness measures, particularly with regard to the health needs and services for women and children. Eliot's mentor, Yale public health professor Edwards Park, wrote a letter to Dunham, expressing his concern for Eliot's welfare. "I can't help but be worried in regard to Martha," he wrote. "I hope that she does not get caught up in the thick of things. She feels so intensely that she might take a pop-shot or two at a couple of parachute troopers, and, as the result, be beheaded." Eliot returned safely, with a newly piqued interest in other nations' approaches to women's and children's health services.[43]

Between 1948 and 1960, Eliot served among the most senior American medical representatives to the burgeoning international rights institutions. Even as her

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[43] For Eliot and Dunham's attempt to work in France during World War I, see Martha May Eliot, interview by Jeannette Bailey Cheek, Cambridge, MA, November 1973-May 1974, Schlesinger-Radcliffe Oral History Project, tapes and transcript, 25; for Eliot's tour in 1941, see "Mission Develops U.S. Civil Defense," *New York Times,* February 13, 1941, 6; for Park's concern for Eliot's wellbeing, see Park to Dunham, 11 February 1941, folder 38, Eliot Papers.

responsibilities in Washington grew, she took on high-level engagements in the United

Nations International Children's Emergency Fund (UNICEF) and the World Health

Organization (WHO). In 1947 Eliot took four months leave from Children's Bureau, first

to serve as the vice chairman for the American delegation for WHO's founding

committee. She was the sole female signatory for WHO's constitution. She then took on

the role of Chief Medical Consultant to the newly-established UNICEF. Between 1949

and 1951, Eliot took two more years of leave to serve as assistant director general of the

World Health Organization. During these years, her scope of interest went far beyond

Europe. She traveled to far flung places—Vietnam, Cambodia, Hong Kong, and Israel—

discovering the "limitless opportunity" and the "urgency of need" for WHO's efforts to

train local public health workers. Just as she had been lauded by American colleagues

for her work on EMIC, when Eliot resigned from this position she received accolades

from the world's leaders in the movement for international health rights. WHO's

Director General, Dr. Brock Chisholm declared, "Those of us who have had the privilege

of working with her have been filled over and over again with a sense of deep

admiration for her indefatigable energy and her boundless enthusiasm." Eliot's

commitment to public service in the field of maternal and child health increasingly

shifted toward international issues and organizations.[44]

In a presentation to a panel of international experts in maternal and child health,

Eliot expressed a set of underlying truths about the interconnectedness between poverty

and ill health among women and children. "Undernutrition," "malnutrition," and the

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[44] For Eliot's career in international health, see Richard Pearson, "Dr. Martha M. Eliot, 87, Noted Pediatrician, Dies," *The Washington Post*, February 19, 1978; Martha May Eliot, "Child Feeding in Europe under the International Children's Emergency Fund," *American Journal of Public Health and the Nations Health* 38, no. 1 (1948): A5; Dorothy Barclay, "Godmother to the Nation's Youngsters," *New York Times,* April 6, 1952, SM17; for Eliot's travels and her impressions of the need for expert involvement in global women and children's health work, see Eliot to Ira Hiscock, 10 April 1951, Folder 158, Eliot Papers; for Brock Chisholm's commendation of Eliot's service at WHO, see clipping, WHO newsletter, May-June-July 1951, Folder 162, Eliot Papers.

"lack of other necessities of life" lay at the heart of children's health problems the world over. To resolve the dire health problems of the world's children, "expectant and nursing mothers must be well fed and well cared for, if they are to bear and nourish healthy children." Eliot stressed that international institutions needed to plan "careful and well-organized expenditure[s] of money and effort." This belief in public institutional leadership paralleled her commitment to government-led interventions in the United States. In Eliot's view, "there can be no more important objective than the salvaging of damaged child life and the building of strong and healthy men and women who can play a full part in the reconstruction of a devastated world." Just as the moral logic of patriotism lay at the root of EMIC's rationale, a moral plea drove Eliot's call for public engagement in global maternal and child health.[45]

Eliot saw herself as a uniquely qualified specialist and advisor for international maternal and child health work. She presented US expertise in this field as, in her words, a potential "transplant" for "seeding" competently-led maternal and child health service programs in other nations. Eliot saw herself as an "international servant" called "to be the carrier of modern knowledge and skill from one country, where such knowledge had been acquired or put to work, to another where the new facts had not yet found their way in the customs and habits of the people." Eliot believed the American tradition in social policy innovation was in itself exceptional, and also that the international health rights community was drawing directly on this tradition.[46]

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[45] Eliot, "Child Feeding in Europe," A1-A7.

[46] For Eliot's views on her role as an expert, see Martha May Eliot, "Individual Welfare in the World Crisis [no date], Folder 92, Eliot Papers. Eliot seems to have been susceptible to a tendency, which some recent human rights historians dispute, namely, to believe that the movement for international human rights grew substantially out of an American ideology of liberal human rights, and that Americans played the lead role in formulating international rights work. For the notion that American, New Deal principles drove early United Nations rights formulations see Elizabeth Borgwardt, *A New Deal for the World: America's Vision for Human Rights* (Cambridge, MA: Belknap Press of Harvard University Press, 2005). For an alternative historiographic perspective that views the post-war direction of international rights work as a set of fluid, transnational conversations about how global institutions should respond to the lessons of World War II, see

Whereas Eliot's involvement in international health issues began with the needs of European children before and during World War II, Lenroot's involvement started in Latin America in the 1920s and 1930s. She pioneered the Pan-American Union's work to disseminate expert advice on maternal and child health between the US and Latin American governments, and she asserted the particular leadership of women and feminists in child rights work. She published widely in Latin American public health journals and served on an array of child welfare panels in Uruguay and Peru throughout the 1930s and 1940s. Beginning in 1947, Lenroot served as UNICEF's US executive board member, maintaining this role until her retirement in the summer of 1952.[47]

By the late 1950s, Eliot and Lenroot, along with other Bureau-based colleagues, had become world-renowned experts in the field of international women's and children's health. To their colleagues in American public health, they summarized the work that WHO was undertaking, explaining that aid work for mothers and children fell into three general categories: "mass health campaigns" to eliminate infectious and other epidemic disease, like malaria, tuberculosis, and yaws; administrative guidance, training, demonstration projects, and material support for maternal and child health centers; and "food conservation programs mostly done through [the United Nations'] Food and Agricultural Organization." In this array of interventions, including not only

Paul Gordon Lauren, *The Evolution of International Human Rights: Visions Seen*. 2nd ed., (Philadelphia: University of Pennsylvania Press, 2003); and Akira Iriye, Petra Goedde, and William I. Hitchcock. *The Human Rights Revolution: An International History*, (New York: Oxford University Press, 2012).
[47] For the role of women in the Pan American Union, see Donna J. Guy, "The Politics of Pan-American Cooperation: Maternalist Feminism and the Child Rights Movement, 1913-1960, *Gender & History* 10, no. 3 (1998): 450. See also Anne-Emanuelle Birn, "Uruguay on the World Stage: How Child Health Became an International Priority,"*American Journal of Public Health* 95, no. 9 (2005): 1506-1517. For Lenroot's involvement in the Pan American Union, see Pan American Child Congress, Box 20, Folders 11 & 12, and Box 21, Folders 1 & 2; History of International Activities, 1970-1974 (2 Folders), Box 21 Folder 11 to 12; Inter-American Child Welfare Work--Bulletins and Articles, 1939-1943, Box 20 Folder 7; Inter-American Conference on Problems of War and Peace, 1945, Box 20 Folder 8, Lenroot Papers; for Lenroot's work at UNICEF in the 1950s, see Memoirs of Katharine Lenroot: Remarks at a Luncheon with UNICEF Friends on the Occasion of her 80th Birthday: Helenka Pantaleoni; US Committee for UNICEF, Box 32, Folder 12, Lenroot Papers; See also Eliot to Lenroot, 7 August 1951, Folder 155, Eliot Papers.

health care but also nutrition and public health education, the international health rights movement inherited the fullness of the settlement-house movement's understanding of how to improve the health of children.[48]

In international health rights work, Eliot and Lenroot had found a place where they could continue to initiate programs founded on a structural, justice-based approach to health services. Here, they found allies who also wanted to push toward a "social determinants of health" approach to health service design. According to historian John Farley, some WHO staffers believed that, in the wake of the discoveries of penicillin, DDT, and an array of vaccines, medical interventions alone could eradicate disease world-wide. WHO's Director-General Brock Chisholm, however, agreed with women like Eliot and Lenroot, arguing that "the microbe is no longer the main enemy" and that not just poverty, but even "superstition" and "religious intolerance" were the underlying problems. Just as the women of the settlement-house movement had devoted themselves to the mission of ameliorating the living and working conditions of the disadvantaged industrial working class, these women approached their work with a distinctive vision that inherently ran counter to conventional wisdom about the triumph of medicine over disease. In this way they were a part of the 1940s human rights movement that, in the words of historian Samuel Moyn, may have done "far more to transform the terrain of idealism than . . . the world itself."[49]

Eliot spent the final years of her career teaching in higher education and designing municipal child welfare work back in the United States. During the mid-

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[48] Jessie M. Bierman and Martha M. Eliot, "WHO Contributions to Child Health," *Public Health Reports* 73, no. 5 (1958): 402-11, pp. 405-406. For other reports of international child health work, see Martha M. Eliot, "Advisory Services of the World Health Organization," *British Medical Journal* 1, no. 4661 (1950): 1027-32; and Martha M. Eliot, "International Efforts for Human-Welfare," *Children* 3, no. 5 (1956): 170-76.
[49] For the internal disputes at WHO about the role of "magic bullet" medical intervention versus social medicine style work, see John Farley, *Brock Chisholm, the World Health Organization, and the Cold War* (Vancouver: University of British Columbia Press, 2008): 2-4, 17; for Moyn's remark about the role of 1940s human rights work, see Samuel Moyn, *The Last Utopia: Human Rights in History* (Cambridge, MA: Belknap Press of Harvard University Press, 2010): 9.

1960s, the civil rights movement and the Great Society put health care coverage for the indigent and the elderly back on the federal political agenda. Thanks to this resurgence of liberal political policy experimentation, the last chapter of Eliot's career came full circle: back to a time when large-scale health reform seemed possible, and back to the urban health and welfare issues that had enlivened her forebears in the settlement houses. Eliot led the way in turning maternal and child health work from a field of practice to a field of research, doing in the early 1960s what the women at Hull-House had done at the turn of the twentieth century through their partnerships with the University of Chicago's School of Social Service Administration. The public health academy became the site where these former Children's Bureau leaders would mentor a new generation of American maternal and child health experts, who fostered the ideology of justice in health invented in the settlement houses.

In 1956, when she stepped down as the Children's Bureau's Director, Eliot decided to move back to Boston, the city of her youth. In 1957 she became the chair of the department of child and maternal health at Harvard's School of Public Health. In 1959 she founded Massachusetts Citizens for Children, a Boston-based children's advocacy organization. Eliot continued to teach through the late-1960s, inculcating students with a practical understanding of how policy change for women's and children's health had occurred over the course of her career.[50]

In her lecture notes for a 1964 course for public health students at Harvard, Eliot outlined the interconnectedness of the Bureau's activities. She and her colleagues were political players, "stimulat[ing] action through legislation." They had also set standards

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[50] For Eliot's career during the 1950s, see "Biography of Dr. Martha May Eliot," website of the National Library of Medicine, National Institutes of Health, "Changing the Face of Medicine," accessed January 26, 2014, https://www.nlm.nih.gov/changingthefaceofmedicine/physicians/biography_99.html; for Eliot's work with Massachusetts Citizens for Children, see "Mission," Massachusetts Citizens for Children website, accessed January 26, 2014, http://www.masskids.org.

of care for health care providers. Public health bureaucrats had also devoted themselves to strengthening private institutions. She taught her students about the networks that she and her Bureau colleagues fostered with the League of Women Voters, labor organizations, the General Federation of Women's Clubs, consumer protections and veterans groups. As a teacher, Eliot aimed to pass on to future public health professionals and civil servants the ethos of innovation and institutional collaboration that had been born in the settlement-house movement.[51]

Eliot's decision to finish her career in academic public health and municipal maternal and child health work was hardly unique. Her colleagues who had run EMIC with her similarly spent the end of their professional lives in the academy. Harry Becker, Eliot's deputy, became a professor of community health at Albert Einstein Medical College in New York. Edwin Daily, who had fielded many of EMIC's logistical policy issues, became the lead public health bureaucrat for the New York City Department of Health's Maternity and Infant Care-Family Planning Project. This program provided prenatal and infant health care for twelve thousand New Yorkers in the early 1970s. Jessie Bierman, who coordinated EMIC's local level administration, especially in California, had a long career at the University of California's School of Public Health, where she was the first faculty member to teach child health. At Berkeley, she not only taught, but also recruited colleagues, especially female doctors, to staff the children's health services of the Children's Hospital in economically disadvantaged Oakland. Like Eliot and Lenroot, Bierman balanced her career in the American public health academy with international engagements, among them the directorship of WHO's division for Maternal and Child Health in the 1950s. For this cadre of former EMIC bureaucrats, a career in maternal and child health meant local level health practice and teaching, based

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[51] Handwritten notes, Children's Bureau – Maternal and Child Health -- Harvard School of Public Health 5, 25 May 1964, Folder 790, Eliot Papers.

out of an academic medical center, along with municipal, state, and international public service. In light of the politically inhospitable climate for EMIC-style federal programs up that lasted from the late 1940s into the mid-1960s, these former federal bureaucrats turned toward international and local endeavors, and through these channels managed to teach their strategies and mentor new generations of public health and social policy reformers.[52]

The late 1940s were a turning point, not just for the women of the Children's Bureau, but also for the men of the Public Health Service and FSA health care cooperatives. Thomas Parran was the highest level health service official to leave the federal government as Cold War conservatism shifted away from progressive health policy ideas. In light of the AMA's "medical McCarthyism" accusations against Parran for misusing federal funds and supporting political activities that were "in opposition to American democratic processes," Truman chose not to re-appoint him as Surgeon General. For Parran, as for Eliot and Lenroot, Washington had become a difficult political environment. Like them, he found international health work and the academy to be more hospitable. After playing a leading role in the early years of WHO, Parran accepted a post as the founding dean of the University of Pittsburgh's new School of Public Health.[53]

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[52] For Becker's career, see "Health Executives Development Program Set for June," *American Journal of Public Health* 64, no. 2 (1974): 154; and Harry Becker, interview by Peter A. Corning, New York, 6 December 1966, Columbia Oral History Project, transcript and tapes; for Edwin Daily's career, see Edwin F. Daily, Aileen R. Sirey and Lucille S. Goodlet , "New York City's In-Hospital Family Planning Program," *Family Planning Perspectives* 2, no. 3 (1970): 35-40; for Jessie Bierman's career, see Jessie Bierman, interview by Pauline Stitt, published in Regina Markell Morantz-Sanchez, Cynthia Stodola Pomerleau, and Carol Hansen Fenichel, *In Her Own Words: Oral Histories of Women Physicians* (Westport, CT: Greenwood Press, 1982), 118; and Earl Siegel, "In Memoriam, Jessie M. Bierman, 1900-1996," *American Journal of Public Health* 87, no. 4 (1997): 700-701.
[53] For the Red Scare rousting of Parran, see Grey, *New Deal Medicine*, 163-4; for the term "medical McCarthyism" coined by Ernest Boas of the leftist medical organization, the Physicians Forum, see Jane Pacht Brickman, "'Medical McCarthyism': The Physicians Forum and the Cold War," *Journal of the History of Medicine and Allied Sciences*, 49, no. 3 (1994): 382. For Parran's career after serving as US Surgeon General, see Farley, *Brock Chisholm, the World Health Organization, and the Cold War*, 67, 143, 194.

In 1946, as the political tide began to turn away from New Deal experimentation, the FSA's Chief Medical Officer, Frederick Mott, left his post for Canada, where he helped to pilot the government-directed health service system in Saskatchewan, which would become Canada's blueprint for its eventual nationwide health care system. There he also served as Canada's representative to WHO. Friends from the FSA and other advocates of social medicine followed him to Canada, among them Milton Roemer and Henry Siegerist. [54]

In 1951, Mott returned to the US. By then, John Lewis, the president of the United Mine Workers of America, had obtained a commitment from the nation's largest coal owners to create the union's Welfare and Retirement Fund. Mott helped design the fund's health service system, a program that historian Michael Grey calls "one of the largest and most comprehensive union-sponsored medical care delivery programs in the United States of the postwar era." Over the course of the 1950s and 1960s, the UMWA health system became the labor movement's great claim to fame in attaining quality health care for coal miners, who had once been the sickest subset of organized laborers. The UMWA's benefit system also became a model for progressive health policy ideals. While health care work at the UMWA's fund was designed by the New Deal generation, by the late 1960s and early 1970s, American public health leaders like Paul Cornely joined its forces and continued to see the fund as "a pioneer and leader in providing comprehensive health care." Like the women of the Bureau, the men of the FSA helped build new organizations and projects that would give rise to a new generation of American progressive and even radical public health activists. [55]

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[54] Grey, *New Deal Medicine*, 164-5.

[55] For scope and significance of UMWA, see Grey, *New Deal Medicine*, 167-178. For Cornely remarks on UMWA, see "Two Noted Professionals Join Fund Medical Team," clipping from United Mine Workers Journal, 11 Sept 1972, Box 4, Folder: United Mine Workers of America 1972-1974, Paul Cornely Papers; for more on the UMWA health service programs, see Starr, 315-319, and also Ivana Krajcinovic, *From Company*

The career paths of civil servants from the Children's Bureau, the USPHS, and the FSA show something profoundly important but as of yet not well-documented: a thread of ideological continuity persisted from the 1890s invention of the settlement-house movements, through the 1940s pinnacle of government-designed health policy, and into the mid-1960s, when the Medicaid and Medicare Amendments to the Social Security Act expanded health care coverage to the indigent and the elderly. These 1965 developments created health care rights for the elderly and the poor, but not for children or pregnant women.

The biographies of these career public servants show how these key agents rose in stature during the New Deal and World War II and persisted during the Cold War to envision how justice could play out in health policy. These men and women remained devoted to the belief that in America, health services should be universally available and offered to all citizens without a means test, thereby avoiding the stigma of health care as a welfare benefit. These bureaucrats believed that public servants, in international organizations, as in federal, state and local government, were politically and morally obligated not only to make medical care more widely available but also to sever the connection between poverty and ill health at home and around the world. Although the Cold War foreclosed federal health policy experiments and although Medicaid and Medicare left out health security for mothers and their children, these powerful conservative forces did not prevent health policy leaders of the New Deal and war era from holding tightly to their vision of health justice.

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*Doctors to Managed Care: The United Mine Workers' Noble Experiment (*Ithaca: Cornell University -- ILR Press, 1997).

A cadre of present-day public health researchers and practitioners, many of them women, have inherited the mission of creating health justice for women and children, as well as the set of settlement-house movement-based tactics that link research, bureaucratic innovation, and political advocacy. Like their predecessors, these scholars, public policymakers, and political advocates continue to face off against powerful opponents who believe that health is a matter of "personal responsibility" rather than a concern based on the common good or individual rights.[56]

In the mid-1990s, while biotechnologists focused on research missions such as finding cellular and genetic explanations for preterm labor among black women, "another strategy" for how to intervene in the health outcomes for pregnant black women and their infants "was being formulated." This approach objected to the biomedical industry's quest for biological explanations for—and medical responses to—the maternal and infant health statistics of phenotypically black pregnant women and their babies. Based in federal agencies and academic institutions, a host of mostly female researchers began to pursue a very different agenda. Among them are some exemplars—Carol Hogue, a professor of maternal and child health at Emory University, Marie McCormick, the former chair of the Harvard Medical School's Department of Maternal and Child Health, and Diane Rowley, a leader in national disparities research and the former director of the national Center for Disease Control's Maternal and Child Health Epidemiology Program. For the past twenty years, these women, along with many other researchers and public health bureaucrats, have sought to understand how "the social and political impact of being an African American woman in the United States, racism, and the combined effects of gender, racism, and relative social position"

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[56] For the definition of and the progressive response this conservative viewpoint, see Meredith Minkler, "Personal Responsibility for Health? A Review of the Arguments and the Evidence at Century's End," *Health Education and* Behavior 26 (February 1999): 121-41.

contribute to "the gap" between white and black infant and maternal outcomes. In general, "disparities research" like theirs aims, at the end of the day, to "eliminate health differences derived from systematic, persistent discrimination against disadvantaged social groups." This work represents a modern iteration of the professional research agenda that was born in the settlement houses, rose in status and power during the first half of the twentieth century, and was dealt a near death blow during the Cold War.[57]

Like the careers of the women of the settlement houses and the Children's Bureau, a policy agenda has blossomed from this research. The Healthy Start program represents the biggest national project to address maternal and child health and is funded through Title V. Born in 1991 to direct services to areas where infant mortality was twice the national average, Healthy Start now has over one hundred sites throughout the nation. The program uses federal funds to provide services to prenatal and infant health services, including "home visitation, . . . perinatal case management, risk assessment, depression screening, [and] health education." Relying on existing understandings of the specific health problems that contribute to premature infant death, the program has created new strategies to increase medical care usage by disadvantaged women, improve infant health outcomes and decrease health disparities.[58]

My dissertation suggests that a program like Healthy Start rests on the shoulders of over a century of commitment and work toward maternal and child health justice.

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[57] For the alternative to the bio-genetic approach to black maternal and infant health outcomes, see Richard Davis and James W. Collins, "Genetics or social forces? Racial disparities in infant mortality," in *Toward Equity in Health: a New Global Approach to Health Disparities*, ed. Barbara C. Wallace (New York: Springer, 2008): 175; for the "social and political impact of being an African American woman," see Diane L. Rowley, "Closing the Gap, Opening the Process: Why Study Social Contributors to Preterm Delivery Among Black Women" *Maternal and Child Health Journal* 5, no. 2 (2001): 71; for research on black and white maternal and infant health disparities, see Carol J. Rowland Hogue, "Towards Reducing Disparities in Disparities Research," *American Journal of Epidemiology* 170, no. 10 (2009): 1195-6.
[58] National Healthy Start Association, "Saving our Nation's Babiess: The Impact of the Federal Healthy Start initiative," 2nd ed., [no date, first edition published October 2011], accessed January 26, 2014, http://www.nationalhealthystart.org/site/assets/docs/NHSA_SavingBabiesPub_2ndED.pdf.

Despite the Cold War's severing of the line of politically charged maternal and child health expertise, not to mention more recent political attacks on federal involvement in health service delivery, today's leaders in the field have largely inherited the tasks and ideology that this dissertation traces. Present day experts in this field realize that problems like the "racial disparity in stillbirth rates," have been "known to exist in the United States for almost a century." According to historian Elizabeth Fee, women in public health and medicine, like their forebears, have continued to "see public health as a way to combine scientific interests and social concerns," and they remain "clustered in areas traditionally considered female: food and nutrition, public health nursing, and maternal and child health." One female public health professional explained that "women have a political vision" and are predisposed "to link science to practical applications, to effect some source of social change."[59]

   This dissertation has used the concept of health justice to encompass the complex ethos that has been a source of continuity for professionals from the late nineteenth century through the present day. The protagonists in this work had a two-fold communitarian and rights-based vision and a corresponding idea of how they could intervene to improve maternal and infant health. They held to the argument that health for women and children during pregnancy and infancy was essential for the common good. By the end of the New Deal and the years of World War II, they become increasingly bold, arguing that health, along with health care, was a right for all women and children as citizens and as human beings. Today, the roots of this justice-based approach to maternal and child health are especially intriguing, as contemporary

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[59] For knowledge of racial disparities over the course of a century, see Carol J. Rowland Hogue and Robert Silver, "Racial and Ethnic Disparities in United States: Stillbirth rates: Trends, Risk Factors, and Research Needs," *Seminars in Perinatology* 35, no. 4 (2011): 231; and Elizabeth Fee and Barbara Greene, "Science and Social Reform: Women in Public Health," *Journal of Public Health Policy* 10 (1989): 173-4.

epidemiological research reveals that inequality in itself is correlated with poor population health outcomes, including infant and maternal mortality.

Much of today's political debate about progressive health policy dwells on the availability of health insurance to all Americans. As the protagonists of this dissertation understood, the question of whether the public will take real responsibility for protecting the health of women and children goes way beyond the matter of health insurance. A health justice approach to women's and children's wellbeing has long been a call for a broad range of interventions: the provision of high-quality and easily-accessible health care services; protection of safe working conditions and labor rights, including under-represented groups such as domestic workers; the building of toxin-free affordable homes; and the creation of infant and child nutrition programs, like WIC, as well as subsidized day care and universal preschool education, to name a few. Last but not least, a health justice approach insists that social policy needs to address racial and socioeconomic inequality systematically.

The settlement-house movement's community improvement and occupation health work, the Sheppard-Towner programs, Titles V and VI, the crippled children's program, the New Deal health cooperatives, and EMIC are just several dots on the timeline of work on behalf of health justice for women and children. Many more can be added: the establishment of Medicaid, the expansion of state-based maternal and child health benefit programs, the creation of WIC nutritional supplementary vouchers for poor women and children, and the Affordable Care Act, to name a few. The controversies over all of these programs, and the backlash against them by conservative stakeholders, can be understood as a reaction against the concept of justice in health.

The extent of justice in society can be evaluated based on whether public policies as a whole situate maternal and child health as a matter of common welfare and

individual right, or rather as a commodity and a personal responsibility. The men and women who drove federal health justice programs between the 1890s and the 1950s saw answers to this profound question as a fundamental determinant of the moral character of American society. Recently, the "Other 98%" movement has placed a spotlight on the problem of inequality. How present-day social policy will address this problem remains one of the most substantial and morally charged question in American political life, and one with powerful implications for health. Just as it did over the course of the twentieth century, the principle of health justice remains alive, pressing, and intensely contested in twenty-first century American political life.

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Biography

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