The Struggle over Employee Benefits: The Role of Labor in Influencing Modern Health Policy

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HEALTH CARE POLICY HAS OFTEN BEEN DESCRIBED as the work of political actors seeking to benefit the larger community or a particular group of individuals. In 20th-century America, those actors worked in a historical context shaped by demographic and political pressures created during a period of rapid industrial change. Whereas scholars have placed the emergence of European social welfare in such a larger frame, their analysis of movements for health insurance in the United States has largely ignored the need for a frame. If anything, their studies have focused on the lack of a radical political working-class movement in this country as an explanation for the absence of national or compulsory health insurance. Indeed, this absence has dominated analyses of the failure of health policy reform in this country, which generally ignore even these passing historical allusions to the role of class in shaping health policy. Explanations of why health care reform failed during the Clinton administration cited the lack of coverage for millions of Americans but rarely alluded to the active role of labor or other working-class groups in shaping the existing health care system.

This article proposes an alternative understanding of the development of health policy in the United States, by examining the association of health policy with the relationships between employers and employees.

The Milbank Quarterly, Vol. 81, No. 1, 2003
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350 Main Street, Malden, MA 02148, USA, and PO Box 1354,
9600 Garsington Road, Oxford OX4 2DQ, UK.

Health policy is not a “failure” of the dream. Instead, the social welfare and health insurance systems that governments and voluntary, or commercial, insurance established were a direct outcome of the pressures brought by the organized and unorganized labor movements. An increase in dependency created by industrial and demographic changes, conflicts between labor and capital over the political meaning of disease and accidents, and attempts by the larger political system to mitigate a variety of social crises all helped create new health policy options. Reforms that undercut the socially dangerous connection among disease, disability, and class provided better access for working-class people to modern medicine and hospital care but distanced some unionized workers and some immigrant groups who had formed self-help organizations from control over their own health care.

As Alan Derickson demonstrated, these reforms, often spurred by the demands of organized labor, led to dramatic improvements for unionized workers. But even though organized labor pushed for national health insurance for its members, the irony of labor’s success was that it soon was dominated by the providers—insurance carriers, hospitals, and professionals—and also undermined broad-based movements for the universal coverage of all Americans (Derickson 2000). Derickson’s work implicitly addresses an earlier generation of historians such as Paul Starr, Daniel Hirshfield, and Ronald Numbers who looked at the unsuccessful struggle for national health insurance as an indictment of labor’s inability to influence health policy (Hirshfield 1970; Numbers 1978, 1982; Starr 1982). In contrast, we believe that labor can claim a victory of sorts but that this victory (i.e., Blue Cross insurance for many in the labor movement) caused labor to withdraw from the struggle over the definitions of disease and health themselves. Ultimately, the power to decide what was and what was not a “health” matter passed from labor and its organizations to the professionals and institutions that labor helped establish.

In this article we review the ways since the Civil War that labor has tried to define the role of health and health care as the nation’s economy shifted from one based on agriculture to one based on industry and, finally, service. Basic changes in the routines of life took their toll on American workers and their families and ultimately affected health care (Blackmar 1989; Rothman 1971; Wilentz 1984). During the 19th century, as the workplace moved from farm to factory, city life compounded problems of dependence. Unemployed workers not only lost their wages, they frequently also lost their housing and food, often leading to the disintegration of their families. Health and welfare, therefore, became

the focus of broad reform movements. In the Northeast, the United States' most urbanized and industrialized region, reformers concentrated on health and welfare. Labor and capital each struggled to reformulate how workers and their families, now heavily dependent on wages, could be supported during periods following accidents, diseases, and layoffs. The development of health insurance schemes was one product of this contentious, but mutual, effort.

In the late 19th and early 20th centuries, as workers in industrializing America found themselves in increasingly desperate circumstances, many turned to socialist and radical labor organizations that promised to correct the social and economic inequalities caused by the dislocations of unfettered industrial capitalism. Many immigrant groups and some workers formed fraternal or union-based organizations to provide either monetary support or actual health services to their members. As conflicts between labor and capital intensified, conservative business forces sought ways to depoliticize contentious aspects of labor relations.

Especially after the 1930s, as the centrality of ethnicity and class in defining America's communities waned and as national and local labor movements grew more conservative, large portions of working-class populations found fraternal and union-controlled systems unappealing (Gerstle and Fraser 1989). Blue Cross, a nongovernmental, nonprofit hospital insurance program, was organized in the 1930s and over the next 30 years enrolled a large percentage of unionized workers throughout the nation. During the cold war, membership in Blue Cross (and other voluntary health insurance plans) grew enormously throughout the nation as literally millions of union members received its hospital insurance coverage (Derickson 1994; Markowitz and Rosner 1991). After World War II, health and safety receded as critical labor issues and were succeeded by concerns about health insurance and hospital care programs. Relatively apolitical bargaining over wages and health benefits replaced the bitter political disputes that had raged earlier over union recognition, monetary protection for injured workers and their families, the speed of work, the safety of equipment, and the dangers of new chemicals.

The Workplace and Health Policy

The rise of the factory system amplified the struggle between labor and capital and the importance of health and welfare in that conflict. In its most basic form, the struggle to control the means of production provided

the context in which health programs and health care have developed, as disputes frequently revolved around wages, hours, and working conditions. As David Montgomery, David Noble, David Brody, and other historians have documented over the past 30 years, the American workplace was fundamentally transformed from one in which workers largely controlled the means of production into one in which management slowly took control. The development in the late 19th century of mass production processes that largely deskilled a workforce that had been composed mainly of artisans, and the introduction in the second decade of the 20th century of Taylorism, which broke work into discrete tasks that could be performed by a largely unskilled labor force, along with the assembly line, all diminished workers' control of the workplace and also made it much more dangerous (Montgomery 1987). Management's view of workers as little more than interchangeable parts played an important role in capitalism's political battles with labor. At the turn of the century, labor organizers were well aware that underpaid, overworked, and poorly fed workers were more likely to be injured or incapacitated on the job. A machinist working 12 to 14 hours a day could not stay alert enough to avoid being injured by unguarded machinery in a dimly lighted, noisy, and humid factory. Many strikes in modern American history—from the railroad strikes of 1877 to the Flint autoworkers' sit-downs of 1937 and through the United Mine Workers' strike of 1977—tried to redress those conditions endangering workers' health and safety. In contrast, employers, fearing a loss of control over production and the added costs of improving work conditions, resisted making any concessions.

This widespread concern over working conditions reached a peak in the first decade of the 20th century in the wake of the revolutionary social and economic changes that America had just undergone. The world's new economic colossus also was home to some of the most dangerous workplaces anywhere. Speedups; monotonous tasks; and exposure to chemical toxins, metallic and organic dusts, and unprotected machinery all threatened American workers. For instance, the death rates in mining in England, Germany, and France were fewer than 1.5 per thousand workers during the first years of the 20th century. But in the United States, more than three miners per thousand could expect to die while working in a mine during any given year (Reeve 1907). Clearly, the enormous wealth produced by the new industrial plants was achieved at an inordinate social cost. "To unprecedented prosperity . . . there is a seamy side of which little is said," reported one observer in 1907. "Thousands of wage

earners, men, women and children, [are] caught in the machinery of our record-breaking production and turned out cripples. Other thousands [are] killed outright How many there [are,] none can say exactly, for we [are] too busy making our record-breaking production to count the dead" (Reeve 1907, 791).

Before the 20th century, a variety of state and federal statutes addressing specific conditions provided minimal workplace protections. Progressive reformers charged that the country lagged woefully behind industrialized Europe. During the first decades of this century, this movement brought together a coalition of radicals, reformers, unionists, and business leaders, all united by a belief that greater regulation of society and industry was necessary. Discussions of occupational safety and health were part of broader debates about workers' housing, sanitation, health care, unemployment, and social insurance. Indeed, some reformers argued that occupational safety and health could be addressed only as aspects of other social and environmental problems (Rosner and Markowitz 1985). The explosion of job actions, labor unrest, and strikes in the early decades of the 20th century cannot be understood without looking into the intensification of work, speedups, the introduction of power tools in the dusty trades, and other changes that accompanied the development of mass production and industrialization.

At the same time that the country was reorganizing its workplaces, the medical community was rethinking its own understanding of disease, often bringing it in conflict with social reformers and labor groups. Before the acceptance of the germ theory, practitioners and laypersons alike understood disease in highly personal and situational terms. Much of medical therapeutics rested on the belief that diseases reflected an individual's particular social, personal, hereditary, and economic circumstances. As Charles Rosenberg wrote, "The body was seen, metaphorically, as a system of dynamic interactions with its environment. Health or disease resulted from a cumulative interaction between constitutional endowment and environmental circumstance" (Rosenberg 1979, 5). That is, it was this special relationship between an individual and a complex, highly particularized environment that caused illness.

Medical practitioners and the general public subscribed to the same assumptions about disease, that it could be rooted in personal behavior such as drinking, social position, poor living quarters, an unhealthful urban lifestyle, and, finally, unhealthful indoor work (Warner 1986, 58). A practitioner needed to have a complete knowledge of the patient's

life history in order to make an accurate diagnosis and provide a plan of treatment. But with the development of the germ theory in the late 19th century, physicians searching for simpler and more universal explanations rejected such personalized and multicausal understandings of pathology. "Consumption," characterized by spitting, coughed blood, and weight loss, is a good example of the profound impact that bacteriology had on physicians' understanding of working-class illness. Most of them had adopted the term *tuberculosis* after Robert Koch identified the tubercle bacillus in the early 1880s. The new term obscured the relationship between the workplace and this particular disease and dampened a potential source of conflict between workers in the dusty trades and factory owners who might be held accountable for the disease if it were thought to originate in the work experience (Rosner and Markowitz 1991).

Unions and the workforce, however, insisted on using the older 19th-century terms *consumption* or *phthisis* to describe the condition. From their perspective there was nothing new about what was causing them to cough, wheeze, spit blood, and waste away: Physicians "have given the old-time consumption a new name," the *Granite Cutters' Union Journal* observed, "and talk learnedly about it, but what does that amount to when men are dying in our midst almost daily of this fell disease?" Writing that the rate of disease should "strike terror to the heart of every granite cutter," the union declared that the focus of attention should be on preventing the dusty conditions and controlling the speed of work because "the men work at a faster clip than the constitution of any human machine is able to stand up to" (official correspondence 1908, 31:1).

Robert Koch's discovery of the tuberculosis bacillus and the development of the germ theory of disease in the 1880s were enormous breakthroughs for medical science. Many leading medical researchers and educators, flushed with confidence as a result, simply equated consumption with a bacterial disease and looked inward to the laboratory and science for its diagnosis and treatment. Although this theory was crucial to the development of American medicine in general, it also broke away from common understandings about the body and its relationship to the social and economic environment. The medical profession looked away from the workplace at the very time that changes in the industrial environment were creating unprecedented health and safety hazards.

With the revolution in bacteriology that followed the discoveries of Pasteur, Lister, and Koch in the mid-19th century, a new faith in

laboratory science emerged among not only physicians but also public health workers. "Bacteriology thus became an ideological marker, sharply differentiating the 'old' public health, the province of untrained amateurs from the 'new' public health, which belonged to scientifically trained professionals" (Fee 1987, 19). Despite the different professional mandates of public health workers and physicians, members of both professions who subscribed to the science of medicine and public health agreed on the significance of the disease-specific germ entity in creating consumption. Modes of bacteria transmission had to be clearly identified for an effective campaign against the disease to be mounted. Why were the poor so likely to be infected? Their hot, crowded dwellings allowed the germs to spread easily among a population weakened by inadequate nutrition and horrid living conditions. Why did children appear to be a high-risk group? Tainted milk from tubercular cows poisoned them. Why did individuals not in any particular risk group come down with the disease? They had a hereditary predisposition that left them vulnerable to infection. For the new public health practitioners, the specificity of the bacterial agent was paramount, and accordingly they regarded the older generation's emphasis on cleaning up the general environment as misdirected and inefficient. One advocate of the new regime summed up the revolution in ideology that overtook the field in the 1880s: "Before 1880 we knew nothing; after 1890 we knew it all; it was a glorious ten years" (Fee 1987, 19).

Ironically, just as the medical profession was turning away from understanding disease as rooted in the social and personal environment of workers and the poor, the transformation of the American industrial and urban landscape was making such an understanding all the more relevant. The prevalence among the working class of contagious diseases like diphtheria, influenza, tuberculosis, and typhoid spurred progressive reformers and consumer groups to introduce older sanitarian ideals about the relationship between health and the environment into their social welfare framework (Tomes 1998).

For instance, New York's booming garment industry relied on piecework, done in the city's slums. The same diseases infecting tenement dwellers could, therefore, be transmitted to the middle-class men, women, and children who bought the dresses, shirts, and trousers sewn in germ-laden rooms. It was this terror that led the National Consumers League to become active in tenement reform and antituberculosis campaigns. Its label on goods, along with that of the International Ladies

Garment Workers Union, identified clothing manufactured under hygienic conditions. The league became involved in a wide variety of labor-related issues, including fire safety, workers' compensation, and occupational disease legislation. Campaigns against "phossy jaw," the disfiguring disease of match makers, lead poisoning among painters, tuberculosis among factory workers, and safety in factories and mines were carried out by labor unions, muckrakers, social welfare reformers, and settlement workers (Mayo 1911). In Illinois, the state factory inspector pointed to the deleterious effects of dust generated by workers polishing, buffing, and grinding metals. In New York State, a new factory investigation commission responded to the public outrage following the notorious Triangle Shirtwaist Fire that killed 146 women and teenage girls in a Greenwich Village garment factory whose exits had been locked (Harrison 1912; Hoffman 1910, 1911a, 1911b; International Wood-Worker 1906; New York State 1912, 1913).

While a few prominent public health physicians such as Yale University's C-E.A. Winslow and the National Consumers League's Alice Hamilton participated in these larger movements in the first two decades of the century, the general perspectives of the medical community, labor, and consumers began to diverge. It was not until the second decade of the 20th century that the public health profession took official notice of industrial hygiene (Winslow 1909). Christopher Sellers, Claudia Clark, Christian Warren, Alan Derickson, and Allison Hepler, among others, documented the importance of the new field of industrial medicine, whose practitioners helped link the work environment to industrial diseases (Clark 1997; Derickson 1998; Hepler 2000; Sellers 1997; Warren 2000). But even then, public health workers rarely incorporated demands to improve factory conditions into their campaigns to control tuberculosis and other infectious diseases among the industrial workforce (Apfelbach 1917; Northrup 1919; Pennsylvania Dept. of Labor and Industry 1916; U.S. Dept. of Labor 1917, 1919; U.S. Dept. of the Treasury 1916).

On a more concrete level, Progressivism's fight to improve workplace conditions achieved several legislative victories, most important of which was the passage of workers' compensation laws. In the decade after 1911, the year of the Triangle Shirtwaist Fire, 25 states passed laws guaranteeing some form of financial compensation to workers injured on the job. Although Great Britain, Germany, and other European countries had established national workers' compensation programs by the late

19th century, the American system developed only gradually at the state level.

Beginning in the industrial states, support for workers' compensation spread quickly, and by 1930, almost all the states provided payments to injured workers or their families. While each state adopted different mechanisms for judging the extent of workplace injuries and the amount of money to be awarded for particular accidents and the types of injuries incurred, all the legislation shared certain features. First, there were "no-fault" systems in which awards were made regardless of who or what was responsible for the injury. Second, the workmen's compensation laws addressed the problem of accidents and injuries, not disease. Finally, they generally were mechanisms administered by insurance companies that provided relatively small awards for many workplace injuries and excluded risks covered in the liability tort system, whose awards were often much larger. These workers' compensation systems helped spur a dramatic change in both the ideology and the program of safety and health reformers.

Mutual Aid and Insurance

Long before the Progressive movement sought legislative solutions to the growing problems of dependence created by industrial accidents and disease, the workers themselves organized a variety of institutions and programs aimed at creating mutual aid societies that would alleviate the interlocking problems created by unemployment, poverty, and sickness.

Throughout the late 19th century, workers in the highly industrialized states of Massachusetts and New York could expect to be unemployed an average of two months of every year. In New York City in 1900, 13.2 percent of all workers—both male and female—were unemployed for one to three months. Another 9.3 percent were out of work for four to six months, and 2.8 percent were jobless for seven to 12 months. For much of the late 19th and early 20th centuries in any given year, a quarter of an already poorly paid workforce could expect to be unemployed (Keyssar 1986; Rosner 1982).

Each year, millions of workers could expect to be ill and out of work. Not surprisingly, many tried hard to create some sort of hedge. An early 20th-century survey by the U.S. Bureau of Labor Statistics found that American-born workers spent a significant percentage of their income

on "industrial" policies that provided burial benefits to its members. In contrast, immigrant families often organized fraternal associations, *landsmanschaft* societies, "lodges," or other workingmen's associations for various forms of death benefits and medical and disability insurance. In New York City alone, 5,000 *landsmanschaft* societies counted more than 500,000 immigrants and their children as members (Beito 2000; Soyer 1997). Many immigrant workers throughout the nation devised extensive, if inadequate, methods to alleviate some of the harshest consequences of dependence caused by unemployment, injury, death, old age, and illness (Beito 1989; Kalet 1916; Soyer 1997; Sydenstricker 1917). In addition to the many self-help organizations, a few local unions in New York and other large cities developed health and welfare plans to address the consequences of illness, accidents, and death for their members. But these plans reached only a relatively small number of organized workers and rarely, if ever, provided for hospital benefits, since at that time, the home or doctor's office was the locus of most care (Kalet 1916; Markowitz and Rosner 1987; Montgomery 1987; Rosner and Markowitz 1985, 1987; *The Survey* 1910; Sydenstricker 1917; Trauner 1977; *Women's Label League Journal* 1913).

Three major problems plagued many fraternal and union health plans. First, few of the plans were organized with any real sense of the demands that would be placed on them. Generally, reserves were inadequate because most of the fraternal and union funds tried to keep direct costs to members extremely low (Stevens 1990). Second, even though the plans generally excluded family members, the great majority of low-wage workers still could not afford the premiums (Sydenstricker 1917). Third, most of the plans provided a very small cash benefit meant to defray the costs of funerals, drugs, doctors' bills, or hospital care. Few fraternal or union groups could offer to pay more than just a small percentage of the real costs of an illness for families without enough income even to pay for rent, clothing, food, and other needs. Benefit plans made payments over relatively brief periods, and the policies often excluded industrial accidents and hospitalization (Sydenstricker 1917).

With no government insurance and with only a few proprietary alternatives, communities of immigrants had to look to their own meager resources to protect them. One of the few systematic studies of these organizations found that 14 fraternal societies and 11 trade unions offered some form of health insurance to nearly 125,000 persons (Chapin 1914; Kalet 1916; Sydenstricker 1917; U.S. Dept. of Labor 1917). The

immigrants' use of fraternal societies was especially important in the cities, and in some ethnic groups, membership was nearly universal. As Edgar Sydenstricker, a statistician with the Public Health Service, remarked, "It is interesting to note . . . that nearly all of the Slav families carried insurance in their racial fraternal organizations which had sick-benefit features, while most of the native-born workers who were insured had policies in commercial companies which provided for only life and accident insurance" (Sydenstricker 1917, 434).

Workers and unions themselves organized health and benefit societies, self-insurance programs, disability compensation, old-age pensions, and even clinics and hospitals (Derickson 1988). By the beginning of the 20th century, a variety of union-sponsored mutual aid and benevolent societies existed. In 1877, the granite cutters' union set up the first national union sick-benefit program, and others soon followed. The barbers' union organized a sick-benefit system in 1895, as did the tobacco workers' union in 1896 (Klem and McKiever 1953).

Health care continued to be a disputed issue between management and labor. The central disagreements pertained to control and class interest. With health and disease a major source of friction, corporations often provided benefits to win the allegiance of the workforce (Berkowitz and McQuaid 1980). But union representatives often saw these benefits as tools for undermining worker and trade union solidarity or as attempts to make workers dependent on the company's goodwill. The development of welfare capitalism in a number of industries in order to forestall union- and worker-supported benefit programs led to suspicions and distrust. At best, workers saw the programs as inadequate and temporary (Asher 1987; Brody 1960; Cohen 1990; Rosner and Markowitz 1987; Zahavi 1988). At worst, they viewed them as part of management's efforts to cover up the dangers of the workplace and to hide deaths or disabilities caused by unsafe and unclean working environments.

Immigrants in the growing cities of the East Coast and Midwest turned to the various fraternal and union-sponsored plans to a significant extent, although how much they did so is difficult to quantify. But it affected broader debates about the responsibility of government to provide some form of universal protection, such as compulsory health insurance. For example, in the late teens and 1920s, the American Federation of Labor (AFL), the umbrella for most of the nation's trade unions, joined with conservative insurance companies to oppose proposals for compulsory health insurance. Samuel Gompers, leader of the AFL, saw

government sponsorship of health insurance as a threat to the power of trade unionism. If all workers, both unionized and nonunionized, were provided protection, their loyalty to their union would be compromised. In the 1920s, labor's fears were heightened as businesses developed corporate welfare plans as part of their antiunion efforts (Cohen 1990). Others in the industrial unions, however, did support universal health protection and challenged Gompers on this issue (Hoffman 2001).

Occupational Diseases and the Transformation of Workers' Compensation

The Great Depression highlighted disease as one reason for the massive disruptions in family and community life. As workers lost jobs in the early 1930s and found it impossible to find new ones, they searched for reasons to explain their inability to support their families. For older workers or workers with disabilities caused by exposure to industrial toxins, new jobs were particularly difficult to find. This led many to begin to link their physical disabilities and health problems to their increasingly precarious social and economic position. In desperation, many initiated a series of lawsuits blaming their employers. The nation's attention was again fixed on employers' responsibilities for causing chronic, debilitating industrial diseases. In the Depression's increasingly contentious climate of class conflict, juries held employers culpable to a degree previously unheard of in American legal history, and victories emboldened more of the unemployed and their lawyers. In 1933, in New York State alone, the foundry industry faced more than \$30 million in lawsuits (*Business Week* 1933; Tillson 1934, 263). Furthermore, in the face of obvious suffering, judges were more and more likely to hold companies accountable for death and disability resulting from known risks. Unlike earlier decades when the legal doctrines of assumed risk (i.e., by taking a job, a worker automatically "assumed" the risks of employment and, therefore, responsibility for occupational injury and/or death) and fellow servant rules (i.e., responsibility for an industrial accident was attributed to the victim's "fellow" worker, thereby protecting employers from responsibility) tended to favor employers, the current rash of lawsuits and the circumstances of the Depression changed the rules of the game.

Since the Progressive Era, workers' compensation had been extremely effective in mitigating the conflict between workers and management

over disabling accidents that cost workers their earning power as well as their physical integrity (Bale 1986). But because the compensation system had been devised to address the issue of accidents, not long-term chronic industrial disease, those advocating the inclusion of occupational disease in the state compensation systems were unsure how to proceed.

Early compensation legislation barely mentioned the issue of work-related disease. The states commonly maintained, as Anthony Bale pointed out, that it was “difficult to establish whether a particular case of illness [was] due to strictly occupational causes or to a combination of occupational and non-occupational causes.” Except in cases of specific poisons such as phosphorus or lead in which acute symptoms could be linked to exposure on the job, most industrial diseases were not so clear-cut. Second, occupational diseases usually had “no particular moment of origin.” Hence, unlike an accident that could be fixed in time and place, the etiology of a disease was much murkier, and so it was difficult to ascribe responsibility to a particular industry or company for a worker’s disease. Not until workers began using the courts to claim liability awards for industrial diseases did state courts and legislators grudgingly begin to include industrially related diseases in the workers’ compensation system (Bale 1986, 469–70).

By the end of World War I, there were 42 workers’ compensation jurisdictions in the United States. But only four—California, Hawaii, Massachusetts, and the federal government—provided compensation for occupational diseases. All the other jurisdictions excluded occupational diseases from compensation in one of three ways: by limiting the scope of the law to injuries resulting from an accident; by adverse rulings by the courts and commissions; and by express provisions of the legislation.

In 1919, Carl Hookstadt, an official in the Bureau of Labor Statistics, noted the “paradox” of contemporary laws and regulations: “Our workmen’s compensation laws have been enacted in the vague belief that industrial accidents were inevitable and constituted a permanent and integral part of our industrial life.” He noted that “these same reasons . . . are now used by the courts and commissions against compensation for occupational diseases” (Hookstadt 1919, 220; Andrews 1913; Hookstadt 1921; *Monthly Labor Review* 1916). Accidents were once understood to be an unusual event whose occurrence was a result of negligence or fault on the part of employers or employees. Therefore, in the 19th century, the courts could adjudicate responsibility and restitution for

injury. By the early decades of the 20th century, however, underlying social assumptions regarding the nature of industrial accidents had subtly shifted. Now workers' compensation laws rested on the new premise that accidents were inevitable, indeed intrinsic to the industrial process and therefore unsuitable for a liability system designed to determine fault in order to adjudicate. Nonetheless, the irony that Hookstadt described was clear: although occupational diseases also were intrinsic to the job, without sufficient pressure placed by workers' demands on the legal system, the politicians who designed the workers' compensation systems largely ignored disease.

Insurance companies, industry, labor, and government now faced the question of how to define and compensate disability caused by occupational diseases. Traditionally, workers' compensation systems determined a specific dollar amount according to the type and severity of the accident. Loss of a limb, an eye, or a life each were assigned a price, and workers or their families could count on receiving a set amount for a particular accident. These "scheduled" payments might differ across the states, but all were based on the principle of a specific award for a specific event.

How could the financial and social crisis created by the lawsuits concerning occupational diseases be defused? What constituted a compensable disease? If only disabling diseases were to be compensated, how should disabilities be defined? Could the prospect of future disability be compensated today? Was it necessary to have demonstrable impairments? Who was to diagnose, evaluate, and decide on the degree of disability?

During the Depression, the old model of immediate compensation for an accidental injury was an actuarial potential for disaster. Insurance and industry spokespersons thus rejected a definition of disability based solely on a worker's stated inability to perform work. If "proof" of the existence of a disability was a worker's loss of income, then millions of jobless people could file claims. Industry pressed for a system that depended on a physician's opinion regarding the worker's ability to perform his or her duties. It was the doctor, not the victim, who should decide who was capable of work (Kossoris and Freed 1937).

This change had a long-range impact. It further disassociated diseases from class relationships, but it also gave working-class groups better access to health care. The process of dissociating income protection as a primary goal of health policy that began in the first decades of the century

accelerated (Fox 1986; Fox and Fronstin 2000). No longer was disease a social welfare problem in which workers received financial protection for unemployment due to disability. Now disease was more exclusively a medical problem, separate from the social conditions that had created dependence. For a number of reasons, insurance and industry leaders were more confident that a system answering to the medical profession would serve their own interests in limiting compensation claims.

In the 1930s, new specialists in occupational medicine did not come from the reformist public health traditions that had produced Alice Hamilton and C-E.A. Winslow. Rather, they were more likely to be employed by industry and to spend time in the laboratory. This change in the structure of the profession not only affected the subjective opinions that guided the diagnosis of individual patients, but it also helped reshape definitions of industrial disease when medical boards became the final arbiters in occupational disease cases. Without a comprehensive national social and health insurance program, workers' compensation was the only recourse for many to seek restitution for the diseases and disabilities created by the industrial workplace.

A debate broke out over the very notion of disease itself. Industrialists insisted that industrialization had made meaningless the traditional dichotomy between healthy and diseased. The new dichotomy was ability or disability for work. The common understanding of medicine and public health had not kept pace with the changes in the new industrial society that, for example, exposed millions of people to man-made dusts and chemicals. In modern societies dependent on coal, gasoline, and other new forms of energy, dust and fumes in the working and living environment were no longer exceptional. The inhalation of dust was an everyday occurrence for people living in industrial communities and the growing urban centers. Health and disease were part of one continuum, not two dichotomous categories. For example, it was not the presence of dust in workers' lungs that was pathological, only the existence of "excessive" amounts that limited a person's ability to work. Management argued that the boundaries between normal and abnormal, healthy and diseased, had to be redrawn to accommodate the new industrial realities (Rosner and Markowitz 1991).

Labor representatives and their advocates defended a more traditional model of health and disease. The presence of dust and chemicals in the environment, however prevalent, could not be considered normal. In humans, they produced physiological changes that were part of a

disease process and indicated a fundamental imbalance between humans and their environment. This was not natural but, instead, the product of choices made by the community. Disease was the result of conscious social decisions, and it was the role of social workers, public health, labor officials, and management to control and regulate the environment in order to protect the public.

The new problems that chronic industrial diseases posed for the medical and public health community created a confusing environment in which management and labor could have radically different interpretations of the origins and nature of occupational diseases. Unlike accidents, the cause and effect of these diseases were rarely so apparent. Except in cases of acute poisonings or death, chronic diseases might or might not show symptoms at a particular time. Often the symptoms would appear years, or even decades, after a person's exposure to toxins. Some workers became sick after relatively short exposure to toxic materials, whereas others were far more tolerant. Some workers might show physiological changes but no behavioral symptoms. Others might not display any physiological changes. Some people believed that physiological changes that only seldom interfered in a worker's ability to earn a living were of little significance. Other people saw the issue differently, believing that physical limitations, whether or not they affected a person's work, were unacceptable and should be redressed. In the face of such medical uncertainty, the political agendas of both management and labor became important.

Unions and Health Insurance during and after the Depression

The significance of labor's involvement in the history of hospital insurance has generally been neglected. By the time of the Depression, organized labor supported national health insurance, but this support turned out to undermine labor's political support for a national system of health care for everyone—organized and unorganized, employed or not employed. Health insurance—a method for *paying* for health care—began to displace the *provision* of health care as a primary goal for organized labor. Although union members often formed an insurer's subscriber base, labor's participation in the fight for health insurance often was stormy. Some conflicts were concrete: disputes about rates, comprehensiveness of services, and number of directors. Underlying these issues

was a desire by labor to have an equal voice in the management and control of a significant working-class service. While the leaders of the voluntary insurance movement may have seen themselves as responsible community representatives providing a necessary, important service to hospitals and patients alike, some portions of the labor movement began to see health care providers in a new light. In the years following the initial enthusiasm about neutral “third parties” administering important programs that had once caused intense contention, union officials’ perception of insurance companies as impartial intermediaries between consumers and hospitals eroded (Derickson 1994; Klein 1999, 2001; Markowitz and Rosner 1991).

As hospitals became the focus of much of health care and emerged as a critical “cost center,” voluntary insurance became an enormous industry that was consuming labor’s resources without labor’s representation. Until World War II, labor and its immigrant constituents had had their own insurance systems. Then during and after the war, they had embraced voluntary insurance because of its image as a community service organization. Labor gave up its claim to sovereignty over health services in the belief that “third parties” would adequately represent its interests. But as hospital rates rose and elites far removed from the everyday pressures of working-class life assumed control over health financing, this trust evaporated.

The decline of immigrant fraternal associations and union-sponsored clinics and insurance, together with the shift of labor’s focus away from shop-floor control as a means of controlling occupational disease and accidents, presaged a fundamental change in the relationships between the health care providers and their working-class patients. Power and control over health services moved away from communities, workers, and patients into the hands of those who, while purporting to represent the community’s interest, had relatively little contact with the community itself. Hospital trustees, once deeply involved in running a charity facility, now rarely had more than periodic contacts with their facilities. Financing, once an integral part of the charity hospital’s social and moral ideology, now was controlled by agencies and organizations far removed from the everyday needs of their patients’ institution. The patients themselves, once the objects of charity and the organizers of the incipient insurance system (however inadequate) now often did not know what their insurance covered or how it actually worked. By the late 20th century, the uninsured patient was no longer the focus of the hospital

mission but was now regarded as either a source of income or a drain on the voluntary hospital's resources.

During the Depression, as millions of unemployed workers faced desperate times, organized labor found itself in crisis as the new Congress of Industrial Organizations (CIO) challenged the long-standing supremacy of the American Federation of Labor (AFL). In the end, the split within labor bolstered unionism as the CIO pressed ahead, organizing workers by industry instead of by craft. CIO leaders promoted different organizational strategies, and they looked to the national government for protection and sometimes even encouragement. Walter Reuther and the United Auto Workers (UAW), along with other leaders of the CIO, even went so far as to endorse the calls for national health insurance. At its first national convention in 1938, the CIO supported a national health program, and some of the larger unions supported federal health insurance initiatives like the various Wagner health insurance bills advocating universal coverage for all Americans. This was a dramatic break with traditions supported by the AFL that perceived national health insurance as a threat to the welfare funds that numerous locals had built up over the years. The CIO's leadership in heavy industry accepted the notion of outside supervision of health and welfare benefits, and the AFL insisted on control over its financing.

The redefinition after World War II of health as an insurance issue, rather than a workplace issue, began with this struggle in the 1930s. While labor and management fought over competing notions of disease and corporate responsibility, hospital administrators and their trustees battled a deep financial crisis as the Depression forced larger and larger numbers of impoverished clients into their general wards and emergency rooms. Unable to extract money from their clientele, many institutions faced the prospect of either shutting services or restricting admittance. The unions, especially those associated with the new Congress of Industrial Organizations, for the first time began to abandon the older ideals of self-reliance, independence, and voluntarism (Cohen 1990). But a much larger group looked for a source of health insurance that would require relatively little of the union's scarce financial or administrative resources but that would be free of managerial control.

In "third parties," particularly voluntary agencies that were outside the traditional arena of management-labor conflict regarding wages, hours, and working conditions, union officials saw the possibility for providing their workforce with a needed benefit without risking losing the loyalty

of the workforce to management. At the same time that unions were searching for a means of offering health benefits to a broader cross section of their membership, the weaknesses and inadequacies of the fraternal health plans became evident, especially as hospitals replaced doctors' offices as central to medical care and as payment replaced charity as the institution's primary financial basis. In addition, the fraternal organizations themselves began to decline as ethnic identification and immigrant ties to particular neighborhoods and communities loosened during and after World War II.

Organized labor showed a growing interest in Blue Cross in the 1930s and 1940s because it could be incorporated into both the local AFL's craft union welfare structure as well as the national CIO's collective-bargaining agreements. The AFL's welfare funds could buy services from Blue Cross without giving up their autonomy, and the CIO could bargain with the steel and auto industries for management to buy service plans. Because Blue Cross was a nonprofit service plan rather than a commercial, profit-making indemnity plan, it allayed labor's long-standing distrust of commercial insurers suspected of profiteering from the misery of workers and their families. Blue Cross was attractive also because it paid for services in hospitals as they were emerging as a central source of health care for millions of Americans. It was seen as a "community" plan that addressed pressing community needs without taking sides in the heated labor-management conflicts of the Depression and the postwar period.

The special circumstances of World War II helped Blue Cross grow. In 1943 the Internal Revenue Service ruled that fringe benefits would not be considered income and therefore were not subject to the wage freeze (Fox 1993). In addition, the government reimbursed war industries on a "cost plus" basis: total costs plus a set percentage for profit. This meant that a company that paid for its employees' hospital and medical insurance could now pass along the entire cost to the government and also could make a greater profit. This opened the door to private commercial insurance, leading eventually to the managed care system we have today.

By the mid-20th century, more than 200 industries had employer- and employee-sponsored group health plans for their workers (Klem 1944). Among the more important employee-sponsored plans were the Hospital and Medical Care Program of the United Mine Workers of America Welfare and Retirement Fund; the Labor Health Institute of Saint Louis (Local 688, International Brotherhood of Teamsters, AFL); the Health Institute of the United Auto Workers, CIO,

Detroit; the Union Health Center, International Ladies' Garment Workers' Union (ILGWU); and the AFL Medical Service Plan of Philadelphia, Sidney Hillman Medical Center of the Male Apparel Industry of Philadelphia (Amalgamated Clothing Workers, CIO) (Klem and McKiever 1953). All these programs grew out of labor's interest in providing its members with alternatives to management-sponsored health programs and were built on established traditions of independent, union-provided health care. The ILGWU, for instance, had organized its own health clinic as early as 1913. In fact, though, employers controlled the overwhelming majority of plans, even though they were established through a collective-bargaining process.

Health Concerns after World War II

During World War II, Starr noted, "the general shift in American labor relations from conflict to accommodation" helped solidify the importance of Blue Cross to both unions and management (Starr 1982, 313). Between 1945 and 1947, the number of workers whose collective-bargaining agreements provided hospital protection or other health benefits doubled, from 625,000 to 1,250,000 (Reed 1947). Then, "between 1948 and 1950 the number of workers covered by negotiated health plans jumped yet again from 2.7 to more than seven million. By the end of 1954, twelve million workers and seventeen million dependents had enrolled in collectively bargained health plans" (Starr 1982, 313).

From labor's perspective, Blue Cross was a dramatic improvement over the commercial carriers that were its main competitors. From the start, Blue Cross promised the labor movement a nonprofit, centrally organized administrative mechanism that would give union workers a needed service. But the shift also initiated a gradual change in the purpose of health insurance. A benefit to workers who needed financial support during periods of unemployment caused by injuries or disease became a major buttress of the system of hospitals and physicians that provided the health care. Insurance companies no longer paid workers directly but instead reimbursed professionals and institutions.

Despite their differences, however, management, labor, and third-party payers were able to reach a compromise. From September 1944 through September 1945, more than 340 collective-bargaining agreements secured Blue Cross protection for more than 175,000 workers and their families (Reed 1947). By mid-1946, Blue Cross estimated that it

covered 550,000 employees and their dependents for hospitalization in New York City alone, about one-fifth of the total number of its subscribers (Pink 1946). Blue Cross expanded in the context of massive political upheavals in the nation's labor and liberal establishments. By the late 1940s, the American labor force was "watching a parade . . . a mass migration" of unions into Blue Cross (Tilove ca. 1950).

Despite the appearance of a close and mutually rewarding alliance, the relationship between the leaders of the voluntary insurance movement and labor was inherently tense. Especially in the late 1950s, when the voluntary hospital was the focus of union organizing drives, the older arguments about the role of labor and communities themselves providing for their own members began to undermine the newly forged relationship between the voluntary "third-party" insurers and the labor leaders.

Voluntary insurance's image had become linked to that of the voluntary hospital during the 1950s, a decade that viewed the hospital as "a technological and community institution with little conflict between the two goals" (Stevens 1989, 227). But as hospital costs rose and the public awareness of unequal access to quality health care increased, this benign vision of the hospitals' dual functions blurred. Blue Cross's traditional portrayal of itself as a partner in league with a benevolent community institution now was altered, and its partnership with hospitals was criticized by those who wanted insurance providers to play a more active regulatory role in holding down hospital rates. Instead, Blue Cross paid out more to the hospitals and charged higher premiums to its subscribers, maintaining its traditional stance as a passive collection agency. By the late 1950s, however, Blue Cross had emerged as the preeminent financial agent of America's hospital system. From the unions' perspective, it had new responsibilities and obligations to oversee, if not manage, the costs of medical care to its members. Blue Cross's leaders were taken by surprise at the intensity of the unions' anger and frustration. Only a few years before, they believed, "there was mutual respect—the ability to listen to each other." In the early 1950s, the unions believed that "Blue Cross was the best deal in town." Now gulfs of disagreement opened (J.L. Shurtleff and B. Cohan, interview, May 31, 1989).

In the postwar period, organized labor generally forfeited any semblance of control over the actual delivery and distribution of health care services. With the exception of the United Mine Workers, which maintained a series of hospitals and clinics in the coal-mining regions of the East, few unions continued to offer care to their members directly. Instead, the unions bartered for benefits through collective bargaining.

Unlike the *landsmanschaft* societies, the early union health clinics and the benefits coming through fraternal orders, the new insurance system was largely outside the lives of the workers, both on and off the job. Health care became a narrowly defined aspect of workers' welfare benefits, controlled by professionals largely ignorant of the broad social forces that affected workers' lives and well-being.

In the early postwar period, the booming economy, the political quietude of the cold war, and the general euphoria that accompanied the end of nearly two decades of depression and war muted any opposition to this new apolitical arrangement between labor and management. But in the late 1950s and throughout the next two decades, the effects of unrestrained industrial production on both the workers' and the broader population's health highlighted the distance between the health care system and the lives of most of the population.

By the 1960s, social activists and others began to charge that the health care system of hospitals, doctors, and health insurance companies had less to do with the health of the population than with its own economic success. Linked with the civil rights and antipoverty movements, these critics condemned the American medical establishment as having little interest in offering an equitable distribution of services or even dealing with the everyday health concerns of most Americans.

Medicare and Medicaid legislation, passed at the height of the civil rights movement and federal antipoverty activities, was perhaps the most dramatic federal attempt to make medical care a societal obligation. Even here, the historical link to health insurance and work helped shape the program. First, Medicare, as a title of the Social Security Act, tightened the link between work and insurance. As an insurance program for those who paid into Social Security, it explicitly covered retired workers, thereby relieving labor organizations from this growing financial and moral burden. Second, it reinforced the stigmatization of health services for the poor by linking Medicaid to the state-administered means-testing and eligibility requirement that often eliminated many of the unemployed poor from coverage (Davis 1978). Except for revisions in Medicaid coverage in the 1980s and, perhaps, the State Children's Health Insurance Program most recently, there has been no successful attempt since 1965 to create universal coverage for Americans that was not linked to employment.

While the civil rights and antipoverty movements had limited appeal to many workers, some unions, such as the United Automobile Workers;

Local 1199 (New York City hospital workers); the United Mine Workers; and others tried to form alliances around common issues. Many other workers supported the demand for health and safety legislation because of the increase in injuries associated with the speedup in production necessitated by America's growing involvement in Vietnam. Indeed, a significant reason for the passage of the Occupational Safety and Health Act of 1970 that established the Occupational Safety and Health Administration and the National Institute for Occupational Safety and Health was the rise in accidents occasioned by a full-employment economy (Ashford 1976; Stellman 1973).

A postwar management-labor concord holding that greater and greater access to health care would be exchanged for labor's ceding control over health benefits temporarily quieted the growing discontent over the inaccessibility of health care. One example was the outcome of labor-management collaboration on the Employee Retirement and Income Security Act of 1974 (ERISA). Labor and management, as Daniel M. Fox and Daniel C. Schaffer pointed out, entered into a Faustian bargain with the major corporations in which the management-labor committee was able to protect self-insured employer insurance plans from state regulations while leaving the private and voluntary insurance companies to bear the brunt of state regulations. While relieving union and management welfare plans of unwanted interference, the bargain ultimately had the effect of undercutting care for the growing number of nonunionized workers. Furthermore, the movement for universalism was quashed (Fox and Schaffer 1989; Gottschalk 1999). As the unionized workforce declines in number and percentage of the employed and as part-time workers are increasingly used as replacements for full-time union members, the number and percentage who are uninsured or underinsured continue to rise. By 1996, only 37 percent of the American workforce had adequate insurance coverage, despite the creation of what Marie Gottschalk termed the "shadow welfare state" (Gottschalk 2000; Rosenstock 2000).

The Unraveling of Employment-Based Insurance

During the 1970s, as the "crisis" of health care slowly changed from one of access to one of costs, it became apparent that labor had given up

more than it had gained. Both the creation of management-controlled HMOs (health maintenance organizations), which were completely unaccountable to the labor movement, and the extraordinary rise in costs underscored the distance between the broad population of working people and the system that ostensibly offered them care. As the percentage of workers in unions declined and the number of part-time workers and self-employed workers who were denied health benefits increased, the fault lines that had first appeared in the 1950s began to widen considerably. Without the unions' power to push for a national system of guaranteed care and with the costs of health care rising beyond the means of many small or medium-size businesses, millions of unorganized and/or unemployed workers faced a crisis. Now, like their 19th-century counterparts, modern workers know that their own future is uncertain and that their survival could easily depend on charity or chance. As the system of voluntary care continues to erode under the pressure of rising costs and challenges from the proprietary interests of managed care, as unions continue to decline in power, and as the government appears unwilling to assume political leadership and to be hostile to organized labor itself, the demand to redress the inequities of American health care has grown louder. The current political leadership notwithstanding, we can expect that large numbers of Americans will demand greater accountability from government itself.

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