Honor Thy Father and Mother:

Defining and Solving the Problem of Old Age in the United States, 1945-1961

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Submitted in partial fulfillment of the
requirements for the degree
of Doctor of Philosophy
in the Graduate School of Arts and Sciences

COLUMBIA UNIVERSITY
2014

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ABSTRACT

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In the twentieth century, Americans got old. The average lifespan grew from forty-eight to seventy-eight years of age and new policy questions and ethical challenges accompanied this demographic transition. How should old age be defined? Who would care for the nation's elders? What should older Americans give back to their communities and what should they expect from their government? Where would the infirm elderly live? Where would they die? This project returns to the middle of the twentieth century when experts within universities, foundations, social welfare organizations, and the federal government took on these questions and sought lasting solutions to the mounting problem of old age. More specifically, *Honor Thy Father and Mother* investigates how "old age" came to be defined as a social problem worthy of federal attention in the 1950s and how that federal attention shaped a national discussion on the nature and needs of the elderly.

From the 1930s to the 1950s, the definition and problems of old age were in flux. Scientists, social workers, policy makers, doctors, and religious leaders challenged the viability of chronology as a medical and political marker of old age and questioned the wisdom of seeking longevity over a purposeful and dignified end. Their perspectives, while present in scientific, medical, and political discourse, did not translate into broad, well-funded federal programs. In their stead, the government threw its financial and

administrative weight behind what I call the Medical Security Solution: initiatives such as bio-medical research and Medicare, which sought to cure the diseases of old age and relieve financial insecurity by covering the health care costs of social security recipients.

Honor Thy Father and Mother explores how the Medical Security Solution captured the attention of policy makers, activists for the aged, and senior citizens in the middle of the twentieth century and what ideas were lost in this process. This project offers a needed history of the assumptions that continue to frame, and limit, public discussions on care for the elderly.

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ACRONYMS

AARP: American Association of Retired Persons

ACS: American Cancer Society

AFL: American Federation of Labor

AFL-CIO: American Federation of Labor and Congress of Industrial Organizations

AICP: Association for Improving the Condition of the Poor

AMA: American Medical Association

DNC: Democratic National Committee

FSA: Federal Security Administration

GRC: Gerontological Research Center

GSS: Gerontology Study Section

HEW: Department of Health, Education, and Welfare

HIP: Health Insurance Plan of Greater New York

NCI: National Cancer Institute

NCOA: National Council on the Aging

NCSC: National Council of Senior Citizens

NIH: National Institutes of Health

NRC: National Research Council

NRTA: National Retired Teachers Association

PHS: Public Health Service

SSA: Social Security Act

SSRC: Social Science Research Council

WHCA: White House Conference on Aging

ACKNOWLEDGEMENTS

This dissertation is dedicated to my parents,

Sharyn and Stephen Mann

In my grandparents' living room, in the months between and after their deaths, I began to articulate this dissertation. I did so with the help of my parents Sharyn and Stephen Mann, my uncle, Ira Wolff, my cousin, Erica Wolff, my brother, Joseph Mann, and my husband, Benjamin Tweel. While I had no idea where a project on aging in America would take me, I always knew where it began—in a house filled with relatives trying to care for their elders.

From the moment I embarked on this project, I have had the unfailing support of my advisors. Since I first arrived at Columbia, Casey Blake has been so much more than just an intellectual mentor. It is due to his example and help that I became a teacher in my own right, learned how to advise students, and articulated a way to be a scholar engaged with and beholden to the community around me. Working with him on the Freedom and Citizenship program has been one of the great privileges of my graduate education. I feel profoundly lucky to have a mentor who always takes an equal interest in my intellectual, moral, and familial growth. This dissertation, and my professional aspirations are due, in no small part, to his friendship.

I was not supposed to enroll in Ira Katznelson's yearlong course on 20th century American politics; I was supposed to be studying for my orals. Thankfully, neither he nor I were deterred by my pending exams. Professor Katznelson and his remarkable course

changed my academic interests and my career—I felt not only intellectually at home, but profoundly challenged. The questions, or might I say "puzzles," posed in that room remain the preoccupations I still gladly carry with me. It has been a gift to conceptualize and write this dissertation under his able influence.

I appeared at Professor Stanley Katz's office in Princeton eager to talk about philanthropic history. He had no reason to let me in, but, of course, he did. And because no good deed goes unpunished, he had to follow that visit up with numerous trips to New York to sit on my orals exams and dissertation defense. I have always been so very touched by the energy he has put into my education and professional growth. Professor Katz has the uncanny ability to fully understand the ethical and personal stakes of my research. His comments put me back on the right course and remind me that my work can and should resonate with those currently crafting policy. I am grateful for the depth of his kindness and generosity.

At every stage of my intellectual career at Columbia, Professor Betsy Blackmar has guided me. From our first year historiography class, where I wanted to write about culture, to the following year, where I decided I was really going to write about legal history, to the year after that where it would be about philanthropy, to the day I walked into her office with a dissertation proposal about aging – she has not only given me support but has given me the patience and precision of her magnificent mind. I have never encountered a thinker like her. She sees the large and the small, the context and the exception. She knows how to frame an argument, and how to lead you through the stickier points of intellectual conception. I am so very grateful for the time she took with me and have learned so much about how to read, to write, and to think from her example.

I only hope to be as devoted a reader and mentor to my own students as she has been to me.

In the closing months of this multi-year project, three scholars came to my aid. Keith Wailoo, who had just taken on a new position as vice dean of the Woodrow Wilson School of Public and International Affairs, not only took time to read my dissertation and sit on my defense, but he also sent me detailed typed advice on how to improve the work. I am awed by the care he put into my project and his intellectual generosity. Alice Kessler-Harris met with me on multiple occasions, took the time to read my dissertation, and has given me crucial guidance on how to conceptualize the project. Susan Hartman also read the entirety of the dissertation and offered me much needed council and mentorship.

Columbia not only gave me extraordinary mentors, but inspiring peers. In my first year of graduate school, I had the intimidating distinction of having Thai Jones, the only graduate student who had already published a book, assigned to read my written work. If I can write at all, it is because of Thai. He not only spent endless hours walking me through the ways in which I could improve my prose but inspired me to enjoy crafting a narrative. He introduced me to other writers, set me up with a journalism course, and helped me get my work published. I am so very grateful for his friendship and guidance. Victoria Phillips, Melissa Borja, and Jessica Adler's friendships sustained me throughout graduate school. They are extraordinary scholars, caring mothers, and are brimming with just the right amount of irony to get me through any situation. It has been one of the great gifts of this project that Jessica and I are now engaged in some of the same fundamental questions about healthcare and policy. She has spent endless hours helping me work

through this dissertation and I so look forward to our shared endeavors. Joanna Dee Das, whom I met later in graduate school, has also read and given feedback on almost every chapter of this dissertation. She is a gifted thinker and I know how much this project has benefited from her advice.

This dissertation received generous funding from the Doris G. Quinn Foundation, the Institute of Political History, the Dirksen Congressional Center, the Howard and Natalie Shawn family, the American Historical Association, the Rockefeller Archive Center, Columbia University, and the Center for Historical Research at The Ohio State University. I am grateful to the historians at Ohio State, John Brooke, Nicholas Breyfogle, Christopher Otter, and John Burnham, who not only helped fund the final years of dissertation writing, but contributed to this project by giving me office space, constant feedback on my chapters, and a welcoming intellectual community. This project also benefitted from the kindness of librarians at the National Archives in College Park, the Bentley Historical Library at the University of Michigan, the Bernard Becker Medical Library at the University of Washington, the Reuther Library at Wayne State University, the Elmer L. Andersen Library at the University of Minnesota, the Phillips Memorial Library at Providence College, the Rockefeller Archive Center, the Wisconsin Historical Society, the Harry S. Truman Library and Museum, the Yale University Library, and the Columbia University Libraries.

For the past fourteen years, my husband has read every word I have written. No matter how exhausted he is, how many hours he has worked, or how much he just wants to retreat and play music, he sits down with a pen to edit my pages. I am consistently touched by how much he values and respects what I do. He gives quietly, constantly, and

without restraint. This dissertation is due as much to his good husbanding as his exceptional parenting skills. I feel blessed for his company, his love, and his partnership. Since the day I started writing a dissertation about old age, many of my hours have been magically spent nurturing new life. I started the dissertation the month my daughter, Mia Aviva, was born and completed it in the days leading up to my son Louis Jacob's birth. In my daughter's words, "I just love you so."

This dissertation is dedicated to my parents, Stephen and Sharyn Mann. My father, through a bludgeoning technique he likes to call conversation, taught me how to think. More than a teacher, he has always been my intellectual sparring partner. He takes on every subject I have ever been interested in, from Jewish philosophy to avant-garde performance art to cultural property law, and makes sure that I capably approach a topic from every perspective. His mind, so quick, agile, and capacious, is matched by compassion and tenderness. I am endlessly grateful to him and know that any intellectual success I have is due to his vigilance and support.

I would never have written this dissertation without the intimidating example of my mother. She built her own life to honor and enrich the lives of her parents. Although she never made it seem like a sacrifice, I am in awe of her devotion. In a culture that often glorifies independence, she is a woman who embraces obligations. By so honoring my grandparents, she gave my entire extended family a center of gravity.

As I wrote the chapters of this dissertation, I thought often of my mother. I imagined her hovering around the white kitchen table at 41 Old Field Lane, making sure my grandfather got the crunchy end of the bread, that my Nana received a piping hot cup of instant decaf coffee, that their medicines were properly laid out, and that there was

enough food in their fridge so that they could have the pride of feeding the family. Thank you for showing me how complicated, how important, how challenging, how enriching, and how joyous it can be to truly care for one's elders.

INTRODUCTION

A Significant Old Age

"I know what it is I am now experiencing.
I know what the frailty is, I know what the fear is.
The fear is not for what is lost.
What is lost is already behind the locked doors.
The fear is for what is still to be lost."
—Joan Didion[1]

"Aging," my grandmother liked to remark, "is not for sissies."[2] Well into her eighties, this regal woman had weathered the loss of friends, parents, siblings, aspects of her mobility, eyesight, and hearing. She spent decades fighting for her husband's life only to fight again for the right to usher him towards a peaceful death. She suffered from numerous chronic diseases, the most debilitating of which was emphysema, and fretted constantly about how she and her family would continue to provide for her basic needs. My grandmother compensated for these challenges with structured garments, elegant scarves, family obligations, and an unparalleled wit. More than anyone, she seemed perplexed by her own longevity, aware of its extraordinary blessings and very real burdens. My grandmother was hardly alone. Throughout the twentieth century, the average American lifespan increased from forty-eight to seventy-eight years of age. By 2030, experts predict that 20% of the U.S. population will be over sixty-five.[3] And once citizens reach the ripe age of sixty-five, they can expect to live into or past their eighties.[4]

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[1] Joan Didion, *Blue Nights* (New York: Alfred A. Knopf, 2011), 188.
[2] It has recently come to my attention that the great Bette Davis had a similar saying, "Old age is no place for sissies." Bette Davis, the official site, http://www.bettedavis.com/about/quotes.html.
[3] Harry R. Moody and Jennifer R. Sasser, *Aging: Concepts and Controversies*, 7th ed. (Thousand Oaks, CA: Sage Publications, 2012), xxiii.
[4] *See* The Official Site of the U.S. Social Security Administration, http://www.ssa.gov/planners/lifeexpectancy.htm.

Americans are living longer, dwelling in a stage of life marked as much by the addition of years as by the fear, anxiety, and uncertainty of loss.

Honor Thy Father and Mother explores the ethical debates and policy solutions triggered by this demographic transition. Accompanying the rise of old age in the twentieth century, in itself a remarkable achievement of public health innovations, were new challenges and questions. How should old age be defined? Who would care for the nation's elders? What should older Americans give back to their communities and what should they expect from their government? Where will the infirm elderly live? Where will they die? This project returns to the middle of the twentieth century when scientists, social workers, academics, foundations, and the federal government took on these questions and sought lasting solutions to the mounting problem of old age.

More specifically, this dissertation investigates how "old age" came to be defined as a social problem worthy of federal attention in the 1950s and how that federal attention shaped a national discussion on the nature and needs of the elderly. From the middle of the 1930s to the middle of the 1950s, the definition and problems of old age were in flux. Scientists questioned whether old age was reversible, while urban and rural Americans pondered whether it was something to strive for or to avoid. The hardships that plagued this ever-elongating stage of life forced Americans to think about the elderly as a distinct social group and aging as a social problem. While policy makers and social scientists sought to define the problem of old age in the concrete terms of poverty and disease, social workers, intellectuals, and religious leaders believed the elderly required more than mere financial or physical security. These thinkers argued that the social and spiritual health of the aged mattered and that such well-being was fully contingent on maintaining

a respected position within the larger society. “Old age,” wrote Rabbi Abraham Joshua Heschel, “is an age of anguish. The only answer to the age of anguish is a sense of significant being.”[5]

By 1961, the definition, the problem, and the solution to old age at the federal level had crystallized. Gone were the multifaceted definitions of aging and its attendant problems. In their stead, congressmen and policymakers came to agree that old age could be defined chronologically at the age of sixty-five and that the essential, and treatable, problem for citizens over sixty-five was poverty due to health failure. This intellectual consolidation had the added effect of reducing the elderly into a monolithic bloc, undifferentiated by race, class, gender, or region.

A conversation formerly centered on the ethics of care became one centered on the feasibility of a solution. To solve the problem of old age, Congress funded scientists to research chronic disease through the National Institutes of Health and, with ample public pressure, offered numerous bills to give social security recipients hospital insurance. Such forms of federal policy making, which I refer to as the Medical Security Solution, influenced and constrained the way in which the problems of old age came be articulated in senior centers, universities, and professional training programs. How, and why, in the 1950s the debate over the multiple problems of old age narrowed at the level of national policy making to the Medical Security Solution is the historical puzzle this dissertation sets out to solve.

[5] Rabbi Abraham Joshua Heschel, “The Older Person and the Family in the Perspective of Jewish Tradition, ” in *Aging with a Future: A Selection of Papers Defining Goals and Responsibilities for the Current Decade; Reports and Guidelines from the White House Conference on Aging* (Washington, D.C.: U.S. Dept. of Health, Education, and Welfare, Special Staff on Aging, 1961), 42.

By focusing on the ascendency of a policy agenda, the dissertation follows in the tradition of scholars like Jacob Hacker and Margaret Weir, who have drawn on the extensive literature on agenda setting to craft historical narratives that plot the rise of policy ideas.[6] But more than asking how the Medical Security Solution came to dominate policy conversation, this dissertation asks the equally critical question of what was lost in the process. What ideas circulated in Washington, D.C., in the 1940s and 1950s but never received the same kind of attention? Why did these ideas fail to gain ground and what are the repercussions of this loss?

By many measures, the Medical Security Solution was successful. Medicare and repeated amendments to the Social Security Act lifted numerous elderly out of real or imminent poverty and funding for medical research and hospitals offered Americans the chance to live better with formerly crippling chronic diseases. There were and continue to be predictable and unpredictable consequences of these policy accomplishments.

The singular drive to cure or to solve old age overlooked the very nature of aging itself—that it remains irreversible. Despite every scientific advance, human beings age and die. By establishing age-based policies that have added years to the American lifespan, subsidized institutional care, bolstered hospital care, and arguably fostered the growth of the senior citizens lobby, the Medical Security Solution exacerbated many of the hardships first described in the middle of the twentieth century. The material challenges of long-term housing, disability, disease, and unemployment persist. As do the

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[6] Margaret Weir, *Politics and Jobs: The Boundaries of Employment Policy in the United States* (Princeton: Princeton University Press, 1992), xiii; Jacob S. Hacker, *The Road to Nowhere: The Genesis of President Clinton's Plan for Health Security* (Princeton: Princeton University Press, 1996).

For more literature on agenda setting *see* John W. Kingdon, *Agendas, Alternatives, and Public Policies* (New York: Longman, 2003); Frank R. Baumgartner and Bryan D. Jones, *Agendas and Instability in American Politics* (Chicago: University of Chicago Press, 1993); and William H. Riker, *Agenda Formation* (Ann Arbor: University of Michigan Press, 1993).

existential agonies of uselessness, isolation, and an undignified death. Financial incentives to institutionalize the elderly remain entrenched in federal policies, and the creation of age-based entitlements and subsequent age-based interest groups, continue to exacerbate intergenerational tensions.

"One father," uttered Heschel to a rapt audience in 1961, "finds it possible to sustain a dozen children, yet a dozen children find it impossible to sustain one father."[7] Caring for the aged, Heschel knew, would always be a personal and communal challenge. In the middle of the twentieth century the United States government took up that challenge. And now, in the second decade of the twenty-first century, it is crucial to think through the contours of this relationship. What assumptions have guided major federal policies on the elderly? What assumptions that are no longer consonant with current ideas on aging continue to inform policymaking? Are there other policy paths that would better serve current and future needs?

By returning to the ethical debates, value-driven conversations, and openness to the reality of aging and death that dominated policy conversations in the 1950s, *Honor Thy Father and Mother* aims to recast and animate a political discourse that is too often restricted by the policy paths already taken.

[7] Abraham Joshua Heschel, "To Grow in Wisdom," in Abraham Joshua Heschel, *The Insecurity of Freedom: Essays on Human Existence* (New York: Farrar, Straus & Giroux, 1966), 70.

Background and Methodology

In the 1920s, charity workers, political activists, labor organizers, doctors, and writers awoke to the mental and physical needs of the aged poor.[8] The corresponding developments of industrialization and urbanization left many aged without job prospects or nearby extended families at the time of the Great Depression.[9] The informal network of state- and religious-run charities and poorhouses failed in the face of the mass-unemployment and destitution that disproportionately afflicted a growing number of individuals over forty. For the first time, the plight of dependent elders warranted national attention.

Within the decade, spokesmen across the United States pressed the government to enact pension programs. By the time President Roosevelt came into office, some thirty states had enacted pension programs, albeit unevenly; only 3% of those deemed aged were receiving state funds in 1935. The fight for pensions continued through the 1930s in the popular Townsend Old Age Revolving Pension Plan, Upton Sinclair's End Poverty in California (EPIC) plan, and Robert Noble's spurious Ham & Eggs movement. All of these groups argued that the government should give a stipend to those deemed too old to work, whether forty, fifty, or sixty-five.[10] Both encouraging and mollifying these popular social movements was the growing interest in the European intellectual tradition of social insurance.[11]

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[8] W. Andrew Achenbaum, *Shades of Gray: Old Age, American Values, and Federal Policies since 1920*, (Boston: Little, Brown, 1983); Henry J. Pratt, The Gray *Lobby* (Chicago: University of Chicago Press, 1976).
[9] Carole Gratton and Brian Haber, *Old Age and the Search for Security: An American Social History,* (Bloomington: Indiana University Press, 1993).
[10] Pratt, *The Gray Lobby*.
[11] "Historical Background and Development of Social Security," The Official Site of the U.S. Social Security Administration, http://www.ssa.gov/history/.

At its base, the philosophy of social insurance, or the social welfare tradition, maintained that governments should provide some measure of economic security. First enacted in 1889 by Otto von Bismarck in Germany, social insurance programs spread quickly across Europe. American yearnings for such programs began with Theodore Roosevelt in 1912 and reached an apex during the Great Depression. In 1927, Abraham Epstein, a weathered state pension advocate announced, “It’s time for a group that will do nothing but work to create old-age pensions.”[12] Mindful of the sullied public reputation of the word *pension*, Epstein titled his organization The American Association for Old Age Security, later to be renamed the American Association for Social Security. Epstein’s rebranding held.

In 1934, President Roosevelt issued an executive order to create the Committee on Economic Security with the goal of studying and solving the problem of economic insecurity in America. On August 14, 1935, the President signed into law the monumental Social Security Act. Through this act, writes historian Michael Katz, “old-age security broke loose from its earlier association with poor-relief; forged ahead of every other kind of social insurance; and earned its privileged place as the only irreversible and untouchable welfare program in American history.”[13] Explicitly designed as a financed earned right and not a charitable handout, the Social Security Act offered eligible elders “economic security with dignity.”[14]

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[12] Pierre Epstein, *Abraham Epstein: The Forgotten Father of Social Security* (Columbia: University of Missouri Press, 2006), 78.
[13] Michael B. Katz, *In the Shadow of the Poorhouse: A Social History of Welfare in America* (New York: Basic Books, 1986), 211.
[14] James Schulz and Robert Binstock, *Aging Nation: The Economics and Politics of Growing Older in America* (Westport, CT: Praeger Publishers, 2006), 55.

In 1935, the aged—or "oldsters," as they were then often called—were not exclusively defined chronologically. In fact, numerous doctors and scientists working in the 1930s pushed for a biological, rather than chronological definition of old age, claiming that physical markers and not simply the passing of years best defined old age. They looked at the correlations between poverty, chronic disease, family history, and psychology to determine that the onset of senescence or old age was relative rather than uniform. These early gerontologists believed that employment and usefulness would stave off the markers of old age. Still, they had little control over industry policies that pushed workers out of jobs at the early age of forty. Some factories even retired women at thirty-five.[15]

The Committee on Economic Security understood both the harsh economic reality of forced retirement and the absolute social necessity of keeping the young employed. The committee settled on sixty-five as the marker of old age for its economic feasibility. At the time, life expectancy at birth was fifty-eight. Taking their cues from existing state pension systems and the recently passed Railroad Retirement System, the committee recognized that sixty-five was a number that could be sustainably financed through payroll taxation. As historian Andrew Achenbaum writes, "As a result of the Social Security Act, old age—defined for administrative purposes as the attainment of age sixty-five—for the first time became a criterion for participation in several important programs at the federal level."[16] The Social Security Act fundamentally changed the relationship between the government and its older citizens. From 1935 on, the U.S. federal

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[15] *See* Chapter I.
[16] W. Andrew Achenbaum, *Shades of Gray*, 40.

government committed itself to the well-being of its unemployed elders, who hereby would be defined as individuals over sixty-five years of age.

By the 1940s, the pension movement of the 1920s and 1930s had largely collapsed. Having achieved the Social Security Act, popular participation in pension-oriented groups diminished and political organizers focused attention elsewhere. The complete lack of political activity on behalf of the elderly led political historian Henry Pratt to label this period "the Dismal Years."[17] Then, just as the pension movement dribbled to a halt, the field of biomedical research exploded.

Science and war proved productive partners. The utilization of penicillin, skin grafts, and blood transfusions "enhanced public belief that scientific research offered an endless frontier on which a happier, healthier life could be built."[18] After the Second World War, Congress went to work, sponsoring a spate of legislation to update American health care. According to health policy expert Theodore Marmor, federal spending after WWII focused on three areas: "medical research, hospital construction, and federal health insurance programs."[19] In the 1940s, the government funded medical research through the National Institutes of Health and subsidized 25–30% of postwar hospital construction through the Hill-Burton Act (1946).[20]

While the federal government got into the bio-medical business, older Americans, responding to the unintended consequences of the Social Security Act, such as forced retirement, joined together in community halls and religious institutions to figure out where they stood in the postwar order. "By setting an arbitrary retirement age," the

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[17] Pratt, *The Gray Lobby*.
[18] Victoria Angela Harden, *Inventing the NIH: Federal Biomedical Research Policy, 1887–1937* (Baltimore, MD: Johns Hopkins University Press, 1986).
[19] Theodore R. Marmor, *The Politics of Medicare*, 2nd ed., (New York: A. de Gruyter, 2000), xxiv.
[20] Ibid.

editors of *The Senior Rights Movement* argue, "the Social Security Act had inadvertently circumscribed the problems of persons over 65 as a distinct set of social problems. As such it provided a coherent basis for their solidarity and common identity and gave a newfound sense of legitimacy to elderly demands for social justice."[21] The demands of the elderly and their advocates in the 1940s remained case specific. While some groups required better housing, others requested reemployment programs, or basic social services. In 1950, this nascent group of politically conscious elderly collided with an energized bio-medical industry and fair-deal policy wonks at the first National Conference on Aging.

At the behest of the Federal Security Administration (the agency tasked with implementing the Social Security Act), a key group of old-age activists met in Washington, D.C., on August 13, 1950, for the first National Conference on Aging. Few conference attendees agreed on a definition of old age, but all were convinced that it had become a serious national problem. They sought multiple solutions to what they understood as a complex intersection of needs.[22] Eleven years later, at the 1961 White House Conference on Aging, a majority consensus on the solution to the problem of old age emerged. Expansive conversations on the ethics of intergenerational obligations were quieted by advocates for a new kind of American—the senior citizen. By the close of the conference, a coalition defined the problem of old age as poverty caused by health failure and advocated for a single solution—the creation of Medicare.[23]

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[21] Lawrence A. Powell, Kenneth Branco, and John B. Williamson, *The Senior Rights Movement: Framing the Policy Debate in America* (New York: Twayne, 1996), 133.
[22] U. S. Federal Security Agency, M*an and His Years: An Account of the First National Conference on Aging* (Raleigh: Health Publications Institute, 1951).
[23] *The Nation and Its Older People: White House Conference on Aging* (Washington, D.C.: U.S. Dept. of Health, Education, and Welfare, Special Staff on Aging, 1961).

A confluence of factors led discrete actors to first narrow and then medicalize their definition of *care*. For one, society came to trust a booming biomedical industry. For this reason, funds dedicated to eldercare were often put into medical research and hospital growth. In the twenty years covered by this dissertation, the budget for the National Institutes of Health grew from 3 million to over 1.4 billion dollars, with chronic and end-of-life diseases being a primary focus of research. In addition, the failure to pass national health insurance after WWII spurred policymakers in the Truman administration to seek alternative solutions. Policymakers zeroed in on the elderly as a group that could serve as a catalyst toward universal health care. Subsequent Democratic administrations followed suit, pushing for Medicare alongside unions, nonprofit groups, and private businesses. The rise of special interest lobbies also helped provide a model for elder activists, who in the 1950s and early 1960s banded together to form such groups as the American Association of Retired Persons (AARP), National Council of Senior Citizens (NCSC), National Association of Retired Federal Employees (NARFE), and the National Council on Aging (NCOA). Many of these organizations relied on timely political wins to shore up participation and funds. This occurred in tandem with the consolidation of industries with a significant financial investment in the elderly, such as pharmaceutical companies and nursing home providers.

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This dissertation returns to the middle of the twentieth century, when discussion of the problems of old age remained expansive, the intellectual debates about solutions cut across disciplines, and the coalitions that successfully lobbied for Medicare were formed. What factors led a seemingly diverse set of parties invested in eldercare to

narrow both their definition of proper care and their political agenda? To provide an answer, *Honor Thy Father and Mother* focuses on actors deliberating on the problems of, and solutions to, old age in the federal government, nonprofit groups, universities, and lobbying organizations. The dissertation follows individuals, such as Oscar Ewing from the Federal Security Administration, Nelson Cruikshank of the AFL-CIO, and Ollie Randall from the Community Service Society and the National Council on Aging, while also closely plotting the dialogue that took place going into and coming out of the first National Conference on Aging (1950) and the first White House Conference on Aging (1961). In tandem, the personal papers of old age activists and federal archives from the Federal Security Administration reveal how various approaches to eldercare transformed through dialogue, outside political pressure, and policy viability.

The definition of *old age* evolved throughout the period covered by this dissertation. Driven as much by medical knowledge as political wrangling, the phrase itself requires careful historical treatment. To fully understand the medical perspective on the definition of old age and how it conflicts with and informs the larger policy conversation on care for the elderly, this project relies on the personal papers of early gerontologists, such as E. V. Cowdry, and such journals as *Geriatrics* (1946) and the *Journal of Gerontology* (1946).

Honor Thy Father and Mother begins in Chapter I with an analysis of how physicians and scientists conceptualized old age from the 1940s to the 1950s and concludes in Chapter V with the ascendency of the Medical Security Solution at the 1961 White House Conference on Aging. The intervening chapters trace conflicting models of eldercare, the rise of vested private interests, and the feedback loop between federal

policies and normative descriptions of the elderly and their needs. Chapter II looks closely at the conflicting opinions on the problems and solutions to old age offered by the social worker Ollie Randall, the social scientist Clark Tibbitts, and the policymaker Oscar Ewing. Chapter III explores how doctors, scientists, religious leaders, and political operatives discussed the definitions, the problems, and the solutions to old age at the first National Conference on Aging. The penultimate chapter looks at the rise of the senior citizen and the relationship between Congressional action and senior group formation.

Historiography

Old age has not proved a seductive topic for contemporary historians. Other stages of life, such as youth, tend to get more attention. In the past ten years historians and other humanities scholars have written only a handful of books and dissertations on the topic.[24] The great majority of work on this subject has been conducted within the confines of social work, under the heading of gerontology, and medicine, in the field of geriatrics. This oversight is problematic. There are not enough researchers questioning the long relationship between policy and eldercare and little attention is given to how certain habits of interaction have evolved historically. In the end, crucial conversations on care for the elderly are conducted in a historical vacuum. In the 1970s and 1980s, the

[24] Jason G. Roe, "From the Impoverished to the Entitled: The Experience and Meaning of Old Age in America since the 1950s" (Ph.D. dissertation, University of Kansas, 2012); Tony King Yang, "The Needs of a Lifetime: The Search for Security, 1865–1914" (Ph.D. dissertation, University of California, 2009); Hyung Wook Park, "Refiguring Old Age: Shaping Scientific Sesearch on Senescence, 1900–1960" (Ph.D. dissertation, University of Minnesota, 2009); Katherine Anne Otis, "Everything Old Is New Again: A Social and Cultural History of Life on the Retirement Frontier, 1950–-2000" (Ph.D., The University of North Carolina at Chapel Hill, 2008); Erin Gentry Lamb, "The Age of Obsolescence: Senescence and Scientific Rejuvenation in Twentieth Century America" (Ph.D. dissertation, Duke University, 2008); Theresa R. Snyder, "Old Age Homes in Philadelphia, 1870–1929: Creating, Promoting, and Negotiating Middle Class Community" (Ph.D. dissertation, University of Pennsylvania, 2002); Laura Davidow Hirshbein, "The Transformation of Old Age: Expertise, Gender, and National Identity, 1900–1950" (Ph.D. dissertation, The Johns Hopkins University, 2000).

scholarly landscape looked different. Historians and social scientists took on the history of old age, publishing monumental books tracking the changing position of the elderly in society. In a political climate that degraded "old geezers" for robbing the state, these scholars created the field of old-age history.

The first works on the topic posed the question: when did the elderly lose their status in society? In books such as *Aging and Modernization* (1972), edited by Donald O. Cowgill and Lowell D. Holmes, the answer was what they termed *modernization*.[25] These authors argued that with the onset of industrialization, American society took a sharp turn away from honoring the aged. Factory work rendered elderly workers economically useless, which in turn denigrated their social position in society. Five years later, David Hackett Fischer in *Growing Old in America* amended this theory.[26] Rather than a sharp turn, Fischer claimed that a set of evolving ideas, which occurred before industrialization at the close of the 18th century, transformed the position of the elderly in American society. The new nation required a different set of religious and political beliefs that idealized the spirited energy of youth. From the country's beginning, the aged—especially widows–were a blighted afterthought. In 1978, W. Andrew Achenbaum in *Old Age in the New Land: The American Experience since 1790*, challenged Fischer's periodization.[27] Achenbaum claimed that despite changing intellectual ideals, the economic and professional position of the elderly was relatively stable until the Civil War. It was only after the Civil War that the aged increasingly came to be seen as a social problem due to a complex confluence of political, social, and economic factors. In these

[25] Donald O. Cowgill and Lowell D. Holmes, *Aging and Modernization* (New York: Appleton-Century-Crofts, 1972).
[26] David Hackett Fischer, *Growing Old in America*, (New York: Oxford University Press, 1977).
[27] W. Andrew Achenbaum, *Old Age in the New Land: The American Experience since 1790* (Baltimore: Johns Hopkins University Press, 1978).

works, the authors overlook the flip side of their proposed question, that the elderly might have lost their status even as they retained their political prowess.

On the heels of Fischer and Achenbaum, Thomas R. Cole and Brian Gratton reframed the guiding historiographic question of the 1970s. Rather than focusing on the degenerating social position of the aged, Cole, in *The Journey of Life: A Cultural History of Aging in America* (1992), pondered the more elusive question of what it means to grow old.[28] His work, which centered on social awareness and self-perceptions of aging, incorporated the changing scientific discussions of old age and depictions of the elderly in popular media. Cole observed the connection between old age and disease along with the relationship, documented by other scholars, between the declining position of the elderly and the idealization of individuality and youth.

In *Urban Elders: Family, Work, and Welfare among Boston's Aged, 1890–1950* (1986), Brian Gratton rejected both modernization theorists (like Cowgill and Holmes) and what he calls attitudinal theorists (like Fischer and Achenbaum).[29] Gratton returned to the primacy of economic factors without positing a clean break from the days when people respected their elders and the days they stopped doing so. In place of a general study of old age, Gratton focused on a particular group of elders working in Boston during a sixty-year period. Attitudinal changes, Gratton argues, did not make the elderly dependent, government policies did. In his estimation, working class elders kept their jobs until policies mandated early retirement, which pushed the aged into a dependent position. While Gratton might put too much emphasis on a single cause, he rightly

[28] Thomas R. Cole, *The Journey of Life: A Cultural History of Aging in America* (New York: Cambridge University Press, 1992).
[29] Brian Gratton, *Urban Elders: Family, Work, and Welfare among Boston's Aged, 1890–1950* (Philadelphia: Temple University Press, 1986).

pursues the complexity of how, when, and why old age is defined as a social problem and the varied outcomes of federal solutions.

All of the historians listed above focus on the position of the elderly in the decades before 1950. While many gesture to the complicated problems afflicting the elderly in the second half of the twentieth century, their primary research concludes where this dissertation begins. The scholarly work on seniors as a political interest group picks up where the literature on old age leaves off, interrogating the rise of the elderly as a political power.

Running parallel to the history of old age as a physical and social phenomenon is the history of elderly political activism and the senior citizen. This scholarly tradition begins with agitation for state and later federal pensions from social groups in the first two decades of the twentieth century and often concludes with the creation of the Social Security Act in 1935.[30] Distinct from the robust literature on the rise of pensions in the first half of the twentieth century, *The Gray Lobby* (1976) by Henry Pratt, *Shades of Gray: Old Age, American Values, and Federal Policies Since 1920* (1983) by Andrew

[30] Among the robust and growing literature on the history of the Social Security Act, the following works provide a good foundation on the topic: Edwin E. Witte, *The Development of the Social Security Act* (Madison: University of Wisconsin Press, 1962); Clarke A. Chambers, *Seedtime of Reform: American Social Service and Social Action, 1918–1933* (Minneapolis: University of Minnesota Press, 1963); Roy Lubove, *The Struggle for Social Security, 1900–1935* (Cambridge: Harvard University Press, 1968); J. Douglas Brown, *An American Philosophy of Social Security: Evolution and Issues* (Princeton: Princeton University Press, 1972); Martha Derthick, *Policymaking for Social Security* (Washington, D.C.: Brookings Institution, 1979); Carolyn L. Weaver, *The Crisis in Social Security: Economic and Political Origins* (Durham: Duke University Press, 1982); W. Andrew Achenbaum, *Social Security: Visions and Revisions* (New York: Cambridge University Press, 1986); Michael B. Katz, *In the Shadow of the Poorhouse*;, Jill S. Quadagno, *The Transformation of Old Age Security: Class and Politics in the American Welfare State* (Chicago: University of Chicago Press, 1988); Edward D. Berkowitz, *America's Welfare State: From Roosevelt to Reagan* (Baltimore: Johns Hopkins University Press, 1991); Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge: Belknap Press of Harvard University Press, 1992).

For more on the history of the grassroots pension movements of the 1920s and 1930s *see* Abraham Holtzman, *The Townsend Movement: A Political Study* (New York: Bookman Associates, 1963); Alan Brinkley, *Voices of Protest: Huey Long, Father Coughlin, and the Great Depression*, (New York: Knopf, 1982); and Edwin Amenta, *When Movements Matter: The Townsend Plan and the Rise of Social Security* (Princeton: Princeton University Press, 2006).

Achenbaum, and *The Senior Rights Movement* (1996) by coauthors Lawrence Powell, Kenneth Branco, and John Williamson, track the rise of multi-issue senior citizen political lobbying groups after 1930.[31] These scholars draw a distinction between pension movements solely concerned with unemployment and the senior citizen movement that emerged in the 1960s.

For Pratt, the major shift occurred when seniors (those over sixty-five) began to organize for themselves in the later 1950s and build sophisticated multi-issue organizations that could function without a single charismatic leader. Achenbaum follows Pratt's general timeline but places the issue of values at the center of his work. Rather than a strict policy history, he traces how certain value debates, such as equity vs. adequacy or self-reliance vs. dependency, have dominated political discussions and policy outcomes. The essays in *The Senior Rights Movement: Framing the Policy Debate in America* analyze how political consolidation occurred, contributing to this scholarly lineage by crediting the labor-senior alliance. In tandem, these books, and others on the topic, trace the policy history of the senior-lobby and the creation of Medicare.[32] For scholars of the pension movement, political agitation concludes with the creation of the Social Security Act. For scholars of the senior movement, political agitation begins in the late 1950s. This dissertation opens in the decade in between. It does so in order to look closely at how a set of ideas attracted the attention of policymakers before a significant senior movement developed around them.

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[31] Pratt, *The Gray Lobby*; And Powell, Branco, and Williamson, *The Senior Rights Movement*.
[32] This literature is complemented by the great body of work in political science on the rise of interest groups. For more on how senior citizens do and do not function as an interest group *see* Christine L. Day, *What Older Americans Think: Interest Groups and Aging Policy* (Princeton: Princeton University Press, 1990), Robert B. Hudson, *The Aging in Politics: Process and Policy* (Springfield, IL: C. C. Thomas, 1981).

In *Old Age and the Search for Security: An American Social History* (1993), Carole Haber and Brian Gratton offer a synthesis of aging scholarship from the 1970s to the 1990s.[33] They break down the available research into four fields: the colonial period, the economic status of the elderly, work and retirement, and poor houses. This dissertation posits another category, the history of federal care for the elderly. This field, indebted to the extensive writings of Andrew Achenbaum, would pose, to name only a few, the following questions: How did the elderly become a social problem the federal government sought to solve? What solutions did the government offer and why? How did federal solutions alter the contours of the problem? Such a field would connect the rich literature on the history of old age and senior citizens with the extensive body of work on the development of the American welfare state.

In recent years, the literature on the American welfare state has emerged from its preoccupation with the relative size or strength of the state to an investigation of the diverse mechanism of American governance. In addition to looking at federal expenditures, scholars in this tradition have pursued, for example, the governing powers of public-private partnerships and the extensive tax code.[34] Inspired by this scholarship, this dissertation focuses both on the more traditional welfare policy of Medicare and on the less traditionally studied mechanism of the National Institutes of Health. Scholarship on American health care and health insurance relies on and mirrors the history of the

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[33] Haber, *Old Age and the Search for Security*.

[34] For a general discussion on the size and development of the American State *see* Stephen Skowronek, *Building a New American State: The Expansion of National Administrative Capacities, 1877–1920* (Cambridge: Cambridge University Press, 1982) and Karen Orren and Stephen Skowronek, *The Search for American Political Development* (Cambridge: Cambridge University Press, 2004).

For a few examples of the way in which the American welfare state functions outside of European social welfare mechanisms see Margaret Weir, Ann Shola Orloff, and Theda Skocpol, *The Politics of Social Policy in the United States* (Princeton: Princeton University Press, 1988) and Christopher Howard, *The Hidden Welfare State: Tax Expenditures and Social Policy in the United States* (Princeton: Princeton University Press, 1997).

American welfare state. It begins by asking why, when other Western and Northern European countries were developing national health insurance programs, the United States failed to do so.[35] Current scholars are building on this body of work by describing the mechanisms of the American health care system and its peculiar reliance on private, non-state, actors.[36]

In addition to the scholarship on the tools of American welfare policy, historians and political scientists have worked tirelessly in the past two decades to describe the uneven nature of the American welfare state. They have highlighted the long-instantiated distinction between public assistance and social insurance and the way in which welfare policies favored white workingmen over women and minorities such as African Americans.[37] Where public assistance, or means-tested relief programs such as Aid to

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[35] Daniel S. Hirshfield, *The Lost Reform: The Campaign for Compulsory Health Insurance in the United States from 1932–1943* (Cambridge: Harvard University Press, 1970); Ronald L. Numbers, *Almost Persuaded: American Physicians and Compulsory Health Insurance, 1912–1920* (Baltimore: Johns Hopkins University Press, 1978); Beatrix Hoffman, *The Wages of Sickness: The Politics of Health Insurance in Progressive America* (Chapel Hill: University of North Carolina Press, 2001); Jill S. Quadagno, *One Nation, Uninsured: Why the U.S. Has No National Health Insurance*, New York vols. (New York: Oxford University Press, 2005); Lawrence R. Jacobs, *The Health of Nations: Public Opinion and the Making of American and British Health Policy* (Ithaca: Cornell University Press, 1993).

[36] *See* Colin Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth-Century America* (Princeton: Princeton University Press, 2003); Jennifer Klein, *For All These Rights: Business, Labor, and the Shaping of America's Public-Private Welfare State* (Princeton: Princeton University Press, 2003); Jacob S. Hacker, *The Divided Welfare State: The Battle over Public and Private Social Benefits in the United States* (New York: Cambridge University Press, 2005); Christy Ford Chapin, "Ensuring America's Health: Publicly Constructing the Private Health Insurance Industry" (Ph.D. dissertation, University of Virginia, 2011); Paul Starr, *Remedy and Reaction: The Peculiar American Struggle over Health Care Reform* (New Haven: Yale University Press, 2011).

[37] For a general history that plots the development of the two-tiered welfare state and the uneven treatment of poverty *see* Katz, *In the Shadow of the Poorhouse*; Daniel Levine, *Poverty and Society: The Growth of the American Welfare State in International Comparison* (New Brunswick: Rutgers University Press, 1988); James T. Patterson, *America's Struggle against Poverty: 1900–1980*, (Cambridge: Harvard University Press, 1982); Edward D. Berkowitz, *America's Welfare State: From Roosevelt to Reagan* (Baltimore: Johns Hopkins University Press, 1991).

For more on the way in which American welfare policies favored particular categories of working men as well as the repercussions of these policies on women and African Americans more broadly *see* Linda Gordon, *Pitied but Not Entitled: Single Mothers and the History of Welfare*, 1890–1935 (New York Free Press, 1994); Alice Kessler-Harris, *In Pursuit of Equity: Women, Men, and the Quest for Economic Citizenship in 20th Century America* (New York: Oxford University Press, 2001); Ira Katznelson, *When*

Families with Dependent Children, retained the stigma of dependency and poverty, social insurance, or entitlement programs, most famously Social Security, created standardized criteria and prepayment structures for a subset of working men that allowed them to feel deserving of the federal boon. This distinction in the organization of the welfare state bolstered socially and economically established racial and gender hierarchies.

In tandem this literature provides the groundwork for thinking through the creation of Medicare. Federal health insurance for the elderly expanded on the successful entitlement structure of the Social Security Act, bolstered private insurance, and arose as a response to the failure to implement national health insurance. My project relies heavily on the rich legislative and political history of Medicare produced by historians, political scientists, and sociologists, while highlighting the opinions of the aged and old-age activists in the years leading up to the legislation.[38] In doing so this dissertation draws attention to how interested parties articulated the problem of old age before and after a major federal policy was crafted and offers a needed history of how a set of assumptions around care for the elderly came to dominate policy conversations in the 1950s.

Honor Thy Father and Mother seeks to enrich public and private discourse on eldercare by reviving the relevant debates that took place between the close of World

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Affirmative Action Was White: An Untold History of Racial Inequality in Twentieth-Century America (New York: WW Norton, 2006).

[38] Eugene Feingold, *Medicare: Policy and Politics: A Case Study and Policy Analysis* (San Francisco: Chandler Pub. Co., 1966); Richard O. Harris, *A Sacred Trust* (New York: New American Library, 1966); Peter A. Corning, *The Evolution of Medicare: From Idea to Law* (Washington, D.C.: Office of Research and Statistics, U.S. Social Security Administration, 1969); Henry P. Brehm and Rodney M. Coe, *Medical Care for the Aged: From Social Problem to Federal Program* (New York: Praeger, 1980); Sheri I. David, *With Dignity: The Search for Medicare and Medicaid* (Westport, CT: Greenwood Press, 1985); Rashi Fein, *Medical Care, Medical Costs: The Search for a Health Insurance Policy* (Cambridge: Harvard University Press, 1986); Monte M. Poen, *Harry S. Truman Versus the Medical Lobby: The Genesis of Medicare* (Columbia: University of Missouri Press, 1996); Jaap Kooijman, *—and the Pursuit of National Health: The Incremental Strategy toward National Health Insurance in the United States of America* (Amsterdam: Rodopi, 1999); Theodore R. Marmor, *The Politics of Medicare*, 2nd ed. (New York: A. de Gruyter, 2000); Jonathan Oberlander, *The Political Life of Medicare* (Chicago: University of Chicago Press, 2003).

War II and the passage of Medicare. Fundamental questions such as what does proper care look like, what really are the hardships of old age, and who should be responsible for the nation's elders dominated policy conversations in the 1950s and have since receded. This dissertation features these discussions to question how the contemporary eldercare system developed and to offer alternative conceptions of the problems and solutions to one of the major demographic upheavals of the twentieth and twenty-first centuries.

CHAPTER I

Old Cells, Aging Bodies, and New Money:
Scientific Solutions to a Social Problem, 1945-1953

"Until the moment it is upon us, old age is something that only affects other people."[1]
Simone de Beauvoir

I: Introduction

On July 30, 1965, the 57-year-old President of the United States honored the 81-year-old former President by traveling to Independence, Missouri to sign into law a bill that would give America's elders federally funded health insurance. With the passage of Medicare, Harry Truman's admittedly imperfect policy became Lyndon Johnson's political windfall: Johnson could now claim to have solved the "problem of old age."

The problem of old age started to attract public and political attention in the 1930s, when the corresponding developments of industrialization, urbanization, and mass unemployment collided with the Depression, leaving many of the aged without jobs or support from their extended families. These forces affected a group whose numbers were on the rise. Advances in public health had transformed life expectancy in America: from 1860 to 1930 the percentage of the American population over sixty-five had more than doubled. In ten years, from 1930 to 1940, there would be an additional 36.5 percent increase in this group, at a time when the entire population increased by only 7.2 percent.[2] The so-called problem of old age, which first appeared on the streets of American towns and cities, soon became the much-debated subject of social workers, academics, and politicians.

By 1965, the problem of old age seemed clear. Individuals became old at the age

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[1] Simone de Beauvoir, *The Coming of Age* (New York: Putnam, 1972), 5.
[2] Statistics compiled by the Metropolitan Life Insurance Company and quoted in E.V. Cowdry, "The New Public Health," *The Scientific Monthly*. 55, no. 4 (Oct. 1942): 355.

of sixty-five and lost their dignity when the costs of illness led to poverty. Medicare, then, was an ingenious solution: pay for healthcare for those over sixty-five and relieve both illness and poverty for the aged. Yet, in the 1930s and 1940s, scientists and doctors, who first confronted rising numbers of elders, came to a radically different definition of old age and its problems. They pushed for a biological definition of old age as well as a conceptual separation between disease and aging.

Led by the cytologist Edmund Vincent Cowdry, these scientists and doctors designed a field of inquiry with both a multi- and interdisciplinary bent—gerontology. They sought to investigate the basic mechanisms involved in aging life, from plants to humans, as well as the reasons behind desolation, poverty, and illness in old age. They challenged chronological definitions of old age and offered analytic frameworks for discovering what healthy aging could look like. Cowdry and his peers believed that by viewing aging through a moral and biological lens they could transform the elderly from a social problem into a social asset. To do so, they would have to discover and then promote optimal social and medical living choices for Americans at a much earlier age than 65.

From 1937 until 1953, the burgeoning discipline of gerontology depended on the generosity of a single source, The Josiah Macy Jr. Foundation. Ideologically committed to Cowdry's approach to old age, the Macy Foundation sponsored conferences, books, an academic club, and a journal dedicated to gerontology. The financial insecurity of this arrangement and the transformation of the federal government's relationship to scientific research at the close of World War II pushed gerontological funding from the private to the public sector.

In the field of gerontology, money mattered. By the 1950s, research funding from the federal government largely came through the newly established, and recently enriched, National Institute (and later Institutes) of Health (NIH). Since funding came from an arm of the federal government dedicated to curing specific diseases and promoting biomedical research, the multi-disciplinary gestalt of the earlier aging research agenda waned.

In the second half of the twentieth century, the mechanisms of aging would be discovered in laboratories, the diseases of old age treated in hospitals, and the social problems of the elderly studied in universities. This separation of disciplines, which came with vast inequities in financial resources, reduced the possibility of a multi-pronged approach geared to enhancing the well-being and status of the elderly. Instead, the country marshaled its wartime resources and sought to combat old age as a physical pathology with a biomedical cure. By the middle of the 1950s the assumptions that would be built into the Medical Security Solution were institutionally entrenched.

II: Old Cells

In a St. Louis morgue, five frozen bodies awaited transport. The year was 1947 and thirty days prior, each of the bodies, ranging in age from newborn to an 80-year-old, had been "carefully wrapped," their skin primed for scientific evaluation.[3] In the lab of the famed cytologist, E.V. Cowdry, assistants excised isosceles-shaped samples from thirty-one regions of the body, immersed the triangles in "1 per cent acetic acid for

[3] E.V. Cowdry, Zola Cooper, and Warren Smith, "Program of Research on Aging," *Journal of Gerontology* 2, no. 1, (Winter 1947): 31.

twenty-four hours," and then stained the detached epidermis with hematoxylin.[4] This method allowed the scientists to study "the whole epidermis from within, the ducts of sweat glands, hair follicles, and many sebaceous glands."[5] Cowdry liked to say, "While we are in life we are in death."[6] This study of skin cells would, in precise terms, prove this saying to be true.

Cells age, but not uniformly. In the body, some cells divide and reproduce, others dry out, wither, and eventually die. Even within these cells, the rate and purpose of aging varies. Nerve cells, for example, can live over 2000 times as long as white blood cells. The epidermis, Cowdry explained, "is Nature's most effective frontier tissue. In it, life and death are more closely joined than anywhere else."[7] Cowdry fixated on the relationship between the dying cells on the surface of the skin and the living ones beneath them. Human beings are at once a composite of new cells, aging cells, and dead cells. In the skin, "dead epidermal cells act as a shield and protect the living cells within."[8] As protectors, they have a necessary, life-giving function. In contrast to the society he saw around him, in the body, "aged . . . cells are not consigned to oblivion. They still serve the rest and are given positions of great importance."[9] This was neither the first nor the last time Cowdry would move seamlessly between the society of cells and the society of man.

E. V. Cowdry experienced the grand in the particular. This founding father of gerontology spent a lifetime culling the interaction of cells for moral guidance on how

[4] Ibid.
[5] Ibid.
[6] E.V. Cowdry, "The New Public Health," 360.
[7] E.V. Cowdry, Zola Cooper, and Warren Smith, "Program of Research on Aging," 31.
[8] Ibid., and E.V. Cowdry, "Citizen Cells," unpublished manuscript, undated, box 142, folder 1, pp. 58-59E. E.V. Cowdry Papers, Bernard Becker Medical Library Archives, Washington University School of Medicine, St. Louis, MO.
[9] Ibid.

best to organize society. In his parlance, he was not only interested in the cell as a discrete unit of life but also as a "citizen" of the body. Educated at a remarkable time for interdisciplinary science, Cowdry plotted a career that afforded him the peculiar ability to be a man of science who aimed to fix what he perceived as an "ethical slump" in "mutual responsibility."[10]

Born in Macleod, Canada, in 1888, Cowdry came to the United States to study anatomy at the University of Chicago, where he received a Ph.D. in 1913. From there, his rise was meteoric. After obtaining a faculty position at Johns Hopkins, he traveled to China to become one of the first professors at the Rockefeller Foundation's Peking Union Medical College. As an associate member of the Rockefeller Institute he traversed the world isolating organisms involved in such diseases as malaria and yellow fever. In 1928 he returned to the United States permanently to head the cytology program at the Washington University School of Medicine in St. Louis.[11]

Cowdry arrived as a biologist at a pivotal moment in the history of the field. On the heels of the vast reorganization of American medical schools in 1910 and 1920 came the rise of molecular biology and investigations into the biochemical mechanisms of cell performance.[12] He also came of age in what Hamilton Cravens describes as the "halcyon days of interdisciplinary scholarship in American culture."[13] From the 1920s until the 1950s, biologists subverted a taxonomic tradition where "the whole was a structure no greater than or different from the sum of its parts," to embrace a holistic vision of the

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[10] Ibid., 58–59.

[11] *National Encyclopedia of American Biography*, vol. 61, 1981, in box 1, folders 10–11, E. V. Cowdry Papers.

[12] Keith Benson, Jane Maienschein, and Ronald Rainger, *The Expansion of American Biology* (New Brunswick: Rutgers University Press, 1991): 2.

[13] Hamilton Cravens, "Behaviorism Revisited: Developmental Science, the Maturation Theory, and the Biological Basis of the Human Mind, 1920s-1950s in Ibid., 133.

world where discrete parts interrelated to create a “dynamic, functional unity.”[14] Whether that whole was defined as the body, a cell, or a disease, by the 1920s scientists from numerous branches would have to collaborate to gain true understanding.

Cowdry’s early work followed this multidisciplinary model. He claimed that cytology was “the center of integration of related sciences. The biologist and the bacteriologist, the physiologist and the pathologist all contribute material of the utmost importance to our knowledge of cells.”[15] In 1923 he published the popular textbook *General Cytology*, which was an edited volume of essays on cell structure, function, and mechanisms from across the field.[16] In 1930, he even branched out beyond hard science in *Human Biology and Racial Welfare.* As one reviewer put it, “The general theme of the volume is man and his place in the universe and the degree of control that he has acquired over his destiny.”[17] In addition to editing the book, Cowdry contributed a chapter that sought to destabilize presumptions about cells and give a basic outline of what scientists actually knew about these “vital units.” The word *cell*, he claimed, “is a misnomer and a relic of the past. . . . Vital units are not empty spaces, as the word suggests, but filled with a fluid substance.”[18] At its most basic level, a cell can be likened to an engine, although, Cowdry continued, “it is in every respect a more efficient mechanism. . . . The cell takes in crude materials and makes them into finished products (e.g., adrenalin) which influence other industries or tissues, themselves composed of cells.”[19] Cytologists,

[14] Ibid., 133-134.
[15] E. V. Cowdry, *Human Biology and Racial Welfare* (London: Lewis, 1930): 202.
[16] E.V. Cowdry, *General Cytology* (Chicago: University of Chicago Press, 1924).
[17] E.B. Reuter, “Review of Human Biology and Racial Welfare,” *The American Journal of Sociology* 36, no. 3 (November, 1930): 482.
[18] Cowdry, *Human Biology and Racial Welfare*, 187.
[19] Ibid., 193.

Cowdry believed, had the unique ability to see order, variability, productivity, and harmony in cellular life. It was a realm of pure remarkable moral beauty.

Cowdry lived between worlds, the cellular and the social. When he returned to America on the eve of the Depression, he bore witness to droves of impoverished and discarded elderly. He could not square this sight with the intergenerational relationships he had witnessed in China, where Confucian notions of filial piety continued to structure society. In contrast to what he perceived as widespread "neglect" of the elderly in the United States, elders in China were "highly venerated."[20] He often wrote that the "neglect of the aged is an indictment of modern civilization."[21]

In this instance and others, Cowdry believed that the cell community represented the moral high ground, providing a more humane way to cope with aging cells.[22] According to the historian of medicine Hyung Wook Park, "Cowdry came to think that while elderly people were suffering from social isolation and economic hardships due to the strengthened age discrimination and destruction of private pensions, the aged cells in the body were still actively contributing to the survival of the whole organism as its important members."[23] In 1936, Cowdry went public, broadcasting his theory of the "body anatomic" and the "body politic" in *The Scientific Monthly*.

"Are methods of regulation within the human body of any interest to those responsible for regulation within the nation?" Cowdry asked his readers. He referred to the social order of men as the "body politic" and that of cells as the "body anatomic." It was his contention that the "anatomic" had much to teach the "politic." "It is clear," he

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[20] E.V. Cowdry, "Body Anatomic and Body Politic," *The Scientific Monthly* 42, no. 3. (March, 1936): 224.
[21] Ibid.
[22] Hyung Wook Park, "Refiguring Old Age: Shaping Scientific Research on Senescence, 1900—1960" (Ph.D diss., University of Minnesota, 2009): 263.
[23] Ibid., 239.

wrote, "that the cells of the body anatomic belong together and live a common life dedicated to the welfare of the whole. In these respects the cells are much more social than human beings."[24] The relationship between the individual cell and the body fascinated Cowdry. "The unity of a human being is more impressive than that of any nation, even the most totalitarian one thus far conceived. The individual cells project themselves into the whole dynamically, each kind in its own way."[25] To uncover the collective, Cowdry focused on its parts. In an unpublished manuscript, aptly titled "Citizen Cells," he describes how cells both individuate and participate.

For a general audience, he limited his description of the citizen cell:

> Each cell is made up of a mass of living material enclosed in a delicate, yielding, cell-membrane. . . . The living material is of fluid consistency and will escape if the membrane is ruptured. It is divided into two parts. The outer part is called the cytoplasm and it always contains granular material of various kinds, often including droplets of fat. . . . The inner part is known as the nucleus. It, in turn, is separated from the cytoplasm by a second membrane, the nuclear membrane. . . . In this most secluded region of the anatomy of the citizen-cell are located the substances that determine the hereditary qualities.[26]

Of equal importance to the structural similarities between cells are their functional differences. With an unsubtle display of politics, Cowdry summarized the purpose of various cells as follows: "The muscle cells may be likened to manual laborers. . . . The gland cells may be looked upon as manufacturers. . . . The nerve cells are the oldest and wisest. . . . The fat cells have something in common with bankers, since they store potential, not actual, energy and give it up reluctantly on demand."[27] Holding this entire system together are aging and dead skin cells. They "are not only utilized but are given

[24] Cowdry, "Citizen Cells," 17.
[25] Ibid., 21
[26] Ibid., 11.
[27] E.V. Cowdry, "Woods Hole Conference on the Problems of Aging," *The Scientific Monthly* 45, no. 2. (March 1937): 223.

positions of great importance. Without this thick, delicate and flexible covering the body anatomic could not endure."[28]

From cellular interaction, Cowdry gleaned an ethics of intergenerational obligation. Aging is at once natural and inconsistent; individuals, like cells, will take on the characteristics of old age at different chronological ages due to the relationship between their social and biological health. "Unemployment" for cells results in "wasting and death." Instead of squandering their skills, cells, such as fibroblasts, can live on "with regular duties so light as to be little known. . . . but they are ready to help in emergencies."[29] While many cells can live in isolation in Petri dishes, they always gravitate quickly to other cells, particularly ones they have had prior "relations" with. Even separated from their natural environment, "cells show a marked inclination to behave as they did when they were parts of the body anatomic. If taken from the heart they contract rhythmically; if removed from glands, they attempt to arrange themselves in a kind of glandular structure."[30] From these behaviors, Cowdry derived axioms for the body politic. Aged human beings must engage both in useful tasks and in meaningful relationships throughout their lives; they cannot be cut off from meaningful work or social institutions.

Cowdry's inquiries into the nature of old age came largely through the benevolence of the Macy Foundation. This was not unusual in the first half of the twentieth century, where dollars for biological research came almost exclusively from similar tax-exempt entities, such as the Rockefeller Foundation, the Carnegie

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[28] Ibid., 224.
[29] E.V. Cowdry, "Body Anatomic and Body Politic," 223-4.
[30] Cowdry, "Citizen Cells," 21.

Corporation, the Russell Sage Foundation, and the Guggenheim Foundation.[31] Before World War II, scientists themselves, leery of federal financing, preferred private dollars.[32] While Cowdry would be able to locate diverse dollar sources for his cancer research, for which he would later become world renowned, the Macy Foundation was the only institution invested in multidisciplinary efforts to understand the socio-biological reality of old age.

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In 1872, John D. Rockefeller's Standard Oil made Josiah Macy and his sons wealthy men. After only a decade in the oil industry, the Macys' Long Island Oil Company became a part of Standard Oil.[33] It took fifty years and a subsequent generation to come up with a coherent vision of how best to deploy the extra dollars. In 1930, Mrs. Kate Ladd, the youngest daughter of Josiah Macy Jr., decided to establish a scientific, mission-driven, charity.[34]

Inspired by the tenets of Quakerism and the trials of a lengthy illness, Mrs. Ladd dreamed up a foundation that would reverse current medical trends, which atomized a patient into body parts, and current philanthropic funding trends, which privileged biochemical and physiological research over psycho-biological and sociological research.[35] In a letter to the foundation she wrote, "Believing, as I do, that no sound structure of social or cultural welfare can be maintained without health, that health is more than freedom from sickness, that it resides in the wholesome unity of mind and

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[31] Benson et al., *The Expansion of American Biology*, 6.
[32] Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982): 338.
[33] The Josiah Macy Jr. Foundation, *The Josiah Macy Jr. Foundation, 1930-1955: A Review of Activities* (New York: The Josiah Macy Jr. Foundation, 1955): 1-3
[34] For more on the history of the scientific charity movement *see* Robert H. Bremmer, *American Philanthropy*, 2nd ed. (Chicago: University of Chicago Press, 1988).
[35] Macy Foundation, *The Josiah Macy Jr. Foundation*, 5.

body, I hope that your undertaking may help to develop more and more in medicine in its research, education, and ministry of healing the spirit which sees the center of all its efforts in the patient as an individuality."[36]

At the outset, the foundation, named in honor of Mrs. Ladd's father, valued "cross-disciplinary, integrative research that promised practical payoffs."[37] An initial gift of five million dollars and subsequent gifts by Mrs. Ladd allowed the relatively small foundation (in 1932, the Rockefeller's principal fund was $147.5 million) to single-handedly create the field of gerontology.[38]

This process began when the foundation's leaders encountered Cowdry while they were consulting with the National Research Council (NRC), an arm of the federal government dedicated to scientific research, in the mid-1930s. At the time, Cowdry chaired the NRC's Division of Medical Sciences and had much to say about the Macy Foundation's program area on lifecycles.[39] Childhood and adolescence, Cowdry often remarked, should not be the only studied stages of life. Having spent his earlier career funding childhood development studies at the Laura Spellman Rockefeller Memorial Fund, Lawrence K. Frank, the Macy Foundation's vice president, understood the skewed research emphasis.[40] Soon Frank and Cowdry were plotting a way to integrate aging and chronic degenerative diseases into the foundation's program agenda. In fact, both believed that the diseases associated with aging would soon be the major health crises afflicting Americans.

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[36] Ibid., 6.
[37] W. Andrew Achenbaum, *Crossing Frontiers: Gerontology Emerges as a Science* (Cambridge, UK and New York: Cambridge University Press, 1995): 61.
[38] Rockefeller Fund, "Treasurer's Report," 1932, Rockefeller Foundation Archives. Rockefeller Archive Center, Sleepy Hollow, New York (hereafter designated RAC).
[39] Achenbaum, *Crossing Frontiers,* 62.
[40] W. Andrew Achenbaum, *Profiles in Gerontology: A Biographical Dictionary* (Westport, CT: Greenwood Press, 1995): 130.

Cowdry accepted a conservative first project from the foundation: he would edit a comprehensive book on arteriosclerosis, a vascular disease that overwhelmingly afflicts the aged. "Man," the saying went, "is as old as his arteries."[41] Cowdry determined that arteriosclerosis is "a chronic disturbance of the vessels which manifests itself by deposits of the most varied kinds in the vascular walls."[42] This process becomes acutely hurtful to the body when deposits build up and deform the vascular walls.[43]

Research in arteriosclerosis and other degenerative diseases soon transformed into a broader agenda. As one report maintained,

> When the Macy Foundation began its operations, the degenerative diseases, though they claimed a large share of the available medical care, received less attention from investigators than their importance justified. A great body of knowledge turned up in the past decades of research has shown that the heart and circulatory system were so inextricably interrelated with such other systematic functions as those of the kidneys, the nervous system, musculature, and metabolism of the whole body that research into the degenerative processes must move along many fronts at once.[44]

In October of 1935, Cowdry pressed a receptive Macy Foundation to broaden its involvement in the "problems of aging." In lieu of the single-disease research model, he proposed a multi-disciplinary conference and published symposium that would consolidate all the available scientific research on aging. He believed that the best scientific and social research could help discover what healthy, productive, and dignified aging would actually look like. Nothing of this scope had been previously attempted.

Modern scientific inquiry into the nature of aging had commenced in the late nineteenth century with the pioneering work of Elie Metchnikoff. Metchnikoff, renowned

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[41] E. V. Cowdry, *Arteriosclerosis: A Survey of the Problem* (New York: Macmillan, 1933).
[42] Ibid., 8.
[43] Ibid.
[44] Macy Foundation, *The Josiah Macy Jr. Foundation*, 80.

for his innovative work on immunity, dabbled in what he termed gerontology, the study of old age, from the Greek for *old man*. He came to believe that the lactic-acid bacilli in yogurt would deter aging.[45] In the early twentieth century, aging again came under scrutiny with I. L. Nascher's textbook, *Geriatrics: The Diseases of Old Age*, and the sociologist G. Stanley Hall's *Senescence: The Last Half of Life*.[46] Nascher developed the term geriatrics as opposed to gerontology to focus attention on doctors' curing the specific ailments of old age. Even before Cowdry transformed the field of inquiry, these scientists offered a radical departure from previous conceptions of aging, which described the process as the ongoing ephemeral loss of "vital heat."[47]

III: Aging Bodies

In the summer of 1937, the Macy Foundation granted Cowdry's request, funding a published symposium and two-day conference at Woods Hole, Massachusetts.[48] Cowdry hoped the conference would ameliorate the missteps of both the scientific community and the government. He railed in *The Scientific Monthly*: "The problems of growth, the upswing of the curve of vital processes, are being energetically attacked with adequate financial support. Those of aging, the downsizing of the curve resulting inevitably in death, are on the contrary shamefully neglected."[49] Money, he claimed, had not only been disproportionately allocated to the diseases of youth, but federal dollars in the form of the recently passed social security act had, rather than solving the ailments of

[45] Elie Metchnikoff, *The Prolongation of Life* (London: Heinemann, 1907).
[46] I. L. Nascher, *Geriatrics* (Philadelphia: Blakiston, 1914); G. Stanley Hall, *Senescence: The Last Half of Life* (New York: D. Appleton, 1922).
[47] For more on the early history of scientific research into aging, *see* Park, "Refiguring Old Age."
[48] E. V. Cowdry, *Problems of Ageing* (London: Bailliere, Tindall & Cox, 1939): xi.
[49] E.V. Cowdry, "Woods Hole Conference on the Problems of Aging" *The Scientific Monthly* 45. no. 2 (August 1937): 189-191.

old age, allowed citizens to assuage their guilt when it came to the elderly. He wrote, "Hundreds of million of dollars are appropriated annually to keep old people from actual want. This is really conscience money. We know that they suffer in mind and body and to pay them a small [fee] is the easiest way out for us. . . . Consequently in the length and breadth of the country probably less than $50,000 a year is spent on constructive research designed to reveal the processes of aging."[50]

Cowdry and Frank handpicked the conference participants whose papers were published as *Problems of Ageing*. The goal was to find scholars willing and able to cross intellectual frontiers. The duo sought thinkers capable of learning other fields, refashioning their basic assumptions, and communicating both the stakes and results of their research to diverse audiences. The book came out in 1939 and in the historian of gerontology Andrew Achenbaum's estimation announced "the emergence of gerontology as a field of inquiry in the United States."[51] Divided into twenty-five chapters, the compilation featured essays on the aging process in plants, protozoa, insects, and invertebrates. It looked at the effects of time on the cardiovascular, digestive, reproductive, nervous, and urinary systems, the degeneration of lymphatic tissue and skeletal structures, as well as the eyes and ears. In addition, chapters examined the psychology of old age and current demographics.[52]

Perhaps the most unusual part of the compilation was the introduction written by the philosopher John Dewey. Cowdry and Dewey first met while working in China. They exchanged tips and pleasantries in 1920 and grew acquainted with one another's spouses.

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[50] E. V. Cowdry, "Report of the Committee on Biological Processes of Aging," March 19, 1938, box 25, folder 3, E. V. Cowdry Papers.
[51] Achenbaum, *Crossing Frontiers.*
[52] Cowdry, *Problems of Ageing.*

Cowdry followed Dewey's career and writings when he returned to the US. In 1930, he asked Dewey to submit a chapter on education to *Human Biology and Racial Welfare*, an edited volume on current research on mankind.[53] While collecting authors for the *Problems of Ageing,* he again asked for Dewey's assistance. When the manuscript was in, he wrote to Dewey, "I have read with very keen interest . . . your introduction for the book on Aging. It is exactly right. You strike precisely the notes which are important in bringing our work before the public."[54]

Cowdry chose Dewey because he wanted the book to open with moral gravity and scientific skepticism. "It is a common experience," began Dewey, "that the solution of one type of problem brings with it new and unforeseen problems."[55] "Upon its face," he continued, "the problem of saving a greater number of lives was a similar special problem. . . . It was met by improvements in medical care and by improved dietaries and measures of public sanitation."[56] Success in the realm of public health and medicine extended the human lifespan and inadvertently created the "problem of old age."[57] The problem, Dewey argued, existed in important ways outside the confines of medicine. "Biological processes," he reminded readers, "take place in economic, political and cultural contexts."[58] All measures to solve the very recent dilemma of old age would be "mitigative rather than constructive, unless they are accompanied by changes in the cultural social structure which will give the group of older persons a status of moral

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[53] Cowdry, *Human Biology and Racial Welfare.*
[54] E. V. Cowdry to John Dewey, May 6, 1938, E.V. Cowdry Papers.
[55] Cowdry, *Problems of Ageing*, xxvi.
[56] Ibid.
[57] For more on the history of public health in the United States *see* John Duffy, *The Sanitarians: A History of American Public Health* (Urbana: University of Illinois Press, 1990). George Rosen, *A History of Public Health*, Expanded ed. (Baltimore: John Hopkins University Press, c1993).
[58] Ibid., xxxii.

security and social value as well as material security."[59] A book describing aging through scientific modes opened with a humble disclaimer: science and medicine would never be enough.

Lawrence Frank summarized *Problems of Ageing*'s findings into four axioms, none of which were immediately intuitive to those working in the field. The first was that scientists were undecided on whether aging is an "involuntary process which operates cumulatively with the passage of time" or a process stimulated by "infections, toxins, traumas, and nutritional disturbances."[60] For this reason, students of aging, Frank wrote, "are faced repeatedly with the crucial issue of how to distinguish between normal senescence and the pathology of old age."[61] In this way, the book made a crucial distinction between old age as a set of illnesses and old age as a natural process. The second axiom contended with the prevalent desire to have statistical norms: "Attempts to establish statistically derived norms of ageing are often productive of more confusion than clarity because they may obscure any real insight into the sequence of events which result in 'ageing' of different individuals."[62] The penultimate axiom concluded that the aging process is not uniform. Not only is it not uniform between different cells of the body, different organs, and different systems, but it is also widely variable between individuals. Chronological definitions of old age did not accurately reflect biology. The work's final axiom concerned treatment. "In no other aspect of medicine and health-care," Frank wrote "is the concept of the psychosomatic unity of the organism more important than in the care of the aged, since the older individual faces life with all the

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[59] Ibid.
[60] Lawrence K. Frank, "Preface," in Cowdry, *Problems of Ageing*, xiii.
[61] Ibid., xv.
[62] Ibid., xiv.

emotional patterns of his past."[63] Thus, *Problems of Ageing* contained no clear guidelines on the actual problems of aging. Rather, the work exposed the difficulty of generalizing about the aging experience and analyzing old age outside of specific social contexts.

Following the Woods Hole conference and the publication of *Problems of Ageing*, the participating scientists created the Club for Research on Ageing. Modeled after similar societies founded in Europe, the American version would be well-funded by the Macy Foundation and remain active throughout the war. At the outset, the multi-disciplinary group took up a broad range of questions: "How and why should aging be studied as a scientific and social problem? What were the appropriate experimental organisms to investigate senescence? What was the difference between chronic illness and 'normal' aging? How did the aging of the population affect industry, and what were the American corporations' responses to their aged employees?"[64] In 1946, the Club became the Gerontological Society and founded the *Journal of Gerontology*, with, unsurprisingly, the financial assistance of the Macy Foundation, to publish its findings.

The first issue opened with a statement of purpose by Frank. Gerontology, he claimed,

> is not just one more highly specialized discipline, the latest addition to the already long and ever lengthening list of "ologies" that make up the academic roster. Nor is it merely an applied science, like most of engineering and technology. . . . Gerontology reflects the recognition of a new kind of problem that will increasingly command the interest and devotion of a variety of scientists, scholars, and professional workers, all of whom are needed to study such problems as human growth, development and aging, ecology and regional planning, mental hygiene, human conservation, or cultural change.[65]

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[63] Ibid., xvii.
[64] Park, "Refiguring Old Age," 290.
[65] Lawrence K. Frank, "Gerontology," *Journal of Gerontology* 1, no. 1 (Winter 1946): 1.

Rather than a single description of the aging body and its ailments, the scholars who published in the first issues of the *Journal of Gerontology* investigated the mystery of aging with a tender mix of awe for the biological process that begins at conception and sympathy for the suffering of elderly men and women.

1946 was a banner year for journals of old age. In addition to the *Journal of Gerontology*, a group of physicians organized the American Geriatrics Society and began publishing *Geriatrics*. The journal from its founding announced a new field of medicine, a clinical specialty born of pediatrics, designed to study and treat diseases of old age. Teeming, from its opening issue, with ads from pharmaceutical companies claiming to cure "urinary antisepsis," "fat digestion," "renal toxicity," and "hypertension," to name only a few illnesses associated with age, the journal *Geriatrics* had a clear sense of what it meant to be old. It meant being sick. The diseases of old age were many. In addition to cancer and heart disease, the "incidents of old age" were "postoperative states, pneumonia, hepatic cirrhosis, malignancy, fractures of bones, uremia, eye conditions, and hypertensive encephalopathy."[66] Mental pathologies, such as "senile psychosis, involutional melancholia," and "menopausal syndrome" accompanied these physical manifestations.[67] A more general biological perspective on the "aging processes" offered by Professor Anton J. Carlson is summarized toward the end of the journal:

> gradual tissue desiccation; gradual retardation of cell division, capacity of cell growth, and tissue repair; gradual retardation in the rate of tissue oxidation; cellular atrophy, degeneration, increases cell pigmentation, and fatty infiltration; gradual decrease in tissue elasticity and degenerative changes in the elastic connective tissue; decreased speed, strength, and endurance of skeletal

[66] Edwin J. Doty, M.D., "The Incidence and Treatment of Delirious Reactions in Later Life," *Geriatrics* 1, no. 1 (January-February 1946): 21.
[67] Harold D. Palmer, M.D., "Mental Disorders of Old Age," *Geriatrics* 1, no. 1 (January-February 1946): 54.

> neuromuscular reactions; decreased strength of skeletal muscles; and progressive degeneration and atrophy of the nervous system, impaired vision, hearing, attention, memory, and mental endurance.[68]

To geriatricians, aging was a degenerative state that, once revealed, required intervention.

Gerontologists took a radically different approach. Rather than a cure for disease they began to strive for an operative and descriptive definition of normal or healthy aging.[69] Dr. Edward J. Stieglitz, a physician at the University of Chicago and Cowdry's intellectual co-conspirator, described gerontology in terms of *constructive medicine.* "Constructive medicine follows the ancient axiom of war," he advised, "attack is the best defense."[70] More than simply preventative medicine, "constructive medicine has very definite positive implications. The objective of obtaining . . . [a] nearly optimum level of health for the individual."[71] Old age was not connected to chronology, but rather to a set of compounded health risks. If doctors could manage those health risks at an early stage, then patients could live healthy and productive lives until they died.

Stieglitz, a dedicated clinician, conceptualized geriatrics as a subset of gerontology and argued, throughout his career, against a disease-focused model of clinical care. In its stead he pushed his vision of constructive medicine, which would care, in the most holistic vision of the word, for patients by helping them create long-term strategies to manage their physical forms in specific social and economic environments. Cowdry reiterated this approach when he wrote, "What is needed is a return of some physicians to the old time role of guide, philosopher and friend. . . . Perhaps the greatest

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[68] Henry L. Ulrich, M.D. F.A.C.P., "Cardiovascular Deterioration, *Geriatrics* 1, no. 1 (January-February 1946): 152.
[69] Achenbaum, *Crossing Frontiers*, 2.
[70] Edward Julius Stieglitz, *The Second Forty Years* (Philadelphia: Lippincott, 1946): 302-03.
[71] Ibid.

economic and humanitarian contribution of public health in the future is to maintain socially useful activity as long as possible in this very large fraction of the population."[72] But to advance this clinical model and support the growing research agenda to define healthy aging, the Society would have to secure more funds.

As early as 1940, scholars within the Club for Research and Ageing and program officers at the Macy Foundation recognized that the field of gerontology faced financial problems. Although individual scientists were able to acquire outside funding and even government support, interdisciplinary research into aging was not a hot topic. Even the most committed gerontologists, Cowdry included, made their careers pursuing more traditional and well-financed research projects. The creation of the National Institute of Health and the meteoric rise of federally funded scientific research during WWII offered Frank and Cowdry an unprecedented approach: they could make gerontology and the problems of aging part of the federal government's scientific research agenda.

IV: New Money

For the first half of the twentieth century, the federal government trailed the philanthropic sector as a partner in scientific innovation. Federal funds for health and science emphasized public health concerns, such as infectious disease and sanitation, and were distributed through the Public Health Service, the Hygienic Laboratory, and the Department of Agriculture. Government support, moreover, was limited to sparse and understaffed government laboratories. Meanwhile, foundations like the ones created by John D. Rockefeller and Andrew Carnegie brought hierarchy and order to medical

[72] E.V. Cowdry, "The New Public Health," 356.

education and laboratory research.[73] The non-profit and private sector, more than any government program, was responsible for modernizing American medicine and addressing the great health crises of the early twentieth century.[74]

Preparations for war tipped the balance. War, asserts historian Victoria Harden, "revealed the indispensability of science, both pure and applied, to national defense and the general welfare."[75] Starting with the National Research Council in 1916, designed to promote wartime science research, the federal government eased into funding large-scale science projects.[76] Although the private sector would continue to be the main source of scientific funding until World War II, the First World War set the stage for the massive financial and philosophical transition to come.

The astounding success of WWII research programs, which resulted in radar and the atom bomb, to name only a couple of applications, dazzled the country. Unbridled optimism in the curative powers of medicine and the problem-solving techniques of biologists, physicists, chemists, and engineers adorned the nation's headlines.[77] As Harden writes, "The great achievements in science during World War II . . . enhanced public belief that scientific research offered an endless frontier on which a happier, healthier life could be built."[78]

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[73] *See* Robert E. Kohler, *Partners in Science: Foundations and Natural Scientists, 1900-1945* (Chicago: University of Chicago Press, 1991).

[74] *See* ibid.; Starr, *The Social Transformation of American Medicine;* Daniel M. Fox, *Power and Illness: The Failure and Future of American Health Policy* (Berkeley: University of California Press, 1995)

[75] Victoria Angela Harden, *Inventing the NIH: Federal Biomedical Research Policy, 1887-1937* (Baltimore: Johns Hopkins University Press, 1986): 73.

[76] Benson, *The Expansion of American Biology,* 6.

[77] For more on the post-war expansion of research science, Stephen P. Strickland, *Politics, Science, and Dread Disease: A Short History of United States Medical Research Policy* (Cambridge: Harvard University Press, 1972); Starr, *The Social Transformation of American Medicine.*

[78] Harden, *Inventing the NIH*, 180.

Following the War, the United States would become the greatest funder of scientific research in the world. It offered congressmen a way to promote health, research, and government power without funding social programs or redistributing wealth. In many ways, research came to be seen as a solution for all health problems. Public health initiatives fell to the wayside and a conversation about access to healthcare became politically fraught. As the sociologist Paul Starr summarizes, "At home the advance of science and medicine, like economic growth, offered the prospect of improved well-being without requiring any profound reorganization of society. Liberal opinion held that America had transcended the need for drastic political reform by incorporating progressive change into its free institutions. Medical science epitomized the postwar vision of progress without conflict."[79] For the duration of the twentieth century, health research would be the vehicle by which politicians across party lines demonstrated their compassion for America's ailing citizens.

More than any arm of government, the NIH came to embody this trend.[80] The NIH grew out of the Hygienic Laboratory, an arm of the Public Health Service created as a bacteriology laboratory to alleviate infectious and contagious diseases. In 1938, the new NIH opened its own laboratories on a privately funded estate in Maryland. While the labs lay fallow during the war years, their coffers were soon to be filled by a willing Congress.

With the world wars seemingly resolved, President Truman had to decide what to do with the ever-expanding war-research infrastructure. Vannevar Bush, an esteemed engineer and director of the Office of Scientific Research and Development (OSRD, the agency tasked with coordinating war research), urged the President to rethink the

[79] Starr, *The Social Transformation of American Medicine*, 336.
[80] For More on the NIH *see* ibid., 340; Harden, *Inventing the NIH*.

government's relationship to science. In his comprehensive report, *Science, the Endless Frontier*, he argued against the applied "programmatic" science sponsored during the war years. In its stead he claimed that basic, fundamental, scientific research would best push the country forward. "Discoveries pertinent to medical progress have often come from remote and unexpected sources, and it is certain that this will be true in the future," he wrote in his 1945 report. "Further progress requires that the entire front of medicine and the underlying sciences of chemistry, physics, anatomy, biochemistry, physiology, pharmacology, bacteriology, pathology, parasitology, etc., be broadly developed."[81] The Manhattan Project, the OSRD's greatest success, relied on years of basic scientific research. While Bush called for a National Science Foundation, which did eventually come into being in 1950, many of his principles and OSRD's ample funds were first absorbed by the NIH, whose budget increased from $180,000 in 1945 to $4 million in 1947.[82]

This monetary boost came at a time when the federal government began to allow grants to go to outside institutions, garnering a set of welcome, and demanding, affiliates.[83] Universities, private laboratories, and independent scholars could now apply to the NIH to receive research dollars. The extramural program, writes health policy experts Robert Cook-Deegan and Michael McGeary, "quickly became NIH's largest activity and involved NIH with a whole new set of constituents, namely researchers in

[81] Vannevar Bush, *Science: The Endless Frontier: A Report to the President on a Program for Postwar Scientific Research* (Washington, DC: National Science Foundation, 1945, 1960).
[82] Starr, *The Social Transformation of American Medicine*, 342.
[83] James T. Patterson, *The Dread Disease: Cancer and Modern American Culture* (Cambridge: Harvard University Press, 1987): 180.

universities, medical centers, and other non-profit research institutions."[84] Within years, the two continue, "the NIH changed from being the research arm of the federal public health enterprise to being the keystone of the national biomedical research enterprise, and the more it focused on biological research, especially molecular biological research, the more support it enjoyed from its new constituencies."[85]

The NIH's most politically effective constituency came in the form of the American Cancer Society. As life expectancy grew in the early twentieth century, so did the incidence of cancer. Cancer, writes the oncologist and historian Siddhartha Mukherjee, "is imprinted in our society: as we extend our life span as a species, we inevitably unleash malignant growth (mutations in cancer genes accumulate with aging; cancer is thus intrinsically related to age)."[86] "Between 1900 and 1916," he continues, "cancer-related mortality grew by 29.8 percent, edging out tuberculosis as a cause of death. By 1926, cancer had become the nation's second most common killer, just behind heart disease."[87]

Cancer terrified the public. The slow, painful, mysterious death that came to be known as the "dread disease" haunted popular writers and even prompted the Public Health Service (PHS) to dabble in scientific research in the early 1920s.[88] As the health care scholar Stephen Strickland reports, "it was really cancer that worried people most. And it was cancer that gave the people's elected representatives in Congress an easier

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[84] Robert Cook-Deegan and Michael McGeary in *History and Health Policy in the United States: Putting the Past Back In* edited by Rosemary A. Stevens, Charles E. Burns, and Lawton R. Rosenberg (New Brunswick and London: Rutgers University Press, 2006): 190.
[85] Ibid.
[86] Siddhartha Mukherjee, *The Emperor of All Maladies: A Biography of Cancer* (New York: Scribner, 2010): 6.
[87] Ibid., 24.
[88] Stephen P. Strickland, *Politics, Science, and Dread Disease: A Short History of United States Medical Research Policy* (Cambridge: Harvard University Press, 1972): 6.

handle on biomedical research."[89] By 1937, political will matched public fear and a National Cancer Institute (NCI) was created, but, like the NIH, it accomplished little until after WWII. The Second World War had rendered cancer, in Mukherjee's words, "a politically silent illness."[90] The philanthropist Mary Lasker and her band of activists put cancer back on the public agenda by making the disease a high society cause célèbre.

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Mary Lasker embodied the confidence of post-war America. Born Mary Woodward in Wisconsin in 1900, she remade herself as a darling of the East Coast fashion world by mass-producing women's professional clothes. In 1939, she fell for advertising mogul Albert Lasker. In 1940, Mrs. Lasker found her calling. After witnessing her mother's painful illness and slow death, she declared, "I am opposed to heart attacks and cancer . . . the way one is opposed to sin."[91] She modeled her crusade as a productive cross between religious evangelism and modern day advertising techniques. "If a toothpaste," she proclaimed, "deserved advertising at the rate of two or three or four million dollars a year then research against diseases maiming and crippling people in the United States and in the rest of the world deserved hundreds of millions of dollars."[92]

She mobilized doctors, politicians, fundraisers, advertising executives, journalists, and publishers for a total "war on cancer."[93] Lasker soon took over The American Society for the Control of Cancer and rebranded it the American Cancer Society (ACS), deploying, in Patterson's words, "aggressive methods of fund-raising." [94] From that point

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[89] Ibid., 13.
[90] Mukherjee, *The Emperor of all Maladies*, 27.
[91] Ibid., 110.
[92] Ibid., 111.
[93] *See* ibid.; Patterson, *The Dread Disease.*
[94] Patterson, *The Dread Disease*, 172.

on the organization would forego lengthy memorandums on the best standards of cancer care for an all-out fundraising and ad campaign that would electrify the American public.[95] By 1948, the ACS had collected a whopping fourteen million dollars.[96] The ACS also lobbied on behalf of the NCI, whose budget expanded from $1.75 million in 1946 to over $14 million in 1947.[97]

The Laskerites, as Mary Lasker's acolytes came to be called, were also capitalizing on a trend. Single-disease health advocacy had begun earlier with the success of the March of Dimes campaign against Polio.[98] "The power of disease advocacy," note Cook-Deegan and McGeary, "became more apparent after the war."[99] In the ensuing years, patients and advocates would organize societies around myriad specific diseases, as non-profits ceased investing directly in research and put their efforts into lobbying.

The American Cancer Society was one of the first health organizations to launch a government-focused strategy successfully. They realized that attaining federal backing through Congress would rapidly transform the financing and scope of their cause.[100] This strategy of harnessing scientific prowess to address a single disease challenged Vannevar Bush's post-war strategy of basic rather than applied scientific research and required a multi-pronged attack. To subvert the habits of post-war funding, Lasker reignited the language of war. From the late 1940s on the effectively branded "war on cancer" would entice politicians, citizens, patients, and doctors alike.

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[95] Mukherjee, *The Emperor of All Maladies*, 112-113.
[96] Patterson, *The Dread Disease,* 172.
[97] Ibid.
[98] Mukherjee, *The Emperor of All Maladies*, 94.
[99] Robert Cook-Deegan and Michael McGeary, "The Jewel in the Federal Crown: History, Politics, and the National Institutes of Health," in *History and Health Policy in the United States: Putting the Past Back In*, 180.
[100] Mukherjee, *The Emperor of All Maladies*, 113.

In 1948, the Laskerites helped push the National Institute of Health to become the National Institutes of Health, plural, by absorbing the newly created National Heart Institute. Five other additions were to follow, including the NCI. In 1950, Congress permitted the Surgeon General to expand, as needed, similar disease-specific institutes.[101] In this way, the NIH could benefit financially from the rise of single-disease advocacy groups, which were eager to fund their specific cause.[102] That a hygienic laboratory built to cure acute diseases became, in the middle of the twentieth century, a major institute attempting to cope with complex chronic disease through research, is part of a larger trend noted by Daniel Fox.

In his seminal work, *Power and Illness*, Fox upends the traditional narrative regarding scientific research. He opposes the notion that medicine and science progress; rather, he claims, they change and adapt to different contexts.[103] In the American setting, this change developed around a single misstep. Instead of facing the particularity of chronic disease as the major health affliction, U.S. policy expanded a health infrastructure built around infectious diseases: "Contrary to what most people—even most experts—believe, deaths from chronic disease began to exceed deaths from acute infections almost three-quarters of a century ago. But U.S. policy, and therefore the institutions of the health sector, failed to respond adequately to that increasing burden. Today, leaders in government, business, and health affairs remain committed to policy priorities that have long been obsolete."[104] For example, for years U.S. policy subsidized

[101] Starr, *The Social Transformation of American Medicine*, 343.
[102] Ibid.
[103] Daniel M. Fox, *Health Policies, Health Politics: The British and American Experience* (Princeton: Princeton University Press, 1986).
[104] Daniel M. Fox, *Power and Illness: The Failure and Future of American Health Policy* (University of California Press, 1993).

hospital growth rather than funding in-home care to help individuals manage long and complex chronic diseases. "Most of the people," Fox continues, "who made and influenced policy assumed that the institutions and methods that seemed to be succeeding against acute infectious disease could be effective in the struggle against death and disability from chronic degenerative conditions."[105] Research institutes, hospitals, insurance plans, and late-stage medical intervention are all approaches that work well for acute diseases, such as influenza. They are, however, an exceedingly expensive and inefficient way of helping patients live well with chronic degenerative ones, such as diabetes.

The early gerontologists understood this problem. They faced aging as a set of interwoven health risks that had to be preempted and managed from middle age on. Still, these researchers and clinicians needed to stay afloat and at the end of the 1940s the federal government was the single best source for sustained funding. In the 1950s, many of gerontology's founders, including Cowdry, would make a name for themselves in the field of cancer research or other single-disease research areas. While they remained interested in broad questions about the aging process, gerontology became a footnote to their professional careers.

In 1941, the Federal government spent $18 million dollars of its annual budget on medical research. By 1951, that number had jumped to $181 million ($1.6 billion in 2012 dollars). If scientists researching aging wanted to compete at a federal level, they had two choices: describe old age and its attendant pathologies as curable diseases, à la Lasker, or explore the basic biological mechanisms of old age, à la Bush.

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[105] Ibid.

"At first," remarks Achenbaum, "gerontology was not greatly affected by changes in Big Government's ties to Big Science. Few, after all, did research on ageing in 1945." By 1951, he continues, "the federal government was contributing 75 percent of all direct costs for aging research."[106] While the actual dollar amount remained relatively small—only $283,075 per year ($2.5 million in 2012 dollars)—especially compared to the big ticket items like cancer, infectious diseases, and cardiovascular diseases, the impact of the funding shift loomed large.

The director of the NIH, Dr. L. R. Thompson, accepted the Club for Research on Ageing's invitation to witness its proceedings in January of 1940. After the meeting, the Macy Foundation leapt into action, offering to pay for a gerontologist to join the NIH for one year.[107] By July 1940, Dr. Edward J. Stieglitz took up his post as the first head of a national Unit on Gerontology. [108] E. V. Cowdry had this to say about the appointment: "[U]nder the able direction of Dr. E. J. Stieglitz. . . . A new kind of public health is being conceived. It is a union of what is best in medicine and sociology."[109]

In 1946, the NIH expanded its interest in aging, creating the Gerontology Study Section (GSS), a funding program designed to promote multidisciplinary research into aging. Three years later, the unit disbanded, rendered ineffectual by the number of discipline-based applications. As Hyung Park writes, "Ironically, the multidisciplinary approach to aging that the GSS hoped to encourage became a major cause for its disbanding. . . ."[110] Scientists, rather than applying to pursue work in a multidisciplinary

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[106] Achenbaum, *Crossing Frontiers*, 94.
[107] For more on the details of the agreement, *see* Betty A. Lockett, *Aging, Politics, and Research: Setting the Federal Agenda for Research on Aging* (New York: Springer, 1983).
[108] N.W. Shock, "The United Public Health Service Baltimore City Hospitals Research Section on Gerontology," *Journal of Gerontology* 2, no. 2 (April 1947): 169.
[109] E.V. Cowdry, "The New Public Health," *The Scientific Monthly* 55, no. 4 (October 1942): 356.
[110] Park, "Refiguring Old Age," 342.

category, merely applied within their chosen discipline or to the specific disease they sought to cure. Arguably, the only successful gerontological program within the NIH in this period was Nathan Shock's research center. Shock, previously an assistant professor of physiology at the University of California Medical School, replaced Stieglitz in 1941 when the Macy Foundation support expired.[111]

Nathan Wetherill Shock was fluent in numbers. The son of a mathematics teacher, he received his first degree in chemical engineering, his second degree in organic chemistry, and finally his Ph.D. in physiology in 1930 from the University of Chicago. In 1932, Shock took a position at the Institute of Child Welfare at the University of California, Berkeley, where he was first exposed to the benefits of longitudinal studies on humans with a study that tracked 100 ten year olds for eight years.[112] He would later become famous for a similar study tracking aging.[113]

In 1941, he took this expertise to the NIH, where he became head of the Unit on Gerontology, which under his care eventually became the internationally renowned Gerontological Research Center.[114] According to Achenbaum, "Shock transformed the federally supported GRC into a highly visible research center and site for training investigators interested in basic 'mechanisms involved in aging'. When Shock arrived in Baltimore in 1941, he had one lab assistant; when the GRC in 1975 became the Intramural Program of the new National Institute on Aging, he was overseeing the

[111] N.W. Shock, "The United Public Health Service Baltimore City Hospitals Research Section on Gerontology," 169.
[112] Nathan W. Shock Papers, 1906–1989; 1927–1988, Bentley Historical Library, University of Michigan, http://quod.lib.umich.edu/b/bhlead/umich-bhl-921099?subview=standard;view=reslist.
[113] For more information on The Baltimore Longitudinal Study *see* Lori Aratani, "Volunteers in a 50-year-long study provide invaluable data on the aging process," *The Washington Post*, May 19, 2009.
[114] "Nathan W. Shock, PhD," National Institute on Aging, National Institutes of Health, http://www.grc.nia.nih.gov/docs/shock.htm.

activities of 175 researchers and visiting scientists."[115] Shock accomplished this feat through his devotion to the hard sciences, particularly biology, and his ability to allow researchers in other fields to tangentially relate their work to aging.[116]

He limited inquiry to two main questions: "What are the underlying biological factors that produce what we perceive as aging?" and "What are the mechanisms that produce impaired performance with age?"[117] The laboratory conducted studies on the effects of time on kidney and heart function, as well as on "sensory capacity" and metabolic recovery after exercise.[118] The goal for Shock and his collaborators was a fuller understanding of the influence of time on basic biological functions; there was no immediate cure, disease, or policy goal in sight. In this way, the GRC became a monument to Bush's postwar dream of federal scientific funding. Gerontology, as a government-funded area of scientific research, abandoned the pursuit of scientifically informed standards for healthy aging to research the biological mechanisms that could prevent aging itself.

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In 1955, the Macy Foundation offered a wish packaged as a fact: "Medicine as a science and an art has now come full circle, from concern with man as the basic unit of interest in organs and systems of the body, then to study of the cell, and now at last back to recognition of man as an indivisible unit of mind and body."[119] For the previous ten years, gerontology had embodied this belief; scholars from across fields had collaborated

[115] Achenbaum, *Crossing Frontiers,* 97.
[116] Ibid., 95.
[117] "Nathan W. Shock, PhD," National Institute on Aging.
[118] Shock, "The United Public Health Service Baltimore City Hospitals Research Section on Gerontology," 170.
[119] Macy Foundation, *The Josiah Macy Jr. Foundation*, 63.

and combined approaches to change the way individuals prepared for old age and treated the elderly. The next ten years would be markedly less holistic; for those within the halls of political power, scientifically facing the problems of old age would come solely to mean curing the diseases of old age and researching the processes of aging. Until the end of his life, Cowdry rejected this dualistic biomedical approach.

Spending the bulk of his career researching cancer, a problem of relentless growth, he would remain one of the country's strongest advocates for the study of deterioration. He wrote, "Aging is taboo, while cancer is all the rage. . . . Of the two, knowledge about aging and action springing from it are more needed than new facts about cancer."[120] For Cowdry, as it was later for Susan Sontag, society's fixation on cancer was not without reason. The disease fit the zeitgeist of the time, its metaphors evoking the rhetoric of battle, capitalism, and technology.[121] Although pharmaceutical companies, hospitals, nursing homes, longevity specialists, and eventually research scientists and politicians would try to envelop the language of aging in that of cancer, as a war to be won, Cowdry claimed otherwise. He wrote, "Old age, unlike all other hazards of life, is crushing because there is no way to avoid it. An individual may, perhaps, avoid both cancer and the atom bomb; at least, he has a fighting chance of doing so. But his only way to avoid aging is to die young."[122]

Old age, he pleaded, could not be conquered or cured; it had to be faced. Cowdry's voice echoed in schools of social work, public health departments, and gerontology programs across the country. But in the halls of NIH-funded labs his

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[120] E.V. Cowdry, "The Broader Implication of Aging, " *Journal of Gerontology* 2, no. 4 (October 1947): 277.
[121] Susan Sontag, *Illness as Metaphor* (New York: Farrar, Straus and Giroux, 1978).
[122] E.V. Cowdry, "The Broader Implication of Aging," 277.

approach gave way to the relentless desire to discover, to solve, and to end old age. In the late 1950s and 1960s, politicians followed suit, describing old age as a social problem and not a social asset, as a curable disease and not a natural process—thus, the body politic and the body anatomic drifted further apart.

CHAPTER II

From Personal Care to Federal Care: Two Solutions to the Problem of Old Age, 1949-1950

"Will you still need me,
Will you still feed me,
When I'm sixty-four?"
-Paul McCartney, The Beatles

I: Introduction

In 1949, old age, as a demographic problem, attracted federal attention. Fourteen years after the Social Security Act established a chronological mark for the aged, 65 and over, Oscar Ewing, the director of the Federal Security Agency, invited a group of experts on aging to Washington, D.C., to determine how the federal government should best approach "the problems which arise with the aged population."[1] In an amorphous field, sparse with data, specialists, and working options, two authorities stood out: the self-trained social worker Ollie Randall and the University of Chicago-trained sociologist Clark Tibbitts. The two arrived in Washington with careful articulations of the proper definition of the elderly, the afflictions that beset them, and the appropriate solutions.

The data exposed troubling trends. Americans were living longer and reproducing less. In 1900, 3.1 million Americans, just 4.14% of the total population, were over 65. By 1950 the number would jump to 12.3 million, 8.1 % of the population. Dips in birthrates, despite the baby boom, exacerbated this upward shift. Two rather than five children homes had become the norm and this augured a dependency crisis, as familial, financial,

[1] "Proceedings of the Committee on Aging, United States Public Health Service," April 22, 1949, folder 051.2, box 129, record group 235, Federal Security Agency, National Archives, College Park, MD.

and social responsibilities fell solely to the middle aged.[2] As demographers described the problem of old age in terms of scale and dependency, a growing class of physicians and biomedical researchers described the health afflictions of old age through research into degenerating or deformed cells. For the geriatricians, the problem of old age was the affliction of chronic disease, the next frontier for a medical profession emboldened by sharp reductions in infant mortality; old age was not a social trend but a biological disease with potential medical cures.

Randall and Tibbitts incorporated, responded to, and challenged both of these models in their comprehensive visions of proper eldercare. The aged could not be fully described or treated as a set of data points nor could physical disease be isolated from social context. While Randall and Tibbitts agreed on the scope and complexity of the problems, they offered productive differences on how the problems should be solved. Where Randall relied on a highly individualized local model, which I call personal care, Tibbitts believed that the problems required a centralized, or federal, solution.[3]

In the Spring of 1949, it seemed that the continuum between Randall's personal care and Tibbitts's centralized care would set the intellectual parameters for a national discussion on the problems of and solutions to old age. Yet as Randall and Tibbitts stepped into the Federal Security Agency meeting, a third option was brewing. At the exact moment social workers and social scientists recognized the mounting problems of the elderly, the Truman administration, frustrated with thwarted attempts to pass government sponsored health insurance, settled on the aged as the key to a new political

[2] "The Study of Adjustment in Old Age," 1944, folder 6139, box 499, series 1, subseries 82, Record Group 1, Social Science Research Council Archives, 1924–1990, Rockefeller Archives Center (hereafter designated RAC), Sleepy Hollow, NY, 1.

strategy of incrementalism. Social Security beneficiaries, Ewing and others claimed, could be the first recipients in an incremental approach to bring health insurance to all. For Randall and Tibbitts the mounting numbers of the elderly was a social problem. For the Truman administration, it was a solution. This divide would eventually limit the content of the Randall-Tibbitts debate and establish a federally-funded medical solution to the problems of old age.

II: Ollie Randall and Personal Care

Ollie Randall paid attention to words: *home, time, living, loss, illness* and *independence.* She fixated on them, obsessed over how they were deployed, and imagined how they could best be put to use. A philosopher of care, her ideas came from a professional life devoted to the extreme and mundane hardships faced by New York's elders.

Randall, a prolific writer and speech-giver, left her own story. Born on September 3, 1890 into a large extended family, she grew up in a household that valued both adventure and duty. By her own admission, her professional interests paid homage to her childhood. Her father came from a long line of Rhode Islanders and in the late 1880s ventured out west to try his hand at ranching where he met her mother, a schoolteacher from Illinois. The family soon returned to Rhode Island. Mr. Randall took up work in the newspaper business and Mrs. Randall stayed home to raise their four girls. The family—great-grandparents, grandparents, parents, and children—lived on the same

street.[4] “We had a great, big house on Cranston Street,” recalled Randall, “and then they built a small house out of what had been the barn and that’s were I was brought up.”[5]

Responsibility mattered in the Randall household. Every morning, at precisely 10:00 a.m., Ollie would bring her great-grandmother her morning blend. She wrote, “I grew up in a family with a lot of older people in it. I counted on them and they counted on me.”[6] Each of the girls went to the Baptist church on Sundays and took jobs to pay for college. At the time, multi-generational households were an American norm. As late as 1948 only 4.5% of elderly men and 3.3% of elderly women lived in institutions, while the vast majority moved in with their children.[7]

In the first decade of the twentieth century older people had yet to be recognized as a distinct category of the needy.[8] Tossed in with other needy groups in local poorhouses, they were the nonspecific wards of religious societies and new scientific charities. Social workers, policy makers, health care professionals, and charity workers all struggled with how to deal with their particular plights. In her 60-year career, Randall would change that. “When I started,” she recalled, and “wanted to work with the old people they thought I was nuts. Nobody was bothering with old people.”[9] Randall attributed her ability to see the afflictions of the elderly to the relative ease of her own grandmother’s final years. Her proximity to a good old age and a good death showed

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[4] Ollie Randall, “Reminiscences of Ollie A. Randall, Transcript of Oral History Interview, 1981,” Community Service Society Project, Columbia Center for Oral History, Columbia University, New York, NY., 1-5.
[5] “Reminiscences of Ollie A. Randall,” 5.
[6] “Reminiscences of Ollie A. Randall,” 6.
[7] Otto Pollack and Glen Heathers, *Social Adjustment in Old Age: A Research Planning Report*, Social Science Research Council Bulletin 59 (New York: Social Science Research Council, 1948), 25.
[8] *See* M Michael B. Katz, *In the Shadow of the Poorhouse: A Social History of Welfare in America* (New York: Basic Books, 1986); Robert H. Bremmer, *American Philanthropy* (Chicago: University of Chicago Press, 1988); Kathleen D. McCarthy, *Lady Bountiful Revisited: Women, Philanthropy, and Power* (New Brunswick: Rutgers University Press, 1990); Kathleen D. McCarthy, *Women, Philanthropy, and Civil Society* (Bloomington: Indiana University Press, 2001).
[9] “Reminiscences of Ollie A. Randall, ” 14-15.

Randall the possibilities of aging with dignity. It also taught her that even in the best situations, aging is a period of life fraught with the complexity of loss.

She often told the following story. As a young girl she happened upon her great-grandmother talking to herself. The aged woman looked at her granddaughter's perplexed stare and said, "'Sit down over there and I'll tell you something that will be handy one day for you. There comes a time in every woman's life (when) she must talk with someone who understands about living and life. At 104 I don't think there is anyone around who knows more about life than me.'"[10] Recognition of the intangible hardship of emotional isolation continued to inform Randall's philosophy of care even as she struggled to address the acute ailments of America's discarded elders: unemployment, homelessness, and chronic disease.

After graduating from Pembroke College in 1912, Randall secured a position at one of the few agencies in the country with a program for the elderly: the Association for Improving the Condition of the Poor (AICP).[11] Within a few months she ran all of the organization's programs dedicated to elders. She loved the job and quickly took to her boss, who, in her estimation, "was not held down by . . . habits and all the rest of it."[12] At the agency, she tried to figure out which programs did and did not effectively serve their population, ensuring that the services responded to an actual rather than just a perceived need.[13] She described her position as follows: "if you're in social work working with

[10] "Reminiscences of Ollie A. Randall," 17.
[11] For more on the AICP *see* Lilian B. Brandt, *Growth and Development of AICP and COS (A Preliminary and Exploratory Review)* (New York: Community Service Society of New York, 1942).
[12] "Reminiscences of Ollie A. Randall," 22-23.
[13] Ibid.

people, your job is to know what those needs are. What the people need, not what you need."[14]

With the coming of World War I, Randall embarked for Paris to work for the Red Cross, setting up a program for wounded soldiers. There, she learned how to create functioning systems from scratch. She wrote, "What you did, in those days, because there was no precedent, was that you did what you could with what there was."[15] Randall came to believe in this approach, consistently breaking through bureaucracy and customs to solve problems. "The only training I got," she boasted, "was to be given the job to do."[16] When she returned to AICP at the end of the war, her philosophy of care had the following attributes: respond to need, act flexibly, and bypass bureaucracy to get the job done.

The employees of the AICP recognized, before the federal government did, that new labor practices in the early 20th century would disproportionately affect the aged (at the time defined as anyone over 40) and consequently set up two programs, a sheltered workshop and a summer camp. At the Old Men's Toy Shop, AICP ensured "that individuals who were not able to compete in the labor market because they cannot cope with the demands of time or production" remained employed.[17] The shop not only offered "protected working conditions for older people," but also helped continue "the habit of work as it has been known to many of them . . . in such a way that there is self-respect retained because there is a weekly pay envelope."[18]

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[14] Ibid.
[15] "Reminiscences of Ollie Randall," 25.
[16] Ibid.
[17] Ollie Randall to Mrs. Margaret Lighty, June 11, 1947, folder 10, box 1, Ollie Randall Papers, 1914-1975, Social Welfare History Archives, Elmer L. Andersen Library, University of Minnesota, Minneapolis, MN.
[18] Ibid.

In 1916, the AICP complemented the shops with Sunset Lodge, a summer vacation home for the aged. For three weeks every summer, the elderly cared for by the AICP became "part of a large community of camps for girls, small children, and family groups" at Sunset Lodge.[19] The important idea, Randall pronounced, was that the elders "do as others do."[20] They lived with people of all ages and celebrated the summer the way other Americans wished to celebrate the summer at the time, outdoors.[21] While Randall enjoyed assisting in these programs, the two institutions she spearheaded, Ward Manor and Tompkins Square House, both defined her career and arguably transformed eldercare in the country.

In 1926, William B. Ward of the Ward Baking Company donated an estate in Dutchess County, New York, to the AICP for a permanent home for the elderly. Randall reminisced, "I'll never forget seeing Mr. Ward sit down and draw a check for $75,000. I never saw anybody do it before and I've never seen anybody do it since but that's what he did when he handed it over to us."[22] From its founding until 1945, Randall managed Ward Manor, which became a physical articulation of the values of its inhabitants rather than its founder or manager.

Randall recognized that her residents came to the Manor because they had nowhere else to go. Many suffered from debilitating financial and emotional loss, arriving at Ward Manor feeling useless and discarded. In addition to creating a physically adequate space, she wanted to restore in her residents the feelings of dignity and self-worth. To do so, she believed the Manor had to be self-governing. "What we tried to do,"

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[19] Randall, "Care of Old Folks Now and In The Future," November 9, 1938, folder 401, box 34, Ollie Randall Papers, 10.
[20] Ibid.
[21] Ibid.
[22] "Reminiscences of Ollie A. Randall," 29.

she related, “was to get self-government in the home for the old people. . . . But I mean they would take responsibility and be taking over. Because it was where they were living. And that hadn’t been done in any home for the aged up to that time.”[23] Participation, in this model, was not a choice but a requirement. Randall observed that residents suffered when they weren’t truly needed. Hobbies and activities did not carry enough weight to give meaning and purpose to a resident’s day. For this reason the Manor required that every well person “share in some of the work of the home to the extent of his physical ability.”[24]

With the infrastructure for Ward Manor taken care of, Randall began her next project: a housing unit for semi-dependent living.[25] Responding to a dearth of housing, rising unemployment, and extended life years without a pension, Randall set out to create low-cost apartments that would suit the aging body. Her team “planned a house which would have rooms for sixty old people—furnished or unfurnished as desired; housekeeping or not as desired; elevator; plenty of plumbing; a dining room and cafeteria with food at cost, a recreation room, a roof garden.”[26] Although the residents would not have access to in-house nursing care there would be “a resident hostess whose business it is to know whether anything is needed.”[27] For all of this, the cost would only be $20 a month. For the site the team chose Tompkins Square Park—an area that even Randall agreed could be construed as questionable. She saw beyond the park’s shady reputation to its given amenities. The park, she wrote, “has Wanamakers within walking distance; Christodora House, which opens all its doors to our family of tenants; churches of all

[23] Ibid.
[24] Randall to Mrs. Margaret Lighty, June 11, 1947.
[25] Ibid.
[26] “Reminiscences of Ollie Randall,” 10.
[27] Ibid.

denominations; library; bus which goes by the door; and it is a place which is real in the hearts of our local political leaders for every tenant is a potential voter."[28] The aged would be integrated rather than set apart from the social, spiritual, and political life of the neighborhood. Randall believed in this project to such a degree that she actually moved in upstairs.

After creating two old-age homes, Randall came to be haunted by the word *home.* Institutional living, for most, is a last resort. It is the culmination of financial, physical, and familial loss, a desperate conclusion to a series of living arrangement mishaps. For this reason, Randall understood that there was something almost cruel in the title "home for the aged." "Home," she lectured in 1940, "is not merely a residence or a dwelling place to us—it is a place around which most of the precious memories of our life cluster, and one which we have shared at one time or another with loved ones of our families."[29] "Even at best," she continued, "a home [for the aged] . . . is an impersonal substitution for a very personal place—no matter how poor or how good it was, or how good our substitute may be."[30] The article before the noun mattered. Professionals working in the field had a mandate to make "a home" or "the home" work, and to do so they needed to focus their attention on making residents feel "at home."

To start, Randall advocated that caretakers learn as much as they could about their residents to help parse the idea of home. What qualities did they associate with home? What did they need to feel a sense of belonging and community? Did they need chaplaincy, work, or a kitchen? Once physical needs were met institutions had to think

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[28] Randall to Mrs. Margaret Lighty, June 11, 1947.
[29] Randall, "OAR talks to Department of Welfare Agencies," April 3, 1940, folder 402, box 34, Ollie Randall Papers.
[30] Ibid.

carefully about emotional ones. The question of independence was crucial in this respect. Elders "are not children," Randall reminded audiences across the country. One cannot ignore the challenges of transition or impose a set of rules that infantilize men and women who have made independent decisions their entire lives.[31]

Independence, Randall astutely realized, was always an illusion. "None of us is genuinely 'independent' of others." For Randall, this was an empowering and not a limiting discovery. Once one realized that independence was a helpful feeling rather than an empirical reality, then it was possible to "achieve for the old person a *sense* of independence in any setting."[32] Homes had "the responsibility of adapting their facilities to the needs of the old people, rather than attempting to insist that old people conform to the facilities offered."[33] Equally important to a sense of independence was a sense of meaningful association and usefulness. For this reason, she often said: "The household and not the house is the most important factor in an institution."[34]

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Randall's professional experience as a caretaker to New York's elderly within but especially outside their own homes informed how she defined old age. "Time was when, folks were divided into two groups," exclaimed Randall, "'the quick or the dead.'"[35] By the 1940s, life had come to be measured in stages: childhood, adolescence, adulthood, and old age. In Randall's estimation, one entered a stage of life because of a confluence of factors, not neat chronology. This was especially true for the ill-defined stage of life,

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[31] Ibid.
[32] Randall, "Importance of Living Arrangements," May 26, 1947, folder 403, box 34, Ollie Randall Papers.
[33] Ibid.
[34] Randall, "Diversional Interests for Our Aged Guests," April 25, 1938, folder 401, box 34, Ollie Randall Papers.
[35] Ibid.

old age. “The other day,” she related, “I sat in a meeting in which some of us were talking of clothing budgets for the ‘aged,’ and a board member of the committee said ‘What do you consider an aged person?’ The answer came, for we were thinking in terms of public assistance, ‘sixty-five years or over’. ‘But’, came the shocked voice of the board member, ‘I am 65, and I am not aged!’”[36]

While the passing of days, weeks, months, and years could externally mark numerical age, Randall, like E.V. Cowdry, recognized that old age is something far more relative—experienced, despite the official demarcation, in the ephemera of subjective judgments. Still, in addition to governmental mandates, with the passage of the Social Security Act, that defined old age as beginning at 65, employers and doctors sought other demarcations. For employers, old age occurred when an individual could no longer work. This definition had its own subjective character depending on the nature of the work, the biases of the field, and the whims of the employer. For doctors and other medical professionals, old age came to be conflated with chronic disease. It was, above all, a physical state of decay, clearly viewed through the lens of heart disease and cancer. Randall fought off both of these definitions. She maligned employers for forcing able-bodied men and women out of the workforce and squandering American manpower. She also reminded doctors “that the chronically ill are persons of all ages, and that all aged are not chronically ill.”[37]

Aging, she pronounced, is a natural part of the process of living. What do “we really think,” she asked, “when we let ourselves think of ‘growing old?’ Most of us instinctively avoid thinking of it at all, at least for ourselves, either consciously or

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[36] Randall, “Care of Old Folks Now and in the Future.”
[37] Randall, The Chronically Ill Who Live in the Community,” Date?, folder 404, box 34, Ollie Randall Papers.

unconsciously. Many shudder emotionally away from the bogey it presents." "We forget then," she continued, "that aging, or growing older, is happening to every human being each moment, each hour, and each day he is privileged to go on breathing. . . . Growing old is a natural process, as natural as growing into adolescence and into adult life."[38] No one has a problem with the *growing* part of this equation. The word *growing*, she noted, "implies constant change, and usually change for the better." The problem is the second part of the phrase, *old*. "So, growing old is generally conceived of as a process of growth up to the period of old age, the beginnings of which occur at different times in growth for every human being, but which, when it is reached, is considered to be a kind of 'dead end.'"[39] Old age, it seemed to Randall, was too often conceived as something outside of the flow of time, the static end of a life marked by change.

For Randall, the final stage of life was defined not by a lack of development, but by a different set of developments. If adulthood could be understood as a period of attainment—such as money, spouses, and children—old age could be seen as the opposite: it was the stage of life marked by departure. "Old age," Randall wrote, "is a period of losses—loss of family, of friends, of job, of health, of income, and most important of all, of personal status."[40] It doesn't begin at the same time for everyone. It begins when the losses trigger unexpected needs. As a social worker, Randall addressed the question of old age at the point that it became a problem to be solved. She relied on an operative definition that assumed a kind of emotional or physical disability.

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[38] Randall, "The Psychological Aspects of Aging," May 28, 1947, folder 403, box 34, Ollie Randall Papers, 1.
[39] Ibid.
[40] Ibid.

Old age, she argued, had to be defined by looking at the needs that arose from external losses and internal responses. The kind of loss that propelled one into the stage of old age was acutely personal and could only be understood within the parameters of an individual's life. The elderly, she insisted in speech after speech, were not a group that shared common traits and needed common aids. Rather than easily placing people inside or outside the category of the aged, Randall's definition pushed caretakers to see the final stage of life as a trajectory marked by profound individualism, which, nonetheless, relied on the social world.

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According to Randall, the ailments of old age came in two categories: the external and the internal. Among the former were the problems of financial insecurity, health failure, and lack of adequate living arrangements. Among the latter were the crises of social isolation, personal status, and self-worth. Aspects of these issues were timeless, having afflicted elderly men and women throughout history, but more often they were created and compounded by modern conditions of industrialization and urbanization.

American industries discarded older workers, forcing out able employees. Thus, one of the first forms of loss was financial. "[I]t is a fact that in our disregard of aged people we are as carelessly wasteful as we are of other material resources…Older people are not kept on their jobs; they are not rehired if they're fired; they are forced to retire whether they are ready or not; they are forced to dependency whether they want it or not."[41] By the late 1940s, life expectancy averaged approximately 68 years. Industrial workers, some retired at 40, had to contend with 20-odd years of life without adequate funds for themselves and their dependents. Compounding professional losses came

[41] Ibid.

physical ones. Even without the trials of cancer or heart disease, eyesight, hearing, agility, and strength dwindled in old age, complicating the obligations of daily life and commonly tipping the family budget towards increasing health care costs.

The financial burden of professional and physical loss challenged not only aged individuals but also their families. Randall lamented the trials of intergenerational conflict, which tended to spike when working adults had the dual burden of providing for both their parents and their children. “I am not sure you will agree with me,” she began, “but it seems that while we can intellectually accept the fact that as a practical or physical measure several generations cannot easily arrange to live together, there is a distinct lag between the acceptance of this and any change in attitude toward what we can or do accept in the matter of family relationships.”[42] Living spaces have radically changed, she continued; “The large family mansions in which it was expected that the older people would continue to live, with the younger generations joining them in different degrees of independence, or dependence, are familiar to us in real life as well as in fiction. But it is a phenomenon rapidly disappearing today because of industrial and social factors. For us working with older people in the crowded city, the situation in which it is physically possible for this plan of living to obtain is practically non-existent.”[43] Chronic disease made these already complicated living situations worse.

Empathizing with the challenges of caretakers, Randall wrote:

> There is nothing which taxes one’s patience more than caring day in, day out, for the needs of the old person whose chances of progress to restoration of health are negligible or nonexistent, but whose daily needs continue on the same, if not on an increasingly demanding level. This is also true in those cases of mild mental affliction—which include loss of memory, lack of orientation, forms of suspiciousness which may develop into what we speak

[42] Ibid., 3.
[43] Ibid., 2.

> of as a persecution complex, and confusion which often creates intolerable disorder in the household. [44]

For these families, she recognized, there were not enough options. Few places offered adequate and affordable institutional care and even fewer provided appropriate mental health services. Moreover, home care programs could rarely provide enough resources for older persons or their depleted caretakers. Health and proper housing were, therefore, two of the most critical problems facing elders and their families.

Still, Randall argued that the greatest afflictions of old age were not the external ones but the feelings of isolation and uselessness that accompanied them. She recognized that the loss of community and purpose diminished an aged individual's sense of self. To fully explain this process, she focused on the issue of time.

"Time," Randall mused, "has a very new and different meaning for us as we near the end of the road. It has, strangely enough, a sharply reduced value, in that, as we have more of it to use personally as 'leisure time,' with less skill or practice in so using it, it becomes a kind of drug in the daily market of our lives. Time becomes synonymous with boredom. . . . The past is now longer than the future can possibly be."[45] "Killing time," she continued, "a common pastime among older people, is a murderous activity in more ways than one since it kills so much more than time. It kills initiative, interest, and in the end it can kill the personality of the person who indulges in the practice too often and too long."[46] To Randall, there is nothing meaningful, productive, healthy, or even deserved about a life bereft of purpose. She writes, "to feel useless or unimportant to others as well

[44] Randall, "Old Folks in the World of Today—In the Family," 1947?, folder 402, box 34, Ollie Randall Papers, 20.
[45] Randall, "The Psychological Aspects of Aging," May 28, 1947, folder 403, box 34, Ollie Randall Papers, 5.
[46] Ibid., 6.

as to one's self is the most devastating experience a person can have."[47] The experience of uselessness, be it within one's professional or familial life, leads to a personal crisis of value. When a person stops believing he is useful to others, she wrote, "he ceases to be important to himself."[48] "If we are to understand old people, we must first realize that old age constitutes a genuine threat to practically all which has been held dear, with the major threat being to the intrinsic importance of the individual to his community, to his family, but even more devastating, to himself."[49] Thus, "[i]f we can salvage that value—that sense of 'intrinsic importance'—to an elderly person, whether dependent or independent, we have made I think our greatest contribution to his personal contentment."[50]

Weaving together the subjective emotional ailments with the material and physical ones, Randall ranked the problems of old age in the following order: the loss of personal status, financial strain, family friction, housing, illness, social isolation, and unfulfilled spiritual needs.

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Randall, never one to indulge in too much talk, had solutions. Old age could not be magically or medically ignored, cured, or perpetually staved off. It had to be dealt with, its inevitable hardships understood, and its unnecessary pains ameliorated. Four groups, according to Randall, had responsibilities in this area: middle-aged individuals, the family members of elders, public and private institutions, and finally the federal government.

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[47] Ibid., 6.
[48] Randall, "Old Age and Old People," late 1940s?, folder 313, box 29, Ollie Randall Papers, 1.
[49] Ibid., 2.
[50] Ibid., 3.

Randall had an unwavering conviction that old age is "essentially one's own personal business."[51] In tandem with her notion that elders can only be understood and cared for as individuals, she believed that each individual had an obligation to prepare for his or her own old age. "While, I have said, it would be disastrous to live with our eyes and our minds always directed beyond the present to this future, which every one of us secretly or subconsciously hopes to reach, even while we may shudder away from the thought of it, I believe it important for us to recognize that our present tendency to push the thought away, to close our minds to it, is proving to be equally disastrous in its results."[52]

Americans must acknowledge that they will age, that they will lose abilities, and that they will die. This is the only way to cultivate good habits that will serve oneself and one's family in the later years. It is not society's job to do this, thought Randall; it is one's own.

It is "our personal business," Randall exclaimed, to "prepare intellectually for changing satisfactions as the years are added one by one. . . . If we think we'd like to read and want to derive pleasure from it when we have time, we should develop the habit of finding time for reading at last a half hour or an hour a day now." [53] Regarding our own health, she preached, "it is our personal business to know more than the mere diagnosis . . . . We should focus our attention not on how we are to die of it, but how we may live *with* it."[54]

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[51] Randall, "Old Age as Personal Business," March 14, 1944, folder 402, box 34, Ollie Randall Papers.
[52] Ibid., 2.
[53] Ibid., 11.
[54] Ibid., 19.

Randall's model for successful aging was her mother. "For ten years," she wrote, "I have watched my own mother making with some effort, very carefully concealed, the change in status and identity attendant upon ceasing to Mrs. Randall, a person of substance in her own community."[55] She lost her home, her husband, and her community. Yet despite these hardships, Randall's mother knew enough about herself and her own habits to adjust to a life without those identity stabilizers. She knew after years in a house filled with family that she could not live alone. With the assistance and support of her children she decided to split her time between the homes of each of her daughters. Rather than take on a position outside the family, she tried to become as helpful as possible within her children's homes. It was now possible, wrote Randall, "for her to fit quietly into the family life of each home, keep herself busily occupied, and so useful that she is a real loss when she moves on."[56] Even still, with the comforts of financial independence, a nourishing place to live, and social intimacy, the affliction of the loss of status pressed on. Her mother, she commented, in these settings came to be defined through her subordinate relationship to her children. Randall admired that her mother had accepted the reality of her position and managed to successfully adapt: "being deprived of the status to which she has been accustomed, and an identity of her own, apart from that of being our mother, her habits of life are making it possible for her to accept the role which circumstances have brought her in old age."[57]As the middle aged have an obligation to prepare for old age, aged individuals have an obligation to try to adapt and to make themselves useful in the environment they find themselves in.

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[55] Randall, "Old Folks in the World of Today," 1947?, folder 402, box 34, Ollie Randall Papers, 11.
[56] Ibid., 10-11.
[57] Randall, "The Psychological Aspects of Aging," May 28, 1947, folder 403, box 34, Ollie Randall Papers, 11.

The burdens of old age, Randall recognized, were rarely borne solely by the aged individuals, but also by their younger family members, who provided financial and emotional assistance. She recognized that while family living arrangements in the twentieth century had changed, religious and political ideals surrounding the family had not. She wrote, "In our Christian communities we have been taught early to 'Honor thy father and thy mother.' There is no finer precept for family life. Perhaps we need to re-examine, not the precept itself, but the manner in which it can find acceptable expression today."[58] The family, she argued, "is the fundamental unit of our society and our democracy," and yet it bears the "brunt of all the aspects of the industrial changes, the geographical shifts, and the general social apathy." [59] We do not need to change our definition of the family, she insisted, "but we may change our ideas of what is a natural living arrangement for members of a family, if the individuals who compose it are to be happy and self-sufficient persons in the community."[60]

Primarily, Randall believed that it was "the personal business" of the family to create a workable living arrangement. Ideally, elders should remain in their home and caretakers should have ample support from the community. Circumstances, however, often make this arrangement both physically, financially, and emotionally impossible. It is at this point that responsibility shifts from the individual and family to the immediate community and larger government. Randall described the transition. "[W]e are transferring upon our collective shoulders the burden, hitherto assumed largely by the

[58] Randall, "Old Age and Old People."
[59] Randall, "Sociological Aspects of Aging," speech given at the annual American Medical Association meeting before 1951, folder 315, box 29, Ollie Randall Papers, 2-3.
[60] Randall, "Old Folks in the World of Today—In the Family."

family and the intimate community, of giving support to retired and destitute old people. We and other nations have, as a collectivity, assumed the responsibility of filial duty."[61] The responsibility, thought Randall, once assumed had to be met. She wrote that the "speed with which middle age, if not old age, has overtaken us individually and collectively had caught everyone short. There is unpreparedness in every aspect of economic, social, and personal life for this dividend of years granted to us."[62] The most immediate need was housing.

Once in-home care ceased to be an option, families were left to navigate a barren landscape of inadequate institutions. In the 1940s, older individuals and their families had the following alternatives to in-home care. They could choose between varieties of boarding houses with different kinds of caretakers, such as foster families, nursing homes adjacent to or affiliated with hospitals, private or public homes for the aged, and state hospitals. "I don't believe I need to remind you that until recently in this country there were only two plans for caring for dependent elderly people—the county almshouses or city homes, and homes so-called, established by churches or fraternal orders. . . . And the conditions in these we may agree probably even beggared the descriptions of a Mr. Dickens. In many places they still do."[63] The available options were not only physically inadequate but philosophically missed the mark. "Then too the homes in many instances believe that once a person was accepted, and provided with the essentials of living such as food and shelter, it was up to that person to 'take it and like it.' If he didn't, the fault was his. He was a charity charge and independence of thinking was something he was

[61] Randall, "The Aged: Then and There, Here and Now," 1941 or 1949, folder 412, box 36, Ollie Randall Papers, 6.
[62] Randall, "Sociological Aspects of Aging," 1-2.
[63] Ibid., 1.

supposed to have left outside the door when he entered it."[64] Communities had to not only build new homes and fix existing ones, but they also had to fix the collective vision of these homes.

On an exploratory trip to Sweden in the 1930s, Randall pointed out a "particularly lovely building" to her bus driver.[65] She often told of his response. "Why that's the village home for old folks," he told her, "When you see the biggest, finest kept house and garden in the village, you know that is the home for old folks. They deserve the best we have."[66] Randall recognized that on a strictly material level, many American homes rivaled Sweden's. Yet, at a certain point, material comfort didn't matter if the residents and the community felt discarded and disrespected. In our homes, she wrote, "we have to reestablish the individual in his own estimation."[67] To do so, the old folks home had to be a point of pride for the entire community.

Although Randall spent much of her time refining the purpose of the old age home, she knew that the need for such a home represented broader challenges. For society, the issue was not old age per se, she noted, but the soaring number of elderly. To cope with this problem of scale, Randall recommended that nonprofits, foundations, and local governments begin a rigorous process of data collection in order to fully understand the mutual or conflicting needs of individuals as they related to employment, health, housing, and family life. To cope with a systemic problem, Randall believed one had to extend listening skills beyond the aged themselves. For this reason she wanted the data to reflect the holistic needs of the community rather than the particular needs of the elderly.

[64] Randall, "Care of Old Folks Now and In the Future."
[65] Randall, "Old People as We Know Them," March 21, 1938, folder 401, box 34, Ollie Randall Papers.
[66] Ibid.
[67] Ibid.

For example, she urged family agencies to "discover what effect the presence or absence of older people in the family has upon the family."[68]

In tandem with data collection, she called for a serious reevaluation of the mental and physical capacity of those deemed aged. She wanted to divert efforts from the disabilities of aging to the abilities of the experienced. She wrote: "I cannot help but feel that what we are essentially saying to our older people is 'Get out of the way. We will see that you don't go hungry; we will treat you with a good deal of quite inexpensive deference, we will, perhaps, dole out a little to add to what we have you save up yourselves but, nevertheless, get out. Cultivate the art of growing old gracefully—whatever that means—but don't by any chance do anything useful enough to command a wage or a salary.'"[69] In addition to the "reorganization of business and industry in order to conserve and utilize precious and currently wasted manpower," Randall called for a "similar reorganization of other social institutions, such as the school, the church, the social services, and civic and governmental units."[70] Schools had to prepare children to think about living longer, adult education classes had to be offered, and social services had to move from a youth- centered approach to one that included multiple generations and elders. Randall tasked local government, non-profits, and religious groups with the previous list of obligations. Health care professionals had a different set of responsibilities.

Randall had a nuanced understanding of illness and disability. Patients do not need a diagnosis or straight prognosis, she claimed; what they need is a careful analysis of "the degree of need established by the degree of disability for the several types of

[68] Randall, "Sociological Aspects of Aging," 4.
[69] Randall, "The Aged: Then and There, Here and Now."
[70] Ibid., 3.

services—medical care, physical care, including personal services and attendance as well as nursing care, services to meet social and emotional need . . ."[71] The goal of care, she contended, must lie in "a fuller use of the individual patient himself, in spite of, or because of, his disability."[72] For this reason, Randall was wary of the new institutional entity called the nursing home, where disability became identity and purposeful work came to be replaced by days of waiting.

For Randall, the majority of the responsibility for the problems of old age fell to individuals, their families, and their communities. Still, she believed that the federal government had to continue its involvement and do a better job intervening. She wrote, "We have in the United States today one of the most effective and largest Social Security programs which has ever been developed. . . . However, if one scrutinizes it and analyzes it as to what it actually provides, you may agree with me that 'social security' is something of a misnomer, for what we have in fact is a program of 'economic security.'"[73] Randall believed that the federal government had "a moral and real responsibility for seeing that people do not rust out, but wear out gradually as active members of the communities in which they live."[74] If business or industry could not "find ways and means of providing sheltered opportunity for work to older people," then the government should "develop the machinery to profit by the productiveness of older persons who may be denied the chance to function in other settings."[75]

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[71] Randall, "The Chronically Ill Who Live in the Community," 1948, folder 404, box 34, Ollie Randall Papers.
[72] Ibid., 3-4.
[73] Randall, "Needs of the Aged," November 15, 1946, folder 402, box 34, Ollie Randall Papers, 4–5.
[74] Randall, "Old Age as Personal Business."
[75] Ibid.

Randall arrived in Washington optimistic and cautious. She understood the magnitude of the problem, the real possibility of solving aspects of the crisis, and yet remained extremely modest about the kind of care that would work. She distrusted systems that could not accommodate particularities and bureaucratic institutions that lost sight of individual responsibility and agency. She called for a collective rethinking of the aged's position within the family, the local community, and the broader society. Not only should elders be conceptualized and cared for as part of a family unit but each individual should understand that he or she will, if lucky, get old.

III: Clark Tibbitts and Centralized Care

Clark Tibbitts excelled in meetings. He knew how to run them, participate in them, and organize them. He even knew how to make them productive. He was a statistics man, educated in the social sciences, and devoted to fixing problems at a macro level. In 1929, he received a PhD in Sociology at the University of Chicago, studying under the luminaries William Ogburn and Ernest Burgess. He went on to a joint career as an academic and a policy analyst. His interest in aging came not from his family but from his academic and professional life. He believed that with the help of good research and good ideas, the federal government could solve major social issues, such as old age.[76]

Tibbitts did not begin his career interested in the elderly. Like many sociologists at the time, his early work focused on immigrant politics and urban blight with one

[76] Clark Tibbitts, "Biography, 2-1-51," box 4, Papers, Speeches, and Reprints: 1929–1982, Clark Tibbitts Papers: 1926–1985, Bentley Historical Library, University of Michigan, Ann Arbor, MI.

eccentricity, a fascination with organized crime.[77] During the Depression, Tibbitts left his post as a sociology instructor at the University of Michigan to become the Coordinator of Urban Research at the Federal Emergency Relief Administration and later the Field Director of the National Health Survey for the U.S. Public Health Service, where he first came across the afflictions of the elderly.[78]

The Survey sought "to determine the amount of sickness experienced by the general population."[79] To begin, Tibbitts had to create an operative definition of sickness. He wrote: "Sickness itself is difficult to define. When is one sick and when not?" For the purpose of the study they settled on what he argued was a subjective definition: "those who were disabled or unable to perform their normal duties . . ."[80] The ability or inability to "perform one's usual work is not an objective item," acknowledged Tibbitts."[81] Still, the canvassing pressed on and the staff managed to determine two categories of disease: the acute and the chronic. The acute diseases, such as scarlet fever and smallpox, "last only a short period and can be cured without much cost."[82] Not only could families economically carry the cost of care, but medical advancements had widely reduced the number of acute disease cases.

Chronic disease was another matter. The "long" and "disabling experience" of cancer, heart disease, arthritis, diabetes, and crippling conditions required expensive treatment. Moreover, chronic disease threw the "breadwinners out of work" and

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[77] For more on the history of sociology *see* Scott Gordon Scott Gordon, *The History and Philosophy of Social Science* (London and New York: Routledge, 1991); Donald K. Sharpes, *The Evolution of the Social Sciences* (Lanham, MD: Lexington Books, 2009).
[78] Clark Tibbitts, "Biography, 2-1-51."
[79] Tibbits, "The Field Activities and Sampling Procedure of the United States Public Health Service National Health Survey," enclosed in letter from Clark Tibbitts to Professor R. D. McKenzie, November 1, 1937, box 4, Clark Tibbitts Papers.
[80] Ibid.
[81] Ibid.
[82] Ibid.

demanded “constant attention.” The whole family, Tibbitts lamented, “may have to organize around the sick person—young people who wish to get married . . . have to stay home to care for the parent.”[83] Tibbitts observed that while medicine had eliminated many acute diseases, chronic diseases would continue to grow in importance. There were, he wrote, “more old people” and “city life doesn’t provide care.”[84]

Tibbitts also observed the correlation between poverty and poor health. He wrote: “Disabling illnesses of all kinds increase as income drops. There is 57 percent more disabling sickness among persons who are on relief than among persons in families having annual incomes of $3,000 or more. Chronic disease is 87 percent more frequent at the bottom than at the top of the income scale.”[85] Not only did poverty reduce access to health care, but this reduced access plunged families deeper into poverty. The plights of the parents, he knew, determined the financial and then the physical opportunities of the children. When, in 1938, the University of Michigan asked him to return to run the recently created Institute of Human Adjustment, Tibbitts had come to the conclusion that the problems of soaring numbers of elderly afflicted with chronic disease would pose a great burden to the United States.

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In 1937, the estate of Horace and Mary Rackham made a six million dollar bequest to the University of Michigan to found an institute dedicated to “applying the findings of science to those problems of human imbalance.”[86] Horace Rackham, a former neighbor of Henry Ford, made his fortune when Ford convinced him to incorporate the

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[83] Ibid.
[84] Ibid.
[85] Ibid.
[86] Institute of Human Adjustment, “Graduate School Announcement,” Date?, Clark Tibbitts Papers.

Ford Motor Company for free and invest in the fledgling company. Rackham devoted his fortune to helping the intellectual community in Detroit and the University of Michigan.[87] Rackham's institute would help foster social adjustment through social service centers with active research arms. It began operations with a speech clinic, a psychological clinic, a vocational guidance demonstration center, and a community center.[88]

The term *social adjustment* had purchase in 1937. By 1942 its overuse prompted Verne Wright in his broad literature review of the topic to lament, "many authors use the term 'adjustment' or 'social adjustment' but they rarely define it."[89] Ernest Burgess, Tibbitts' mentor at Chicago and later Chairman of the Committee on Social Adjustment at the Social Science Research Council (SSRC), had an operative definition based on Josiah Stamp's *The Science of Social Adjustment* (1937). Burgess noted that Stamp had used the term to mean "societal adjustment," which had two components: the first is the "adjustment of society and its institutions to the changing situation. . . . The other half is the adjustment of individuals to the changes which are taking place and to the social situation."[90] From the outset Tibbitts and Burgess believed that aging in the United States was a problem of societal adjustment.

For eleven years, from 1938 to 1949, Tibbitts directed the Institute and worked to establish the societal adjustment problems of the elderly as equal to those of children and adolescents. By 1943 Burgess, who was then 57 years old, joined Tibbitts on his quest.

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[87] "Horace and Mary Rackham," http://www.rackham.umich.edu/about_us/what_is_rackham/horace_and_mary/

[88] "Graduate school announcement," April 1944, Institute for Human Adjustment Annual Reports 1939–1948, box 1, Clark Tibbitts Papers.

[89] Verne Wright, "Summary of Literature on Social Adjustment," *American Sociological Review* 7, no. 3 (1942): 408.

[90] "Council Minutes, Council Minutes September, 10–12, 1940," folder 1250, box 208, series 1, Committee Projects, Record of Group I, Committee on Social Adjustment, Social Science Research Council Archives: 1924–1990, RAC.

His Committee on Social Adjustment at the SSRC focused its attention and funds on this question of "old people."[91] Their argument went as follows: Since the creation of Social Security, old age had become "recognized as a national responsibility," and yet there had been few if any "systematic studies" on older people outside of their need for economic assistance. [92] In short, older people had been studied as a category of the worthy poor but not as a comprehensive minority group. The Committee decided to put together a subcommittee on adjustment in later maturity and invited Clark Tibbitts to participate and to assist in designing a research conference on the topic.

The conference, held in Chicago on June 24th and 25th, 1944, opened with a "Definition of Old Age," by Ruth Shonle Cavan, another Chicago trained sociologist. Cavan urged her listeners to rethink old age in terms of someone's "age role" within a community. She commented, "The age role that a person plays is determined in large part by the group of which he is a member. The group, whether a factory organization, union, school board, or neighborhood, defines old age, not in terms of years alone but in terms of capacities, mannerisms, interests, appearance."[93] Like Randall, Cavan agreed that an individual's age role also existed as a subjective state and she requested that scholars ask, "How do people define old age for themselves? Under what conditions do they feel old?"[94] In 1944, there was still some hope that a better non-chronological definition of old age could be achieved and therefore studied. The rest of the conference focused on creating methods to actually study what proper adjustment to old age looked like.

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[91] "The Study of Adjustment in Old Age."
[92] Ibid.
[93] Ruth Shonle Cavan, "I: Research on the Definition of Old Age in Conference on Research Planning in the Field of Adjustment in Old Age," 1944, folder 6139, box 499, series 1, subseries 82, Record Group 1, Social Science Research Council Archives, RAC.
[94] Ibid.

In 1948, the SSRC finally published a record of its early studies on elders in *Social Adjustment in Old Age: A Research Planning Report*. The text opens with a defense of the project that places the problems of old age in line with the afflictions of other minority groups—such as African Americans, adolescents, or criminals—and goes on to relay the particular predicament of demographic realignment: "Thus the dynamics of a continuing decrease of the younger and a continuing increase of the older population groups constitute one of the characteristic demographic phenomena of our time—a phenomenon fraught with social implications."[95] The problems posed by this demographic reality intensify with urbanization, "the reduction in living space per family unit, the resulting shift from a three-generation to a two-generation family system, and the increase in standards of living and care which are considered appropriate to make the fulfillment . . . [of] traditional obligations increasingly difficult."[96] This new social crisis, the report asserted, would benefit from a social scientific approach based on accurate descriptions rather than mere aspirations.

For this reason, the report abandoned Cavan's proposal of studying age roles. In its stead, SSRC scholars recommended accepting the definition of old age imposed by the Social Security Act. The reality of age typing had to override the dream of its disappearance. "Hardly ever before has a culture permitted such a degree of chronologically exact age typing for all people," Otto Pollak, the report's editor, wrote.[97] "In our present-day culture . . . with its birth registration and frequent use of birth certificates, mathematical awareness of chronological age has led to a situation where age

[95] Otto Pollak, *Social Adjustment in Old Age,* 2.
[96] Ibid., 3.
[97] Ibid.

typing is based not so much on manifestations as on expectations of changes with age."[98] Pollak thought, "social research must recognize the existing social situation and use the existing society's definition of old age which is still predominantly chronological."[99] The only exception to this rule arose in particular systems. For example, if age typing in industry defined the elderly as over 40 then social scientists have an obligation to take on that definition while studying that system. Social science cannot, the argument went, create optimal conditions without studying suboptimal ones first. Although possibly detrimental, age typing was the current social reality, and researchers had to assume its existence. The report did not mention whether or not academics would contribute to age typing by solidifying its presence with such studies.

With a chronological definition of old age in hand, the report described the problems elders faced: "Problems of old age arise therefore chiefly in two ways: (1) as the result of declining physical or mental capacities which make it difficult or impossible to satisfy one's needs in ways previously employed, and (2) the individual reaches the chronological age which places him in the old age group as defined by society."[100] The first condition focused on loss that occurs naturally due to the biological process of aging. The second refered to the pressures imposed by or correlated with societal attitudes.

Tibbitts contributed to this formulation by focusing on how changes in societal attitudes could actually deter physical and mental deterioration. He wrote: "The generalized popular notion about older people appears to be that they are physically and mentally deteriorated; eager to withdraw from responsibility and from social participation at an arbitrary age." However, he continued, "[t]he growing knowledge about older

[98] Ibid.
[99] Ibid.
[100] Ibid., 40.

people has revealed . . . that mental decline may be greatly retarded through the exercise of mental capacities; that most people do not wish to withdraw from work or from their fellows; and that they wish to retain a large share of responsibility for their own management."[101]

To keep older people mentally alert, in better health, and thus out of poverty, Tibbitts believed the federal government had to be involved in combating stereotypes and putting the elderly back to work. For this reason, adult education became the cornerstone of the Tibbitts' answer to the problems of old age. He came to this solution through two professional endeavors at the institute: a survey of elders and the first adult-learning courses in the country. In tandem, these projects offered precision to his overall theory and led him to advance a particular ideal of government involvement in the problems of old age.

Following the conference, the SSRC and the Institute partnered to launch a pilot study of the "Socio-Psychological Problems of Aging." In Washtenaw County, Michigan, the Institute conducted "comprehensive interviews with one hundred older residents." This project, the first of its kind to have "older people identify the problems of aging in a free-interviewing situation," sought to generate "a detailed list of the problems attendant upon aging," gather "information regarding the variety of adjustments (and maladjustments)" and offer a "hypothesis for further investigations."[102] Through this study, Tibbitts concluded that the elderly want, in the following order, financial security, physical health and comfort, living arrangements (ideally in their own homes), affection,

[101] Clark Tibbitts, "Meeting the Needs of Older People: memorandum to Mr. John L. Thurston, Assistant Administrator for Programs, Federal Security Agency," June 21, 1949, box 4, Clark Tibbitts Papers.
[102] Ibid.

activity, and religion.[103] The desire for spiritual solace at the end of life featured prominently in Tibbitt's encounters with the aged and he came to believe that houses of worship could help alleviate the psycho-social ailments of old age.

Financial and physical health, affection, and activity—four out of a list of six—could all be tackled, to some degree, by keeping elders intellectually and professionally engaged. As early as 1944 he partnered with Wilma Donahue, head of the Psychology Clinic at the Institute, to launch the first university courses that would be "given to older people themselves on the topic of problems, adjustments, and activities in later maturity and old age."[104] Tibbitts was immensely proud of these courses as they proved that old age could be planned for and that the aged wanted to remain intellectually active. The courses demonstrated that the elderly could be professionally retrained and would be willing to take on other forms of work. A year after they offered the first class, the duo brought the course to cities across the Midwest and Canada. In addition they aired twenty-six radio shows and planned the first comprehensive conference on aging, "Living through the Older Years."[105]

By 1949, Tibbitts believed that the problem of social adjustment in old age could be alleviated through widespread adult education that would extend from the individual to industry. For this to be effective, he believed the country needed a central authority, like the Federal Security Agency (FSA), to call national attention to the problem and offer local groups comprehensive and accurate information.

Tibbitts also voiced concerns about leaving such a large social problem in the hands of discreet groups more eager to fund medical research into longevity than social

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[103] Ibid.
[104] Institute for Human Adjustment, *Annual Report*, box 1, Clark Tibbitts Papers., 6.
[105] Ibid.

research into problems like employment. "Society," he wrote in a letter to John L. Thurston, Assistant Administrator for Programs at the FSA, "has placed a premium on longevity (and) is supporting research on disease in a rather handsome fashion."[106] Medical research, Tibbitts argued, cannot be the only form of intervention into man's later years. He continued, "Poorly conceived, narrow, and expensive plans for meeting some of their needs will become a growing plague on the total community. It is time now to study the entire situation with the view to giving older people well-rounded satisfaction within the limits of the ability of the community to pay."[107] The federal government had to step up first to educate society and then to balance and organize a set of hodgepodge approaches to eldercare that exacerbated, rather than solved, problems.

In 1949, Randall and Tibbitts had arrived at similar ends through different means. The social worker and the sociologist would describe the problems of old age with the same words: housing, employment, intergenerational tension, and self-worth. Yet, beneath this surface, cleavages existed. While Randall saw the value of a single clearinghouse for data, best practices, and a coherent American reeducation campaign, she remained extremely wary of monolithic models of care that did not envision the aged as capable of self-governance. Tibbitts had a more optimistic vision of government involvement. For him, statistics accurately described a problem of such magnitude that federal intervention was necessary. Most importantly, the two ascribed responsibility in opposite directions. For Randall the chain of responsibility began with the individual. For Tibbitts it began with the state.

[106] Ibid.
[107] Ibid.

At the exact moment the SSRC and the Institute for Human Adjustment called for federal attention to the problems of old age, the Truman administration sought a political solution to the stalemate around universal health care. Thus, while Randall and Tibbitts arrived at the FSA meeting hoping to alleviate the ailments of America's elders, the Truman administration was about to devise a plan to use the potential political clout of the elderly to push universal health care through Congress.

IV: A Federal Solution to the Problem of Universal Health Care:

In 1942, *Fortune* magazine announced the American public's support for National Health Insurance at a whopping 74%.[108] It seemed just a matter of time until the United States offered every citizen the right of healthcare. In 1944, President Roosevelt called for an "Economic Bill of Rights" proclaiming that every American had the "right to adequate medical care."[109] With Roosevelt's untimely death, Harry Truman took up the mantle and tried unsuccessfully to push national health insurance through the clenched jaws of the Republican Congress.[110] After leaving office, Truman reflected, "I have had some bitter disappointments as President . . . but the one that has troubled me most, in a

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[108] *See* Peter Corning, "Social Security History," http://www.ssa.gov/history/corningchap3.html; Fortune Magazine survey, July 1942, in Hadley Cantril, ed. *Public Opinion 1935-1946*, (Westport CT: Greenwood Press, 1978).

[109] Franklin D. Roosevelt, *The Public Papers and Addresses of Franklin D. Roosevelt*, 13 vols., William D. Hassett, ed. (New York: Random House, Harper, 1938): 40–42.

[110] For more on the fight for national health insurance in the United States *see* Raymond Munts, *Bargaining for Health; Labor Unions, Health Insurance, and Medical Care* (Madison: University of Wisconsin Press, 1967); Daniel S. Hirshfield, *The Lost Reform: The Campaign for Compulsory Health Insurance in the United States from 1932-1943* (Cambridge: Harvard University Press, 1970); Ronald L. Numbers*, Almost Persuaded: American Physicians and Compulsory Health Insurance, 1912-1920* (Baltimore: Johns Hopkins University Press, 1978); Monte M. Poen, *Harry S. Truman Versus the Medical Lobby: The Genesis of Medicare*, (Columbia, Miss.: University of Missouri Press, 1996); Beatrix Hoffman, *The Wages of Sickness: The Politics of Health Insurance in Progressive America* (Chapel Hill: University of North Carolina Press, 2001); Jill S. Quadagno, *One Nation, Uninsured: Why the U.S. Has No National Health Insurance*, (New York: Oxford University Press, 2005); Paul Starr, *Remedy and Reaction: The Peculiar American Struggle over Health Care Reform* (New Haven: Yale University Press, 2011).

personal way, has been the failure to defeat organized opposition to a national compulsory health-insurance program."[111]

The President's tepid approval ratings, the postwar Congress's conservative bent, and the powerful alliance of anti-national health insurance special interest groups led by the American Medical Association combined to thwart health insurance legislation from 1945 to 1947. In 1948, the President resigned himself to the fact that national health insurance would have to be an "ultimate aim" rather than a proximate one.[112] A new tactic was required. The President asked Oscar Ewing, his new head of the Federal Security Administration (the implementation arm of the Social Security Act), to convene a National Health Assembly and complete a 10-year health plan.[113] The medical community and the advocates of national health insurance would have to work together.

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Oscar Ewing had the right amount of ambition. Born in Greensburg, Indiana in 1889, he took up political posts as a point of duty. The valedictorian of Indiana University came from a long line of ardent Democrats and began running for office in high school. More than political power, Ewing craved an interesting life filled with diverse people, ideas, and responsibilities. In college, he decided to major in philosophy to focus on how to "put things together and make sense out of . . . the meaning of the whole rather than breaking down the parts."[114] His proclivity for coherence and

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[111] Poen, *Harry S. Truman Versus the Medical Lobby*, ix.
[112] For more on the incremental approach, *see* Theodore R. Marmor, *The Politics of Medicare*, 2nd ed., Social Institutions and Social Change (New York: A. de Gruyter, 2000); Jaap Kooijman, *And the Pursuit of National Health: The Incremental Strategy toward National Health Insurance in the United States of America* (Amsterdam: Rodopi, 1999).
[113] For more on the assembly see Oscar Ross Ewing in J. R. Fuchs, "Oral History Interview, Oscar R. Ewing," http://www.trumanlibrary.org/oralhist/ewing1.html, Harry S. Truman, Library Independence, Missouri,188-190.
[114] Ibid., 10.

completeness helped him pull ideas and people together. As a student at Harvard Law School he earned the praise of his professors and peers, many of whom found themselves at the other end of the political spectrum. In his career as a lawyer, Ewing managed to move smoothly between the private and public sectors, representing railroads, pharmaceutical companies, and the aluminum industry, while prosecuting high-profile criminals for such crimes as sedition and treason.[115]

In the early 1940s, Ewing's political astuteness and social adroitness propelled him into the position of consigliere to the Democratic Party. President Roosevelt appointed him assistant vice chairman of the Democratic National Committee, where, in the 1944 convention, he supported Senator Harry S. Truman for Vice President. When Truman became President, he wanted Ewing to head the Federal Security Administration.[116]

Despite eventually concerning itself with the challenges of longevity, The Federal Security Agency (FSA) had a brief lifespan of 14 years. In 1939, this sub-cabinet level agency subsumed the previously independent Social Security Board, which was tasked with implementing the goals of the 1935 Social Security Act. In that year, the FSA merged the Social Security Board, the Public Health Service, the Office of Education, the Civilian Conservation Corp., and the U.S. Employment Service under the same roof. The Agency's mission was too vast. By the time Ewing took over the agency in 1947, the Social Security Board once again attained institutional independence as the Social Security Agency with Arthur Altemeyer as Commissioner. In 1953 the FSA dissolved

[115] Ibid., 95.
[116] Ibid., 172-174

when President Eisenhower reorganized and renamed this hodgepodge social service agency the Department of Health, Education, and Welfare.

Ewing took up the post of head of the Federal Security Administration in 1947 with little social policy experience and no agenda. It was clear that Truman didn't appoint him to the FSA for his professional experience as a social service administrator. Rather, he appointed him because he knew politics. Ewing recalled, "The Federal Security Agency was politically a very sensitive position. Its activities affected every man, woman and child in the United States, and the President wanted someone heading the Agency who would be alive to the political consequences of what might be done."[117] At the outset, Ewing had two goals: to help enact the administration's agenda and to boost the President's image.[118]

Ewing's fight for national health insurance came at the President's behest. The spar with Congress, Ewing observed, "took place before I was Federal Security Administrator, before I even got interested in national health insurance." "After I became Administrator," he continued, "I realized that President Truman was strongly in favor of national health insurance. . . . Accordingly, at the request of the President, I called a conference to consider the health problems of the country, not merely national health insurance but every phase of health problems that faced this country."[119] Ewing recognized that he had to turn the conversation away from health insurance to health care if he wanted to cultivate a productive conversation between organized opposed interests. His conference, the National Health Assembly was such a success that even the vitriolic head of the American Medical Association, Dr. Morris Fishbein—one of the greatest

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[117] Ibid., 147-148.
[118] Ibid.
[119] Ibid., 179-180.

opponents of national health insurance—told Ewing that "it was the best conference that had ever been held in this country on health problems."[120] The conference presented Ewing and the Truman administration with a glimmer of hope. National health insurance as previously conceived might be off the table, but perhaps some kind of compromise, under the guise of health care, could be reached.[121]

Improbably, the famed publisher William Randolph Hearst, Jr. put Ewing on the path to actually developing national health insurance for the aged. At some point in 1949, Ewing recalls, Hearst "invited me over for cocktails."[122]

> He and I were talking and he said, "I'm very much in favor of your idea for national health insurance. But the thing that worries me about it is that if anything went wrong, if it didn't work, the upheaval that would result would be catastrophic because we would have a completely different system of medicine". Then he added, "Isn't there some small segment of the problem that you could pick out, apply your health insurance program to it, use it as a pilot plan operation?" This suggestion made a great deal of sense and it started me on my search for a limited program.[123]

Ewing left the party and immediately called the three Social Security big wigs—Arthur Altmeyer, Wilbur Cohen, and Isadore Falk—"to ask them if there was some part of our program for national health insurance that we could put out, get it going and use as

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[120] Ibid., 189-190.

[121] Interestingly, the Assembly also recommended that the FSA, to better get a handle on the relationship between old age and chronic disease, look into the 'broader aspects of aging'. *See* Sue Schock Roderick, interview by Herman Brontman, research associate with the Federal Security Administration, "The White House Conferences on Aging: Their Implications for Social Change," University of Southern California, 1984, 41.

[122] Ewing dates this meeting to the fall of 1951. However, the scholar Jaap Kooijman discovered a letter from I. S. Falk to Ewing dating the meeting to 1949. I confirmed the existence of this letter, which does remark on Ewing's meeting with Mr. Hearst and their discussion of a limited national health insurance proposal. While it is unclear whether Ewing and Hearst met before or after the 1949 FSA meeting with Tibbitts and Randall, it is clear that Ewing settled on this approach before the group began planning the National Conference on Aging. I. S. Falk to Oscar Ewing, 22 November 1949, Falk Papers, box 69, folder 710, Yale Library, New Haven, CT; *See* Kooijman, *… and the Pursuit of National Health: The Incremental Strategy toward National Health Insurance in the United States of America*, 119.

[123] Ewing, Fuchs 218-219.

a pilot plant operation."[124] They trio hedged. Louis Pink, a dear friend and former client, handed Ewing the idea of the elderly. Pink, an insurance expert with New York Blue Cross/Blue Shield, suggested "that the Government try to do something for the over sixty-five group so that the health insurance companies would have some actuarial data that would enable them to insure the over sixty-five group. He said that without such actuarial data an insurance company wouldn't know what premiums to charge or what risks the insurance should cover."[125] When Ewing came back to Altmeyer with this idea, it seemed to him that the trio had already imagined this option. At the close of the 1940s, a new strategy for national health began to emerge; health insurance would mirror the history of voting: enfranchisement would be incremental, offered to one group at a time.

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When Randall and Tibbitts arrived in room 5051 of the Federal Security Building on April 22, 1949, FSA Assistant Administrator John L. Thurston announced his desire that the day be a "cross between a seminar and a Quaker meeting."[126] The goal of this spirited and erratic discussion would be a "blueprint" for federal involvement in the problems of the aged. What began as a conversation soon turned into a plan: the FSA would host the first National Conference on Aging. Originally designed by Randall and Tibbitts to foster a productive national dialogue on the problems of, and solutions to, old age, the Conference would, inadvertently, establish the elderly as a visible voting bloc with attendant lobbying groups. In the decade following the Conference, the National Council on the Aging (NCOA) and the National Council of Senior Citizens (NCSC)

[124] Ibid., 220-221.
[125] Ibid.
[126] "Proceedings of the Committee on Aging, United States Public Health Service, " April 22, 1949, folder 051.2, box 129, record group 235, Federal Security Agency.

would come into being and build a vibrant political coalition that advanced iterations of the Truman administration's novel policy plan, nicknamed Medicare. For a decade to come health care would trump personal care as a solution to the problems that afflicted individuals over 65 years of age.

CHAPTER III

Dependent Not Old:
The First National Conference on Aging, 1950–1952

"We live in time—it hold us and moulds us—but I've never felt I understood it very well."[1]
Julian Barnes, *The Sense of an Ending*

I: Introduction

"You should live so long," chirped N. S. Haseltine, in a snarky *Washington Post* piece. "And because you will," he continued, "national experts convened here to talk over what should be done for you."[2] The day was August 13, 1950; the place was Washington, D.C, where over 5000 "out of towners" descended on the sweltering city to attend a conference-packed weekend. In addition to the meagerly populated National Conference on Aging, the Army and Navy Union of the U.S.A, the International Typographic Union, the Croatian Fraternal Union of America, and the Pi Phi Fraternity competed for broadcast minutes.[3] With only 816 people in attendance, the National Conference on Aging, at the stately Shoreham Hotel, still managed to capture the country's attention. Newspapers from California to New York reported on the massive implications of this recently discovered social problem.

For one thing, the guests were colorful. The infamous Dr. Francis E. Townsend arrived prepared to push his latest pension plan, $150 a month for everyone over sixty.[4] Then came the "Texas cyclone," an avuncular figure with "the longest name, longest beard, and longest tongue of Texas," Arlon Barton Cyclone Davis, to advocate for pay-

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[1] Julian Barnes, *The Sense of an Ending*, (New York: Alfred A. Knopf, 2011), 3.
[2] N. S. Haseltine, "Experts are Creeping Up on Age," *Washington Post*, August 13, 1950: B3.
[3] "Thousands Expected to Attend Conventions Here This Week," *Washington Post*, August 13, 1950: R7.
[4] "Dr. Townsend Credits Plan with Avoiding Revolution," *Washington Post*, August 12, 1950: 10.

as-you-go pensions and demonstrate his sixty-nine years of impeccable health.[5] Representatives arrived from General Electric, Eastman Kodak, The Josiah Macy Foundation, life insurance companies, hospitals, and social welfare agencies. Eric Johnson, president of the Motion Picture Association of America, the unstoppable health advocate Mary Lasker, scholars and activists such as Clark Kerr, E. V. Cowdry, and Ollie Randall, as well as labor leaders Walter Reuther and Nelson Cruikshank, hunkered down for back-to-back sessions on the indignities and challenges faced by America's elders.

For three days, interested parties gathered to confer on the "problem of old age." Despite a wide range of professions represented, and lively exchanges of opinion, the participants arrived at surprisingly similar conclusions. Whether they attended the meeting on "Employability and Rehabilitation" or "Living Arrangements," these new experts claimed that the hardships of old age could be discussed primarily through the language of dependency. Rather than culling from Ollie Randall's expansive terminology of personal care, the conference participants came to believe that the problem of old age, for both individuals and society, was the emotional and physical toll incurred by financial and physical needs. The aged in America had become a dependent class. This crisis of dependency had clear solutions: create programs that would allow the elderly to remain financially and physically independent.

The first National Conference on Aging achieved mixed results. Although the Conference established the elderly and their hardships as national issues, replete with federal committees and popular journals, the goals stated by the conference participants came to be overshadowed. In a matter of years, politicians, reformers, and the elderly themselves recast the expansive, multifaceted, and intergenerational problem of

[5] "Texas' Davis Here For Aging Parley," *Washington Post*, August 11, 1950: 12.

dependency into the specific hardship of poverty caused by mounting health-care costs. Solutions transformed as well; job-retraining programs gave way to data collection initiatives, and the emphasis on early health-care interventions disappeared, as the quest for health insurance for those over sixty-five years of age took on a political life of its own. The lasting results of the first National Conference on Aging would be the demonstration, albeit nascent, of the growing power of America's senior citizens and the marriage of this power with Oscar Ewing's hospital insurance program.

II: The First National Conference on Aging

In 1950, Oscar Ewing had problems. Since taking over the Federal Security Agency (FSA) in 1947, he had become a maligned figure in Washington. As the fall man for Truman's thwarted National Health Insurance program, Ewing acquired a slew of high-profile detractors. In the summer of 1949, the *Los Angeles Times* reported that Ewing's "bumptious personality" thwarted Truman's plan to create a cabinet level welfare department.[6] The newspaper noted, "[T]he 60-to-32 vote by which the Senate vetoed the plan and thus killed it…stemmed from distrust of Ewing," who would have been slated to run the department.[7] In a profile titled "Ewing: Deeply Sincere Man or Designing Politician?" *The Sun* attempted to get a handle on the vitriol. Was Oscar Ewing, "a quiet, mild-mannered, deeply sincere man who left a lucrative law career to serve his country," or a "skillful, designing, power-thirsty politician bent on fastening the 'welfare state' tighter and tighter upon the American people.…" The article concluded on

[6] "Senate Balks at Power for Ewing," *Los Angeles Times*, August 18, 1949: A4.
[7] Ibid.

a favorable note, subtly blaming the anti-health-insurance lobby for skewering a man motivated by a duty to give all Americans independence.[8]

Ewing, of course, sided with *The Sun* and often shared the following story: In the late 1940s, his friend Mike Gorman received a call from Clem Whitaker, head of the same advertising firm, Whitaker and Baxter, that the American Medical Association (AMA) had hired to turn the country against national health insurance. Gorman told Ewing that Whitaker said, "'…all you have to do to beat it is to give it a bad name, and have a Devil. America's opposed to Socialism, so we're going to name National Health Insurance 'socialized medicine.' That gives it a bad name. And we've got to have a Devil, we first thought of making President Truman the Devil, but we believe he's too popular. But this man Ewing is a perfect Devil, and we're going to give him the works.'"[9] The plan worked. In the late 1950s, years after Ewing retired from the FSA, congressmen still urged him to stay away from the hospital insurance bill he helped create, lest the bill be tarnished with his name.[10]

On July 16, 1950, the House shot down Truman's second attempt to get a cabinet-level position for welfare, this time titled The Department of Health, Education, and Security. Again the *Los Angeles Times* reported, "[O]pposition in the House was based on the fear that the plan would be an entering wedge for socialized medicine, of which Mr. Ewing is a leading champion."[11] On August 3, 1950, just a week and a half before the National Conference on Aging, Representative Frank Buchanan dragged Ewing in

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[8] "Ewing: Deeply Sincere Man or Designing Politician," *The Sun*, August 21, 1949.
[9] Oscar R. Ewing and Peter A. Corning, interviewer "Reminiscences of Oscar Ross Ewing." Columbia University Oral Histories, Social Security Project: Oral History (1966), Columbia University, New York, 50–51.
[10] Oscar R. Ewing and J. R. Fuchs, interviewer "Oral History Interview, Oscar R. Ewing," http://www.trumanlibrary.org/oralhist/ewing1.html, Harry S. Truman, Library Independence, Missouri, 49.
[11] "Twice Rejected," *Los Angeles Times*, July 16, 1950: B4.

front of the house select committee to investigate lobbying to defend his "propaganda foundry."[12] The *Chicago Daily Tribune* carried the story: "Under the searching examination of Rep. Clarence Brown, Ohio Republican, there was nothing for it but to put on a bold front, and this Ewing did, proclaiming that it was 'not only his right but his duty' to propagandize in favor of the Truman compulsory medical insurance program."[13] What a relief it must have been for the battered Ewing to spend his next few weeks on a topic everyone—conservative, liberal, rural, and urban—could sympathize with. Eventually, everyone, if they were fortunate, got old.

Ewing gathered the press on June 7, 1950, to announce the Conference. On behalf of President Truman, he began, the Federal Security Agency had recently issued invitations to "to a large number of individuals and organizations…asking them to join in a National Conference on Aging.… It is our hope that this Conference will discuss and develop helpful attitudes and perhaps policies in the various aspects of this problem, and that it will examine the broad effects of the so-called aging process, the extent of population changes, and their social and economic implications.… I earnestly hope that out of this Conference will come a greater understanding of what is happening to America as a result of our lengthening life span, and some indication as to how to make these changes strengthen the health, the happiness, and the well-being of all our people."[14] The FSA had actually been gearing up for this Conference since 1949, when Ewing first invited experts, like Randall and Tibbitts, to D.C. to discuss the plight of the

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[12] "Ewing's Propaganda Foundry," *Chicago Daily Tribune*, August 3, 1950: 14.
[13] Ibid.
[14] Oscar Ewing, "Remarks by Oscar Ewing, Federal Security Administrator, At Press Conference, Room 5554, Wednesday, June 7, 1950, 3:00pm," folder 051.2, box 129, record group 235, Federal Security Agency, National Archives, College Park, MD.

aged.[15] Moreover, the impetus came less from Truman and more from Ewing, who was presented with this mounting social crisis by reformers at the same time he settled on the aged as a solution to his own political problems.[16] Still, Ewing's spin worked. He visited the aged at Welfare Island for a *New York Times* photo op and wrote op-ed essays for papers including the *Washington Post*.[17] For the moment, the horrific plight of the destitute aged overshadowed his political misfortunes. The press soon wrote about the FSA and Ewing as saviors of America's impoverished grandpas and grandmas.

The push towards public relations did not undermine the content of the conference. Organized around eleven subject areas (Population Changes and Economic Implications; Income Maintenance; Employment, Employability, and Rehabilitation; Health Maintenance and Rehabilitation; Education for an Aging Population; Family Life, Living Arrangements, and Housing; Creative and Recreational Activities; Religious Programs and Services; Professional Personnel; Aging Research; Community Organization) the three-day meeting in D.C. produced a wealth of data, recommendations for further research, and consensus policy recommendations.[18] Structured and populated by non-governmental activists and hosted during the early days of the Korean War, the conference reflected the broad interests and shared values of a country ready to mobilize its resources.

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[15] *See* Chapter II.
[16] *See* Chapter II.
[17] "Oscar Ewing Visits Aged on Welfare Island," *New York Times*, July 20, 1950: 35; "Our Old Folks Have 'New Lease on Life'; How to Enrich It?" *Washington Post*, July 2, 1950: B2.
[18] *Man and His Years: An Account of the First National Conference on Aging* (Raleigh: N. C., Health Publications Institute, 1951), 8.

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On the evening of August 14, Ewing welcomed his esteemed guests. "Since the call was first issued for this Conference on Aging, a great deal has happened on the international scene. The attack on the Republic of Korea has, of course, had tremendous repercussions. Overnight the whole focus of our national thinking has been sharply altered."[19] War, Ewing believed, would remind Americans that the country needed its workers. The problem of old age, he contended, was also a problem of manpower. From the Conference's opening banquet, a focus on work and employability would characterize this national gathering on the problems of old age. Discussions within all of the eleven subject areas reflected this preoccupation with work and usefulness, but two areas best illustrate the contours of this trend: "Population Changes and Economic Implications" and "Health Maintenance and Rehabilitation."[20]

Man and His Years, the published proceedings of the Conference, opens with a demographic rather than biological description of old age. In the section titled "Population Changes and Economic Implications," a group of thirty-two participants, with academic backgrounds in economics, statistics, and sociology, as well as professional experience in life insurance companies, medicine, and welfare programming, sought to describe what the aged population across the country actually looked like. To begin, they had to agree on a working definition of the aged. "It was immediately evident

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[19] Oscar Ewing, "Address by Oscar Ewing, Federal Security Administrator, Delivered at Conference on Aging Banquet, Shoreham Hotel, Washington D.C.," Monday Evening, August 14, 1950 7:00pm, folder Speech Conference on Aging, box 41, Oscar R. Ewing Papers: 1918–1976, Harry S. Truman Library, Independence, MO.

[20] For an excellent account of the rise and fall of federal employment policy ideas and policies *see* Margaret Weir, *Politics and Jobs: The Boundaries of Employment Policy in the United States* (Princeton: Princeton University Press, 1992).

that any attempt to discuss the problems of an aging population demanded a clear understanding of what 'old age' means, as well as an understanding of the factors that together make up the problem," the group opened their summary. Like the social scientists at the Social Science Research Council (SSRC), the Conference attendees decided that age was relative and that, for the purposes of composing a study they would settle on the arbitrary age of sixty-five offered by the Social Security Act.[21]

Without context, the numbers seemed neutral. An early glance at the 1950 census predicted that those over sixty-five represented 8% of the population, totaling 12.4 million.[22] The census also demonstrated that while life expectancy at birth had rapidly increased, longevity had remained static; millions more were able to reach the age of sixty-five, but life expectancy at sixty-five was only a year and a half more than it would have been in 1900.[23] As the participants filled out these numbers by looking at geographic distribution, gender, and employment trends, the picture began to look bleak.

While young people move, older people "stay put."[24] Even with the small migration of older people to Florida and California, "it is the migration of young adults, leaving the old folks behind, that is affecting the various differences in age composition in geographic areas."[25] The result would be large swaths of older Americans without nearby children to move in with or rely on during a health crisis. Still, the group concluded, the statistics in this area were greatly lacking and required further study. On the subject of gender, the group had data. "In 1900," they reported, "men 65 and over outnumbered women. Today there are about 90 men to every 100 women in that age

[21] M*an and His Years: An Account of the First National Conference on Aging,* 16.
[22] Ibid., 17.
[23] Ibid.
[24] Ibid., 19.
[25] Ibid.

group."[26] When talking about the problem of the aged, they noted, they were often discussing the problem of non-working widows.[27]

In addition to this issue of widows, the group noticed a trend toward the "decreasing employment of men 65 years and over."[28] "The percentage of men remaining in the labor force after 65 years of age dropped from 68 in 1890 to 42 in 1940."[29] Although the drop paused during World War II, the numbers were moving in the wrong direction.[30] The combination of non-working widows and non-working men over sixty-five meant that a massive dependency crisis was looming. Adult and middle-aged Americans would have the dual task of financially supporting children and parents.

The group concluded, however, that dependency was not inevitable. "We have a resource going to waste, and the problem is how to utilize that resource."[31] The problem of old age, the group concluded, is distinctly not chronological in nature: it is "the inability to continue earning…either because of a decline in physical power or because of prevailing social attitudes and policies."[32] Since the problem is truly one of "economic invalidity," which can potentially affect individuals of every age, the solution, they determined, must not be age-centric. The country should look carefully at every type of economic invalidity and determine the best way to the put the most people back to work. When the primary solution of new employment opportunities and job retraining programs fails, the group advocated a government-sponsored safety net. Dependents, they concluded, will always exist and should be provided for through "cash benefits for

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[26] Ibid., 20.
[27] Ibid.
[28] Ibid., 23.
[29] Ibid.
[30] Ibid.
[31] Ibid., 31.
[32] Ibid.

individuals who need financial assistance, and services of one type or another for those who are chronically ill or whose health is otherwise impaired and who require medical, nursing, or domiciliary care, or housekeeping services in their own homes."[33] Dependency, they aptly explained, while largely economic, was often related to health concerns. It was up to the leaders in medicine, pharmaceuticals, hospitals, and nursing to determine the exact contours of the relationship between illness and old age.

Tellingly, the title of the section devoted to health was not "Health Care" or "Health Coverage" but rather "Health Maintenance and Rehabilitation."[34] Leaders of major medical, nursing, hospital, and non-profit groups at this time still emphasized strategies to avoid chronic disease and rehabilitate patients; if these were not an option, they advocated palliative care.[35] Edward Stieglitz was on the planning committee, and his vision of constructive medicine pervaded the goals of the group. They summarized, "[T]he emphasis through was on the preparation for later life, on the prevention of disease and disability, and on the promotion of the best health attainable by the individuals. Convinced that the aging can and should play a more active role in our society, the section stressed positive health for older people."[36]

The group began by trying to "identify the health and medical needs of older people and then to explore the ways in which these needs could be met."[37] As usual, definitions proved unwieldy. Rather than proposing concrete definitions for "older people" or "health," the working group located six assumptions or guiding principles.

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[33] Ibid., 38.
[34] Ibid., 104.
[35] The stated goals of the group were as follows: "To indicate measures for promoting positive health of the aging; To indicate measures for preventing premature disability; To indicate measures for providing treatment and care—therapeutic, rehabilitative, and palliative—for the aging sick and disabled." Ibid.
[36] Ibid.
[37] Ibid., 103.

The first, *relativity of health*, concluded that, even for an individual, health is relative and can "always be improved."[38] The second principal was that individuals should "strive for o*ptimum health* or that degree of health which will lead to well-being and a satisfactory adjustment to life."[39] Optimum health they also recognized as relative, however, subject to the "limitation of medical therapeutics, and the physiological consequences of aging."[40] *Aging*, the group's third working assumption, "is biological change, associated with the passage of time, which manifests itself in modifications of organic structure and function."[41] Chronological categories, such as "later maturity" for the ages between forty and sixty, could be located and labeled, but the addition of years was not the "greatest foe of older people."[42] The single greatest threat to a dignified old age, as the group determined in *aging and disease*, their fourth guiding principal, is actually disease, or the "insidious, often unrecognized, and progressive impairment of health."[43] The penultimate principal, *accent on the individual*, insisted that aging was a uniquely individualized process that both requires an individualized approach from health professionals and a commitment to his or her own health by the elderly.[44] The concluding assumption, which the group said "shaped much of the discussion of the section," was "that older people must not be put in a special pocket or segregated from the rest of society. It is one thing, ran the thinking, to devote special attention to the long-neglected health needs and problems of the aging. It is quite another to consider the needs in a

[38] Ibid., 105
[39] Ibid., 105.
[40] Ibid., 106.
[41] Ibid.
[42] Ibid.
[43] Ibid.
[44] Ibid., 107

vacuum or to meet them by setting up new and separate machinery totally unrelated to existing health services."[45]

The "Health Maintenance and Rehabilitation" participants also offered conclusions that opposed the prevalent assumption that hospital growth offered the best solution to the health-care needs of the country. By the time of the conference, hospitals had overtaken the nation as the appropriate provider or space for modern clinical care.[46] In thirty years, between 1920 and 1950, the number of general hospitals grew by 17.4% and hospital beds-per-capita increased by 34.5%.[47] By the mid-twentieth century, hospitals had effectively seduced Americans with, in historian Charles Rosenberg's words, the "allure of innovation."[48] They did not start out that way.

In the nineteenth century, the hospital, Rosenberg writes, "was something Americans of the better sort did for their less fortunate countrymen; it was hardly a refuge they contemplated entering themselves."[49] Marked as a place frequented by the indigent and dependent, the hospital had a tarnished reputation.[50] Those who could afford to retained private medical care in the comfort of their own homes, avoiding the shame of institutional care. As scientific discoveries, such as antiseptic surgery, enabled doctors not just to care for the ill but to cure them, the hospital's standing rose. Between 1870 and 1910, the hospital, the sociologist and historian Rosemary Stevens writes, was

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[45] Ibid.
[46] For more on the history of hospitals in the United States *see* Morris J. Vogel, *The Invention of the Modern Hospital, Boston, 1870*-1930 (Chicago: University of Chicago Press, 1980); David Rosner, *A Once Charitable Enterprise* (Cambridge: Cambridge University Press, 1982); Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987); Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989).
[47] William G. Rothstein, *American Medical Schools and the Practice of Medicine: A History* (New York: Oxford University Press, 1987), 127.
[48] Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987), 7.
[49] Ibid., 20.
[50] Ibid., 5.

“transformed from an asylum for the indigent into a modern scientific institution.”[51] In addition to the success of the veterans health system after World War I, positive outcomes in the fields of obstetrical deliveries, appendectomies, and tonsillectomies, made hospitals acceptable and necessary spaces of care for more and more Americans.[52]

By the 1920s, middle class Americans expected to pay for medical care received in hospitals. A “mixed economy” emerged where charity and proprietary hospitals competed for patient dollars.[53] When the Depression hit, middle-class Americans bemoaned the rising cost of health care. In 1918, hospital expenses in Columbus, Ohio, came to 7.6% of an average family’s medical bills; by 1929 a national survey estimated costs at 13%.[54] By the 1950s, remarks Paul Starr, “it was the poor, rather than the rich, who stood out as different from the rest of the society.”[55] Although hospitals and clinics were originally built for the poor, by the 1930s, impoverished Americans could barely afford medical care. The Depression forced the federal government’s hand as the extraordinary health needs of the nation overwhelmed the private medical system. Federal medical relief came through such entities as the War Food Administration, the Children’s Bureau, and the Veterans Administration.[56] As this was still inadequate, a comprehensive national health insurance program seemed to be the necessary solution. Comprehensive health insurance, as part of a larger social insurance policy, succeeded in Europe while withering politically in the United States. This divergence, hotly debated by

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[51] Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989), 17.
[52] Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982).
[53] Ibid., 147.
[54] Paul Starr, *Remedy and Reaction: The Peculiar American Struggle over Health Care Reform* (New Haven: Yale University Press, 2011), 37.
[55] Starr, *The Social Transformation of American Medicine*, 373.
[56] Rosemary Stevens, *American Medicine and the Public Interest* (New Haven: Yale University Press, 1971), 268.

historians, is often explained through the strength of socialist parties in countries including Germany, Britain, and France.[57] In the European model, health or sickness insurance was always part of a broader social agenda to provide an economic safety net.[58] In contrast, when health insurance reappeared as a political option in the United States after the Depression, it became solely associated with paying for medical bills.[59] Despite support from the majority of Americans and two consecutive presidents, Roosevelt and Truman, federally sponsored health insurance was quashed by the AMA's expensive public relations campaign and Congress.[60]

With national health insurance off the table politically, Congress and President Truman looked for ways to enhance and expand health care for all Americans. Trying to expand health care without upsetting the AMA or approaching the issue of coverage led U.S. policy makers in two directions: they could fund scientific research or hospital construction.[61]

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[57] *See* Daniel S. Hirshfield, *The Lost Reform: The Campaign for Compulsory Health Insurance in the United States from 1932-1943* (Cambridge: Harvard University Press, 1970); Ronald L. Numbers, *Almost Persuaded: American Physicians and Compulsory Health Insurance, 1912-1920* (Baltimore: Johns Hopkins University Press, 1978); Lawrence R. Jacobs, *The Health of Nations: Public Opinion and the Making of American and British Health Policy* (Ithaca, N.Y.: Cornell University Press, 1993); Beatrix Hoffman, *The Wages of Sickness: The Politics of Health Insurance in Progressive America* (Chapel Hill: University of North Carolina Press, 2001); Lawrence R. Jacobs, *The Health of Nations: Public Opinion and the Making of American and British Health Policy* (Ithaca, N.Y.: Cornell University Press, 1993); Jill S. Quadagno, *One Nation, Uninsured: Why the U.S. Has No National Health Insurance*, (New York: Oxford University Press, 2005); Rosemary A. Stevens, Charles E. Burns, and Lawton R. Rosenberg, *History and Health Policy in the United States: Putting the Past Back In*, (New Brunswick: Rutgers University Press, 2006); Paul Starr, *Remedy and Reaction: The Peculiar American Struggle over Health Care Reform* (New Haven: Yale University Press, 2011).

[58] Starr, *The Social Transformation of American Medicine*, 238.

[59] Compulsory health insurance first appeared as a political option during the Progressive era. *See* Beatrix Hoffman, *The Wages of Sickness: The Politics of Health Insurance in Progressive America* (Chapel Hill: University of North Carolina Press, 2001)*;* Starr, *Remedy and Reaction.*

[60] *See* Monte M. Poen, *Harry S. Truman Versus the Medical Lobby: The Genesis of Medicare*, (Columbia, MO: University of Missouri Press, 1996).

[61] *See* Stephen P. Strickland, *Politics, Science, and Dread Disease: A Short History of United States Medical Research Policy* (Cambridge: Harvard University Press, 1972); Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989).
Also *see* chapters I and IV for more on the development of scientific research.

As early as 1942, the American Hospital Association (AHA) organized a commission to shore up support for hospital expansion.[62] With millions of returning veterans afflicted with complicated wounds, the hospital industry was desperate for aid. "Almost without dissent," reports Starr, "two hospital construction programs were adopted immediately after the war—one to expand the Veterans Administration hospitals, the other to aid the nation's community hospitals."[63] The 1946 Hospital Survey and Construction Act, commonly known as the Hill-Burton program, solidified the hospital, and later its old-age affiliate, the nursing home, as the natural and necessary place for health care in America.[64] In twenty-four years, starting in 1947, Hill-Burton brought 3.7 billion dollars of federal funds and 9.1 billion dollars in matching state funds to hospital construction.[65] Between 1946 and 1952, general hospital admissions increased 26%.[66] For the first time, Americans across the country had access to hospital care. Citizens could experience the positive effects of Hill-Burton; the negative ones were more complicated to see.

As beacons of modern medical prowess, hospitals had to keep up with the latest biomedical research and technologies. Unlimited expansion and technological growth, while arguably good for medical care, also meant rising costs, for the hospital and consequently its patients. A pivotal study conducted by Milton Roemer and Max Shain in 1959 concluded that the rise in the number of hospital beds had the effect of pushing doctors to hospitalize patients, creating an unending feedback loop. The rise of the

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[62] Starr, *The Social Transformation of American Medicine*, 348.
[63] Ibid.
[64] *See* Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*; Bruce C. Vladeck, *Unloving Care: The Nursing Home Tragedy* (New York: Basic Books, 1980).
[65] Starr, *The Social Transformation of American Medicine*, 350.
[66] Stevens, *In Sickness and in Wealth*, 220.

hospital begat the unending need for more hospitals. As Paul Starr summarizes, "[A]s hospital beds were built, physicians admitted patients they would otherwise have treated at home. 'A half century ago,' they noted, 'only the most desperately ill were hospitalized; cases of pneumonia, tonsillectomies, deliveries, heart attacks, fractures were treated at home or in the doctor's office. Today not only are these cases hospitalized, but so are cases of multiple-tooth extractions, psychoneurosis, epilepsy, diabetes for insulin stabilization, or any obscure condition for diagnosis. All this is made possible by an increase in the relative supply of beds, and reciprocally it creates pressures for continual expansion of the bed supply.'"[67] The conference attendees in the "Health Maintenance and Rehabilitation" section wanted to reverse, or at least stall, this trend.

They asserted that the bulk of medical spending must be used for early intervention. Rather than attend to disease at the end of life, they argued that health-care professionals should focus on preparing middle-aged individuals for years of optimal health in their homes. The emphasis should remain on creating the "well person" rather than coping with the sick one.[68] For this reason, isolating the elderly from other age groups in terms of health care did not make sense. The group wrote, "[H]ealth programs for the aging should be developed within the framework of our total health services. Further fragmentation would be wasteful and would perpetuate an undesirable social concept."[69] Finally, although the group agreed that hospitals were necessary for health care, they advocated a move away from institutional care: "[I]n the opinion of the section, the current tendency to rely almost exclusively on institutional care, is wasteful and inadequate. For acute phases of chronic illness, hospital facilities are undoubtedly

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[67] Starr, *The Social Transformation of American Medicine*, 364.
[68] *Man and His Years*, 108
[69] Ibid., 107.

necessary. But for many aged persons, care in the home may lead to better physical and emotional adjustment."[70] The group determined that designing a healthcare system that would prevent the physical ailments associated with old age and keep the elderly within their communities would dramatically reduce physical dependency.

By the end of the conference, attendees conceptualized the problem of old age as one of financial and physical dependency, which was not essentially correlated with chronology. They believed the best programmatic solutions would extend human beings' capacity for usefulness throughout their lifespan. The hardships of old age could be mollified with early intervention health care, job retraining, and a recasting of the social reputation of the elderly. When all else failed, the non-profit sector and the government should provide a monetary and goods-based safety net. At the close of the conference proceedings, Clark Tibbitts, reflected these conclusions through a final set of predictions: "It appears reasonably safe to predict, therefore, that within the course of the fairly immediate and long-term future there will be: Increasing appreciation of the importance of older people in the national manpower mobilization program; Increasing momentum of a national movement for conservation, reclamation, and utilization of our human resources; Increasing interest and action by public leaders, press, radio and television, conferences, institutes, and other educational forces; Steadily changing attitudes—on the part of labor and industry, the community, older people themselves; and ultimate solution of a major national problem through the processes of American democracy."[71]

The Conference concluded on August 16. Within weeks the precise content results morphed into a diluted national commitment to the elderly. The *Washington Post*

[70] Ibid., 119.
[71] Ibid., 308.

August 16 article was one of the last to reflect accurately the emphasis on employment: "The changing national attitude toward 'the aged' has been publicly recognized by President Truman in his simple and wise message to the National Conference on Aging. The message called for elimination of arbitrary age limits on retirement and the determination of methods for making use of the experience, knowledge and obvious productivity of those aged in a technical sense only."[72] The National Conference would indeed change the position of elderly within the federal government, the states, and the country at large, but it would do so in a way that promoted chronological age and lost sight of the intergeneration problem of dependency.

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In 1949, Ollie Randall dazzled FSA employees with her vast expertise on the problems of old age. As one of the few individuals everyone agreed was an expert on this issue, her opinions mattered.[73] A year later, much had changed. Ewing opened the National Conference on Aging by giving Randall an award but closed it by giving Clark Tibbitts the power to create actual policy.

Randall had been marginalized almost immediately following the April 22, 1949, FSA meeting.[74] On July 1 of that year, she followed up with John Thurston, the FSA's assistant administrator, writing, "[I]t has therefore occurred to me that one of the first steps might be the consideration of a plan to call together an assembly similar to the National Health Assembly called by Mr. Ewing in 1948."[75] She received only a curt reply

[72] "Hope for 'The Aged'," *Washington Post*, August 17, 1950: 8.
[73] *See* Chapter II.
[74] *See* Chapter II.
[75] Ollie Randall, "Letter from Ollie Randall to John L. Thurston," July 1, 1949, file 051.2, box 129, record group 235, Federal Security Administration.

five months later.[76] Ollie Randall would be credited for bringing the plight of the elderly to the attention of the nation and receive accolades from those within the federal government, but she would never officially join their ranks. When Ewing presented Randall with an award on the opening night of the Conference, he stated,

> There are, in fact, few aspects of the problems with which this Conference is concerned, on which Miss Randall does not speak with authority. She has dealt with legislatures and with business and industry.… She has labored unceasingly to develop medical facilities for the aged and to establish educational programs. She was the Director of the first modern housing project for older people. She has worked with many communities in many parts of the country to develop programs of a similar nature and has labored unceasingly to change attitudes toward the aged.… For all this, Miss Randall, I salute you as a true pioneer in the field in the problems of the aging. And in behalf of this Conference, I take great pleasure in awarding you this Citation."[77]

Randall accepted the award graciously and left at the end of the conference to push her vision of personal care for the aged in cities across America. She would start her own organization, The National Council on Aging, serve on New York State's joint legislative committee on problems of the aging, spearhead a multi-year Ford Foundation grant on the aged, and be instrumental in conceptualizing best practices of care for the needy aged.

Tibbitts fared better in terms of attaining power within the federal government. On January 24, 1951, Ewing appointed Tibbitts chairman of the FSA's new Committee on Aging and Geriatrics.[78] He left the University of Michigan to run the Committee, which had as its mission, "to keep itself informed as to emerging problems and knowledge in the aging field, to explore implications for federal departments and stimulate interest within them, and to aid the country in other appropriate ways in making

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[76] John L. Thurston, "Letter from John L. Thurston to Ollie Randall," December 5, 1949, file 051.2, box 129, record group 235, Federal Security Administration.
[77] FSA, "Citation for Randall," August 13?, 1950, box 41, Oscar R. Ewing Papers.
[78] Federal Security Agency Office of the Administrator, "Press Release," January 24, 1951, box 4, Clark Clark Tibbitts Papers: 1936–1985, Bentley Historical Library, University of Michigan: Ann Arbor, MI.

sound and fruitful adaptations to our aging population."[79] Tibbitts, an academic by predisposition, believed that education and awareness, in and of itself, would lead to change. The Committee's essential position within the FSA would be as a clearinghouse for all things relating to aging. They would assist in data collection, field requests, and promote a better vision of aging across the Untied States. To alter the public attitude on aging, Tibbitts partnered with radio and TV stations, adult education programs, and, in June of 1951, began publishing the journal *Aging.* The Committee's collected information showed results. In two years, the National Conference on Aging and the FSA had put the problems of old age on the national agenda.

The Conference helped to create the first publically recognized specialists on the elderly. When the FSA first toyed with the idea of a national meeting, staff members had a difficult time locating more than 500 people working on the issue.[80] Finding experts who could talk on the topic was, Thurston recalled, a challenge: "It was recognized that, while many people were interested in various aspects of the problem, there was little systematic knowledge on which to organize a definitive program. Likewise, there was, at the time, no adequate identification of persons qualified to talk on the numerous phases of the subject."[81] Within months, the FSA had collected 2,000 names of individuals with useful experience in the field of aging. By January of 1951, that number had jumped to 10,000.[82]

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[79] The Federal Security Agency, *Aging.* 1, June 18, 1951.
[80] Clark Tibbitts, "Progress Report of the Staff and Committee on Aging and Geriatrics for 1951–1952, FSA, " folder First National Conference on Aging, box 5, Clark Tibbitts Papers.
[81] John L. Thurston, "First National Conference on Aging: A Preview of Maturity," *Industrial and Labor Relations Review*. 4, no. 2 (January 1951): 165.
[82] Tibbitts, "Progress Report of the Staff and Committee on Aging and Geriatrics for 1951–1952, FSA."

The first national conference also begot more conferences, publications, and commissions. From 1950 to 1952, the FSA recorded fifty conferences across the United States dedicated to the plight of the elderly.[83] The sessions took place at universities, at welfare societies, and at the state level. In August of 1950, only New York and Connecticut had official commissions on aging. By 1952, fifteen states had established commissions or similar entities to study and take care of their elderly, and more states followed.[84] In addition, in the two years following the conference, forty-four universities decided to offer courses on aging, many in the category of adult education.[85] And as scholar Henry Pratt notices, "as many articles are listed in the standard geriatrics-gerontology index for the six-year period ending in 1955 as in the entire forty-eight years preceding."[86]

Immediately following the Conference, the Bureau of Labor Statistics created a position "in the aging field," the Housing and Home Finance Agency began to analyze housing options for the aged, the Public Health Service and the Bureau of Old Age and Survivors Insurance created new research initiatives, and the Bureau of Public Assistance added improvements for the elderly."[87] Most importantly, the Conference established the FSA as the administrative coordinator for all things having to do with the elderly.

If Tibbitts overplayed the significance of the Conference, scholars have underplayed it. Positioned between the pension movement of the 1930s and the Medicare movement of the 1960s, the 1950s are often referred to as the "dismal years" in old age

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[83] Ibid.
[84] Ibid.
[85] Ibid.
[86] Henry J. Pratt, *The Gray Lobby* (Chicago: University of Chicago Press, 1976), 43.
[87] Clark Tibbitts, "What's Next? Chapter 14 Draft," 1951?, folder First National Conference on Aging, box 5, Clark Tibbitts Papers.

activism.[88] Henry Pratt, an expert on the rise of the senior citizen lobby, declared in his 1976 book that the 1950 Conference "did not achieve any dramatic results."[89] This estimation is shortsighted. The Conference altered the position of the elderly, as a social group, within the federal government, pushed the ailments of the elderly to the forefront of public discussions, announced the potential voting power of the elderly, and inspired the first draft of what would become Medicare. As Tibbitts remarked, "[C]onferences, in themselves, are not action programs. Nevertheless, they are essential; they provide for exchange of ideas, threshing out of problems, and stimulation of new activities."[90]

III: Hospital Insurance

Ten days after the National Conference on Aging came to a close, Ewing's strategy of limiting health insurance to the elderly got a major boost. On August 28, President Truman signed into a law an amendment that expanded social security benefits to ten million more Americans.[91] From 1950 on, the formerly limited Old-Age and Survivors Insurance would now be open to such laborers as domestic servants and agricultural workers, to name only a few.[92] For the crafters of social security, such as

[88] *See* Pratt, *The Gray Lobby*; Henry J. Pratt, *Gray Agendas Interest Groups and Public Pensions in Canada, and the United State*s (Ann Arbor, MI.: The Univ. of Michigan Press, 1995); W. Andrew Achenbaum, *Shades of Gray: Old Age, American Values, and Federal Policies since 1920* (Boston: Little, Brown, 1983).
[89] Pratt, *The Gray Lobby*, 42.
[90] Clark Tibbitts, "What's Next? Chapter 14 Draft."
[91] "1950s Chronology," Special Collections, History, Social Security Online, http://www.ssa.gov/history/1950.html.
[92] For more on the history and development of the Social Security Act *see* Edwin E. Witte, *The Development of the Social Security Act* (Madison: University of Wisconsin Press, 1962); Arthur J. Altmeyer, *The Formative Years of Social Security* (Madison: University of Wisconsin Press, 1966); Roy Lubove, *The Struggle for Social Security, 1900-1935* (Cambridge: Harvard University Press, 1968); W. Andrew Achenbaum, *Social Security: Visions and Revisions* (New York: Cambridge University Press, 1986); Jill S. Quadagno, *The Transformation of Old Age Security: Class and Politics in the American Welfare State* (Chicago: University of Chicago Press, 1988); Edward D. Berkowitz, *Mr. Social Security: The Life of Wilbur J. Cohen* (Lawrence, Kan.: University Press of Kansas, 1995).

Wilbur Cohen and Isadore Falk, this was the dream. From the origins of federal welfare, there existed a distinction between "public assistance" and "social insurance." "Public assistance," writes historian Michael Katz, "is means-tested relief. It is what we usually think of as welfare.… Social insurance is not means tested. It is an entitlement for everyone eligible by virtue of fixed, objective criteria, such as age, disability, or unemployment, and its benefits cross class lines."[93] Where Old Age Assistance carried the stigma of welfare and the "unworthy" poor, Old Age and Survivor's Insurance did not. With the 1950 amendments, more Americans would qualify for the contributory social security benefits than for the stigmatized old age assistance.[94]

Ewing considered the passage of the 1950 amendment one of the great successes of the Truman administration and his own political career. In addition to the benefits for all Americans, the amendment gave Ewing an unprecedented opportunity. As Jaap Kooijman notes, "[T]he amendments of 1950 made the social security program dominant in the American welfare state, providing universal coverage to the majority of Americans. Linking a national health insurance program to the social security system made more sense than in the years before since the number of Americans included within the system had increased."[95] Now, more than ever, Ewing recognized the benefits of advocating for chronologically based health care coverage.

The Conference had also given Ewing more confidence and ammunition. He had garnered support from the private insurance industry and the hospital industry and had marshaled public sentiment on behalf of the elderly. Unlike the large number of

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[93] Michael B. Katz, *In the Shadow of the Poorhouse: A Social History of Welfare in America* (New York: Basic Books, 1986), ix.
[94] Jaap Kooijman, *…and the Pursuit of National Health: The Incremental Strategy toward National Health Insurance in the United States of America* (Amsterdam: Rodopi, 1999), 127.
[95] Ibid.

conference attendees in social work, medicine, or other health care fields, representatives of insurance companies fought to define old age chronologically. After congratulating Ewing on the Conference, R. McAllister Lloyd, president of Teachers Insurance and Annuity Association of America, had this to say: "[O]f course, there are many objections to a fixed chronological age but the alternatives have been found to be worse, and I believe it would be harmful to the pension movement in this country to have the Conference make a recommendation that fixed retirement ages are not desirable."[96] In addition to insurance companies benefiting from retirement plans, private hospital insurance programs were interested in having the government determine and take on the risks of insuring those over sixty-five.[97]

In 1951, Ewing made some headway with the hospitals. He realized, after meeting with New York hospital representatives, that these institutions wanted and needed more government aid. They could not say so, however, because of the power of the AMA.[98] He wrote, "[T]he truth about the matter is that in this day and age, whether anyone likes it or not, both our schools and hospitals have got to depend on tax money, because the taxing units are the only ones that can really raise money to meet these gigantic needs. The American Medical Association came out—as I recall, they didn't want the government to contribute to medical research. They were going to raise 10 million dollars a year for medical research. They raised about $600,000, the first year and then abandoned the effort."[99] There were two ways to persuade the hospitals to support some form of federal

[96] R. McAllister Lloyd , "Letter from R. McAllister Lloyd to Oscar Ewing," August 16, 1950, file 051.2, box 129, ,record group, 235, Federal Security Administration.
[97] *See* Chapter II.
[98] "Oral History Interview, Oscar R. Ewing," 57–58.
[99] "Reminiscences of Oscar Ross Ewing," 54.

insurance. One, to show doctors how this program would not affect their salaries, and two, to let the AMA realize that they were fighting grandparents, not socialists.

Most importantly, Ewing saw, first hand, the potential political power of the elderly. Before the Conference even began, the *Washington Post* mentioned the elderly as a voting bloc. In "Elderly Bloc in Politics: Fogyism or Wisdom," the journalist Malvin Lindsay took Ewing's bait. "The elderly may be getting pushed around in the business world," he wrote, "but they are getting more strongly entrenched at the ballot box every day."[100] Fifty percent of voters, Lindsay claimed, would soon be over sixty-five. Politicians would rapidly awake to the fact that individuals over sixty-five had enormous political potential. Uses of the phrase *Older Person* in the *Congressional Record*, notes Pratt, went "from six in 1953 to a full column in 1955 and one and one-half columns in both 1956 and 1957."[101] The Conference gave visibility to the problems and growing power of the elderly. Now it was up to Ewing to create the legislation.

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Ewing had to convince the brains behind Truman's social security legislation to offer a limited version of national health insurance.[102] In 1949, Arthur Altmeyer, Wilbur Cohen, and Isadore Falk, Ewing recalled, "were completely wedded to national health insurance and didn't want to take less."[103] In fact, in reaction to Ewing's suggestion of a constricted national health insurance bill, Falk composed a document with alternatives to age limitations.[104] Quickly, however, the group came around. After talking to Cohen and

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[100] Malvin Lindsay, "Elderly Bloc in Politics," *Washington Post*, August 5, 1950: 4.
[101] Pratt, *The Gray Lobby*, 43.
[102] *See* Chapter II.
[103] Reminiscences of Oscar Ross Ewing," 73.
[104] I. S. Falk, "Some Alternatives to Comprehensive National Health Insurance," November 28, 1949, folder 710, box 69, Isidore Sydney Falk Papers: 1918–1984, Yale Library, New Haven, CT.

Falk, Ewing remembered Altmeyer telling him, "'[I]t's perfectly feasible, and we will try to help out, if you think that's the wise thing to do.' He indicated that he would much prefer national health insurance, but he would bow to my judgment on that, if I thought that this was the politic thing to do."[105] By 1951, Cohen and Falk had buckled down and completed all of "the technical work" necessary to write the legislation.[106]

To craft a politically feasible program, writes Theodore Marmor, Ewing, Cohen, and Falk "assumed the administration could most easily build an issue majority in the Congress by narrowing previous demands and tailoring them to meet the objections of critical congressmen and pressure groups."[107] Thus, the legislation avoided the four major objections to national insurance: "(1) general medical insurance was a 'give-away' program, which made no distinction between the deserving and undeserving poor; (2) it would substantially help too many well-off Americans who did not need financial assistance; (3) it would swell utilization of existing medical services beyond their capacity; and (4) it would produce excessive federal control of physicians, constituting a precedent for socialism in America."[108]

Cohen and Falk found a way to integrate health insurance into the newly expanded and nationally respected Old Age and Survivors Insurance program. By limiting health-care benefits to Social Security recipients over sixty-five (and their spouses), they avoided a means test, as well as charges that they were giving benefits to the undeserving. In this case, the elderly would have prepaid for their benefits. Moreover, as Cohen and Falk would show statistically in the coming year, the elderly could not

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[105] "Oral History Interview, Oscar R. Ewing," 79.
[106] "Reminiscences of Oscar Ross Ewing," 73.
[107] Theodore R. Marmor, *The Politics of Medicare, 2nd ed.,* (New York: A. de Gruyter, 2000), 11.
[108] Ibid.

afford private insurance nor would private insurance cover the elderly. The next step was to limit reimbursements in such a way that would mollify the AMA. Without proper infrastructure to deter or manage chronic disease, the elderly entered hospitals at greater rates than the young, and once they entered, they stayed for twice as long as other patients.[109] This rise in admissions and lengths-of-stay came at a time when the cost of hospital care was exponentially expanding.[110] The idea of confining national health insurance to hospital care had been alive since 1944, when it was suggested and then dismissed by the Social Security Board.[111] Now it came back as a crucial way to make Ewing's plan viable.

In 1949, Falk prepared a document, which offered incremental approaches to universal health care. In "Some Alternatives to Comprehensive National Health Insurance" he offered the pros and cons of restricting national health insurance to hospital coverage. He wrote:

> The most common of such proposals suggests a start with hospitalization only. Then, after this is well established and operating smoothly, it is proposed to organize the medical benefits (physicians' services)—perhaps first in the limited form of physicians' services for hospitalized cases (in-patient care), later extending this second benefit to services for non-hospitalized cases attended in the out-patient department or clinic of the hospital, in the physician's offices and in the patient's home. On this pattern, additional services would become insurance benefits at later stages, in one sequence or another (laboratory services, unusually expensive prescribed medicines and commodities, dental care, home-nursing, etc).[112]

While there were numerous advantages to such an approach, not the least of which was avoiding having to negotiate immediately with physicians, dentists, nurses, laboratories,

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[109] Starr, *The Social Transformation of American Medicine,* 368.
[110] Ibid.
[111] The Social Security Board had discussed limiting health insurance to hospital coverage in 1944 but did not pursue this option because it was seen as too limited. Richard O. Harris, *A Sacred Trust* (New York: New American Library, 1966), 54.
[112] Falk, "Some Alternatives to Comprehensive National Health Insurance," 4.

and pharmaceutical companies, to name a few, Falk recognized there were also important risks.[113] "Insurance limited to hospital care," he argued, "would invite excessive hospitalization of insured persons and would lead to excessive capital expenditures for construction costs, and thus would needlessly raise the cost of sickness care."[114] Furthermore, "since the insurance would operate only after a patient is sick enough to be hospitalized, the insurance system would be neglecting its opportunities to provide incentives for preventative care and for care early in illness."[115] Still, hospital insurance was a start, and in 1951 it looked like the best political option. As Wilbur Cohen would later surmise, "anyway, it's all been very Hegelian. The state and federal proposals for compulsory health insurance were the thesis, the A.M.A.'s violent opposition was the antithesis, and Medicare is the synthesis."[116]

On June 25, 1951, Ewing was ready to announce. He gathered the press to the FSA offices at 330 Independence Avenue and read the following words: "I am recommending that the President include in his legislative program a plan which would provide hospitalization insurance up to 60 days a year for persons 65 and older and dependents of deceased persons insured under Old-Age and Survivors Insurance system."[117] This, he claimed, was a simple program. Patients would have the costs of up to sixty days a year of hospital care completely covered. Moreover, the cost of these visits would be paid directly to hospitals with existing social security payroll deductions. The program, he emphasized, would not require any new taxes.[118] Finally, the states

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[113] Ibid., 5.
[114] Ibid., 7.
[115] Ibid.
[116] Wilbur Cohen, quoted in Harris, *A Sacred Trust,* 55.
[117] Oscar Ewing, "Statement at Press Conference, June 25th, 1951," folder FSA Old Age, box 33, Oscar R. Ewing Papers.
[118] Ibid.

would retain control over how the program was administered. “The plan,” he emphasized, “contemplates decentralization of administration wherever possible through the States. Payments to a hospital would be made in accordance with an agreement entered into between the hospital and the State, or between the hospital and the Federal Security Administrator when a State does not wish to administer the program.”[119] Ewing took the next seven months to gather more data on insurance costs for the elderly and persuade members of Congress to submit the bill.

Responses to Ewing’s announcement were either lukewarm or vituperative. The *Washington Post, Chicago Tribune*, and *New York Times* highlighted the fact that in addition to wage earners over sixty-five and their spouses, care would also be “made available to widows of insured wage earners and surviving children under eighteen.”[120] They also remarked on the palpable demand by quoting Ewing. “These people as a whole,” the *New York Times* quoted, “need much more than the average amount of hospitalization, they have much less than average income with which to meet the costs of hospitalization, and much less than average opportunity to obtain insurance.”[121] Still, journalists agreed that opposition to the program would be fierce.

Of all the articles from this moment, “Bait for the Elderly” in the *Chicago Tribune* stands out for its vitriol. “Oscar Ewing,” the piece opened, “is reported to be planning to spring a New Deal vote catching trap for older people which makes the various pension schemes that have come out of California look like a dime a dozen dodges.”[122] That was only the beginning. The article went on to say, “[T]his is an

[119] Ibid.
[120] “Free Hospital Care for Those Over 65 Urged,” *Chicago Daily Tribune*, June 26, 1951.
[121] “U.S. Outlines Plan of Care for Aged,” *New York Times*, June 26, 1951: 24.
[122] “Bait for the Elderly,” *Chicago Tribune*, June 11, 1951: 14.

invitation to oldsters to take a bed at the expense of the public. It would encourage imaginary illness and malingering on a wholesale scale, for the beneficiary would be given encouragement to hunt up a hospital and provide himself with food.… Pretty soon the New Dealers would control most of the medical facilities and personnel in the country."[123] Although loose on a few facts, the conservative press got two things right: Ewing did hope this would be a first step toward national health insurance, and he did believe the elderly voters would advocate for the policy. From this program, the article continued, "it would be but a short step to consummating the plan for government medicine for everyone," and "The New Dealers can hope for perpetuation in office by buying up the votes of the elderly."[124] Ewing countered, "It is difficult for me to see how any one with a heart can oppose this thing."[125]

In January of 1952, Ewing wrote to President Truman: "In accordance with your request, I hand you herewith a memorandum outlining the proposed Old-Age and Survivor's hospitalization insurance plan. I strongly urge that the plan be made a part of the President's Program."[126] For the last year, despite Ewing's pleas, Truman had hedged. As Ewing conveyed, "the President was quite reluctant to give up his fight for national health insurance. I mean, temperamentally, President Truman did not like to give up a fight. He felt that the best way to get something done was to keep on fighting for your ultimate goal, but if you have to, if you have settle for less, well, settle. Whereas I thought we would be completely stymied for an indefinite period if we didn't back down

[123] Ibid.
[124] Ibid.
[125] Ewing, quoted in "U.S. Outlines Plan of Care for Aged," *New York Times*, June 26, 1951: 24.
[126] Ewing, "Letter to President Truman, January 22, 1952," folder FSA Old Age, box 33, Oscar R. Ewing Papers.

to some extent."[127] Ewing composed this letter to persuade. He began with the issue of need. Voluntary insurance, he claimed, had almost completely left out individuals over sixty-five and their beneficiaries. This program will cover a needy group, it will avoid invading "a field of any substantial interest" to the profit or non-profit companies, and it will "give badly needed assistance to hospitals in the form of payments for many services now given free to charity patients." [128] Moreover, Ewing continued, the program has private and congressional support.

Months before, Ewing had quietly convinced the Catholic Hospital Association that this program would help in the fight against Communism and endeared, or so he thought, Congressional leaders such as Senators George, Hunt, Kerr, Hill, Murray, and Lehman, as well as Speaker Rayburn, to the program.[129] After enumerating his list of what came to be precarious supporters, Ewing concluded with an argument he knew Truman would like: "[Q]uite apart from all my other reasons for urging the inclusion of this plan in the President's Program is the fact that its enactment will give us experience in administering a small segment of your national health insurance program before the entire program is put into effect. This pilot-plan experience will be invaluable in the development of the most comprehensive program."[130] This was not defeat. This was another way to win Truman's battle for national health insurance. Or so he thought.

On April 10, 1952, Senators James Murray (D-Montana) and Hubert Humphrey (D-Minnesota) introduced Ewing's hospital insurance bill in the Senate while Representatives John Dingell (D-Michigan) and Emanuel Celler (D-New York)

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[127] "Reminiscences of Oscar Ross Ewing," 79.
[128] Ewing, "Letter to President Truman, January 22, 1952."
[129] Frederick E. Robin, "Letter to Oscar Ewing," undated, folder FSA Old Age, box 33, Oscar R. Ewing Papers.
[130] Ewing, "Letter to President Truman, January 22, 1952."

introduced it in Congress.[131] Truman gave Ewing permission to move forward but never truly put his weight behind the program. Neither the Senate nor Congress had hearings on the bill. Ewing recalled, "they couldn't even get hearings on Medicare, when I had it introduced."[132] In the fall of 1953, the situation looked bleak. The Truman administration had failed to implement national health insurance and failed to enact restricted hospital insurance. "But with the end of the Truman administration," remarked Ewing, "also came the end of any real pressures for national health insurance."[133] What did not end, remarkably, was the pressure for Medicare.

As Ewing and Wilbur Cohen predicted, "the Eisenhower people… didn't seem to realize the immense political potential of this group."[134] As the cost of medical care continued to rise, so did the organizational capacity of the elderly. "Between 1953 and 1963, expenditures for all health services more than doubled. The price of hospital beds rose 90 percent, while physician's fees increased 37 percent."[135] Local old age groups, religious societies and Golden Ring Clubs began to agitate for help, and a new lobbying group, The National Council of Senior Citizens, pushed congressmen towards enacting Ewing's hospital insurance program. These groups rapidly abandoned the content of the early debates on aging.[136] The definitions and solutions to the problem of old age voiced at the first National Conference on Aging gave way to the language of political

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[131] "1950s Chronology," Special Collections, History, Social Security Online, http://www.ssa.gov/history/1950.html.
Copies of the bill can be found in Oscar Ewing's papers and a short discussion of the bill, in James L. Sundquist, *Politics and Policy: The Eisenhower, Kennedy, and Johnson Years* (Washington: Brookings Institution, 1968).
[132] "Reminiscences of Oscar Ross Ewing," 68.
[133] "Oral History Interview, Oscar R. Ewing," 49.
[134] Wilbur Cohen quoted in Harris, A Sacred Trust, 64.
[135] Marmor, *The Politics of Medicare*, 4.
[136] The rise of senior citizens as a political interest group reflects broader trends in the trajectory of American liberalism after the New Deal. For more on the transition from reform liberalism to rights-based liberalism *see* Alan Brinkley, *The End of Reform: New Deal Liberalism in Recession and War*, (New York: Alfred A. Knopf, 1995).

expediency. The AMA now had to battle with an organized front of aged activists, who demonstrated that America's deserving grandfathers and grandmothers were suffering from poverty caused by health failure. The federal government had the obligation to help American children care for their parents in a healthcare system spinning financially out of control.

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Later in life, Ewing liked to deny the connection between the first National Conference on Aging and his hospital insurance program. He did so for an important reason. Perhaps more than anyone else involved in the insurance program, he realized that Medicare did not solve the root problems of old age in America. He understood that sixty days of hospital insurance per year once one turned sixty-five would not assuage the dependency crisis. "No," Ewing said in 1966, "no, there wasn't any particular connection," between the Conference and the legislation.[137] The Conference, he related again in 1969, "dealt with the problems of aging and many of those are not within the health field. The older generation have environmental problems, problems with relatives, and many other problems outside of the field of health."[138] Still, there is ample evidence that Ewing knew just how to use the Conference to serve his political ends. It wasn't that Ewing didn't care about the elderly, he did. It was just that he was a political realist on a practical mission, and the elderly were key to his success.

First, Ewing knew through his experience with the National Health Assembly that public assemblies and conferences, if well attended by the press, could galvanize the American public. As he related in a 1966 oral history, "[O]ur job was a job of educating

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[137] "Reminiscences of Oscar Ross Ewing," 83.
[138] "Oral History Interview, Oscar R. Ewing," 58.

the public on it, and once the public was educated on it, the Congress came around very fast."[139] Ewing made sure that the presidents of Columbia Broadcasting and of the Motion Picture Association had a seat on the Conference's advisory committee.

Most importantly, the conference gave Ewing an idea. To fight the AMA, he originally wanted to organize an American Patients Association.[140] After August 1950, he realized that the elderly could be that association. The numbers were on his side: "You had 19 million people over 65, and you had 185,000 doctors," he said. Although it would take another few years for the nascent old age lobby to organize around Medicare, senior citizen councils across America would prove Ewing right. The first National Conference on Aging would provide the foundation to make Medicare a political reality. It would not, however, save Ewing's reputation.

For fifteen years following the Conference, Ewing remained persona non grata in Washington, D.C. Even when congressman Aime Forand (D-Rhode Island) submitted new versions of Ewing's bill in Congress, he deferred Ewing's persistent offers of help. Ewing himself understood that he was a political hindrance. He quietly assisted the proponents of Medicare, Forand, Nelson Cruikshank of the AFL-CIO, and Senator Patrick McNamara (D-Michigan), but more often he stayed away from the fight.[141] In the 1960s, Lyndon Johnson remembered the 1952 hospital insurance bill. As Ewing recalled, "President Johnson was very gracious about one thing. In view of President Truman's having, in his administration, been the sparkplug that brought about the first introduction of the legislation, President Johnson went clear out to Independence, Missouri, to sign the

[139] "Reminiscences of Oscar Ross Ewing," 35, 66.
[140] "Oral History Interview, Oscar R. Ewing," 49.
[141] Ibid.

bill in the presence of former President Truman; and President Johnson asked me to accompany him on the trip."[142]

Between 1950 and 1965, the contours of American politics around health policy transformed. The power structures shifted in Congress, interest groups lost and attained influence, and the Medical Security Solution beguiled the country. More than just the politics changed. By the middle of the 1950s, the conversation around the problems of old age grew ever more anemic; chronological age came to be an accepted way of dividing the old from the young, aging became a disease to be solved, and death came to be understood as an unnatural rather than natural occurrence. The American state, having taken up the obligation to care for its aged citizens would, inadvertently, create the parameters of how senior citizens were socially, medically, politically, and personally defined.

[142] Ibid., 90.

CHAPTER IV

From Many Came One:
Senior Citizens and The Health Care Consensus, 1953-1960

"But the crowning glory of old age is influence."[1]
Cicero

I. Introduction

At the start of 1957, Congressman Aime J. Forand was easy to miss. Although he held a coveted position on the House Ways and Means Committee, he kept a low profile. Slightly balding, bespectacled, and dressed in ill-fitted suits, he had few legislative victories or public accolades. His fellow congressman from Rhode Island, John E. Fogarty, was a different matter. Fogarty, dashing and with a full head of hair and a bow tie, was a political superstar. Fellow congressmen and journalists across the nation called him "Mr. Public Health," credited him with building the National Institutes of Health and saving the lives of millions of Americans.[2]

But 1957 proved to be an unusual year. Newly labeled *senior citizens* organized and agitated for change. At golden age clubs, city rallies, and letter writing campaigns they urged their officials in Washington to "do something" on their behalf. Their voice and their vote were persuasive. The recently merged AFL-CIO also pressed for change. Under the able leadership of its head of Social Security, Nelson Cruikshank, the AFL-CIO revived Ewing's dormant bill and began a nine-year skirmish to pass federally funded health insurance for the elderly. Congressman Forand would become the face of the bill, while Congressman Fogarty would squirm, for a time, in its shadow.

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[1] Cicero, *Cato Maior De Senectute*, http://penelope.uchicago.edu/Thayer/E/Roman/Texts/Cicero/Cato_Maior_de_Senectute/text*.html
[2] Howard A. Rusk, M.D., "Mr. Public Health: Death Ends Efforts by Rep. Fogarty To Give U.S. Freedom From Disease," *New York Times*, January 15, 1967: 54.

Although a Democrat and outward supporter of Forand's plea to give health insurance to social security recipients, Fogarty would come to advance an alternative to federal health insurance for the aged. As the National Institutes of Health's most ardent supporter, he believed that the problem of old age could be ameliorated through bio-medical research into the diseases of old age, a government office solely dedicated to coping with the problems of the aged, and initiatives that stimulated local and state action. Fogarty believed that bio-medical advances would eventually cure the diseases of old age; Forand believed that the elderly first needed to be able to afford available medical care.

In January of 1958, Fogarty offered a solution that he believed would stall rash action on the Forand bill, allow some time for the states to articulate their own policies, and remind elder Americans that politicians across the country cared about their plight. He proposed a White House Conference on Aging (WHCA), which would take place at the start of 1961.[3] For the second time, the government would host a national gathering on the problems of old age. This time, the capacious definitions of old age, its attendant problems, and the appropriate policy solutions would be largely tapered into a single phrase: health insurance.

In the decade since the Federal Security Agency's 1950 Conference on Aging, convergent trends aligned and a powerful coalition made up of labor activists, Democratic politicians, and even a presidential candidate came to believe that the problem of old age, which they primarily understood as financial indigence due to

[3] The White House Conference on Aging was originally slated to take place on December 31, 1958, but was then pushed back until January 9 of 1961. *See The Nation and its Older People: White House Conference on Aging,* Washington, D.C.: U.S. Department of Health, Education, and Welfare, Special Staff on Aging, 1961.

considerable medical needs, could be solved by extending social security to cover limited health care. This logic became so persuasive that even objections to the Forand bill came to be packaged in alternative health insurance or health care proposals.

In the lead-up to 1961, the Forand coalition accrued strength by strutting its secret weapon: a mass of politically toned seniors with the proven power to swing elections. This septuagenarian force came to believe that health insurance would relieve their ailments, convincing the nation that old age need not be bravely faced when it could be legislatively solved.

II. Bye Bye Oldsters Hello Seniors

Following the first National Conference on Aging in 1950, cities and states across the country feted their oldsters. In 1953, Chicago lauded its seniors with a festival titled "Golden Years for Oldsters," a campy celebration where a crowd of over 1000 crowned an elderly couple at a "golden wedding."[4] In 1954, the city followed up with "Seniorama," a theatrical "Tableaux" highlighting the many craft skills of Chicago's oldsters.[5] In states from California to Georgia to Pennsylvania, governments and welfare groups offered the aged free weeks at summer camps and catered sailing trips.[6] In New York, the welfare department and the St. John's Guild entertained 600 elderly with a cruise to Bear Mountain replete with "sandwiches, milk, fruit juice, and cookies."[7] And

[4] "Festival of Golden Years For Oldsters To Draw Thousand," *Chicago Daily Tribune*, June 26, 1953: 3.
[5] Lois Baur, "Seniorama to Be Held Wednesday," *Chicago Daily Tribune*, May 23, 1954: e4.
[6] "59 Oldsters enjoy one week of camp activity," *Afro-American*, Baltimore, MD, July 3, 1954; "Smile When you say 'Old' To These Sprightly Ladies," *Philadelphia Tribune*, July 24, 1954: 9.
[7] "600 'Seniors' Sail to Bear Mountain,' *New York Times*, July 21, 1953: 21.

in California, Glendale Family Services received rave reviews for giving every oldster a dollar in a Christmas card at its annual Christmas Dinner.[8]

Aged Americans did not mind the pandering or the praise. What they did mind was being called "oldsters." Following a riveting performance by an "orchestra of septuagenarians," Samuel Samuels of the William I. Sirovich Day Center at 203 Second Avenue, faced a crowd of 400 aged New Yorkers in 1953 and announced: "'We don't want to be called 'old man or old woman, we are senior citizens.'"[9] Three years later, the conundrum of what to term old people prompted the *Journal of Lifetime Living* to conduct a survey where they asked "mature men and women" what they wanted to be called. Oldster was officially out, elder was "slightly more acceptable," and the winning term, embraced by over 53% of those polled was "senior citizens."[10] Even a "little brown lady with silver hair" prickled when a reporter for the *Pittsburgh Courier* deigned to use the phrase "golden years." "We don't like the word," she replied. "We prefer to be called 'senior citizens.'"[11] By 1958, the name change had crossed the Atlantic where elders in the U.K. requested the title "senior citizens" at that country's annual conference of the Institute of Housing.[12]

The term *senior citizen* first arrived in the printed media in 1938, in a *Time* magazine article about politics in "the great and screwy State of California." In a state prone to fear its "oldsters," the Democratic candidate for senator, Sheridan Downey, *Time* reported, "had an inspiration to do something on behalf of what he calls, for

[8] "Senior Citizens to be Feted Tuesday," *Los Angeles Times*, December 16, 1956: J8.
[9] "Old Folk Become 'Senior Citizens,'" *New York Times*, May 19, 1953: 27.
[10] "What's in a Name??" *Philadelphia Tribune,* October 2, 1956: 6.
[11] "Don't Say 'Golden Years' They'd Rather be called Senior Citizens," *Pittsburgh Courier*, April 6, 1957.
[12] "Renaming of Old People Suggested," *Manchester Guardian*(U.K.), September 2, 1958.

campaign purposes, 'our senior citizens.'"[13] The term lay dormant during the war, only to resurface with a vengeance in the 1950s.

In 1952, Thomas C. Desmond, the great advocate for the aged and New York state senator, announced the country's first "Senior Citizens Month" with an admirable statistic, "New York State's elderly citizens are producing an estimated total of $1,000,000,000 a year in goods and services."[14] Other states, such as Massachusetts, Pennsylvania, Illinois, Florida, and Maryland, to name only a few, soon followed by offering their own Senior Citizens Day, Week, or Month.[15] In 1956, New York City trumped them all by actually renaming Times Square "Senior Citizens Square" for a twenty-four hour period. By 1959, Senator Norris Cotton (R-New Hampshire), proposed a bill to make the movement national and declare the fourth Sunday in September, "Senior Citizens Day."[16]

In less than a decade, seniors' push to rebrand worked. The aged had transformed themselves from needy and grateful charity recipients called oldsters to capable and strong senior citizens. They went from a group whom others talked for and about, to one with its own increasingly public and persuasive voice. In the 1950s, commented sociologist Arnold Rose, "the elderly themselves…became 'aging conscious.'"[17] The term itself reflected the burgeoning self-awareness that one's chronological situation could be fabricated into a vibrant political identity. This transition was aided, and

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[13] "Men Under the Moon," *Time*, October 24, 1938: 14.
[14] "Older Workers Hailed," *New York Times*, April 28, 1952: 16.
[15] Don Stirling Raymond, "Senior Citizenry Hailed," *Christian Science Monitor*, May 4, 1954: 12; "City to Celebrate Sr. Citizens Wee," *Philadelphia Tribune*, April 10, 1956: 7; "'Senior Citizens' Month Proclaimed," *Washington Post*, April 23, 1957: B9.
[16] "Proposed Bill Would Honor Elderly Folk," *New Journal and Guide* (Norfolk, VA), February 11, 1959: 15.
[17] Arnold Rose, "Political Implications," in Clark Tibbitts and Wilma Donahue, eds., *Politics of Age: Proceedings of the University of Michigan 14th Annual Conference on Aging*, Ann Arbor, Mich., June 19–20, 1961 (Ann Arbor: University of Michigan, Division of Gerontology, 1962), 138.

arguably even prompted, by the creation and rapid growth of senior centers and golden age clubs following the Social Security Act and World War II.

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Centers for older people began cropping up across the country in the early 1940s.[18] Designed as hobby, leisure, or social clubs for a new class of retired elders, these centers offered a warm place to play checkers, practice sewing, or simply have much needed conversation. By the early 1950s, religious groups and local governments across the country had opened centers for the elderly. As a representative from the Episcopal Church remarked to the *Washington Post* in 1952, "hundreds of clubs known as Golden Age, Senior Citizens, Senior Leaguers, and other names have mushroomed all over the country. Their object is to provide programs to keep persons 60 and over interested and youthful."[19] As local papers filled with announcements welcoming any retirees to weekly meetings, checker tournaments, and craft contests, crowds soon required larger spaces. In 1957, the demand even prompted the city of Chicago to build a twenty-room headquarters for more than 700,000 participating seniors.[20]

By 1957, there were over 200 golden age clubs in the State of New York alone, peppered from Staten Island to Niagara Falls. Their origins were as varied as their stated purposes. Senator Desmond claimed that they were "true 'do it yourself' operations," often created by a "single senior citizen." The really successful ones, he observed, the ones with energized leaders and top-notch programming, strategically affiliated with

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[18] *See* Jean M. Maxwell, *Centers for Older People, Guide for the Programs and Facilities: The Report of a National Council on the Aging Project* (New York: National Council on the Aging, 1962).
[19] "Episcopalians Start Golden Age Program," *Washington Post*, May 10, 1952: 9.
[20] "Open 20-Room Center For Headquarters for the Aged," *Chicago Defender* May 4, 1957: 5.

service clubs, large organizations, or religious groups.[21] Even Desmond seemed to realize that these clubs, which presented themselves as simple social organizations, could quickly become more robust forums for social action.

In a profile piece for *Commentary Magazine,* Sylvia Rothchild charted such a transformation at a golden age club called Hecht House in Dorchester, Massachusetts. She described an opening day filled with anxious elders waiting at the door. Six men arrived an hour early and, with nowhere else to go, spent the time "fingering their newspapers" and "waiting for someone to open the door." Each day, the crowd grew, twelve became twenty-five and soon elders across the area "poured into the center."[22] Like similar clubs, the one at Hecht House was meant to be a lounge, "where older people could meet friends, read, hear lectures, play checkers and other games."[23] And again, as at so many other meeting areas throughout the country, social workers and volunteers urged members to "govern themselves." Rothchild described how the group "rapidly elected officers, appointed committees, and began to make their own rules, play their programs, and become independent of their sponsors." This process and the club itself "meant so much to each individual"; it was not an addition to busy lives, Rothchild argued, it was their lives. The club "was a substitute for work," she continued, "a more comfortable home…for many it was the only contact with the world."[24]

"Though they came for recreation, they did not leave their problems at home," she wrote.[25] Discussions drifted from the need for more part-time jobs, to the intricacies of old age assistance, hospital care, and housing. Participants asked the appointed group

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[21] Stafford Derby, "New York: Golden Age Clubs," *Christian Science Monitor*, February 28, 1957: 20.
[22] Sylvia Rothchild, "From the American Scene: Sixty-Five and Over," *Commentary* Vol 18. (1954): 549.
[23] Rothchild, 555.
[24] Rothchild, 555.
[25] Ibid.

worker at Hecht House to invite speakers on these topics and gather useful information. On one particular day, Rothchild reported an interchange among a group of men who often shared competing tales of who had the "worst landlady." One man described his urgent need for "a room and a bathtub for five dollars a week," and tried to "interest the community in a lowcost housing project for older people."[26] The conversation escalated. A few days later, Rothchild recounted, the oldest man in the club walked in and declared, "'Men we need to be strong and fight the politicians.'"[27] The elderly began to slowly turn their attention to politics and transform themselves from the recipients of inadequate charity to organized senior citizens.

Although much political organizing in senior clubs arose organically, other forms were strategically implanted. In his study of golden age clubs in Cleveland, Ohio, the historian William Graebner argues that the movement was always a form of top-down social control. Responding to fears that elders had become political pawns in Hitler's Germany or Francis Townsend's pension movement, social workers, welfare agencies, and academics in Cleveland decided that America's aged would be best controlled through community integration. In Graebner's words, "The Golden Age Clubs were designed to reintegrate an embittered and isolated older generation into American social life and, more important, to insure that older persons properly studied political issues, voted for major party candidates, shunned Townsend and other undesirable leaders, and otherwise acted like reasonable and responsible Americans." By 1952, Cleveland-style golden age clubs had mushroomed to 35 clubs with over 2000 members across the

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[26] Ibid.
[27] Ibid.

Midwest and East Coast.[28] Whether the senior citizen movement emerged through manipulation or spontaneous need, by the middle of the 1950s politicians and social scientists began to take notice.

In a prophetic article published in the 1954 issue of *The Journal of Gerontology*, political scientist Abraham Holtzman turned his attention to the peculiar rise of "independent political action" by America's aged population.[29] Opening with a bit of narrative history, he reminded readers "protection for the old was provided in varying degrees by most of the major countries of the world long before our Congress was compelled to deal with this problem in the depression decade of the 1930s." While forces such as industrialization, urbanization, and reduced infant mortality affected America and Europe equally, a strong labor movement and Socialist party in European countries, Holtzman argued, "preempted the role which old age pension movements fulfilled in the United States."[30] The pension movement and its incarnation in broader senior political agitation was simply due to a lack of a strong labor movement that could have obtained more expansive social programs from the federal government. Today, he augured, "An aggressive, influential labor movement now concerns itself with politics. Its leaders have committed themselves to a campaign, political as well as economic, to ensure the future security of their members."[31] He predicted that the aged would "continue to agitate American politics."[32] Holtzman was right. The newly merged AFL-CIO and its unflappable head of Social Security, Nelson H. Cruikshank, would serve, inspire,

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[28] William Graebner, "The Golden Age Clubs," *Social Science Review*, The University of Chicago, September 1983: 416–17.
[29] Abraham Holtzman, "Analysis of Old Age Politics in the United States," *The Journal of Gerontology*, Vol. 9, No. 1 (January 1954): 56.
[30] Holtzman, 57.
[31] Holtzman, 63.
[32] Holtzman, 64.

persuade, partner with, and sometimes simply use senior citizens to advance its political agenda, which at the close of the 1950s was a focused drive to give social security recipients health insurance.

III. If At First You Don't Succeed…
Nelson Cruikshank and the Revival of Health Insurance for the Elderly

Nelson Hale Cruikshank was a tall man with clear values. Born in the undistinguished town of Bradner, Ohio, to a distinguished father, he grew up in a household with an uncompromising sense of right and wrong. His father began his career as a grain dealer and soon established a "sizeable business," representing the Cruikshanks on the Toledo produce exchange.[33] His son recalled a religious man who was ahead of his time. A man who brought the teachings of Walter Rauschenbusch and Harry Ward to the dinner table and was as impeccable with his words as his actions.[34] In one story, the younger Cruikshank liked to share, his father stood up to the entire Toledo exchange. The other merchants wanted to "push him to the wall" if he didn't agree to set the price of grain paid to all the farmers, and the elder Cruikshank "stood on the floor of the exchange of said, 'You can ruin me and you can make me bankrupt, but you can't make me do this.'"[35]

His father survived that Toledo coup, only to succumb, years later, to the financial upheaval of the Depression. "The grain business," his son recalled, "was pretty well shot."[36] Despite growing up with resources, Cruikshank had spent his youth working. He

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[33] Nelson H. Cruikshank and Peter A. Corning, interviewer, "Reminiscences of Nelson Hale Cruikshank," Columbia University Oral Histories, Social Security Project: Oral History (1965), 412–14.
[34] Ibid., 416.
[35] Ibid., 414.
[36] Ibid., 416.

started as a deck hand on freighters on the Great Lakes, where he joined his first union, the Seafarers' Union.[37] With his father's income diminished, Cruikshank decided to help his family by paying his own college tuition at Ohio Wesleyan, a Methodist university attended by his father, grandfather, and grandmother. At Ohio Wesleyan, Cruikshank studied economics and theology. After graduation in 1925, he enrolled at Union Theological Seminary after hearing that Harry Ward was on the faculty and Reinhold Niebuhr might be coming.[38]

Cruikshank began his ministry as the country's fortunes decomposed. He started out as an assistant pastor of a small church in Brooklyn, but soon moved into relief work, or what he described "as the only expanding industry…in the city."[39] He eventually took over the relief work for the Brooklyn Federation of Churches and realized that the Protestant church, unlike the Catholic Church or agencies such as United Jewish Appeal, did not have a highly functioning social service agency, because it had previously catered primarily to middle-class families. After a few years building the agency, Cruikshank decided that he was just "putting shin plasters on a sick economy."[40] He moved to New Haven, Connecticut, and, for a few years, cobbled together a career between churches and the Workers' Education Bureau. In 1933, he got his first stint as a part-time labor organizer, for the American Federation of Labor.[41] Although he would eventually settle down in a permanent position with the AFL, he spent the interim years bouncing between the Works Progress Administration, Farm Security Administration, and the War

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[37] Nelson H. Cruikshank, Alice M. Hoffman, and Howard S. Hoffman, *The Cruikshank Chronicles: Anecdotes, Stories, and Memoirs of a New Deal Liberal* (Hamden, CT: Archon Books, 1989), 2.
[38] Ibid.
[39] Ibid., 418.
[40] Ibid., 419.
[41] Ibid.

Manpower Commission. In 1944, the AFL hired Cruikshank to direct the organization's Social Security department.[42] His first order of business was to coordinate the national health insurance lobbying efforts of the AFL and the Congress of Industrial Organizations (CIO), at the time one of the few points of agreement between the two great labor organizations.[43]

The AFL and the CIO hoped that something like Britain's National Health Service would take hold in the United States.[44] From 1944 until 1954, Cruikshank fought, unsuccessfully, for national health insurance while pushing for the expansion of prepaid group practice plans at a local level. As Jennifer Klein writes in her pivotal book, *For All These Rights: Business, Labor, and the Shaping of America's Public-Private Welfare State*, "During this initial phase of health insurance activism the labor movement saw health security as a two-tiered project: a federal government subsidy for insurance nationally and group practice plans at the community level."[45] Cruikshank believed that the country's retired workers deserved health security as a right and that addressing their health care needs was a policy priority worth pursuing from every angle.

One of the more interesting and less reported failures of this partnership was labor's support of the Health Insurance Plan of Greater New York (H.I.P.), an HMO-style health collective started by Fiorello La Guardia in 1944. H.I.P. offered prepaid medical care through group practices. As one flyer advertised, for "one modest premium," members of H.I.P. would receive "comprehensive care" from family doctors, specialists, and surgeons. Preventative care, home care, and hospital care would all be covered

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[42] Cruikshank, Hoffman, and Hoffman, The Cruikshank Chronicles, 108.
[43] "Reminiscences of Nelson Hale Cruikshank," 29.
[44] Cruikshank, Hoffman, and Hoffman, *The Cruikshank Chronicles*, 121.
[45] Jennifer Klein, *For All These Rights: Business, Labor, and the Shaping of America's Public-Private Welfare State*, (Princeton: Princeton University Press, 2003), 160.

without “bills,” “claim forms,” or “red tape.” And with H.I.P. “doctors don’t earn more when you’re sick. They’re paid to *keep you healthy.*”[46]

In 1949, Cruikshank traveled to New York to reach out to “more than a score of ranking AFL leaders,” and explain the value and urgency of programs like H.I.P. AFL leaders, he told the crowd, “must not wait for Congress to pass compulsory national health insurance.”[47] On January 15, 1954, Cruikshank publically supported H.I.P. before the House Committee on Interstate and Foreign Commerce:

> As our members continue to gain experience with the orthodox type of commercial insurance and medical society plans, that experience is being reflected in increasing dissatisfaction and disillusionment. Some unions have found the answer by joining comprehensive, group-practice prepayment plans such as HIP and Permanente.... I believe that plans of this type have a great potential and hold great promise as one avenue toward a solution of the health problems of a substantial number of the people of this country. They stand as an example of what can be done, and of what the commercial insurance and medical society plans so notably fail to do.[48]

While the AFL sought to bolster H.I.P., the American Medical Association sought to destroy it. The organization used its medical code of ethics to condemn “any public advertising designed to attract prospective members for a prepaid group-health plan.”[49] Without public advertising, programs like H.I.P. would never be able to compete. Although the AMA would eventually reverse this ruling, the damage had been done. When the AFL and CIO joined forces , they wanted a new strategy, one that no longer

[46] H.I.P Flyer, MSS 1002, Box 5, Folder 26 , Nelson Cruikshank Papers, 1927–1989, Wisconsin Historical Society.
[47] Oliver Pilat, “Department of Labor,” *New York Post Home News*, May 19, 1949.
[48] Excerpts from Nelson H. Cruikshank, Director of Social Insurance Activities, American Federation of Labor Before the House Committee on Interstate and Foreign Commerce, January 15, 1954 (put out by H.I.P.) MSS 1002, Box 5, Folder 26, Nelson Cruikshank Papers.
[49] Edward P. Morgan Broadcast, February 18, 1955, American Broadcasting Company, *New York Post*, May 14, 1954, in MSS 1002, Box 5, Folder 26, Nelson Cruikshank Papers.

relied on the specter of national health insurance or the precarious stature of prepaid groups plans.

The merger of the AFL and CIO in 1955 united over 15 million workers.[50] Even before the merger took place, both organizations had revved up their political organizing, partly in reaction to the 1952 Republican election sweep.[51] After the merger, the AFL-CIO kept up the momentum, establishing a Social Security Committee with Cruikshank at the helm and setting up a multiyear lobbying strategy to reduce the shortcomings in the social security act.[52]

When it came to Social Security legislation, observed Cruikshank, "there was no ideological difference between the AFL and the CIO." His little department "was the first point of agreement."[53] In the spring of 1955, the AFL-CIO leadership decided that "there were two major gaps" in the Social Security Act they wanted to close: "[O]ne was the lack of coverage for permanent and total disability, and the other was the hospital or medical protection for the retired."[54] National Health insurance had failed to draw support for over a decade, and the AFL-CIO craved a new strategy.

Cruikshank, perhaps more than anyone at the time, knew the struggle ahead. He had been studying, and losing to, the AMA for over fifteen years. Even his past wins were, in retrospect, strategic losses. In the 1940s, he had started with Morris Fishbein, the combative spokesman for the AMA. Cruikshank wanted to expose him for a fraud: "People just wouldn't believe that here was a sheer propagandist, a guy that just made up

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[50] *See* Robert H. Zieger, *American Workers, American Unions, 1920–1985* (Baltimore: Johns Hopkins University Press, 1986); Jill S. Quadagno, *One Nation, Uninsured: Why the U.S. Has No National Health Insurance*, New York vols. (New York: Oxford University Press, 2005), 53; and Nelson Lichtenstein, *State of the Union: A Century of American Labor* (Princeton University Press, 2002).
[51] Zieger, *American Workers, American Unions*, 204.
[52] "Reminiscences of Nelson Hale Cruikshank," 17.
[53] Ibid., 57.
[54] Ibid., 17. *See* also Quadagno, *One Nation, Uninsured*, 53.

evidence as he needed it. And he developed that trick, incidentally, of always giving something that sounded like an absolutely authentic statistic. If he wanted to say that around 15 percent of a certain group suffered mortality from this or that, he wouldn't know at all, but he would say at '15.36 percent.'"[55] Cruikshank watched as Fishbein developed his false-precision technique, first on the radio and then on television, where no respondent had the time to counter his numbers. Eventually, Cruikshank realized that the best way to deal with the AMA and Fishbein would be to "debunk the man and not his facts."[56] If he could destabilize Fishbein's veneer of honesty, all of the facts would be subject to doubt.

Cruikshank's eureka moment came in the form of a small article, "Dr. Pepys's Diary," written in the *Journal of the American Medical Association*. There, Fishbein's week-long trip to London was recorded in delicious detail. After an entire week spent cavorting about town, the eminent doctor spent exactly "an hour at the headquarters of the British Health Service." After asking about "some of their forms" he "dashed…to the airport and read a detective story on the way from London to Paris."[57] On February 22, 1949, on the nationally broadcast "Town Meeting on the Air," Cruikshank loaded his bullet. As doctors piled into the public event, a lone labor lawyer approached Cruikshank and asked, "How can I help you?" Cruikshank responded, "Ask Fishbein what he knows about the British Health Service." As audience questions rolled in, the lawyer stood up to face Fishbein and asked, "[H]ave you had a chance to study the British Health Service, and what is your appraisal of it?"[58] Fishbein responded "yes" and went on to give his

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[55] "Reminiscences of Nelson Hale Cruikshank," 180.
[56] Ibid., 181.
[57] Ibid., 184–185.
[58] Ibid., 185–186.

abysmal review of the Service. Seizing his moment, Cruikshank leapt to the floor, grabbed the microphone, and with the article in hand "read the damn thing." He told the audience how Fishbein "was dined by Lord Moren, how he was out at the races at Ascot, how he was here and there, the whole week, and then said, "and finally he ended up with one hour," at the British Health Service, "before he dashed off to the airport and put his nose in his detective story."[59] The audience revolted, Fishbein was discredited and eventually barred by the AMA from being on air. Cruikshank had a short moment in the sun before he realized his blunder. His personal triumph was a major political misstep. The only result from this hubristic performance was that, "the AMA got an awful lot smarter."[60]

Cruikshank would not make that mistake again. To achieve any form of health insurance, the AFL-CIO would have to ploddingly outmaneuver and outwit this commanding organization. In 1956, he decided to go slowly and assess the AMA's legislative strength. He wanted a "limited objective" and an "attainable" goal."[61] Before attempting health insurance for the aged, the AFL-CIO would test the AMA's muscle with disability insurance.[62] As the political scientist Robert Hudson would later surmise, "if anyone had a better claim than the elderly to the title of deserving poor it was the disabled worker."[63] The disability insurance bill, which had come close to passing before, was modest in its approach. It added to the existing social security program cash benefits

[59] Ibid., 187.
[60] Ibid., 187.
[61] Ibid, 17.
[62] Wilbur J. Cohen, director of research for the Social Security Administration, had been pushing for disability insurance for years. For more on this *see* Edward D.Berkowitz, *Mr. Social Security: The Life of Wilbur J. Cohen* (Lawrence: University Press of Kansas, 1995), 23; and Theodore R. Marmor, *The Politics of Medicare*, 2nd ed. (New York: A. de Gruyter, 2000).
[63] Robert B. Hudson, *The Aging in Politics: Process and Policy* (Springfield, IL: C. C. Thomas, 1981), 78.

for totally and permanently disabled persons aged fifty and over.[64] In addition, the bill avoided the sting of socialized medicine by allowing private medical practice to retain its payment structure.[65] Still, the AMA opposed the bill, because some physicians worried that the government would be interfering in the doctor-patient relationship by offering a standard for determining if a person was disabled, despite a provision that left the determination up to doctors.[66]

On July 17, 1956, the Disability amendment to the Social Security Act passed the Senate, but only by a hair. Cruikshank, breaking Senate rules, was ambling up in the gallery when Lyndon Johnson, gestured for Cruikshank to join him "in that little private office of his."[67] Johnson, peering at Cruikshank demanded, "How many votes do you think you've got." When Cruikshank responded, "we had about 50," Johnson countered, "You have like hell. You're about three votes short right now.… I'll tell Walter George to keep on talking for an hour and in that hour you've got to round up those three votes."[68] Johnson suggested the three names, Cruikshank got the votes, and in 1956 Americans got disability insurance. For the AFL-CIO, the win on disability was, in Cruikshank's words, "a kind of wedding ceremony." Disability insurance demonstrated "that the AMA could be defeated."[69] It was now time to tackle health insurance for the aged.[70]

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[64] Peter A. Corning, *The Evolution of Medicare: From Idea to Law*, (Washington, D.C.: Office of Research and Statistics, U.S. Social Security Administration, 1969), 75.
[65] Hudson, *The Aging in Politics*, 78.
[66] Corning, *The Evolution of Medicare*, 75.
[67] "Reminiscences of Nelson Hale Cruikshank," 44.
[68] Ibid.
[69] Ibid., 57.
[70] Quadagno, *One Nation, Uninsured*, 53.

The idea for Medicare, Cruikshank always claimed, came from the people not the leadership.[71] "We never had to sell the medicare notion at all," he recalled, "There were a lot of demands for it."[72] "Our people were really hurting…people that were middle-aged and trying to send their kids to school were being hit by the old people's medical bills and union meetings all over the country were discussing this…. This was a felt need. There was nothing cranked up about this at all."[73] While the impetus might have bubbled up from the bottom, Cruikshank wasted no time unifying old age groups to pursue his legislative agenda. In the waning months of 1956, he launched a multiyear, multipronged, full-force battle to secure health insurance for retired Americans.

Cruikshank took up where Oscar R. Ewing left off, working with Robert Ball, I. S. Falk, and Wilbur Cohen on a bill that would retain the logic of the 1952 Murray-Dingell bill but extend coverage.[74] Labor leaders wanted to retain the same health coverage they had won through collective bargaining.[75] As the journalist Richard Harris notes in his treatment of Medicare, "pressure from the membership was to gain for a man and his wife during retirement years the same protection they had while employed."[76] While the bill's crafters settled on a 0.5% tax increase, sixty days of hospitalization, and another sixty days of nursing home care, they were split on the extent of other forms of

[71] *See* chapters II and III for more about how the incremental approach to health insurance developed. The incremental approach is also well discussed in Jaap Kooijman, *—and the Pursuit of National Health: The Incremental Strategy toward National Health Insurance in the United States of America* (Amsterdam: Rodopi, 1999); Marmor, *The Politics of Medicare*; and Monte M. Poen, *Harry S. Truman Versus the Medical Lobby: The Genesis of Medicare*, (Columbia: University of Missouri Press, 1996).
[72] "Reminiscences of Nelson Hale Cruikshank," 15.
[73] Ibid., 75–76.
[74] Richard O. Harris, *A Sacred Trust* (New York: New American Library, 1966), 72. *See* also chapter III.
[75] For more on this topic, *see* Raymond Munts, *Bargaining for Health; Labor Unions, Health Insurance, and Medical Care* (Madison: University of Wisconsin Press, 1967).
[76] Harris, *A Sacred Trust*, 72.

coverage.[77] Some believed that the bill should include insurance for doctor visits, or, at the very least, surgical benefits.[78] Cruikshank, despite a renewed sense of power, recognized that he would never get through Congress with such an overt challenge to the AMA and nixed anything directly affecting physicians. Ever the strategist, he also thought that politicians in support of the bill could blast on the trail "Look, we're not doing anything with the doctors…. We're not touching the doctors. What are you squawking about?"[79] The team settled on surgical benefits, an inclusion that liberal physicians who supported the bill actually objected to, claiming "if you just had the surgical benefits, you would be putting a premium on carving people up."[80] The compromises did not worry Cruikshank, who never expected the bill to actually pass. In 1957 he held, "we didn't expect to pass it, not that year or the next year. When you first put in a bill like this, you put in a couple of things that you know you may have to give away and also it's a kind of an educational bill and so you stake out what you want."[81] In 1957, Cruikshank did not need a perfect bill, what he really needed was a congressman willing to put his name on the document.

He started with a congressman from Tennessee, Jere Cooper, chairman of the Ways and Means Committee, the committee largely in control of social security and income taxation.[82] Cooper supported the bill but simply did not want to take on a big fight while in poor health. After Cooper, Cruikshank and the AFL-CIO's Director of the

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[77] James L. Sundquist, *Politics and Policy: the Eisenhower, Kennedy, and Johnson Years* (Washington: Brookings Institution, 1968), 296.
[78] "Reminiscences of Nelson Hale Cruikshank," 24.
[79] Ibid., 25.
[80] Ibid., 26.
[81] Ibid., 26.
[82] For more on the Ways and Means Committee, *see* John F. Manley, *The Politics of Finance: The House Committee on Ways and Means*, (Boston: Little, Brown, 1970); Julian E. Zelizer, *Taxing America: Wilbur D. Mills, Congress, and the State, 1945–1975*, (New York: Cambridge University Press, 2000).

Department of Legislation, Andrew Biemiller, went down the ranks of the Ways and Means Committee. His team failed to persuade the all-powerful Congressman Wilbur Mills (D-Arkansas) to join the effort and finally approached the fourth-ranking member of the committee, the unassuming congressman from Rhode Island, Aime Forand.[83]

IV: Becoming Mr. Senior Citizen

Until he entered Congress, Forand had little financial stability. Born on May 23, 1895, in Fall River, Massachusetts, he moved to Rhode Island at the age of twelve and by thirteen had to leave school.[84] His father had developed cataracts and was quickly going blind. With his father out of work and a family of ten to support, Forand started working sixty hours a week in a local cotton mill. With "ten mouths to feed on $8 a week," he was still "determined to get some kind of education."[85] He saved up about fifteen cents a week and used the money to take extension courses in shorthand and typing. He eventually worked his way up to the weaving shed of the mill, "cleaning bobbins as they'd come off the looms," so he could practice his typing in the afternoons. This was a man who knew how to master a skill: "When the radio came in I sat by the radio and I'd take down all the speeches I could. When I'd go to church, I'd take down the sermons. I was taking advantage of anything that was coming down the pike."[86] Before leaving to fight in World War I, he secured a job as a bookkeeper at a local metal company, but when he returned home as a sergeant major, steady employment eluded him. He drove a

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[83] "Reminiscences of Nelson Hale Cruikshank," 20. *See* also Henry J. Pratt, *The Gray Lobby* (Chicago: University of Chicago Press, 1976), 53.
[84] Aime Forand and Peter A. Corning, interviewer, "Reminiscences of Aime Forand," Columbia University Oral Histories, Social Security Project: Oral History (1966), 1.
[85] Ibid., 2.
[86] Ibid., 4.

three-ton gravel truck, a dump truck, "did pick and shovel work," and worked in a grocery and a bakery. In his words, "It's easier for me to say what I did not do than what I did do."[87]

In 1922, he started his career in politics, working odd jobs to support a position in the state legislature. After a short stints as a journalist, a congressional aide, and an expert on state veterans' relief for the governor's office, he ran for Rhode Island's 1st Congressional district. In 1936, Aime Forand packed up his belongings and took his first relatively stable job as a United States congressman.

Outside of his coveted position on the Ways and Means Committee, Forand had little to show for his congressional career in 1957. Although he had carved out a set of legislative interests, including the plight of veterans and the unemployed, few of his bills ever passed.[88] In 1949, he lost a public fight to increase benefit payments to the unemployed. [89] When Cruikshank first approached Forand, the congressman vacillated. "Seizing" on Forand's hesitation, Cruikshank and his colleagues pushed forward, persuading him, wrote Harris, with repeat visits, "descriptions of the bill's merits and all sorts of assurances to ease his misgivings."[90] At the very close of the session, on August 27, 1957, Forand agreed to submit the bill. Cruikshank remembered the event as "perfunctory" and told the following story: "Finally, when we were pressing him, it was near the end of the session, he said, 'Well, you boys assure me that this is all right and that this is soundly drawn,' and we said, 'Yes.' He said, 'All right, I'm just not going to

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[87] Ibid., 6.
[88] Scrapbook 1944, "Newport News," 8/09/46, Box 7, Aime J. Forand Papers, 1918–1972, Providence College, Rhode Island.
[89] Scrapbook 1949, p. 62, "Providence Journal," 6/26/54, Box 7, Aime J. Forand Papers.
[90] Harris, *A Sacred Trust*, 73.

have time to read it, but I'll put it in and I'll read the speech.' That's how it became the Forand bill."[91]

In Forand's recollection, his interest in health insurance for the aged was anything but perfunctory. He explained his commitment through his own family's history with poverty and the debilitating health of his father.[92] And, to those who asked, he eagerly related his long legislative commitment to this issue: in 1923 he helped the Fraternal Order of Eagles provide pensions for seniors, throughout his career he committed himself to soldiers' relief, and from the "minute" he got into Congress he "seemed to gravitate to the welfare field."[93] In 1957, Forand believed that Cruikshank and crew came to him because his "record was established in the welfare field…they knew I'd been searching for something."[94] In his memory, he even made some changes to the bill before deciding to drop "the bill in the hopper."[95] Despite divergent origin stories, the outcome of Forand's decision to submit the bill was conclusive. Congressman Aime Forand became Mr. Senior Citizen, the great champion of America's ill and deserving elderly.

Forand did not have to wait long to reap the rewards of attaching his name to the bill. Before he submitted the document, Cruikshank had contacted the *Providence Journal's* Selig Greenberg, a journalist with an interest in the problems of old age. Greenberg and the *Journal* praised the bill and Forand for such a progressive piece of legislation. "Before long," quipped Harris, "Forand had become far more interested in the measure and far more optimistic about its prospects."[96]

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[91] "Reminiscences of Nelson Hale Cruikshank," 426.
[92] Ibid., 17.
[93] "Reminiscences of Aime Forand," 18.
[94] Ibid., 20.
[95] Ibid., 20.
[96] Harris, *A Sacred Trust*, 73.

The *Providence Journal* was just the beginning. Within a year, citizens across the country joined, the Forand "crusade," as journalist and policy maker James Sundquist termed it.[97] The bill's immediate popularity took everyone, even Cruikshank, by surprise. Was this a sign of the AFL-CIO's spectacular organizing, a truly grassroots effort from seniors, or a reaction to the AMA's publicized objections? Aime Forand often remarked that the "AMA has published this bill better than I could have done myself."[98] The AMA would eventually increase its lobbying budget "five-fold" to fight the policy.[99] On October 11, 1957, the *Congressional Quarterly* reported "Lobbies and population figures are pushing Congress toward a decision on Federal medical insurance for the aged."[100]

By 1958, the bill had become so popular that presidential hopeful Senator John F. Kennedy sent staff members over to Forand to help draft his own version.[101] Within three years, legislation that had barely made it to the floor, Sundquist observed, "would become what some considered 'the foremost issue in the presidential campaign.' It would be the subject of more congressional mail, at least in some offices, than any other bill."[102] The prospect of an actual bill that would reduce the costs of old age ignited seniors and gave the movement something specific to rally around. For almost a decade, elders had been urging that something be done on their behalf. Now, they had a policy, centers to help them organize, and the strength of the AFL-CIO. If elders voiced a myriad of problems in the early 1950s, by the late 1950s they were mobilizing around one solution, the Forand bill.

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[97] Sundquist, *Politics and Policy*, 297.
[98] "Reminiscences of Aime Forand," 21.
[99] Marmor, *The Politics of Medicare*, 24.
[100] "Increase in Oldsters Pushes Medical Insurance Decision," Congressional Quarterly, October 11, 1957.
[101] "Reminiscences of Aime Forand," 36.
[102] Sundquist, *Politics and Policy*, 297.

As Zalmen J. Lichtenstein, program director of the Council of Golden Ring Clubs, recalled "thousands of elderly people were involved in conferences, neighborhood meetings, distribution of scores of thousands of leaflets printed in English, Italian, Yiddish, and Chinese, in door-to-door canvassing. Clubs, centers, and groups of retirees of churches, synagogues, trade unions, and others joined in this mass education program to enlighten the community about the importance of social security and the need to expand it by including medical care."[103] While some of these groups acted alone, Lichtenstein's collection of Golden Ring Clubs explicitly followed "the same legislative goals and objectives as the Social Security Department of the AFL-CIO."[104]

As elder constituents broadcast their support for the bill, congressmen like John Fogarty, had to face facts. If they were not going to overtly support Forand, they had better find another way to appease the agitated throngs of seniors demanding that something be done in Washington. In 1958, to keep his reputation, "Mr. Public Health" needed his own solution to the problem of old age.

V. Mr. Public Health and The Soft Opposition

Compared to Forand, Fogarty had an easier go at childhood. One of six children, he graduated high school in Glocester, Rhode Island, and followed his father into the bricklaying profession. In 1936 he was elected president of the Bricklayers and Masons

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[103] Zalmen J. Lichtenstein, "Direct Political Pressure Groups" in *Politics of Age: Proceedings of the University of Michigan 14th Annual Conference on Aging*, Ann Arbor, Michigan, June 19–20, 1961 (Ann Arbor: University of Michigan, Division of Gerontology, 1962): 152.
[104] Ibid.

Union, Local No. 1., a title he kept until he won his first Congressional campaign in 1940.[105]

Fogarty excelled as a congressman, garnering power, legislative victories, and hundreds of accolades and awards. He served the second district of Rhode Island for forty-seven years and died, at his Capitol Hill office, the day the ninetieth Congress opened.[106] Fogarty had a brand: across the country his name became synonymous with health. He was the "political architect of the federal government's vast program of medical research," as one reporter put it in 1967. "It is no exaggeration to say that for the past 15 years he was politically the single most important person in medical research in the United States." [107] As the chairman of the Subcommittee of the House Appropriations Committee responsible for Labor, Health, Education and Welfare, Fogarty tended to the budget of the National Institutes of Health, bolstering its funds from 3 million in 1947 to 1.4 billion in 1967, the year of his death.[108] He played a pivotal role in the expansion of funding for medical research that hoped to ameliorate the diseases of old age, such as cancer and heart disease. While few understood why he cared about medical funding, everyone understood how he ably procured his super-sized budgets.

Fogarty, who started his congressional career in naval affairs, began angling for a more powerful appointment at the close of WWII.[109] As the junior congressman from Rhode Island, he reached out to Forand, his senior colleague, asking for his assistance in

[105] James Stewart Healey, *John E. Fogarty: Political Leadership for Library Development* (Metuchen, NJ: Scarecrow Press, 1974), 25.
[106] D. S. Greenbert, "Representative Fogarty Dies at 53," *Science* Vol. 155., No 3759 (January 13, 1967): 180.
[107] Ibid.
[108] Philip H. Abelson, "John Edward Fogarty," *Science* Vol. 155, No. 3762 (February 3, 1967): 523.
[109] Healey, *John E. Fogarty*, 26.

securing an appointment on the Committee on Appropriations.[110] He had been in Congress seven years before he got an appointment he could grow with. In 1947, he made it onto the Appropriations Sub-Committee for the Labor Department and the Federal Security Agency (which, in 1953, became the department of Health, Education, and Welfare). Labor and FSA was actually not his first choice, but he quickly made the most of the appointment, rising to chairman of the subcommittee in 1949.[111]

The chairmanship gave Fogarty the opportunity to actually solve problems. "It's nothing personal," D. S. Greebert reported Fogarty saying, "Nothing happened to me when I was a kid that made me decide that medicine has to be improved. It's just that I feel that as long as people are sick, something has to be done to make them feel better."[112] Fogarty once told a reporter that in 1949 he encountered a young man who couldn't walk without the help of two canes. When Fogarty asked "what's wrong with you?" the man responded that no one had ever heard of it. Fogarty's response to this encounter was to call up the surgeon general and ask about multiple sclerosis: "what it was all about, how many people had it, what were we doing about it. He told me that almost nothing was known about it, and that we weren't doing anything about it. So, I got them $500,000 as a starter to get to work on it."[113]

Fogarty's interest in medical research quickly became a consuming passion. He set out to convince Americans that the best strategy for American prosperity was federal funding for bio-medical research, which he often claimed was the same as public

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[110] John E. Fogarty to Aime Forand, January 4, 1947, Subject Folders, Box 11, Folder 111, John E. Fogarty Papers, 1941–1967, Providence College, Rhode Island.
[111] D.S.G. [D. S. Greenbert], "Fogarty, Medical Research is No Place for Economy," *Science* Vol. 135, No. 3505 (March 2, 1962): 715.
[112] Ibid.
[113] Ibid., 716.

health.[114] “It is my considered opinion,” he announced to the House in 1950, “that public health is one of our foremost instruments of national defense. With the threat of war hovering over our heads, it is foolhardy even to consider the slightest curtailment of any service or project which is directed toward preventing disease and promoting health. More than ever, in a period of national emergency, it is essential that we press forward to more gains against the ravages of sickness.”[115] Not only would medical advances secure the country’s borders, but, Fogarty believed, it would also function as a means of cutting federal expenditures.

He matched this oratorical strategy with a savvy ability to work the legislative process to demand larger and larger budgets for the NIH. Fogarty understood that because appropriations bills start in the House and then make their way to the Senate, he would need an ally in the Upper House. Senator Joseph Lister Hill, a Democrat from Alabama who had already supported hospital growth in the landmark Hill-Burton legislation from 1946, became Fogarty’s ally.[116] Named after Joseph Lister, the great medical pioneer of antiseptic surgery, Hill, like Fogarty, had an inclination to believe that scientific research could solve most, if not all, of the country’s problems.[117]

With the help of the NIH director, James Shannon, Fogarty and Hill implemented a strategy whereby the NIH as well as each of the separate institutes within the NIH could request funds. For example, in the 1943 appropriations budget the NIH’s requested funds included the Microbiological Institute, the National Institute for Neurological Diseases

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[114] For more on the history of public health in the United States *see* John Duffy, *The Sanitarians: A History of American Public Health* (Urbana: University of Illinois Press, 1990).
[115] “Expanded Medical Research is essential to the protection of the Nation.” Speech by Congressman John E. Fogarty, 2nd Rhode Island District, before the House of Representatives—For Release August 23, 1950. Speeches, Box 3, Folder 3, Fogarty Papers.
[116] D. S. Greenbert, “Representative Fogarty Dies at 53,” 180.
[117] Richard Harris, "Annals of Legislation: Medicare," *New Yorker*, July 16, 1966.

and Blindness and other basic medical problems not covered by other institutes. In addition to this overall request, institutes within the NIH such as the National Cancer Institute, the National Heart Institute, the National Institute of Arthritis and Metabolic Diseases, the Institute of Dental Research, and the National Institute of Mental Health, came in with separate budget requests.[118] The result was a majestic increase in the Institutes' overall budget.[119]

Fogarty's budget process began with a hearing. Scientists would come before his subcommittee and instead of defending the budget requests, they would be asked, why not more? Fogarty would demand that his witnesses describe their original budget requests and what happened to that request as it passed through the Bureau of the Budget. But even the original ask would not be enough for Fogarty. He wanted NIH scientists and doctors to dream up what they could do with almost unlimited funds. As a journalist in *Science* divulged, "Fogarty holds the belief that medical research is no place for economy, and after his witnesses pay lip service to the need for centralized fiscal planning, they graciously concede that they could use some more money, and Fogarty piles it on."[120]

Once Fogarty got his number, he would cajole the often-skeptical Appropriations Committee with his "mastery of his subject," "his ability to rattle off lists of lifesaving developments that have resulted from federally financed research, and his glowing predictions of a great break-through around the corner." When the bill arrived on the

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[118] *See* Chapter I for a discussion of the rise of the NIH.
[119] Subject folders, folder 283, box22, 82nd Congress 2nd Session, House of Representatives Report No. 1602 Department of Labor, Federal Security Agency and Related Independent Offices Appropriations Bill, 1953. Mr. Fogarty, from the Committee on Appropriations, submitted this following Report To accompany H.R. 7151, Fogarty Papers.
[120] D.S.G., "Fogarty, Medical Research is No Place for Economy," *Science* Vol. 135, No. 3505 (March 2, 1962): 715–16.

floor, he would be ready "to inundate with facts any economy-minded member who questions the need, and to demand a roll-call vote whenever his budgets are threatened."[121]

If all else failed, Fogarty would look at his colleagues and say that you are either for or against medical research. In the end, during the Fogarty years, the House was always for medical research.[122] The bill would then go to the able hands of Hill in the Senate, where sometimes the number would rise yet again, and then back to conference for a settlement. In 1950, the NIH received 52.1 million dollars; in 1954, 71.15 million dollars; in 1955, 81.268 million dollars—and the numbers would only go up.[123]

Fogarty's evangelical zeal for scientific funding attracted the devotion of doctors, scientists, and financial leaders in the field. Most importantly, his decades long friendship with the savvy and monetarily endowed Mary Lasker gave him the power to move money within and outside of the legislative arena.[124] His intimate relationship with the Laskers' American Cancer Society (ACS) is evidenced by an exchange he had in 1950 over tickets to the Broadway show *South Pacific*. On April 19, John H. Teeter of the ACS wrote to Fogarty, "I don't like to wind up making a request—but I've been asked to try to get tickets for *South Pacific*—for the evening of May 16 or 17. Do you suppose you could help me out?"[125] Fogarty procured the tickets and responded on May 1, "Because of the many requests made of me for tickets I would appreciate it if you would not publicize the

[121] Ibid., 716.
[122] Ibid.
[123] Subject Folders, Box 22, Folder 295, Draft 6/27/55, Material for Mr. Fogarty (speech or letter), Fogarty Papers.
[124] Western Union Telegram, August 21, 1951, Mary Lasker to John E. Fogarty, Subject Folders, Box 21, Folder 261, Fogarty Papers.
[125] John H. Teeter, American Cancer Society to John E. Fogarty, April 19, 1950 General Correspondence, Box 12, Folder 171, Fogarty Papers.

fact that I was instrumental in securing them."[126] But more than simple exchange of favors and mutual advancement marked the relationship between Lasker and Fogarty. There was a true and tender affection between the two. They congratulated each other on their successes, enjoyed sharing meals, and, when necessary, eased each other's grief and mourning.[127]

By 1956, on the eve of Forand's bold legislative announcement, Fogarty had accrued files of almost amorous letters from medical professionals. Doctors and scientists working on arthritis, cerebral palsy, blindness, neurological diseases, and cancer thanked him heartily for the ability to pursue their work.[128] The great cancer doctor Sydney Farber wrote, "The entire medical profession and everyone who benefits from research owes you deep gratitude for the magnificent fight you have kept up for so many years, to increase our resources in behalf of the health of our people."[129] Hospital officials praised him and relied on him for consistent renewal of the Hill-Burton act.[130] Most importantly, his constituents recognized his worth and praised his accomplishments.[131]

Even his colleague from the great state of Rhode Island, Aime Forand, rose in praise. In June of 1956, Congress bestowed on Fogarty the honorific "chairman of the better health of the nation" and Forand declared, that "the 'lion's share' of the credit for expansion of facilities and advancement of research at the National Institutes of Health

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[126] Fogarty to Stanley D. Davies, May 1, 1950, General Correspondence, Box 12, Folder 171, Fogarty Papers.
[127] Western Union Telegram, August 21, 1951, Mary Lasker to John E. Fogarty, Subject Folders, Box 21, Folder 261; Fogarty to Mary Lasker, June 20, 1952, Subject Folders, Box 11, Folder 112, Fogarty Papers.
[128] Subject Folders, Box 21, Folder 260 (Letters from different societies to Fogarty) National Mental Health Committee, Cerebral Palsy Foundation, National Society for the Prevention of Blindness, Fogarty Papers.
[129] Subject Folders, Box 32, Folder 454, Sydney Farber Children's Cancer Research Foundation to John Fogarty, September 28, 1953, Fogarty Papers.
[130] *See* letters in Subject Files, Box 26 and 27—letters, Fogarty Papers.
[131] National Institutes of Health, Box 46, Folder 569, "Letter to the Editor from William R. Dodd," *Providence Journal*, September 25, 1956, Fogarty Papers.

goes to Rep. Fogarty."[132] By 1958, the tides had surely turned. Forand, not Fogarty, was being hailed as the country's great progressive savior. Fogarty's constituents agreed, putting pressure on him to do more that just offer his lukewarm support for federal health insurance for the elderly.

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Since entering Congress, Fogarty had tried to advance the well-being of the elderly. He just had his own approach to policy. He used his powers of appropriation to advance research into mental health, disability, and rehabilitation.[133] In 1955, he even tried to create a Selected Committee on Problems of the Aging in the House.[134] Throughout his career, he preferred initiatives that solved ailments at the level of scientific research or set up bureaucratic institutes and committees with the sole purpose of researching and curing problems. His success financing the NIH came largely through such a bureaucratic technique, which set up separate institutes with their own budget requests. The Forand bill was not exactly his policy bailiwick, it did not cure the problem of aging at a biological level nor did it set up a single government institution geared to taking care of elders. Moreover, it infuriated many of his friends in the medical profession. Still, Fogarty could not solely rely on his legacy of supporting scientific research. In 1956 and 1957, he met with Clark Tibbitts and Ollie Randall to learn about the problems afflicting American elders and ongoing public and private initiatives to address them.[135] He was particularly persuaded by Randall's approach, which

[132] Box 7, Scrapbook 1956, p. 30 article in Journal Bulletin June 20, 1956, Forand Papers.
[133] Pratt, *The Gray Lobby*, 109.
[134] Healey, *John E. Fogarty*, 31.
[135] Subject Folders, Box 32, Folder 451, Letter to Fogarty from George F. More, May 24, 1956, and letter to Ollie Randall from Fogarty, January 2, 1957, Fogarty Papers.

concentrated on broad articulations of the problem and local, grassroots, initiatives.[136] For Fogarty, as for Randall, this method was not indicative of a theory of government that universally privileged state over federal action. When it came to scientific research, Fogarty always fought for a robust federal government. But the problems of old age, he contended for a time, would be best tackled locally.

In 1958, he came up with a temporary solution to his political problems. In January, Fogarty submitted H.R. 9822, a bill to convene a White House Conference on Aging. To prepare for the conference, states would have the funds and the time to prepare their own responses to the problems of old ages.[137] The Act "authorized grants of $5,000 and $15,000 per State to carry out their responsibilities," which included both the creation of statewide conferences and the publication of new data and recommendations.[138] In this way, Fogarty hoped to use the federal government to spearhead a nationwide effort to solve the problem of old age through local means.

Fogarty was not the only congressman hedging his bets in 1958. Although social welfare proponents bristled with the Eisenhower administration from 1953 to 1956, two important innovations in the field of aging took place. In addition to the 1954 amendments to the Social Security Act, which extended old-age and survivors' insurance coverage to farmers, domestic employees, and other self-employed workers, the Eisenhower administration offered what they called Medicare, or health insurance to

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[136] Speeches, Box 7A, Folder 7, October 10, 1958, Letter to Fogarty from John E. Fletcher, Chief, Office of Research Information. In this speech he explains the problem of old age as one of poverty, homelessness, unemployment, and illness, Fogarty Papers.
[137] Pratt, *The Gray Lobby*, 108.
[138] Address by Fogarty at the First National Conference Luncheon of Joint Council to Improve the Health Care of the Aged Sheraton-Park Hotel, Washington, D.C., June 12, 1959. Speeches, Box 8A, Folder 5, Fogarty Papers.

dependents of the armed forces, and established a federal council on aging.[139] At the Office of Aging, Clark Tibbitts continued his work ambitiously, forging numerous partnerships with states, helping them to establish local legislative committees on the aged and national governors' conferences on the issue.[140] Still, for the elderly, this was just not enough.[141] In the winter and spring of 1958, individual congressmen proposed eighteen separate bills having to do with the aged, nine of which called for a Bureau of Older Persons to be created within HEW.[142] On March 18, Congressman Roy W. Weir (DFL-Minnesota) presided over hearings to figure out which of these bills Congress should pursue. Fogarty had a real stake in the hearings. He supported the Bureau but wanted to make sure that his Conference came first. Not surprisingly, he was also the first witness called to the floor.

Fogarty opened his testimony with a coy reminder of his stature, "thank you for allowing me to delay my appearance until this hour because of some work I had already programmed for the Appropriations Committee, which has to do with this very thing we talking about this morning."[143] After reminding the crowd that he controlled a significant budget, he went on to explain the logic behind his own bill. First, his conference would follow in the tradition of similar successful conferences on behalf of Children and Youth. Secondly, it would give local power to people in the States who can come up and share

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[139] Robert Ball, "Perspectives on Medicare," *Health Affairs* 14, No. 4. (1995): 66; Sundquist, *Politics and Policy*, 296.
[140] Ibid., 295.; also *see* Pratt, *The Gray Lobby*, 42.
[141] For more on aging policy under Eisenhower *see* Corning, *The Evolution of Medicare: From Idea to Law*, 75.
[142] Hearings before a Subcommittee of the Committee on Education and Labor, House of Representatives, Bureau of Older Persons (Aged and Aging) 1680-1, Eighty-Fifth Congress. Hearings held in Washington, D.C., March 18, 19, 20; April 22, 23, 24, and 30, 1958. (Washington, D.C.: Government Printing Office, 1958): 1.
[143] Ibid.

their own workable solutions.[144] He then went on to remind the audience that he had a particular stake in this issue, having helped create it through his generous funding of bio-medical research. He announced, "the increasing number of people living in old age represents an achievement of the medical research and improvements in medical care which we have been supporting for more than two decades. I would like to pause here to say that all of the members of this committee that I know have supported the Appropriations Committee on medical research to their fullest extent. That is one of the reasons we have the longevity enjoyed by some of our older persons today."[145] If Congress can create the gift of longevity, he claimed, it can surely figure out a way to make that gift worthwhile.

In addition to advocating for his own bill, part of Fogarty's strategy at the hearing was to postpone the creation of a Bureau on Aging. From a policy perspective, Fogarty actually supported the creation of such a Bureau. He consistently criticized the federal government for not doing enough on behalf of the elderly and voiced his concern about understaffing and the decentralization of power. Nonetheless, he knew the Eisenhower administration would reject this kind of bureaucratic reshuffling, and he wanted to get some real action on this issue when he went back to constituents.[146]

While it was relatively easy to dismiss a push for the Bureau, it was harder to get everyone to accept his Conference. Herbert Zelenko, a congressman from New York, aided his cause: "May I ask the gentleman just one question? You agree that all of the other legislation has great merit. But, as I understand it, you feel that by H.R. 9822, we should first…get the benefit of collective thought of the most people before going into

[144] Ibid., 3.
[145] Ibid.
[146] Ibid., 111.

specific legislation; is that correct?"[147] After receiving an affirmative nod Zelenko continued, "Is it your feeling that by proceeding this way we would, in the initial stages, overcome, let us say…going into specific legislation which might be blocked and thereby set us back in the program?"[148] This vague question received an equally vague response from Fogarty. According to the political scientist Henry Pratt, "the tenor" of Fogarty's remarks "was that he had been correctly interpreted." The Conference would provide a strategic delay to all current legislation on the topic, most importantly, the polarizing Forand bill.[149]

Fogarty closed his argument with an unusually charged interchange with Dr. Robert H. Hamlin, who served as the assistant to the Secretary for Program Analysis at HEW. Hamlin doubted the efficacy of the Conference. Tone-deaf to the political cachet of simply doing something on this issue, he reminded the congressmen that the president could easily call for such a conference, thus rendering their legislation completely unnecessary.[150] After a biting interchange, Fogarty jumped on Hamlin, "What do you think is wrong with this approach of the White House Conference on Aging! What is bad about it! In view of your experience with the White House Conference on Education what would be bad about this approach!"[151] Fogarty won the verbal spar. Hamlin stepped down and the White House Conference emerged as the best proximal solution. "Conceivably," comments Pratt, "the House subcommittee could have endorsed both, Fogarty's White House Conference idea and the Bureau of Older Persons concept, there

[147] Ibid., 10.
[148] Ibid., 10.
[149] Pratt, *The Gray Lobby*, 110.
[150] Hearings before a Subcommittee of the Committee on Education and Labor, House of Representatives, Bureau of Older Persons (Aged and Aging) 1680-1,157.
[151] Ibid.,159.

being no logical inconsistency between them; but after the hearings concluded it chose to endorse Fogarty's idea and to shelve the others for the moment. Legislative strategy, more than the merits of the case, lay behind the decision."[152] For Fogarty, the hearings had been a home run. He delayed action on the Bureau and secured his conference.

During the 1959 hearings on the Forand bill, Fogarty could relax. He had a bill and a position. He supported all efforts to help the elderly but he believed that some would be more productive and politically expedient than others. In a speech prepared for the Ways and Means committee on July 14, 1959, he beseeched, "Why not explore the possibilities of several large scale experiments in the various proposals for achieving better medical care of the aged that have been put forward in the last decade? Why not see if there may be still other approaches worth exploring?"[153] Research, he argued, still offered the best solution. "The point I want to stress is simply this. A great, proud, wealthy and humanitarian nation no longer can afford to let millions of elderly, helpless, or dependent citizens suffer needless pain, disability, and death. We have the medical knowledge to alleviate many of their medical problems…. Some means must—I repeat—must be found to bringing that knowledge to those who need it most." [154] For "Mr. Public Health," old age would remain a disease with a biomedical cure. The goal of the federal government should be to spearhead the cure while the states received funds to administer the band-aids.

To his vocal constituents, many of whom supported the Forand bill, Fogarty strategically deployed his legacy and his Conference, "There is no question in my mind that Congress should take steps to provide such medical care. This area has troubled me

[152] Pratt, *The Gray Lobby*, 112.
[153] Ways and Means Committee Speech, July 14, 1959, Speeches Box 8A, Folder 5, Fogarty Papers.
[154] Ibid.

for a number of years and I have been doing everything I can to tackle the problem through my own field of medical research and by such things as my sponsorship of the White House Conference on Aging. All this, of course, while working closely with my colleague in Congress, Aime Forand, in an attempt to strengthen and broaden his bill."[155]

In 1958 and 1959, Fogarty scored strategic points, but the match was just beginning. Between 1958 and 1961, the year of the Conference, Cruikshank, Forand, and seniors across the country discovered two crucial allies, Senator Patrick McNamara (D-Michigan) and presidential hopeful Senator John F. Kennedy (D-Massachusetts), garnering enough momentum to convince even circumspect old age groups that the fight for health insurance equaled a fight for their own security.

VI. Convincing the Nation

Less than a year after Forand submitted his famed bill, the congressman, then almost sixty-five, announced that he would retire from the House in 1960. Opposition to his bill was ferocious and personal. He received numerous disturbing letters from doctors calling for the removal of his body parts.[156] He even received a prescription for "One tranquilizer: repeated often as a cure for the confusion and panic which you must have been suffering when you drafted this unreasonably expensive and shortsighted bill."[157] Upon hearing of Forand's retirement, Cruikshank offered these parting words, "While we regret that anyone should wish to demote you from Congress, we would certainly welcome you to our department here in the AFL-CIO!"[158] Walter Reuther followed suit

[155] Letter from Fogarty to friends, June 1, 1960, JEF Subject Folders, Container 2, Fogarty Papers.
[156] *See* Folder 253, Box 9, Forand Papers.
[157] Prescription Dr. Robert B. Neu, Arlington, Virginia, 3/13/60, Folder 253, Box 9, Forand Papers.
[158] MSS 1002, Box 5, File 7, December 23, 1958, to Aime Forand from Cruikshank, Cruikshank Papers.

writing, "The nation would be better served if there were more Aime Forands representing its interests within the halls of congress."[159] With Forand out of Congress, Senator Patrick McNamara, the elder Democratic statesman from Michigan, emerged as a new voice on behalf of seniors in Washington. McNamara would head the Senate Subcommittee on Problems of the Aged and Aging, a public relations goldmine.

The idea for a Senate subcommittee on the aging, did not actually originate from a senator. According to Richard Harris, William Reidy, a staff member of the Senate Committee on Labor and Public Welfare, "had become convinced that the problems of the increasing number of old people in this country were acute and that they affected far more people than just the elderly themselves—mainly their children."[160] Reidy reached out first to Senator John F. Kennedy. Kennedy agreed with Reidy's estimation of the problem but planned to offer his support for the cause in other ways. In February of 1959, the Senate authorized Joseph Lister Hill, Fogarty's great ally, to set up Reidy's subcommittee. Senator Patrick McNamara received the chairmanship.[161]

A month later, McNamara reached out to Cruikshank alerting him to the new subcommittee and asking "What are the major problems of the aged and what priorities, if any, could be established in determining what the Federal government should do in meeting these problems?"[162] In April, Cruikshank responded. "As you know," he began, "we believe that much more should be done by the federal government in meeting this situation. We have been especially concerned with the addition of health benefits for the

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[159] Walter P. Reuther to Aime Forand, Western Union Telegraph, February 19, 1960, Folder 253, Forand Papers.
[160] Harris, *A Sacred Trust*, 69.
[161] Ibid.
[162] McNamara to Cruikshank, March 24, 1959, Mss 1002, Box 8, File 38, Cruikshank Papers.

aged through the social security system, and we urge your Committee to explore the kinds of health services which older citizens are now receiving from public clinics."[163]

McNamara took Cruikshank's advice. To pursue the problem of old age, his committee would design a series of town hall hearings across the country. The opening year would take on the problem of health care. As McNamara announced, "A major reason for starting this year's hearings on the aged's health problems…was the unanimous position of the Subcommittee's majority members that 'The No. 1 problem of America's senior citizens is how to meet the costs of health care at a time when income is the lowest and potential or actual disability at its highest.'"[164] The press release continued with an explicit argument against the findings of the 1950 Conference on Aging, "Contrary to a widespread belief that the aged have no special problems of their own…they have almost three times as much chronic illness as do young people. Their medical expenditures are nearly twice as high, on a per capita basis, as the expenses of younger persons."[165] By the time the subcommittee got to work, those who supported and designed the incremental approach to health care had convinced politicians and much of the public that health care costs were both the worst and most solvable problem of old age.[166]

From the start, "the hearings got headlines."[167] Kicking off in Washington, D.C., and then spreading out cross the country, McNamara's hearings gave individual seniors the opportunity to speak directly to the American public. The public knew little about the

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[163] Cruikshank to McNamara, April 28, 1959, Mss 1002, Box 8, File 38. Cruikshank Papers.
[164] Press Release, Subcommittee on Problems of the Aged and Aging 1959 or 1960, Mss 1002, Box 8, File 38, Cruikshank Papers.
[165] Ibid.
[166] *See* Chapter II and III for additional background.
[167] Harris, *A Sacred Trust*, 91.

predetermined structure of the event. Rather than planned, the hearings felt remarkably organic. As one staff member described, "The Senator's policy in conducting the hearings was unique, as far as I know. After listening to the experts on both sides, he simply opened up the microphone to anyone in the room who wanted to have his say. Well, the old folks lined up by the dozen everyplace we went. And they didn't talk much about housing or recreation centers or retirement problems or part-time work. They talked about medical care. For the first time, we had these people telling what life was like for them—and letting us know that they were more than a lot of statistics."[168] It did not hurt that many of the opening experts actually discussed health care.[169] "The upshot," the staff member concluded was, "front-page stories everyplace we went. This gave the movement its first big push forward on the national scene."[170] Through the hearings, the personal pleas of America's medically needy elders dominated articles, radio programs, and television shows.

In February of 1960, the subcommittee released an official report; not surprisingly members "strongly urged social security financing of medical care for the aged."[171] Two months later, *Business Week* featured a story headlined "A Challenge that can't be ducked." "Health insurance for the aged," it reported, "is fast becoming the No.1 issue facing Congress this year. And there is political dynamite to it: Any candidate suspected by the millions of old people (and those concerned about their health problems) of taking a cold or know-nothing attitude toward the issue is likely to be in serious trouble this

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[168] Ibid.
[169] For more on the hearings, *see* Box 724, Folder Age and Aging, The Patrick Vincent McNamara Collection, Reuther Library, Wayne State University, Detroit, Michigan.
[170] Harris, *A Sacred Trust*, 91.
[171] Eugene Feingold, *Medicare: Policy and Politics: A Case Study and Policy Analysis*, (San Francisco: Chandler Pub. Co., 1966), 106.

election year."[172] Not only had the McNamara hearings succeeded in turning public opinion towards the issue of old age, but it had done so in a way that made health insurance seem like the most pressing concern. The article continued, "One thing about the issue is clear: Although plenty of politicians may see it as a vote-catching devise, there is nothing synthetic or phony about the problem. Everyone who has seriously studied the situation has concluded that the provision of better health care for the aged is a serious—and growing—problem."[173]

As the McNamara hearings circled the country, support for health insurance for the aged tumbled into the offices of conservative politicians. The opposition would have to get creative. Throughout the 1950s, republicans and southern Democrats had been able to simply oppose, ideologically, any expansion of social security to include health insurance.[174] By 1960, they needed to offer their constituents a counter policy. Interestingly, rather than develop an alternative solution to the problem of old age, they decided to provide health care for the needy through a progressive federal tax.

Where liberals, writes Theodore Marmor in his comprehensive study of Medicare, ended up "proposing *limited* hospital-surgical insurance," conservatives advocated "broader benefits for a small class among the aged—the destitute."[175] This approach to health insurance would be articulated in a bill presented by Democratic Senator Robert

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[172] "A Challenge that can't be ducked," *Business Week*, April 16, 1960, Exhibit 2, in Congressional Record Proceedings and Debates of the Eighty-Sixth Congress, Second Session. Vol. 106, June 2 1960, No. 100. *See* also, Senate: The Retired Persons Medical Insurance Act, Mss 1002, Box 8, File 38, Cruikshank Papers.

[173] Ibid.

[174] For more on the political history of Southern Democrats *see* Richard Franklin Bensel, *Sectionalism and American Political Development, 1880–1980* (Madison: University of Wisconsin Press, 1984), Ira Katznelson, *When Affirmative Action Was White: An Untold History of Racial Inequality in Twentieth-Century America* (New York: WW Norton, 2006), and *Fear Itself : The New Deal and the Origins of Our Time* (Liveright Publishing Corporation, 2013), also by Ira Katznelson.

[175] Marmor, *The Politics of Medicare*, 27.

Kerr of Oklahoma and Congressman Wilbur Mills of Arkansas. In this bill, the means tested approach, so maligned by liberal policy makers, demanded that individuals over sixty-five demonstrate their financial indigence before receiving medical coverage.[176] However, once they qualified, these individuals could receive comprehensive medical care, which included but was not limited to, doctors' visits, hospital stays, prescription drugs, and nursing home visits.[177] To fund the program, legislators included a federal income tax, which would work in coordination with matching state funds. From the outset, this raised red flags. Few states, if any, could actually provide the ample funds needed to implement such a program. For this reason, when Kerr-Mills was eventually adopted in 1960, legislators and scholars rightly claimed that the policy had little chance of having a productive national impact.[178]

In 1960 moderate Republicans also offered their own solutions to the old age problem, again in the realm of health insurance, by emphasizing state initiatives and private insurance options.[179] One in particular concerned Nelson Cruikshank. Cruikshank greatly admired New York Senator Jacob Javits, and wanted to understand the origins of a particular section of his bill, which would give elderly individuals choice over their

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[176] For an in-depth discussion of the relationship between means-tested and entitlement programs *see* Michael B. Katz, *In the Shadow of the Poorhouse: A Social History of Welfare in America* (New York: Basic Books, 1986); Alice Kessler-Harris, *In Pursuit of Equity: Women, Men, and the Quest for Economic Citizenship in 20th Century America* (New York: Oxford University Press, 2001); Linda Gordon, *Pitied but Not Entitled: Single Mothers and the History of Welfare, 1890–1935* (New York Free Press, 1994), and Margaret Weir, Ann Shola Orloff, and Theda Skocpol, *The Politics of Social Policy in the United States* (Princeton, NJ: Princeton University Press, 1988).

[177] Marmor, *The Politics of Medicare*, 27–29.

[178] For more on the creation and evolution of Kerr-Mills *see* Feingold, *Medicare: Policy and Politics*; Jonathan Engel, *Poor People's Medicine: Medicaid and American Charity Care since 1965* (Durham: Duke Univeristy Press, 2006); and Paul Starr, *Remedy and Reaction: The Peculiar American Struggle over Health Care Reform* (New Haven: Yale University Press, 2011).

[179] For a thorough history of the policy fight for Medicare as well as alternatives to the Forand bill, *see* Starr, *Remedy and Reaction*; Marmor, *The Politics of Medicare*; Harris, *A Sacred Trust*; and Feingold, *Medicare: Policy and Politics*.

private insurance carriers.[180] When Cruikshank went to visit Javits's office, he discovered that the push for individual choice came from a single origin. In his words, "It was simply that in discussing this with Javits, his first proposals were to allow free choice.... We traced down the source of it. A bunch of retired teachers in New York that were in the American Association of Retired Persons—an outfit which is subsidized by Continental Casualty Company—came down to see Javits and told him that they thought medicare ought to give a principle of free choice and that one ought to be able to use the tax money to buy this other insurance they had."[181] The young, but financially endowed, insurance collective and nascent lobbying group AARP was, by 1960, stretching its newfound political muscle and getting into the policy game. While the McNamara hearings would push Medicare's long-time opponents to propose alternative policies, the upcoming election, and the momentum it gave to senior citizens, would quiet the softer critiques of the Forand bill that came from such organizations as the AARP.

VII. Senior Citizens Get Organized

In 1947, Dr. Ethel Percy Andrus founded the National Retired Teachers Association (NRTA), the organizational predecessor to the American Association of Retired Persons (AARP).[182] Forced to retire at age sixty-five, Andrus started to coordinate retired teachers to argue for better pensions and tax benefits. According to William Fitch, the executive director of AARP in the 1960s, Andrus's original intent was

[180] Feingold, *Medicare: Policy and Politics*, 103.
[181] "Reminiscences of Nelson Hale Cruikshank,", 159.
[182] *See* Charles R. Morris, *The AARP: America's Most Powerful Lobby and the Clash of Generations* (New York: Times Books, 1996).; Henry J. Pratt, "Old Age Associations in National Politics," *The Annals of the American Academy of Political and Social Science,* 415 (1974):106; and William C. Fitch and Peter A. Corning, interviewer, "Reminiscences of William C. Fitch, Sr." Columbia University Oral Histories, Social Security Project: Oral History (1966), Columbia University, New York.

to persuade “older people to help themselves and each other.” NRTA “was really not intended to be a senior citizens’, golden age type of group, but really to see if there isn’t a more responsible role for older people to play in retirement.”[183] Almost immediately, the organization’s members began discussing the need for some form of health insurance. At the time, it was nearly impossible to find a policy written for those over sixty-five that would provide adequate coverage throughout old age. As Fitch recalls, “So the president of the group…went to almost every major insurance company to see whether or not an insurance policy could be written for persons in retirement that couldn’t be canceled, where pre-existing conditions wouldn’t be eliminated.”[184]

In 1955, Andrus found her answer from a thirty-one-year-old New York insurance broker, Leonard Davis, who had just secured a deal with Continental Casualty Company to provide life-insurance policies for 800 retired teachers in New York.[185] Although later defamed for caring more about his commercial interests than the needs of AARP members, Davis became Andrus’s strategic and financial partner.[186] Davis agreed to invest $50,000 in a program that would make NRTA members eligible for the New York State benefits. His initial investment paid off. By 1972, disclosed Pratt, Davis’s holdings in NRTA-AARP insurance products were valued at a whopping $184 million.”[187]After 1955, the program expanded rapidly and in 1958, the duo created a new organization, AARP, to handle the insurance requests of non-teachers; NRTA and AARP shared office space and staff but retained separate boards of directors.[188] AARP insurance policies not

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[183] “Reminiscences of William C. Fitch, Sr.,” 1.
[184] Ibid., 2.
[185] Pratt, “Old Age Associations in National Politics,” 111.
[186] Morris, *The AARP,* 23.
[187] Pratt, “Old Age Associations in National Politics,” 111.
[188] Ibid., 112.

only "sold by the tens of thousands" but proved to insurance companies that retirees could be "good risks, who paid their premiums on time."[189] Peter Corning, while conducting an oral history with William Fitch, summarized the AARP insurance experiment as follows, "In effect, the experience of your insurance program was that it was a profitable undertaking in general—at least for the segment that the population that your members consists of."[190] William Fitch replied, "Very much so. Not only for our own members, but I think it pioneered the way for many other insurance companies."[191] Insurance companies now wanted to cover the elderly.

As Forand's bill circulated from 1958 to 1960, the NRTA and the AARP publically offered "lukewarm" support of the policy and privately advocated their own semi-private version of the bill.[192] The remunerative AARP insurance policies gave them a significant financial stake in keeping old age insurance within the private sector, or so they originally thought. When Medicare finally did pass in 1965, AARP made a killing selling supplementary Medicare insurance called Medigap.[193] In 1960, William Fitch took up the position of Executive Director to the NRTA and AARP and, with Andrus, crafted a political approach that responded to seniors' desire for federal health insurance. He came from a government background and knew how to operate in Washington, D.C.

Fitch discovered his interest in the aging while "on loan to the State of Israel" as a Social Security official from 1955 to 1956. Originally deployed to help the country develop its own social insurance program, he soon became interested in the radically different cultural assumptions that surrounded aging and the elderly. In his words, "I

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[189] Morris, *The AARP,* 24.
[190] "Reminiscences of William C. Fitch, Sr.," 8.
[191] Ibid.
[192] Robert Ball, "Perspectives on Medicare," *Health Affairs* 14, No. 4. (1995): 67.
[193] Morris, *The AARP*, 213.

watched how older people were being used in the upbuilding of the State of Israel. There really wasn't any chronological barrier to employment. Anyone who was able and interested and willing to work had a job regardless of how old they were, so I became perhaps much more closely interested in the problems of older persons—housing and income and supplementary employment, that sort of thing."[194] Fitch returned to the United States in 1956 to serve as the Director of the Office of Aging.[195] Back in Washington, he grew acquainted with Fogarty while putting together a report, at the congressman's request, on the elderly in Rhode Island.[196] In the opening days of 1958, Fitch was with Fogarty at a late-night emergency meeting at an airport in Washington, when Fogarty hammered out the details of the White House Conference on Aging.[197]

For two years, Fitch worked as the staff director for a Conference designed to empower states and stall action on the Forand bill. In 1959, the NRTA and AARP approached the expert on aging and asked if he "didn't want to practice what [he'd] been preaching" and take over the two organizations as the executive director.[198] Fitch took the job the following year and with the help of Andrus began to articulate a more subtle and strategic position on the pending Forand bill.

First, the duo attempted a genuinely bipartisan approach to aged health care, speaking at Democratic and Republican assemblies and even reaching out to the AMA.[199] Throughout the 1960s, Fitch and the NRTA-AARP hedged. They seemed to support

[194] "Reminiscences of William C. Fitch, Sr.," 2.
[195] Ibid., 31.
[196] Ibid., 32–33.
[197] Ibid., 41.
[198] Ibid., 43.
[199] Ibid., 65.

Fogarty and Forand, while pursuing alliances with Democrats and Republicans.[200] And though they still offered their own approach to federally funded healthcare, featuring private insurance options, the coming election, and a small campaign wing working for John F. Kennedy, rendered senior support for Medicare visible. Soon even soft opposition from the likes of the AARP became publically unpalatable, especially to seniors. The NRTA-AARP, Fitch stressed in 1966, was "never against…a national health program."[201]

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In 1960, the Kennedy campaign had an idea. The candidate of youth would win the presidency with the organized support of the old. Before Forand had the chance to withdraw to a sedate retirement, the phone rang. It was Kennedy, asking the congressman to be the national chair of a campaign group called Senior Citizens for Kennedy.[202] Since 1958, Kennedy had realized the power of the senior vote. He devoted ample energy to crafting his own version of the Forand bill and listened carefully as advisors, like Myer Feldman, told him that health care for the elderly "was a big issue" and that it could "have a great effect on the outcome of the Presidential election in 1960."[203]

When Kennedy called, Forand "couldn't turn the fellow down."[204] This was a way back into politics by spearheading an issue that had made his name. But he did have one condition. Having himself become a senior citizen, he needed some extra help. The Kennedy camp generously provided Forand with a full-time traveling companion,

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[200] Ibid.,60–65. *See* also AARP July 28, 1960—Letter from Executive Director William C. Fitch to Miss. Grace Byrne, enclosed speeches from Fitch and Andrus from 1960, including Republican Resolutions Platform Committee Speech, Box 28, Folder 406, Fogarty Papers.
[201] Ibid., 62.
[202] "Reminiscences of Aime Forand,"36.
[203] Summarized in Harris, *A Sacred Trust*, 87.
[204] "Reminiscences of Aime Forand,"38.

evidence, perhaps, that by 1960 his name was powerfully and usefully synonymous with health care for the aged.[205] Senior Citizens for Kennedy partnered with golden age clubs across the country to rally on behalf of this young senator. The campaign endowed the fledgling senior's movement with an organizational structure and a proximal goal.

On November 3, leading up to the election, Senior Citizens for Kennedy staged one of their many rallies in support of Kennedy. They chartered over 100 buses to shuttle seniors to New York's Union Square. Over 4000 seniors paid 30 cents for the privilege of hearing the Republicans slammed by former governor Herbert Lehman: "The Republican leadership does not care whether you are young or old; it does not care what your problems are," Mr. Lehman said, "The Republican leadership just doesn't care unless you happen to be big business."[206] The 106-year-old "grand marshal," Broadus A. Jackson, regaled the crowd with tales of his recent transfer of party alignment.[207] He had voted for Republicans since 1876 but now he was a Democrat for the sole reason that Republicans did not support medical care for the elderly.

That same year, the *New Republic* featured the article "Watch Out for Grandpap." In it Gerald W. Johnson wrote, "Pundits of many shades of opinion have wondered at the recklessness of the Eisenhower Administration in inviting the massive retaliation of old people by torpedoing the Forand bill that would have provided medical care for persons over 65 by raising social security payments. The usual comment is that there are 16 million Americans now past 65, and the vast majority of them are voters."[208] And it's not just the old people that were furious. The article continued, "An aged and ailing parent is

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[205] Ibid.
[206] Edith Evans Asbury, "4,000 Aged Attend Democrats' Rally: Members of Clubs in City Charter Buses to Hear Attacks on G.O.P.," *New York Times* November 4, 1960: 23.
[207] Ibid.
[208] Gerald W. Johnson, "Watch Out for Grandpap," *New Republic*, May 9, 1960, 8.

a burden on many an American who is under 65—just how many nobody knows, but probably several millions. Their resentment may be even more bitter and lasting than that of the old folks themselves."[209] The resentment seemed to have spilled out onto Richard Nixon.

After Kennedy won the election, Cruikshank paid a visit to his old friend, Arthur Flemming, Eishenhower's Secretary of HEW. Flemming and Cruikshank had attended college together at Ohio Wesleyan and worked side by side at the War Manpower Commission. Cruikshank had always believed that Flemming supported the Forand bill and confronted him on this issue as he watched his friend clean out his desk. Eisenhower was leaving office, and Nixon had lost the election. "At that point I thought it was safe to let our hair down a bit," recalled Cruikshank, "And I said to him, 'Art, this was an awfully close election…. You know, it was just so close that if your man Nixon had adopted medicare, he would be being inaugurated tomorrow.'"[210] Flemming replied, "Well, I think you're right. It would have made the difference. It was that close."[211]

Democratic officials were equally convinced that seniors had helped secure the election. As Pratt argues, "Senior Citizens for Kennedy had convinced top-level Democratic politicians that the basic hypothesis upon which the operation was organized has been correct. Elderly voters could be appealed to, like the farm vote or the Negro vote, on the basis of their own separate identity and self-interest."[212] And, as of 1961, that self-interest was squarely in the Democratic camp. Medicare would be integrated into the official party platform and become a crucial issue in the Kennedy White House.

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[209] Ibid.
[210] "Reminiscences of Nelson Hale Cruikshank," 106.
[211] Ibid.
[212] Pratt, *The Gray Lobby,* 71.

VIII. Conclusion

In the early 1950s, oldsters gathered in public to celebrate their skills. They touted their abilities and basked in the glow of charitable organizations willing to give them a meal and take a photograph. In 1960, aggressive seniors had replaced these accommodating oldsters. Gone were concerts and hobby shows. In their stead, senior citizens rallied by the thousands to voice their political opinions. The promise of health insurance, the strategic coordination offered by the AFL-CIO, the popularity of the McNamara hearings, and the organizational capacity of Senior Citizens for Kennedy combined to offer seniors a chance to mobilize for a single, concrete, solution.

In 1958, Fogarty secured his Conference. But the interim years had not been kind to his cause. While the Conference proposal fulfilled Fogarty's political needs, as did his continued generous funding of the NIH, his policy ideals were dwindling beneath the Medicare momentum. In addition to furthering medical research into the diseases of old age, he wanted to explore the nuanced problems that confronted American elders and offer local, tailor-made solutions. He urged states to pursue their own statistics, create reports, and ask the same philosophical questions about the nature of care that occupied the federal government: What are the obligations of the government to its aging citizens? Should government take over care for the aged or aid caregivers? Should the needs of the aged take precedence over other concerns? But on the eve of his great conference, the battle lines had been drawn. As Kennedy prepared to enter the White House, health insurance for the aged emerged as a litmus test that put policy makers squarely for or against America's senior citizens.

CHAPTER V

Obligated to Act:
The 1961 White House Conference on Aging

"Survival, it is called. Often it is accidental, sometimes it is engineered…always it is temporary."[1]
Wallace Stegner, Crossing to Safety.

I. Introduction

For almost two decades, the United States federal government sought to define and solve the problem of old age. Policy analysts argued over which characteristic best described the elderly—chronology, anatomy, unemployment, or disease—and which programs would best ameliorate the affliction: job retraining, adult education, preventative health care, and finally, federal health insurance. Going into the White House Conference on Aging (WHCA), another question would be posed, one centered less on circumscribing ailments and more on understanding the nature of obligation.

For much of American history the obligation to care for the elderly fell to an aged person's children, local community, or lastly a religious or civic charity.[2] By the middle of the twentieth-century, this safety net had visibly eroded. Clinicians, gerontologists, social workers, religious leaders, community volunteers, political scientists, and politicians tried their best to stitch together an ethical response to this palpable need. As each safety net (family, community, state) requested further assistance, demand grew for the federal government to intervene. As politicians and their aides zeroed in on a

[1] Wallace Stegner, *Crossing to Safety*, (New York: Random House, 1987), 324.
[2] For more on the history of elderly poverty in the United States *see White House Conference on Aging, Background Paper on Federal Organizations and Programs* (Washington, D.C.: Government Printing Office, 1960); Michael Harrington, *The Other America: Poverty in the United States*, rev. ed., reprint (New York: Simon & Schuster Inc., 1993; 1962); Michael B. Katz, *In the Shadow of the Poorhouse: A Social History of Welfare in America* (New York: Basic Books, 1986); James T. Patterson, *America's Struggle against Poverty: 1900–1980* (Cambridge: Harvard University Press, 1982); and Jill S. Quadagno, *The Transformation of Old Age Security: Class and Politics in the American Welfare State* (Chicago: University of Chicago Press, 1988).

definition of the problem of old age and a working solution, they exhumed a question seemingly put to rest in the 1930s: does the federal government have a special obligation to assist its aged citizens?

"One of the most important responsibilities of the White House Conference on Aging," a circulated preconference paper specified, "will be to evaluate and to make recommendations concerning the role of the Federal Government in the aging field."[3] The paper questioned "how far is it right or necessary for the Federal Government to assume responsibilities that heretofore have been primarily those of private individuals and groups or of State and local governments?"[4] In other words, who should be responsible for the elderly? How does ascribing obligation in one direction relieve or divert obligation in another? These questions always haunted the conversation around eldercare, but at the WHCA, they would have an explicit, if brief, airing.

While speakers such as Rabbi Abraham Joshua Heschel, Ollie Randall, and Senator Barry Goldwater would explore the contours of intergenerational and government responsibility, the interventions they suggested would be starkly and immediately overshadowed. John Fogarty's carefully designed conference, would, in the end, be remembered for unleashing an oratorical tsunami on behalf of federal health insurance for the elderly. This public relations coup was due in no small part to the anglings of Nelson Cruikshank and the AFL-CIO's growing collection of allies. Not only did the conference provoke a surge of public support on behalf of medical insurance for the aged, but it helped create a senior citizens lobbying group to advocate for what came

[3] *Background Paper on Federal Organizations and Programs,* 1.
[4] Ibid., 37.

to be called Medicare. Four months after the conference, 67% of Americans favored "having the Social Security tax increased in order pay for old-age medical insurance."[5]

Medicare did not actually become law in 1961, 1962, or even in 1964. As Theodore Marmor eloquently writes, "Battles like Medicare are fought in public but settled in private."[6] While it took another presidential election and Democratic wins in Congress to actually push Medicare out of the Ways and Means Committee, the White House Conference on Aging sealed the Democratic front on behalf of Medicare. From 1961 on, a set of assumptions dominated policy for the elderly: Old age is best defined chronologically; the great hardship of old age, financial indigence due to rising medical costs, could be relieved by offering funds for medical intervention; and, finally, the Federal government has a unique responsibility to take care of its citizens once they acquire sixty-five years of age.

II. Designing the 1961 White House Conference on Aging

The 1961 White House Conference on Aging (WHCA) made the 1950 conference seem dinky. Three years of analysis, professional development, state conferences, and $2,156,000 in appropriations preceded the event. The majority of those dollars went directly to the states, which in turn used the funds to produce a plethora of conferences and reports. Although written documents could agree that old age was a torturous, financially unstable time for most elderly Americans, state conferences populated by politicians, doctors, labor leaders, and activists vehemently disagreed on the appropriate

[5] On June 9, 1961, a Gallup Poll took up the question of old-age medical insurance. Interviewing date 5/17-22/61, Survey #645-K Question #24A. George Gallup, *The Gallup Poll: Public Opinion, 1935–1971* (New York: Random House, 1972), 1721.
[6] Theodore R. Marmor, *The Politics of Medicare*, 2nd ed., (New York: A. de Gruyter, 2000), 73.

solution to the hardships. For three years, their disagreements dominated local conversations and paved the way for a conference that, while broad in intent, was limited in outcome.

Before the WHCA even opened, the press reported accusations that the conference was rigged. In October of 1960, labor leaders suggested that unless the conference organizers provided stipends for delegates to attend, the meeting "would reflect only the views of well-to-do persons."[7] By which, they meant doctors. State conferences, designed to prepare for the WHCA, ended in disaster. The Illinois Conference on Aging concluded with a "dispute over a recommendation opposing federal medical assistance to the aged."[8] As the opening date approached, press-reported accusations of delegate stacking grew even more frequent. On January 8, a day before the WHCA began, the *Baltimore Sun* described a public slight to Wilbur Cohen. The "architect of the present social security system," would not attend because, he claimed, "the American Medical Association, private insurance interests and business representatives had stacked the conference."[9] Cohen and the press had one thing right: the conference was stacked, but just not that successfully.

In the months leading up to January 9, Cruikshank and his colleagues at the AFL-CIO had hatched a plan to use the conference as a propaganda tool to promote health insurance for social security recipients. Without the manpower to stack the conference with delegates, they hoped to capture the crowd by strategically placing sympathetic supporters in crucial meetings. To do so, Cruikshank and his colleagues needed to figure out how the proceedings would be organized.

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[7] "Labor Requests Aid For Talks on Aged," *New York Times*, October 14, 1960: 6.
[8] "State Parley on Aging Ends on Angry Notes," *Chicago Daily Tribune*, September 8, 1960: 114.
[9] "Aged Parley Trouble Eyes," *Baltimore Sun*, January 8, 1961: 6.

In 1958, Congress determined that the Department of Health, Education, and Welfare (HEW), which was then under the leadership of Arthur S. Flemming, would organize the conference. Flemming appointed a former Republican congressman from New Jersey, Robert Kean, as chairman, and Kean, with the help of HEW and an advisory committee, settled on the theme, "Aging with a Future—Every Citizen's Concern," and a structure. There would be twenty subject matters, to be tackled by smaller working groups.[10] Each of the working groups would be tasked with creating both summaries and actual policy statements following the meeting. From day one, the conference leaders knew they had to tread carefully around the juggernaut of health insurance for the aged.

They sought to both tackle and defer the policy question. Days before the conference, Kean explicitly stated that "catastrophic illness of the aged" was "one of the main problems to be faced" and, with the advisory committee, concluded that a key question would be "How far should the Federal Government go to help the retired pay their bills."[11] Still, the organizers hoped to evade particular policy ramifications, even going as far to ban the phrase "Forand bill" from the proceedings.[12] They were also mindful of how delegates would position themselves in the different working groups. William Fitch, who served as the staff director for the conference for two years, recalled

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[10] The twenty subject matters were (1) Population Trends: Social and Economic Implications (2) Income Maintenance, including Financing Health Costs (3) Impact of Inflation on Retired Persons (4) Employment Security and Retirement (5) Heath and Medical Care, including Institutional Care (6) Rehabilitation (7) Social Services (8) Housing (9) Education (10) Role and Training of Professional Personnel (11) Family Life, Family Relationships, and Friends (12) Free Time Activities, Recreation, Voluntary Services, Citizenship Participation (13) Religion (14) Research in Gerontology: Biological (15) Research in Gerontology: Medical (16) Research in Gerontology: Psychological and Social Sciences (17) Local Community Organization (18) State Organization (19) National Voluntary Services and Service Organizations (20) Federal Organizations and Programs. *See The Nation and Its Older People: White House Conference on Aging* (Washington, D.C.: U.S. Dept. of Health, Education, and Welfare, Special Staff on Aging, 1961), 12–13.

[11] "Aged Parley Trouble Eyes."

[12] "White House Conference on Aging Bars Discussion of Specific Plans," *Washington Post, Times Herald*, September 27, 1960: C1.

an internal debate over where to place the subject of medical financing, in the section on "Health and Medical Care" or "Income Maintenance."[13]

As "doctors and insurance people" were "jockeying" to fill the working group they believed would take on this issue, the conference organizers, without leaking it to the AMA, decided that the discussion of medical financing belonged in "Income Maintenance."[14] They agreed that health insurance was really an economic issue and that this placement would garner the broadest crowd.[15] As Fitch recalled, "Well, basically, as long as it was to be an amendment under Social Security, and as long as Social Security was basically income maintenance, we decided that it would all be discussed as an amendment to the Social Security part of it rather than something that would be a separate program in health."[16] A conversation about health care came to be explicitly understood as one about health insurance and income security. If Cruikshank knew about this internal protocol decision, he kept it to himself.

Five days before the conference began, Cruikshank prepped George Meany, president of the AFL-CIO, for his opening speech. "It is very clear," Cruikshank related, "that the chief battleground will be on this question of medical care for the aged under social security. As you know this is the burden of the speech that you are delivering Monday night at the Shoreham." The AMA, Cruikshank continued, "has made a major project of covering state conferences…. As a result only ten states have come up with a positive recommendation of medical care through social security."[17] Monday night, he

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[13] William C. Fitch and Peter A. Corning, interviewer, "Reminiscences of William C. Fitch, Sr. ," Columbia University Oral Histories, Social Security Project: Oral History (1966), 94.
[14] Ibid.
[15] Ibid., 97.
[16] Ibid., 94.
[17] "Internal Document, To President Meany from Nelson Cruikshank, January 4th, 1961," MSS 1002, Box 1, File 22, Cruikshank Papers, Nelson Cruikshank Papers, 1927–1989, Wisconsin Historical Society.

related, is the AFL-CIO's chance to do more with less. With only 150 delegates to 257 physician and dentist delegates, labor was outnumbered. The strategy for "our delegates," he noted, "will be to present at all the work groups and subject sessions to which they are assigned a reasonable and logical approach to the problem of medical care so that the middle-of-the-road groups…can be won over." "What our boys need," Cruikshank offered in conclusion, "is a good locker-room talk from the head coach before they go into the field where the odds are rather heavily against them."[18] The AMA would have a different strategy, trying deliberately to overpower the "Health and Medical Care" section, which they misguidedly thought would take on the question of health insurance.[19]

III. Opening Day

On January 9, President Eisenhower, with only eleven more days in office, began his day with an early bipartisan twist. He breakfasted with Senator Barry Goldwater and met with George Meany, before addressing, at 10 am, the opening session of the White House Conference on Aging.[20] It had been three years since Fogarty first proposed the conference, and thousands of delegates arrived prepared. And if they weren't, "large kits with programs, reports, study materials" awaited them.[21]

In Constitution Hall, Eisenhower addressed a stately audience of over 3000. The men wore suits, ties, respectable black-rimmed glasses; the women wore calf-length skirts with sensible black shoes. Within this sea, a few baldheads, nuns' habits, and some

[18] Ibid.
[19] *See* John R. Lindsey, "How the Social Security boys broke through," *Medical Economics*, February 13, 1961, in MSS 1002, Box 1, File 22, Cruikshank Papers.
[20] "Washington Proceedings," *New York Times*, January 10, 1961: 18.
[21] *Aging* (U.S. Federal Security Agency) March 1961, MSS 1002, Box 1, File 22, Cruikshank Papers, 4.

flair in the form of laced hats could be spotted. Seated behind Eisenhower, the other keynote speakers—Senator McNamara, Congressman Fogarty, and Secretary Flemming— awaited their turns.[22] The musical selections by the United States Marine Band and thoughtful comments by the conference organizers ignited the crowd.[23] The audience gushed. With every leading thinker in the field of old age attending, the conference was sure to be an occasion of real political importance.

Congressman John Fogarty was more skeptical. In 1961, he was over conversation; he wanted action. When he first introduced the bill in 1958, Fogarty admonished his fellow politicians, "In spite of the many surveys, books, and conferences on aging, the greatest accomplishment to date has been the output of words."[24] To promote local activity on behalf of the elderly, the financially savvy Fogarty built into his bill an appropriations budget, which would be offered to states as an incentive to prepare for the WHCA. And prepare they did, with document after document and an outpouring of committee meetings and conferences.[25]

From 1958 until 1960, Fogarty could tolerate this outpouring of research recommendations, policy reports, and conflicting data on the elderly across the states. In 1961, he strongly felt that the country had collectively said enough on the topic. "This past year," he beseeched WHCA attendees, "has been called the 'gerontological year.' Never before have so many meetings, studies and reports been devoted to the subject of aging. I would like to agree with this thought but cannot. I have been critical of the

[22] Ibid., 8–9.
[23] *The Nation and Its Older People*, 51.
[24] John Fogarty quoted in *The Nation and Its Older People*, 3.
[25] Each of the delegate states produced reports, as did numerous specialists. The total number of publications exceeds 400.

preconference accomplishments. I have made the distinction between *activity* and *action*."[26] The WHCA, he urged on opening night, had to be about action.

For Fogarty, action in this arena meant something quite specific and bureaucratic. He wanted the conference to bring about a Federal Commission on Aging, which would have independent agency status and report to the president. Not surprisingly, he also called for a "special research section in the Commission to encourage, stimulate, and disseminate information that will prevent or correct many of the threats of illness, disability and the other difficulties that plague the later years."[27] Aspects of the Fogarty solution would eventually triumph in the Older Americans Act, but not until 1965.[28]

Action, for those participants from labor, social work, medicine, and industry would not mean another commission; it would mean the success or defeat of the Forand bill. In the years between 1958 and 1961, the Forand bill absorbed national politics, even providing a pivotal wedge in the 1960 presidential election.[29] Entire organizations had been created to urge politicians to support or thwart the bill.[30] Senator Patrick McNamara's Senate Subcommittee's public hearings gave a national stage to the growing power of senior citizens groups, the social security department of the AFL-CIO, and social welfare activists. The AMA followed suit, bolstering its defense with increased

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[26] *The Nation and Its Older People*, 58.
[27] Ibid., 60.
[28] The Old Americans Act passed on July 14, 1965. The Act, with relatively modest funding compared to Medicare, created an Administration on Aging. Fogarty preferred an independent agency rather than an administration within the Department of Health, Education, and Welfare. For more on Fogarty's response *see* Henry J. Pratt, *The Gray Lobby* (Chicago: University of Chicago Press, 1976), 115.
[29] Josephine Ripley, "Forum Develops Aid-For-Aging Views," *Christian Science Monitor*, January 10,1961: 1.
[30] *See* chapter IV for more information.

spending and renewed coalitions across the health care industry.[31] Both camps arrived at the conference ready to put the opposition to rest.

Over three thousand people would attend the meeting, 2,565 of whom had the honor of being voting delegates. The now graying Clark Tibbitts; Wilma Donahue, who spearheaded adult education in the 1940s at the University of Michigan; Ollie Randall, who built some of the first old age homes; and E. V. Cowdry, the respected cytologist and founding member of the field of gerontology, came to offer their input. Despite the high-powered collection of experts on aging, business executives, government operatives, media darlings, and medical professionals with wide ranging proficiencies, the WHCA would be a single-issue skirmish, with a clear winner.

IV. Taking Over the Conference

On Monday afternoon, participants got to work, discussing everything from recent research in gerontology to demographic patterns. While vibrant "activity" took place across the groups, the "action" was in the sections on "Health and Medical Care" and "Income Maintenance." Stacked with physicians, the "Health and Medical Care" section looked powerful from the outside, but, upon arrival, attendees realized they explicitly lacked the authority to make policy recommendations on the financing of medical care. This privilege went to the group meeting on "Income Maintenance," where physicians and their allies held only 37 out of the 269 delegate positions and 77 of the delegates came from the AMA's opposition, labor and social welfare groups.[32]

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[31] Richard Harris, "Annals of Legislation: Medicare, " *New Yorker*, July 16, 1966: 49. *See* also Richard O. Harris, *A Sacred Trust* (New York: New American Library, 1966), 74.
[32] *See* John R. Lindsey, "How the Social Security boys broke through," *Medical Economics*, February 13, 1961, Cruikshank Papers.

John R. Lindsey, a journalist for *Medical Economics,* witnessed the proceedings. When he entered a sub-group dedicated to "Income Maintenance" in Foyer B-5 of the Shoreham hotel, Dr. Ernest B. Howard from the AMA took the floor railing, "Shall we have a Big Brother welfare state in which Big Government pays our medical bills for us? Social Security medical care is socialized medicine." When Howard sat down, a "stocky man across the table rose to his feet. He was Anthony G. Weinlein, director of research and education for the Building Service Employees International Union, A.F.L.-C.I.O. He said, "I think all of us have heard these arguments before. All we're trying to do is help people to a decent old age."[33] The match of wills and rhetoric pressed on. Finally, Workgroup I-5 quieted for a vote. Sixteen supported "Social Security medicine"; twelve opposed it. Lindsey described the breakdown: "*For Social Security medicine:* five labor union representatives, four public welfare officials, four leaders of retired citizens groups, a young man with the Fair Employment Practices Commission in California, a retired professor of education, and Mrs. Shirpser of Berkeley Calif. *Against Social Security medicine:* four physicians, five insurance company executives, a businessman, a lawyer, and an unaffiliated private citizen."[34] The other working groups in "Income Maintenance" concurred, with a final vote of 170 to 99.[35]

When the physicians twiddling away their delegate votes in the "Health and Medical Care" working group heard about the vote, they proposed their own amendment against federal health care financing for the elderly. Repeating the party line they wrote, "Compulsory health care inevitably results in poor quality health care."[36] The section

[33] Ibid., 201.
[34] Ibid.
[35] Ibid., 202.
[36] Ibid.

adopted the amendment with a vote of 165 to 122. Intercommittee warfare ensued, with Conference Chairman Robert Kean called in "for a ruling."[37] Kean concluded that everyone had a right to state opinions on medical care, but that the working group on "Health and Medical Care," had "no right to pass any recommendation on financing such care."[38] With that, the AMA had visibly lost.

The pro-Medicare contingent captured the ruling and then proceeded to secure public opinion within and outside the conference. "The applause in Constitution Hall was deafening," when Dr. Warren Draper, a physician for the United Mine Workers and a delegate with "Health and Medical Care," read his minority report before the conference, stating: "'It is distressing to be told by organized medicine that the quality of care that the individual physician renders will be influenced by the source of payment."[39]

On January 12, the day the conference concluded, the *Baltimore Sun* broadcast, "The AFL-CIO and the AMA fought it out today, and the AFL-CIO won."[40] The Conference's conclusions, the *Sun* reminded readers, are not "binding." The overwhelming decision on behalf of Medicare "merely lets the world in general, and the United States Congress in particular, know how the majority of the 2,600 delegates from several hundred organizations interested in the problems of aging feel about the situation."[41] "We got burned, all right," reflected the former president of the AMA, Dr. David Allman.[42] While Allman blamed "the stacking done by the Social Security boys—

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[37] Ibid, 204.
[38] Robert Kean, quoted in Ibid., 204.
[39] Ibid, 208.
[40] Howard Norton, "Conference on Aged Backs Social Security Health Plan," *Baltimore Sun*, January 12, 1961: 1.
[41] Ibid.
[42] Dr. David B. Allman quoted in John R. Lindsey, "How the Social Security boys broke through,", 182.

the union guys, the social welfare people,"[43] Dr. Golda Nobel advanced a slightly more nuanced assessment. In her report to the American Medical Women's Association, she acknowledged that nineteen out of twenty sections "were almost completely obscured by one controversial issue…the method of payment for medical care for the aged." This was not a simple problem of stacking a strategic working group. In her words, "It did not require a penetrating mind to recognize that the W.H.C.A. was a ploy for what turned out to be a highly successful launching of a trial balloon, which, far from being shot down, was buoyed up higher and higher by an enthusiastic and demanding plurality.… The priority over the many equally important problems of the aged, given to the polemic problem of medical payment, suddenly transformed the conference into what might be described as an indignation-meeting."[44]

This "indignation-meeting" did not bolster the AMA's cause with Dr. Nobel. Rather, she related to her fellow female physicians, "it became impossible to participate in this conference and remain insensitive to the intense hope, as expressed by the many, in the direction of resolution." This issue was a "paradox for the medical profession." It was a tribute to a field that had helped bring about "lower mortality, improved health and longer life span." Meanwhile, the AMA's political stance had cast "its members as an enemy of the people." "The truth is simply this," Dr. Nobel concluded, "the medical profession has already given up many of its prerogatives to lay hospital administrators, to quasi-governmental bureaus, to insurance groups. By continuing with its attitude of political neanderthalism, it will forfeit many of its remaining powers. And not merely the

[43] Ibid.
[44] Dr. Golda Nobel's Report to the American Medical Women's Association was enclosed in John H. Barclay's letter to Nelson Cruikshank, February 7, 1961, MSS 1002, Box 1, File 22, Cruikshank Papers. 2.

profession, but also the quality of medical care will suffer."[45] At the close of the conference, experts had voiced their support of Medicare, the press and the public had concurred, and even doctors were challenging the ranks.

V. Who is Obligated? The Rabbi, The Social Worker, and The Senator

Although barely reported, dissent at the conference did not exclusively come from the AMA. Religious leaders, social workers, and conservative politicians offered their own assessments of its direction. Some supported health insurance for the aged but raised concerns about the single-minded focus of the conference; others urged thinkers to see the Forand bill in a larger framework of the proper role of the federal government. Although these soft and hard dissents did not deter the surge of support for the Forand bill, they exposed the pitfalls that would continue to haunt both the Medicare movement and the eventual policy.

In the throes of the conference, the soft critiques offered by the bill's supporters gained ground, igniting conversations and stimulating a rethinking of the parameters of care for the aged. At the close of the conference, and in the ensuing years, concerns offered by the likes of Rabbi Abraham Joshua Heschel and Ollie Randall were overshadowed by the growing conservative opposition, which conflated the particular case of health insurance for social security recipients into a wider argument against a bloated federal government.

Born in Poland, Rabbi Abraham Joshua Heschel arrived in America at the end of World War II. An intellectual luminary in Europe, Heschel established himself in America as a theological and moral force for the Jewish and interfaith community. He

[45] Ibid.

published works on medieval Jewish philosophy, Hasidism, and theology, eventually articulating his own philosophical approach to religion in his pivotal works *Man Is Not Alone* (1951) and *God in Search of Man* (1955).[46] His ethical code extended beyond the page and the classroom: he believed faith demanded action. He took stands on the major ethical questions of his day, speaking in Washington, D.C., forging a close alliance with Martin Luther King Jr. and championing the civil rights movement. In 1961, many Americans knew Heschel's name; what they did not know was his particular take on the nature of family obligation.

At the meeting on "The Older Person, Family Life, and The Services They Need," the great rabbi stood to speak and presented his audience with a harrowing description: "I see the sick and the despised, the defeated and the bitter, the rejected and the lonely. I see them clustered together and alone, clinging to a hope for somebody's affection that does not come to pass. I hear them pray for the release that comes with death. I see them deprived and forgotten, masters yesterday, outcasts today."[47] Looking at his audience he continued with a reproof: "What we owe the old is reverence, but all they ask for is consideration, attention, not to be discarded and forgotten. What they deserve is preference, yet we do not even grant them equality. One father finds it possible to sustain

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[46] Abraham Joshua Heschel, *Man Is Not Alone: A Philosophy of Religion* (New York: Farrar, Straus & Young, 1951) and *God in Search of Man: A Philosophy of Judaism* (New York: Farrar, Straus & Cudahy, 1955).

[47] This article has been reprinted as "To Grow in Wisdom," Abraham Joshua Heschel, *The Insecurity of Freedom: Essays on Human Existence* (New York: Farrar, Straus & Giroux, 1966), with the quoted passage on p. 70. The text also appears as "The Older Person and the Family in the Perspective of Jewish Tradition," in *Aging with a Future: A Selection of Papers Defining Goals and Responsibilities for the Current Decade; Reports and Guidelines from the White House Conference on Aging* (Washington, D.C.: U.S. Dept. of Health, Education, and Welfare, Special Staff on Aging, 1961).

a dozen children, yet a dozen children find it impossible to sustain one father."[48] The audience was listening.

This was the second time Heschel had addressed an interfaith crowd in Washington, D.C. A year earlier, he had challenged prevailing attitudes to the so-called problem of youth. At the White House Conference on Children and Youth, which took place on March 28, 1960, he questioned the efficacy of focusing on "youth" outside of their relationships with adults. He pronounced, "The heart of the Ten Commandments is to be found in the words *Revere thy father and thy mother*. Without profound reverence for father and mother our ability to observe the other comandments is dangerously impaired."[49] But reverence, he asserted, will not develop automatically it must be earned. The onus, then, is on the parents, the adult generation, to be worthy of such a feeling. He went on, "The problem we face, the problem I as a father face, is why my child should revere me. Unless my child will sense in my personal existence acts and attitudes that evoke reverence—the ability to delay satisfactions, to overcome prejudices, to sense the holy, to strive for the noble—why should she revere me?"[50] Before fretting over the moral fiber of the young, Heschel insisted that adults, parents, had the obligation to fret over themselves.

But parents, he conceded, can only do so much. American culture and policy, he maintained, created an unfortunate division between the world of the young and the world of the old. Age segregation dismantled the opportunities for shared learning, shared joy, and shared wonder. "Our society," he lectured, "is fostering the *segregation of youth*, the separation of young and old. The adult has no fellowship with the young. He has little

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[48] Heschel, "To Grow in Wisdom," *The Insecurity of Freedom*, 70.
[49] Heschel, "Children and Youth," *The Insecurity of Freedom*, 40–41.
[50] Ibid.

to say to the young, and there is little opportunity for the young to share the wisdom of experience, or the experience of maturity."[51] At a conference devoted to describing the problems of the young, Heschel called attention to the fact that thinking about any problem as that of the young, or that of the old, will only lead to a further dismantling of the familial relationships. Heschel urged a multigenerational approach to the problem of youth, one that refrained from extracting the young from the kinship relationships that marked their lives. He pursued a similar approach at the White House Conference on Aging.

Heschel overtly endorsed using the "Social Security mechanisms" to provide "medical care for the aged," but he did not think this would solve the problem of old age.[52] The problem, he reiterated throughout the conference, was more than material well being; it was the agony of psychological and spiritual insecurity.[53] Echoing the earlier position of Ollie Randall, he described the "ills of old age" as "(1) The sense of being useless to, and rejected by, family and society; (2) the sense of inner emptiness and boredom; (3) loneliness and the fear of time."[54] The only answer to the hardship of old age was "a sense of significant being."[55]

Rather than focusing on what the elderly need, Heschel believed that the elderly themselves had to focus on the way in which they are still needed, on their obligations at this stage of life. "What a person lives by is not only a sense of belonging but also *a sense of indebtedness*. The need to be needed corresponds to a fact: something is asked of man,

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[51] Ibid., 48.
[52] Heschel, "To Grow in Wisdom," *The Insecurity of Freedom*, 71–72.
[53] Ibid., 73.
[54] Ibid., 75.
[55] Ibid., 77.

of every man."[56] In concert with this approach the delegates of the "Patterns of Living" section concluded with a Senior Citizens Charter that listed not only the "Rights of Senior Citizens" but also the "Obligations of the Aging."[57] One obligation was "to prepare himself to become and resolve to remain active, alert, capable, and self-supporting, and useful so long as health and circumstances permit and to plan for ultimate retirement."[58]

Finally, he urged his audience to focus not only on physical space but also on time. "Time is the only aspect of existence which is completely beyond man's control. He may succeed in conquering space, in sending satellites around the moon, but time remains immune to his power."[59] Time posed a specific challenge to the aged, for, "Old age has the vicious tendency of depriving a person of the present." It does so because the "aged thinks of himself as belonging to the past." [60] This tendency must be balanced by attitudes and policies that offer the elderly an opportunity to be present, to continue the process of growing. "It is precisely this openness to the present," Heschel argued, "that he must strive for."[61]

Even though many of Heschel's solutions to the crisis afflicting elders required internal work, he offered a number of policy solutions to aid Americans in this conceptual revision. First, the government should abandon chronological age from all policies. "The most delightful resolution the White House Conference on Aging could pass would be to eliminate from now any mention of the date of birth from the certificate."[62] Secondly, the government could urge private industries, insurance

[56] Ibid., 78.
[57] The *Nation and Its Older People*, 118.
[58] Ibid.
[59] Heschel, "To Grow in Wisdom," [Or other essay title, if that's not it], *The Insecurity of Freedom*, 80–82.
[60] Ibid.
[61] Ibid.
[62] Ibid., 71.

companies, advertising agencies, and social service organizations to abandon the conflation of leisure, retirement, and old age.[63] "While we do not officially define old age as a second childhood, some of the programs we devise are highly effective in helping the aged to become children," he insisted.[64] The emphasis on recreation, he continued, "aggravates rather than ameliorates a condition it is trying to deal with, *namely the trivialization of existence*."[65] In line with the attitudes of Clark Tibbitts and the work of Wilma Donahue at the University of Michigan, Heschel believed that there should be serious senior universities to foster continued intellectual engagement and skill reeducation for the elderly. This would have the added benefit of giving the middle aged and young the impression that seniors are capable of growth. "The goal," he contended, "is not to keep the old man busy, but to remind him that every moment is an opportunity for greatness."[66]

Returning to the logic of his "Children and Youth" speech, Heschel protested seeing the problems of the aged outside the hardships and pressures of the modern family, which he endowed with his own definition based as much on action as blood. Even today, the expectation of care resides in the family unit, but, he continued, "such expectation presupposed the concept of a family which is not only an economic unit but also an interplay of profoundly personal relations. It thinks of the family not only as a process of living together but also of a series of decisive acts and events in which all

[63] For more on the history of retirement in the United States *see* William Graebner, *A History of Retirement: The Meaning and Function of an American Institution, 1885–1978* (New Haven: Yale University Press, 1980); Katherine Anne Otis, "Everything Old Is New Again: A Social and Cultural History of Life on the Retirement Frontier, 1950--2000" (Ph.D., The University of North Carolina at Chapel Hill, 2008); and Andrew Achenbaum, "What Is Retirement For?" *Wilson Quarterly*, Vol. 30, No. 2 (Spring, 2006): 50–56.
[64] Heschel, "To Grow in Wisdom," *The Insecurity of Freedom*, 74.
[65] Ibid., 79.
[66] Ibid., 70.

members are involved and by which all are inwardly affected."[67] By isolating kinship networks into individual units, the obligation to work together and to enjoy one another, Heschel worried, would dissolve. For Heschel, this problem was as much economic as it was cultural: "Children today experience their highest moments of exaltation in a children's world, in which there is no room for parents. But unless a fellowship of spiritual experience is re-established, the parent will remain an outsider to the child's soul." "One of the beauties of the human spirit," he maintained, is that we "appreciate *what we share*, we do not appreciate *what we receive*."[68] To reconstitute the position of the elderly in society, Heschel argued, the government could assist in creating policies that aid intergenerational relationships and cater to kin networks rather than individuals. Age segregation, he insisted at a conference dedicated to the aged, could foster rather than solve the maladies of old age as well as the trials of youth.

Like Heschel, Ollie Randall offered a soft critique of the narrowing agenda of the conference. Summarizing the proceedings to the National Council of Jewish Women, she remarked, "It really surpassed my gloomiest expectations…. I am happy to say that the general atmosphere—once one could talk of something other than medical care and the AMA's position—was favorable to well organized discussion and the development of a series of interesting policy statements and recommendations."[69] While she did endorse using social security to finance medical care for the elderly, she urged further focus on the conflicts between generations, local needs, and retirement practices, and, most importantly, the mounting housing crisis.

[67] Ibid., 82.
[68] Ibid., 83.
[69] Ollie Randall, "*Spanning the Generations 3/5/61 National Council of Jewish Women Newark, NJ*," Box 30 File 327, Ollie Randall Papers, 2, Social Welfare History Archives, University of Minnesota Libraries, Minneapolis, Minnesota.

Since Randall ran her first old age home in the late 1920s, the institutional landscape for housing the elderly had transformed. The problem, as she saw it, was twofold: there was a dangerous shortage of feasible low-income housing for elderly couples and singles and there was a growing trend toward proprietary nursing homes, which separated the elderly from communities.[70]

One of the most dramatic, and unexpected outcomes, of postwar public policy in the arena of old age was the growth of proprietary nursing homes. Responding to a public outcry about alms and poorhouses, the 1935 Social Security Act stopped public funds from going to individuals housed in such institutions. The unintended result was the rise of privately owned homes for the elderly.[71] The 1946 Hill-Burton Act and its subsequent amendments contributed significantly to this trend, building incentive structures for homes for the aged to become their own kind of medical facilities, nursing homes.[72] "With the advent of nursing homes," physician and aging expert William C. Thomas comments, "proprietary homes—businesses operated for a profit—grew from virtual nonexistence to dominate the whole field of long-term care."[73] This development he argues, flew "in the face of the hundreds of years of health care in the health facility

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[70] Although some aged Americans benefited from public housing for low-income families it was not until 1956 that provisions for singles, which were the majority of the needy elderly, were made available. By the 1960s, private housing for the aged, which moved in to the fill the need and received subsidies from the federal government, became a big business. For more on housing policy for the elderly *see* Ollie A. Randall, "Some Historical Developments of Social Welfare Aspects of Aging, " in Gerald J. Gruman, *Roots of Modern Gerontology and Geriatrics: Frederic D. Zeman's* "*Medical History of Old Age*" *and Selected Studies by Other Writers* (New York: Arno Press, 1979), 45; Robert N. Butler, *Why Survive?: Being Old in America* (New York: Harper & Row, 1985), 125–129; William C. Thomas, *Nursing Homes and Public Policy: Drift and Decision in New York State* (Ithaca: Cornell University Press, 1969); Frank E. Moss and Val J. Halamandaris, *Too Old, Too Sick, Too Bad: Nursing Homes in America* (Germantown, MD: Aspen Systems Corp., 1977).); Bruce C. Vladeck, *Unloving Care: The Nursing Home Tragedy* (New York: Basic Books, 1980); Susan Vanhorenbeck, *Housing Programs Affecting the Elderly: A History and Alternatives for the Future* (Washington, D.C.: Library of Congress, Congressional Research Service, 1982).

[71] For more on the history of privately owned nursing homes *see* Vladeck, *Unloving Care*.

[72] Ibid., 43.

[73] Thomas, *Nursing Homes and Public Policy*, 2.

tradition and despite the predominance of critical judgment of professionals and leaders."[74]

Randall agreed. By 1960, there were somewhere between ten and eleven thousand nursing homes in the United States, and this was just the beginning.[75] By 1980 that number would jump to 17,000 nursing homes with an agregate revenue of over 12 billion a year. Much of that revenue, 60% within each home, came directly from the federal government.[76] After undertaking a fourteen-year study of these types of institutions, the former associate counsel to the U.S. Senate Committee on Aging, Val J. Halamandaris, had this to say in 1977: "The average senior citizen looks at a nursing home as a human junkyard, as a prison, a kind of purgatory, halfway between society and the cemetery, or as the first step of an invisible slide into oblivion. Nursing homes are not only synonymous with death, but with the notion of protracted suffering before death."[77] In 1961, Randall hoped the Conference would help redirect this trend. She wanted housing for the elderly but she wanted such housing to be responsive to the complex social and medical needs of the aged.[78] "Adequate housing," the working group on the subject concluded, "means housing which the aging can afford, which meets the special physical needs of the aged, and which is designed to avoid isolation from the rest of the community or an institutionalized feeling."[79] One of the most important aspects of old age housing, Randall argued for two decades, was its placement within a larger

[74] Ibid.
[75] Vladeck, *Unloving Care*, 45.
[76] Ibid., 3, 23.
[77] Moss and Halamandaris, *Too Old, Too Sick, Too Bad*, 14.
[78] *See* chapter II.
[79] *The Nation and Its Older People*, 181.

intergenerational community. That prospect grew ever more difficult with the rise of suburbs, exurbs, and industrially designed proprietary nursing home buildings.[80]

Geneva Mathiasen, Randall's colleague at the National Council on Aging, and a cohort of likeminded experts prepared a background paper on local community organization for the conference that reflected another of Randall's longstanding concerns: that single-minded approaches would never adequately deal with the complex and case-specific ailments afflicting the country's elders. Obstacles to solving the problem of old age, the paper opened, were philosophical as well as methodological, "our society is confronted not only with how to provide services, but with questions of family versus community responsibility." Each community, the paper argued, had to struggle with these debates and provide local approaches. They had to find solutions to "what should be done" as well "how it should be done."[81]

Drawing on the example of Mr. and Mrs. Malady, the writers insisted that communities across the country could see the results of misbegotten community plans, which did not exactly fit local needs. The 78-year-old Mrs. Malady suffered from arthritis, heart disease, and cared for her blind 84-year-old husband on a meager pension and Social Security. With few surviving friends and no nearby family, the couple could use support. They could benefit, the essay continued, from "a specially designed housing project," a "recreation center," "homemaker services," or "homecare." But, in their community, as in most, the actual services are standardized and limited. It would be "valueless" to Mrs. Malady to have, for example, a home for the aged dedicated to single

[80] For more the history of suburbanization *see* Kenneth T. Jackson, *Crabgrass Frontier: The Suburbanization of the United States* (New York: Oxford University Press, 1985).
[81] White House Conference on Aging, *Background Paper on Local Community Organization* (Washington, D.C..: Government Printing Office, 1960), 22–23.

living. Moreover, it could be detrimental for their quality of life to be pushed into a nursing home, and a "chronic hospital might be useful for a period of time, but what happens to the Maladys after they leave the hospital doors?" The only answer, the writers concluded, is to retain multiple professions and perspectives in community planning."[82]

This approach, which privileged the local over the federal, would be echoed, albeit with a different tenor, by Senator Barry Goldwater of Arizona. Goldwater, a political representative of the growing postwar conservative renaissance, maintained a philosophical approach that joined a respect for individualism, with skepticism over social planning at a federal level and a deep fear of Communism.[83] He would come to offer the harshest and most lasting critique of the single-minded policy focus of the conference.

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In a photograph snapped at the WHCA, Senator Barry Goldwater is seated next to Rabbi Heschel. Although the two shared a similar style in suits, their facial hair, glasses, and positions on the American family and the problem of old age quickly brought their fundamental differences to light.[84] Whereas Heschel pushed for benevolence and generosity at every level of planning, from the family to the federal government, Goldwater believed that benevolence was a scarce resource. If the government gave too much, children would start to give too little.

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[82] Ibid., 22–23, 29.
[83] For more on conservative thought in twentieth-century America, *see* Donald T. Critchlow and Nancy MacLean, *Debating the American Conservative Movement: 1945 to the Present* (Lanham, MD: Rowman & Littlefield Publishers, 2009); and Paul Pierson and Theda Skocpol, *The Transformation of American Politics: Activist Government and the Rise of Conservatism* (Princeton: Princeton University Press, 2007).
[84] *Aging* (Federal Security Agency), Cruikshank Papers, 11.

Barry Morris Goldwater, a business man from Phoenix, came to Washington, D.C., in 1952 as a United States Senator.[85] As the inheritor of a family dry goods company, he advanced a political ideology centered on personal responsibility, individualism, and states rights. He was a conservative before the term married social issues, like abortion, with economic ones, like low taxes. As head of the family business, he was relatively progressive, integrating his stores, instituting limited workweeks, and offering employees fringe benefits.[86] As a senator, he believed strongly in leaving governing policies to individuals and the states, even voting against the 1964 Civil Rights Act.[87]

Throughout his life, he remained a man of contradictions, bucking party loyalty in the 1990s by supporting federal intervention for a woman's right to choose and allowing openly gay soldiers to serve in the military.[88] President Eisenhower had this to say about Senator Goldwater, "Barry, you speak too quick and too loud."[89] Rick Pearlstein surmised decades later, "Goldwater had a flair for self-dramatization."[90] In 1961, Goldwater was busy crafting his political persona and a coherent conservative ideology to go with it. Opposition to a ballooning welfare state was his trump card.

In 1960, Goldwater published *The Conscience of a Conservative*, a ghostwritten screed, which set out to convert the nation.[91] Conservatives, the book argued, were not against social welfare, rather they were for personal responsibility and fearful of a strong

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[85] For more on Goldwater, *see* Robert Alan Goldberg, *Barry Goldwater* (New Haven: London, 1995) and Rick Perlstein, *Before the Storm: Barry Goldwater and the Unmaking of the American Consensus* (New York: Nation Books, 2009).
[86] Bart Barnes, "Barry Goldwater, GOP Hero, Dies," *Washington Post*, May 30, 1998: A01.
[87] Ibid.
[88] Ibid.
[89] Ibid.
[90] Rick Perlstein, *Before the Storm*, 21.
[91] Goldberg, *Barry Goldwater*; Perlstein, *Before the Storm*, 51.

and suffocating state. Moreover, federally mandated charity dangerously bolstered government power and spending while having a deleterious affect on the character development of Americans. One "of the great evils of Welfarism," he maintained, was "that it transforms the individual from a dignified, industrious, self-reliant *spiritual* being into a dependent animal creature without his knowing it."[92]

Goldwater extended these ideas in his speech at the White House Conference on Aging. Like Heschel, he made family life the center of his comments. Unlike Heschel, he saw the threat to family life coming not from the actions of actual family members but from a malignant outside source, Communism. He decried, "Family responsibility which is built by the understanding and love of the members of the family between each other and as a unit is the great strength of free people and the family is the basic target of communism everywhere in this world. Destroy the mutual respect and love that members of the family have for each other and you have effectively destroyed the spiritual strength of any nation."[93] Familial destruction, Goldwater argued, would come from the shift in responsibility from the children to the state. He broadcast, "The key word here, I submit, is the word 'responsibility.' Where does responsibility primarily lie in questions affecting the family and its aged members?... It is a problem too intimate for cold handling by bureaucracy…. If the attitude develops that we don't have to worry about mother and father because the Federal Government is going to take care of them, then you have pretty much destroyed both ends of the line of responsibility in the family, the responsibility of the parent to the child and the child to the parent."[94] If the government

[92] Barry M. Goldwater, *The Conscience of a Conservative* (Shepherdsville, KY: Victor Publishing Company, 1960).
[93] Barry Goldwater, "Family Life and Older Persons," in *Aging with a Future*, 11.
[94] Ibid., 12, 15.

stepped in, he insisted, first children would stop taking care of their parents and then parents would have no reason to take care of their children. In essence, Goldwater centered his vision of familial obligation on the essential selfishness of all parties.

Goldwater, Randall, and Heschel were all concerned with personal and familial responsibility, yet they came to drastically different conclusions about how such responsibility could be cultivated. Randall hoped to give the aged the gift of personal responsibility by creating self-run aged centers, educating the young and middle aged about the demands of old age, and keeping the elderly engaged in communal life.[95] Heschel agreed but added another layer. He felt that mutual responsibility for family members had to be pursued through shared learning and work opportunities. Age segregation, not Communism, loomed as the largest threat to family obligations. Heschel and Randall urged federal policy that supported kinship and communal relationships. Although the elderly surely needed help with the rising cost of healthcare they also needed policies at the level of urban planning, housing, employment, and reeducation that would help them productively participate in the social and economic life of the country.

Rather than a proactive response towards cultivating family obligations, Goldwater felt that the status quo worked and that any intervention to ease the financial burdens on families would diminish individual responsibility. He concluded his conference remarks, "Let's not, then, dash off into some new frontier that will in the long run bring more trouble to all of us. Let's take the steps necessary to encourage our people to take care of themselves and their families, and the problems in this general field will be solved as they have always been solved by the Americans themselves."[96] As

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[95] *See* chapter II for further discussion.
[96] Goldwater, "Family Life and Older Persons," in *Aging with a Future* , 17.

Goldwater pursued his political ambitions in the early 1960s and repeatedly offered his conflation of Medicare with Communism and the dissolution of personal obligation, progressive and Democratic concerns about Medicare became less salient. By the middle of the 1960s, anyone who wanted to offer a soft critique of the policy, or use the phrase "personal responsibility," ended up sounding a little too much like a Goldwater Republican.[97]

VI. The National Council of Senior Citizens

One month after the WHCA closed, President John F. Kennedy spoke before Congress. Still echoing the dreams of an incremental approach to health insurance, he began, "Ill health and its harsh consequences are not confined to any state or region, to any race, age, or sex, to any occupation or economic level. This is a matter of national concern."[98] Still, solutions must begin somewhere, and Kennedy led with the elderly and followed with the children:

> Those among us who are over 65—16 million today in the United States—go to the hospital more often and stay longer than their younger neighbors. Their physical activity is limited by six times as much disability as the rest of the population. Their annual medical bill is twice that of persons under 65—but their annual income is only half as high. The nation's children—now 40 percent of our population—have urgent needs which must be met. Many still die in infancy. Many are not immunized against disease which can be prevented, have inadequate diets or unnecessarily endure physical and emotional problems.[99]

[97] For more on how the phrases "personal responsibility," "personal independence," and "self-sufficiency," moved between liberal and conservative rhetoric in the 1960s and 1970s *see* Gareth Davies, *From Opportunity to Entitlement: The Transformation and Decline of Great Society Liberalism* (Lawrence: University Press of Kansas, 1996).
[98] John F. Kennedy, "Special Message to the Congress on Health and Hospital Care," February 9, 1961, http://www.jfklink.com/speeches/jfk/publicpapers/1961/jfk27_61.html.
[99] Ibid.

The needs of the elderly and the needs of children must be met, but government, he conceded bore "only a part of the responsibility."[100] The Kennedy administration would adopt the Ewing approach to national health insurance. They would strive for broad national health programs through incremental policies. Medicare would be the primary obligation and the rest would have to follow.

Kennedy offered his own version of Medicare. He proposed "that all persons aged 65 and over who are eligible for social security or railroad retirement benefits" receive 90 days of inpatient hospital coverage, 180 days of nursing home services following hospital visits, outpatient clinical diagnostic services if the costs exceed $20, and coverage for visiting nurses.[101] Although still primarily a hospital insurance program, the surgical benefits included in the original Forand bill were dropped. The Kennedy bill would be financed by a small increase in social security contributions from employers and employees and an "increase in the maximum earnings base from $4800 a year to $5000."[102] In this way the policy would be financially self-supporting. Most importantly, he argued, "This program is not a program of socialized medicine. It is a program of prepayment of health costs with absolute freedom of choice guaranteed. Every person will choose his own doctor and hospital."[103] The following week, Senator Clinton Anderson (D-New Mexico) and Congressman Cecil King (D-California) introduced Kennedy's bill.[104]

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[100] Ibid.
[101] Ibid.
[102] Ibid.
[103] Ibid.
[104] Marmor, The Politics of Medicare, 31.

Despite widespread public support, the King-Anderson bill languished in the Ways and Means Committee.[105] Kennedy responded to the congressional stonewall by using his defeat to shore up even more national attention to the issue. As Marmor writes, "Although he had rejected the use of arm-twisting tactics within the Congress, Kennedy hoped to put indirect pressure on legislators by going to the public with an educational campaign about the legislation denied him in 1961."[106] The WHCA and the remnants of Senior Citizens for Kennedy came to his aid yet again; this time, in the form of the National Council of Senior Citizens.

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Elders had been agitating for self-representation, and their own lobby, since the pension movement of the 1930s.[107] Oliver Carlson, secretary of The Liberal League for Adequate Pensions, pleaded in 1949 "that those drawing old-age pensions should dump pension promoters overboard and run their own organization."[108] In 1955, a popular radio host continued this tradition by pushing old folks to organize their own union:

> We are faced with the obvious fact that our senior class is growing tremendously and becoming a factor of potent political power. This is a power of which our politicians are well aware. It could be organized like the veterans, the farmers, or the unions, into a political pressure group, which at the very least could defend itself against discriminatory practices. It could wield its mature influence in the directions of national safety and betterment.[109]

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[105] Ibid., 32.
[106] Ibid., 38.
[107] For more on the history of the pension movement *see* W. Andrew Achenbaum, *Shades of Gray: Old Age, American Values, and Federal Policies since 1920* (Boston: Little, Brown, 1983); Henry J. Pratt, *Gray Agendas: Interest Groups and Public Pensions in Canada, Britain, and the United States*, (Ann Arbor: The Univ. of Michigan Press, 1994); Roy Lubove, *The Struggle for Social Security, 1900–1935*, (Cambridge: Harvard University Press, 1968); and Quadagno, *The Transformation of Old Age Security: Class and Politics in the American Welfare State.*
[108] The Watchman, "Older Folk Urged to Run Own Group," *Los Angeles Times*, November 21,1949: A1.
[109] "Dean of Commentators Urges Union for Aged," *Philadelphia Tribune*, May 31, 1955: 12.

At first blush, the National Council of Senior Citizens (NCSC) looked like such a union. Elders swarmed political rallies, gathered for letter campaigns, and staged events across the country alerting politicians to their growing power. Upon closer examination, the NCSC was a one-issue coalition, created by labor unions to harness the senior vote and present the image that the fight for Medicare came solely from America's aged citizens.

Although one could credit Oscar Ewing for introducing the idea of a senior citizens group that would lobby on behalf of Medicare, the journalist Richard Harris locates the NCSC's conception at the WHCA. There, a conversation took place between Aime Forand, Nelson Cruikshank, Charles Odell from the United Auto Workers Union, and James Cuff O'Brien from the United Steel Workers. Odell and O'Brien argued for the merits of a seniors group, while Cruikshank hesitated, fearing a renaissance of the Townsend movement. Harris reported Cruikshank saying, "The Townsend people, back in the thirties, were widely irresponsible…. If they'd had their way, the United States would have been bankrupt inside a year." Cruikshank feared that a seniors group "might create a sort gerontocracy that would plague the government for one handout after another."[110] In the summer of 1961, Odell and O'Brien moved forward with the idea. They secured a small amount of funds, persuaded the now renowned Forand to chair the organization, and set up a small office in Washington, D.C.[111]

With the structure of the National Council of Senior Citizens determined, Odell and O'Brien went back to Cruikshank. According to Cruikshank, the duo

[110] Nelson Cruikshank, quoted in Harris, "Annals of Legislation: Medicare, " 51.
[111] Ibid.

wanted a formal endorsement from the A.F.L.-C.I.O. and money.[112] This time, he was persuaded by their argument: the elderly needed the labor movement and the labor movement needed the elderly. Summarizing their logic, he recalled,

Look, labor can't do this alone. It's got to be more than a labor cause. The old people are interested in this, but they're inarticulate, they have no way of channeling their influence to Congress, they don't know how to be effective with Congress. They've got to have a paper, a bulletin, a little staff of field people and people that can talk their own language, appeal to their own interests, get them to take part in political action and legislative action. And the labor movement can't do this…. Its political activity is ragged and known…. You need a broader base and this is the way to get it.[113] Moreover, Cruikshank understood that a fight which pitted organized labor against organized medicine, would never garner public sympathy. A fight between organized medicine and aged Americans, they gambled, would.[114] The A.F.L.-C.I.O. agreed to sponsor and fund the organization.

Six thousand thank you letters from seniors awaited Forand after Kennedy's 1960 win. Until the founding of the NCSC, they were left unanswered.[115] These letters now formed the basis for a growing coalition of seniors and senior groups that would participate in the NCSC's political mission, the passage of Medicare. When Oscar Ewing received his form letter, he wrote back delighted by Forand's new mission. Then, in a post script, he reminded the former congressman of his own decade long strategy, "Just on the basis of naked political power, can 185,000 doctors have more weight than 16

[112] "Reminiscences of Nelson Hale Cruikshank,", 203.
[113] Ibid., 208.
[114] Ibid.
[115] Harris, "Annals of Legislation: Medicare, " 51.

million people who are 65 and over? If these 16 million voters organize they can easily put the doctors in their place, Ewing wrote."[116]

While Forand urged a grassroots approach to funding and political organizing, the NCSC survived, and flourished, off of two major donations, one from the A.F.L.-C.I.O. and the other from the Democratic National Committee (DNC).[117] Kennedy's election alerted the DNC to the voting power of the elderly. Leaders within the party came to believe by 1961 that the aged vote won a number of key districts and contributed to Kennedy's win.[118] With the AMA marshalling its troops, the DNC decided to keep the NCSC afloat with small donations.

With funding secured, the organization morphed from a loose confederacy of interested elders to a structured lobbying group.[119] As William R. Hutton, a public relations professional hired to run the organization remarked, "The AMA had all the money, and we had all the old people. My job was to switch them from the bingo circuit to social action."[120] And that he did. While the NCSC remained a collection of golden ring clubs and aged activists, through Hutton, "the council became an important pressure point in the push for Medicare, holding giant rallies, organizing major letter campaigns to

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[116] "Letter from Oscar Ewing to Aime Forand September 21, 1961," Box 58, Folder Aging Correspondence, Oscar R. Ewing Papers, The Harry S. Truman Library and Museum, Independence, Missouri.
[117] Harris, "Annals of Legislation: Medicare, " 51.
[118] Ibid.
[119] For more on senior citizens as an interest group *see* Henry J. Pratt, *The Gray Lobby* (Chicago: University of Chicago Press, 1976); Robert B. Hudson, *The Aging in Politics: Process and Policy* (Springfield, Ill.: C. C. Thomas, 1981); Christine L. Day, *What Older Americans Think: Interest Groups and Aging Policy* (Princeton: Princeton University Press, 1990); Henry J. Pratt, *Gray Agendas Interest Groups and Public Pensions in Canada, and the United States*, (Ann Arbor: The University of Michigan Press, 1995); Charles R. Morris, *The AARP: America's Most Powerful Lobby and the Clash of Generations*, (New York: Times Books, 1996); Lawrence A. Powell, Kenneth Branco, and John B. Williamson, *The Senior Rights Movement: Framing the Policy Debate in America* (New York: Twayne, 1996).
[120] Harris, "Annals of Legislation: Medicare, " 51.

Congress," as Robert M. Ball remarked.[121] Hutton, Cruikshank, and others also devised a series of strategies to enhance Medicare's public appeal while zeroing in on the districts of key Ways and Means Committee members.

The voice and look of massive groups of elderly provided the main thrust of the public relations campaign, but the Medicare strategists widened their tent by appealing, recalled Ball, to "the sons and daughters of the elderly," to those Americans "most at risk for the hospital bills of their parents."[122] At the same time that proponents of Medicare extended their audience to the middle-aged they fostered multi-organization coalitions through joint projects. The popular pamphlet "We Support?" listed over sixty different national organizations that had come out in favor Medicare. The pamphlet itself had been a feat of collaboration, published by the American Association of Social Workers, with the printing costs covered by the United Steel Workers and the mailing costs by the AFL-CIO.[123] Finally, Forand and Cruikshank devised a plan to use the NCSC to target key members of the Ways and Means Committee.

When Peter Corning interviewed Forand for the oral history Social Security Project he asked, "One of the comments that's been made about the National Council is that as a young organization seeking to play a role and influence the course of a major piece of legislation, it seemed to have a very firm grasp of exactly where the problem lay, and I mean specifically the Ways and Means Committee. It has been said that you were the person who was responsible for formulating for the National Council what the

[121] Robert M. Ball, "Perspectives on Medicare," *Health Affairs* 14, no. 4 (1995): 67.
[122] Ibid.
[123] "Reminiscences of Nelson Hale Cruikshank," , 316; and "We Support… Health Benefits for the Aged Through Social Security," National Association of Social Workers Pamphlet Date 1961?. MSS 1002, Box 1, File 16, Cruikshank Papers.

problem in Congress was and how it needed to be solved. Is that true?"[124] Forand responded with hearty agreement. The NCSC had been instrumental in organizing senior meetings in the congressional districts of the Ways and Means committee members. George Smathers (D-Florida) would credit Lyndon Johnson for changing his vote in 1965, but Cruikshank worked tirelessly with the NCSC on the ground in Florida to influence his position. In Cruikshank's words, "Well, we really went to work—the National Council of Senior Citizens and our unions and everybody else—to really make these demonstrations…. For instance, in Fort Lauderdale, they had to change the hall three different times. Smathers came and looked out over a sea of several thousand old people. And while they were orderly and all, there were banners all over the place for medicare and everything else."[125]

By 1962, the NCSC had 1,500,000 members and had been involved in thirty-five congressional races, offering their support to pro-Medicare candidates. [126] On May 20 of that year, NCSC with the help of seventy independent senior organizations, put together twenty-eight mass rallies across the nation to support Kennedy's health insurance initiative."[127] In July, the group organized a petition signed by 2.5 million people on behalf of the plan.[128] While scholars disagree on the actual impact the NCSC had on the eventual Medicare vote in Congress, few would disagree that the fight for health

[124] Aime Forand and Peter A. Corning, interviewer, "Reminiscences of Aime Forand," Columbia University Oral Histories, Social Security Project: Oral History (1966), 66.
[125] "Reminiscences of Nelson Hale Cruikshank," 79.
[126] James MacNees, "Bill on Care of Aged Seen Sure of OK," *Baltimore Sun*, November 8, 1962: 3.
[127] "National Rallies Back JFK Health for Aged Plan," *Atlanta Daily World*, May 6, 1962: A1.
[128] "2.5 Million Petitioners Back Kennedy Health Plan," *Washington Post, Times Herald*, July 5, 1962: A7.

insurance consolidated the senior citizens movement.[129] Seniors might not have created Medicare, but Medicare surely helped create senior citizens.

From 1962 until its final passage in 1965, the fight for Medicare moved from the realm of broad public relations to the closed doors of the United States legislature. As political scientists, historians, and economists have carefully plotted, the policy battle would be fought pawn by pawn in Congress. Still, it took the 1964 election to remove the final legislative roadblocks. Lyndon Johnson's vision for a caring, obligated, central government bested Goldwater, and the Democrats obtained thirty-two new seats in the House.[130]

Despite almost 14,000 pages filled with years of testimony on the subject in the Ways and Means Committee Chairman, Willbur Mills had, until 1964, been able to stall reporting a Medicare bill. After the election, he had to act.[131] But the way he did surprised everyone, Democrat and Republican alike. Mills, with the assistance of Wilbur Cohen, decided to merge the Republican alternatives to Medicare with the King-Anderson bill in what Cohen would call the "three-layer-cake" approach.[132] The final bill included a hospital insurance program (Part A), a voluntary doctor's insurance program (Part B), and an expanded version of Kerr-Mills, now called Medicaid.[133] Mills pushed through a far more expansive view of federal health care while retaining much of the

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[129] *See* Pratt, *The Gray Lobby; Achenbaum, Shades of Gray*; and Christine L. Day, *What Older Americans Think: Interest Groups and Aging Policy* (Princeton: Princeton University Press, 1990).
[130] Marmor, *The Politics of Medicare*, 45.
[131] Ibid., 42.
[132] Ibid.,48.
[133] For a thorough discussion of the policy history of Medicare see Marmor, *The Politics of Medicare*; Eugene Feingold, *Medicare: Policy and Politics: A Case Study and Policy Analysis (*San Francisco: Chandler Pub. Co., 1966); Harris, *A Sacred Trust*; Peter A. Corning, *The Evolution of Medicare: From Idea to Law* (Washington, D.C.: Office of Research and Statistics, U.S. Social Security Administration, 1969); Rashi Fein, *Medical Care, Medical Costs: The Search for a Health Insurance Policy* (Cambridge: Harvard University Press, 1986); Jonathan Oberlander, *The Political Life of Medicare* (Chicago: University of Chicago Press, 2003).

logic of the first proposal in 1952, which spotlighted institutional care, bolstered private insurance options, and allowed doctors to set their own rates.

The pitfalls of the bill, including a massively inflated budget, incentives for doctors and hospitals to raise their prices, lack of cost-control mechanisms, and administrative complexity, have been well debated, as has the impact the bill has had on relieving elderly poverty.[134] In 1959, 35.2% of Americans over sixty-five years of age lived below the poverty line. In 2000 that number had dropped to 10%.[135] What has been less understood is how the drive to pass such a program inadvertently quieted a series of crucial conversations on the nature of old age, on age segregation, and on the viability of intergenerational health and social policies.

VII. Conclusion

Two years after the passage of the historical legislation he spent decades fighting for, Cruikshank pensively reflected, "there are many ironies in this matter."[136] Rather than paving the way towards national health insurance, he believed that Medicare buttressed the private insurance industry:

> Now that it's passed, I think all the pressure for national health insurance is removed. You see, it's not just that it fills the gap for the group of the population which non-governmental insurance could not fill, but removes the intolerable burden from the non-governmental health insurance…. In other words, what we were really doing was making voluntary insurance

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[134] For a historical treatment of these debates *see* Jonathan Oberlander, *The Political Life of Medicare*.
[135] Health Care Financing Administration, "Medicare 2000: 35 Years of Improving Americans Health and Security," July 2000, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/TheChartSeries/downloads/35chartbk.pdf. It is important to note how incomplete these statistics can be. Good statistics on elderly poverty take into account the vast differences in economic security among minority groups. For more on such disparities *see* U.S. Department of Health and Human Services, Administration in Aging, *A Profile of Older Americans* http://www.aoa.gov/Aging_Statistics/Profile/2011/docs/2011profile.pdf.: 11.
[136] "Reminiscences of Nelson Hale Cruikshank," 392.

> viable, for all—shoring it up for almost all of the working population of the country.[137]

For Cruikshank, as for Truman, Ewing, Cohen, and the vast majority of its greatest proponents, Medicare was never the goal. It was always the compromise.[138] No one imagined a permanent policy of age segregation in health care financing or the contagious impact that would have on the acceptance of age segregation more generally.

Despite his cynical rejoinder, Cruikshank concluded his remarks on Medicare, particularly the benefit of structuring federal benefits through payroll taxes, on a more optimistic note. "When the working man agrees to pay a payroll tax, he's buying not just medical benefits, but he's buying his dignity and self-respect, which to him is very real and worth money."[139] For the elderly, Cruikshank realized, Medicare became its own kind of lifeline.[140] It restored dignity by giving the aged a method to finance old age. He might have added that the policy also helped seniors forge a special relationship with the government, establish political power, and ignite discussions on the trials of aging in a country culturally fixated on youth. Arguably, Cruikshank's optimism in the program would only have been enhanced as Medicare eventually refined its financing to reign in health care costs in 1983 through prospective payments and became part of a larger national health insurance program with the Affordable Care Act in 2010.

In the opening month of 1965, Fogarty, who had come to accept Randall's vision of eldercare, offered his own, parting concerns: "We are on the threshold of enacting a program of health care for the aged and most of us will agree that action is long overdue."

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[137] Ibid.
[138] *See* Robert Ball, "Perspectives on Medicare," *Health Affairs* 14, No. 4, 1995.
[139] "Reminiscences of Nelson Hale Cruikshank," 393.
[140] Interestingly, when Cruikshank retired from the AFL-CIO in 1965 he became President of the National Council of Senior Citizens.

America's great proponent of medical research continued, "However, I am deeply concerned that some may be misguided into believing that health-care is the total answer to the needs of the elderly."[141] Fogarty's concern was rightly placed. The fight for equity for the aged did not end in 1965, but a certain kind of policy conversation narrowed. The Medical Security Solution, with its myopic focus on health care, medical progress, and health insurance, obscured crucial aspects of a prolonged old age, not least of which was the need for a dignified and peaceful place to end life.

In a 2011 *New York Times* piece, "How Medicare Fails the Elderly," Jane Gross, a journalist who spent a decade "studying the elderly," hit on a central theme that has dogged conversations about aged care in this country.[142] Namely, that the overwhelming optimism that old age could be medically solved stymied serious conversations on confronting the end of old age and the reality of death. She argued that Medicare was primed to help the elderly sustain life, but not at all equipped to help them face death. While Medicare would not reimburse assisted living costs or home health aids for her ailing mother, it would, she writes, "pay for 'heroic' care for a woman who was dying of old age, not a disease that could be treated: Diagnostic tests. All manner of surgery. Expensive medications. Trips to the emergency room."[143] In many ways, Medicaid, and not Medicare, has come through as the only long-term, non acute-care, solution available to elders, and, here too, financial incentives support institutionalization. "For millions of older Americans," write the political scientists James H. Schulz and Robert Binstock, "Medicaid is the only means by which long-term custodial care can be supported. Each

[141] "Older Americans Act," 1/27/65 Folder 8 Speeches Box 14B, John E. Fogarty Papers, 1941–1967, Providence College, Rhode Island.
[142] Jane Gross, "How Medicare Fails the Elderly," *The New York Times,* October 15, 2011.
[143] Ibid.

year half a million people 'spend down' their assets in order to qualify for long-term care assistance available under Medicaid."[144] Many of these "frail older people may end up being placed in nursing homes because institutional care, not home or community-based care, is the only form of long-term care for chronic disease paid for under the U.S. system."[145] There is a mismatch Gross rightly observes, "between what is covered and what is actually useful…. This mismatch tortures our elderly, drains the Medicare trust fund and leaves adult children with depleted retirement reserves."[146]

Seventy-one years before Gross wrote this article, cytologist and gerontologist E.V. Cowdry proffered his own concerns about the treatment of chronic disease. In the aptly titled 1940 article "We Grow Old," Cowdry agonized over how medical intervention might be misused on the aged: "To prolong their suffering is, like war, a misuse of science."[147] This early bio-medical innovator focused attention on how terms like *health care*, or even *care,* for that matter, must be carefully defined before being single-mindedly pursued. Cowdry understood that words mattered. How the elderly were defined, how their health needs were characterized, and how solutions were articulated would lay the groundwork for decades of federal policy.

By 1961, the Medical Security Solution and its attendant conflations overpowered political discourse: old age and the number sixty-five, health care and hospital care, and economic security and health insurance, to name only a few. It is the challenge of contemporary policy makers to untangle these conflations. To rethink the basic building

[144] James Schulz and Robert Binstock, *Aging Nation: The Economics and Politics of Growing Older in America* (Westport, CT: Praeger Publishers, 2006), 209.
[145] Ibid., 155.
[146] Jane Gross, "How Medicare Fails the Elderly," *The New York Times,* October 15, 2011.
[147] E.V. Cowdry, "We Grow Old," *Scientific Monthly* Vol. 50, No. 1 (January, 1940): 54.

blocks of the current eldercare architecture and offer careful definitions of old age, its benefits, its challenges, its needs, and its gifts. Only then will a serious conversation on the nature of government responsibility to the elderly be lucid and useful.

CONCLUSION

A Long Life and A Good Death

"One season only,
and it's done.
So let the battered old willow
thrash against the windowpanes
and the house timbers creak.
Darling, do you remember
the man you married? Touch me,
remind me who I am."
—Stanley Kunitz[1]

"Is it worth it?"[2] With these four words esteemed physician and gerontologist Robert Butler challenged forty years of American attitudes and policy making around old age. After decades of scientific research and federal policy, he wrote in his groundbreaking 1975 book *Why Survive?*, "we cannot promise a decent existence for those elderly alive."[3] The United States federal government has poured billions of dollars into defeating chronic disease, life-sustaining technologies, and institutions, such as hospitals and nursing homes, designed for medical intervention. Is it worth it? Is the extension of life the only valuable goal?

For many, this is an unthinkable—even reprehensible—question. Morally, politically, and personally it is unpalatable to imagine life not worth saving. Butler understood those stakes. He did not want a society that withdrew health care based on age or one that saw swaths of citizens as unworthy of medical research and intervention. Rather he posed the question to urge every politician and citizen to have a strategy by which they could answer, "yes, it is worth it"; to have a way to endow these additional

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[1] Stanley Kunitz, excerpt from "Touch Me," from *Passing Through: The Later Poems, New and Selected* (New York: WW Norton, 1995), http://www.theatlantic.com/past/docs/unbound/poetry/antholog/kunitz/touchme.htm.
[2] Robert N. Butler, *Why Survive?: Being Old in America* (New York: Harper & Row, 1985), xi.
[3] Ibid.

years of life, between sixty-five and eighty-five or seventy-five and ninety-five, with security, purposefulness, and joy.

Butler, who passed away in 2010, was not the first to embark on such a quest. Scientists, social workers, policy makers, doctors, and religious leaders have, since the close of World War II, attempted to relieve the burdens of old age. Collectively they have challenged the definition of old age, the viability of chronology as a medical and political marker, the dissolution of intergenerational relationships and obligations, and the dangers of myopically seeking longevity over a purposeful and dignified end. Their perspectives, while present in scientific, medical, and political discourse, did not translate into broad, well-funded federal programs.

In their stead, the government threw its financial and administrative weight behind initiatives, such as bio-medical research and Medicare, which sought to cure the diseases of old age and relieve financial insecurity by covering the health care costs of social security recipients. I have referred to this approach as the Medical Security Solution.

In this dissertation, I have asked how and why the Medical Security Solution captured the attention of policy makers, activists for the aged, and senior citizens in the middle of the twentieth-century, as well as what ideas were lost in this process. It is my contention that three trends in the postwar period aligned to support this solution: a belief in the curative powers of bio-medical science, the political need for an alternative to national health insurance, and the emergence of socially organized elders ready to take on a cause. By 1961, the viability of Medicare as a solution to the problem of old age muted,

but did not erase, two decades of capacious conversations on the complex challenges of providing for America's aged citizens.

Those conversations survived in university classrooms and gerontology-training programs, and even managed to come to light in a few policy initiatives, such as the Americans with Disabilities Act, which benefited the elderly without segregating them from other age groups.[4] Still, the ideas advanced by such experts as E. V. Cowdry, Ollie Randall, and Abraham Joshua Heschel never arose as a serious policy alternative to the Medical Security Solution. They failed to so for a number of reasons. For one, experts, suspect of the push to medically cure old age, were still willing to help the elderly through any feasible means. Rather than sacrifice the good for the perfect, they quieted or postponed their concerns. Moreover, many remained optimistic that Medicare would be the first step toward universal health care. In addition, it was difficult to translate their proposals, which advocated for intergenerational planning, reemployment initiatives, an end to age-specific policies, local housing and home care initiatives, and, finally, public conversations on the limits of science, technology, and life itself, into actual federal policies. Finally, and most importantly, these critiques of the Medical Security Solution fell to the wayside as seniors themselves consolidated around Medicare. Fighting for federal policy in the 1960s endowed seniors with a solid political identity. One of the effects of the Medical Security Solution was the creation of a powerful senior citizens lobby dedicated to retaining, and not challenging, the benefits of the Medical Security Solution.

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[4] I would like to thank Professor Elizabeth Blackmar for alerting me to the way the Americans with Disabilities Act corresponds with the policy ideals of Randall and Heschel.

By plotting the ascendant assumptions of the Medical Security Solution—that old age can be defined chronologically, that the elderly are a special social problem, and that this problem can be solved through medical intervention and government-sponsored health care—this dissertation offers a measured approach to thinking through a formative period in American policy making. By many appraisals, the Medical Security Solution was a success; it delivered results. More Americans are living well past sixty-five years of age and have been saved from debilitating poverty. Still, the drive to solve the problem of old age overlooked the basic fact that old age is not the kind of problem that can actually be solved. Eventually, if one is lucky, it will arrive. And when it does two basic needs still persist: how to keep living and how to die.

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For E. V. Cowdry, and his colleagues, old age was not a problem; it was a risk factor. As a scientist leading an interdisciplinary movement, gerontology, he encouraged physicians, politicians, and other researchers to describe and discover what a healthy old age could look like. He wanted a bio-medical research program that would untangle assumptions that pushed the elderly out of jobs, communities, and homes. One that tackled the following types of questions: How did genetics, nutrition, and intellectual pursuits induce or deflect the onset of chronic disease? How much did chronology even matter in the onset of most diseases associated with old age? Was the passing of years, poverty, or unemployment the greatest risk factor in deteriorating physical health? Through generous funding from the Josiah Macy Jr. Foundation, Cowdry and other early gerontologists capably pursued this research agenda through conferences, publications, and even a journal. They sought a biological definition of old age that would increase the productivity and social use of those currently deemed too old to contribute.

As funding moved away from the nonprofit sector to the federal government, and to the National Institutes of Health (NIH) in particular, the gerontologists' interdisciplinary research agenda narrowed. The extraordinary growth of the NIH in the postwar era and the Institutes' penchant for funding research for single diseases or basic science altered the focus of biological gerontology. As it became harder to secure funds to investigate what healthy aging looked like, labs initiated projects on curing single diseases and extending life.

As congress continued to enlarge the budget of the NIH, policy makers in the Truman administration angled for a way to give all Americans health insurance. Their failure to do so collided with a motivated group of social-welfare advocates urging the government to do more on behalf of its aged citizens. In response to grassroots efforts to bring the elderly to the attention of the nation, the Truman administration called for the First National Conference on Aging, to take place in August of 1950. This conference lifted the national profile of the elderly, offered specialists the opportunity to articulate the complexity of the hardships of old age, and, perhaps most importantly, gave Oscar Ewing the momentum to offer the aged solution to universal health care.

Ollie Randall, a luminary in the field of social welfare for the aged, delivered one of the most articulate visions of aged care leading up to and during the conference. Like Cowdry, she eschewed chronological definitions of old age, settling instead on an understanding of old age based on need. In addition to basic economic security and housing, the elderly needed, more than anything else, to remain involved and useful to society. Nothing mattered more to Randall than that the elderly continue to work and live within communities. She wanted dignified, self-run, living arrangements, where older

Americans could continue to make choices for themselves and give back to society. She advocated early intervention, reeducation, continued employment, and pan-generational policies geared to preparing citizens of all ages for a healthy and productive lifespan.

While Randall moved seamlessly between the language of the physical and spiritual needs of the elderly, conference attendees settled on a more concrete framework to describe the problem of old age. Attendees, particularly those confronted with the enormous material needs of the elderly, concluded that the problems of old age were poor health and economic dependency. To solve these problems, however, the government should not focus its attention solely on the elderly. Rather it should treat these two problems as they arose across the life cycle. All age groups required preventative health care, job retraining, and financial assistance. To solve the problem of old age, the federal government should start by ameliorating the dual hardships of chronic disease, through preventative health care, and economic dependency, through job-retraining programs or financial assistance.

In 1950, the conference's interventions persuaded reporters, physicians, social workers, religious leaders, and academics. They did not, however, persuade policy makers within the federal government. With the Social Security Act, the viability of age-based policies became ever more attractive. Policy makers eager to help needy Americans sought to capitalize on the success of the aged as a worthy group of poor, rather than abandon the category of old age altogether. Although administrators, like Oscar Ewing, agreed with the conference's conclusions, they saw the aged as a way out of their own political quagmire and believed that by making the aged a solution to their own problems they would, in turn, solve the hardships of the aged. At the conference,

Ewing witnessed the visual and rhetorical power the aged had over Republicans and Democrats alike. Everyone gets old, including congressmen and senators. He forged ahead with his plan to offer sixty days of hospital insurance to America's worthy social security recipients.

Health insurance for social security recipients arose as a solution to the problem of universal health care, not to the problem of old age. Offering such health insurance as a policy sought to capitalize on a relatively popular and funded entitlement program, Social Security, and avoid a direct confrontation with doctors by limiting insurance to hospital fees. The country had already deemed retirees a uniquely worthy class of American citizen, and the Truman administration believed that federally supported health insurance for this group would be an appropriate first step towards national health insurance for all Americans. Still, Ewing's bill foundered until the dual forces of an empowered AFL-CIO and a growing senior citizens movement pushed the proposal, now called the Forand Bill, to the forefront of national politics.

In the 1950s, individuals over sixty-five years of age began to visualize themselves as a particular social group with political needs. Calling themselves senior citizens, they came together in new social clubs, political action groups, and lobbying organizations. At the outset, different groups of seniors articulated different needs, such as employment and affordable housing. With the creation of the Forand Bill, the momentum of the 1960 Kennedy campaign, and the realization that health insurance for social security recipients was a viable political option, these groups coalesced. Through the help of organizations affiliated with the AFL-CIO, senior groups began to organize meetings, rallies, and political campaigns to support what came to be called Medicare.

The seniors, or perhaps more accurately, the seniors and their backers, the AFL-CIO, became so persuasive that political representatives across the country who did not support Medicare offered their own solutions to the problem of old age. By the late 1950s and early 1960s, even their solutions came in the form of medical security. To solve the problem of old age, congressmen and senators supported a robustly funded NIH, the construction of hospitals, and versions of health insurance for needy elders. Congressman John Fogarty, the man who singlehandedly built the modern NIH budget, convinced his colleagues to host a second conference on behalf of the aged to stall the political scepter of Medicare.

Despite Fogarty's intentions, the 1961 White House Conference on Aging offered a national platform to demonstrate support for Medicare. Seniors, specialists in the field, and experts across industries joined before the press in a public cry on behalf of health insurance for America's deserving elders. Although overshadowed, the conference also hosted a soft, but cutting, critique of the singular drive to solve old age through medical security. "In enabling us to reach old age," Rabbi Abraham Joshua Heschel stated, "medical science may think that it gave us a blessing; however, we continue to act as if it were a disease."[5] Heschel also alerted attendees to the pitfalls of cultural and political age segregation. He urged the government to drop chronological definitions of old age and set up policy programs that sought to mend the mounting cleavage between generations through joint initiatives, particularly in the realm of education. Returning to the spiritual and existential needs that haunted Randall, Heschel pronounced, "It is marvelous indeed that for the first time in history, our society is ready and able to provide for the material

[5] Abraham Joshua Heschel, "To Grow in Wisdom, " in Abraham Joshua Heschel, *The Insecurity of Freedom: Essays on Human Existence* (New York: Farrar, Straus & Giroux, 1966), 71.

needs of its senior citizens. Yet in addition to the problem of material security we must face the problem of psychological and spiritual security."[6] Heschel's words survived the conference; they were republished and quoted. They hit a nerve but did not translate into policy.

By 1961, the Medical Security Solution was ideologically entrenched. In the two decades following World War II, a powerful faith in medicine and a particular policy idea, Medicare, captured the country's attention. Grassroots activists and policy makers agreed that, to help the aged, the government should cure the diseases of old age in laboratories and ensure economic security for deserving elderly through health insurance. When Lyndon B. Johnson signed Medicare into law on July 30, 1965, Americans across the country lauded the president. A dignified old age was finally secured.

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The Medical Security Solution did not solve the myriad hardships of old age, it did, however, add years to American lives. In 1986, the sociologists S. Jay Olshansky and A. Brian Ault announced that a fourth stage of epidemiologic transition had arrived, "the Age of Delayed Degenerative Diseases."[7] After passing through eras marked by pestilence, pandemics, degenerative and man-made diseases, mankind, in nations such as the United States, had managed to defer, by decades, mortality from chronic ailments.[8] By 2050, the United Nations predicts that one out of every five individuals in the world

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[6] Abraham Joshua Heschel, "The Older Person and the Family in the Perspective of Jewish Tradition, " in *Aging with a Future: A Selection of Papers Defining Goals and Responsibilities for the Current Decade; Reports and Guidelines from the White House Conference on Aging* (Washington, D.C.: U.S. Department of Health, Education, and Welfare, Special Staff on Aging, 1961), 41.
[7] *See* S. Jay Olshansky and A. Brian Ault, "The Fourth Stage of the Epidemiologic Transition: The Age of Delayed Degenerative Diseases," *The Milbank Quarterly*, Vol 64., No. 3 (1986): 355–391.
[8] Ibid.

will be over the age of sixty-five.[9] Not only are human beings over sixty-five populating the earth at a remarkable rate but those individuals are now slated to live even longer lives. In this new order, men and women can expect to live well into their eighth decade. In the United States today, the number of individuals over eighty is growing annually at 3.8% and centenarians are considered the fastest rising age group.[10]

Robert Butler referred to this demographic transition as *The Longevity Revolution.*[11] In his groundbreaking book of the same name, Butler offered scholars and policy makers a way out of the verbal noose created by the phrase *the problem of old age*. Rather than fixating on a falsely static category, old age, Butler reminded readers that the gift of twentieth-century public health and medical intervention was an increase in longevity, an increase in the human lifespan. A focus on the challenges of a longer human lifespan, rather than a stage of life called old age, offers a number of insights that reveal the adverse implications of the Medical Security Solution and can assist future policymakers.

By focusing on what it means to live longer, rather than what it means to simply be old, four issues, which have been exacerbated by the drive to cure old age, are revealed. The first deals with the pitfalls of the category of old age, which throughout the mid-twentieth century allowed policy makers to envision a homogenous group with similar needs.

The late political scientist, and mentee of Ollie Randall, Robert Binstock, and his colleague James H. Schulz refer to the era between 1935 and the 1970s as the age of

[9] United Nations, Department of Economic and Social Affairs, Population Division, “World Population Ageing: 1950–2050,” http://www.un.org/esa/population/publications/worldageing19502050/.
[10] Robert N. Butler, *The Longevity Revolution: The Benefits and Challenges of Living a Long Life* (New York: Public Affairs, 2008), 13.
[11] Ibid.

“compassionate ageism.”[12] In their words, “Researchers, journalists, and politicians took what was a very *heterogeneous* group of people and attributed to them the *same* characteristics, status, and just desserts—creating an artificially homogenized group that they labeled ‘the aged.’”[13] The results of this approach were mixed. On the one hand this allowed the aged to become a special class of citizen with their own entitlement programs. On the other hand, it elided crucial differences, such as need, race, class, gender, and region, which would have allowed for more nuanced policies in the realms of housing, health care, and pensions. It also promoted a set of policies that segregated the aged from other groups and promoted age-based political identity.

The second issue is that of health not health insurance. As individuals survive cancer, heart disease, and other forms of chronic disease they are more likely to succumb to Alzheimer’s disease or other forms of dementia. As Butler writes, “Unless we find ways to prevent or cure Alzheimer’s and other severe dementing diseases, the world will shortly be confronted with epidemic proportions of these diseases. People over eighty-five, the fastest growing population, also manifest the highest rates of Alzheimer’s disease, approaching a conservatively estimated 20 percent.”[14] As the philosopher John Dewey prophesized in his introduction to Cowdry’s *Problems of Aging* in 1939, “the solution of one type of problem brings with it new and unforeseen problems.”[15] Longevity planning in this arena recognizes that Alzheimer’s is a disease that affects more than just the patient. It poses significant challenges for that patient’s surviving spouse, children, friends, and, even, institutional home. Thinking about the diseases of

[12] James Schulz and Robert Binstock, *Aging Nation: The Economics and Politics of Growing Older in America* (Westport, CT: Praeger Publishers, 2006), 7.
[13] Ibid.
[14] Butler, *The Longevity Revolution*, 121.
[15] E. V. Cowdry, *Problems of Ageing* (London: Bailliere, Tindall & Cox, 1939), xxvi.

old age as a communal and pan-generational issue would aid patients as well as caretakers, perhaps by leading to programs such as subsidies for families working with home care programs or tax breaks for institutions that are willing to locate in the center rather than the outskirts of towns.

Thinking carefully about health in terms of the human lifespan has led researchers past the hardships at the end of the lifespan to how those hardships can be averted at the beginning of the lifespan. As scientists and doctors recognized as early as the 1940s, healthy aging begins in youth. Butler bolsters this claim, writing, “Because many of the diseases of longevity originate in utero and in early childhood, we need a life-span perspective to guide all aspects of health care. With genes accounting for only some 25-percent of one’s health and longevity, our environment and personal behaviors account for the rest.”[16] The category of old age fostered the illusion that health care intervention could begin productively after an individual turns sixty-five. The category of longevity helps dismantle this illusion.

The third major issue, and one that has been duly recognized by social workers, political scientists, economists, and politicians, is that a longer lifespan requires a serious vision for long-term care. In 1970, in an effort to cut federal funding for skilled nursing home care after ninety days, Wilbur Mills, echoing a prominent belief, claimed, “It is utterly impossible for me to believe that medical science has not gotten to the point where most of these people will not be so improved at the end of 90 days they can get what it takes to care for their needs in less expensive types of nursing homes.”[17] Mills was wrong. A longer lifespan has only meant a greater need for skilled long-term nursing

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[16] Butler, *The Longevity Revolution*, 192.
[17] Wilbur Mills, quoted in Butler, *Why Survive?,* 290.

home care. As Schulz and Binstock summarize, "if you are lucky enough to live a long life, then you are likely to end up needing some form of long-term care. A person who reaches the age of 65 has a four out of ten chance of spending some part of his or her remaining life in a nursing home. Currently, the overwhelming majority (75%) of people age 85 and older has long-term care needs, and about one in five is in a nursing home on any given day."[18] Due to its optimism, the Medical Security Solution failed to deal with a pressing need of longevity: extended and diverse forms of care in the final stage of life. Instead, policies like Medicare created adverse incentives that over-hospitalized patients and ignored basic living needs. Here again, thinking about this issue as an intergenerational challenge can be illuminating. Randall always favored local planning for the elderly. She wanted children and family members to decide with their aging parents the best housing solution. Diverse financing for myriad forms of long-term housing needs to be an option. Some families will need only home-maintenance services and low-level nursing care; others will require medical institutions. A policy approach of this type, which necessitates the deployment of subsidies, tax breaks, and entitlement programs, would not be easy to implement. But for many families and for many ailing elderly, it would be an appropriate and humane way forward.

Finally, and most astoundingly, the forty-year obsession with solving the problem of old age through Medical Security led to a glaring and now politically instantiated oversight: citizens will die. Ensuring a dignified and peaceful death is a challenge of both a prolonged lifespan and the current institutional landscape. It is a trial that Congress, whether its members are permitted to admit, has played an outsized part in creating. Before the alarm of "death panels" rang from partisan opposition to a provision in the

[18] Schulz and Binstock, *Aging Nation*, 173.

Affordable Care Act (which would have offered funding for optional end-of-life counseling, such as hospice), the Special Committee on Aging in the United States Senate called a hearing to discuss "Death with Dignity."

In 1972, three years after Elizabeth Kubler Ross published *On Death and Dying*, her disarming account of institutional death in the United States, Senator Frank Church (D-Idaho) declared "At least 80 percent of the population of this Nation now dies in institutions—hospitals, nursing homes, and other facilities of one kind or another. Yet not very long ago, the largest percentage of Americans died in their own homes, quite often with other generations of their own families in residence or nearby."[19] Congress, he argued, has a particular obligation as "so many actions taken by Congress within recent years are directly related to the type of institutions available to most Americans. It has been said, and I am sure it will be said at these hearings, that Medicare put entirely too much emphasis upon institutionalization of patients, thereby increasing costs of treatment and anxiety among patients."[20] This is not an easy issue, Church admitted, and there are "no easy answers." But there needs to be a "public discussion" and greater "public understanding" on all of the "issues related to death and dying in the United States…."[21] This hearing would be the start.

The first witness, Dr. Arthur E. Morgan, plaintively retold the story of how his beloved wife died. After his wife endured a brain injury from a fall, Morgan could no longer care for her alone and moved her to a nursing home eight miles from where he

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[19] Senator Frank Church, Death with Dignity: An Inquiry into Related Public Issues, Hearings before the Special Committee on Aging, United States Senate Ninety-Second Congress Second Session, August 7, 1972 (Washington D.C.: U.S. Government Printing Office, 1972): 2. *See* also Elisabeth Kubler Ross, *On Death and Dying* (New York: Macmillan, 1969).
[20] Church, Death with Dignity, 3.
[21] Ibid., 4.

lived. This was not the end of her life or the end of their romance. He recalled, "I used to visit her every day, and she once said to me, 'I wish there was somebody I could talk to; I would like to tell them how much your visits mean to me.' Her expression was imperfect, but she would sometimes speak a little and say, 'This means so much to me.'"[22] Eventually, she lost her sight, her hearing, her speech, and most of her motion. Still, for some of that time, Morgan continued, "the affection between us was enough to give joy."[23] Later, though, "her responses were largely ended and life was mostly a burden." She tried to stop eating but the nursing home had a policy of force-feeding. Morgan's wife "opposed having the nurse pry her mouth open to put food in it."[24] Because he was there every day and probably because he was a doctor, he successfully fought the policy, but only in his wife's case. "Toward the end," he concluded, "she was allowed…not to eat and…her last days were not disturbed as they might have been otherwise."[25] Morgan along with the senators in the room did not know exactly how to proceed. They were terrified of policies that could unduly shorten someone's life or of determining whom, if anyone, should ever make the profoundly difficult decision of withdrawing care. But they did not cower from the difficult conversation or thrust it beyond the realm of their responsibility. They knew a dignified death mattered to most Americans, and they wanted the government to provide some context for a realistic discussion, rather than a proscription, on how to prepare for the end of life.

The complexity of ethically and medically confronting the reality of death is but one in a series of confounding issues overshadowed by the hubristic drive to solve what

[22] Dr. Arthur E. Morgan, Death with Dignity, 9.
[23] Ibid., 7.
[24] Ibid., 9.
[25] Ibid., 7.

never should have been termed a problem. Old age, Congressman Fogarty often pronounced, is the boon of public health and medicine. To reach old age, one has to survive diseases, accidents, and a host of trials that living demands. The obligation of society, of government, might not be to solve old age, but rather to reframe longevity as the ultimate gift; to return to some of Cowdry, Randall, and Heschel's insights and imagine the aging person within his or her social relationships and obligations; and to endow this final stage of life with its own kind of purposeful dignity.

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