

Health Care for the “Truly Needy”: Nineteenth-Century Origins of the Concept

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THE USE OF MORAL CATEGORIES TO DETERMINE individual eligibility for health and human services has been important historically in the formation of social policy. One need only recall President Reagan’s use of the notion of the “truly needy,” or the distinctions between Medicare and Medicaid, Social Security and Welfare, to realize the centrality of popular conceptions of human worth in determining entitlement (Stevens and Stevens, 1974). In earlier periods of American history, the terms “deserving” and “undeserving,” “worthy” and “unworthy,” were used to define who was to be cared for and what services were to be provided through a variety of charitable or public programs. In general, the organization and intent of these programs reflected widely different opinions regarding the social worth of the recipients of the service. Although these value-laden notions have permeated decisions concerning programs for the dependent and sick in our society, the evolution and development of such notions are rarely studied or acknowledged. In the area of health care certainly this has been the case.

Let us look at the historical uses of ideas of worthiness as they affected the development of the American health care system. The definition of the “worthy” and the “unworthy” will be shown to have

changed significantly over the course of the nineteenth and early twentieth centuries, and to have been used in distinctly different ways by those parties who were influential in shaping health services. The variety of definitions of the "truly needy" will be shown to reflect far more the different political and social interests of charity workers, hospital and dispensary trustees, and public spokesmen, than any basic philosophically consistent moral position.

There are two long-standing attitudes toward the poor and dependent. The first holds that poverty is a temporary station in life from which one can ultimately emerge. This notion had its roots in Christian doctrine, but was reinforced by the experience of the early Republic, particularly in the preindustrial, preurban notions of the natural healthfulness and prosperity of American society. Other historians have shown that in this early period there developed a sense of responsibility toward the poor that is reflected today in the concern among many Americans to aid the "truly needy." The second tradition, also rooted in Christian theology, views the dependent and poor not as worthy or needy but as responsible for their own condition in life. This harsher attitude toward the poor and dependent came to dominate upper- and middle-class ideas in the United States during the period of massive industrialization, urbanization, foreign immigration, and social dislocation at the end of the nineteenth century. While there had always been a deep suspicion of the poor earlier in American history, those responsible for charity aid chose to view the pervasive poverty that accompanied industrialization and massive immigration in terms of nativist and social Darwinist notions of individual failure and "foreign" tendencies among the needy. We will here limit our attention to the attitudes toward the foreign male worker rather than to other groups—blacks, women, or American Indians—whose experience with racism and sexism demand special attention.

After placing the changes in health rhetoric in a larger social perspective, we will then look specifically at the origins of the modern health care system and how arguments over the "misuse" or "abuse" of medical care by the "unworthy" and "undeserving" were used by those with special interests to introduce separate services for the "moral," the "immoral," the "wealthy," and the "poor." Within the context of growing distrust of immigrants, unemployed, and the poor, there were tremendous variations in definitions of the worthy and

what constituted worthiness. Over time, the concept of those who were deemed worthy of free health services shifted as moral decisions based upon social and personal criteria were replaced by monetary surrogates. Although the working poor, those who were stable members of working class communities, were perceived as appropriate recipients of free health care early in the century, the ability to pay physicians and institutions became the dominant criteria by the early part of the twentieth century.

By looking closely at medical care, we see that nineteenth-century trustees, interested in promoting the usefulness of charity hospitals and dispensaries, developed relatively broad criteria for evaluating the "worthiness" of patients who applied for admission; when their institutions abandoned their early charitable orientation toward the poor and became "voluntary" institutions which sought to serve the paying patient as well, hospital trustees narrowed the definitions of the "worthy." In contrast, doctors, largely dependent upon individual private practice, adopted strict definitions of "worthiness" which were aimed at restricting the ability of "paying" patients to use "free" charity health services. They defined all but the absolutely destitute as "abusers" of medical charity.

State officials, concerned with the long-term effects of dependency on individual character and on state financing, adopted still different criteria for defining the worthy as they sought to limit long-term dependency, or "pauperism." At the turn of the century, there was a vagueness to the concept of worthiness which allowed the different actors to profess their commitment to the social and moral goals of "decreasing pauperism and dependency" while, in fact, they were redefining their own roles within the contours of the developing health care system.

Our present health system took shape during the late nineteenth century and early decades of the twentieth century (Rosner, 1982), a period when American attitudes toward the needy and the dependent were being dramatically redefined. In the fifty years between 1873 and 1923, for instance, the hospital system in this country grew from a small group of about 170 institutions, many of which were mental asylums, to over 4,500 institutions, most of them devoted to general medical treatment. Furthermore, the older charity system dominant in the nineteenth century was replaced by the more modern "voluntary" system which was organized around paying patients. Central

to the debates over the expansion and reorganization of health services at that time were the questions of the “worthy” and the “unworthy,” and which institutions and professionals should serve them.

Origins of the Notion of Worthiness in the United States

Nineteenth-century American attitudes toward the poor were, in part, shaped by changing religious notions within a rapidly industrializing and growing urban society. Traditional religious ideas had emphasized that the poor were an eternal presence in human society, and that they were both necessary and useful. On the one hand, poverty taught humility and gratitude to those who suffered it. Poverty was a blessed state and the poor were rewarded with salvation. On the other hand, the existence of the poor provided the wealthy with an opportunity to practice charity and kindness, and therefore promised salvation for the almoner as well (Bremner, 1956:16–17).

In Europe, with its long-standing and ubiquitous poverty and highly developed urban and industrial base, the notion that there was a “permanent” class of poor appeared reasonable, and theological justification gave solace to those worried about the problem of mass poverty. But, in America, acceptance of the inevitable existence of poverty was anathema to many. With an expansive continent and a rapidly growing economy during the first half of the century, there was a belief among the largely Protestant, English-speaking population of the early Republic that the potential for individual betterment and improvement was limitless. The existence of poverty was seen as a sign of individual failure for white American males rather than an inevitable law of society (Rothman, 1971).

In contrast to the relatively depressed European economies the fact that there was an abundance of opportunities for work in America led many to believe that there was no reason for want. Poverty, still mostly limited to the growing urban communities, was often viewed as a form of individual punishment for the unresourceful (Bremner, 1956:17). The abundance that characterized this agrarian society reinforced notions of the extraordinary nature of American life—that the United States, unlike its European counterparts, was capable of per-

manent wealth and health. It was noted that the country was prosperous and extremely healthful when compared with European society, and this was taken as a sign of the blessed character of the American environment and lifestyle (Rosenberg, 1963).

It was within this context of a relatively healthy, prosperous, homogeneous, and rural country that attitudes toward the growing populations of the urban centers were gradually formed. The native and immigrant poor who came to work in factories and who suffered from a variety of infectious and chronic illnesses that seemed to arrive with them became symbols of decay and immorality to many Americans. With little understanding of the larger economic and social forces that were creating commercial trading and industrial centers, many reformers began campaigns to control individuals who were felt to be undermining and destroying the moral values and qualities of an earlier era. By the 1830s, the poor who lived in East Coast cities were objects of organized charitable efforts intended to save sinners as well as restore the nation to its previous salubrious and moral state. Some, like Horace Greeley, promoted westward removal, while others sought to improve the moral strength of the urban poor through missionary work, religious instruction, and direct aid (Smith-Rosenberg, 1971; Rosenberg, 1963).

Charity and Reform in the Prewar Years

As late as the 1840s, the growing material wealth of the country made poverty appear transient and temporary. Furthermore, the notion that the country was not necessarily plagued by permanent and widespread poverty gave American Protestantism and charity workers optimism and energy. In the first few decades of the nineteenth century, the belief that poverty could be eliminated led to vigorous movements in growing urban communities to organize various programs that would reach out and reform the poor, the sinful, and the intemperate. Bible and tract societies, soup kitchens, dispensaries for medical care, and city missions were instituted by the various religious denominations, all with the intent of affecting the behavior of the poor and wayward sinner. In 1814, the Society for the Prevention of Pauperism was organized in New York by merchants interested in "scientifically"

investigating the causes of poverty in the city. Members of the Society looked at intemperance, winter unemployment, and other factors that created poverty with the hope of identifying and eliminating its source (Smith-Rosenberg, 1971:28). Although few would advocate or accept the idea that there should be a classless society in America, the growing commitment to political egalitarianism, especially during the Jacksonian period, provided the base for a widespread pietistic movement to attack want and other social ills. Later, in the 1850s, the vibrant public health movement that began to attack the environmental causes of illness also had a similar pietistic origin (Rosenberg, 1976:109–122).

The hopeful character of charity work with its emphasis on eliminating poverty began to change, as did popular attitudes toward the poor. By the middle years of the nineteenth century, it became obvious that the older image of a country peopled by a homogeneous group of English-speaking Protestants was irrelevant at best. In the three decades before the Civil War, the population living in cities grew from about 500,000 to nearly 4,000,000. In the older cities along the East Coast, the increase was especially dramatic: Philadelphia tripled its population, from 161,000 to over 500,000; Boston doubled, from 61,000 to 133,000; and New York quadrupled, from under 200,000 to over 800,000. Even in the younger sections of the country, urbanization became a recognized and widespread phenomenon. In the Midwest, for instance, Chicago, merely a fort in 1832, had a population of over 100,000 by 1860. Similarly, Pittsburgh, Cincinnati, Louisville, Saint Louis, Cleveland, Detroit, and Milwaukee grew rapidly during these decades (Boyer, 1978:67–68).

The growth of American cities was directly connected with the tremendous influx of immigrants in the antebellum decades. More than a half million Europeans arrived in the 1830s, followed by millions more in the 1840s and 1850s. Between 1847 and 1854, the years of the potato famine in Ireland, over 1.2 million impoverished Irish Catholics landed and settled in the Eastern port cities of New York, Philadelphia, and Boston. In the years immediately after the Civil War, Italians, Russian Jews, and other southern and eastern European groups crowded into the cities of the East and Midwest, creating ethnic communities where language, religion, and customs were different from those that had come before.

Immigrants and Charity in the Postwar Period

The early reform effort that had emphasized the ability of the poor to control and direct their own fate was replaced by a much more repressive and harsh ideology as the problems of poverty became massive and overwhelming. After the Civil War, writers, critics, and politicians began to fear that American society was becoming more like European society—with its widespread poverty, disease, rigid class divisions, and labor unrest. These changes were attributed to the immigration of the foreign poor. As American cities grew and a growing industrial economy fostered a series of economic crises, and as the differences between the rich and the poor increased, many began to search for a common cause for what appeared to be the destruction of the homogeneous, prosperous, egalitarian, agricultural society of earlier days (Higham, 1955:35–37). By the 1880s, after a series of economic disasters which spurred the development of the Knights of Labor and more radical labor organizations advocating the abolition of the “wage system” and even capitalism itself, a general questioning ensued over the future of what appeared to be a highly polarized country.

The deep class and social differences in American society fostered a variety of often contradictory responses. In the decades immediately following the 1880s, for instance, a vibrant reform movement sought to ameliorate class inequities through education, settlement work, and philanthropy, and to modernize the political, industrial, and social organizations necessary for the efficient functioning of the newly developing industrial state. Other reformers, however, rather than advocating a reshaping of American institutions, advocated a return to the simpler agrarian past. Intent on trying to recreate the moral order of the romantically idealized preurban, preindustrial, and preimmigrant community, some turned to the homilies and moralisms of past decades in an attempt to control the surface disorders which accompanied the poverty, crowding, and industrialization then enveloping the country.

Of central concern to all reformers, Progressives as well as moralists, was the development of social and class divisions within the cities. It was here that the masses of non-English-speaking, disease ridden,

and poverty stricken immigrants were forced to live in squalid, cold water, airless tenements and shanties. It was here as well that the foreign poor became identified as the source of society's growing ills. The relative inexperience of Americans with poverty, and the lack of understanding that isolated the immigrants and their children from the English-speaking population, fostered a deep-seated distrust of the immigrant poor crowded in the East Coast and Middle West cities. Furthermore, the competition between native-born workers and immigrants for low-paying factory and day-labor jobs created tensions within the working-class groups. The depressions of the 1880s and the prolonged depression of the 1890s, combined with large-scale immigration, allowed industrialists to cut wages by up to 20 percent. American workers thus viewed the immigrant poor as a source of the disruption that was enveloping society. A general consensus developed among the native-born equating poverty, immigration, sinfulness, and individual failure with foreign birth. Conversely, wealth, American nativity, and material success were equated with righteousness and moral behavior.

A brief review of the rhetoric of one popular late nineteenth-century revivalist indicates the power of the equation between sin and poverty, wealth and morality. Dwight L. Moody was, perhaps, the most popular and influential revivalist preacher of the period. With extraordinary financial support from a number of extremely wealthy industrialists and merchants such as Cyrus McCormick and George Armour in Chicago, Jay Cooke and John Wanamaker in Philadelphia, and Cornelius Vanderbilt, William Dodge, and J. P. Morgan in New York, Moody preached to audiences sometimes numbering in the hundreds of thousands. In revivals in Chicago, Boston, Brooklyn, and New York, he preached a version of what would become known as the gospel of wealth. At the New York City revival in 1876, for instance, Moody spoke to a largely middle-class audience and tried to explain why the current depression had put 50,000 working men out of work and on the streets: "I know there is great misery and suffering in this great city," he began, "but what is the cause of it? The sufferers have become lost from the Shepherd's care," he explained. "When they are close to Him, under His protection, they are always provided for." Moody, fearful that his point might be lost on his audience, some of whom might have been out of work, explained his point in even simpler terms: "If you had a son who wouldn't obey

you, you would not expect him to prosper." For Moody and the thousands who listened to him, unemployment and poverty were a judgment from God (McLoughlin, 1959:254).

Not only did poverty and unemployment come to reflect God's judgment, but wealth came to reflect morality: "It is a wonderful fact that men and women saved by the blood of Jesus rarely remain subjects of charity, but rise at once to comfort and respectability," Moody exhorted. For Moody, there was a direct secular payoff to righteousness and moral behavior. Many of his wealthy backers had been poor, but few of the nonchurchgoing slum dwellers showed any signs of getting rich (McLoughlin, 1959:252–253).

One can see, therefore, that by the late nineteenth century, American attitudes toward the poor were ambivalent at best—and that there was a growing belief that many of the poor were unworthy of help. Nativism, hatred of the foreigner, fear of Catholics and Jews, and a suspicion that working-class immigrant populations were susceptible to foreign doctrines like socialism and communism created an extremely harsh environment for the poor and dependent in America. Eventually, poverty came to be viewed with compassion as long as it was temporary, and the poor themselves seemed intent on escaping it. However, when it appeared that poverty was a permanent condition of life and there was little hope for individual escape, compassion was often replaced by vicious antagonism and even hatred. It was within this context that permanent poverty, a condition relatively new to America, became the focus of discussion among the politicians and intellectuals who formulated policies toward the poor.

Permanent Poverty, Pauperism, and the Charity Movement

A variety of different spokesmen sought to explain the conditions of life in the rapidly developing cities. Some, like the Progressives and socialists, sought to place the development of the slums of the city within the perspective of the changes overtaking American society as it developed from a rural, agrarian base into an industrial, urban society. Students of labor, like John R. Commons, sought to understand how automation, industrialization, and the factory system had undermined the autonomy of skilled craftsmen by making them

“wage-slaves,” incapable of demanding high pay for their skills. Others sought to place the burden of poverty on the immigrants themselves by pointing out the close association between poverty and those recently arrived in the country. “In the poorest quarters of many great American cities and industrial communities one is struck by a most peculiar fact—the poor are almost entirely foreign-born. No other great nation has a widespread poverty which is foreign to its own native people,” reported one Progressive reformer (Hunter, 1904:261–262). To many Americans, the correlation between poverty and immigrant status pointed to two simple half-truths: first, that poverty was an imported disease, foreign to America and brought to it by the immigrant; second, that poverty was eradicable only in so far as immigration could be controlled and foreign qualities of the immigrant could be eradicated through assimilation. But, in the face of the seemingly overwhelming number of southern and eastern Europeans then entering the country, many feared that such efforts could reach only a small proportion of immigrants. “Within the last decade new swarms of European immigrants have invaded America, drawn from their homes in the eastern parts of central Europe,” complained one observer in the 1890s. “These immigrants . . . come from a lower stratum of civilization than the German immigrants of the past, and . . . are less quickly amenable to American influences, and probably altogether less improvable than are the Irish. There seems to be a danger that if they continue to come in large numbers, they may retain their own low standard of decency and comfort.” The problem for this observer was that only a few “of the recent immigrants become rich. Many, it may be truly said, remain poor” (Hunter, 1904:270).

The fact that many poor remained poor was troubling to those responsible for aiding them. Given the nativist tendencies among many charity spokesmen and the strong power of social Darwinist explanations, it was assumed that there were now large numbers of poor incapable of escaping poverty because of “inherited” weaknesses, made dependent by diseases and disability, or in danger of becoming dependent on public or private charity because of character flaws which made them “professional paupers” who “plead destitution for purposes of dishonest gain.” One major goal of charity was to distinguish among those who were made dependent by the “honest” burdens of disease, those whose disease was brought upon themselves by licentious or immoral behavior, and those who chose permanent dependence as a way of life.

Seeing poverty as a product of personal, rather than societal, failures, charity workers were especially concerned about the dangers of creating paupers—or pauperizing—large numbers of the susceptible poor through what was called “indiscriminate” almsgiving. “In a legal sense a pauper is one who depends upon public charity . . . but pauperism . . . is a far more widespread and subtle thing. . . . Men or women, who have the ability to obtain for themselves the necessities of life . . . are often enticed into pauperism by relief given them during a time of temporary need. In nearly all cases, he who continually asks aid becomes a craven, abject creature with a lust for gratuitous maintenance” (Hunter, 1904:68–69). This group dominated the concerns of charity workers by the end of the century, making charity an extremely stingy enterprise. The poor person “is given as little relief as possible, and the givers of relief endeavor to bring to bear upon him every agent of repression for the purposes of making pauperism intolerable to him” (Hunter, 1904:68).

Distinguishing between the Poor and the Pauperized

Preventing pauperization had been a long-standing concern of charity workers but took on new and ominous meaning as the dimensions of poverty expanded and as the number of suspicious poor, primarily immigrants, sought limited services from charity organizations. New methods for eliminating people from charity roles were devised. Of special importance was the development of bureaucratic methods for determining need through means tests, detailed exchange mechanisms, and other seemingly “scientific” methods.

Sociologists, charity spokesmen, and politicians all became involved in attempts to make distinctions among the poor. Claiming that it was possible to determine “scientifically” who was in need, many different schema were developed. All claimed that the categorization was objective, effective, and efficient in defining the different groups among the poor, and many assumed that the basic cause of poverty in the first place was characterological (Giddings, 1901; Giddings, 1911). No longer was charity equated with *caritas*—love—and no longer were the poor perceived to be less fortunate brethren who could benefit from the example of benevolence from those in the community who were more fortunate. Now, charitable activities came from the

head rather than the heart. The act of giving itself was dictated by the then-current theories of efficiency, effectiveness, and objectivity. The goal of "scientific" charity was to control the potential for evil that seemed inherent in all who appeared and sought help. The claim to objectivity made by business and science had not been important to charity in earlier eras when the poor seemed less alien in culture, language, and dress. But objectivity became the code word for what was at heart an attempt to use charity as a mechanism for social control. By the end of the century, differentiating between the poor who were deserving of care because of infirmity or high unemployment, and the undeserving whose condition could only be exacerbated by "indiscriminate" alms became a serious issue for academic sociologists as well as religious leaders and charity workers.

Some sought to develop absolute categories by which to evaluate the poor. Robert Hunter, for instance, a well-known Progressive, developed a system designed to consider all those factors which were useful for "philanthropy if any real progress is to be made in the treatment of pauperism" (Hunter, 1904:76-77). In his table of "dependents and their treatment," he listed those who were absolutely dependent: the aged and children; the crippled, blind, and deaf and dumb; and the insane. For this group he suggested that permanent care in institutions or in the community should be provided. The second group were those "dependent capable of self-support" including "professional vagrants," beggars, and the "morally insane." For them Hunter prescribed "industrial education, repression, confinement for [the] protection of society." The third group were those who were "temporary dependents likely to become chronic." This group included "the sick" (especially convalescents), inebriates, and drug addicts. Their complete cure was required, after which all charity was to be terminated. For Hunter, like so many others during the Progressive era, the intent was to find ways of limiting charity to those who were capable of supporting themselves. By adopting a model for "efficient discrimination" of the poor and management of poverty in a society where poverty appeared out of control, Hunter used science and business methods to categorize and control.

Others, however, were not so lenient and, instead, sought to adopt categories which led to repressive attitudes and actions. In a paper entitled "How to Care for the Poor without Creating Pauperism," Professor C. R. Henderson, a well-known sociologist from the University of Chicago, explained the problem of differentiating between

two groups of unworthy poor. "Very properly does the topic assigned me distinguish sharply between the 'poor' and the 'pauper.'" Henderson explained that there were at least five social classes, the "social" class whose members "seek to promote the welfare of the community" and four other classes whose members were all, in a variety of ways, degraded, debased, and even dangerous. The "unsocial" class included people "indifferent to the fortunes of their neighbors"; the "pseudo-social" class were those who "pretend to be good citizens but are in fact mere parasites and hypocrites"; the "anti-social" class included "criminals of various grades"; and finally the "sub-social" class were those "so defective in mind and body that they were unfit . . . and under temptation" (Henderson, 1896:182). Henderson addressed the topic of "pauperism" because pauperism led to "vice, crime and imbecility," all "inevitable consequences of the disease." Although he assumed that "we are to care for the poor" because "all the forces of our civilization compel us to," he felt it essential to civilization to differentiate between needed relief and the indiscriminate almsgiving that ultimately led to pauperism. "For several decades we had no very large towns and cities into whose cesspools the waste of human life could flow," Henderson bitterly pointed out. "In the rural communities the shirk had but slender chances, for every man knew the physical resources of his neighbors. . . 'Scientific charity' was the law: If a man will not work, neither shall he eat." Employing a Spencerian logic that easily equated social organization with the destruction of the laws of nature, Henderson bemoaned the passing of the simpler rural America. "Those days have passed away. Our very civilization is preserving the feeble and futile. Our charity and our medical and sanitary science conspire to sustain the people who cannot or will not support themselves" (Henderson, 1896:183).

Henderson considered it essential for those concerned with caring for the poor to recognize the contradictory nature of their enterprise: "It is so easy for a weak nature to lean on a convenient strong arm. . . . Once started on this slippery incline it is easier to slide to the bottom than climb unaided to the top." Using the analogy of contagious disease, Henderson argued that "example is contagious. A whole street may be corrupted when the public opinion of the neighborhood has been infected by an example of public relief. What was at first begged as a favor and taken as a gift is later regarded as a right" (Henderson, 1896:185).

He further advised that as long as charity remained in the hands

of private societies that could withdraw it at any time, the poor would remain in a subservient and dependent position and would therefore not be a threat to the social order. Support for the poor in industrializing America was becoming too serious an issue to be left in the hands of moralists.

By the last years of the nineteenth century, American attitudes toward the poor had hardened into an ideology that equated extreme and permanent poverty with thriftlessness and individual failing while, at the same time, recognizing the need to address poverty through public policy. Although American charity was committed to finding a variety of ways to uplift and reform individuals, it often did so with deep suspicion. Charity leaders firmly rejected ideas that shifted blame for immigrants' squalid living conditions onto society itself. For instance, a spokesman for the Brooklyn Association for Improving the Conditions of the Poor, one of the oldest charity associations in the country, summarized the feelings of many in his 1889 Annual Report: "What are the causes of poverty? Unjust taxation? Unequal distribution of wealth? Inadequate wages? Monopoly? Unjust social and industrial organization? Doubtless these all combine to produce poverty. . . . But undeveloped or ill-developed character contributes to pauperism more than all social causes combined. Ignorance, incompetence, idleness, thriftlessness, to say nothing of more serious vices, are the commonest causes of poverty. . . . The intelligent industrious householder rarely requires charity" (Brooklyn Association for Improving the Conditions of the Poor, 1889:13). In the aftermath of the serious economic downturn of 1888–1889, and the growth in political clout of labor unions, such analysis sought to reject the growing perception that forces for individual success were beyond the control of individuals themselves.

As we have seen, American attitudes toward the poor changed substantially during the nineteenth century. Whereas early in the century the majority of the poor were native-born and English-speaking and were considered "worthy" of local help and charitable aid, by the end of the period the growing number of poor were perceived to be alien intruders who were potentially abusers of the benevolence of charity. Scientific charity and, later, public welfare were seen as methods for objectively determining those who could be aided and those who might be harmed through permanent dependence, thus controlling the danger that increasing poverty posed for the society as a whole (Lubove, 1965).

Worthiness and Health: Who Should Serve Whom?

The attitudes toward the poor exhibited by social scientists, charity spokesmen, and politicians were reflected as well in the attitudes of those responsible for the health of the nation, although the peculiar nature of the dangers from infectious diseases at the end of the nineteenth century led to very different responses. Rather than allow the weak, the intemperate, and the immoral to fester and die, as was advocated by some social Darwinists, public officials advocated other means of control. In 1891, for instance, Dr. John Shaw Billings, Surgeon General of the United States, addressed the American Academy of Political and Social Sciences in Philadelphia on the topic of "Public Health and Municipal Government." He observed what was then becoming a recognized epidemiological fact: death rates of particular wards and blocks varied directly "with the poverty of their inhabitants." Many public health officials and individual citizens saw poverty, and its attendant high mortality, as a sign of the failures of the society to clothe, shelter, and provide adequately for its population. But Billings felt that poverty itself was often a reflection of individual moral failings. He accepted the dominant idea in nineteenth-century America that there were two distinct groups of poor: the "worthy" poor; and the "great numbers of incompetent, vicious, idle, deformed, or starved brain[ed]" people who "have been poured into this country by immigration during the last fifty years, and have filled our slums and tenement houses, our hospitals, asylums, alms-houses, and jails to overflowing." Billings explained that "there is a distinct class of people who are structurally and almost necessarily idle, ignorant, intemperate, and more or less vicious, who are failures, or the descendants of failures, and who for the most part belong to certain races" (Billings, 1891:6–8). This group of "unworthy," "undeserving," "vicious," or "dangerous" poor were undoubtedly made up of the Catholics, Jews, Irish, Italians, and East Europeans who were crowded into the large urban slums (Higham, 1975).

While Billings and others might have felt an inclination to allow the "unworthy" to falter and die as a consequence of their "wastefulness, idleness, and improvidence," from a public health perspective they knew this was impracticable. Any infectious illness among this group would spread to those honest, moral, and worthy individuals who also lived in the city. "Mingled with those who might not be

worth saving on their own account, is a much larger number of honest, industrious, and fairly intelligent and energetic poor people," Billings explained. "We must look after [the unworthy], and help them, for the sake of others, if not on their own account. When diphtheria prevails in a tenement-house many school children are in danger. Typhus and smallpox do not confine their ravages to the vicious and foul after they have acquired malignancy amongst them" (Billings, 1891:7).

It was not only public health that was affected by nativist arguments regarding poverty. Even the developing system of personal health services—hospitals, dispensaries, and private office practice—was shaped by these notions. Historically linked to the system of charitable social services through formal institutional affiliations as well as tradition, health care managers, trustees, physicians, and policy makers reacted to the changing social environment by incorporating popular attitudes and interpreting them to fit their experience regarding broad health needs as well as narrower interests. A close inspection of the battles over institutional organization among these various parties illustrates the varied uses of moral criteria to shape our health system.

At the end of the century, doctors were in a state of crisis with regard to their practices. They felt increasingly threatened by the proliferation of dispensaries (free-standing and hospital-affiliated outpatient services) that provided services for working-class people free or at a minimal charge. The physicians-in-training who staffed these clinics were eager to provide care to the working poor with the expectation that they could later draw on these patients for their private practices. For them an expansive definition of the worthy poor, those worthy of dispensary services, was very useful. But for private practitioners needing working poor people to fill their practices, the presence of free clinics was a threat. These practitioners, therefore, embraced a much narrower definition of the "worthy" and maintained that the provision of services free of charge to persons capable of paying a private practitioner would result in pauperization.

Private physicians adopted the idea of a restrictive use of dispensaries from a variety of demographic factors. The practice of nineteenth-century medicine had been intertwined with life in an earlier "walking" city; the new physical separation of white collar, blue collar, and different immigrant groups into distinctly different physical locations tended to change the nature of medical practice. Here-

tofore, medical care was largely the responsibility of local practitioners who worked out of private offices and the patient's home. There were few hospitals until the later years of the century and most practitioners were generalists with few specialty pretensions. The success of one's medical practice depended upon the personal bonds that bounded community practitioners to their patients—dependent upon the good will and social acceptance by their patients to a degree that seems extraordinary today. In the absence of formal criteria for evaluating the competency of practitioners, patients looked for courtesy, manners, and understanding as the basic components of good medical practice.

In the late part of the century, however, many physicians joined thousands of other white collar and professional people in a massive migration to the "streetcar suburbs," leaving the older communities to working people and to the growing commercial and industrial enterprises that were overtaking the urban environment (Warner, 1962). It is not surprising, then, that many practitioners adopted the same middle- and upper-class views of the poor—those who seemed so far away and different from themselves (Rosner, 1982). The definitions of the "worthy" poor and the "undeserving" shifted substantially as physicians lost contact with poorer communities. "The extremes [of wealth] should not be so marked in America as in foreign cities. But poor foreigners from the lowest dregs of European countries have poured into our cities bringing with them, of course, their debased standard of living, intelligence, morality, earnings, etc. They segregate, fail to assimilate and reproduce the foreign conditions under our very eyes . . . These paupers lived on nothing in Europe; they have no notion they can earn more here with which to wipe out their degradation. Ideas come slowly to them. No strenuous, public-spirited community forces employers to pay these brutes enough to emancipate them from their brutality, nor compels them to live apart from their imbruted fellow-countrymen, to learn American conditions of life, nor insist on evolution from degradation into decency as a condition of tolerance" (Hoople, 1903:271–272).

Let us now discuss the concept of medical charity as it was understood at the turn of the century and the process by which arguments like that of the physician quoted above on the "abuse" of medical charity by the "unworthy" were used to shape and organize separate health services for different members of the working class. The results of those debates are still with us today in the form of distinctions

between clinic services for the working poor and indigent and private services for middle-class populations—public services for diseases of “immorality” and private treatment for acute, or “temporary” conditions.

Hospitals, Public Spokesmen and the Working Poor

As late as the 1880s and 1890s hospitals in the United States were often undifferentiated welfare institutions which provided to the poor and homeless services that were only tangentially related to medical practice. For instance, women’s and children’s hospitals often sheltered unmarried pregnant women from social ostracism; orphaned children would often spend years in foundling hospitals. Even what might today be considered a general hospital would likely house patients who were working people temporarily unemployed, unable to continue working, or displaced from their homes by urban development, or other forms of social dislocation (Vogel, 1980; Rosner, 1982).

More often than not, the social situation of the patient, rather than the medical capabilities of the institution, determined that the patient should be placed in the hospital. Consider the superintendent’s description of one group of patients who were admitted to Methodist Hospital in Brooklyn:

Thirty-one of our patients were clerks. Most of them lived probably in a boarding house. They were young men, just beginning to make their way in life. They occupied a small cold hall bedroom perhaps. They could afford nothing better. . . . The life they lived was tolerable and even pleasant while health continued, but how dismal it became when broken in upon by illness. What a desolate room that is in which one of these young men lies sick. The landlady is kindly disposed, but what can she do? Her other rooms are all occupied, and there are no conveniences for warming this. . . . There creeps over the house also, quite possibly, a suspicion of typhoid fever, and all shun that room, and some talk of moving away. The young man soon sees that he is ruining his landlady’s business. If he could only go to a good hospital, what a relief it would be to everybody concerned. He can go. He comes to ours, and without money and without price he is tenderly nursed back again to health. Can that young man ever forget such Christian kindness? On the contrary he will go forth from the hospital better fitted morally, as well as physically, to fight the great outside battle (Methodist Hospital, 1896).

For this young man the hospital was an alternative to the boarding house only because of the social conditions that surrounded his illness, not because of the medical facilities available in that nineteenth-century institution. The superintendent himself viewed the hospital as much as a refuge and housing service as a medical facility. He saw the hospital's purpose as restoring the young clerk to both physical and moral well-being (Methodist Hospital, 1890). Implicit in this purpose was the recognition that the clerk was one of the respectable, working poor in need of temporary aid. Furthermore, the needs of the institution to keep itself filled and thereby fulfill its own mission of caring for the poor demanded a relatively liberal interpretation of those worthy of hospital care (Methodist Hospital, 1887).

The origins of smaller American non-governmental charity hospitals were intimately linked to the communities that sponsored them. Most hospitals were started by local merchants and religious and community leaders in response to perceived community needs. Except for the relatively small number of large Protestant institutions that antedated the Civil War, many charity hospitals drew their support and patients from one of the ethnic or religious communities. Hospitals appeared whose names denoted the particular group they served: i.e., Jewish, Lutheran, Cabrini, German, and Lincoln Hospitals in New York City and Brooklyn. Unlike the larger institutions and city-wide organized charitable societies, those institutions were closely linked culturally, economically, and politically to the communities they served (Rosner, 1980; 1982) and therefore exhibited fewer of the condescending, victim-blaming attitudes of the larger facilities. In the late years of the century, the numbers of these hospitals, dispensaries, soup kitchens, and other services grew significantly to meet the obvious need of large numbers of homeless, unemployed, and sick people in diverse communities.

Particular economic downturns were especially important in spurring the growth of these charities. The depression of 1894–1897, for instance, was the most severe in the nation's history to that time. Half of the nation's workers became unemployed, 642 banks were closed, and nearly 16,000 businesses succumbed. Over 50,000 people marched on Washington in "General Coxey's Army," and many believed that the country was on the verge of revolution. In the wake of this severe depression, hospital trustees began a general expansion of their medical services; the number of outpatient clinics and inpatient hospitals increased as well. "We are apparently in the very flood-tide

of the creation of new charities, for it appears that 345 more charities were reported in the year 1896 in New York City than in 1895" (Smith, 1898).

As the depression deepened, however, hospital and dispensary administrators began to feel the economic pressure induced by providing a wide range of services, and the need to somehow limit access of "free" patients increased. This was accomplished in part by shortening the length of stay, and in part by trying to attract a paying clientele to the hospital. Eventually this necessitated a redefinition of those appropriate for care and a limitation on the kinds of services available. Trustees began to turn away those solely in need of nonmedical services, such as food and shelter, and to restrict their patient population to those in need of medical care. As a result, those who had previously used the hospital for nonmedical reasons came to be viewed as malingers and abusers of services provided by the very institutions that had been founded to serve them.

From the earliest days of hospital care, there were implicit and explicit differences between charity and public hospital patients. Charity hospital patients, although poor and often immigrants, were perceived to be morally redeemable and medically curable. They were the "worthy" poor whose diseases or conditions were finite. Although inmates might be in the institution for long periods of time by today's standards, it was widely accepted that those poor who suffered from terminal or chronic illnesses or diseases such as alcoholism, insanity, or venereal diseases would be the responsibility of public facilities.

Because of the ability of community trustees to determine eligibility for care, there was only limited concern through most of the century that the "unworthy" poor might be able to "abuse" hospital charity. One English commentator wrote in 1856 what was a commonly accepted truism in this country as well: "It is . . . very generally understood that hospitals belong to the class of charities least open to abuse, [for] the want against which they make provision is measured and tested not only by the assertions of the applicant, but also by the experience of those who dispense their benefits" (Guy, 1856:12). Clearly trustees and administrators would recognize anyone not "truly needy."

But by the end of the century in response to a more general perception of the growing number of unworthy persons, and especially after the severe depression of the 1890s, hospitals began again to

redefine those worthy of care. In short order, some charity institutions cut out large numbers of "free" patients and sought private patients instead (Rosner, 1982). Also, public officials began to feel that the widespread nature of medical charity could potentially cause major social problems. Stephen Smith, the famous public health physician in New York State, believed that the possible benefits of providing care to the poor were less significant than the harm that medical charities might foster for the larger community. He suggested that a motto should be adopted by managers of charitable dispensaries and hospitals which would read: "Medical Charities should never pauperize the sick poor." Medical charity "is the inlet through which the habit of pauperism first creeps into the poor man's house; it is the ready introduction to permanent pauperism and deception," he explained (Smith, 1898:12–13).

Influential public officials like Stephen Smith, concerned with the broad social implications of the widespread use of charitable services, saw the problem largely in terms of the administration of institutions: if the institutions themselves were unable to limit their own growth, then state inspection and regulation should serve to limit their services.

The debates between trustees and government functionaries caused great divisiveness in the late nineteenth century. Trustees themselves were split between those wedded to their long-standing paternalistic obligation to the poor of their community and those worried about their financial ability to support the growing numbers of homeless and destitute crowding their dispensaries and emergency rooms.

The Hospital Abuse Controversy

As the special interests of doctors, hospital trustees, and public spokesmen became more evident, many began to focus on the poor themselves as the propagators of what became known as the "dispensary evil" and "hospital abuse" controversy. For the first time, the working poor, who had earlier been considered the "worthy" individuals "deserving" of charity care because of their stable position in the community, were now being defined as the "unworthy" who were abusing the system of free medical charity. While earlier decades saw the debate over worthiness revolve around moral and social criteria applied to the poor, the new debates revolved around the financial ability of

people to buy health care. The concept of worthiness changed as the interests of the actors changed.

“How can we prevent the abuse of dispensaries by unworthy people, while continuing to do good to the deserving poor?” asked J. West Roosevelt at a meeting of the New York Academy of Medicine. “By ‘unworthy people’ I mean people who are able to pay for their medical attendance, and therefore are not fit objects for charitable aid” (Roosevelt, 1894:127). Mr. Roosevelt went on to say that there were a great many individuals abusing their charitable privileges but that the exact number was impossible to determine because of the unwillingness of the charities to keep proper records of the social class of their patients. “Indeed, the actual number of individuals treated annually in our dispensaries is unknown. The methods of registering patients in vogue at the different institutions differ so much that it is impossible to make more than a very vague estimate of the total number,” he continued. He noted, however, that in spite of poor record keeping, it was possible to estimate that “at least 350,000 and possibly as many as 450,000 persons were treated in [New York] city during 1892” (Roosevelt, 1894:127).

The implications for medical practice of this large number of cases treated in the city’s dispensaries was of special concern to Roosevelt. The dispensary, after all, was an outpatient facility that drew the same ambulatory patients upon which the office practitioner depended. “Of course the persons upon whom the results of the reception of imposters bear most directly are the physicians who are thus deprived of practice. It is natural that they should protest against the abuse.” But Roosevelt parted ways with the physicians in their struggle against the dispensaries at this particular point. Roosevelt—a trustee, not a physician—thought that the economic argument put forward by the private practitioners was not, in and of itself, legitimate. Economic self-interest was not cause for eliminating private charities. Rather, Roosevelt felt that it was the degradation of the poor themselves that was of most concern. “It is unfortunate that the protest has usually been against this evil simply because certain physicians either are or think they are injured thereby. If this were all the harm done, the doctors would have a weak case,” he observed. Roosevelt believed, however, that the “treatment of unworthy people is wrong . . . because . . . it is injurious to the whole public. It increases the public burden by fostering pauperism. . . . Medical advice is as much a

commodity as bread, and to give the one or the other to the unworthy is wrong."

Roosevelt's statements illuminated a fundamental difference between the perspectives of trustees, especially those concerned with public policy, and practitioners who were more concerned with a narrower self-interest in protecting their independent office practice. The definitions of "unworthy" and "deserving" poor took on variously different meanings. Increased dependence created a greater social burden on those who supported charity and on the larger society as well. For the physician practicing in his private office, the issue was less complex; "abuse" was the use of services by those who could afford to visit his office but who chose instead to go to the free dispensary or hospital clinic.

Divisions among Physicians

The physicians' position regarding the abuse of medical charities was complicated by the differing interests in the dispensary among hospital- and medical-school physicians and community-based private practitioners. Medical school educators and hospital-based physicians used dispensaries as a source of clinical material for teaching or as a "feeder" for developing private practice. For young physicians who were fortunate enough to attain a dispensary or hospital appointment, access to the outpatient service was essential for eventually establishing a lucrative private practice at a time when medicine was extremely overcrowded (*Journal of the American Medical Association*, 1898). From the perspective of established practitioners, however, the dispensary was a threat: "Every doctor in a large city knows that the staff members of dispensaries and hospitals are using the charity clinics as feeders of their private office, and that good incomes are secured by [this] trickery," complained one practitioner (Gould, 1908:22). Since private solo practice was predominant, battles over charity dispensary and hospital "abuse" became extremely common among practitioners and charity workers alike. "It has been said that there is a dispensary evil; that an institution primarily established for the care of indigent sick cares for the well-to-do and able-to-pay as well; that thousands of patients, who should pay their family physicians, receive free treatment; that people actually owning rented property or a thriving

business, a corner grocery, a meat shop, a notion store pass themselves off successfully as worthy of medical charity," complained one physician in Cleveland. The problem, as this physician saw it, was that "free medical treatment" left "the neighborhood physician with much less work and a smaller income than is justly his" (Henick, 1911:824).

The growing concern among charity workers and public spokesmen over the proper scope of medical charity quickly assumed an important role in the political debates occurring among medical practitioners. Practitioners began to discuss pauperism and adapt charity arguments to their own uses. The President of the Rhode Island Medical Society proclaimed that "a large number of people are being taught that it is no dishonor to join the ranks of the dispensary attendants," while other private practitioners remarked that "charity is a mockery . . . only a cloak wherewith men, women and children are taught that something can be had for nothing and the price paid is a stunted and blunted conscience, a dear price; and the result is an increasing list of paupers and ever growing communism" (Chase, 1896:211). The internal economic crisis of the profession at the turn of the century was often framed in the rhetoric of charity and took the form of a political and ideological attack on liberal interpretations of both need for and worthiness of free care. Clearly, in their view, medical practitioners were being called upon to make the most direct economic sacrifice in this situation.

The various actors in this tiny but significant drama were all using charitable notions of worthiness in different and often contradictory ways. Charity workers assumed that it was the temporarily unemployed, the dislocated boarding-house clerk, or a family that had fallen on "hard-times" who composed the "worthy" poor. The institutions that were organized for charity, therefore, were organized to serve this particular class within the population.

Physicians, however, had substantially different ideas concerning the definitions and criteria for determining worthiness (Howle, 1898). Specifically, the "worthy" individual was defined as one who avoided the institutions and depended upon private practice for care. The person who depended upon "free" or clinic services was immediately suspect. For many physicians, it was not the temporarily displaced who was the appropriate recipient of charity care. Rather it was only the pauper—the very person who in earlier times was the truly "unworthy"—who should be treated in the clinic free of charge. The

appropriate patient for the clinic was "a person actually so destitute that medical attendance and medicines must be given to him outright, or for the merest pittance, or he must go without them" (Wiggin, 1897:521-522).

In the years following the turn of the century, America's hospitals began a crucial transformation from charitable enterprises for the working people to institutions which depended upon patient payments from white collar workers (Rosner, 1982; Vogel, 1980). During this period, there were heated and often vituperative exchanges between administrators, trustees, and doctors over the degree to which patients who could not pay should be treated by attending physicians. The latter, feeling that they were no longer obligated to provide gratuitous care for those who entered the hospital and paid for hospital services, sought payment as well. Trustees, concerned with attracting private and paying patients to their newly redefined "voluntary" institutions, needed to make sure that those who paid for care were not treated with the same condescension that the charity patients encountered. Hence, what were once debates over the dimensions and limits of "worthiness" began to subside in a growing concordance of mutual interest between physicians and trustees (Reverby and Rosner, 1979). A common position regarding paying and free patients was slowly arrived at as trustees organized separate physical quarters for paying (i.e., private) and "charity" patients.

The rationale for separating patients according to class criteria was often strained. In its simplest form, the terms of this segregation described patient relations to the institution and the physician: they were either "private" in their contract arrangement, or were impoverished "wards." (As these terms persisted, they later came to describe accommodations rather than their occupants.) In a paper read to the New York City Medical Society in 1901, one prominent physician put forth what was to become an implicit justification for such separation: "People who have money and are willing to pay for a bed in a public hospital [i.e., any governmental or voluntary hospital] should not be thrust into a ward in companionship with a pauper." He maintained that "the pauper had no right to share in their treatment and, further, that the criminal pauper had sacrificed all rights other than what justice and humanity deem should be his" (Hillis, 1901:721-725). The editors of the *Journal of the American Medical Association* were even more pointed when they discussed the problem

of hospitals which provided free care to those who might otherwise seek care from a private practitioner. In an editorial entitled "Abolish the Hospital Grafter" the editors stated:

Let us apply the remedy [to the hospital abuse] . . . absolute segregation of charity patients from pay patients. Those who really have no means will perforce go to the genuine charity hospitals, while few of those who have any income will sink their pride so far as to enter an institution patronized by none but the destitute. When the only alternative is a pay hospital where none are treated free, the deed is done. So long as rich and poor are treated under one roof, the well-to-do will not scruple at getting free treatment if they can as no stigma attaches to residents in an institution where many pay their way (*Journal of the American Medical Association*, 1905:1691).

Summary

In varying degrees and in myriad ways, this admonition to separate clients according to class was adopted in many of our institutions. The distinctions in types of care provided for public hospital and voluntary hospital patients, private and semi-private room patients, and even private practitioners' patients, "clinic" patients and "teaching" patients embodied in the debates which were raging over the moral worthiness criteria nearly a century ago were repeated during the Depression of the 1930s. As one physician complained: "Throughout my medical experience, I have listened to complaints by hospital workers of many people who crowd wards and clinics without the slightest moral justification, presuming on the timidity or cupidity of hospital management to permit them to get something for nothing" (Van Etten, 1934).

I have demonstrated that such attitudes which have reappeared continually throughout this century developed in the last years of the nineteenth century and provided the legitimacy for differentiating services according to class criteria. The boundaries between those we consider unworthy and worthy have never been especially clear, nor has there been any explicit consensus. Rather, the concepts have been subject to tremendous manipulation by a variety of parties to lend legitimacy to what is fundamentally a political issue in which these parties have a definite stake. The central change was from a society with an inherent distrust of the poor to one in which the marginally

employed and stable working people were suspected of acting as if they were poor.

I have outlined the nineteenth- and early twentieth-century debate over the method for organizing new health services and selecting those to be served. As a result of this debate the worthiness of individuals ceased to be measured solely by moral and social criteria, but became embedded in more explicit financial considerations. Since the beginning of the Reagan presidency, the old arguments regarding the rights of the poor and the locus of responsibility for poverty have taken on a new and more urgent significance. Although the language used today is significantly different from the angry, moralistic, and class-biased rhetoric of the nineteenth-century debates, there is a similarity of meaning and analysis in arguments over definitions of the "truly needy," over the proper eligibility criteria for a variety of health programs like Medicaid and Medicare, and for the scope of other social service programs such as food stamps and welfare. The proper dimensions of what has been called the "social safety net" of human services has been often and heatedly discussed, and entails decisions about the limits of moral and social responsibility for poverty and dependence.

President Reagan himself has readdressed the old moral arguments regarding the causes of poverty, crime, and illness in his discussions of Social Security and eligibility criteria for social and health services. While there are elderly, disabled, and sick who may properly fall into the category of the "truly needy," the President assumes that there are large numbers who have misused the system and benefited from it at the expense of the average taxpayer. In this, he evokes a deep-seated middle- and upper-class antipathy and distrust of the poor, the dependent, and the unemployed. "We will continue to fulfill the obligations that spring from our national conscience," the President has stated, "those who *through no fault of their own* must depend on the rest of us, the poverty-stricken, the disabled, the elderly, all those with *true need* can rest assured that the social safety net of programs they depend on are exempt from any cuts" (*New York Times*, 1981a. My emphasis). This "national conscience" is not that of the early days of the Republic, but one that found its expression in the later nineteenth century.

These policies toward the poor and the dependent are rooted in a popular notion that human beings have a dangerous and fearsome potential for evil that can only be restrained through the vigilance

of the institutions of society. The President revealed his fundamental assumptions regarding human nature in a recent speech attacking "social thinkers of the 1950s and 60s who discussed crime only in the context of disadvantaged childhoods and poverty-stricken neighborhoods. . . . The underlying premise [of social scientists] . . . was a belief that there was nothing permanent or absolute about any man's nature—that he was a product of his material environment, and that by changing that environment . . . we could permanently change man and usher in a great new era." In contrast, he detailed his view that there were some "absolute truths" regarding human nature, one of which was "that men are basically good but prone to evil." He felt that "only our deep moral values and strong social institutions can hold back that jungle and restrain the darker impulses of human nature" (*New York Times*, 1981b). In the area of human services this "darker impulse" is presumed to have led many to abuse or misuse the benevolent services provided by governmental agencies and private citizens.

Many Americans share the President's view. Only last February a federal agency, the Advisory Commission on Intergovernmental Relations, sponsored a poll of 1,000 men and women asking which federal programs they would choose to cut if financial constraints demanded it. When presented with "public welfare" programs, those polled readily accepted widespread cutbacks. When presented with the possibility of cutting programs designed to "aid the needy," however, those polled chose, instead, to maintain these very same programs (*New York Times*, 1982). The seemingly contradictory response of the population reflects the different connotations attached to the words "welfare" and "needy." This, in turn, gives rise to different attitudes toward the "worthy" and the "unworthy" poor, attitudes which are embodied in and reinforced by various forms of social and health legislation. While the poll indicates the confusion in American attitudes toward the poor and needy, it also reflects a long history which included both the optimism and concern for the poor and dependent in the early Republic and the distrust and even contempt that developed in the late nineteenth century. Ironically, both traditions blame the victims of economic and social change for their condition. As the economic and social problems of the late nineteenth century became more complex, many chose to blame the growing number of poor, helpless, and dependent rather than address issues of social equity and redistribution (Rosner and Turk, 1980).

In the 1980s, as the economy contracts we are faced with a similar choice: either we will choose once again to blame the sick and the poor for their dependency, illness, and poverty, or we will seek to redistribute the available goods and services equitably across all social groups and classes.

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