A Place to Die: Nursing Home Abuse and the Political Economy of the 1970s

Gabriel Winant

When Emily Eckel arrived at John J. Kane Hospital for her first day of work in 1975, what struck her immediately was the apparatus of bodily constraint. "When I started, I didn't know what a geri-chair was. The first time I walked in and saw them lining the halls, I was shocked." Kane was a huge public long-term care facility for the elderly and disabled, owned and operated by Allegheny County, in the suburbs of Pittsburgh. Geri-chairs were seats with a bar extending across the front, serving to restrain the patient. Eckel smuggled a tiny camera in with her each day in a cigarette case and pretended to take up smoking so she could document what she saw.[1]

Eckel was looking for trouble. A young woman radicalized by the antiwar movement, she was a member of the New American Movement (NAM), an organization founded in 1971 by New Left veterans seeking strategies for the new decade. After graduating from college, Eckel moved into a Pittsburgh commune with other NAM members. Also living there were two social workers employed at Kane, who returned to the house each day with horror stories. Eckel and fellow NAM member Joseph Nagy decided to put theory into practice. They applied and were hired at Kane and, along with social worker Mary Lewin, began work on an exposé. The resulting report, *Kane Hospital: A Place to Die,* detailed endemic abuse of patients. Published by the Action Coalition of Elders (ACE), a local elder-rights group, the report triggered an uproar that reached all the way to Washington.[2]

The Kane scandal was one of the most dramatic of a 1970s wave of nursing home scandals. It prompted local, state, and federal investigations, and set in motion a political conflict that lasted for years. In his 1977 book *Too Old, Too Sick, Too Bad*, Utah senator Frank Moss, chairman of the Senate Subcommittee on Long-Term Care described Kane

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[1] Emily Eckel interview by Gabriel Winant, March 30, 2016, audio file (in Gabriel Winant's possession).

[2] Eckel interview; *Kane Hospital: A Place to Die* (Pittsburgh, 1975), in U.S Congress, Senate, Special Committee on Aging, Subcommittee on Long-Term Care, Part 26—Washington, D.C., *Trends in Long-Term Care,* 94 Cong., 1 sess., Dec. 9, 1975.

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as "something like a Dickens novel." The systemic abuse revealed at Kane—one of the worst such scandals—offered a living tableau of industrial society coming undone.[3]

This article uses the scandal at Kane to explore the socioeconomic transition of the 1970s. It proceeds in five sections. First, it places the crisis of long-term care within the architecture of the New Deal state. Second, it traces the history of Kane within this context, showing how the postwar order externalized care work onto the economic margins, an approach that became increasingly ineffective as economic decline worsened in the New Deal's industrial core. As the problem of elder care grew and required policy redress, it became absorbed into the formal economy through health care policy—turning it into a medical problem. Third, it examines the group of activists who revealed the abuse at Kane, finding their intellectual origins in the same socioeconomic transition that produced the crisis. Fourth, it goes inside the institution, showing how structural antagonisms of class, gender, and race became manifest in the conditions of abuse. And fifth, it follows the political fallout from the scandal, showing why the increasingly prevalent neoliberal solution to any policy question—privatization—did not prevail.

The exposure of abuse by activists in 1975 reveals the vast changes wrought by the end of the postwar industrial economy, not only in terms of job loss but also for the entire system of social reproduction. Deindustrialization spurred the growth of dependency. It also stimulated, through public health care entitlements, the increase of social support for managing that dependency—a trend at odds with the general decline of social welfare. This article offers a new account of the 1970s—one in which the very dislocations that gave rise to market liberalization also created vast new areas of public intervention, creating new work forces and new arenas of workplace activism.[4]

Health care has grown to the point that it now forms the largest employment sector across the cities and towns of the superannuated rust belt. This vast zone of economic activity enjoys enormous public subsidies to serve its aging clientele. It also has created an overwhelmingly feminized low-wage work force. Around these developments, a more fundamental set of political questions has emerged. Who must suffer the socioeconomic consequences of deindustrialization? Whose job is it to care? And who will pay? The first places to deindustrialize on a large scale, such as Pittsburgh, were the first to encounter these questions. Proving difficult to answer, they have not gone away.[5]

Old Age and the New Deal Order

"*Long-term care for older Americans stands today as the most troubled, and troublesome, component of our entire health care system,*" warned a 1975 report from U.S. Senate Special Committee on Aging. "It is costly and growing costlier. It is increasing in numbers,

[3] Frank E. Moss and Val J. Halamandaris, *Too Old, Too Sick, Too Bad: Nursing Homes in America* (Frederick, 1977), 16.

[4] On dependency, see Nancy Fraser and Linda Gordon, "A Genealogy of Dependency: Tracing a Keyword of the U.S. Welfare State," *Signs,* 19 (Winter 1994), 309–36.

[5] See, for example, Guian A. McKee, "Health-Care Policy as Urban Policy: Hospitals and Community Development in the Postindustrial City," Dec. 2010, Federal Reserve Bank of San Francisco Working Paper 2010–10, https://www.frbsf.org/community-development/publications/working-papers/2010/december/health-care-policy-urban/; Joe Carlson and Beth Kutscher, "On the Bubble?," *Modern Healthcare,* March 2, 2013, http://www.modernhealthcare.com/article/20130302/MAGAZINE/303029990; and Shawn Gude and Rachel M. Cohen, "Baltimore since Beth Steel: Hopkins Hospital Workers Fight for 15," *Dissent,* June 26, 2014, https://www.dissentmagazine.org/author/shawn-gude-and-rachel-m-cohen.

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already providing more beds than there are beds in general hospitals. And there is every reason to believe that many more beds will be needed." In his 1980 study of the abuse epidemic, the health policy scholar Bruce Vladeck noted that, in addition to a very well-known abuse case in New York, "similar scandals were occurring or have since occurred in Illinois, California, Texas, Pennsylvania, and Ohio; and formal government investigations were undertaken in all those states, as well as in Connecticut, New Jersey, Minnesota, Wisconsin, Michigan, and Kansas."[6]

It is not a coincidence that the nursing home scandals and investigations largely occurred in states in the industrial core. To be sure, the proximate causes of nursing home abuse, overcrowding, and understaffing could in theory occur anywhere. Yet the first major wave of nursing home scandals occurred in the 1970s, and their regional concentration remains striking. Historically specific forces stood behind the 1970s outbreak of scandals in the emerging rust belt—forces that linked institutional conditions for the elderly to the conjoined 1970s crises of the industrial order and New Deal state.[7]

In no major city was the decay of the postwar industrial order more advanced than in Pittsburgh, a city whose undiversified economy was organized around steelmaking. Steel's decline began earlier than other mass production industries. Accordingly, Pittsburgh had the nation's lowest labor force participation rate in the country by the late 1960s. It outstripped Newark, Detroit, and St. Louis in African American unemployment—the canary in the coal mine of industrial decline. The weakening of industrial employment and the consequent proliferation of social dependency threw existing systems for caregiving into crisis. The advanced state of this process in Pittsburgh led to an especially acute situation—demand for care spiked while social capacity plummeted.[8]

The economic transition of the 1970s caused the nursing home abuse crisis in industrial centers because it knocked out a main pillar of the postwar political economy and policy regime: the male-headed, single-wage household. This model had once seemed to be an answer to questions of care and social reproduction. Wages and benefits had flowed through productive breadwinners. Their wives, through their unwaged labor, reproduced the household and community—caring for the young, the sick, and the old. Social rights generally presumed the breadwinner's existence or compensated for and stigmatized his absence.[9]

[6] U.S. Congress, Senate, Subcommittee on Long-Term Care of the Special Committee on Aging, *Nursing Home Care in the United States: Failure in Public Policy,* 94 Cong., 1 sess., Jan. 1975, p. iii. Emphasis in original. On nursing home scandals and elder abuse in the 1970s, see Claire Townsend, *Old Age: The Last Segregation* (New York, 1971); Mary Adelaide Mendelson, *Tender Loving Greed: How the Incredibly Lucrative Nursing Home "Industry" Is Exploiting America's Old People and Defrauding Us All* (New York, 1975); and Bruce C. Vladeck, *Unloving Care: The Nursing Home Tragedy* (New York, 1980), 4.

[7] On nursing home routine, see Timothy Diamond, *Making Gray Gold: Narratives of Nursing Home Care* (Chicago, 1992); and Nancy Foner, *The Caregiving Dilemma: Work in an American Nursing Home* (Berkeley, 1995). See also Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Garden City, 1961).

[8] On the maturity and decline of the steel industry in the 1950s, see Kristoffer Smemo, Samir Sonti, and Gabriel Winant, "Conflict and Consensus: The Steel Strike of 1959 and the Anatomy of the New Deal Order," *Critical Historical Studies,* 4 (Spring 2017), 39–73. On labor force participation, see Community Action Pittsburgh, "Target Neighborhood Report," Feb. 1969, folder 5, box 126, Records of the Health and Welfare Planning Association (Historical Society of Western Pennsylvania, Pittsburgh). On unemployment, see "Jobs Are Lagging for Negro Youth," *New York Times,* March 3, 1968, p. 74. Thomas J. Sugrue has shown how black unemployment was the leading edge of urban-industrial decline. See Thomas J. Sugrue, *The Origins of the Urban Crisis: Race and Inequality in Postwar Detroit* (Princeton, 1996), 91–178. The idea of a neoliberal "crisis of care" comes from Nancy Fraser, "Contradictions of Capital and Care," *New Left Review,* 100 (July–Aug. 2016), 99–117.

[9] On the postwar policy regime, see Fraser and Gordon, "Genealogy of Dependency"; Alice Kessler-Harris, *In Pursuit of Equity: Women, Men, and the Quest for Economic Citizenship in 20th-Century America* (New York, 2001); Marisa Chappell, *The War on Welfare: Family, Poverty, and Politics in Modern America* (Philadelphia, 2010); and Kar-

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Yet there existed one social right that presumed no wage earning at all: retirement. Over the postwar decades retirement had become newly available to millions of working-class Americans who lived longer thanks to the massive increase in economic security enjoyed by their class. In 1930 only 4.2 percent of the Pittsburgh area's population was over 65; by 1970, it was 10.6 percent. Today, this figure approaches 20 percent. Working-class old age remained, however, a vexed question. On the one hand, retirement represented the final reward for a lifetime of work—the culminating transaction in the wages-productivity bargain that defined postwar class relations. On the other hand, it was a suspension of the terms of that bargain. Socialized retirement looks at once like deferred wages and like wages paid in return for no productivity at all. Retirees were simultaneously worthy bearers of earned social rights and pathologized dependents in need of care.[10]

This contradiction between earned rights and pathologized dependency was built into the architecture of the New Deal policy regime. That tension, however, became aggravated as the economic basis for that regime fell apart. In the emerging rust belt, industrial decline created a demographic imbalance between growing numbers of working-class retirees and a shrinking working population. By decimating the earnings of working-class men and pushing more women into the work force, factory job loss also ate into the supply of household labor. Economic restructuring in the 1970s thus shifted elder care out of the household and into the institutional sphere. The retired formed a growing surplus population. The institutions that absorbed this surplus were legacies of the New Deal state, and the 1970s would not leave them unchanged. Deindustrialization had also devastated the fiscal capacity of local government, eating into the urban public's ability to shoulder the care burden even as demand built.

Origins of the Crisis

In 1958 the government of Allegheny County, Pennsylvania, opened John J. Kane Hospital, a new long-term care facility for the elderly and disabled. With 2,200 beds, Kane was one of the largest institutions of its type in the country. A piece of high modernist design just outside Pittsburgh, it seemed a fitting postwar replacement to the two local run-down almshouses. According to the *Architectural Record,* "Individual closets, private bed lights and color schemes do much to eliminate what the architects refer to as the 'institutional curse.'"[11]

en M. Tani, *States of Dependency: Welfare, Rights, and American Governance, 1935–1972* (New York, 2016). On gender and household labor, see Heidi I. Hartmann, "The Family as the Locus of Gender, Class, and Political Struggle: The Example of Housework," *Signs,* 6 (Spring 1981), 366–94.

[10] On retirement, see Jill Quadagno, *The Transformation of Old Age Security: Class and Politics in the American Welfare State* (Chicago, 1988). Citizens' Advisory Committee to the Southwestern Pennsylvania Regional Planning Association, "A Time for Concern: The Status of Elderly and Handicapped in Western Pennsylvania," Feb. 1972, box 1, Reports on Allegheny County, p. 1 (Archive Service Center, University of Pittsburgh, Pittsburgh, Pa.). "Age of Population," *Pittsburgh Today,* http://pittsburghtoday.org/indicators/age/demographics/age-of-population/. Caroll L. Estes et al., "The Medicalization and Commodification of Aging and the Privatization and Rationalization of Old Age Policy," in *Social Policy and Aging: A Critical Perspective,* ed. Carroll L. Estes et al. (Thousand Oaks, 2001), 45–60. See also Laura Katz Olson, *The Political Economy of Aging: The State, Private Power, and Social Welfare* (New York, 1982).

[11] "Tough Job for Kane Hospital," *Pittsburgh Post-Gazette,* Feb. 22, 1958, p. 1; Frances Walker, "Consultant Sets Motif at Kane Hospital," *ibid.,* March 8, 1958, p. 16; "Tripartite Hospital for Chronics," *Architectural Record,* 5 (May 1958), 199–206, esp. 204.

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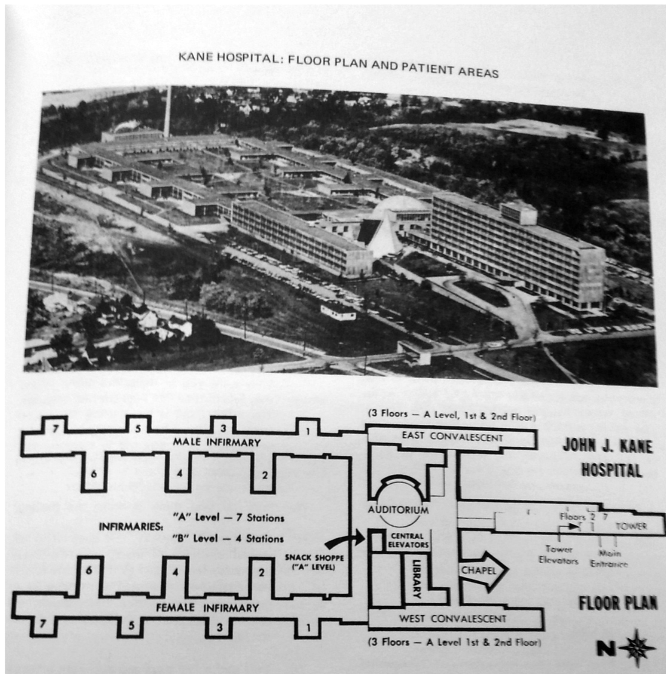

This image shows the floor plan of the John J. Kane Hospital in Allegheny County, Pennsylvania, which opened in 1958. *Reprinted from* Kane Hospital: A Place to Die *(Pittsburgh, 1975), p. 7, in U.S Congress, Senate, Special Committee on Aging, Subcommittee on Long-Term Care, Part 26—Washington, D.C.,* Trends in Long-Term Care, *94 Cong., 1 sess., Dec. 9, 1975.*

At the 1958 opening, a speaker promised that "Kane will put new life in the hearts of aging bodies, and change despair and apathy of old people who are sick and poor into a new desire to live again and to return to their homes." Although the new $22.5 million facility seemed a break with the past, some people had doubts. The Pennsylvania Economy League warned that rehabilitation needed to be the facility's focus, or the hospital would "degenerate into a glorified version of the old county home." Indeed, within three months of opening, Kane had 1,600 of its 2,200 beds full—largely with patients transferred from the almshouses—and was swamped with 6,600 inquiries for the remaining 600 spots. Kane's director required that applicants seeking custodial care—"those not seriously ill, but merely needing a place to stay"—be rejected. The institution's function was rehabilitative. With its requirement of poverty for admission, Kane ran on direct appropriation of funds by the county and the intake of public assistance dollars paid out to the indigent elderly. In other words, Kane was a medical facility—a hospital in fact as well as in name—with a nonmedical funding stream from the welfare state.[12]

As early as 1960, signs of trouble with this model appeared. The *Pittsburgh Press* editorialized that year that Kane suffered from a severe shortage of medical and nursing staff. One doctor told the paper, "if each doctor here were three people, he could not get his

[12] "Tough Job for Kane Hospital," 1. See also Pennsylvania Economy League, Inc., Western Division, "Organization and Initial Operation of the New Allegheny County Institution District Hospital," Feb. 1957, box 21, Pennsylvania Economy League Records (Archive Service Center); William Faust, "What Is the Future of Kane Hospital?," *Pittsburgh Press,* May 5, 1968, *Pittsburgh's Family Magazine* section, p. 12; and "Policy Set for Kane Hospital," *Pittsburgh Post-Gazette,* April 25, 1958, p. 1.

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work done in a day." By 1962, the county moved to relax the indigence requirements as a way to attract paying patients.[13]

Money was a problem at the nexus of old age and medicine across the country at the end of the 1950s. Over the postwar years, federal support for bioscience research and hospital construction, as well as the spread of collectively bargained health insurance, rapidly drove up the cost of health care. While price escalation was a concern for insured Americans, it made health problems potentially ruinous for those on the margins of the labor market. Retirees averaged medical costs twice as high as those of younger people, but they had incomes half as large. By the 1960s, political demand for a solution became widespread, handing liberals a potent issue. After the 1964 Democratic election landslide, reform sailed through Congress.[14]

The passage of Medicare and Medicaid in 1965 transformed the landscape of long-term care. The new programs committed the federal government to pay for the institutionalization of the elderly specifically through its health insurance entitlements—and Medicaid in particular. Medicare would pay for a limited period of skilled nursing care, while Medicaid would pay for indefinite institutionalization for the elderly poor. Because the only access to indefinite public support was through a poverty program, the needy elderly tended to become pauperized. After using up their limited months of Medicare funding, they had to spend down any assets to the point where they qualified for Medicaid. A means-tested health insurance program accordingly grew into the largest funding source for long-term care. The social and economic marginality of the old became interwoven with their medical care.[15]

Increasingly, elders' social right to dignity and security were realized through health policy. A general set of social rights thus narrowed into specifically medical entitlements. Kane, accordingly, underwent a paradoxical shift. For its first seven years, the hospital had been a fundamentally medical facility with a nonmedical revenue base in general public assistance, social security, and county appropriations. After 1965, though, Kane began to turn into a general custodial home, fed increasingly by a public health insurance funding stream. Having initially served a specifically medical purpose paid for with general social funds, it now came to serve a general social purpose paid for with specifically medical funds. Unlike county appropriations—a flat annual sum—the patients themselves carried social insurance with them: the more patients Kane treated, the more reimbursement it received. Kane thus took the frail elderly and turned them into patients. For a moment, this seemed a solution to a social problem. In the long run, it created a new, worse one.[16]

[13] "Improving Kane Hospital," *Pittsburgh Press,* April 22, 1960, p. 21; Thomas P. Snyder, "County Plans to Ease Kane 'Pauper' Rule," *Pittsburgh Post-Gazette,* Dec. 25, 1962, p. 25.

[14] Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York, 1989); "Health Security for the American People," June 13, 1961, folder 107, box 6, Isidore Sidney Falk Papers (Manuscripts and Archives, Sterling Memorial Library, Yale University, New Haven, Conn.); Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York, 1982), 368; Jonathan Oberlander, *The Political Life of Medicare* (Chicago, 2003); Julian E. Zelizer, "The Contentious Origins of Medicare and Medicaid," in *Medicare and Medicaid at 50: America's Entitlement Programs in the Age of Affordable Care,* ed. Alan B. Cohen et al. (New York, 2015), 3–20.

[15] See Laura Katz Olson, *The Not-So-Golden Years: Caregiving, the Frail Elderly, and the Long-Term Care Establishment* (Lanham, 2003), 5. See also Jonathan Engel, *Poor People's Medicine: Medicaid and American Charity Care since 1965* (Durham, N.C., 2006).

[16] John B. Williams, Judith A. Shindul, and Linda Evans, *Aging and Public Policy: Social Control or Social Justice?* (Springfield, 1985); Carroll L. Estes and Elizabeth A. Binney, "The Biomedicalization of Aging: Dangers and Dilemmas," *Gerontologist,* 29 (Oct. 1989), 587–96; Winsor C. Schmidt, "Medicalization of Aging: The Upside and the Downside," *Marquette Elder's Advisor,* 13 (Fall 2011), 55–88.

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The same set of issues regarding the link between productivity and social citizenship that plagued old-age policy also shaped Kane as a workplace. The postwar settlement had conferred social rights on the working class through employment, particularly industrial employment. Breadwinning men, direct beneficiaries of this social enfranchisement, disbursed these rights to their families, in theory securing the whole deserving working class. Largely excluded from this regime, however, were the heavily feminized and nonwhite work forces in many nonprofit workplaces—health care providers among them. Congress extended wage and hours protections to hospital workers only in 1966 and collective bargaining rights in 1974.[17]

At Kane, this problem came to the surface when three different groups of workers staged sit-down strikes on June 30, 1966. At 11 a.m., staff in the laundry stopped working, complaining of excessive heat in their area. Attendants joined them at noon, and kitchen helpers at 2 p.m. All three groups were protesting the refusal of the county commission to approve a pay increase. Although the county board eventually agreed to raises in 1966, one in five Kane employees was still paid less than federal minimum wage in 1968. Administrators always struggled to attract enough staff.[18]

Low wages prevailed across the regional hospital industry. In 1970, faced with a union drive, Pittsburgh's flagship Presbyterian-University Hospital increased hourly minimum wages from $1.75 to $1.95. Soon after, the regional hospital council called for wage hikes to $1.95 for seven thousand workers across western Pennsylvania. Hospital workers' wages had climbed by 40 percent since only 1967, and health care administrators began to fret about spiraling wage bills. "I wish that I could tell you that improved methods, economies, better operation, etc. would offset this impact, yet I am sure you can understand that this is not so," warned the executive director of Montefiore Hospital to his board in 1966, describing possible wage hikes of between 40 and 75 percent. "The prospects for the future are rather grim," he concluded. Four years later, after the rapid pay increase at the end of the decade, Montefiore's treasurer reported, "if the wage scales of other areas become the pattern for this area, it is likely that hospital costs may rise by as much as 25% more." The disappearance of "the traditional gap between hospital pay scales and those of the business community" threatened to make hospital care unaffordable, he cautioned.[19]

But the labor market in the traditional "business community" was not a stable reference point, with industrial employment in Pittsburgh experiencing a sharp contraction. From 1960 to 1970, metropolitan-area employment in metals manufacturing fell from 162,514 to 128,142—a process that accelerated further in the first half of the 1970s. Even at the peak of the 1960s boom, in 1967, Pittsburgh's unemployment rate was nearly 5 percent—the third-highest of all major metropolitan areas in the country. With huge waves of layoffs in steel in 1971 and the 1974–1975 period, unemployment reached 9 percent by the middle of the decade.[20]

[17] Samuel Wolfe, ed., *Organization of Health Workers and Labor Conflict* (Farmington, 1976); Leon Fink and Brian Greenberg, *Upheaval in the Quiet Zone: 1199SEIU and the Politics of Health Care Unionism* (Urbana, 1989).

[18] William Pade, "Sit-Down Flares at Kane Hospital," *Pittsburgh Press,* June 30, 1966, pp. 1, 10; Thomas E. Sellers, "Union Leader Hits Kane Hospital Pay," *Pittsburgh Post-Gazette,* Feb. 27, 1968, p. 21; "36 Aides Okayed for Kane," *ibid.*, Aug. 9, 1974, p. 15.

[19] "Hospital Grants Wage Increases to 700 Employes," *Beaver County (PA) Times,* Feb. 17, 1970, p. A4; Dolores Frederick, "Hospitals Deny Raises Are Planned to Block Unions," *Pittsburgh Press,* March 18, 1970, p. 27; "Report of the Executive Director," Sept. 21, 1966, folder 1, box 3, Records of Montefiore Hospital (Historical Society of Western Pennsylvania); "Report of the Treasurer," Oct. 21, 1970, folder 4, *ibid*.

[20] U.S. Department of Commerce, Bureau of the Census, *U.S. Census of Population and Housing: 1960—Pittsburgh, Pa., Standard Metropolitan Statistical Area,* Final Report PHC(1)-9 (Washington, 1962), p. 171, table P-3;

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Industrial decline had two primary effects on hospital work. First, it drove hospital workers to seek higher wages, since they needed to stretch their paychecks further to support families and communities pummeled by manufacturing job loss. This necessity was particularly powerful for black workers, who were overrepresented in both steel layoffs and low-wage hospital jobs. At Kane, one-fifth of the work force was black—a higher rate of African Americans than in the county population overall, and these workers remained at the bottom of the workplace hierarchy. Second, industrial decline caused a demographic shift, as young people began to leave the region to seek better luck elsewhere. This shift left the remaining elderly shorn of traditional family care systems. A 1966 report, anticipating rising demand for elder care, warned, "Allegheny County is now on the threshold of a period in which these problems will increase alarmingly." During the 1970s, the number of residents living in households larger than five—a rough index of the capacity of extended family support systems—would fall almost by half. Tellingly, a 1976 study of a downtown men's shelter found that the number of elderly boarders had doubled since 1955. At Kane, the average length of stay doubled during the 1973–1975 recession, rising from 625 days to 1,166.[21]

While the country as a whole was aging, Pittsburgh was doing it faster. By 1977, 12.3 percent of the region was over 65, compared to 10.9 percent nationwide. This trend accelerated the expansion of the health care industry, which absorbed more of the local economy with each graying resident. Hospitals and nursing homes now had access to new funding streams in Medicare and Medicaid and enjoyed rising demand from an aging and less healthy population. But these institutions were also dealing with both a fast-growing wage bill and public opprobrium about rising prices. In seeking to economize, hospital administrators set up a trade-off between patients and employees: wages and staffing levels against the cost of care. The staff at Kane were "underpaid and overworked," and demand for custodial care exceeded what the facility was intended to provide. A local politician declared himself "very much concerned about the abuse heaped on the personnel at Kane Hospital."[22]

Industrial decline brought one further element of pressure to bear on Kane. A majority of Allegheny County's tax revenue derived from industrial real estate—hitherto a fiscal

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U.S. Department of Commerce, Bureau of the Census, *U.S. Census of Population, 1970,* vol. I: *Characteristics of the Population* (Washington, 1972), part 40, table 87. William Allan, "Pittsburgh in Danger of Losing Status as 'Boom' Town," *Pittsburgh Press,* Aug. 4, 1967, p. 14; Community Action Pittsburgh, "Target Neighborhood Report"; "Layoffs Spread at Steel Mills," *New York Times,* Aug. 7, 1971, p. 29; Alvin Rosensweet, "Jobless Rate of 8.8% Tied to Steel Layoffs," *Pittsburgh Post-Gazette,* Jan. 5, 1977, p. 29.

[21] "Urban League Blasts Kane Plan," *New Pittsburgh Courier,* Oct. 28, 1978, p. 1; Citizens' Advisory Committee to the Southwestern Pennsylvania Regional Planning Association, "Time for Concern"; Ad Hoc Planning Committee on Home Health Services, "A Proposed Coordinated Home Health Services Program for Allegheny County," June 2, 1966, folder 7, box 87, Visiting Nurse Association of Allegheny County Records (Archive Service Center); Laura C. Leviton, "The Implications of an Aging Population for the Health Care System in Southwestern Pennsylvania," Health Policy Institute, Graduate School of Public Health, 1981, p. 78, item 24, box 6, Bernard Greenberg Collection, *ibid.*; "Background Information, Long Term Care," n.d., p. 23, folder 2, box 88, Records of the Health and Welfare Planning Association.

[22] Regional age-structure data are from Citizens' Advisory Committee to the Southwestern Pennsylvania Regional Planning Association, "Time for Concern." National comparison comes from Beaufort B. Longest, "The Pattern of Utilization of Inpatient Hospital Services in Southwestern Pennsylvania: Report of a Study," Health Policy Institute, Policy Series No. 1, Nov. 1980, folder 8, box 136, Records of the Health and Welfare Planning Association. "Fiscal Trends: Allegheny County and Institution District, 1968–1974," Dec. 1975, item 7, box 26, Pennsylvania Economy League Records; Robert Johnson, "Hunt Urges 'Medical Motels' to Ease Kane Hospital Strain," *Pittsburgh Press,* Oct. 6, 1967, p. 42.

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asset. A 1969 report explained, "the amount of taxable money has, to some degree, great leeway because the county is so industrialized and received a majority of [its] taxable income through resources of industrial real estate." Hints of fiscal trouble, however, were already appearing. Because plants were increasingly idle from the late 1960s onward, their assessed value declined, and their value to the county tax base with it. As early as 1969, the county was borrowing money just to meet payroll. Debt-service payments crept upward, and new borrowing grew costly. As a result, the county repressed wages. The share of county spending going to wages between 1968 and 1974 fell from half the budget to one-third.[23]

Over the same period, county expenditures increased ten times faster than tax receipts—a rise driven largely by the growing reliance on health entitlements for revenue. In 1973 Kane brought in $7.9 million in state and federal dollars. The next year, this figure doubled, and Kane's Medicare and Medicaid reimbursements became the largest source of county revenue. The spike in Kane's budget was a countercyclical economic effect. Medicaid, a poverty program, tends to expand in hard times, and in November 1973 began the worst economic contraction since the Great Depression, lasting into 1975. The state also increased Medicaid reimbursement rates in late 1973, recognizing the worsening economic pressure on nursing homes. When the private industrial economy shrank, in other words, the public care economy grew.[24]

The region underwent such economic contractions spasmodically, but its population of needy elderly expanded steadily. The vise of economic restructuring squeezed care labor out from the household and into publicly supported institutions, which disproportionately employed women of color at low wages. With tax collection falling behind expenditures, the local government's ability to adequately fund services became increasingly strained, even with the growing revenue stream from federal health entitlements. The results showed at Kane.

Exposing Kane

Conditions at Kane deteriorated due to the interconnected dynamics of long-term industrial decline, regional aging, and state fiscal crisis, wreaking havoc on the quality of work at the institution, and thus on the quality of care. Allegheny County in the mid-1970s institutionalized between 8 and 10 percent of its oversized elderly population, compared to 5 percent nationwide. But this structural dynamic—the industrial-demographic-fiscal crisis—did not become a political crisis on its own. It required an agent.[25]

It was not a coincidence that NAM members exposed the scandal at Kane. The activists who authored *Kane Hospital: A Place to Die* were immersed in a political culture with

[23] Steven Ward, "Allegheny County Annual Report and Fiscal Affairs," 1969, folder 63, box 36, Civic Club of Allegheny County Records (Archive Service Center); Thomas P. Snyder, "Bond-Paid County Job Total Rises," *Pittsburgh Press,* Feb. 2, 1969, p. 1; "Fiscal Trends."

[24] Fiscal data are from "Fiscal Trends." "State Ups Aid to Nursing Homes," *Reading (PA) Eagle,* Sept. 28, 1973, p. 4. Recession dating is from "US Business Cycle Expansions and Contractions," n.d., *National Bureau of Economic Research,* http://www.nber.org/cycles.html. On the 1970s fiscal crisis, see James O'Connor, *The Fiscal Crisis of the State* (New York, 1973); and Greta R. Krippner, *Capitalizing on Crisis: The Political Origins of the Rise of Finance* (Cambridge, Mass., 2011). On fiscal crisis, public health, and elder care specifically, see John Craig and Michael Koleda, "The Urban Fiscal Crisis in the United States, National Health Insurance, and Municipal Hospitals," *International Journal of Health Services,* 8 (April 1978), 329–49; Carroll L. Estes and Robert R. Alford, "Systemic Crisis and the Nonprofit Sector: Toward a Political Economy of the Nonprofit Health and Social Services Sector," *Theory and Society,* 19 (April 1990), 173–98; and Sandra Opdycke, *No One Was Turned Away: The Role of Public Hospitals in New York City since 1900* (New York, 1999).

[25] *Kane Hospital,* 14.

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a high level of theoretical sophistication. The central concern of those activists was their isolation from the concrete social problems to which they believed their brand of politics offered the solution. They began as a theoretical tendency without a political praxis, and they knew it.[26]

NAM was one of the radical organizations that emerged from the wreckage of Students for a Democratic Society (SDS). SDS, the flagship organization of the young Left, had, by the end of the 1960s, become bitterly factionalized around questions of class and strategy. The organization split at its 1969 convention between the Revolutionary Youth Movement faction, which took an expansive view of the working class that included students, soldiers, and the unemployed (and which shortly gave rise to the Weather Underground); and the Worker Student Alliance, which insisted that only the traditional proletariat was capable of revolutionary action. NAM, emerging in 1971, had two major distinguishing features: a commitment to socialist-feminism and a willingness to work on immediate projects short of revolution. As a Pittsburgh chapter founder recalled, "NAM was an attempt to create some sanity and a real organized Left." These two traits attracted to the organization in 1974 the couple who would take on significant intellectual leadership—the activist writers Barbara Ehrenreich and John Ehrenreich.[27]

Although NAM's membership was uniformly anticapitalist, the organization's culture had formed as a reaction against the immediatist militancy of SDS's final days. NAM was born from the recognition that the revolution had not happened and was not imminent; its purpose was to understand why not and to prepare for a longer struggle. Critical influences for NAM were figures such as Sheila Rowbotham, the socialist-feminist activist historian; E. P. Thompson, who saw class consciousness as the product of willful action rather than mechanical economic determination; and Antonio Gramsci, whose ideas helped identify specific mechanisms by which a "hegemonic" class enlisted elements of a subordinated ("subaltern") class toward its own purposes. Gramsci's Marxism characterized society as divided into internally heterogeneous blocs, rather than along the clean lines of unitary proletariat and bourgeoisie. And, importantly for NAM members, his thinking allowed for a long road to revolution, with intermediate steps.[28]

NAM was also distinguished from much of the sectarian Left by its feminism. Where misogyny had pervaded the late-1960s New Left, NAM's break with sectarianism created space for more equal gender politics. One of the first actions taken by the Pittsburgh chapter was a six-week summer course on socialism and feminism, attended by seventy women. In its second national convention, NAM required that all leadership bodies be at least half women.[29]

NAM's project, at heart, was to find a place for the socialist movement in a postindustrial society. With factory jobs disappearing, America's class composition was in flux. How

[26] Eckel interview; Draft history of New American Movement (NAM) Pittsburgh chapter, n.d., folder 16, box 1, Joni Rabinowitz Papers (Archive Service Center).

[27] Victor Cohen, "Interview with Joni Rabinowitz and John Haer," *Works and Days,* 28 (Spring–Fall 2010), 158; "Working Papers," n.d., folder 29, box 2, Rabinowitz Papers; Barbara Ehrenreich and John Ehrenreich, application for NAM membership, Oct. 21, 1974, folder 7, box 2, Barbara Ehrenreich Papers (Schlesinger Library, Harvard University, Cambridge, Mass.).

[28] Material from socialist-feminist conference in Yellow Springs, Ohio, July 1975, folder 11, box 15, Ehrenreich Papers. Sheila Rowbotham, *Woman's Consciousness, Man's World* (London, 1973); E. P. Thompson, *The Making of the English Working Class* (New York, 1963); Antonio Gramsci, *Selections from the Prison Notebooks,* ed. and trans. Quintin Hoare and Geoffrey Nowell-Smith (New York, 2005); T. J. Jackson Lears, "The Concept of Cultural Hegemony: Problems and Possibilities," *American Historical Review,* 90 (June 1985), 567–93.

[29] On sexism and the New Left, see Sara Evans, *Personal Politics: The Roots of Women's Liberation in the Civil Rights Movement and the New Left* (New York, 1979). Draft history of NAM Pittsburgh chapter, n.d., folder 16, box 1, Rabinowitz Papers; Cohen, "Interview with Joni Rabinowitz and John Haer," 165–67.

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could socialism, traditionally a blue-collar ideology, adapt to the new order? How could activists articulate the common interests of residual and emergent class formations, rather than allow them be pitted against each other?

Given NAM's ideological origins, the organization was seeking a new theory of social class and political strategy for the 1970s. The Ehrenreichs played a key role in developing this. They had met in graduate school in New York in the 1960s. Both were active in the antiwar movement but became particularly involved with health care politics in the early 1970s: John worked for a time for Local 1199, the hospital workers' union, and Barbara was active in the Women's Health Movement and worked for the organization Health Policy Advisory Center (Health/PAC)—a kind of left-wing health policy think tank. From their experiences and studies, the two reached a proposed theoretical resolution to the late 1960s debates in the SDS. They argued that American capitalism had come to require a buffering layer between labor and capital, a stratum they eventually named "the professional-managerial class." The function of this group, they argued, was to operate the institutions of social control, reproducing the whole class system: social workers, teachers, and nurses were examples. It was from this standpoint that in NAM narrated political history and developed its political strategy.[30]

The Ehrenreichs' analysis, developed over the course of the 1970s, represented an attempt to explain the political failure of the New Left. Many people agreed that, at the core of that problem had been the gap between the New Left and the working class. But the nature of this gap and the solution to it had caused the dispute that dissolved SDS into factions. The Ehrenreichs proposed that the New Left had misapprehended its own social origins in the professional-managerial stratum and thus missed the historical reason for its failure to organize the proletariat: the mutual antagonism of professionals and proletarians, which was structural. This friction was part of the reason for the existence of the middle class from which the New Left sprang.[31]

It was counterproductive for leftists to ignore their own position in society, the Ehrenreichs argued. They proposed that, instead of spreading Marxism to steelworkers, the task of middle-class radicals was to break the loyalty of the professional stratum to the existing social order: to radicalize their own world and realign professionals with the working-class people whom professional institutions aimed to control. In Gramscian fashion, this meant analyzing the ideological operation of those institutions: Whom did the ideology of professionalism recruit into a dominant coalition? Whom did professionalism subordinate? And who might be broken away from the dominant coalition to join the subordinates?[32]

In their analysis, the Ehrenreichs focused on health care institutions as particularly clear examples. In hospitals, they argued, a male elite leadership successfully exercised hegemony over feminized staff through professional ideology. In a 1973 essay, they disapprovingly quoted a worker speaking of "pride in being one of the trio in the medical profession, the physician, the nurse, and the medical technologist." They lamented such

[30] The Ehrenreichs eventually published their analysis in 1977. See Barbara Ehrenreich and John Ehrenreich, "The Professional-Managerial Class," *Radical America,* 11 (March–April 1977), 7–31. For their early joint work, see Barbara Ehrenreich and John Ehrenreich, *The American Health Empire: Power, Profits, and Politics* (New York, 1970). Their ideas were well known in NAM by the mid-1970s. Barbara Ehrenreich, notebook, 1974, folder 17, box 23, Ehrenreich Papers.

[31] On the New Left in this period, see Howard Brick and Christopher Phelps, *Radicals in America: The U.S. Left since the Second World War* (New York, 2015), 171–217.

[32] Ehrenreich and Ehrenreich, "Professional-Managerial Class," 16.

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"workers who do not see themselves as workers." Here was professionalism functioning successfully as hegemonic ideology, capable of co-opting into the dominant coalition those workers needed to carry out health care's social control functions over working-class patients.[33]

The nurse, they thought, stood at the hinge. Those above her were politically out of reach for any progressive upheaval in health care, those below were necessary participants. From 1950 to 1969, the number of hospital employees had tripled from 662,000 to 1.8 million, and the hospital work force became increasingly complex and stratified. How nurses aligned would determine the balance. In a speech in the late 1970s to the National League for Nursing, Barbara Ehrenreich insisted, "within our commercialized and often anti-health medical system, only nursing retains the values and skills to reconstruct health caring as an organized social endeavor. What holds nursing back from taking its proper place in the leadership of a broad populist health movement? Has nursing become too entangled in its own internal professional hierarchies?"[34]

Feminist analysis thus proved critical to the challenge to professional ideology. The emergent social order, as the Ehrenreichs pointed out, was rewiring the circuits of women's labor, routing it increasingly through hospitals and similar professional bastions. The Ehrenreichs imagined a populist challenge to elite and managerial authority, based in an alliance of patients, workers, and defiant professionals. Barbara had glimpsed this possibility during her work with Health/PAC in a series of protest activities targeting insurers and hospitals, most dramatically in the occupation of Lincoln Hospital it the Bronx. She came into NAM in part to evangelize about what she had seen and the theoretical lessons she had derived—lessons for which NAM was primed. The absorption of care work from the margins of the economy into its core created, she thought, the grounds of a feminist alliance connecting the disparate components of the coalition she imagined. As she concluded her 1973 book *Witches, Midwives, and Nurses,* "to reach out to women health workers *as workers* is to reach out to them as *women*."[35]

NAM shared the Ehrenreichs' analysis. Not only were they influential voices within the organization, but their 1970 study of the health care industry had been supported by a foundation run by Victor Rabinowitz, the father of Joni Rabinowitz, the founder of the Pittsburgh NAM chapter. She recalled, "there was a whole movement on the part of NAM to develop an analysis of a 'professional managerial class.' Barbara Ehrenreich, who was in NAM as we were thinking this through, was a big part of developing that analysis. Many of us had been to college and didn't see being a professional as a detriment." A 1975 national socialist-feminist conference—initiated by a NAM chapter and with the Ehrenreichs in attendance—determined that immediate campaign goals should include the organization of health care, child care, and clerical workers. According with theory, NAM activists

[33] Barbara Ehrenreich and John Ehrenreich, "Hospital Workers: A Case Study in the 'New Working Class,'" *Monthly Review,* 24 (Jan. 1973), 24.

[34] *Ibid.*, 8, 13–15; Ehrenreich and Ehrenreich, *American Health Empire*. See also Barbara Ehrenreich and Deirdre English, *Witches, Midwives, and Nurses: A History of Women Healers* (New York, 1973); Barbara Ehrenreich, speech at National League for Nursing, Aug. 21, 1978, folder 16, box 17, Ehrenreich Papers. Emphasis in original.

[35] Merlin Chowkwanyun, "The New Left and Public Health: The Health Policy Advisory Center, Community Organizing, and the Big Business of Health, 1967–1975," *American Journal of Public Health,* 101 (Feb. 2011), 238–49; Barbara Ehrenreich, "Giving Power to the People: The Early Days of Health/PAC," *Health/PAC Bulletin,* 18 (Winter 1988), 4–8; Gabriel Winant, "The Making of *Nickel and Dimed:* Barbara Ehrenreich and the Exposé of Class in America," *Labor,* 15 (March 2018), 67–79; Ehrenreich and English, *Witches, Midwives, and Nurses,* 103. Emphasis in original.

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in early 1975 were embedded in eight workers' organizing drives nationwide. Of these, three focused on hospital workers (including a campaign in Pittsburgh), two on day care workers, two on university clerical staff, and one on academics.[36]

The NAM chapter in Pittsburgh consisted of thirty-five members in 1975. Three were members of the Service Employees International Union, working in the health care industry; two were teaching assistants, and four were professors. Two were professionals in local government, one a health inspector. There was one clinic administrator, a drug counselor, a family counselor, and a few freelance writers. The chapter contained a smattering of others—a steelworker, a few cab drivers, a postal worker—but most were right out of the Ehrenreichs' argument.[37]

If NAM's members—Eckel and Nagy included—were perfect exemplars of the emergent professional-managerial class, patients at Kane represented the social residue of the disintegrating old working class. Typically, they had spent down any remaining assets to qualify for Medicaid so they could stay indefinitely. Workers at Kane, overwhelmingly women, stood for the new working class—with all its attendant divisions between proletarian and professional. "The staff were mainly women, there was clearly a hierarchy," recalled Eckel. "The RNs were definitely more middle-class. They certainly got paid more but they had a lot of responsibility. The nurses' aides, people like me—I was unusual for having been to college, I didn't mention that much. A lot of them were doing it because it was what they could find."[38]

At Kane, Eckel and Nagy saw an opportunity to put theory into practice, so they applied for jobs as nurse's aides. They intended from the outset to blow the whistle and to do so in a way that aligned proletarian, professional, and patient on one side, and the administration on the other. "I had a lot of empathy for the patients and I was trying really hard to understand the staff and get to know a little bit about what their lives were like," said Eckel. The problems at Kane were real and structural in origin; the scandal was a political creation of NAM members.[39]

Life and Death on the Inside

The crisis at Kane was not a product of some sudden state of emergency. Eckel recalled how the place ran according to routine. "When we got there, there was always a sign-in about who had which rooms or beds. We were supposed to clean up the patients. We had about six weeks of training. There were rules about how often they were supposed to be bathed and how often their adult diapers were changed. And the nurses had rules about when they were supposed to change dressings." Following professional routine did not inhibit neglect and abuse; routine was the context within which abuse happened. "It was always just really hard in the morning because I'd go into these rooms and there would be people who had been incontinent and had clearly been in their incontinence for a long time. There were always several people like that."[40]

[36] Cohen, "Interview with Joni Rabinowitz and John Haer," 160. On the Ehrenreichs' Rabinowitz connection, see Ehrenreich and Ehrenreich, "Hospital Workers," 27. Mark Mericle, "Workplace Organizing Status Report," Feb. 21, 1975, folder 29, box 2, Rabinowitz Papers.

[37] Joni Rabinowitz to Mark Mericle, Feb. 10, 1975, folder 29, box 2, Rabinowitz Papers.

[38] Eckel interview.

[39] *Ibid.*

[40] *Ibid.*

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When Eckel and Nagy joined Lewin at Kane, they began gathering evidence. The eventual results were revealed in *Kane Hospital: A Place to Die*. While Eckel did not attempt to recruit others to describe life inside Kane, Lewin did so successfully. The exposé, consequently, consisted in large part of staff testimony as well as images and analysis. As one nurse's aide described the conditions, "about one quarter of the people at Kane Hospital are confined in geri-chairs all day long. People who have difficulty walking or are troublemakers, are kept in geri-chairs. They are lined up in hallways, against walls and around tables. Often they stay in one place all day long." She added, "the geri-chairs are in very bad condition. They are sticky with urine, food and saliva. They are seldom cleaned. Most of the foot rests are stuck. It takes months to get anything repaired at the hospital shop, so a lot of the women sit with their feet dangling all day long. This cuts circulation to their lower legs, causes foot arches to drop, and leads to a loss of strength in their legs. Patients confined in geri-chairs and not given any exercise, soon lose their ability and desire to walk."[41]

The overuse of geri-chairs was of a piece with the general resource shortage. Linen was constantly unavailable. The hospital lacked sufficient wheelchairs. Food quality was low. Recreational equipment and activities were almost non-existent. Personal supplies (such as bedpans and towels) and personal aids (such as false teeth, braces, and hearing aids) were scarce and had to be shared or awaited for months. Some beds lacked bed rails to keep patients from falling and curtains to maintain privacy. Above all, though, Kane was understaffed. "Kane Hospital needs at least 150 additional nursing personnel each day to meet minimum state standards," wrote Eckel, Nagy, and Lewin. Professional attention by doctors, physical therapists, and other specialists was extremely scarce; patients might go months, even years without seeing one.[42]

The consequences of these shortages were the simultaneous degradation of patient care and the overuse of confinement by staff to manage. A nurse's aide told the story of Herbert Fitzwalt, a diabetic disliked by the staff for always being thirsty. He was confined in a geri-chair. "His legs were extended; the back of his heels resting on the floor in a puddle of urine. I helped him up in the chair and he complained that 'his foot really hurt today.' The dressing on his right heel had begun to come off, so I examined his right foot more closely. His dressings were soaked in urine. An open decubitus ulcer was draining and bleeding slightly. I examined his lower leg and found it swollen about twice its normal size." A nurse found later in the day that the dressing on his bedsore (decubitus ulcer) had not been changed for several days. While dressings were supposed to be changed daily, it was common for patients to wait several days—a situation that caused unnecessary infection. "Because patients are not changed and washed when they are incontinent, because many of them are confined in geri-chairs all day with no exercise, and because bed patients are not turned or positioned regularly, many patients develop bedsores." Nurse's aides did not like to report bedsores because doing so would generate a formal record of neglect.[43]

The lack of sufficient staff and resources and the objectification of patients into medical problems led, in combination, to regular abuse. Assistance to get to the bathroom often required heavy lifting for a long period of time by two aides, which meant neglect of

[41] *Kane Hospital,* 12–13.
[42] *Ibid.*, 26–59, esp. 26.
[43] *Ibid.*, 27.

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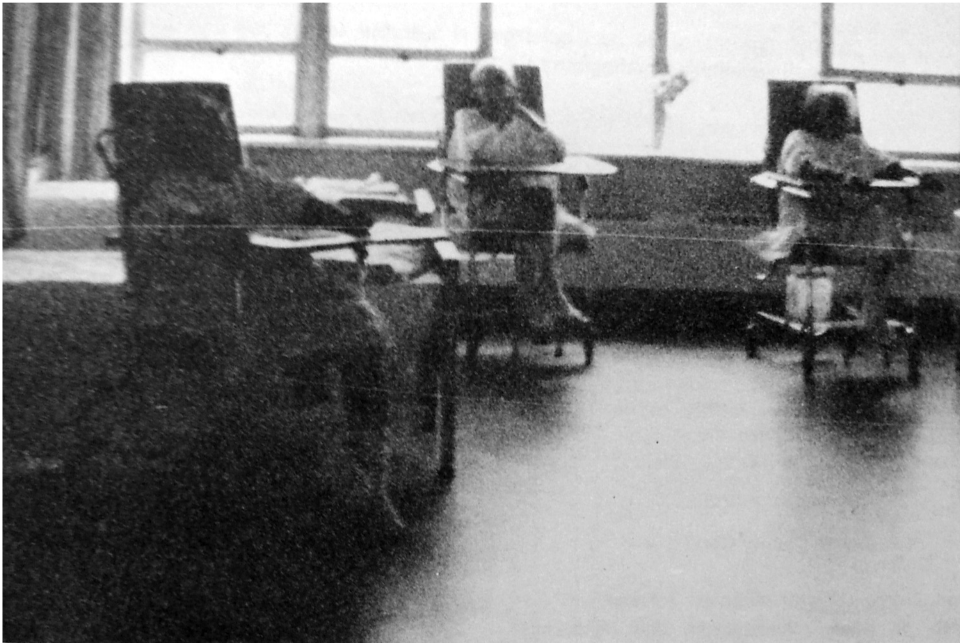

This photograph was taken with a pinhole camera as part of an exposé of John J. Kane Hospital in the mid-1970s. This image shows patients strapped into geri-chairs, where they were often left to sit all day. *Reprinted from* Kane Hospital: A Place to Die *(Pittsburgh, 1975), p. 13, in U.S. Congress, Senate, Special Committee on Aging, Subcommittee on Long-Term Care, Part 26—Washington, D.C.,* Trends in Long-Term Care, *94 Cong., 1 sess., Dec. 9, 1975.*

other patients. "On most floors patients are permitted to defecate where ever they are at the time." This neglect caused bowel and bladder illnesses to worsen, generating avoidable catherization and incontinence. It was common for patients to go a month without being bathed. "Every day the patients get sworn at—asked if they are 'full of shit today' and called 'old bastards' and the like. Some patients fight back during [clothing] changes, but most are scared and offer no resistance."[44]

The hostility of the encounter between underresourced staff and terrorized patients represented the worst possible iteration of the Ehrenreichs' antagonism between the professional-managerial class and the working class whose life it manages. "The aide smiled at the patient and said, 'You know I hate dagos don't you?' The patient was taken to the bathtub and sat quietly as the aide continued to berate him. 'You know I hate you. Now that you are in the tub, I ought to drown you.' The aide soaked the washcloth in the water and slapped the patient on the head and the shoulders several times with the cloth. 'The headlines in tomorrow morning's paper are going to read, '"Aide Kills Patient In Bathtub."'" The next bath the aide gave was to a black man who had a case of diarrhea. The aide sprayed his genitals with cold water, saying, "You better learn never to shit yourself again, nigger." Such behavior was far from uncommon. Staff would also make jokes of patients' sexuality, forcing them to swear, masturbate, or talk about sex.[45]

[44] *Ibid.*, 28–29.
[45] *Ibid.*, 41–45, esp. 41–42.

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One quarter of Kane's patients were confined in geri-chairs for the full day. The hospital also used restraints on patients in wheelchairs and beds. A rehabilitation aide watched as nursing aides took a patient whom she had helped learn to walk again and brought him back into confinement. "It's easier for them," she explained, "one less patient moving around. They can move him out to lunch ten times faster in a chair than he can walk with supervision. In a couple of weeks all the rehab work we've done is undone. His desire to walk is gone." Patients were also regularly sedated "based on the needs of the hospital staff to reduce their work load and create a quiet, calm, orderly environment." A study of the physical environment of the hospital reported, "We found that the overwhelming message conveyed by the living environment is that patients are interchangeable nobodies . . . It is no wonder that most of the residents we talked to and observed had adopted a helpless stance with respect to their environment." Eckel recalled, "Most everyone was very depressed. So they were kind of like flat affect. Though I can remember people screaming on occasion." Kane, in other words, worked as a mill for reducing members of the old working class first to bare life, and then death. One thousand residents died per year, in a facility with just over two thousand beds. In a very real sense, staff made up the front line in an intergenerational class conflict—a lethal iteration of the social struggle identified by the Ehrenreichs between the emergent bloc of professional-managerial workers and the residual proletariat.[46]

In his classic essay "Necropolitics," Achille Mbembe defines sovereignty as "the capacity to define who matters and who does not, who is *disposable* and who is not." The disintegration of industrial society caused a crisis of social reproduction for human leftovers, who both had rights and had to be disposed of. The midcentury welfare state both secured the rights of retirees and simultaneously enforced their disposal by processing them into medical problems. The postwar policy regime had been a kind of biopolitics: state power, through social insurance and investments in bioscience, lengthened and shaped the biological lives of working-class people, often to their benefit. As the political-economic basis of that regime fell apart, biopolitics devolved partially into necropolitics. A policy regime for sustaining working-class life became, at Kane, a regime for gradually liquidating it.[47]

Viewed this way, Kane comes to resemble another kind of expanding state institution in this period—similarly an excrescence from the decaying urban industrial order: the prison. The carceral state grew in the 1970s and 1980s to manage political-economic crisis and displacement by criminalizing people of color. Virtually the same could be said of Kane, albeit through the mechanism of medicalization rather than criminalization, and by targeting the surplus elderly population rather than young people of color. This is not to suggest that elder care is the moral equivalent of punishment; merely that the transformation of the 1970s pushed socially marginal human beings out of place, and total institutions caught them.[48]

[46] For figures on annual deaths and discussion of immobilization, see *ibid.*, 6, 47. The IKM Partnership—Architects, *The John J. Kane Hospital Master Plan: Environmental/Behavioral Study* (Pittsburgh, 1978), 51; Eckel interview. On bare life, see Giorgio Agamben, *Homo Sacer: Sovereign Power and Bare Life,* trans. Daniel Heller-Roazen (Stanford, 1998).

[47] Achille Mbembe, "Necropolitics," trans. Libby Meintjes, *Public Culture,* 15 (Winter 2003), 27. Emphasis in original.

[48] Ruth Wilson Gilmore, *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California* (Berkeley, 2007); Loïc Wacquant, *Punishing the Poor: The Neoliberal Government of Social Insecurity* (Durham, N.C., 2009); Elizabeth Hinton, *From the War on Poverty to the War on Crime: The Making of Mass Incarceration in America* (Cambridge, Mass., 2016).

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This photograph was taken with a pinhole camera as part of an exposé of John J. Kane Hospital in the mid-1970s. The caption that ran with this image in the book *Kane Hospital: A Place to Die,* reads: "Woman tied in bed with a sheet—wet, dirty and no bedrails." *Reprinted from* Kane Hospital: A Place to Die *(Pittsburgh, 1975), p. 69, in U.S. Congress, Senate, Special Committee on Aging, Subcommittee on Long-Term Care, Part 26—Washington, D.C.,* Trends in Long-Term Care, *94 Cong., 1 sess., Dec. 9, 1975.*

As in the prison system, those confined in Kane resisted. This took small forms. Eckel recalls how patients—all issued hospital gowns, which circulated freely—would hoard and refuse to wash individually owned clothing items, lest they lose them in the collective laundry. She remembered a man masturbating as a form of performative disobedience and disrespect for the authority of staff. Patient Mary Miller, reported a nurse's aide, would "let other women loose" if she got out of her own geri-chair. "Does not like the hospital," the aide commented. Another, Audrey Pope, "when she thinks that no hospital employees are around . . . hisses and swears about the way she is treated." Mary Washington pretended not to be able to speak to hostile staff, though she held perfectly lucid conversations with friendly aides. Louella Henry, a nonagenarian, looked a nurse's aide in the eye and said, "I curse you, I curse you—that you will live to feel ninety years old in your bones and will know what you've done to me."[49]

Before the publication of the exposé, hospital administrators tended to respond to demands, complaints, and resistance by pathologizing patient grievants. A woman named

[49] On prison resistance, see Heather Ann Thompson, *Blood in the Water: The Attica Prison Uprising of 1971 and Its Legacy* (New York, 2016). Eckel interview; *Kane Hospital,* 13, 43, 53–54.

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Dorthy, for example, was the most demanding patient on her floor, suffering both Parkinson's and diabetes; she could not move any part of her body except her mouth and eyelids. When she asked for the care she needed, "she was screamed at, slapped, and told to 'shut-up' many times by the staff." Dorthy's treatment appears nearly indistinguishable from torture: she was alternately starved and force-fed, strapped to a circoelectric bed that was made to rock with her in it, or slanted so her head was lower than her body. When she complained about how she was bathed, water was thrown in her face. Carrie Knight, a blind patient, was outspoken about the low quality of treatment. The hospital sent a psychiatrist to evaluate her; in his report, he described her as entirely clearheaded but recommended that she be committed if she continued not to cooperate. Whether through explicit punishment or mere isolation and inactivity, Kane could reduce cognitively whole patients to apparent senility. In contrast to its founding rehabilitative mission, it generated degeneration and sped mortality.[50]

Fallout

By late 1975, Eckel, Lewin, and Nagy had finished their report, and they sought out the Action Coalition of Elders, a Pittsburgh community group, to publish the document under its own name. ACE voted in favor, forming the Committee to Improve Kane Hospital (CIK)—composed, in significant part, of NAM members and close allies. Calling the content of the report "terrifying," ACE president William C. Cobbs Sr. wrote: "The residents of Allegheny County pay for this institution and depend on it to rehabilitate their chronically ill parents and grandparents who have nowhere else to go." The condition of Kane was of a piece with a broader social phenomenon, he argued, "society's structured neglect of old people."[51]

ACE first passed the report to Senator Frank Moss's subcommittee in Washington, and the December 1975 hearings became the first public act of the scandal. Allegheny County commissioners vehemently denied the allegations. "It is a tragic commentary that a Senate subcommittee would be allowed to use itself in this manner," lamented Commissioner William Hunt, accusing the senators of seeking to "traffic in the misery" of patients for public acclaim. "Our chief problem is loneliness, . . . and if [the senators] have a cure, let us know."[52]

A series of investigations began. The first, conducted in a rush by the state Health Department, found only minor improprieties. Kane critics alleged that the institution simply cleaned itself up for inspectors. Still, the county commissioners quickly cited the report as evidence for the defense. The Health Department also soon initiated a longer investigation. In February 1976, a group of eighty-eight Kane nurses signed a petition endorsing the testimony gathered by Eckel, Lewin, and Nagy.[53]

[50] *Kane Hospital,* 84–86.

[51] William C. Cobbs Sr., "From the Action Coalition of Elders," Oct. 14, 1975, folder 11, box 7, Marjorie and J. Warren Matson Papers (Archive Service Center); ACE Committee to Improve Kane Hospital to ACE Executive Committee, July 7, 1976, *ibid.*

[52] Lee Gould, "Commissioners Reply to Charges at Kane Hospital," *Washington (PA) Observer-Reporter,* Dec. 11, 1975, p. A9.

[53] Doug Harbrecht, "State Probers Find 'Deficiencies,' No Abuse at Kane," *Pittsburgh Press,* Dec. 11, 1975, p. 1; Committee to Improve Kane Hospital, "Kane Hospital History of Events," n.d., folder 10, box 23, Thomas Merton Center Papers (Archive Service Center).

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In response to the outcry, the county commissioners convened a "citizen panel" to investigate and weigh Kane's future. ACE received a seat on the eleven-member committee, which it filled while continuing to protest the underrepresentation of the elderly, consumers, minorities, and Kane workers. "10 of the 11 proposed members are professionals," complained ACE president Cobbs, "many of them representing the interests of nursing homes and hospitals." Although the committee acknowledged that Kane had access to county funds and cheap borrowing thanks to its public status, the panel quickly recommended a plan that activists feared most, calling for the institution to be privatized. ACE warned, "the change to non-profit status could simply provide county government with a convenient way to unload a difficult problem—while guaranteeing no improvements in patient care and services." Later, Gordon MacLeod, chairman of the panel, privately confirmed this view. In December 1976 he wrote to County Commissioner Thomas Foerster, "your willingness to keep an open mind on the issue of converting Kane Hospital to a non-profit health center should be better recognized." In his view, "the present form of governance can only lead to more and more adverse publicity." Public administration, MacLeod believed, would embolden the workers and "lead over time to growing employee unrest along with shortages of physicians and nurses." He wanted "access to private funds and professional recognition which [Kane] does not enjoy currently."[54]

Through late spring and summer of 1976, the matter came to a head. The citizen committee issued its final report and recommendations on April 10—calling for privatization. Meanwhile, the collective bargaining agreements of county employees were expiring at the end of April, and ACE activists had been reaching out directly to Kane workers. "We believe that a major problem at Kane Hospital is the lack of personnel and supplies necessary to provide good care," ACE declared to Kane staff in a statement. "Many Kane employees have talked with us about their frustration in trying 'to do a good job in an impossible situation.'" They called for hundreds of new hires, opportunities for career advancement, and massive raises.[55]

The practical possibility of the coalition theorized by the Ehrenreichs—workers, professionals, patients—thus began to come into view. The administration clearly felt the pressure of this eventuality. Kane's director, Edward Deverson, called for better wages and working conditions in December but had been unable to move the County Commission on the issue. On April 20 he resigned with a blast of public bitterness. "No one wants to work here since these do-gooders zeroed in us," he said. "Most of them should be patients out here." At the end of April, the CIK demonstrated in front of the local government building, accusing the county commission of cutting millions from Kane's budget. One demonstrator dressed as a county commissioner snatched a giant check away from another protestor sitting in a wheelchair. Faced with the risk of a strike and mounting public

[54] Karolyn Schuster, "Lack of Oldsters, Consumers on Kane Probe Panel Blasted," *Pittsburgh Post-Gazette,* Feb. 4, 1976, p. 21; Kane Hospital Task Force, Finance Sub-committee minutes, Feb. 14, 1976, folder 10, box 7, Matson Papers; Kane Hospital Task Force, Governance Sub-committee minutes, Feb. 14, 1976, *ibid.*; Action Coalition of Elders, "Information for Programmatic Sub-committee, Kane Action Panel," March 3, 1976, folder 11, box 7, *ibid.*; Gordon MacLeod to Thomas J. Foerster, Dec. 22, 1976, *ibid.*

[55] Committee to Improve Kane Hospital, "Kane Hospital History of Events"; "Panel Wants Kane to Be Private," *Washington (PA) Observer-Reporter,* March 29, 1976, p. D1; "Better Working Conditions Equal Better Care: A Statement from the Action Coalition of Elders to the Employees of Kane Hospital," [1976], folder 10, box 23, Merton Center Papers; ACE Committee to Improve Kane Hospital to Planning Committee Members, April 1976, folder 11, *ibid.*

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pressure from activists, the county settled the contract the next day, conceding most of the union's demands.[56]

In June the state released the report of its investigation. It uncovered chaotic record keeping and systematic malpractice. Investigators found hundreds of nursing shifts unfilled in a two-week period. Necessary procedures were not being performed; patients were being unnecessarily immobilized. The report, in other words, confirmed the exposé. The state suspended Kane's permanent license and issued a six-month temporary license instead (potentially renewable up to three times), while giving Kane a month to submit a plan of correction. The next month, Stephen Lenhardt, Kane's new executive director, offered a plan. Largely consisting of new positions and procedures for monitoring patients' rights and care, it offered organizational adjustments to improve monitoring of care and following of procedures, while conceding that the critical issue was increasing staff levels. This was a funding problem—that is, a political problem that elected officials needed to solve.[57]

The six-month time frame of the license-renewal process deescalated the issue. Under pressure, the county dug up $5.1 million additional dollars for Kane, paying for the plan of correction and the creation of 285 new positions. The state legislature also increased Medicaid reimbursement rates for public institutions, which offered the prospect of further budgetary relief. In August, meanwhile, the ACE-NAM alliance broke up. With some gains won, ACE leaders urged a more moderate tone. The organization that had represented the two groups' joint front, the CIK, broke away from ACE and constituted itself as an independent body. Left-wing members of the CIK, such as Joseph Nagy, were able to maintain NAM's presence in the CIK and bring much of their grassroots community support with them when they walked away from ACE, eventually winning funding from local religious groups. Their role in exposing Kane from the inside had won them lasting credibility. With the union contract settled, the budgetary situation seeming to improve, the hospital undergoing internal reform, and the main pressure group in a state of internal flux, the pace of events slowed until the end of 1976.[58]

This cycle of contention and quiet continued through 1977 and 1978. Judging Kane's rate of improvement too slow, Pennsylvania's Health Department banned new admissions in January 1977, renewing the hospital's license to operate for another six months and touching off a new round of conflicts. The CIK began new protests in February over the inaction of the county commissioners. "More staff have been hired there, but the Health Department closed admissions because the understaffing is still critical. You announced a pay increase for registered nurses; then hospital employees were told it was not a pay increase," wrote the CIK in its statement. "The waiting list of people who need care at Kane grows longer each day." The CIK filed a class-action lawsuit on behalf of county residents seeking placement in Kane.[59]

[56] Committee to Improve Kane Hospital, "Kane Hospital History of Events"; Karolyn Schuster, "Kane Director Resigns, Citing Pessimism on Hospital Future," *Pittsburgh Post-Gazette,* April 21, 1976, pp. 1, 5. Committee to Improve Kane Hospital, "Kane Hospital History of Events."

[57] "Pennsylvania Department of Health Investigation of John J. Kane Hospital," June 17, 1976, folder 10, box 23, Merton Center Papers; Richard Arnold, "Kane License Cut to 6 Months," *Pittsburgh Press,* June 17, 1976, p. 1; Allegheny County Institution District, "Plan of Correction," July 14, 1976, folder 12, box 7, Matson Papers.

[58] Committee to Improve Kane Hospital, "Kane Hospital History of Events"; Committee to Improve Kane Hospital, "To Concerned Individuals and Organizations," folder 11, box 7, Matson Papers; ACE Executive Committee to Improve Kane Hospital to ACE Executive Committee, July 7, 1976, *ibid.*; Vince Gagetta, "Kane Hospital Chief: Maintain Public Status," *Pittsburgh Post-Gazette,* Dec. 16, 1976, p. 17.

[59] Richard Arnold, "Kane Penalized, but Kept Open," *Pittsburgh Press,* Jan. 14, 1977, p. A6; Vince Gagetta, "25 Disrupt Commissioners Demanding Changes at Kane," *Pittsburgh Post-Gazette,* Feb. 11, 1977, p. 11; Committee

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In May the U.S. Department of Health, Education, and Welfare (HEW) issued a report endorsing the accusations of the CIK. Inadequate staffing, frequent mistakes, poor record keeping, unsanitary conditions, poor food and service, and overcrowding all persisted to significant degrees a year and a half after the initial scandal. HEW announced that it would cut off the flow of federal dollars to Kane—the majority of the hospital's budget. This would have killed the institution. The county scrambled to reach a resolution with the federal administrators, eventually agreeing on a further reduction of the patient population and new staff increases.[60]

The political situation, unsurprisingly, continued to deteriorate. Later that summer, the Court of Common Pleas found in favor of the plaintiffs in the lawsuit for admission to Kane—a ruling sustained on appeal. The judiciary now recognized custodial care as part of elder rights and ordered that the county begin admitting patients to care, while the federal and local administrations forbade it. Meanwhile, the federal General Accounting Office found that the Kane administration had double billed Medicare and Medicaid for several years in the early 1970s, prompting a new round of U.S. Senate hearings. These hearings became a forum for activists to reveal the ongoing deficiencies of Kane: employee-retention failures were leading to ongoing understaffing, and inspections were fraudulent because the hospital received advance notice. Through 1977, the CIK continued to call for hundreds of new staff at Kane, through filling unfilled positions and creating new ones, and worked with unionized employees to document understaffing and work hazards in daily operations. "Patients with staph infection are still permitted to wander freely through the Infirmary," noted a CIK publication.[61]

This intractable situation forced authorities to consider more drastic proposals. In 1978 county officials prepared and submitted a plan to break up Kane into four public "mini-Kanes"—smaller institutions spread around the area. The plan drew wide opposition from the Left and the Right. On the left, the CIK approved of the notion of keeping Kane public but protested that the proposal would decrease the overall number of beds when need was rising and that the plan had been drafted without patient participation. The Urban League, which was already concerned about access to the facility for African Americans—as patients or staff—predicted that of the four proposed "mini-Kanes," the one slated for Pittsburgh proper would become racially ghettoized while the three in the suburbs would be all white. On the right, Gordon MacLeod, the head of the 1976 Kane citizen panel and chairman of the Department of Health Administration at the University of Pittsburgh's School of Public Health, called for closing Kane and selling

to Improve Kane Hospital, "Statement," Feb. 10, 1977, folder 11, box 7, Matson Papers; Committee to Improve Kane Hospital, "Class Action Lawsuit for Nursing Home Care," *ibid.*

[60] "Kane Funds in Jeopardy," *Beaver County (PA) Times,* March 18, 1977, p. A5; "HEW Gives Specifics on Hospital Deficiencies," *Pittsburgh Press,* May 6, 1977, p. A1; "HEW Lifts Kane Cutoff on Temporary Basis," *ibid.*, May 13, 1977, p. A1; "Commissioners Sign HEW Plan for Kane," *Pittsburgh Post-Gazette,* June 3, 1977, p. 1; Richard Arnold, "Pact with HEW for Kane Puts Patients Up in Air," *Pittsburgh Press,* June 6, 1977, p. B3; Al Donalson, "Kane Nurse Upgrade Detailed," *ibid.*, July 17, 1977, p. A12; "Kane Given Another Six-Month License Renewal," *ibid.*, Sept. 8, 1977, p. A1.

[61] "State High Court Orders County to Provide Care to 2 Elderly," *Pittsburgh Press,* Sept. 3, 1977, p. 8; Richard Arnold, "Repay $1.2 Million, Kane Told," *ibid.*, Sept. 9, 1977, p. A1; Comptroller General of the United States, Report to the Senate Subcommittee on Aging, *Lack of Coordination between Medicare and Medicaid at John J. Kane Hospital* (Washington, 1977); Committee to Improve Kane Hospital, "Testimony: Committee to Improve Kane Hospital, Special Committee on Aging, United States Senate," Sept. 9, 1977, folder 11, box 23, Merton Center Papers; Committee to Improve Kane, "The Kane Conditions," May 10, 1977, *ibid.*; Committee to Improve Kane, "Complaints to Union Getting Action," *ibid.*; Committee to Improve Kane, "The Kane Conditions," July 15, 1977, *ibid.*; Committee to Improve Kane Hospital to Stephen J. Lenhardt, Nov. 1, 1977, *ibid.*

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the property, arguing that the private sector could accomplish long-term care much more cheaply.[62]

This opposition ground the "mini-Kanes" proposal to a halt in the second half of 1978. That November, Republican Richard Thornburgh was elected governor. Thornburgh appointed MacLeod state Health Secretary, elevating the primary opponent of the mini-Kanes plan to the head of the department weighing the proposal, killing the mini-Kanes idea. The issue of privatization once again came to the fore, this time under the name of "no-walls." The hospital, proponents argued, would exist only as an administrative entity that leased beds from private nursing homes. This would let the market do the work of quality regulation. "Regardless of the product or service, I believe most of us would agree that competition is one of the most cost-effective ways to improve quality," wrote Robert Inhoff, a private nursing home administrator who sat on the Kane study committee.[63]

Amid the fallout from the mini-Kanes defeat and the emerging debate over privatization, the collective bargaining agreements settled in 1976 expired. Kane workers spent nearly a month on strike in the summer of 1979, protesting understaffing and inflationary pressure on their wages. Hundreds of patients needed to be transferred to other hospitals, costing the county an additional $1 million. The workers thus presented themselves as a significant force to overcome if the local government wanted to enact privatization. Indeed, testimony from privatization supporters made clear that shrinking the wage bill was the main advantage of private operation. One prominent privatization advocate argued that the public facility suffered from "overstaffing," "excessive staff benefits," and unnecessarily high skill levels among nursing staff.[64]

While the opposition of a militant group of workers to privatization remained only a hypothetical obstacle, the "no-walls" plan faced a more immediate problem. Pennsylvania's Medicaid reimbursed at a lower rate for care in private facilities because the program recognized that public facilities cared for the most difficult cases, so it paid them more. The county administration sought a legal loophole, but there was no way around it: privatization would mean a major loss in Medicaid reimbursement. This obstacle proved decisive. The county resurrected the mini-Kanes proposal. This time around, officials incorporated suggestions made by critics on the left in 1978, and the mini-Kane advocates overwhelmed the privatization backers.[65]

[62] Health Systems Agency of Southwestern Pennsylvania, "John J. Kane Program and Facility Development: Summary of Proposal," folder 9, box 23, Merton Center Papers; Committee to Improve Kane to John Clem, Aug. 21, 1978, folder 11, *ibid.*; "Testimony Delivered by Arthur Edmunds, Executive Director, Urban League of Pittsburgh, at the Health Systems Agency (HSA) Review Committee Public Hearing on John J. Kane Hospital," Oct. 18, 1978, folder 8, box 31, Records of the Health and Welfare Planning Association; Gordon K. MacLeod, "Which Way Now for Home Health Care?," Oct. 25, 1978, keynote address to the Eighth Annual Meeting of the Pennsylvania Assembly of Home Health Agencies, *ibid.*; Health and Welfare Planning Association Ad Hoc Committee on Aging, "Some Comments on Allegheny County's Plan for the Replacement of John J. Kane Hospital," Sept. 28, 1978, draft, *ibid.*

[63] Henry W. Pierce, "Health Group Rejects Mini-Kanes Proposal," *Pittsburgh Post-Gazette,* Nov. 29, 1978, pp. 1, 3; Henry W. Pierce, "County Retreats on Kane Hospital," *ibid.*, May 31, 1979, p. 1; Matthew Kennedy, "Kane Study Hears 'No-Walls' Plan," *Pittsburgh Press,* July 17, 1979, p. A1.

[64] "State Says No to Kane Strike Bill," *Pittsburgh Press,* July 28, 1979, p. A16; R. Gregg Hillman, "Testimony on the Recommendation for Kane Hospital of the Institutional Care Sub-committee," Nov. 15, 1979, folder 10, box 31, Records of the Health and Welfare Planning Association.

[65] Jerry Byrd, "Kane Alternative Search Hits Snag," *Pittsburgh Press,* Oct. 2, 1979, p. A2; Patricia Newbold, "State Medicaid Reimbursement Policies for Long-Term Care," April 15, 1980, folder 9, box 31, Records of the Health and Welfare Planning Association; Robert Foltz to Thomas Levine, "Re: Governance of Kane Hospital," Oct. 1979, memo, folder 10, *ibid.*; Patricia L. Newbold, "Analysis of Operating Costs: Proposed Allegheny County Regional Long-Term Care Centers," Feb. 27, 1980, *ibid.*; Henry W. Pierce, "Panel Backs Revised Plan for Kane,"

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The 1980 decision in favor of the mini-Kanes concluded the public debate initiated by the 1975 exposé. Over several years, the county constructed four new facilities and transferred the patients. A survey of patients after the move found that they thought the "mini-Kanes" a major improvement. Emily Eckel later happened to visit them and found them far superior to the institution she had helped expose in 1975—though, she noted, they were still human warehouses.[66]

Conclusion

Historians have largely understood the late 1970s and early 1980s as the beginning of the neoliberal economic regime. Recession, inflation, and industrial decline are linked, in that account, to privatization, deregulation, austerity, and union decline. What happened at Kane stands at odds with this now-familiar narrative. Why did things go differently with Kane, and what does that difference tell us about the transformations of the 1970s more generally?[67]

To be sure, the scandal at Kane Hospital emerged from the same political-economic processes that produced the neoliberal turn in economic governance more broadly. And a rightward resolution to the Kane crisis—in line with the national and global trend—remained a possibility throughout the five-year policy debate after the scandal. But privatization did not win.

Kane continued as a public institution thanks to two interlocking factors. First, the coalition constructed by NAM members (the CIK) mostly succeeded in embodying the political potentiality identified by Barbara and John Ehrenreich in their work on the health care economy and the "professional-managerial class." The Ehrenreichs had argued for proletarian-professional alliances in the human-service sector at the point of the provision of service and in defense of the quality of that service. The CIK, by forging a working alliance between community activists and staff from multiple levels of the Kane hierarchy, enacted this principle and secured the political leverage that it implied.

Indeed, in the 1990s, when local lawmakers again sought to privatize the mini-Kanes, deploying many of the same arguments as in the 1970s, workers were able to build something resembling the 1970s alliance and win another round. "The key point," writes the sociologist Steven Henry Lopez of this battle, "is not only that workers were angry about privatization but also that they viewed privatization as an issue that connected them directly to their residents in opposition to the county board of commissioners."[68]

The second critical factor in the left-wing victory at Kane was the funding stream on which the institution depended. Privatization advocates might well have won if the "no-walls" plan would not have led to decreased Medicaid reimbursement. But the aging region was overly dependent on institutionalization for its elder care problem, and this so-

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Pittsburgh Post-Gazette, Feb. 27, 1980, p. 3; Robert J. Carroll, "Minority Report: Allegheny County Regional Centers Proposal," March 27, 1980, folder 10, box 31, Records of the Health and Welfare Planning Association.

[66] Chet Wade, "Ross Eyes Mini-Kane Advantages," *Pittsburgh Post-Gazette,* April 8, 1982, p. 35; Linda Jean Walker, "Kane Hospital Relocation Project: Attitudes and Perceptions of Patients" (Ph.D. diss., University of Pittsburgh, 1984); Eckel interview.

[67] On the origins of neoliberalism, see David Harvey, *A Brief History of Neoliberalism* (Oxford, 2005); Judith Stein, *Pivotal Decade: How the United States Traded Factories for Finance in the 1970s* (New Haven, 2010).

[68] Steven Henry Lopez, *Reorganizing the Rust Belt: An Inside Study of the American Labor Movement* (Berkeley, 2004), 114.

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lution was mainly financed by public health care funds—from which a public institution received a preferred rate. While the medicalization of old age at the level of policy was a major structural source of the abuse scandal, it also provided a lever to maintain higher levels of state support.

Indeed, the preservation of public ownership of Kane is an idiosyncratic but illustrative example of one of the most significant, overlooked phenomena in the recent history of American social policy: the dramatic growth of public spending on health care. In 1970 the Centers for Medicare and Medicaid Services spent $62 per capita, but by 2014 that figure was $3,456. In large part this jump is due to the rising cost of care, though that rise is partly driven by Medicare and Medicaid spending. The other major factor accounting for increasing expenditure is, of course, the aging of the population—a trend on which Allegheny County was far ahead of the nation.[69]

While the fiscal sprawl of the health care state has been the subject of intense political debate, it has received little historiographical attention. Yet such dramatic growth contradicts any understanding of economic governance since the 1970s as simple public retrenchment. There is also, of course, an interweaving of public financing and private administration in health care that prevents us from understanding the story as one of uncomplicated welfare state growth. But in fiscal terms, the state's role in the industry has grown enormously, driving the expansion of the entire sector—in 2016 health spending accounted for 17.9 percent of the gross domestic product of the United States.[70]

What was true at Kane in particular holds at a more general level: the medicalization of old age has provided a policy mechanism—albeit a problematic one—for resolving some of the social displacement of industrial and urban crisis. The growth of the health care sector has offered not only a policy answer to the problem of how to manage the old but also a way to replace lost jobs. Pittsburgh is today home to the University of Pittsburgh Medical Center, the largest private employer not only in the city but in all of Pennsylvania, with over sixty thousand employees. The pattern is common in postindustrial cities. Of the nearly 1 million people who work for Ohio's one hundred largest employers, more than one-quarter work for health care providers, with the Cleveland Clinic just shy of Wal-Mart as the state's largest private employer. In Milwaukee, health systems weigh in as the first, third, seventh, twelfth, and fifteenth of the twenty largest employers. In Baltimore, they are eight of the top ten.[71]

The struggle over Kane in the 1975–1980 period represents an early negotiation in the process by which the care economy sprouted from the decay of the industrial economy. More precisely, providing publicly subsidized care offered a *solution* to the social dislocations of industrial decline. This solution created new expectations of social rights. And

[69] Centers for Medicare and Medicaid Services, "National Health Expenditures by Type of Service and Source of Funds, Calendar Years 1960–2014," https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html.

[70] Centers for Medicare and Medicaid, "National Health Expenditures 2016 Highlights," https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf.

[71] Steven Greenhouse, "A Union Aims at Pittsburgh's Largest Employer," *New York Times,* April 2, 2014, p. B1, http://www.nytimes.com/2014/04/03/business/a-union-aims-at-pittsburghs-biggest-employer.html; Ohio Development Services Agency, "Ohio Major Employers—Section 1," April 2017, https://development.ohio.gov/files/research/b2001.pdf; Metro Business Publications, "Milwaukee's Largest Employers," http://www.discovermilwaukee.com/business/milwaukee-s-largest-employers/; Maryland Department of Commerce, "Major Employers in Baltimore City, Maryland," http://commerce.maryland.gov/Documents/ResearchDocument/MajorEmployersInBaltimoreCity.pdf.

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it created new work forces to provide services to meet those expectations. Yet, without self-conscious political action, those social rights and the workplace rights of those new workers did not align; such a misalignment, caused in part by the racialized and gendered devaluation of care work, was part of what led to the Kane scandal.

What the Ehrenreichs and NAM activists apprehended in the 1970s was a political opening at the juncture of the social rights of the growing numbers of needy aged and sick and the gender and class politics of the work force forming to care for them. They won their battle at Kane but lost the war: health care workers remain a largely low-wage work force and marginalized within the labor market along lines of race and gender. The interests of workers and patients—which at Kane were brought into alignment—remain politically unreconciled in general. In a 2014 ruling, the Supreme Court excluded home care workers from the full rights of public employees, due to their interpersonal obligations to their individual clients. The Court, that is, elevated to legal doctrine the antagonism between patient and caregiver.[72]

In the coming years, the country will continue to age rapidly. The care work force appears likely to also maintain its rapid growth. Yet the present model for paying for elder care largely presumes low wages and unstable conditions for caregivers. Day to day, the structure of our political economy reproduces care workers as racialized and gendered subjects. The dynamics that led to elder abuse in Allegheny County in the 1970s, in other words, continue, and on a grander scale: deindustrialization deepens and spreads, dependent populations grow, and the new political economy of care is contested by needy patients, growing work forces, and belt-tightening public authorities. Understanding both what went wrong at Kane and the political process that put it right thus reframes the transition of the 1970s as a crisis of social reproduction; it reveals the forces that continue to contest the transformation of our political economy in the new century. What went wrong at Kane, and the political process that put it right, may be relevant again soon.[73]

[72] Eileen Boris and Jennifer Klein, *Caring for America: Home Health Workers in the Shadow of the Welfare State* (New York, 2012); *Harris v. Quinn,* 573 U.S. __ (2014).

[73] Ai-jen Poo, *The Age of Dignity: Preparing for the Elder Boom in a Changing America* (New York, 2015).

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