Hegemony or Collaboration?: The Role of Foundations in Tuberculosis and Polio Policy, 1885-1930

By Susan M. Chambré

Professor, Department of Sociology and Anthropology
Baruch College, City University of New York

susan.chambre@baruch.cuny.edu

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There is general agreement that foundations play a central role in public policy development, but there are different views on the nature of their involvement. Some observers see foundations as independent actors: they initiate new ideas, programs, and scientific advances. One variant of this view is that foundations are hegemonic, in that their staff and donors formulate a specific agenda and fund scientific and policy research which legitimize the programs and policies they promote. A second, and rather different view, is that they operate in a more collaborative fashion. According to this perspective, donors and staff interact with other policy actors and are important, but not dominant actors in issue networks which develop goals, knowledge, methods and priorities.

These two perspectives agree on foundations' methods and strategies. Foundations anticipate emerging policy issues, fund innovative organizations and institutions, support scientific research which guides innovation and provides legitimacy for new strategies, and they underwrite the cost of demonstration projects which test out new policy methods. What differs then is how foundations develop their agendas. In the independent and hegemonic views, foundations fund programs that forward their agenda. In the collaborative view, policy agendas are developed in a more interactive fashion that involves foundations and other types of policy actors.

I studied the emergence of social policies that were a response to the two major infectious diseases of the first half of the twentieth century: tuberculosis (TB) and infantile paralysis (polio). Materials available at the Rockefeller Archive Center (RAC) enabled me to test out which of these two perspectives best describes the development of these two policy domains. The time frame for the study was between 1885 and 1930. Three interrelated social processes were occurring during that time:

1) foundations were expanding and defining their roles
2) public health was becoming professionalized and institutionalized
3) organizations concerned with specific diseases were being established

The two diseases had different trajectories during that time. TB experienced a sharp decline, while polio was increasing, and became a focal point of fundraising in the early part of the 1930's. Two questions framed the inquiry:

1) What was the role of foundations in organizational and policy development in response to TB and polio in the early part of the twentieth century?

2) What does their involvement teach us about foundations' strategies to influence public policy?

The study focuses on New York for two reasons:

1) The bulk of foundation funding for TB and polio was in that state.

2) Programs and policies in the city and the state were models adopted in other parts of the country.

The fight against TB began in the mid-1880s with the establishment of several private sanatoria in upstate New York, including the Adirondack Cottage (ACS) and Stony World Sanitaria in the Adirondacks, and Loomis in the Catskills. Private philanthropists like

John D. Rockefeller, Sr. (JDR), Mrs. Margaret Olivia Sage and Elizabeth Milbank Anderson, were major supporters of these institutions. First Anderson, and later her foundation, the Milbank Memorial Fund, singlehandedly paid for TB research at the ACS. Once each of them established major foundations, they continued their commitment as early supporters of the National Tuberculosis Association (NTA), the first organization in the U.S. specifically founded to 'fight' a specific disease. First, JDR, and later several of his foundations, contributed to the development of the NTA and its local affiliates. Between 1907 and 1926, the Russell Sage Foundation (RSF) contributed $114,550 to the NTA. In the early 1920's, another Rockefeller philanthropy, the Laura Spelman Rockefeller Memorial (LSRM), supported two NTA affiliates, one serving Brooklyn and Queens, the other serving the rest of the city.

The NTA was the nucleus of a broader set of organizational initiatives involving nonprofit organizations, government and corporations that educated the public in disease prevention in an effort to reduce TB transmission. This national 'crusade' enlisted thousands of adults and children in the first organized 'fight' against a specific disease. Local chapters increased from twenty in 1904 to fifteen-hundred a decade later. Thousands of school children were involved in the NTA's "Modern Health Crusade," which included awards, costumes, games and challenges that rewarded healthy habits. Along with several partners, the NTA and its local affiliates mounted a series of demonstration projects that provided models for the expansion of public health. The NTA worked closely with the Metropolitan Life Insurance Company in a health demonstration in Framingham, Massachusetts. Under the auspices of the Milbank Memorial Fund, NTA local affiliates and public officials developed model public health projects in three sites in New York State. These projects were designed by public officials working closely with representatives of corporations, foundations, and private charities. They were

intended to be templates for government programs. In fact, the success of the Milbank demonstration project contributed to several important changes in New York State: the expansion of rural health departments, the professionalization of health departments in small cities, and the establishment of a network of local health centers in New York City.

The second policy area I studied was the 1916 polio epidemic in New York, the first major polio epidemic in U.S. history. Here also, foundation staff were active collaborators, with public officials, and charitable agencies. Just after the disease was declared to be an epidemic, an initial meeting to identify strategies to contain the disease was held at the Rockefeller Foundation's (RF) office. Within the next several weeks, the RF's board earmarked substantial sums for scientific and epidemiological research. It underwrote some of the city's cost, including the design and distribution of an educational pamphlet, and various public health measures, which included visits to families to determine if affected members had appropriate care, and posting doctors at trains and ferries to certify that people leaving the city had not been exposed to the disease.

Anticipating the long-term impact of the epidemic, RF staff and public officials convened a meeting at the RF's offices to plan the kind of treatment that was needed. Orthopedic surgeons and representatives of health care and charitable institutions formed a Committee on After Care of Infantile Paralysis Cases, whose administrative costs would be paid by the RF for three years. This allowed the Committee to appeal for funds from the public, claiming that all of the funding it received would go for the direct care of children. The Aftercare Committee coordinated the work of existing charities, hospitals and clinics to reach most of the children crippled in the epidemic. Initially designed to be time-limited, the RF extended its support in order to allow for the continuation of its work, and once this funding ended, the Committee obtained support from

the newly established Commonwealth Fund (CF).

The RF also played a vital role in developing a coordinated system of polio care outside of New York City. Support to the State Charities Aid Association was also essential in the development of a cooperative effort outside New York City in which private funds augmented publicly supported diagnostic clinics held for one or two days at a time all over the state. These funds paid for travel by the orthopedic surgeons, whom the state hired and they also provided braces for poor children. Neither of these were likely to be supported by state funds, therefore the RF's agility was important.

Even though these programs were temporary, they had the enduring legacy of establishing community responsibility for polio care as a right of those who had the disease. This was apparent in the fact that the 1935 Social Security Act included public support for crippled children, and when it was established later in that decade, the National Foundation for Infantile Paralysis made a commitment to pay for the care of every person affected.

The archival data I collected on these two policies supports the collaborative view of foundations. There is no evidence in the numerous documents I reviewed that foundation staff had specific ideas or formulas. The interaction among donors, foundation staff, charity workers and public officials is apparent. If there was dominance, it occurred when the donors and the staff followed the lead of professionals and public officials and worked closely with them to develop new institutions and methods. In some instances, public officials turned to foundations to pay for demonstration projects so that innovative approaches became politically expedient, since their effectiveness had been demonstrated. In only one instance did I observe a foundation turn down a new idea. This was the Rockefellers' unwillingness to contribute to the cost of the Milbank Health Demonstration Project. John D. Rockefeller, Jr. (JDR Jr.) expressed an initial

interest, but a key RF staff member thought the proposal should not receive support because its scope was too broad, and included elements that were unlikely to be replicated in public programs. In fact, some of these elements were not incorporated into the final project.

The latter part of the 19th century and the first third of the 20th century was a time of transition in the role the state played in developing public health policy. While states and localities continued to be dominated by party politics, it was a time when public health was becoming more professionalized and scientific. A second important change was in the very nature of public health itself. As a result of the bacteriological revolution, our understanding of disease transmission changed, and there was a greater need for individuals to take responsibility for their own health and for the health of those around them. The challenge to both public and private health agencies – a challenge that continues today – was to motivate individuals to modify their behavior and lifestyles for not only their own health, but for the public's health as well. A final area for discussion and debate at the time, which also has significance currently, is the role of the state, and the nature of collaboration between the state, nonprofit organizations and private philanthropy. The events during this time period set us on a path of public-private partnership that continues to influence policy development today.