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ARTICLE

Cross-Domain Policy Feedback: The Institutionalization of Collective Bargaining Rights for Health Care Workers

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Abstract

This article considers a significant but overlooked set of policy developments in the latter half of the twentieth century: the extension of collective bargaining rights to most health care workers, many of whom were formally excluded for three decades under the 1947 Taft-Hartley amendments. Drawing on primary sources including archival records, an exhaustive review of congressional testimony, and rulings from the quasijudicial agency governing private sector industrial relations, this article shows that health care workers did so in two interrelated processes. First, in coordination with the civil rights movement, workers mobilized and used both disruptive and legal social movement tactics. Second, in doing so they drew the state into and revealed its position in the collective bargaining process between workers and health institutions, facilitating what is conceptualized as cross-domain policy feedback. Cross-domain policy feedback occurs when a policy in one domain (e.g., public health spending) influences the politics of a policy in a seemingly separate one (e.g., labor and employment relations). Such effects, this article suggests, are likely to occur when a policy is relatively large in scale, implicates actors with a diverse set of interests, and offers significant ambiguity and discretion in its implementation. Empirically, this article is the first to chart the institutionalization of collective bargaining rights for health care workers, among the largest group of private sector employees in the postindustrial economy. It also offers a new theoretical and conceptual framework through which to study the ways by which public policies reshape political dynamics—an enduring research agenda for students of American politics and policy.

Keywords: policy feedback; labor; civil rights; unions; race

1. Introduction

Just 26 days before he was assassinated, touring the country as part of his efforts to turn the civil rights movement more squarely toward poverty and economic

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inequality, Dr. Martin Luther King, Jr. spoke to hundreds of largely Black and Puerto Rican hospital workers in New York City. Organized by Local 1199 of the Drug and Hospital Union, the event was part of the union's regular programming to celebrate efforts toward racial equality. Praising the workers' and union's ability to wed traditional labor with civil rights organizing—a dynamic that would later come to be called "union power, soul power"—King told the workers, "You have provided concrete and visible proof that when black and white workers unite in a democratic organization like Local 1199, they can move mountains."[1]

King was retrospectively referring to the economic and political power the group of workers had built through their union, including a recent wave of contracts they had won against the city's otherwise intransigent not-for-profit hospital sector. These contracts, among other things, significantly improved the wages, working conditions, and ultimately lives of thousands of hospital workers across the city and state, who had otherwise been subject to low pay, grueling schedules, and abusive and discriminatory working conditions. They were won despite the fact that most hospital workers were explicitly excluded from the main legal machinery protecting the rights of workers to organize—the National Labor Relations Act (NLRA)—as part of the Taft-Hartley Amendments of 1947. In addition to the contracts in New York City, the union could boast significant influence in the state more broadly and in a handful of other northeastern cities, including Baltimore and Philadelphia.

In praising the workers, though, King's words would also prove prescient. Not only had a group of otherwise marginalized workers helped build a significant base of political and economic power in face of legal and political hurdles; they would eventually upend their decades'-long exclusion from federal labor law. Indeed, in roughly six years' time, hospital workers, along with most other health care workers around the country, would win collective bargaining rights under the NLRA—an important economic right, even if it would become highly circumscribed over time.

The inclusion of health care workers into federal labor law presents a puzzle of sorts for researchers of labor politics. Following significant retrenchments in the 1940s and 1950s, students of American labor law in legal scholarship, policy studies, and political science have characterized the NLRA as being subject to stasis.[2] As the Fordist economy has given way to a more highly dispersed one rooted in services, the text of labor law has effectively stood still, making it more difficult for workers to organize.[3] Of particular note, scholars have spent considerable energy detailing the repeated failures of organized labor to repeal the Taft-Hartley Amendments of 1947, a set of statutory restrictions that undercut organizing protections in several ways. Such scholarly characterizations, however, are not so much wrong as they are incomplete.[4] As implied above, throughout the 1960s and 1970s, millions of health care workers across several institutions did come to secure extensions of collective bargaining rights. This was partially achieved by amending the NLRA to repeal portions of the Taft-Hartley Amendments and, in doing so, end private nonprofit hospital workers' explicit exclusion.

How did these workers—long stratified and marginalized along race, class, and gendered lines—secure these victories? What have been their limitations?

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Drawing on an array of primary source evidence including archival records, an exhaustive review of congressional hearings, and rulings by the National Labor Relations Board (NLRB), this article argues that workers did so in two interrelated processes.[5] First, in coordination with civil rights organizations such as the Southern Christian Leadership Conference, the NAACP, and central leaders including A. Phillip Randolph and Bayard Rustin, workers mobilized in the workplace and the community, drawing on disruptive strikes and protests as well as legal tactics. Second, in doing so they pulled the state into and revealed its position in the collective bargaining process between workers and health provider institutions, activating cross-domain policy feedback. Cross-domain policy feedback effects occur, this article argues, when a policy in one area of governance shapes the politics of another. In the case analyzed below, the use of public health spending helped facilitate the expansion of collective bargaining rights, both in practice and in law, to millions of workers.

This article thus offers several contributions to the literatures on public policy and labor politics. Empirically, it is the first article, to the author's knowledge, that explains *how* most health care workers came to secure collective bargaining rights, adding to the literature in this journal that shows how oppressed groups can secure cornerstone labor and social rights.[6] As health care has grown to become among the single largest source of private-sector employment in the country, this marks a significant development in itself.[7] As the case analysis suggests, this expansion not only helped instantiate rights for a growing set of workers; it also helped fuel the rise of the Service Employees International Union (SEIU), currently one of the largest private-sector unions in the country. Indeed, while collective bargaining rights under the NLRA regime remain limited, they have nevertheless bolstered the political and economic power of millions of workers. Theoretically, in tracing how health care workers secured collective bargaining rights, this article also offers a novel conceptualization of policy feedback. Given the growing importance of public policy to modern-day governance, this new way of thinking about the feedback process opens a broad avenue for future research.

2. Cross-Domain Policy Feedback

In recent decades, scholars working in the policy feedback tradition have made great strides in showing that policies are not just outputs in the political process. Once implemented, they "create their own politics," in E. E. Schattsneider's famous formulation.[8] As researchers have emphasized, they can do so at the mass, organizational, and elite levels.[9] Although well developed, this scholarship tends to treat discrete public policies as if they exist in isolation.[10] Yet given the dramatic growth of state action since the 1960s, there are good reasons to believe that there is significant interplay between policies that exist in seemingly separate domains. Indeed, invoking the thicket of public policies that mark modern-day governance, several scholars have described the American government as a "policyscape," "policy state," and "policy terrain."[11] How might public policies shape one another?

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As a form of theory and concept building, this article thus offers a case and set of broader expectations for *cross-domain policy feedback.* Cross-domain policy feedback occurs when a public policy designed for one discrete area of governance (for example, health care spending, or policy A) observably shapes the politics of a policy in a separate domain (for example, industrial relations, or policy B). Drawing on the existing feedback literature, this article suggests that such effects can occur by reconfiguring resources available to political elites (including elected officials as well as bureaucrats) and organizations; by altering the incentives they face; and by teaching them political lessons about what is—and is not—considered feasible.[12] The observable effects for a given law or policy might happen at the level of programmatic funding (policy A might result in an increase or decrease in funding for policy B), rules regarding access and eligibility (policy A might influence the expansion or restriction of policy B), and/or capacity for enforcement (policy A might bolster or hinder the ability of the state to enforce policy B).

In advancing this concept, this article seeks to reorient scholars toward the ways that public policies shape the activities of organizations, elites, and durable governing institutions. As several students of public policy have noted, as the feedback literature has matured, a great amount of attention has been paid to how policies influence various forms of mass political attitudes and behaviors. Although impressive in its breadth and depth, this literature does not tell us all we want and need to know about how public policy reshapes the political landscape. As early research in the feedback tradition stressed, policies are important not only in shaping how everyday denizens think and act on the political world. As Theda Skocpol argued in her pathbreaking work on the subject, one way that policies make new politics is by "transform[ing] or expand[ing] the capacities of the state."[13] Put another way, policies also help reshape the institutional landscape on which politics take place.

In building the concept of cross-domain policy feedback, this article offers a set of policy- and actor-specific conditions that are likely to facilitate such effects. In doing so, the argument builds on Patashnik and Zelizer's contention that policy feedback effects are produced not only by the internal attributes of policies "but also by the interaction between policy-specific characteristics, the strategic goals of officeholders and clientele groups, and the political forces arising from a contentious and uncertain political environment."[14] In other words, feedback effects do not just flow from the design of a given policy; rather, they are contingent. The analysis is thus attentive to how the attributes of policies interact with and are mediated by relevant political actors—such as elected officials, bureaucrats, organizations, and workers themselves—underscoring the importance of agency alongside structure.[15]

2.1 Scale

Not all public policies are created equally. They vary, among other ways, in their scale—that is, their level of investment, the breadth of their constituencies, and the problems they attempt to solve. Some might seem relatively small. They might, for example, be directed at small sets of target populations, such as

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"pork barrel" projects for particular congressional districts or certain cities.[16] Others, however, act as large interventions in social and economic life. They entail setting up bureaucracies, allocating resources across and diverse constituencies and geographic areas, and providing raw resources—whether monies, infrastructure, or staff—to third-party agents or other levels of governments. In doing so, such policies are likely to touch or "bump up" against existing laws and policies in other parts of social life. Consider the recent rise of the carceral state —an intervention that is unprecedented in other Western democracies[17] and, as researchers have shown, has had significant implications for several domains of society, including immigration.[18] Larger-scale policies, in short, are more likely to facilitate cross-domain feedback effects.

2.2 Discretion and Ambiguity

Public policies vary not only in their scale but also in the level of discretion and ambiguity they offer to such actors in implementing them. Scholars studying other forms of incremental institutional development have demonstrated that the level of discretion or ambiguity given to actors can be a critical variable in explaining change.[19] Building on this literature, this article suggests that when policies offer more discretion or ambiguity over implementation, they are more likely to facilitate cross-domain feedback effects. When ambiguity or discretion is relatively high—or when the boundaries of a given policy are more mutable—political actors such as organized groups, elected officials, or bureaucrats have more room to maneuver. They can stretch the bounds, resources, and meanings of a policy into another domain. Conversely, when the boundaries of policies are more clearly drawn, policies are less likely to facilitate cross-domain effects. As an illustrative example, consider the difference between retirement benefits from Social Security and Temporary Assistance for Needy Families. Although both are at root cash transfer programs, the clear bounds around Social Security render its pay outs more difficult to repurpose for activities in other domains. Meanwhile, the high level of discretion given to state lawmakers over Temporary Assistance for Needy Families has offered lawmakers the ability to use the policy in other areas—such as family planning[20] or childcare.[21]

2.3 Actors with Broad and Diverse Demands

As the feedback literature has shown, policies are likely to produce, activate, or implicate new or preexisting interest groups and political entrepreneurs. As Paul Pierson argued in his canonical essay on the topic, "[p]olicy designs can create niches for political entrepreneurs, who may take advantage of these incentives to help 'latent groups' overcome collective action problems."[22] Take, for example, occupational licensing. As Brink Lindsey and Steven M. Teles show, the growth of these seemingly obscure policies has allowed and encouraged niche interests—including associations representing barbers, for example—to "capture" certain portions of the labor market.[23] Yet once implemented, policies may also activate preexisting groups or actors with sets of interests *broader* than just the "niche" produced by a given policy. Consider, on the other hand, housing.

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As Chloe Thurston demonstrates in her study of discriminatory housing policy, the government's underwriting policies implicated not only the usual "niche" suspects—such as realtors—but also organizations such as the NAACP concerned with racial discrimination, *broadly defined.*[24] Policies are thus more likely to have cross-domain effects when they implicate actors with broader, diverse sets of interests. Such actors are less likely to view policies as existing in isolation; instead, they can act across multiple policy areas to advance their goals. In doing so, they may serve as brokers with one foot in one policy domain and another foot in a second, drawing the resources or logic of one policy into the other.

2.4 The Importance of Agency

Finally, perhaps less so than other types of policy feedback effects, cross-domain effects rest to a greater degree on the agency of political entrepreneurs. That is precisely because such effects often require actors to press on and expand the bounds of a given policy. As Patashnik and Zelizer observe, "Supporters and opponents may not take the feedback effects of preexisting policies as given, but may instead actively seek to amplify or suppress such effects, to the extent feasible within institutional constraints."[25] As is shown in the case below, the cross-domain policy feedback effects observed were contingent on the action taken by several political actors including elected officials, bureaucrats, unions, and workers themselves, the latter to which the article now turns.

3. The Case of Expanding Collective Bargaining Rights to Health Care Workers

3.1 Disruption from Below

As it remains today, formal care work at the middle of the twentieth century was rigidly stratified by race, class, and gender.[26] Physicians were overwhelmingly white men and relatively well paid. As a good body of historical scholarship has demonstrated, they attained a significant amount of power within institutions and held a relatively uneasy if advantageous relationship with management and trustees.[27] Their advantageous position was secured in part economically, in part ideologically, and in part organizationally.[28] Indeed, many have thus argued that hospitals could effectively be considered the "doctors' workshop."[29] Nurses, meanwhile, tended to occupy a somewhat middling position, aspiring for professionalism yet thwarted by management and physicians. Most identified as women and were thus subject to the paternalistic supervision of the overwhelmingly male doctors and management.[30] Their relatively oppressed status within hospitals was in part upheld through the ethos of care in the service of others.[31] Yet they were also predominantly white, granting them some racial privilege, and nursing did serve as a potential site of upward mobility for many working-class women. Once nurses graduated, they would go on to either train nurses within hospitals or work in private visiting-aid programs.[32] But it is worth noting that, with a few exceptions, nurses tended to identify and organize *as*

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professionals, not as workers. They largely eschewed pure trade union tactics and distinguished themselves from those who worked "below" them.[33]

Toward the bottom of the "medical hierarchy," as it has been termed by scholars, were and are nurses' assistants, orderlies and aides, and service workers, including janitors and food preparation workers. For these workers, labor still had meaning but was nevertheless tough. As one orderly reflected, "My boss, he treated me like an animal."[34] Such workers were regularly paid below the minimum wage, forced to work split shifts, and faced abuse from both high-level management (i.e., hospital administrators) and immediate supervisors (i.e., nurses and doctors). Writing to the *Baltimore Afro-American* in 1969, one worker suggested that management "acts as though you're supposed to kill yourself in order to keep your job"—referring to understaffing, lack of air conditioning, and the inability of workers to take water breaks.[35] These workers, furthermore, were also disadvantaged by their racialized and gendered status. A disproportionate number of such workers were people of color, women, and Latino immigrants. Part and parcel of their poor working conditions, "nonprofessional" health care workers thus also faced intersecting racial- and gender-based discrimination. One early union organizer described the occupational segregation at John Hopkins in Baltimore as such: "John Hopkins has: more Black people pushing brooms than White; more Black people washing pots than white; more Black people pushing bedpans than white… these are no accidents."[36]

The marginalization of many hospital and health care workers furthermore reflected their legal exclusion from cornerstone labor and social policies. Though the NLRA of 1935 made no mention of health institutions, private nonprofit hospitals were excluded as part of the Taft-Hartley Amendments in 1947. Although little debate was considered on the exclusion at the time, exhaustive review of the congressional record suggests that it was justified both by Robert Taft, Sr. and other lawmakers on the basis that nonprofit hospitals were local in nature, did not engage in interstate commerce, and were thus not subject to federal regulation under the NLRA.[37] For similar reasons, most health care workers more broadly lacked minimum wage, overtime, and other protections afforded by the Fair Labor Standards Act for the better part of the twentieth century. Many were also excluded from unemployment insurance as well as Social Security.[38]

Despite lacking legal protections, health care workers, particularly those deemed nonprofessionals, began mobilizing. Although a few areas throughout the United States had witnessed some pockets of organizing, particularly Minneapolis and San Francisco, mobilization started *in earnest* in the 1950s in New York City.[39] Spurred by a pair of left-wing organizers affiliated with a pharmacist's union—known then as Local 1199 of the Retail, Wholesale, and Department Store Union—the efforts to mobilize health workers targeted many low-wage frontline care and service workers in the city's large and burgeoning nonprofit hospital sector. As described in more detail below, the efforts were deeply intertwined with the civil rights movement, were highly disruptive, and appear to have inspired organizing efforts in other areas across the country. Indeed, following a handful of breakthrough wins between the late 1950s and

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through the 1960s, Local 1199 spread its efforts to several other states including Maryland, Ohio, South Carolina, North Carolina, and Pennsylvania, among others.[40] By the 1960s, a number of other unions—including the SEIU (then the Building Service Employees International Union); the International Brotherhood of Teamsters; and the American Federation of State, County and Municipal Employees—were active in the health industry.[41]

Reflecting the racialized marginalization of workers, organizing was often materially, strategically, and rhetorically intertwined with the civil rights movement. Newspaper reports described the movement as a "rights–labor" coalition.[42] In several organizing drives, workers and unions received financial support from local NAACP chapters, the Southern Christian Leadership Conference, Black churches, and central leaders such as A. Phillip Randolph and Bayard Rustin.[43] The support was often mutual: archival records show that local unions also contributed substantially to civil rights causes, helping support, for example, efforts to curb police brutality in northern cities and desegregation efforts in the South.[44] Local 1199 sent a delegation to the March on Washington for Freedom and Jobs.[45] Indeed, early hospital unions viewed advancing the civil rights of hospital workers as critical to advancing the interests of their constituency, quite similar to the Congress of Industrial Organizations in the 1940s and on.[46] As mentioned in the introduction, Martin Luther King, Jr. praised the union for their ability to wed civil rights and labor organizing, referring to himself as a fellow "1199er" and pointing to the organization as his "favorite union."[47] Many hospital workers came to forge an identity supported by the logic, "Union power, soul power!"[48] Securing economic and civil rights in a burgeoning industry, in short, were often deeply linked.

Although low-wage health care workers often welcomed the idea of unionization, management, in an industry in which labor costs made up more than half of all expenditures, were not as enthused.[49] Even though the boards of such hospitals were largely composed of reformist progressives, they overwhelmingly decided against bargaining with workers, reasoning that, because they were nonprofit institutions with significant charitable ventures, their responsibility for their patients outweighed the working conditions of staff. Recognizing that they had no legal obligation to acknowledge workers in a collective capacity, management would most often simply refuse to engage with organizers and workers at all.[50] Not only did most health care institutions have no legal responsibility to recognize workers' attempts to file for union elections, but because they were outside the NLRA's purview, management could also simply dismiss workers for organizing activities. Testimonies from workers in Congress and through other historical sources suggest that terminations for organizing or expressing grievances on the job were a regular occurrence in hospitals that began organizing.[51] Other tactics were seemingly more benign; although illegal in industries covered by the NLRA, some hospitals would raise wages and benefits during drives to quell organizing activity.[52] Among many other instances, the worker who wrote to the *Baltimore Afro-American* described being promised a 15 cent per hour raise if she and her colleagues did not unionize.[53]

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Thus, facing resistance from management in virtually all cities and jurisdictions in which they tried to organize, workers deployed their most potent yet riskiest tool: recognition strikes. Precisely the type of work stoppage that the NLRA sought to stymie, they involved striking at a given facility (or number of facilities) to gain union recognition. As one union representative from Ohio put it, "Under these circumstances we ask ourselves, what can we do? At present we have only one more choice, that is to strike."[54] And workers often did so with conviction; in the *Baltimore Sun* in 1969, one organizer warned hospitals and nursing homes, "We'll get to you."[55]

The strikes and protests produced significant disruption in not only the targeted workplaces but also the broader communities surrounding them. In New York City, for example, a string of citywide work stoppages that were directed at some of the largest hospitals lasted months, turned violent, and involved the arrests of several local elected officials.[56] Meanwhile, in Charleston, South Carolina, the dismissal of 12 Black union activists set off a 113-day strike that resulted in an estimated 1,000 arrests.[57] As workers themselves held the picket line, the Southern Christian Leadership Conference worked in tandem to orchestrate boycotts of local stores and, in the words of one organizer, bring "crises" to the community.[58] The strike became so disruptive that then-Governor Robert McNair was prompted to declare a state of emergency and call in the National Guard.[59] According to primary and secondary sources, recognition strikes of similar length occurred in Cleveland, Ohio; Los Angeles, California; Chicago, Illinois; and Pittsburgh and Philadelphia, Pennsylvania; among other places.[60]

To be sure, not all organizing drivers were ultimately successful. For example, despite what one hospital official described as "a bewildering blend of old-style union organizing and the tactics of the SDS and black militants," efforts languished in Pittsburgh.[61] In Pittsburgh and elsewhere, such failures seem to reflect the limitations of civil rights unionism's appeal to local workforces that were disproportionately white.[62] Furthermore, the strikes were painful for both unions, who had just entered the fray and lacked the same level of institutionalized resources that older labor organizations had, and especially workers.[63] As Gladys Stone, a food preparation worker with SEIU testified in Congress, a strike in Cleveland cost her 11 months' worth of pay.[64] Nevertheless, the militant, grassroots efforts described above were important for a number of reasons. They threw into bold relief the oppressive working conditions faced by health workers. In a handful of states, they helped produce laws that formally extended collective bargaining rights to health workers.[65] Even in instances where protective laws were not passed, the disruptive activity resulted in settlements that ultimately improved the lives of workers, including in South Carolina.[66] Yet perhaps of most importance, such efforts pulled state and local lawmakers into the bargaining process itself, a development that, as demonstrated below, helped facilitate cross-domain feedback effects. Indeed, mobilization might not have been sufficient, but it was certainly necessary to push the issue onto elite agendas and ultimately advance the rights of workers.

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3.2 Bringing the State in and Revealing its Place

As a result of the disruptive activity described above, during or running up to a work stoppages in several cities and states, mayors and governors were regularly called in to attempt to mediate an agreement between providers and unions seeking to represent workers.[67] Indeed, the disruptive nature of the strikes often prompted state and local newspapers to call on elected officials to resolve the strikes in the interest of the city or state as a whole.[68] In such bargaining rounds, provider institutions charged that the demands of workers—including wage increases—would inflate their costs and put them at risk of closure. Unions and workers, meanwhile, insisted on their demands for better pay and working conditions. As actors with a diverse set of interests and demands—including those from not only labor and hospitals but also patients and the city more broadly—state and local governments were well suited to serve as *brokers* between two seemingly distinct policy domains.

How might local and state lawmakers resolve such demands? They would do so by promising to use public health care monies—over which, crucially, they had significant discretion—to raise reimbursement rates to help cover the costs of contracts. Such monies came from not only general local and state funds but also the recently implemented Medicaid program—a joint state–federal program directed at insuring those with low income and disabilities. As one expert reflected in the American Hospital Association's journal, the public subsidies flowing into hospitals had shifted industrial relations in hospitals from "bipartite" to "multipartite"—meaning the government, as a purchaser of insurance, had come to play a significant role.[69] Indeed, one prominent hospital official in New York State suggested that "reimbursement [of services] was the name of the game."[70] Unions themselves strategized and devoted entire panels at annual meetings on the importance of third-party payers such as governments.[71] Pressed by health workers and others, state and local officials used their discretion over public health spending to stretch the bounds of what, exactly, it was intended to do. Not only did it fund health care for the otherwise uninsured; it also became a tool for effectively underwriting collective bargaining agreements between health care workers and employers.[72]

As workers mobilized through more disruptive tactics and directly pulled the state into bargaining relationships, they also used legal tactics to reveal the broader role the government was playing in funding health care through the large-scale expansion of public health spending. Recall that nonprofit hospitals, the single largest set of institutions in terms of employment, were the only health provider explicitly excluded from the NLRA.[73] Other institutions, including nursing homes and for-profit hospitals, remained in a liminal zone, neither formally excluded nor covered. Thus, while unions and workers attempted to organize workers in not-for-profit institutions, they also began petitioning the NLRB to take jurisdiction over workers in institutions not explicitly excluded. In 1967, following petitions for elections in for-profit hospitals and for-profit nursing homes in California from SEIU and others, the NLRB asserted jurisdiction over such institutions.[74] Three years later, in *Drexel Home, Inc.*, the NLRB also took jurisdiction over nonprofit nursing homes after petitions from several labor

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groups.[75] In each decision, the NLRB's reasoning pivoted on the question of whether the class of health care provider engaged in interstate commerce and was thus subject to federal regulation under the NLRA. And in all cases, the NLRB ruled that such employers did indeed engage in interstate commerce. Crucially, this reasoning rested on the substantial inflow of insurance payments to providers from third parties, particularly those "received directly or indirectly from the Federal Government through Social Security and Medicare programs," as underscored by the NLRB.[76] In asserting jurisdiction over for-profit hospitals, for example, the Board argued [emphasis added],

> the material effect on commerce resulting from the nationwide individual expenditures for *health care in which proprietary hospitals participates further multiplied and augmented by the numerous public health and welfare enactments of Congress which are financed by the expenditure of public funds in which these facilities also participate, directly or indirectly. These concepts are manifest in the national Medicare program, which has a first year operating budget in excess of $2 billion and which provides for the payment of medical and hospital services to proprietary hospitals*, including the Employer, as well as others, for the benefit of a large segment of our population."[77]

Indeed, by prodding the NLRB, health workers and unions revealed how the relatively large-scale implementation of Medicare and Medicaid—touching states and health institutions across the country—had come to shape the nature of health care delivery. No longer could such institutions be construed as local or parochial. Instead, precisely because of the significant investments form federal health spending, they were employers that came under the purview of national labor law, suggesting that health care workers did indeed have collective bargaining rights. In analytic terms, unions and health care workers activated cross-domain feedback effects.

Despite workers' ability to secure victories through the NLRB in the late 1960s and early 1970s, the Board declined jurisdiction over nonprofit hospitals, a sector much larger and thus arguably more intertwined with interstate commerce than the other institutions mentioned above. In the early 1970s, the American Federation of State, County, and Municipal Employees petitioned for an election for all service employees on Duke University's campus, including those in the University's Medical Center, which was legally considered a private nonprofit hospital. The National Union of Hospital and Nursing Home Employees, meanwhile, petitioned for an election including only those in the medical center. In the case *Duke University*, the Board allowed an election for those spending a majority of their working time *outside* of the university's hospital. Even though the Board conceded that the employer engaged in interstate commerce for some of the reasons described above, they declined to take jurisdiction over the medical center, claiming that it could not do so because of the Taft-Hartley Amendments and Congress's express intent to exclude such workers.[78] Instead, securing protections under the NLRA for private nonprofit hospital workers would require action from Congress—action that itself would ultimately turn on the increasing role public health funding was playing in America's health system.

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3.3 Medicare and Medicaid Help Upend Taft-Hartley

Facing intransigence from management and without a route through the NLRB, nonprofit hospital workers would need to take their fight to the Halls of Congress. In virtually every session since the 1947 Taft-Hartley amendments, a bill was introduced to repeal the exclusion of nonprofit hospitals from NLRA coverage. Yet because they were concerned about exposing labor law to further retrenchments, liberal Democrats and the AFL-CIO—the largest labor federation in the country—did not press the issue.[79] Organizing at the grassroots level as well as the recent extensions of bargaining rights to workers in other health institutions through the NLRB appear to have shifted these calculations, helping push collective bargaining rights onto the agenda.[80] It is worth reiterating that several of the strikes at the local level drew nationwide attention.[81] In addition to attracting national news coverage, the Charleston strike in 1969, for example, required federal officials from the departments of Labor and Health and Welfare to help mediate a resolution between workers and the hospital.[82]

With the cautious go ahead of the AFL-CIO, in 1971 President George Hardy of the SEIU thus finally convinced then-congressman Frank Thompson, Jr., a Democrat of New Jersey, to hold hearings on reform.[83] The initial legislation would have simply repealed nonprofit workers' exclusion from the NLRA, and the first set of hearings was held in the 92nd Congress in late 1971 and early 1972.[84] Representative Thompson (D-NJ) began them by pointing to the industrial unrest as the principal reasons for the legislation making it onto the agenda: "In the past several years we have witnessed a series of bitter labor disputes, some of which we are going to hear about today, and we want to examine the underlying causes of this unrest and determine whether a legislative remedy is called for."[85]

The relative responsiveness from local, state, and federal lawmakers suggests that health care workers were riding a wave of momentum. Yet it is worth noting that passage of such legislation was not inevitable. Indeed, extending collective bargaining rights to nonprofit hospital workers was certainly not preordained. The American Hospital Association (AHA) was staunchly opposed to such legislation and had far more instrumental or political power than hospital workers. In the decades running up, the AHA had begun to wield significant influence in Congress, as evinced, among other things, for their role in designing the favorable funding structure of Medicare.[86] In opposing the legislation, the AHA mobilized their state and local constituencies from around the country—including Ohio, Iowa, California, Colorado, and Texas, among others—to lobby and testify.[87] The AHA also organized a campaign to flood senators and House members with telegrams from local hospital administrators, pleading for Congress to defeat the legislation.[88] Moreover, the AHA was joined in Congress by other influential conservative organizations, including the Chamber of Commerce and the National Right to Work Legal Foundation.[89] The AHA and other lobbyists against the bill contended that bringing private nonprofit hospitals under the purview of the NLRA would invite even more industrial unrest (such as strikes, picketing, and boycotts), impose other rigid work rules that would make delivering care difficult if not impossible (like stricter protections on working hours), and ultimately drive up the costs of health care. The last argument drew

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especially strong appeal given that health care costs and inflation had grown dramatically in recent decades. Attempts to control health care costs, as ineffective as they were, had become a significant priority of congressional lawmakers as well as the Nixon administration.[90]

As well resourced and well organized as their opponents were, however, workers, unions, and sympathetic lawmakers were able to overcome opposition and advance reform by facilitating cross-domain feedback effects. As discussed earlier, the main rationale for excluding nonprofit hospitals from NLRA in 1947 was that they were local in nature and did not engage or affect interstate commerce. Yet in the decades that followed, large-scale policy interventions from the federal government made this reasoning far less tenable. As the NLRB had recently recognized, the federal government was playing an increasing role in subsidizing health insurance coverage and ultimately the revenues of hospitals, particularly through the large-scale implementation of Medicare and Medicaid programs. Add to this the billions of dollars devoted to health training and infrastructure construction by mid-century policy, including grants from the Hill-Burton Act, which had touched an estimated 60% of all US hospitals at the time.[91]

Exhaustive review of congressional hearings and testimony reveals that activists and sympathetic lawmakers of the NLRA amendments made the large, growing, and, crucially, interstate nature of the nonprofit hospital industry a central point in their advocacy, highlighting federal investment and the logic embedded in the NLRB rulings to justify their claims. One SEIU member, for example, opened their statement this way: "Throughout the country, the nonprofit hospitals receive some 55 percent of their income flow from two primary sources. One is the [M]edicare program and the other is the Blue Cross program. Both of these have a very definite interstate aspect."[92] Another reformer described the situation as such: "It is incomprehensible that an industry as large, as complex, as interstate in nature and as important to the whole being of our country as ours, should today be excluded from the national labor laws. With the increasing Federal concern with the health care delivery system, its operations and its financing, the substantial impact on interstate commerce of the voluntary hospital is apparent."[93] To put it more analytically, activists and sympathetic lawmakers revealed the large-scale reform in one domain (the implementation of Medicare and Medicaid) and argued that said reform had implications for other parts of economic and social life (collective bargaining rights).

Opponents of the reform struggled to combat this logic. Given that nonprofit hospitals were growing in size thanks to generous federal reimbursement rates from Medicare, which included funds for capital expenditure, it became untenable to frame them as small, parochial institutions. It was even more difficult to justify private, nonprofit hospitals' exclusion from the NLRA precisely because similar institutions—nursing homes and for-profit hospitals—had recently come under its regulation, a fact that advocates pointed to regularly.[94] When pressed on the distinction between nonprofit and proprietary hospitals, for example, one hospital representative went so far to admit that there was no real difference.[95] Thus, the legislation initially passed out of the House in 1972 on a vote count of 295 to 85 and was poised to fly through the Senate.[96]

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Sensing defeat after the early round of hearings, the AHA lobbied Robert Taft, Jr. (R-OH), the more moderate son of the architect of the Taft-Hartley's amendments, to intervene.[97] To slow down the legislation, Taft, Jr. had the bill reported to his committee in the Senate—rather than having it reported to the floor for a quick consent calendar vote, as was planned by advocates—and introduced his own amendments that largely reflected the wishes of the AHA.[98] Following an additional set of long, drawn-out hearings at his insistence, Taft, Jr. ultimately brokered a deal between hospitals and workers.[99] Nonprofit hospital workers would be granted collective bargaining rights under the NLRA but with several caveats deviating from the original proposal. These include, relative to other industries covered, prolonged notice for termination or modification of contracts by either party wishing to do so, mandatory mediation prior to contract expirations or terminations, and a 10-day notification of intent to strike on the part of unions.[100] The law further redefined health care institutions as covered under the NLRA completely so that most private providers—including all private hospitals and nursing homes, for-profit and nonprofit—would all be under the same legal regime as established by the amendments. In late July of 1974, then-President Nixon signed Public Law 93-360 into law. Effective August 25, 1974, health care workers had partially repealed Taft-Hartley and gained federal legal protections to organize through the NLRA.

4. Discussion and Conclusion

At the middle of the twentieth century, nonprofessional health care workers—long marginalized by race, class, and gender—waged a decades'-long campaign to secure collective bargaining rights. In the face of political, legal, and managerial hurdles, this article argues that they did so successfully through two interrelated processes. First, in coordination with the civil rights movement, workers engaged in both disruptive and legal social-movement tactics: they struck for union recognition, protested in communities, and petitioned the federal government. Second, in doing so they helped draw the state into and reveal its relationship to collective bargaining process in the health care sector, facilitating cross-domain policy feedback effects.

As the health care industry has grown to become among the largest sources of private sector employment in the United States, the significance of these developments and the benefits of such rights should not be understated. Studies have shown, for example, that hospital workers who are unionized have better pay[101] and fringe benefits[102] relative to those who are not and tend to produce better patient outcomes.[103] Related research in the wake of the pandemic suggests that health care institutions that were organized had a lower incidence of COVID-19 spread and fatality.[104] Beyond helping to level the balance of power in the workplace and improve patient outcomes, such organizing rights have bolstered the political power of health care workers. Following the passage of health amendments at the federal level, SEIU celebrated the law as the "greatest" legislative victory in its half-century history.[105] The organization dedicated significant resources to organizing hospitals in an "all-out" campaign around

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the country,[106] with George Hardy suggesting the efforts were the single largest mobilization of workers since those following the passage of the NLRA in the 1930s.[107] Alongside campaigns from Local 1199, the push garnered news coverage from the *New York Times.*[108] Indeed, the extension of collective bargaining rights helped fuel its rise as one of the most powerful forces among organized labor in the country, with roughly half of its two million members coming from health care.[109] The SEIU has also become a core coalitional partner of the Democratic Party, granting its members voice in the political process.

Nevertheless, the reforms outlined above had serious limitations. At minimum, they dulled hospital workers' most potent tool—the strike. As costly and risky as these strikes were, workers' ability to withdraw their labor and engage in disruptive action helped generate economic leverage and garnered the attention of policy makers and elected officials from various institutions. At worst, the legal machinery of the NLRA, even by that time arguably outdated, seemingly sapped the militancy of hospital workers and in many cases made organizing more cumbersome. As one union leader reflected, the law acted as a "yoke around our neck" for future organizing drives.[110] Nor did the amendments anticipate the massive growth in recent decades of home-care work—highly dispersed, fragmented labor that remains difficult to organize through the NLRA.[111] Put briefly, the extensions of collective bargaining through the 1960s and 1970s did not completely overhaul labor law so that it more closely fits with America's postindustrial, service-based economy. Rather, a large and growing sector of the workforce was subsumed by the NLRA as the law was becoming increasingly outmoded and even used by employers to thwart organizing drives. As the COVID-19 pandemic laid painfully bare—featuring frontline health care workers who were short staffed, underresourced, and pushed to the brink—current labor and employment laws governing the health care industry and the postindustrial economy more broadly are highly inadequate.

In addition to helping build a more comprehensive understanding of labor law's trajectory and its relation to a core industry in the American political economy, this article also has theoretical and conceptual insights for the policy feedback literature. In particular, the article introduced the concept of cross-domain policy feedback. As the case analysis suggests, for example, at virtually all stages of development—local, state, and federal action—the use or expansion of public health care spending was critical to workers' ability to secure collective bargaining rights both in practice and in law. Pressed by the grassroots activism of workers, local and state lawmakers, acting as brokers with high levels of discretion over how to deploy or repurpose certain policies, used health care monies as a tool to help underwrite collective bargaining contracts. Similarly, the large-scale intervention of Medicare and Medicaid—policies that poured billions of dollars into states and localities across the country—further deepened the state's role in bargaining relationships between workers and health institutions while offering activists and lawmakers legal and political resources to advance their goals in a seemingly separate domain of governance (i.e., industrial relations). Indeed, as collective bargaining has further developed in the health industry, public spending continues to play a crucial role.[112]

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Given the increasing role that public policy has played in American governance since the mid-twentieth century, a phenomenon that researchers have analogized as the "policyscape" or "policy state," this way of thinking opens a broad avenue for future research by students of public policy—one that pushes scholars to think about the way policy influences the broader political landscape beyond the behavior of individual voters or policy recipients. How, for example, might the dramatic growth of the carceral state have influenced the direction of different social welfare policies?[113] Could recent attempts to expand civil legal aid affect other policy domains, such as the distribution of power within housing markets?[114] How, if at all, might bids to combat climate change shape not only targeted areas—such as transportation, for instance[115]—but also policies directed at protecting potentially displaced workers?[116] This article has offered a preliminary set of policy- and actor-specific conditions that seem conducive to cross-policy feedback, yet additional research is required to pin down exactly under which conditions such processes occur. Such inquiry will be central not only for a more comprehensive discernment of the development of the American state and its public policies but also for understanding who those policies do—and do not—include.

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Notes

[1] "Dr. King's Statements on 1199," folder 6, box 30, Local 1199 Executive Secretary Moe Foner Records #5206-S, Kheel Center for Labor-Management Documentation and Archives, Cornell University Library, Ithaca, NY (hereafter cited as KC-CU).

[2] See Cynthia L. Estlund, "The Ossification of American Labor Law," *Columbia Law Review* 102, no. 6 (2002): 1527–1612; Daniel Galvin, "From Labor Law to Employment Law: The Changing Politics of Workers' Rights," *Studies in American Political Development* 33, no. 1 (2019): 50–86; Kate Andrias, "The New Labor Law," *Yale Law Journal* 126, no. 1 (2016): 1–100; Warren Snead, "The Supreme Court as an Agent of Policy Drift: The Case of the NLRA," *American Political Science Review* 117, no. 2 (2023): 661–74.

[3] On the increased dispersion and "fissuring" of the workplace, see, e.g., David Weil, *The Fissured Workplace: Why Work Became So Bad for So Many and What Can Be Done to Improve It* (Cambridge, MA: Harvard University Press, 2014).

[4] On early failed efforts to repeal Taft-Hartley, see Benjamin Aaron, "Amending the Taft-Hartley Act: A Decade of Frustration," *ILR Review* 11, no. 3 (1958): 327–38. For failure to reform under Lyndon B. Johnson, see Travis M. Johnston, "A Crowded Agenda: Labor Reform and Coalition Politics during the Great Society," *Studies in American Political Development* 29, no. 1 (2015): 89–105. For the ill-fated Labor Law Reform Act of 1978, see Jacob S. Hacker and Paul Pierson, *Winner-Take-All Politics: How Washington Made the Rich Richer and Turned Its Back on the Middle Class* (New York: Simon & Schuster, 2010), 127–32. For reforms defeated under the Obama administration, see Nelson Lichtenstein, "Despite EFCA's Limitations, Its Demise Is a Profound Defeat for U.S. Labor," *Labor* 7, no. 3 (2010): 29–32.

[5] In particular, primary material comes from a variety of sources. Archival materials are drawn from two places: the Service Employees International Union's main collection at the Walter P. Reuther Library at Wayne State University and Local 1199's papers at the Kheel Center for Labor-Management Documentation and Archives, Cornell University Library. Major NLRB rulings on health care workers during the 1960s and 1970s were reviewed, as were all congressional hearings on proposed legislation relating to legislation that would repeal the Taft-Hartley health-related amendments. Additional

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information was culled from national and local newspaper clippings including *The New York Times*, *New York Post*, and the *Baltimore Sun*, among several others; organizational newsletters from unions and health providers (e.g., the American Hospital Association); and trade publications (e.g., *Modern Hospital*).

[6] Premilla Nadasen, "Citizenship Rights, Domestic Work, and the Fair Labor Standards Act," *Journal of Policy History* 24, no. 1 (2012): 74–94; Phyllis Palmer, "Outside the Law: Agricultural and Domestic Workers under the Fair Labor Standards Act," *Journal of Policy History* 7, no. 4 (1995): 416–40.

[7] Earlene K. P. Dowell, "Health Care Still Largest U.S. Employer," The U.S. Census Bureau, October 14, 2020, https://www.census.gov/library/stories/2020/10/health-care-still-largest-united-states-employer.html.

[8] E. E. Schattschneider, *Politics, Pressures and the Tariff* (New York: Prentice-Hall, 1935), 288.

[9] For recent reviews, see Suzanne Mettler and Mallory E. SoRelle, "Policy Feedback," in *Theories of the Policy Process*, 5th ed., ed. Chris Weible and Paul Sabatier (New York: Routledge); Daniel Béland, Andrea Louise Campbell, and R. Kent Weaver, *Policy Feedback: How Policies Shape Politics of Elements in Public Policy* (Cambridge: Cambridge University Press, 2022); Daniel Béland, "Reconsidering Policy Feedback: How Policies Affect Politics," *Administration & Society* 42, no. 5 (2010): 568–90.

[10] For an exception, but as it pertains to behavior as the outcome of interests, see Aaron J. Rosenthal, "Conflicting Messages: Multiple Policy Experiences and Political Participation," *Policy Studies Journal* 49, no. 2 (2021): 616–39.

[11] The language of "policyscape" comes from Suzanne Mettler, "The Policyscape and the Challenges of Contemporary Politics to Policy Maintenance," *Perspectives on Politics* 14, no. 2 (2016): 369–90; "policy state" from Karen Orren and Stephen Skowronek, *The Policy State: An American Predicament* (Cambridge, MA: Harvard University Press, 2019); and "policy terrain" from Jacob S. Hacker and Paul Pierson, "After the 'Master Theory': Downs, Schattschneider, and the Rebirth of Policy-Focused Analysis," *Perspectives on Politics* 12, no. 3 (2014): 643–62. The analysis that is closest to mine comes from Mettler, who argues that policies can have "lateral effects" on one another. But this analysis is restricted largely to budgetary issues at the federal level.

[12] For a detailed discussion of mechanisms in the feedback literature, see Metttler and SoRelle 2022, "Policy Feedback" as well as Paul Pierson, "When Effect Becomes Cause: Policy Feedback and Political Change," *World Politics* 45, no. 4 (1993): 595–628.

[13] Full quote from Skocpol: "Once instituted, policies have feedback effects in two main ways. In the first place, because of the official efforts made to implement new policies using new or existing administrative arrangements, policies transform or expand the capacities of the state." Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge, MA: Belknap Press of Harvard University Press, 1992), 58.

[14] Eric M. Patashnik and Julian E. Zelizer, "The Struggle to Remake Politics: Liberal Reform and the Limits of Policy Feedback in the Contemporary American State," *Perspectives on Politics* 11, no. 4 (2013): 1071–87.

[15] Because policy change is often mediated by organizations and political elites (see Hacker and Pierson 2014), my initial focus here is on them. Yet future research should examine the conditions that facilitate cross-domain effects in mass behavior.

[16] John A. Ferejohn, *Pork Barrel Politics: Rivers and Harbors Legislation, 1947-1968* (Stanford, CA: Stanford University Press, 1974).

[17] Marie Gottschalk, *The Prison and the Gallows: The Politics of Mass Incarceration in America* (Cambridge, MA: Cambridge University Press, 2006).

[18] Juliet Stumpf, "The Crimmigration Crisis: Immigrants, Crime, and Sovereign Power," *American University Law Review* 56, no.2 (2006): 367–419.

[19] James Mahoney and Kathleen Thelen, "A Theory of Gradual Institutional Change," in *Explaining Institutional Change: Ambiguity, Agency, and Power*, ed. J. Mahoney and K. Thelen (Cambridge: Cambridge University Press, 2009), 1–37.

[20] Krissy Clark, "Why Do Welfare Funds Go to Marriage Counseling," *Marketplace*, May 31, 2016, https://www.marketplace.org/2016/05/31/twenty-years-after-welfare-reform-how-are-states-spending-funds/.

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[21] Kathlyn McHenry and Linda K. Smith, *The Intersection of TANF and Child Care* (Washington, DC: Bipartisan Policy Center, 2021), https://bipartisanpolicy.org/report/tanf-and-childcare/.
[22] Pierson, "When Effect Becomes Cause," 600–1.
[23] Brink Lindsey and Steven M. Teles, *The Captured Economy: How the Powerful Enrich Themselves, Slow Down Growth, and Increase Inequality* (Oxford: Oxford University Press, 2017), 92.
[24] Chloe N. Thurson, *At the Boundaries of Homeownership: Credit, Discrimination, and the American State* (Cambridge: Cambridge University Press, 2018), chap. 4.
[25] Patashnik and Zelizer, "The Struggle to Remake Politics," 1083.
[26] For a discussion of the medical hierarchy within hospitals, see Barbara Ehrenreich and John Ehrenreich, "Hospital Workers: Class Conflicts in the Making," *International Journal of Health Services* 5, no. 1 (1975): 43–51.
[27] Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982); Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books 1989).
[28] Starr, *The Social Transformation of American Medicine*; Stevens, *In Sickness and in Wealth*, 153–55.
[29] Starr, *The Social Transformation of American Medicine*, 178.
[30] Jo Ann Ashley, *Hospitals, Paternalism, and the Role of the Nurse* (New York: Teachers College, Columbia University, 1976), chap. 5–6.
[31] Susan M. Reverby, *Ordered to Care: The Dilemma of American Nursing* (New York: Cambridge University Press, 1987), chap. 3; Jo Ann Ashley, *Hospitals, Paternalism, and the Role of the Nurse*, chap. 3.
[32] See Phillip A. Kalisch and Beatrice J. Kalisch, *The Advance of American Nursing*, 3rd Edition (Philadelphia, PA: J. B. Lippincott Company, 1995), chap. 18–20. Indeed, registered nurses would eventually come to be called what sociologists have termed "semiprofessionals," or those who had established key elements of professionalism—particularly a code of ethics, shared occupational identity, and some legal autonomy and social authority—but had yet to totally control entry into the labor market. For more on the limits of nurses' quest for professionalism, see especially Margaret Levi, "Functional Redundancy and the Process of Professionalization: The Case of Registered Nurses in the United States," *Journal of Health Politics, Policy and Law* 5, no. 2 (1980); Amitai Etzioni, *The Semi-Professions and their Organization: Teachers, Nurses, Social Workers* (New York: Free Press, 1969).
[33] Jo Ann Ashley, *Hospitals, Paternalism, and the Role of the Nurse*, chap. 6; Susan M. Reverby, *Ordered to Care*, chap. 7.
[34] Quoted in Leon Fink and Brian Greenberg, *Upheaval in the Quiet Zone: A History of Hospital Workers' Union Local 1199* (Chicago: University of Illinois Press, 1989), 50.
[35] *Baltimore Afro-American*, "Our Readers Say: 'Need Hospital Union,'" August 9, 1969.
[36] Fred Punch quoted in Guan A. McKee, *Hospital City, Health Care Nation: Race, Capital, and the Costs of American Health Care* (Philadelphia: University of Pennsylvania Press, 2023), 132–33.
[37] Deliberation on this provision was scant, especially compared to that concerning other elements of the bill, but economic relief for nonprofit hospitals, still cast as local institutions in nature, appears to have been the motivating factor. The only comment on the floor of the House came from Congressman Klein, who spoke in opposition: "While the number of workers thus deprived of any participation in the terms of their employment may not be large, it seems ironical that organizations devoted to the social welfare should be exempted from bargaining with their own, often underpaid employees." 93 Cong. Rec. 3446 (1947), https://www.congress.gov/bound-congressional-record/1947/04/15/house-section. In the Senate, both the AHA and John Hopkins Hospital lobbied for exclusion in committee hearings. But although an amendment was considered, it was not reported to the floor with the full bill. According to Senator Robert Taft Sr. (R-OH), a primary architect of the bill, the committee did not adopt the amendment "because it was felt it was unnecessary. The committee felt that hospitals were not engaged in interstate commerce, and that their business should not be so construed. We rather felt it would open up the question of making further exemptions." The bill that was reported to the Senate floor made no mention of nonprofit hospitals. However, a floor amendment offered by Senator Millard Tydings (D-MD) explicitly excluded them. Tydings explained that "this amendment is designed merely to help a great number of hospitals which are having very difficult times. They are eleemosynary institutions, no profit is involved in their operations, and I understand from the Hospital Association that

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this amendment would be very helpful in their efforts to serve those who have not the means to pay for hospital service." After a brief debate with Senator Glen Taylor (D-ID), the bill passed the Senate with Tydings's amendment and the conference committee included the full exclusion in the final bill that was signed into law. See 93 Cong. Rec. 4997 (1947), https://www.congress.gov/80/crecb/1947/05/12/GPO-CRECB-1947-pt4-9-1.pdf.

[38] Lucretia Dewey Tanner, Harriet Goldberg Weinstein, and Alice Lynn Ahumuty, *Impact of the 1974 Health Care Amendments to the NLRA on Collective Bargaining in the Health Care Industry* (Washington, DC: Federal Mediation and Conciliation Service Office of Research, 1979), 13–14; Daniel N. Price, "Unemployment Insurance, Then and Now," *Social Security Bulletin* 48, no. 19 (1985): 22–32; Anne R. Somers, *Hospital Regulation: The Dilemma of Public Policy* (Princeton, NJ: Industrial Relations Section, Princeton University, 1969).

[39] Ronald L. Miller, "The Hospital Union Relationship—Part 1," *Hospitals: The Journal of the American Hospital Association* 45, no. 9 (1971): 49–51.

[40] Fink and Greenberg, *Upheaval in the Quiet Zone*, chap. 6–8. It is worth noting that the American Federation of State, County and Municipal Employees was largely organizing workers in fully public hospitals, who, as public employees, were prohibited form organizing through the NLRA. The SEIU and Local 1199 would eventually merge, but not after a dramatic internal falling out among leaders of Local 1199.

[41] E.g., see "Other Unions into Hospital Organizing," *The SEIU Hospital Organizer* (Summer 1975), box 95, folder 95-13, "Hosp./Healthcare Organizing," SEIU Executive Office: George Hardy Records, LR001542_Hardy, Walter P. Reuther Library, Wayne State University, Detroit, Michigan (hereafter cited as GHR-WSU).

[42] E.g., see Jules Loh, "A Rights-Labor Coalition is Born," *The Sunday Sun*, August 24, 1969.

[43] For example, in 1962 A. Phillip Randolph helped organized the Citizens Committee for Equal Rights for Voluntary Hospitals with Local 1199; see Fink and Greenberg, *Upheaval in the Quiet Zone*, 105.

[44] For evidence of a $12,000 donation to SCLC in part from Local 1199 in the year 1961 for civil rights efforts in the South, see "Dr. King Tells: 'Why I am Not Satisfied,'" September 1961, #5206-S, box 30, folder 6, Local 1199 Executive Secretary Moe Foner Records #5206-S, KC-CU; For efforts on police brutality, see "Statement by Local 1199 on Killing of James Powell," July 22, 1965, box 2, folder 2, Local 1199 President Leon Davis Records #5206-PR, KC-CU; correspondence to Bayard Rustin from Leon Davis, May 17, 1965, box 2, folder 2, Local 1199 President Leon Davis Records #5206-PR, KC-CU; also see correspondence from Floyd McKissick, National Director, Congress of Racial Equality to Leon Davis, November 11, 1966, box 2, folder 2, Local 1199 President Leon Davis Records #5206-PR, KC-CU.

[45] See March on Washington, 1199 Delegate flyer, box 2, folder 2, Local 1199 President Leon Davis Records #5206-PR, KC-CU.

[46] Eric Schickler, *Racial Realignment: The Transformation of American Liberalism, 1932–1965* (Princeton, NJ: Princeton University Press, 2016), chap. 3.

[47] "Dr. King's Statements on 1199," box 30, folder 6, Local 1199 Executive Secretary Moe Foner Records #5206-S, KC-CU.

[48] A. H. Raskin, "A Union with 'Soul,'" *New York Times*, March 22, 1970.

[49] *Hospitals: Guide Issue* (Chicago, IL: American Hospital Association, August 1, 1971), "Table 3: Utilization, Personnel and Finances, 1970, by Census Division, State, Service, and Control," 468–79.

[50] Of course, most refusals to allow for a union election were quiet or unceremonious affairs. Yet in a show of collective power and intransigence, on March 3, 1959, president of the General New York Hospital Association went so far as to publicly state their position on unionization: "We [General New York Hospital Association] hereby state our unwillingness to recognize any union as the collective bargaining agencies for our employees." Quoted in Fink and Greenberg, *Upheaval in the Quiet Zone*, 54.

[51] For various examples, see *Extension of NLRA to Nonprofit Hospital Employees*, *Hearings on H.R. 11357 Before the Special Subcommittee on Labor of the Committee on Education and Labor*, *House of Representatives, Ninety-Second Congress, First and Second Sessions: A Bill to Amend the National Labor Relations Act to Extend its Coverage and Protection to Employees of Nonprofit Hospitals, and for Other Purposes* (Washington, DC: United States Government Printing Office, 1972), 16–18 (testimony of Henry Nicholas, vice president, National Union of Hospital and Nursing Home Employees, Retail, Wholesale and Department Store

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Union); *Extension of NLRA to Nonprofit Hospital Employees, Hearings Before the Special Subcommittee on Labor of Tax Committee on Education and Labor, House of Representatives, 93rd Congress, 1st Session, on H.R. 1236, A Bill to Amend the National Labor Relations Act to Extend its Coverage and Protection to Employers of Nonprofit Hospitals, and for Other Purposes* (Washington, DC: United States Government Printing Office, 1978), 172–174 (Statement of Communication Workers); Committee on Labor and Public Welfare, *Coverage of Nonprofit Hospitals Under National Labor Relations Act, 1973, Hearings Before the Subcommittee on Labor of the Committee on Labor and Public Welfare, United States Senate, 93rd Congress, 1st Session, on S. 794 to Amend the National Labor Relations Act to Extend its Coverage and Protection to Employees of Nonprofit Employees, and for Other Purposes. S. 2292* (Washington, DC: United States Government Printing Office, 1973), 23 (testimony of John Sorbie, business manager of Service Employees International Union Local 50).

[52] E.g., see Fink and Greenberg, *Upheaval in the Quiet Zone*, 100; see also, *The Baltimore Sun*, "Hospital Raises Minimum Pay 30 Cents," May 13, 1969.

[53] *Baltimore Afro-American*, "Our Readers Say: 'Need Hospital Union.'"

[54] See *Coverage of Nonprofit Hospitals Under National Labor Relations Act*, 93rd Cong., 1st Sess. (1973), 107–110 (testimony of Albert L. Lake, International Representation, International Union of Operating Engineers).

[55] *The Baltimore Sun*, "Union Leader Warns Hospitals, Nursing Homes: 'We'll Get to You,'" September 15, 1969.

[56] *Long Island Press*, "Police Pickets Clash at Adelphi Hospital," February 22, 1969; *Daily News*, "Assemblymen & 5 Pickets Seized in Adelphi Strike," February 22, 1969; Fink and Greenberg, *Upheaval in the Quiet Zone*, chap. 4–5.

[57] Leon J. Davis and Moe Foner, "Organization and Unionization of Health Workers in the United States: The Trade Union Perspective," *International Journal of Health Services* 5, no. 1 (1975): 19–26.

[58] Quoted in Fink and Greenberg, *Upheaval in the Quiet Zone*, 141.

[59] *New York Times*, "A Hospital Strike Goes on in South, Tensions Rise in Charleston as Workers Reject Offer," July 14, 1969; *New York Times*, "2D Hospital Ends Carolina Strike, 113-Day Walkout Marked by Turmoil in Charleston," July 19, 1969; *Time: The Weekly News Magazine*, "The City: Echoes of Memphis," April 25, 1969.

[60] For prolonged strike activity in New York, Baltimore, Maryland; Pittsburgh and Philadelphia, Pennsylvania; and Charleston, South Carolina, see Fink and Greenberg, *Upheaval in the Quiet Zone*, chaps. 3–7; for evidence in Seattle, Washington; Chicago, Illinois; Cleveland, Ohio; and Los Angeles, California, see, *Extension of NLRA to Nonprofit Hospital Employees*, 92nd Cong., 1st and 2nd Sess. (1971), 23–27 (Statement of George Hardy, General President, Service Employees International Union).

[61] Quoted in Fink and Greenberg, *Upheaval in the Quiet Zone*, 161.

[62] Fink and Greenberg, *Upheaval in the Quiet Zone*, 163–64.

[63] Fink and Greenberg, *Upheaval in the Quiet Zone*, 150–51.

[64] *Coverage of Nonprofit Hospitals under National Labor Relations Act*, 93rd Cong., 1st Sess. (1973), 74–75 (exchange between Gladys Mason and Senator Alan Cranston [D-CA]).

[65] At least six states and localities implemented laws extending collective bargaining rights to health care workers in part as a result of mobilization. See Tanner, Weinstein, and Ahmuty, *Impact of the 1974 Health Care Amendments to the NLRA*, chap. 2; "New York State Union Legislation Expected from Bronxville Strikes," *The Modern Hospital* 104, vol. 3 (1965).

[66] Although the state did not pass protective labor legislation, the Charleston strike did result in a wage raise, a method to deduct union dues form workers' paychecks, and a grievance procedure. See Davis and Foner, "Organization and Unionization of Health Workers in the United States," 23.

[67] E.g., see Robert Kappstatter, "City Offers Aid to End Adelphi Hospital Strike," *Daily News*, March 22, 1969; see also Fink and Greenberg, *Upheaval in the Quiet Zone*, 125–27, 173–77.

[68] E.g., see James A. Wechsler, "A Sick Hospital," *New York Post*, February 21, 1969; discussed in more depth by Sara Gamm, *Toward Collective Bargaining in Non-profit Hospitals: Impact of New York Law* (Ithaca, NY: Cornell University Press, 1968), 20.

[69] As Miller writes, "Through Medicare and Medicaid, the federal government as well as the state government are parties to the hospital managerial process." Ronald L. Miller, "The Hospital Union Relationship—Part 1," 50–51.

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[70] Quoted in Fink and Greenberg, *Upheaval in the Quite Zone*, 124.
[71] "Dealing with Third Party Payers," in *Proceedings of the SEIU Healthcare Industries Conference*, n.d., box 94, folder 94-42, "Health Care Workers," GHR-WSU; "Report of the Workshop on Nursing Homes and Other Services," box 95, folder 95-17, "Hosp./Healthcare Organizing," GHR-WSU.
[72] On Maryland, see Fink and Greenberg, *Upheaval in the Quiet Zone*, 178.
[73] Tanner, Weinstein, and Ahumuty, *Impact of the 1974 Health Care Amendments to the NLRA*, 3–5.
[74] See National Labor Relations Board, *Butte Medical Properties*, 1967, https://apps.nlrb.gov/link/document.aspx/09031d45800a7a11; National Labor Relations Board, *University Nursing Home, Inc.*, 1967, https://apps.nlrb.gov/link/document.aspx/09031d45800a7a12.
[75] National Labor Relations Board, 1970, *Drexel Home, Inc.*, https://apps.nlrb.gov/link/document.aspx/09031d45800a8039.
[76] National Labor Relations Board, 1970, *Drexel Home, Inc.*, https://apps.nlrb.gov/link/document.aspx/09031d45800a8039, 1045.
[77] National Labor Relations Board, *Butte Medical Properties*, 1967, https://apps.nlrb.gov/link/document.aspx/09031d45800a7a11, 267.
[78] National Labor Relations Board, https://apps.nlrb.gov/link/document.aspx/09031d45800a90e8, *Duke University*, 236–39.
[79] Tanner, Weinstein, and Ahmuty, *Impact of the 1974 Health Care Amendments to the NLRA*, 16–17.
[80] See Dennis D. Pointer, "The 1974 Health Care Amendments to the National Labor Relations Act," *Labor Law Journal* 26, no. 6 (1975), 350–51.
[81] E.g., see *Business Week*, "Johns Hopkins Organized," September 6, 1969.
[82] Fink and Greenberg, *Upheaval in the Quiet Zone*, 152–54.
[83] Tanner, Weinstein, and Ahmuty, *Impact of the 1974 Health Care Amendments to the NLRA*, 15–16. See Correspondence from Frank Thompson, Jr. (D-NJ) to George Hardy, folder 95-13, "Hosp. / Healthcare Organizing," GHR-WSU. Correspondence from George Hardy to Jacob Javitas (R-NY), folder 95-13, "Hosp. / Healthcare Organizing," GHR-WSU.
[84] Pointer, "The 1974 Health Care Amendments," 353.
[85] See *Extension of NLRA to Nonprofit Hospital Employees*, 92nd Cong., 1st Sess. (1971), 1 (opening statement of Frank Thompson [D-NJ]).
[86] On the AHA's advocacy around Medicare, see McKee, *Hospital City, Health Care Nation*, chap. 3. On the growing power of nonprofit hospitals more broadly, see Stevens, *In Sickness and in Wealth*, chap. 9–11.
[87] See *Extension of NLRA to Nonprofit Hospital Employees*, 93rd Cong., 1st Sess. (1973); *Coverage of Nonprofit Hospitals under National Labor Relations Act*, 93rd Cong., 1st Sess. (1973).
[88] Pointer, "The 1974 Health Care Amendments to the National Labor Relations Act," 357–58.
[89] See *Coverage of Nonprofit Hospitals Under National Labor Relations Act, 1972, Hearings Before the Subcommittee on Labor of the Committee on Labor and Public Welfare, United States Senate, 93rd Congress, 1st Session, on S. 794 to Amend the National Labor Relations Act to Extend its Coverage and Protection to Employees of Nonprofit Employees, and for Other Purposes* (Washington, DC: United States Government Printing Office, 1972).
[90] McKee, *Hospital City, Health Care Nation*, chap. 5.
[91] U.S. Department of Health, Education and Welfare, *Annual Report, Fiscal 1978: Bureau of Health Facilities Finance Compliance and Conversion* (Washington, DC: U.S. Department of Health, Education, and Welfare, 1978).
[92] See *Extension of NLRA to Nonprofit Hospital Employees*, 92nd Cong., 1st and 2nd Sess. (1971), 87–92 (testimony of Richard Liebes, research director, Bay District Joint Council No. 2, SEIU).
[93] See *Extension of NLRA to Nonprofit Hospital Employees*, 92nd Cong., 1st and 2nd Sess. (1971), 172–79 (testimony of Norman Metzger).
[94] E.g., see *Extension of NLRA to Nonprofit Hospital Employees*, 92nd Cong., 1st and 2nd Sess. (1971), 40–41 (testimony of Henry T. Wilson, Laborer's International Union of North America); *Extension of NLRA to Nonprofit Hospital Employees*, 92nd Cong., 1st and 2nd Sess. (1971), 216–220 (written testimony of Keith D. Hornberger); *Extension of NLRA to Nonprofit Hospital Employees*, 93rd Cong., 1st Sess. (1973), 15 (exchange between Representative William Clay [D-MO] and Lester Asher, Counsel, Service Employee International Union).

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[95] See, *Extension of NLRA to Nonprofit Hospital Employees*, 93rd Cong., 1st Sess. (1973), 69 (exchange between Representative Frank Thompson [D-NJ] and Thomas Lane, labor counsel, the Hospital Association of Pennsylvania).
[96] Tanner, Weinstein, and Ahmuty, *Impact of the 1974 Health Care Amendments to the NLRA*, 18–19.
[97] John K. Iglehart, "Sen. Taft 'Vetoes' Taft-Hartley Amendment," *Hospital Progress* 53 (1972); "Two Bills Die," *Service Employee* 32, no. 6 (1972); Pointer, "The 1974 Health Care Amendments to the National Labor Relations Act," 353.
[98] Pointer, "The 1974 Health Care Amendments to the National Labor Relations Act," Tanner, Weinstein, and Ahmuty, *Impact of the 1974 Health Care Amendments to the NLRA*, 18–21. For labor's frustration with the AHA's involvement, see correspondence from Alan Cranston (D-CA) to George Hardy, October 10, 1972, folder 95-13, "Hosp. / Healthcare Organizing," GHR-WSU. Correspondence from George Hardy to Alan Cranston (D-CA), October 27, 1972, folder 95-13, "Hosp. / Healthcare Organizing," GHR-WSU.
[99] Pointer, "The 1974 Health Care Amendments to the National Labor Relations Act," 350–57. For the hearings in the Senate at Taft, Jr.'s insistence, see, *Coverage of Nonprofit Hospitals Under National Labor Relations Act*, 92nd Cong., 2nd Sess. (1972); *Coverage of Nonprofit Hospitals Under National Labor Relations Act*, 93rd Cong., 1st Sess. (1973).
[100] Tanner, Weinstein, and Ahmuty, *Impact of the 1974 Health Care Amendments to the NLRA*, 21–26.
[101] See Keith A Binder, Hoshne A. Mridha, and James Peoples, "Risk Compensation for Hospital Workers: Evidence from Relative Wages of Janitors," *ILR Review* 59, no. 2 (2006): 226–42.
[102] See Roger Feldman and Richard Scheffler, "The Union Impact on Hospital Wages and Fringe Benefits," *ILR Review* 35, no. 2 (1982): 196–206.
[103] E.g., see Arindrajit Dube, Ethan Kaplan, and Owen Thompson, "Nurse Unions and Patient Outcomes," *ILR Review* 69, no. 4 (2016): 803–33.
[104] Adam Dean, Jamie McCallum, Simeon D. Kimmel, and Atheendar S. Venkataramani, "Resident Mortality and Worker Infection Rates from COVID-19 Lower in Union Than Nonunion US Nursing Homes, 2020–21," *Health Affairs* 41, no. 5 (2022): 751–59.
[105] Memo from George Hardy to All SEIU-Affiliated Locals, July 12, 1974, folder 94-4, "Hosp. / Healthcare Organizing," GHR-WSU.
[106] "All-out" language comes from "Internal ALERT NO. IV to SEIU Local Unions," box 95, folder 95-13, "Hosp. / Healthcare Organizing," GHR-WSU; "Memo to George Hardy from Anthony G. Weinlein re: Hospital Organizing Leaflets," March 13, 1974, box 95, folder 95-3, "Hospital Campaign," GHR-WSU.
[107] Quote from Hardy comes from "Riding an Historic Wave," *The SEIU Hospital Organizer* Summer (1975), box 95, folder 95-13, "Hosp. / Healthcare Organizing," GHR-WSU. Evidence of widescale pamphleting and organizing: "Alert No. 3 to All Affiliated [SEIU] Hospital Local Unions," July 11, 1974, box 95, folder 95-4, "Hospital Campaign," GHR-WSU; "Non-Profit Hospital Organizing Campaign, Leaflet Distribution," July 17, 1974, box 95, folder 95-4, "Hospital Campaign," GHR-WSU.
[108] Damon Stetson, "Hospital Union Plans U.S. Drive," *The New York Times*, December 2, 1973.
[109] Don Stillman, *Stronger Together: The Story of SEIU* (White River Junction, VT: Chelsea Green Publishing, 2010).
[110] Henry Nicholas quoted in Fink and Greenberg, *Upheaval in the Quiet Zone*, 168.
[111] On home-care workers' liminal status vis-à-vis labor law, see Eileen Boris and Jennifer Klein, *Caring for America: Home Health Workers in the Shadow of the Welfare State* (New York: Oxford University Press, 2012); Leigh Anne Schriever, "The Home Health Care Industry's Organizing Nightmare," *The Century Foundation*, August 18, 2015.
[112] One internal SEIU memo colorfully claimed that wages in nursing homes depended more on reimbursement rates than union density. See "Memo from Dan Stewart to Dave Snapp re: Nursing Home 'State Model,'" September 14, 1992, box 6, folder 6-55, "Nursing Home Organizing," SEIU Organizing Department Records, LR001888, Walter P. Reuther Library, Wayne State University, Detroit, Michigan.
[113] The author thanks Marissa Rivera for helping connect these dots in conversation. See Joe Soss, Richard C. Fording, and Sanford F. Schram, *Disciplining the Poor: Neoliberal Paternalism and the Persistent Power of Race* (Chicago, IL: University of Chicago Press, 2011).

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[114] E.g., see Jamila Michener, "Power from the Margins: Grassroots Mobilization and Urban Expansions of Civil Legal Rights," *Urban Affairs Review* 56, no. 5 (2020): 1390–1422.
[115] Annie Karni and Jim Tankersley, "Infrastructure Plan Seeks to Address Climate and Equality as Well as Roads," *New York Times*, April 6, 2021.
[116] Jim Barrett, *Worker Transition & Global Climate Change* (Washington, DC: Pew Center on Global Climate Change, 2001), https://www.c2es.org/wp-content/uploads/2001/12/worker_transition.pdf.

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