# "A Poor Sort of Memory"*: Voluntary Hospitals and Government before the Depression

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FOUR LARGELY UNQUESTIONED ASSUMPTIONS ABOUT voluntary, not-for-profit hospitals appear regularly—yet strangely—in the hospital journals of the early 1980s. First, voluntary hospitals are often presented as private institutions which began as self-sufficient, endowed organizations but which have become inappropriately attuned to the competitive marketplace, largely because of perverse economic and political incentives brought about through recent government regulation. The "return" of hospitals and other medical care organizations to unregulated competition is a central motif for congressional bills of the 1980s, and the idea that voluntary hospitals are, have been, and ought to be regarded as businesses resonates through the hospital literature. Second, there appears to be a general belief that government aid to hospitals started in a big way only in the depression. Thus, government's role can be seen as imposed only because of national emergency—and as only reluctantly accepted. Third, voluntary hospitals present themselves as part of a "private sector" which is clearly differentiated from a

* "'It's a poor sort of memory that only works backwards,' the Queen remarked." Lewis Carroll [Charles L. Dodgson], *Through the Looking Glass*, ch. 5.

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"public sector," as if these distinctions had always been well-understood. Finally, there is the notion that hospitals are neophytes on the political scene. Trustees and administrators are exhorted to seek out legislators and to use available professional organizations to press for legislative or regulatory change, as if lobbying were a new, unfortunate burden of the late twentieth century.

Yet, as anyone in the health field with a long memory can attest, in important respects each of these assumptions is a myth. The history of hospitals shows a long concern about the "public-ness" of private charitable institutions, particularly in the northeastern states. Voluntary hospitals tended to present themselves as public institutions at least up to the 1930s. The flow of government funds to voluntary hospitals has a long and venerable history. And, while there were marked geographical variations in government aid to voluntary hospitals before the depression, the appropriate relationship between government and the hospitals had been debated for decades. Hospital incorporators and officials have also long been effective lobbyists. Benjamin Franklin's account of the founding of the Pennsylvania Hospital, with a matching grant from the Provincial Assembly, stands as a model for successful lobbying by later generations (Franklin, 1754).

Why, then, is there this "poor sort of memory"? Why do such myths exist? We could remark, dismissively, that each generation invents its own history to meet its ideological and practical needs, and that for a "generation of competition" a history of hospitals as private-institutions-gone-awry has, obviously, much to commend it. And we could leave the matter there. Yet there are compelling reasons to reexamine both the history and the myths. This paper begins with an overview of the historical record, to demonstrate government involvement in voluntary hospitals well before the depression. It then examines more closely the different meanings of "public" and "private" that have been inherited and that haunt contemporary debate. Finally, we return to the nature and utility of myth. I shall suggest that a "poor sort of memory" has, in fact, only short-term benefits.

## Development of Cooperative Patterns of Aid

The modern hospital, with its trained nursing staff, well-equipped laboratories, and operating room facilities, its emphasis on organi-

zation and cleanliness, and a patient clientele drawn from all social classes dates only from the 1880s. The great growth in hospital establishment took place between the years 1880 and 1910; in the latter year there were over 4,000 hospitals in the United States, and these were catering increasingly to paying patients (Rosen, 1964; Rosenberg, 1977; 1979; Vogel, 1980; Kingsdale, 1981; Lynaugh, 1981; Rosner, 1980; 1982). Nevertheless, the hospital as an institution long antedates the scientific changes in medicine of the late nineteenth century. Federal, state, and local governments had established precedents for the aid of hospitals well before the 1880s. The hospital was already a "public" institution.

In 1798 federal aid was available to both governmental and private hospitals which served as marine hospitals under the terms of legislation for the "relief of sick and disabled seamen." Then, as now, the prospect of government funds could be a heady inducement for private groups. One of the speakers at hearings on marine hospitals in 1870 remarked that an appropriation for a hospital was "a favorite mode of starting a new town in the West, if it was anywhere on a stream or on a good sized puddle . . ." (cited by Mustard, 1945:43).

States were involved in subsidizing voluntary hospitals to a greater or lesser extent. Early examples were the Pennsylvania Hospital, which received £2,000 from the Provincial Assembly, together with its charter, in 1751, as a matching grant contingent on an equal amount being privately subscribed, and the Massachusetts General Hospital, which was granted the Province House Estate, with authority to sell and use the proceeds, on that hospital's foundation in 1811. In 1816 Massachusetts also began to make annual grants to the Eye and Ear Infirmary, and the New England Hospital for Women and Children (Massachusetts Board of State Charities, 1872:lxviii). Such grants were not seen strictly as substitutes for government hospital provision. States were heavily involved in the provision of psychiatric hospitals, but they were not usually involved in the provision of general hospital care, although, interestingly, California did experiment with the establishment (in 1851) of short-lived state accident hospitals in the mining areas of Stockton and Sacramento (Cahn and Barry, 1936: 139–141). Later, Pennsylvania and West Virginia were to establish state accident hospitals, and some states provided welfare medical care through the teaching hospitals of the state university system. But these were the exceptions that proved the rule. Generally, states which

provided funds for voluntary general hospitals did so on a selective, ad hoc, individualized basis, responding to specific requests from influential local groups. The state of New York was unusual in having a relatively extensive subsidy scheme for hospitals and dispensaries before the Civil War, continuing to the early 1870s. After the 1870s, Pennsylvania became the outstanding example of state aid. A critical report complained that "managing officials [of voluntary hospitals] seem to develop almost a mania to get possession of and disburse public funds" (Pennsylvania Special Committee on Charities and Corrections, 1891:32).

Local governments established infectious disease and isolation hospitals (pest houses), necessary evils in ports and major cities, awaiting the recurring epidemics of smallpox, cholera, typhoid, and diarrhea. Counties and cities provided a substantial amount of hospital care in almshouses for those who had nowhere else to go. Some local governments participated in the founding and support of voluntary hospitals by providing land. Milwaukee, for example, donated land in the 1850s for a Roman Catholic hospital; Philadelphia, in the 1870s, for the new hospital of the University of Pennsylvania. Conversely, as the need arose, a voluntary hospital might serve a government function, acting, for example, as did Mercy Hospital, Pittsburgh, as a public pest house in major epidemics. The beginnings of today's welfare medical system were also evident. In an area where it made little sense to have two separate hospitals—a voluntary hospital for the "deserving poor," selected and admitted by volunteer trustees, and a local government hospital for the residual "indigent"—a small grant to the voluntary hospital to care for the indigent made practical sense. Similarly, in cities with large immigrant populations, such as New York City, government payments to voluntary hospitals supplemented the governmental hospital system. Where government aid existed, its form was determined by a combination of local political conditions, commonsense, the strength of local interest groups, and the taxing structures which obtained in different states.

There are no systematic surveys of hospital financing across the United States in the nineteenth century. However, the distinguished British hospital critic Henry C. Burdett examined the income of seventeen American hospitals, mostly in the Northeast, in 1889 and 1890; his findings illustrate, at least, the range of practices with

respect to government aid. Maine General Hospital received a state appropriation of $5,000 (13 percent of its income in 1890); Methodist Episcopal Hospital, New York, received both state and city money (amount unspecified); Garfield Memorial Hospital in Washington, D.C., received federal funds through congressional appropriations; Hartford Hospital, Connecticut, received $5,000 from the state (12 percent of its income), plus some additional public funds for the care of veterans; and City Hospital, Worcester, Massachusetts, received city appropriations to meet its balances. The percentage of income met by patient payments ranged from less than one percent (at the well-endowed Protestant Episcopal Hospital, Philadelphia) to over 70 percent (the Pennsylvania Hospital and Harper Hospital, Detroit) (Burdett, 1893:719). There were, in short, enormous variations. A more detailed survey of government aid, in 1909, undertaken by the dean of hospital administration, S.S. Goldwater, when he was superintendent of Mount Sinai Hospital, New York, listed examples of local government aid ranging, alphabetically, from Birmingham, Alabama, to Sheboygan, Wisconsin. Goldwater, presenting his findings to the annual meeting of the American Hospital Association, called his listeners' attention to the "distinctively American practice of appropriating public funds for the support of hospitals managed by private benevolent corporations" (Goldwater, 1909:243).

## *The Voluntary Hospital as a Public Institution*

This "distinctively American practice" reflected, in large part, the lack of distinction between "public" and "private" functions in the development of American charitable institutions. Voluntary, not-for-profit institutions grew in the uncharted area between governmental and profit-making ventures. However, as charities they were much more akin to government than to business enterprises. For most of the nineteenth century there was little clear distinction or concern as to what fell most appropriately into the sphere of government, what into the realm of voluntary initiative. Both types of organization were assumed to serve, benevolently, the public interest. In the various programs of government subsidy, at least up to the 1890s, the good will—the public role—of private charitable agencies was assumed;

at all levels of government, appropriations were made on a cooperative, often cozy basis. If charitable care was seen as a legitimate or necessary public function, it remained a public function whether offered in a governmental or a private facility.

As a result, for most of the nineteenth century the word "public" (as used, for example, in the phrase "public charities") meant *for* the public rather than under governmental ownership or control. The State Board of Charities in Connecticut could remark quite naturally in 1906: "There is now public hospital provision in each of the eighteen cities in the state." Assumed as "public" were many hospitals we would now call "private," for example, the Grace and New Haven Hospitals in New Haven, the Hartford Hospital, and St. Vincent's Roman Catholic Hospital, Bridgeport (Connecticut Board of Charities, 1907:101). Each of these hospitals, with others, was regularly aided by the state. The term "public" was both independent of such aid and a rationale for its provision.

The willingness of government agencies to aid not-for-profit organizations in the nineteenth century, if only at the margin or at times of economic distress, allowed government both a responsive and a residual charitable role: responsive, that is, to claim for support from "worthy" groups, and residual in the sense of filling recognized gaps in care. Government hospitals were established where community need was self-evident and private efforts were unavailable: to safeguard the health of the merchant marine, to protect the general public from infectious diseases and contagions, to isolate and treat the mentally unfit, to provide care and shelter to persons wanted by nobody else. Government aid to private charities, whether these were hospitals or universities, assumed a broader, if unspecified, public good, a mutual interest in charitable care, and cooperative patterns of development. In a city such as Philadelphia there were distinctions in culture, prestige, and clientele between an endowed hospital without regular government (state) aid, such as the Pennsylvania Hospital, which could pick and choose among entering patients; a voluntary hospital with state aid, such as the University of Pennsylvania Hospital, relatively free to organize itself as it saw fit but carefully attuned to the political system; and a local government hospital, such as Blockley (the Philadelphia General Hospital), which was necessarily a medical and social dumping ground for social outcasts and the morally unfit (Rosenberg, 1982). However, all were assumed to be public institutions.

## *Liability and Tax Exemption*

It was in this broader sense of the term "public" that not-for-profit hospitals were given legal advantages with respect to liability for injury to a patient caused by their negligence, even where much of the care given was not strictly "charitable" in the sense of being free. (Traditionally, public charities were exempt from such liability.) In the 1870s, for example, the courts held that the Massachusetts General Hospital was a public charity and thus not liable for injuries suffered by a patient—even though it required patients to pay for board according to their circumstances and type of accommodations, limited admissions so that no person individually had the right to demand admission, and let the trustees decide which patients were to be admitted (James McDonald v. Massachusetts General Hospital, 1876).

Tax exemption also affirmed the public nature of the voluntary hospital. In Minnesota and South Carolina public hospitals were exempt from taxes on personal property under state constitutional provision (Ely, 1888:396). Elsewhere, rulings upheld tax exemption for nonprofit hospitals—on the grounds that they were nonprofit, public charities—even where profits were made on at least some patients or services (Philadelphia v. Pennsylvania Hospital for the Insane, 1893; Pennsylvania Hospital v. the County of Delaware et al., 1895). Thus, the voluntary hospital, developing an increasingly eager market of private, paying patients, was given public sanction to expand its plant, services, equipment, and endowment—not necessarily primarily, or even partly, to serve the poor. The Massachusetts General Hospital had endowments or invested property with a reported worth of $1.9 million in 1890 (Burdett, 1893:719). The value of the property alone of "benevolent hospitals" (voluntary and government hospitals combined) in the United States had reached $306 million by 1910 (U.S. Department of Commerce, Bureau of the Census, 1913:22).

Within the hospital the tax-exemption cases ratified the development of profit centers, allowing for what we now call cross-subsidization: the development of a surplus in some areas (in this instance, services to private patients) in order to subsidize charity care, or add to the institution's wealth through construction, purchase, or endowments. That charity, in the sense of giving services free of charge to the poor, was not the overriding public purpose of the hospital at

the turn of the century is illustrated in contemporary tax-exemption cases. In one Illinois case, a hospital was upheld as tax-exempt where only 5 percent of its patients were charity patients; in another, 6 percent were county patients, but reimbursement of $7.00 a week was paid. Even the Chicago Polyclinic—where the great majority of the patients paid for at least part of their care, and where one out of seven patients paid rates at more than cost—was held by the courts to be tax-exempt: on the grounds that no one made a profit, that the hospital was open to all patients (although the nursing school was segregated), and that it received emergency patients from the police (Sisters of Third Order of St. Francis v. Board of Review of Peoria County, 1907; Cook County Board of Review v. Provident Hospital and Training School Association, 1908; Cook County Board of Review v. The Chicago Polyclinic, 1908; German Hospital of Chicago v. Board of Review of Cook County, 1908). A pattern of mutual dependency had developed between voluntary hospitals and government agencies, on the assumption that public needs were thereby met.

## Government and Hospitals at the Beginning of the Century

Given this history, it was not surprising that a national census of benevolent institutions (i.e., voluntary and governmental institutions) published in 1905 concluded that the hospital for the sick was becoming "more and more a public undertaking" (U. S. Department of Commerce, Bureau of the Census, 1905:16–17). Over one million persons were admitted to government and not-for-profit general and special hospitals in 1904. Only one-fourth (24.7 percent) of these were treated in government-owned, chiefly local government hospitals, the remainder in "ecclesiastical" (30.2 percent) and other not-for-profit institutions (45.1 percent). Outside of profit-making hospitals and almshouses, for which information is not available, the great majority of general hospital care was being given in what we now call voluntary hospitals, which were assumed to serve public ends.

Taking the hospital system as a whole, subsidies to voluntary hospitals were a relatively small part of the total picture, with total grants of $2.3 million in 1903, representing 8 percent of the total costs of

TABLE 1
Annual Subsidies to Private and Ecclesiastical Hospitals from Government Funds, Ranked by Percent of the Cost of Maintenance of All Benevolent Hospitals, by Selected States, 1903

| States | Annual Subsidies from Government Funds | Percent of Cost of Maintenance of All Hospitals in the State | Number Admitted during 1904 per 100,000 Population |
|---|---|---|---|
| District of Columbia | $ 97,286 | 33.4 | 5,223 |
| North Carolina | 23,233 | 24.5 | 205 |
| Georgia | 33,900 | 22.3 | 309 |
| Connecticut | 93,349 | 20.1 | 1,817 |
| Pennsylvania | 725,554 | 20.0 | 1,843 |
| Alabama | 13,600 | 17.8 | 235 |
| Maryland | 126,002 | 17.5 | 1,879 |
| Rhode Island | 38,382 | 16.4 | 2,000 |
| Maine | 33,000 | 14.3 | 886 |
| New Jersey | 99,449 | 12.4 | 1,859 |
| Arizona | 11,171 | 12.4 | 1,661 |
| Mississippi | 3,430 | 10.8 | 143 |
| New York | 712,129 | 10.6 | 3,166 |
| Vermont | 5,294 | 7.7 | 859 |
| New Hampshire | 8,641 | 7.4 | 890 |
| Virginia | 9,575 | 5.5 | 720 |
| All other states | 242,341 | — | — |
| Total | $2,276,336 | 8.1 | 1,309 |

Table includes all states where 5% or more of the cost of hospitals were met by government funds in 1903.

*Source:* U. S. Bureau of the Census. 1905. *Benevolent Institutions 1904*, 34–35. Washington, D.C.: U.S. Government Printing Office.

hospital care in the United States (Table 1). However, as the table shows there were large variations. In four states (and the District of Columbia) government subsidies to private institutions represented 20 percent or more of the *total* cost of hospitals in the state. In contrast, in states such as Illinois, Michigan, Ohio, and Massachusetts, such aid represented less than 5 percent of the collective income of hospitals in each state. And in California, Idaho, North Dakota, Oklahoma, Tennessee, and Utah, no government aid to hospitals was reported. While these figures should be interpreted with caution, if only because of the relatively poor state of cost-accounting in hospitals

in 1903, the figures suggest a patchwork pattern of aid, more predominant in the northeastern states, and expressing decisions taken, consciously or unconsciously, about appropriate governmental and private activities.

The census takers suggested that, in some states, subsidy of voluntary hospitals was a matter of policy, an alternative to the provision of government hospitals. But the figures do not bear this out directly. Delaware, for example, with no government-owned hospitals, reported government subsidies to not-for-profit hospitals of only 1.8 percent of the total cost of hospital maintenance in 1903. In Idaho and Oklahoma, there were neither government hospitals nor government aid to voluntary hospitals. It can equally well be argued that the test was not a choice of where tax money should be spent but whether it should be spent at all, irrespective of the ownership versus subsidy question. The responsive and residual roles of government meant that there was little aggressive policy-making by government agencies, although the District of Columbia may be an exception. The figures reported in 1903 are probably the result not of deliberate principle or choice but of the relative availability of tax funds, the ability of voluntary hospitals, profit-making hospitals, and almshouses to meet apparent needs without additional tax expenses, the role of lobbies and vested interests, the inertia of policy-making, and an accretion of tradition.

Some clear observations can, however, be drawn from this early census. First is the relatively important role of government funding as a whole by the early twentieth century. Besides the $2.3 million in subsidy to private hospitals, almost $6.2 million was spent on government-owned hospitals in 1903. Together these government funds represented almost 30 percent of the total hospital income (Table 2). While the largest single income category was paying patients (full pay or part pay), government funds as a whole were more important than contributions and endowments. Indeed, "other income," including endowments, contributions, and loans, represented little more than one-fourth of total hospital income.

Second, the western states tended to rely more heavily on income from private patients than the eastern states. Indeed, in Utah and Oregon, income from private patients exceeded the reported total costs of hospital maintenance in 1903. In California, income from paying patients represented 56 percent of the total cost of hospital

TABLE 2
Sources of Income of 1,493 General and Special Hospitals in the United States, 1903

| Source of Income | Amount | Percent |
|---|---|---|
| Private patients | 12,181,484 | 43.2 |
| Government funds[1] | 8,438,881 | 29.9 |
| Hospitals owned by federal, state, or local government | (6,162,545) | (21.9) |
| Appropriations to private hospitals | (2,276,336) | ( 8.0) |
| Other income | 7,580,504 | 26.9 |
| Total reported income | $28,200,869 | 100.0% |

[1] Government hospitals reported $6,606,085 total costs in 1903, but received $443,540 from pay patients, a net cost of $6,162,545. Appropriations to ecclesiastical hospitals totalled $571,344 and to other private hospitals, $1,704,992.

Figures are for a total of 1,493 hospitals in the United States characterized as benevolent institutions by the U.S. Census Bureau, including 220 government hospitals, 831 private hospitals, and 442 ecclesiastical hospitals. Profit-making hospitals are not included, nor are psychiatric hospitals, nor medical departments of almshouses.

*Source:* U. S. Bureau of the Census. 1905. *Benevolent Institutions 1904*, table XI, 23. Washington, D.C.: U.S. Government Printing Office.

care, a much larger proportion than in New York (29 percent) or Pennsylvania (29 percent). California reported three federal hospitals and eleven city/county hospitals, including those in San Francisco and Los Angeles. However, well over 80 percent of the income of its voluntary hospitals came from paying patients in 1903. There was, thus, more of a distinction in type of income between hospitals under governmental and not-for-profit ownership in California (and other western states) than in states like New York and Pennsylvania with long histories of mixed governmental and private hospital development. However, in all states the idea of hospitals as public institutions remained, i.e., serving the public, not liable for injuries, and tax exempt.

A third observation (Table 1) is the dominant position of New York and Pennsylvania as states with the largest commitment of tax money to voluntary hospitals. In terms of dollar amounts, Pennsylvania and New York spent many times the amount of tax funds on voluntary hospitals as other states. Since their methods of appropriation were quite different, the two states provided a showcase, and

to some a cautionary tale, for discussions on the pros and cons of subsidizing hospitals, as distinct from the more general questions of public versus private charitable interests, which had surfaced well before the turn of the century (Fetter, 1901–1902; Warner, 1908; Fleisher, 1914; Dripps, 1915).

## *Pennsylvania and New York Compared*

Pennsylvania's system of state appropriations to individual hospitals had crept into being over many years. By 1910 the state subsidized voluntary hospitals to the tune of between $2 and $3 million a year. The appropriations were lump sum subsidies, not dependent directly on how many charity patients were treated. Hospitals interested in state funding first petitioned the State Board of Charities, the formal government advisory agency (and weaker forerunner of the Department of Welfare). The applicants then lobbied members of the legislature. In turn the legislature appropriated specified amounts to different institutions, each in a separate piece of legislation. Among legislators, log-rolling and back-scratching insured that most appropriations were successful. As a result, Pennsylvania's voluntary hospitals received one-third of their income from government sources in 1910 (Table 3). However, the lump sum or block grant nature of appropriations, earmarked individually to specific hospitals, appeared by the early 1900s to be corrupt and wasteful, and there was an increasing body of criticism.

New York City's system appeared, in contrast, a model of reform. New York City had a per diem reimbursement system for indigent patients, with standardized rates (the surgical treatment rate was $1.10 per day in 1909), developed from a report presented to the comptroller of the City of New York, Bird S. Coler, in 1899. Coler justified the new system on grounds of efficiency; but the change from block grants to reimbursement was also a change of purpose and of power (Rosner, 1980). Payment on the basis of actual work done for specified indigent persons underlined the central authority of the city to contract for and to reimburse as it saw fit—and to regulate and inspect hospitals. Municipal grants to voluntary hospitals were made under the strict supervision of the City Board of Estimates and Apportionment. These regulations included accounting systems, inspections, controls on which patients would count as proper charges against

TABLE 3
Income of 158 Private (Not-for-Profit) and Ecclesiastical Benevolent Hospitals and Sanatoria, Pennsylvania, 1910, by Source of Income

| Source of Income | Dollars | Percent |
|---|---|---|
| State, county or municipal appropriations[a] | 2,068,769 | 33.2 |
| Care of patients | 2,281,811 | 36.6 |
| Invested funds, donations, and other sources | 1,887,782 | 30.2 |
| Total reported income | 6,238,362 | 100.0 |

[a] Hospitals reporting income from state, county or municipal appropriations: 132.
Hospitals reporting no such income: 26
[b] Number of hospitals included: 158
Hospitals not included (income not reported): 9
Total private (not-for-profit) and ecclesiastical hospitals: 167

*Source:* U. S. Department of Commerce, Bureau of the Census. 1913. *Benevolent Institutions, 1910.* Washington, D.C.: U.S. Government Printing Office. Calculated from detailed tables, pp. 342–343. The table includes hospitals and sanatoria owned by ecclesiastical, missionary, or philanthropic organizations; by fraternal or beneficiary associations; by private corporations held under the auspices of some ecclesiastical or benevolent body; and by other private corporations where the hospital received patients for free or part-pay treatment, "of their own motion," on contract with public authorities, or in behalf of some benevolent organization, p. 46. Excluded are private psychiatric hospitals (notably Friends Hospital, Philadelphia) and an unknown number of small, private, profit-making hospitals, run as adjuncts to private medical practice. With the exception of psychiatric hospitals, probably all of what we would now call not-for-profit general and special hospitals are included.

the city with respect to reimbursement, and publication of amounts received in the hospitals' annual reports. New York City's subsidy system was thus accompanied by regulation to an extent unheard of in Pennsylvania.

New York's system was also considerable. In the government hospitals of New York in 1906, Bellevue and Allied Hospitals gave 354,000 days of hospital treatment at a cost of $613,000. The second branch of the municipal service, the hospitals of the Department of Public Charities, gave 898,000 days at a cost of $798,000. But in addition, almost 998,000 days of treatment were given at the city's expense in private hospitals at a cost to the city of $699,000 (less, per capita, on average than the cost of municipal institutions). For some of the largest voluntary hospitals in New York, as in Pennsylvania,

tax funds represented only a small proportion of their total budgets, but for some with large poverty populations, the city contribution was significant. The amounts received from tax funds by individual hospitals would also have been difficult, perhaps impossible, to replace by other income. In 1907, for example, Lincoln Hospital received over $62,000 from government funds, Mt. Sinai over $54,000, and Beth Israel Hospital over $27,000 (Goldwater, 1909: 267–273). Pennsylvania's system of hospital appropriations might have been sloppy and corrupt. Some might have called it a "crying evil." But New York City's hospitals, too, were firmly tied to the public trough. New York City's experience provided both an antidote for critics of Pennsylvania and an argument that government subsidy did not necessarily lead to graft and greed among public officials.

Whether government subsidy diminished or discouraged private contributions was, however, a matter of some debate. Critics claimed that private charities, by avoiding the stigma of poverty associated with governmental institutions, encouraged individuals to abandon their parents and their children to institutions; that indiscriminate government subsidy encouraged duplication and waste in voluntary institutions, making it impossible to unify or systematize services; and that the availability of tax funds forced charities to become lobbies with one-sided vested interests. Others believed quite simply that public services should be provided in government institutions. On the plus side of subsidy was the supposed advantage of economy. It might be less expensive to subsidize a voluntary hospital or other charity in a small town than to maintain one at public expense. The "spirit" of the private institution, including the supposed lack of the stigma of pauperism associated with government institutions, was also cited in favor of subsidies. Moreover, while the political process of subsidy might corrupt the charities, the private system was at least outside the political spoils system (Warner, 1908:399–419). From the voluntary hospital's view, perhaps the ideal position would be acceptance of government as the universal provider (and thus supporter), while leaving autonomy to the voluntary institution as the "moral family of dependents": in short, subsidy without regulation.

The New York City scheme suggested that voluntary hospitals were no longer to be regarded as autonomous, quasi-governmental agencies, but rather as sellers of services in the medical marketplace—with the

government as purchaser of care for the indigent. Yet the question of whether government aid to private hospitals was justifiable recognition of these institutions as quasi-public institutions, or whether the money was to be seen as direct purchase of services for identifiable poor persons, represented potential differences in administrative relationships between government and private agencies, as well as differences in principle. It was one thing to say that tax appropriations of any sort are liable to abuse, and therefore must be carefully regulated. It was another to assert that government was only involved because it was, in effect, purchasing medical care for its own convenience in the private sector—and that hospitals were only involved in public services because they happened to provide such care.

## Block Grants versus Reimbursement

Goldwater's study of 1909 noted government appropriations to private hospitals in 35 states and the District of Columbia; Canadian government agencies made similar provision in the provinces of Alberta, Manitoba, New Brunswick, Quebec, Nova Scotia, and Ontario. As superintendent of the Mount Sinai Hospital, New York, a major beneficiary of city aid, Goldwater could not be expected to recommend abolishing government aid on principle, but he did favor, with others, a more rational system of tax support. He represented a general reformist concern that abuses in the system be removed, and that regulation be developed to encourage efficiency and the need to work towards a "useful and desirable form of social cooperation" between government and voluntary agencies (Goldwater, 1909:243). Any concerns about public versus private interests were being overtaken subtly by the more general banner of "cooperation."

Even in a state like Massachusetts, with its general prohibition on direct state appropriations to private hospitals, government cooperation with private institutions could be found: in the tax exemption granted by the state to charitable institutions, under a state law committing cities and towns to pay voluntary hospitals for public care, and in state appropriations to certain special institutions. Although often in relatively small amounts, tax funds were trickling into the voluntary hospitals, typically via local government support

for a limited number of "free patients." The idea was growing that hospitals ought to be paid for charity care and that the appropriate source of this payment was government.

If hospitals were to be subsidized because their functions were public, simple block grants had some advantages. The hospitals could be seen, in effect, as acting as government's delegates or agents, and be given a budget to fulfill such purposes. But the block grant system, symbolized by the large state system in Pennsylvania, had produced a dilemma. The hospitals, scrambling for additional appropriations, were behaving competitively rather than cooperatively, and the legislature was loath to sanction any overall plan for block grant distribution (Stevens, 1982). The Pennsylvania system was intensely political. It had opened grants-in-aid to log-rolling among legislators, as they rushed to support each other's votes, and to the use of political influence by different charitable institutions so that their own appropriations would be favorably considered. As a result, Pennsylvania was criticized as a state which fostered the development of unnecessary institutions, was detrimental to private charitable work, had made the philanthropies of the state part of the political system, and was "unscientific" (Fleisher, 1914:111–112). New York City's system, on the other hand, ran the risk of being overregulated and bureaucratic.

Where amounts were relatively small, the lump sum system was clearly more efficient. Thus, the city of Birmingham, Alabama, appropriated $100 a month in 1909 for the support of five beds in St. Vincent's Hospital; Jacksonville, Florida, appropriated $5,000 per year for the support of dependent patients occupying beds in St. Luke's Hospital; Macon, Georgia, provided $6,000 to the Macon Hospital for poor city patients sent to the hospital by public officials; Wichita, Kansas, paid $600 a year to the Wichita Hospital and the St. Francis Hospital; Lexington, Kentucky, and Terre Haute and LaFayette, Indiana, also paid grants for the indigent to selected hospitals (Goldwater, 1909). In these cases the grants represented general expectations of service to the indigent or accident victims rather than a specific amount of care. The hospital held itself in readiness as a charitable institution.

Yet the reimbursement system was beginning to demonstrate its appeal, even before 1910. Other cities besides New York had developed per diem reimbursement systems. Detroit, for example, paid $6.00 per week for the care of city patients receiving general medical and

surgical care. (Higher rates were available for the acute care of delirium tremens and mental disease.) Portland, Oregon, paid for its poor at the rate of $1.00 per patient per day for city patients cared for in local private hospitals. Houston, Texas, contracted with the Sisters of Mercy to pay $0.60 per day for each patient cared for in St. Joseph's Infirmary.

Whether tax funds should be given to privately managed charities at all could be described as the "sore thumb of public administrative policy" (Fleisher, 1914:110). A major advantage of discussing a per diem reimbursement system was that it moved debate about government aid away from such uncomfortable questions of general principle to contractual and administrative considerations. It was one thing to discuss, in theory, the advantage of voluntary philanthropy over government institutions in terms of the supposed superiority of voluntary effort in invention and initiative, its ability to lavish unstinted care on particular patients, and in its superior moral influence. It was entirely another question to assume that government agencies had a duty to pay for at least minimal care for the poor in private institutions and merely talk about how this should be accomplished. A per diem reimbursement system had the apparent advantage of equity, in that each institution might receive the same payment for each individual, and of accountability, since standard procedures would be worked out. In addition, abuse and fraud by patients might be more readily avoided through stringent public investigations as to who was eligible for medical assistance. Such issues were under discussion well before the 1920s.

Some advantages in a reimbursement system could be seen for hospitals. In Pennsylvania, for example, the state grants system could have been used to force hospitals to close, to merge, or to change. Legislative hearings in Pennsylvania between 1910 and 1912, and sweeping proposals from the Municipal Charities Association of Philadelphia in 1913, suggested that such thoughts were by no means unknown. One speaker at hearings in Philadelphia in 1910—the year the Flexner Report recommended major consolidation of medical schools—suggested that the five medical school hospitals in Philadelphia should be merged into one. Consolidation of hospitals was a recurring theme of the hearings, for several thousand hospital beds were lying empty in the State and there was much criticism of "overbedding" (Pennsylvania Joint Legislative Committee, 1910). The

Municipal Charities Association suggested a planned system for hospitals in Philadelphia under which each hospital would act as the receiving hospital for a 50,000 population area. The system would be enforced where necessary through the withholding of state grants; hospitals would be controlled as a "proper governmental function" (Philadelphia Committee on Municipal Charities, 1913:83–84). One-fourth of the income of Philadelphia's hospitals was then flowing from the state. Government could thus have taken an effective proprietary interest and voluntary hospitals become quasi-governmental. While there was little danger of such radical change in Pennsylvania (or elsewhere), a per diem reimbursement system reduced the potential threat to hospitals of government aid being used as a consolidated weapon for reform by redefining the relationship between government and hospitals from one of "principal" and "agent" to one of "buyer" and "seller."

At a more fundamental level, a shift in payment systems, coupled with the careful decisions over who was and who was not a government ward, i.e., a medical assistance recipient, changed the notion of charity in the hospitals themselves. If a "free" patient could be charged to the state or (more usually outside of Pennsylvania) to local government, the patient was no longer "free" as far as the hospital was concerned. If the state or local government reimbursed on a per diem basis, what rationale was to be given for a particular per diem rate? If "free care" were regarded as something that government should reimburse, why should hospitals offer it without such reimbursement? Ironically, by making the government system more efficient through a per diem reimbursement system, a wedge was to be driven between government and nongovernmental agencies. Block grants had assumed, at least, that voluntary hospitals were socially responsible and administratively capable.

## Re-Definition of "Public-ness"

The growing expectation by hospitals that funding ought to be available for the hospital care (but not necessarily for the medical bills) of poverty patients modified the voluntary ideal. The community hospital of the 1920s had ceased, in many respects, to be a charity and had become much more like a business. Hospital incomes rose

rapidly between 1910 and the early 1920s under the impact of increasing specialization, expansion of services and equipment, and the lure of the market for private patients. Neither tax appropriations nor donations could keep up with the continuing increases in the cost of care. Baltimore was but one city where, despite increases in state and city appropriations, all the private hospitals which had provided a signficant volume of free care in 1912–1913 had reduced the number of free days by 1929–1930 (Kingsdale, 1981:368). As the percentage of private patients rose rapidly in hospitals everywhere in the United States, the poor became the residual beneficiaries of care in voluntary hospitals. Instead of being seen as the primary purposes of charities, the poor increasingly became a nuisance. Students of the hospital scene no longer described voluntary hospitals as "public" because they gave away care to the needy, but because of the source of their capital investment drawn, as it was, from a combination of "public" sources, such as donations, gifts, bequests, and taxation (Rorem, 1982). Concurrently, in the 1930s, "public medical services" tended to be defined as those provided under government auspices (Davis, 1937).

Workmen's compensation plans and contributary hospital funds added to the notion of reimbursement for hospital care. The fact that New York City's payments to voluntary hospitals for public charges represented only a fraction of the total costs of such patients was regarded by the hospitals as a serious problem, even in 1910. Workmen's compensation began in 1908 for civil employees of the federal government; by 1920 all but six states had some such legislation. While these laws had relatively little impact on hospital income, their existence, coupled with the pervasive discussions of state health insurance between 1915 and 1920, buttressed the idea that the care of unexpected, accidental sickness ought to be funded by an agency other than the hospital. Before 1900 hospitals could argue, plausibly, that they were public service institutions and thus entitled to some level of subsidy or aid. After 1900, increasingly, the more persuasive economic argument was that hospitals were private community agencies with which government would contract for services. The shift was, however, gradual, and for years there continued to be debates about the proper relationships between government and private agencies.

A national census of hospitals and dispensaries conducted in 1923 found that half (49.7 percent) the total patient days reported for

general hospitals in the United States were attributable to paying patients; one-fifth (19.3 percent) to part-paying patients; and one-third (31.0 percent) to "free" patients (U.S. Department of Commerce, Bureau of the Census, 1925:3). Increasingly, however, the notion of a "free" patient meant that the service to the individual was provided without charge to him, not that, necessarily, the hospital was expected to pay for such care out of its own endowments or collections.

However, voluntary hospitals continued to be the focus for charitable aid by *physicians,* who were expected to render services free to those who could not afford to pay. The odd situation was reached whereby a local or state government would reimburse a hospital for care given to indigent patients only where the physician did not charge a fee. Where patients were charged a fee for their hospital care, the hospital also usually had first call over the physician on collection. The voluntary hospital thus remained the locus of public service by physicians, even as the institution itself became more business-minded. The notion of the "public" hospital was thus becoming more complex.

## *The Sectarian Hospital as a Special Case*

Sectarian institutions provide a good illustration of both the nature and the slowness of the shifts in perception and the continuing ambiguity in the term "public" institution. Government aid to sectarian institutions—whether these were schools, homes or hospitals—had been a heated issue in the years immediately following the Civil War, but even then the meaning of "sectarian" was often not clear. In Pennsylvania, for example, the state constitution of 1873 denied aid to all sectarian institutions; but hospitals could argue, successfully, that since they were open to the public and were not engaged in religious instruction, they were public institutions rather than institutions with a limited sectarian intent and, thus, were entitled to state aid. State aid was, indeed, given on this basis. By 1919, by which time the Pennsylvania system had acquired the stature of a venerable, immutable institution, 66 hospitals which could be termed denominational or sectarian were receiving aid from the state. However, the fuzziness of both the terms "sectarian" and "public" was bound eventually to be called into question.

Following specific complaints, the Pennsylvania courts finally ruled, in 1921, that institutions with religious affiliations were, indeed,

sectarian or denominational and thus *not* eligible for state aid—even where local boards which were largely independent of religious organizations had been established to conduct the hospital and even though the hospital was open to all alike, without distinction to creed, color, or race, and was thus "public" in terms of accessibility to patients (Collins v. Kephart et al., 1921). The legal test was whether the hospital in some way promoted the interests of a sect, whether this was the Institution of Protestant Deaconesses (Passavant Hospital, Pittsburgh), Duquesne University (renamed from Pittsburgh Catholic College of the Holy Ghost in 1911), the Jewish Hospital of Philadelphia, St. Timothy's Hospital, or the Sisters of Mercy of Crawford and Erie Counties (Dubois Hospital), all 5 of which were involved in related legal cases. In effect, the courts ruled that these were not "public" (or quasi-public) but "private" institutions in a limited sense. Thus the definitions of "public" and "private" became further confused.

Illustrative of the ambiguities was the resurrection of the sectarian issue in Pennsylvania only two years later, in 1923, when the state shifted its method of funding hospitals from a negotiated lump-sum grant to an amount based on the number of days of free care given. A reimbursement system suggested that the state was no longer involved in grants-in-aid to institutions because they had a public role, but in a new system of purchasing care. However, if the state was to purchase services, it seemed reasonable to suggest that it should be free to purchase that service in *any* hospital, sectarian or nonsectarian (Hunt, 1923:105).

The Pennsylvania courts were to disagree: "The supervision of the distribution of the state's money to the hospitals selected, and the manner of ascertaining the amount due, effect a change of method only; there is no change in the character of payment; it is still designed to go to a sectarian institution for charitable purposes." Paying for services for the poor in voluntary hospitals was not, in short, to be compared—at least not yet—with buying a bag of flour or any other commodity from a store. State purchase arrangements were still aid and thus "an act of charity moving from the state, though it may be called 'hospital service,' treatment and maintenance, so many pills or so many meals" (Collins v. Martin et al., 1927:389, 402). Thus the prohibition against aid to sectarian hospitals remained—until the commodity approach gained general acceptance. State reimbursement

of sectarian hospitals was reinstituted in Pennsylvania in the 1950s, by which time public purchase of care was seen more clearly as a method of doing business, as buying or contracting, rather than of delegating public functions to nongovernmental agencies.

## *Charity as a Government Responsibility*

In the long run, the shift in view from charity to purchase was an inevitable accompaniment of a per diem system of government aid. Reimbursement systems linked aid directly to the recipients and the number of services given, involving government agencies in questions of eligibility and utilization, while block grants had allowed hospitals flexibility in these areas and the privilege of charging the state their deficits, including days unpaid by private patients or otherwise uncollected. Per diem methods encouraged hospitals to distinguish more sharply between private patients (private accommodations and private physicians), semiprivate patients (patients in small wards, often with private physicians) and ward patients (whose physician services were usually provided free), and to charge costs at least, wherever possible, if not to make a profit on all those who could pay. The Pennsylvania Department of Public Welfare was not alone in encouraging hospitals in the 1920s to increase their charges to all who could pay. Between 1921 and 1924, the total income of 125 hospitals in Pennsylvania rose by over 16 percent; state appropriations dropped by 30 percent; but earnings from patients rose by 21 percent, endowment interest and income rose by 20 percent, and local grants and gifts by 176 percent (Frankel, 1925:9). Thus government itself fostered the changing image of hospitals from agents of the state to independent contractors.

Yet despite the talk of economic self-sufficiency in the mid-1920s, the burden of the cost of care for the poor was evident, particularly in major cities. In Philadelphia and Pittsburgh, one-third of all hospital days were approved for reimbursement by the state Department of Welfare in 1924; and even in cities of under 25,000 population in Pennsylvania, almost one-fourth of all hospital days were attributable to "charity" patients (Frankel, 1925:69). National figures for 1922 show that 18 percent of the combined budgets of governmental and private general hospitals came from tax funds, compared with 65 percent from private patients, and the remainder from philanthropy and other sources (Table 4). Despite the rhetoric of the 1920s, and

TABLE 4
Hospital Income by Sources, Selected Years, 1903–1958 (In Millions of Dollars)

| Source | Percentage | | | | Total Revenue |
|---|---|---|---|---|---|
| | Private Payment | Tax Funds | Philanthropy and Other | Total | |
| 1903 (Benevolent hospitals)[a] | 43 | 30 | 27 | 100 | 28 |
| 1922 (All hospitals)[b] | 59 | 23 | 18 | 100 | 259 |
| (General hospitals)[b] | 65 | 18 | 17 | 100 | 199 |
| 1935 (All hospitals)[c] | 43 | 47 | 9 | 100 | 707 |
| (Short-term, non-federal hospitals)[d] | 62 | 24 | 14 | 100 | 430 |
| 1950 ( " " " " )[d] | 74 | 20 | 6 | 100 | 2,220 |
| 1958 ( " " " " )[d] | 81 | 15 | 4 | 100 | 4,782 |

[a] See Table 2.
[b] U.S. Department of Commerce, Bureau of the Census. 1925. *Hospitals and Dispensaries: 1923*, 18–19. Washington, D.C.: U.S. Government Printing Office. Percentage figures are calculated from the returns of 3,470 hospitals (74 percent response rate for all hospitals) and 2,570 general hospitals (74 percent). Total income figures are for 3,524 and 2,627 hospitals, respectively.
[c] Pennell, E., Mountin, J. W., and Pearson, K. 1939. *Business Census of Hospitals*. Supplement No. 154 to *Public Health Reports*, table 9, 22. Washington, D.C.: U.S. Government Printing Office.
[d] Klarman, H. E. 1962. The Role of Philanthropy in Hospitals. *American Journal of Public Health* 52: 1228. The 1935 data are drawn from E. Pennell, J. W. Mountin, and K. Pearson, *Business Census of Hospitals*. (Supplement No. 154 to Public Health Reports, 1939).

despite efforts by hospitals to reduce the number of free days, commitment of tax funds remained embedded, if only as a residual form of payment. State, county, and city appropriations to 2,570 general hospitals reporting in 1922 (three-fourths of all general hospitals) exceeded $34.5 million.[1] There was, indeed, an increased expectation that government, local government in particular, would pay for the poor, either in government hospitals or by reimbursing voluntary hospitals.

At the same time the relative role of philanthropy had declined. The 1903 and 1922 figures are not strictly comparable; nevertheless, it is instructive to note that the census of "benevolent hospitals"[2] in 1903 found that philanthropy represented 27 percent of hospital income for maintenance (Table 2). In 1922, philanthropy represented 17 percent of the income of general hospitals, more broadly defined. The size of the hospital industry had grown rapidly from an estimated $28 million in 1903 (for benevolent hospitals only) to almost $199 million in 1922 (for general hospitals). This increase predominantly represented an increasing number of paying patients. Hospitals were becoming financially more independent in the sense of not having to rely to a great extent on charitable or tax contributions, and more "private" in the sense of gaining most of their income from the sale of services. But tax-exemption and liability-exemption provisions of "public charities" remained.

By the advent of the depression, hospitals were thus receiving conflicting messages. Perhaps it is more accurate to say that voluntary hospitals could present themselves, as circumstances arose, in guises which were essentially contradictory: that is, as institutions which were, at one and the same time, both public and private, but which were no longer to be regarded as government's agents.

## *The Voluntary Hospital as a Private Institution*

On some occasions the term "public" hospital continued to be appealing. In 1930 a report of an American Hospital Association com-

[1] Unfortunately, the 1922–1923 census, unlike the earlier censuses, only provides summary data. It is not possible to limit observations to not-for-profit hospitals.

[2] Government and not-for-profit hospitals. Excludes proprietary hospitals, psychiatric hospitals, and hospitals which were part of almshouses or other institutions.

mittee objected to the alleged misuse of the designation "private hospital" to cover both privately owned (i.e., proprietary) hospitals and hospitals with general endowment. The term "public hospital" was also, it was claimed, misunderstood when it was limited in meaning to government hospitals. The committee stated firmly that a "general hospital with endowments is a public institution, if it is open to the medical profession and the public" (Babcock, 1930:3). This report suggested classifying nongovernmental hospitals into one class of private (i.e., for-profit) hospitals and another class of general, public, incorporated, or endowed institutions (i.e., voluntary hospitals).

On other occasions the message was more clearly intended to differentiate the voluntary hospitals from government agencies, particularly where reimbursement was at issue. Studies for the Committee on the Costs of Medical Care (1927–1933) reported government subsidy of voluntary health care institutions as particulary widespread in medium-sized cities such as Duluth, Phoenix, and Sioux City (Falk et al., 1933:495). Newark, New Jersey, had voted to reimburse local hospitals at a rate of $4.00 per day for services to charity patients, upon approval of the Municipal Department of Welfare. Indeed, in 1932, the American Hospital Association recommended at its annual convention that municipal subsidies to voluntary hospitals be encouraged as a permanent source of financial support. Such developments could be conveniently seen as official recognition of the value of voluntary hospitals as private entities.

The advent of Blue Cross schemes during the 1930s reinforced both the idea of the "privateness" of hospitals and the idea of third-party reimbursement: four to six million persons were enrolled in such plans by 1940 (Anderson, 1975:41, 45). The plans reinforced the spirit of voluntarism which had been bruited since at least the early 1920s—of self-help, community orientation, and nonprofit organization. With the increasing acceptance of reimbursement for the care of middle-class and indigent patients, voluntary hospitals could be presented as private institutions which had contractual relations with government—as they did with Blue Cross plans—rather than as quasi-governmental institutions. The terms public and private were, therefore, becoming more distinct, although the process was by no means completed in the 1930s.

With new perceptions, new terms became accepted. The terms "voluntary hospital" and "community hospital" were widely used in the 1930s, subtly evoking the notions in the 1920s of distance from

government in terms of ownership (i.e., they were not "compulsory"), and of meeting local needs. Fears that voluntary hospitals might not survive the depression fueled interest in hospital insurance and in defining the role of voluntary hospitals as distinct from, and superior to, government institutions, and thus worthy of special support. Some would even have attempted to bring back the old unquestioned lump-sum subsidy system, with government "making up the deficits" (American Foundation, 1937:1273). Nevertheless, the voluntary hospital survived, shored up after World War II by government aid for construction (Hill-Burton), by rapidly expanding private hospital insurance, and by expanded government aid for the poor through per diem arrangements. Federally assisted vendor payments became available after 1950, extended by the Kerr-Mills Act (1960) and, subsequently, Medicare and Medicaid (1965).

But this more recent history has to be seen as a continuity of themes and processes inherited from the 1920s. As the older, nineteenth-century spirit of delegatory charity (from government to private charities) was overtaken by a stronger stance for government in the progressive years, so this in turn was replaced by the more market-oriented environment of the 1920s. The disasters of the depression provided another set of actors and ideas, but the general directions were inherited. Government aid to hospitals was already, in the 1920s, an important residual element of hospital financing; perhaps a fourth of the income of American hospitals came from tax funds in this period (Table 4). Tax funds to voluntary hospitals to pay for the indigent were regarded by hospitals of the late 1920s as a reasonable expectation. The depression may have consolidated these expectations, but it did not establish radical new directions.

## History, Memory, and Myth

If, indeed, there was considerable (if scattered) government involvement in hospital care before the depression, why do contradictory impressions now exist? Tunnel vision is one possible explanation. Federal programs have been so important to hospitals since 1965 that the word "government" has often been used in the limited sense of federal government. In turn, state and local government roles outside of federal programs have sometimes been dismissed as relatively trivial.

Only in the 1980s, with serious discussions of state and local government responsibilities and other aspects of the "New Federalism," does government as a word reassume its full meaning. Nevertheless, this explanation seems contrived and incomplete.

The simplest response to the question is lack of information. Studies of the role of government, both in terms of developing government hospitals and with respect to government aid to voluntary hospitals, are still largely nonexistent—with some notable exceptions (e.g., Stern, 1946; Rosner, 1982). Reliable or comparable national, historical data sources for hospitals do not exist. Studies of hospital income and expenditures usually start with 1935, when Elliott H. Pennell, Joseph W. Mountin, and Kay Pearson conducted a "business census of hospitals" for the U. S. Public Health Service (see Table 4). Statistics can be powerful persuaders, and this census may well suggest 1935 as a natural baseline for policy making. If comparable figures went back to 1922, or 1903, our perspectives on historical trends in hospital financing might indeed be subtly changed. All of which is to say that perceptions are imprisoned by limited data.

But this cannot be the entire explanation. The relatively heavy commitment of tax funds to voluntary hospitals in Pennsylvania and New York City was well publicized in the contemporary hospital and social service literature. Direct expenditures on hospitals by local governments were known at the time to have increased steadily, relative to the population, between 1902 and 1927. More likely, the rhetoric of voluntarism that distinguished the 1920s spilled over into perceptions of hospitals as the embodiment of "privateness," assuming, in President Hoover's phrase, the "probity and devotion in service which no government can ever attain" (Abbott, 1940:660). From here it is easy to assume that government had never been in the picture at all. Hence, myth conforms to the rhetoric of the day.

## *The Ahistorical Appeal*

There is undoubtedly a reluctance, identified among historians of other sectors of the economy, to accept a large role for government in the history of the United States. Hartz, for example, has described the emergence of negative views towards the role of government in nineteenth-century business development in Pennsylvania as a pragmatic creation of the 1840s and later—after a long period of mixed public

and private economic development, including the building of canals, railroads, and banking systems. Antigovernment theory rationalized the appearance and strengthening of corporate enterprise. It "mobilized democratic individualism in behalf of the corporation, it contrasted corporate operators favorably with politicians, and it cherished the judiciary as a barrier against legislative power" (Hartz, 1948:316). In short, what had been a legitimate role for the state in the past had become a historical encumbrance to be jettisoned.

Whitehead, describing the development of Harvard, Columbia, Dartmouth, and Yale as quasi-public institutions until the late nineteenth century—when the "private" university was largely invented—concludes that Americans try to free themselves from their own past by developing interpretations of history with which to defy that same history—and, thus, untrammeled, move ahead. "Once the visible legal connection between college and state disappeared, some men announced that the colleges and states had never been allied at all . . ." (Whitehead, 1973:192, 240). Such arguments suggest a vigorous utility for historical myths and underline the observation that myths are obviously more than misunderstandings of fact, based on insufficient information. They also act as wish-fulfillment and as functional, crafted self-portrayals of institutions and their ideologies, adapted to particular times and circumstances. The charismatic politician builds on the emotions and wishes inherent in myths. Indeed, a commonly held language—signifying apparently common beliefs—in "free enterprise," a "right to health," "competition" or whatever—is an important element in American coalition-building. Since a commonly accepted history may also serve the interests of consensus builders, it follows that views of history may be periodically readjusted to meet contemporary perspectives and/or needs.

The meaning of words, of course, changes too—like names for children, popular in one generation, old-fashioned in another, only to be rediscovered later. Once-threatening "un-American" words, such as rationing, take on a new acceptability. Other traditionally "good" words, such as "competition" or "quality," acquire new meanings. In the history of voluntary hospitals the mutations of the phrase "public" hospital attest to the usefulness of this process to the changing scene. Voluntary hospitals have been described as public institutions at various times for many different reasons: because they were open to all; because they were not profit-making; because they were charities; because they were not liable for negligence; because they were open

to scrutiny; because they were tax exempt; because they were essential public utilities; because they relied on the general public for capital investment. Each time develops its own meanings. Present times define the phrase public hospital as virtually synonymous with a government-owned institution, thus pushing voluntary hospitals firmly into the private sector. But, of course, this meaning may change again. There is charm, as well as considerable political utility, in the lack of a single meaning. With words like public (or, for that matter, private, voluntary, or community) subject to a potentially wide range of meaning, consensus can be built and change take place under the umbrella of apparent semantic consistency.

Myths about history can also be unconsciously reinforced through accepting a restricted view of events as if it represented wider conditions. Two recent articles in leading law journals on nonprofit enterprise provide a good example of this phenomenon (Hansmann, 1980; Clark, 1980). Both assume that the term "nonprofit" describes an institution's tax status, and that alone—thus suggesting, by omission, that tax exemption has nothing to do with public duties or expectations. Hansmann, for example, sees private hospitals as maintaining nonprofit tax status in part as a matter of inertia and tradition, and tax exemption as giving a potentially important competitive edge over investor-owned institutions. Clark concludes that the "legal favoritism for the non-profit form is based not on sound reasoning and hard data but on intuition." Such arguments reinforce prevailing dicta that not-for-profit hospitals are part of a private sector ranged with profit-making organizations as an alternative to, or distinct from, government intervention; and that the differences between profit and not-for-profit organizations are technical rather than substantive, matters of fiscal management rather than any difference in the purposes of the organization. Such views do not take into account the social assumptions—the values—behind not-for-profit institutions as they have developed: that is, that voluntary hospitals have strong roots as public institutions, and, indeed, that the early tax-exemption cases assumed that hospitals fulfilled public roles.

## *Voluntary Hospitals as Adaptive Institutions*

Yet all of these phenomena have only a short-term utility. Acceptance of the meanings and mythology of the present may channel discussion within too narrow a range of possibilities and inhibit thinking about

long-term causes and effects. In the immediate future, voluntary hospitals of the 1980s may have more to gain from alliances with investor-owned hospitals than with asserting quasi-public functions. But what of a longer-term perspective? History has shown that the ambiguous status of voluntary hospitals as simultaneously both (and neither) public and private institutions has been useful and selectively advantageous in the past as financial and ideological conditions have changed. Moreover, there is a danger of a self-fulfilling prophecy in over-eager identification with the private sector. It may well be that the more "private" the institutional posture, the greater the chances in the future of private sector-government confrontations. Will we continue to have three different types of organizational form in medicine: investor-owned, not-for-profit, and government institutions? Or shall we be content with two: a basic structural dichotomy between a "public" (governmental) and a "private" sector? Although for very different reasons, the idea of the voluntary hospital is threatened in the 1980s, just as it was in the 1930s. It seems sensible to keep all options open.

In the past, voluntary hospitals have, indeed, shown remarkable survival and adaptive skills. The lack of any overarching philosophy for care of persons deemed unable to pay—and the resulting ambiguity as to the appropriate role for government intervention—has provided some political advantages for hospitals over the years. As medical care has been transformed from charitable relief to the purchase of a commodity, the voluntary hospitals have been able to present themselves, as political and economic exigencies arose, as private or public charities, as public utilities, or as businesses. How long this willingness and ability to take on public and private roles continues, in an industry whose rapid expansion appears to have stabilized, if not ended, may depend on a continued acceptance of change and uncertainty and a propensity for redefinition. In the long term it may be advantageous for voluntary hospitals to differentiate themselves from investor-owned institutions as political and economic conditions change. Competition for limited Medicare and Medicaid reimbursements may encourage the not-for-profits of the future to rediscover or invent the image of the voluntary hospital as an altruistic, "public" institution, distinguished in kind from profit making. We may well see calls for block grants and other forms of government aid to replace present reimbursement systems (Sigmond, 1982). Thus, the swings of history may continue.

For the present, discussions of competition, the marketplace, and the supposed recency of government funding should be recognized for what they are—rhetorical flourishes—rather than accepted as historically based. Politicians and lobbyists have, necessarily, a short-range vision and a tendency to overestimate the importance of immediate events. Versions of history for consensus-building and other political purposes have a vigor and utility as myths which may bear scant resemblance to the historical record. Yet the complexity, inertia, and sheer size of the hospital industry demand longer-range considerations, and it is here that history takes precedence over myth. The ability to see beyond the present is possible only through understanding the roots and contexts of contemporary events. The ability to invent and to adapt may flourish most where institutional memory is long—at least long enough to counteract the narrowing tendency of contemporary thinking. History may also suggest a wider range of possibilities than may exist at a particular moment and enable us to focus on change as a theme.

Questions of the "privateness" and "publicness" of not-for-profit hospitals promise to engage scholars and politicians alike in the forthcoming century, at least to the extent they have engaged our predecessors. Will those who seek the longer view avoid the siren-song of myths?

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