Falling Through the Cracks: Poverty, Insurance Coverage, and Hospital Care for the Poor, 1980 and 1982

JUDITH FEDER, JACK HADLEY, and ROSS MULLNER

Georgetown University;
American Hospital Association

A PATCHWORK OF PUBLIC PROGRAMS AND PRIVATE resources pay for hospital care for the poor. Medicaid, the joint state-federal health insurance program, entitles some low-income people to hospital care at little or no charge. But not all the poor satisfy Medicaid's welfare-based eligibility criteria (which vary widely from state to state). As a result, about one-third of the nation's poor lack public as well as private insurance against the costs of illness (Swartz 1984).

Without insurance or the means to pay, the uninsured poor rely primarily on charity to pay for their hospital care. State and local governments support charity care primarily through grants and appropriations to public hospitals. In 1982 they spent $9.5 billion for hospital care (net of revenues received) through appropriations and other non-Medicaid programs (Gibson, Waldo, and Levit 1983, 13). Private hospitals also pay for a substantial amount of care to the poor in the form of designated charity care and uncollectible bills (bad debts), most of which are attributable to people without insurance (Hadley and Feder 1983). We estimate the cost of this care to be about $3.2 billion in 1982.

Critics have always questioned how well public and private charity

Milbank Memorial Fund Quarterly/*Health and Society*. Vol. 62, No. 4, 1984

actually serve the uninsured poor. Access to care depends on public hospitals' budgets, private hospitals' individual decisions on how much free care to provide, and states' Medicaid eligibility, coverage, and reimbursement policies. Events of the early 1980s—economic recession, declines in private insurance coverage, Medicaid cutbacks, and limits on the growth of government spending—have raised concern that the patchwork system of responsibility for care to the poor makes it too easy for people to fall through the cracks.

This paper demonstrates the legitimacy of these concerns. As table 1 records, the number of people potentially unable to pay for hospital care has been increasing steadily since 1979. Between 1980 and 1982, the time period covered by this analysis, the number of people with family incomes below 150 percent of the poverty income increased by 13.5 percent; the number inadequately insured, having either no insurance or private, nongroup insurance only, grew by 7 percent. Medicaid coverage stayed essentially constant, but fell as a proportion of low-income people, from almost 36 percent to 31 percent. Even more dramatic was the 20.9 percent increase in the number of people who were both poor and inadequately insured, the population that is presumably most dependent on free care to meet their needs for hospital services.

While the need for free care was increasing dramatically, hospitals' delivery of free care hardly changed. Between 1980 and 1982 public and private hospitals' free care—the last resort of the inadequately or uninsured poor—increased by only 3.8 percent. Despite relatively healthy bottom lines, most private hospitals provided very little free care and did not increase that level in response to growing poverty or uninsurance in their communities. Public hospitals in metropolitan areas or in communities hardest hit by the joint effects of recession and uninsurance did expand their efforts to provide free care more than any other group of hospitals. But because of their limited resources, their expansion was not enough to cope with the increased demand for free care. Private hospitals heavily committed to serving the poor also tried to provide more free care if their financial health permitted. But public or private hospitals that were in financial trouble in 1980 because of providing a high proportion of care to the poor were forced to reduce their free care as part of a general effort to cut their costs.

In some places Medicaid coverage expanded between 1980 and 1982, making more free care less necessary. When Medicaid expanded,

TABLE 1
Poverty, Insurance Coverage, and Hospital Care for the Poor, 1979–1982

	1979	1980	1981	1982	Percentage Change, 1980–1982
The population in need (millions of people)					
Below 150% of poverty	46.77	53.29	57.81	60.45	13.44%
With inadequate insurance[a]	46.40	46.14	46.76	49.39	7.04
(no insurance)	(29.63)	(*b*)	(31.04)	(33.13)	(11.81[c])
With Medicaid coverage	18.14	19.01	19.46	18.92	−0.47
Below 150% of poverty and inadequately insured[a]	16.71	18.63	20.74	22.52	20.88
(no insurance)	(12.86)	(*b*)	(15.99)	(17.54)	(36.39[c])
Hospital care of the poor[d] *(millions of adjusted patient days)*[e]					
Free care (charity and bad debt)	NA	15.95	NA	16.55	3.76
Medicaid	NA	27.39	NA	27.44	0.18

Sources: Population data are estimates from U.S. Bureau of the Census 1983. Hospital data are estimates based on American Hospital Association and Urban Institute 1982.
[a] Inadequate insurance is defined as either no insurance coverage or private, nongroup insurance coverage only.
[b] People with no insurance coverage cannot be identified from the *Current Population Survey* for this year because the question on private nongroup insurance was not asked.
[c] Percentage change, 1979–1982.
[d] Weighted national estimates based on 1,208 private nonprofit and public nonfederal, short-term, general medical and surgical hospitals which responded to the 1980 and 1982 *Surveys of Medical Care for the Poor.*
[e] Adjusted patient days are a weighted sum of a hospital's inpatient and outpatient care.
NA = Not available.

private hospitals provided more care to the poor. However, some of this Medicaid expansion appears to have been a shift from public hospitals and some was offset by reductions in free care. Futhermore, in many areas Medicaid was cut back. Medicaid, like free care, then, was inadequate to assure access to care for all the poor.

Relying on our piecemeal financing system implies that some people will fall through the cracks. How serious is the problem? Because the evidence reported below is based only on data from hospitals, it cannot tell the complete story. It may be that the newly poor and

uninsured between 1980 and 1982, who went unserved, were in better health or had more assets than those already poor and uninsured. Perhaps they did not need as much of a safety net, or alternatively, perhaps hospitals' triage efforts may have minimized the health consequences of receiving less care. Whether the apparent reduction in access to hospital care represents more efficient use of resources or poorer health can be definitively determined only with data on people.

Evidence from earlier periods, however, strongly suggests that less care means poorer health (Rogers 1982; Hadley 1982). If so, public action is needed to mend the safety net. We will describe two ways to improve the poor's access to care: developing new insurance programs or paying hospitals to provide free care. Insurance is preferable because it can avoid concentrating care for the poor in expensive institutions, and it encourages people to seek care when they need it. Innovative payment and benefit designs can keep insurance costs within reasonable bounds. But cost experience with the open-ended insurance of the past makes governments suspicious of any new public insurance. Overcoming political reluctance will be a long-term task. In the short run, it may be more affordable and acceptable to shore up the system's apparent failure to maintain access for the poor by paying for charity care in hospitals disproportionately serving the poor.

Hospitals' Care for the Poor, 1980 and 1982

All hospitals are expected to provide some free care. But admitting an uninsured woman in labor or providing care to an uninsured accident victim is very different from an open-ended commitment to serve all regardless of ability to pay. Ownership, community circumstances, mission, and resources influence both how much free care a hospital is expected to provide and how much it is able to provide.

These factors suggest that even though the total volume of care for the poor changed little between 1980 and 1982, we would expect that some hospitals responded more than others. Public hospitals generally, but especially big city, public hospitals are major providers of care for the poor. Did their share of total care for the poor go up while private hospitals dumped nonpaying patients? What happened to hospitals' care for the poor in communities especially hard hit by the recession and Medicaid cuts? Regardless of a community's economic

condition, can hospitals committed to serving the poor be relied on to maintain or expand that mission? How does financial status influence a hospital's ability (or willingness) to care for the poor?

To address these questions, we analyze hospitals' care for the poor and financial status in their 1980 and 1982 fiscal years. The data for this analysis come primarily from two surveys, conducted jointly by the American Hospital Association and the Urban Institute (1980, 1982), of hospitals' care for the poor and financial status in their 1980 and 1982 fiscal years. Approximately 3,400 hospitals were surveyed in 1980, and 3,800 in 1982. The universes consisted of all short-term, general, nonfederal hospitals with 100 or more beds plus a random sample of about 400 smaller hospitals in 1980, and 800 smaller hospitals in 1982. About half of the hospitals surveyed responded in each year. However, the data reported here are based on a maximum of 1,208 private, nonprofit and public, nonfederal hospitals that responded to both surveys and supplied responses for several key variables. Proprietary hospitals were excluded because too few responded with complete information. Additional data about the hospitals were obtained from the American Hospital Association's *Annual Survey of Hospitals* for 1980 and 1982.

Table 2 records the distributions of total hospital care, free care (charity and bad debt), and care to Medicaid recipients in 1980 and 1982. The table registers how important public hospitals are in providing free care and how insurance (i.e., Medicaid) improves poor people's access to private hospitals. In the early 1980s public hospitals were responsible for about 22 percent of all hospital care, but provided 40 percent of all free care. In the 100 largest cities, the disproportion is even more striking—big city public hospitals provided 5.5 percent of the nation's total hospital care compared to 20.5 percent of its free care. In contrast, private hospitals provide their proportionate share of care to Medicaid recipients, whose care is paid for. In 1982 private hospitals delivered about 75 percent of Medicaid care, only slightly less than their share of all care.

Somewhat surprisingly, the distribution of care between public and private hospitals changed very little between 1980 and 1982. Although public hospitals maintained their disproportionate role, they did not increase it. The relative lack of movement in the overall distributions means that hospitals generally did not change their efforts in caring for the poor. The data in table 3 show that, for all hospitals, free

TABLE 2
Percentage Distributions and Volumes of Total Hospital Care and Care for the Poor, 1980 and 1982, by Ownership and Community Size[a]

	All care		Free care[b]		Medicaid	
	1980	1982	1980	1982	1980	1982
Percentage distribution						
All hospitals	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Public	21.90	21.63	40.56	40.65	26.49	24.85
Private	78.10	78.37	59.44	59.35	73.51	75.15
Community size and ownership						
100 largest cities						
Public	5.54	5.49	20.12	20.47	11.13	9.07
Private	27.10	27.11	21.44	22.07	33.26	32.50
Other metropolitan areas						
Public	7.56	7.64	10.77	11.02	8.81	9.00
Private	35.51	35.54	25.69	25.12	29.73	30.00
Nonmetropolitan						
Public	8.79	8.50	9.68	9.16	6.55	6.77
Private	15.50	15.71	12.31	12.16	10.51	12.67
Volume of care (millions of adjusted patient days[c])						
All hospitals	302.32	306.29	15.95	16.55	27.39	27.44
Public	66.21	66.25	6.47	6.73	7.26	6.82
Private	236.11	240.04	9.48	9.82	20.13	20.62

Source: American Hospital Association and Urban Institute, 1980, 1982.
[a] Weighted national estimates.
[b] Sum of charity care and bad debts.
[c] Adjusted patient days are a weighted sum of a hospital's inpatient and outpatient care.

TABLE 3

Hospitals' Proportionate Effort in Care for the Poor and Financial Status, 1980 and 1982, by Ownership and Community Size[a]

	Free care[b] as a percent of all care		Medicaid as a percent of all care		Total percentage margin[c]	
	1980	1982	1980	1982	1980	1982
All hospitals	4.82%	4.81%	7.96%	8.41%	3.09%	3.77%
Ownership						
Public	6.59	6.57	7.68	8.43	2.09	2.70
Private	3.87	3.85	8.12	8.40	3.64	4.35
Ownership and community size						
100 largest cities						
Public	17.77	19.75	16.97	15.26	−0.47	1.17
Private	4.30	4.46	11.85	11.63	4.44	4.32
Other metropolitan						
Public	6.86	7.15	10.92	10.74	2.35	1.31
Private	3.55	3.68	8.26	8.34	4.89	4.38
Nonmetropolitan						
Public	5.60	5.34	5.99	7.21	2.21	3.22
Private	3.95	3.71	6.06	6.79	2.04	4.32

Source: American Hospital Association and Urban Institute 1980, 1982.

[a] Weighted national estimates.

[b] Sum of charity care and bad debts.

[c] The hospital's reported total margin as a percentage of total revenues.

care was identically 4.8 percent of total care in both years, with neither public nor private hospitals increasing their levels of effort.

However, this overall lack of change masks some differences among subsets of hospitals. In particular, nonmetropolitan hospitals, both public and private, reduced their free-care effort; metropolitan hospitals generally increased their effort. Most notably, public hospitals in big cities increased the share of their resources devoted to free care, from 17.8 to 19.8 percent. (The next largest increase in effort was 0.3 percentage points by public hospitals in other metropolitan areas.)

Why didn't these shifts affect the distribution of free care between public and private hospitals? Public hospitals' overall resources increased relatively little, so their substantially greater effort produced only a small increase in the volume of free care (table 2). In the 100 largest cities, for example, public hospitals' level of effort increased by 11.1 percent, but this resulted in only a 5.6 percent increase in the volume of free care. Big city, private hospitals' much smaller increase in effort (3.7 percent, on average) actually produced a greater increase in the volume of free care—6.7 percent. In other words, big city, public hospitals increased their effort but not their resources; big city, private hospitals increased their resources and not their effort. On net, there was essentially no change in the distribution of free care between public and private hospitals.

Table 3 also records that hospitals barely changed the share of their care devoted to Medicaid. As with free care, however, hospitals in different communities behaved differently. Medicaid's share increased where free care declined and, conversely, decreased where free care expanded. It appears that charity and Medicaid were more substitutes than complements. As a result, the total volume of care to the poor—free care plus Medicaid—barely increased between 1980 and 1982.

Failure to increase free care occurred despite the fact that nationally hospitals' margins increased between 1980 and 1982. But again this national picture obscures differences between metropolitan and nonmetropolitan hospitals. Public and private nonmetropolitan hospitals, which had relatively low margins in 1980, improved their margins substantially as they reduced their free-care efforts. In contrast, private metropolitan hospitals earned slightly lower margins than in 1980. However, these hospitals' 1980 margins were good by industry standards. Although their margins fell some, if they had fallen by as much as a full percentage point they would have freed up enough resources

to provide an additional 1.25 million adjusted patient days of free care, almost three times the actual increase. Total free care would have increased by 11.5 percent between the two years instead of 3.8 percent.

The data in tables 2 and 3 indicate that most hospitals did not increase their care to the poor in this period. But not all communities experienced equal increases in poverty. Furthermore, in some communities where poverty increased, Medicaid coverage expanded to meet their insurance needs. In other communities, Medicaid contracted. To examine hospitals' responses where the potential demand for free care may have increased the most and the role of the insurance protection afforded by Medicaid, we compare hospitals in communities that had relatively large increases in poverty rates, but that differed in the change in the number of people reporting Medicaid coverage. (Medicaid coverage and poverty rates in 1982 and 1980 were estimated from the *Current Population Survey*.)

Table 4 records that public hospitals increased their free-care effort where poverty increased or where Medicaid coverage fell in the absence of a poverty increase (columns 1, 2, and 4). The greatest increase in effort occurred where poverty grew the most (column 1). This sizeable increase occurred despite the fact that these hospitals' share of revenues from state and local governments fell, due in part, presumably, to the combined effects of the recession on governments' discretionary revenues and the expansion of Medicaid coverage. The data for other communities also suggest that state and local governments' direct expenditures for hospital care substitute to some extent for changes in Medicaid spending, going down where Medicaid coverage went up. (See Hadley 1983 for another analysis of this issue.)

One of the nation's largest public hospitals, Los Angeles County-University of Southern California Medical Center, is excluded from the data shown in column 1 of table 4. It changed its funding of free care between 1980 and 1982 as a result of policy changes instituted by the newly elected county commissioners and the state government. Much of the indigent care reported as free care in 1980 was designated as care to the new county medical indigent program in 1982. Consequently, reported free care appeared to fall, when in reality total care to the medically indigent actually increased. In spite of this increase, the hospital's total revenues from government fell. Thus, its experience was quite consistent with the general pattern for public

hospitals in column 1—increased free care efforts in the face of declining resources.

In contrast to public hospitals, changes in private hospitals' free-care efforts and their margins show little relationship to changes in poverty rates. The biggest changes in free-care efforts and in margins were 0.24 percentage points and 0.27 percentage points, respectively. It does appear, though, that free-care efforts were greatest and margins lowest in the communities with the biggest increase in poverty rates.

The amount of care provided to Medicaid recipients changed relatively little compared to changes in Medicaid coverage. The response was greatest in communities where both poverty and coverage fell (column 4). Both public and private hospitals reduced their share of Medicaid care. In the other communities, private hospitals' and public hospitals' Medicaid care moved in opposite directions; where Medicaid coverage fell, private hospitals cut their Medicaid services and public hospitals increased theirs. The opposite happened where Medicaid coverage expanded.

Comparing changes in area characteristics across the four groups of communities reveals the complex nature of the relations between poverty, unemployment, and insurance coverage. In spite of the dramatic differences in changes in poverty rates, unemployment increased by about the same amount everywhere, between 31 and 38 percent. Private group-insurance coverage fell everywhere, between -0.7 and -7.6 percent on average. But the size of the change varied directly with the increase in poverty, not with the change in unemployment.

Overall, hospitals' proportionate efforts in providing free care expanded the most where poverty went up the most and Medicaid coverage also expanded (column 1). But even there, the growth in the actual volume of total care for the poor, free care plus Medicaid, was small, less than 4 percent, and in no way commensurate with the 45 percent increase in the poverty population. Where poverty rates went up but Medicaid coverage contracted (column 2), total care for the poor went up even less, only 1.85 percent. Ironically, though perhaps not surprisingly, the poor seem to have fared best where poverty increased the least.

That most hospitals did not increase their free-care effort is not terribly surprising. A relatively small number of hospitals, both public and private, account for the bulk of care for the poor (Feder, Hadley, and Mullner 1984). When the demand for free care increases, can

TABLE 4
Hospitals' Care for the Poor and Financial Status, 1982 and 1980, by Areawide Changes in Poverty Rate and Medicaid Coverage[a]

	Large increase in poverty[b]				Small increase in poverty			
	(1) Increase in Medicaid coverage		(2) Decrease in Medicaid coverage		(3) Increase in Medicaid coverage		(4) Decrease in Medicaid coverage	
	1980	1982	1980	1982	1980	1982	1980	1982
Public hospitals	($n = 69$)		($n = 54$)		($n = 39$)		($n = 68$)	
Free care[c] (percent of charges)	13.13	14.55	9.47	10.48	7.29	7.14	11.96	12.63
Medicaid (percent of charges)	12.82	12.38	9.68	10.01	10.95	10.88	10.98	9.63
Government revenues (percent of revenues)	11.17	9.68	9.61	10.08	8.07	4.19	7.18	7.12
Total margin (percent of revenues)	3.38	3.03	3.97	3.70	3.73	3.47	2.21	2.34
Total care for the poor[d] (millions of adjusted patient days)	1.88	1.91	0.74	0.79	0.48	0.48	1.30	1.30
Private hospitals	($n = 336$)		($n = 146$)		($n = 161$)		($n = 334$)	
Free care[c] (percent of charges)	4.39	4.63	3.69	3.57	3.26	3.48	4.30	4.29
Medicaid (percent of charges)	9.67	9.99	10.25	10.21	6.57	6.97	8.51	7.99
Total margin (percent of revenues)	3.67	3.93	4.72	4.76	4.49	4.26	5.15	4.94

Total care for the poor[d] (millions of adjusted patient days)	5.34	5.59	1.98	1.98	1.61	1.73	3.97	3.87
Area characteristics								
Percent below 125% of poverty[b]	21.49	30.41	19.73	24.46	17.22	17.60	20.85	19.80
Percent unemployed[c]	7.72	10.13	7.23	10.00	7.76	10.65	6.94	9.33
Percent with Medicaid[b]	11.09	14.11	10.22	8.63	7.35	8.42	10.29	7.00
Percent with private group insurance[b]	55.37	51.17	58.24	56.56	61.32	60.31	58.06	57.65
Percent change in poverty population, 1980–1982[b]	45.75		26.56		5.86		−2.35	
Percent change in total care for the poor, 1980–1982	3.79		1.85		5.94		−1.94	

Sources: U.S. Bureau of the Census 1981, 1983; American Hospital Association and Urban Institute 1980, 1982.

[a] Based on 1,207 hospitals. Estimates are weighted by hospitals' adjusted patient days to adjust for differences in hospital size. These estimates are not comparable to estimates reported in tables 1–3, which also adjust for the number of hospitals which did not respond or were not surveyed.

[b] Population estimates for hospitals' areas were constructed from the *Current Population Survey*.

[c] Sum of charity care and bad debts.

[d] Sum of charity care, bad debts, and Medicaid.

[e] Bureau of Labor Statistics unemployment rates by county.

these hospitals be counted on to expand their services to the poor? How much of a constraint does financial status place on their ability to respond? Other research (Feder, Hadley, and Mullner 1984) has suggested that a high level of care for the poor is associated with poor financial status. Can a hospital under financial stress respond in the same way as one which is financially healthy?

To address these questions, we examine changes that occurred in a set of hospitals whose proportions of care for the poor in 1980 were above the 75th percentile of the proportion of care for the poor for all hospitals in that year. (In 1980 the 185 hospitals selected provided 13.8 percent of all hospitals' free care and 13.7 percent of all hospital Medicaid care.) These hospitals were then divided into two groups depending on whether they had negative operating and total margins (financially stressed) or positive operating and total margins (financially sound).

Comparing the values of several key variables for these institutions in 1980 and 1982 (table 5) suggests that committed hospitals with strong margins increase their care for the poor. Committed hospitals facing large deficits pursue financial viability over care for the poor. Hospitals under financial pressure in 1980 reduced their free-care load, from 10.3 to 8.1 percent of charges, and their Medicaid proportion, from 21.3 to 19.2 percent of charges. Accompanying the reduction in the proportion of care for the poor was an absolute decrease in the volume of outpatient visits, where a substantial share of care for the poor is provided. Their margins, though still negative on average, improved substantially from -7.5 to -3.5 percent.

Not all of the improvement in stressed hospitals' margins can be attributed to the reduction in care for the poor. In addition to improving their payer mix, stressed hospitals restrained their cost increases; total costs grew by only 1.2 percent over the two years, compared to 12.9 percent for the sound hospitals. Much of the difference in growth in costs appears due to the stressed hospitals' slower growth in full-time-equivalent staff.

Revenues grew at nearly the same rate, about 13.3 percent, in both stressed and sound hospitals. Both groups of hospitals had similar levels and changes from 1980 in the average discount from charges and in the average markup of charges above costs. These similarities suggest that stressed hospitals either would not or could not resort

TABLE 5
Characteristics in 1980 and 1982 of Hospitals Providing a High Proportion of Care for the Poor in 1980, by Financial Status

	Financial status,[b] 1980			
	Stressed (n = 48)		Sound (n = 137)	
Characteristics[a]	1980	1982	1980	1982
Total margin (percent of total revenues)	−7.53%	−3.52%	5.13%	4.31%
Free care (percent of charges)	10.28%	8.11%	7.24%	7.39%
Medicaid (percent of charges)	21.28%	19.22%	14.78%	15.13%
Inpatient days (1,000s)	96.27	97.34	94.83	93.23
Outpatient visits (1,000s)	85.87	79.04	75.79	81.33
Average discount from charges (ratio of patient care revenues to charges)	0.79%	0.76%	0.81%	0.79%
Markup (ratio of charges to patient care expenses)	1.44%	1.51%	1.44%	1.51%
Total expenses (in millions)	$42.42	$43.16	$37.57	$42.42
Total revenues (in millions)	$38.81	$44.04	$41.14	$46.52
Total full-time-equivalent personnel (per 1,000 adjusted patient days[c])	9.61	10.26	9.57	10.96
Member of the Council of Teaching Hospitals (percent)	27.08		24.82	
Public ownership (percent)	29.17		32.12	

Source: American Hospital Association and Urban Institute 1980, 1982.
[a] Unweighted data.
[b] Stressed hospitals had negative operating and total margins; sound hospitals had positive operating and total margins.
[c] Adjusted patient days are a weighted sum of a hospital's inpatient and outpatient care.
[d] Member of the Council of Teaching Hospitals.

to "cost-shifting" as a means of improving margins without having to reduce free care. Rather, financial pressure seems to have resulted in a combination of cutting costs and limiting care for the poor.

The robustness of the results recorded in table 5 was explored in several ways: expanding the sample to include hospitals above the 50th percentile of the proportion of care provided to the poor, limiting the sample to public hospitals only, and distinguishing between chroni-

cally stressed hospitals, which ran deficits every year between 1978 and 1980, and other stressed hospitals. In each case, financial pressure led to reductions in both the relative and absolute volumes of free care.

In sum, then: Why didn't hospitals' care for the poor increase as much as the apparent increase in need between 1980 and 1982? Our analysis suggests four reasons. First, most private hospitals provide relatively little free care, and, even when their financial health was relatively good, their free-care efforts did not vary in response to poverty in their communities. Second, public hospitals in communities where poverty increased or Medicaid coverage fell did expand their share of resources going to free care. But since their total resources were relatively constrained, their impact on the volume of free care was small. Third, private as well as public hospitals that provided the bulk of care for the poor did not expand their efforts; those in good financial health maintained their effort, but those in financial stress cut back. Fourth, private hospitals responded to changes in Medicaid coverage, providing more Medicaid services where coverage expanded. But the response was smaller than the increase in Medicaid coverage and, to some extent, was merely a shift from public hospitals. Moreover, Medicaid did not expand everywhere poverty increased.

Rationing Free Care

Limiting free care is not unique to the 1980s. Historical research on urban hospitals demonstrates that voluntary hospitals' care for the poor has always been constrained. In the nineteenth century, when the poor were the hospitals' only users, voluntary hospitals limited their services to the poor that were considered deserving—"hard working and church-going citizens (who) did not belong in the company of paupers, prostitutes, alcoholics, and the dependent generally" (Rosenberg 1982). The latter—along with the incurable and chronically ill—went to the almshouse, which became the public hospital (Starr 1982).

Over time, as the hospital developed from "a well of sorrow and charity" into a "workplace for the production of health," financial pressures also influenced hospitals' patient-mix (Starr 1982). Curative medicine meant higher costs, exceeding what hospitals could collect in philanthropy and government funds. To relieve their "chronically strained budgets," hospitals turned to patient revenues and began

"enforcing a prudent ratio of pay to indigent patients" (Rosenberg 1981). Different hospitals calculated "prudent ratios" at different levels, with older, well-endowed institutions in the Northeast more inclined toward the poor than newer hospitals in the Midwest and West. But even in older cities with traditions of serving the poor, financial pressures brought less service. As the demand for care from paying patients grew, "the poor became the residual beneficiaries of care in the voluntary hospitals" (Stevens 1982).

In this respect, hospital behavior in the 1980s bears a strong resemblance to behavior in the 1920s and can be understood in similar terms, i.e., maintaining a "prudent ratio." Where demand for free care is rising and paid care falling, maintaining that ratio means rationing care.

How do hospitals ration free care? Based on interviews conducted with hospital administrators in twelve cities in the fall of 1982 and winter of 1983, we identified two strategies: (1) directly prohibiting or discouraging hospital use by people unable to pay and (2) reducing the availability of services heavily used by the uninsured poor. Probably the easiest way to discourage use is to require nonemergency patients without insurance to pay all or part of their bills in advance. Hospitals have enforced this policy to different degrees and in different ways. Some give no nonemergency care without some payment; others make exceptions to that rule. For example, medical considerations may be allowed to override financial ones in specified circumstances—unique cases valued for teaching purposes, cases involving continuation of earlier treatment, or, as described by one financial officer, "whenever the physician screams." Some hospitals apply the cash-up-front rule to either all departments or all departments *except* the one in which free care is considered practically unavoidable—for example, obstetric care by the only hospital in a poor neighborhood. Some target the policy specifically to departments with heavy losses, especially outpatient departments or nonemergency patients in emergency rooms.

A more elaborate, and apparently less common approach to controlling admissions, involves a fixed budget for free care. To enforce a substantial reduction in its free care (necessitated by a deficit), one hospital adopted formal priorities for delivery of nonemergency care (first priority to neighborhood residents receiving primary care from hospital-affiliated physicians; last priority to persons with self-inflicted injuries or illnesses), with selection of cases made by committee on a biweekly basis.

A more subtle approach to limiting charity care entails a transfer of the responsibility for decisions on free care from hospitals to physicians, by making physician groups owners of outpatient departments. Despite the ownership transfer, the hospital continues to influence provision of free care by subsidizing the rent physician groups pay the hospital. But formal decisions on how much free care to offer and enforcement of these decisions becomes the job of the doctors, not the hospital. Hospital officials who have used this approach believe it gives them a way to limit their free-care losses while reducing their liability for community or trustee complaints.

Alongside or independent of utilization controls, hospitals also adopt an alternative approach to reducing free care—cutting back or eliminating services heavily used by the poor. To paraphrase one hospital administrator, "The most efficient way to cut costs is to eliminate services that don't generate revenues." Obviously, services directed to the uninsured satisfy this criterion. Examples hospitals give of such services include social services, hospice care, drug treatment, psychiatric care, and outpatient services.

Private hospitals' efforts to limit free care in these ways generate strong complaints from public hospitals that they are shifting burdens, leaving public hospitals to solve the problems of the uninsured. As described above, public hospitals do respond more than private hospitals to increased need for free care. But their efforts are not open-ended. They too appear to maintain prudent ratios, albeit at significantly higher levels, and to ration care. Between 1980 and 1982 public as well as private hospitals required payments from nonemergency patients, and cut back the availability of outpatient services heavily used by the uninsured. In addition, public hospitals can and do refuse to accept transfers from private hospitals, when patients are transferred simply because of inability to pay (Demkovich 1982).

If even public hospitals are forced to limit free care, it is people, not institutions, who bear the consequences of poverty and lack of insurance. This conclusion is often lost in arguments about patient transfers or dumping. But it is quite consistent with what we know about hospital use by the uninsured. In 1977 the uninsured under age 65 experienced 47 days of hospital care per hundred persons, about half the level experienced by the insured population under age 65 (Davis and Rowland 1983). A larger proportion of uninsured than of insured patients were accident or obstetric cases (Sloan, Valvona,

and Mullner 1984), that is, cases it is difficult for hospitals not to treat. Less serious cases can be deferred or avoided. A 1982 survey (Robert Wood Johnson Foundation 1983) found that 15 percent of uninsured families needed care during the year but did not obtain it—three times the proportion for families with insurance. Consistently, 20 percent of the uninsured, compared to 13 percent of the insured, reported themselves in less than good health.

Policies to Sustain Care for the Poor

Analysis of 1980 and 1982 hospital data implies that a public policy of relying on charity to finance free care means that some people in need of care are likely to go without it. To the extent that more free care is actually delivered when demand increases, much of it will come from public hospitals at local taxpayers' expense. Paradoxically, local taxpayers' ability to pay will be most limited where poverty and the need for free care are highest.

Although the recent economic recession clearly exacerbated these problems, economic recovery will probably not eliminate them. Roughly 14 percent of the population were uninsured before the last recession (Swartz 1984) and changes in the scope of Medicaid and private insurance, independent of the recession, may leave more people uninsured even as the economy improves. At the same time, changes in hospital financing—specifically constraints on third-party payment and greater competition for high-paying patients—are squeezing hospitals' margins and reducing their willingness to deliver free care.

Sustaining delivery of care to the uninsured and the poor is thus a long-term, not a transitory problem. Expanding health insurance or paying hospitals to deliver free care are the two general approaches to solving the problem. To become reality, however, a specific solution must not only guarantee access, but should do so at an affordable cost without placing an unfair financing burden on fiscally strapped local governments. Providing the details of such a solution is beyond the scope of this paper, especially since the "best" solution is likely to vary with local circumstances. But we can outline some of the advantages, disadvantages, and consequences of alternative options within the two general approaches.

Expanding insurance coverage would solve the problem of relying on charity by eliminating the need for it. A good example of how

easily insurance improves access for people unable to pay is private hospitals' willingness to provide care under Medicaid. While insurance clearly lessens, if not removes, ability to pay as a barrier to access, however, it also removes ability to pay as a constraint on hospital revenues. Without alternative constraints, medical costs inevitably rise.

Fear of exacerbating a medical cost escalation that is already considered out of control has, of course, become a major obstacle to expanding public health insurance. In the 1980s, national health insurance disappeared from the policy agenda; incremental improvements in public programs—health insurance for the unemployed—failed to pass the Congress; and existing benefits in Medicare and Medicaid were cut back.

Political caution is understandable, given past experience with public insurance and medical cost inflation. But we are beginning to learn that giving people better access to health care does not require giving providers open access to the public purse. Public and private insurers alike are taking greater responsibility for constraining rates paid to providers and encouraging or requiring more efficient use of hospitals and physicians. These actions not only raise hopes for lower costs in existing programs; they should also make it possible to develop new insurance programs at acceptable public costs.

New programs could be initiated by the federal, state, or even local government, or the Medicaid program could be expanded to cover more of the uninsured. To satisfy growing cost concerns, new insurance programs could incorporate various cost-sharing, benefit, and provider-payment features that depart from traditional Medicaid practice. Free choice of providers, for example, could be replaced with restriction of service to providers that agree to accept program rates. Public insurance could also offer preferred-provider options, sharing with patients any savings gained by obtaining care from providers who discount their charges to the program.

Benefit packages need not eliminate all payment responsibilities for the newly insured. Instead, benefits could be limited to catastrophic protection—covering expenses above a fixed dollar amount or above a certain share of income. Or benefits could be offered in the form of indemnity payments—$200 per day in the hospital, $20 per physician visit.

Terms like these depart from Medicaid's comprehensive protection

but resemble the varied provisions of private insurance policies. Obviously, the narrower the benefits offered by the new insurance policy, the less the policy will improve access to care for the newly insured. But policies need not provide open-ended coverage to offer substantially improved protection for persons now totally dependent on charity for nonemergency care. Shifting from a welfare to an insurance concept might, in fact, make new public insurance programs more acceptable politically. One could consider, for example, allowing the uninsured to purchase (at a subsidized price that varied with income) a "low option" Medicaid benefit, with limited provisions like those just described.

Promising value for the dollar, however, may be insufficient to overcome political opposition to new public programs, especially where federal financing is required. If so, we must find an alternate way to improve access. That alternative would leave the uninsured dependent on charity, but would promote charity care by paying hospitals to provide it.

Paying hospitals rather than insuring individuals is clearly a second-best approach to financing care to the currently uninsured. It is less effective in improving access, since it leaves the uninsured ostensibly dependent on charity and accordingly reluctant to seek nonemergency care. And it is less efficient, since it only covers care in hospitals—the most expensive providers of medical care. Nevertheless, it offers a limited and workable means to assure providers' willingness to serve people unable to pay for care.

How can we pay hospitals to deliver charity care? Under one approach, government could simply agree to pay, say, 50 cents on the dollar for every dollar of charity care hospitals provided. Practically, however, such an open agreement would give away too much and gain too little. These payments would not only aid providers whose efforts to serve the uninsured are stymied by limited resources; they would also go to hospitals not serving the poor, whose free care simply represents the bad debts that arise in the course of doing business.

More desirable than an agreement to pay all hospitals for charity and bad debt is to pay for free care only in hospitals that are providing substantial amounts of free care *and* experiencing financial losses. Research on hospitals' free-care and financial status demonstrates both the desirability and feasibility of this targeted approach (Feder, Hadley, and Mullner 1984). This research shows the following: (1) a small

group of hospitals provide exceptionally large volumes of free care—fewer than 10 percent of the nation's hospitals account for 40 percent of the nation's free care; (2) about one-third of these hospitals incur deficits, not because they are less efficient than other similar hospitals but because they lack sufficient private revenues to subsidize free care; and (3) as shown above, when facing deficits, these hospitals fight for survival by cutting both costs and free care. To sustain these committed, fiscally stressed hospitals' ability to serve the uninsured, extra funds could be provided, either through government grant programs or through upward adjustments to these hospitals' Medicaid and Medicare rates (as authorized by the Omnibus Reconciliation Act of 1981).

The most equitable way to raise extra funds to support charity care is from general tax revenues. But some states, reluctant to increase general taxes, have taken a more innovative approach to fund raising for this purpose—taxing net revenues from hospitals serving the better-off or taxing private insurance premiums to gain funds to aid hospitals serving the uninsured. The tax may be explicit, as in New York and, more recently, Florida; or it may be an implicit part of a hospital rate-setting arrangement, where (as in Massachusetts, New Jersey, and Maryland) third-party rates are adjusted upward to pay all or part of the costs of free care. Depending upon the level of payment awarded for free care, hospitals can be made indifferent to the insurance status of the patients they serve, thus removing financial barriers to access. Either all-payer hospital rate-setting or a new tax and grant approach can achieve the same impact on access. But rate-setting has an additional advantage—its potential for financing payments for free care out of savings from cost constraint.

These approaches to improve access, however, involve a redistribution of revenues that makes them politically unattractive to most hospitals. The winners in this redistribution are the small number of hospitals with few privately insured patients and lots of free care. These hospitals have little to lose from taxes or rate constraints and much to gain from payments for charity. The opposite holds for the losers—the vast majority of hospitals with well-insured, high-paying patients and very little free care.

Given this configuration of interests, it is not surprising that few states have adopted these redistributive arrangements. The hospital industry has supported redistribution reluctantly and infrequently, and only as a part of a broader rate-setting agreement that actually

enhanced, rather than reduced, most hospitals' revenues. In Massachusetts and New York, enhancement came from two sources: (1) Medicare waivers that exempted these hospitals from the Medicare constraints built into the Tax Equity and Fiscal Responsibility Act of 1981 (TEFRA); and (2) the new arrangements' replacement of more stringent limits on rates that were already under state-government control.

Since most hospitals can avoid free care, the few hospitals committed to serving the poor probably cannot count on help from others. Basically, they must fight their own battles to acquire assistance. On their own, they are unlikely to win battles for broader insurance or statewide, all-payer rate setting. But they can win (and have won) bids for special aid for their special problems.

Special aid to special institutions—public or private—seems the least complex, least controversial, and therefore most immediately feasible means of filling in the current system's cracks. Under such a system, the uninsured will continue to depend on charity and charity will continue to mean rationing. Most hospitals will refuse nonemergency care to the uninsured and the hospitals that serve this population may become second class. Although we may bemoan this development, the uninsured may be better off with second-class care than with no care at all. But adopting a second-best policy for the short run should not allow us to lose sight of the long-run best solution—insuring the uninsured and eliminating the need for charity care.

References

American Hospital Association and Urban Institute. 1980, 1982. *Survey of Medical Care for the Poor and Hospitals' Financial Status.* Washington.

Davis, K., and D. Rowland. 1983. Uninsured and Underserved: Inequities in Health Care in the United States. *Milbank Memorial Fund Quarterly/Health and Society* 61(2):149–76.

Demkovich, L.E. 1982. Urban Voluntary Hospitals, Caught in Price Squeeze, Face a Bleak Future. *National Journal* (June 26):1131–36.

Feder, J., J. Hadley, and R. Mullner. 1984. Poor People and Poor Hospitals: Implications for Public Policy. *Journal of Health Politics, Policy, and Law* 9(2):237–50.

Gibson, R.M., D.R. Waldo, and K.R. Levit. 1983. National Health Expenditures, 1982. *Health Care Financing Review* 5(1):1–32.

Hadley, J. 1982. *More Medical Care, Better Health?* Washington: Urban Institute Press.

———. 1983. Medicaid Cuts and Local Governments' Health Care Spending. Working paper no. 1444-03. Washington: Urban Institute.

Hadley, J., and J. Feder. 1983. Hospitals' Financial Status in 1980. Working paper no. 3179-03. Washington: Urban Institute.

Robert Wood Johnson Foundation. 1983. *Updated Report on Access to Health Care for the American People (Special Report, November 1).* Princeton, N.J.

Rogers, D. 1982. The President's Statement. In *Robert Wood Johnson Foundation Annual Report 1982.* Princeton, N.J.

Rosenberg, C.E. 1981. Inward Vision and Outward Glance: The Shaping of the American Hospital, 1880–1914. In *Social History and Social Policy,* ed. D.J. Rothman and S. Wheeler. New York: Academic Press.

———. 1982. From Almshouse to Hospital: The Shaping of Philadelphia General Hospital. *Milbank Memorial Fund Quarterly/Health and Society* 60(1):108–54.

Sloan, F.A., J. Valvona, and R. Mullner. 1984. Identifying the Issues: A Statistical Profile. Paper presented at Conference on Uncompensated Care: Defining Rights and Assigning Responsibilities, Vanderbilt University, April 6–7.

Starr, P. 1982. *The Social Transformation of American Medicine.* New York: Basic Books.

Stevens, R. 1982. "A Poor Sort of Memory": Voluntary Hospitals and Government before the Depression. *Milbank Memorial Fund Quarterly/Health and Society* 60(4):551–84.

Swartz, B.K. 1984. Statement before the Subcommittee on Health, Committee on Finance, U.S. Senate, April 27.

U.S. Bureau of the Census. 1980, 1982, 1983. *Current Population Survey,* March. Washington.

Acknowledgments: The Robert Wood Johnson Foundation provided principal financial support for this article. Additional support was provided by grants from the Metropolitan Life Foundation, the Equitable Life Assurance Society, John Hancock Insurance Co., and the Blue Cross and Blue Shield Association. The authors gratefully acknowledge the overall advice of Sidney Lewine, the research assistance of Nanette Goodman, and the secretarial support of Theresa Jordan and Joan Sanders. Full responsibility for the article's contents, of course, rests with the authors.

Address correspondence to: Judith Feder, Ph.D., Co-director, Center for Health Policy Studies, Georgetown University School of Medicine, 2233 Wisconsin Avenue, N.W., Suite 525, Washington, DC 20007.