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The History of American Health Care

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THE HISTORY OF AMERICAN HEALTH CARE.

Michael R. Niehaus, M.A., B.S.

An Abstract Presented to the Faculty of the Graduate
School of Lindenwood University in Partial
Fulfillment of the Requirements for the
Degree of Master of Science

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Abstract

Health care in America has grown predominately in response to both social and religious need. All though historically social position was the primary determinant of a patients ability to receive health care, today insurance plays a major role in ones ability to receive that care. This thesis will examine some of the social changes which have effected American hospital and its relation to the patients ability to pay.

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THE HISTORY OF AMERICAN HEALTH CARE.

Michael R. Niehaus, M.A., B.S.

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Chapter 1

INTRODUCTION

For centuries before 1800, religious congregations of men and women were involved in healing ministries and health care. Care of the sick from earliest days has been principally the work of the religious organizations. Both men and women healers have known and used herbs and natural substances for the treatment of illness and disease. From ancient Egypt and Rome there is evidence that both men and women practiced the art of healing. In the medical annals of China, a female physician is mentioned as early as 260 B.C. (Green and Krieger 236).

Historians sometimes give Christianity credit for originating hospitals. It is true that the Christian Era gave great impetus to hospital building; it taught that all men are brothers, that loving the unlovable and tending the helpless and relieving another's pain are God given duties. However, in pre-Christian times both Hindus and Greeks planned and organized aid for their helpless citizens. Prince Asoka of India was one of the earliest recorded founders of a hospital; he endowed shelters for men three hundred years before Christ. These buildings were called

"cikista" and were planned both to shelter the sick and to distribute medicines. Asoka gave his hospitals rich endowments to supply them with food, drink, and medicines; he also provided them with doctors and nurses (Green and Krieger 237).

Sanskrit manuscripts based on medical traditions four thousand years old recommended sensible and elaborate rules for cleanliness and diet, and quite lyrical comforts for invalids. Proper light, sunlight without glare, attractive colors, soothing music, perfume, flowers, quiet, and gentleness were all considered very important to health. A Hindu surgeon was required to keep his hands scrubbed and clean, his nails short, his clothing white and immaculate. Sheets were cleaned with steam, instruments boiled, operating rooms were ordered to be well lighted and ventilated but protected from dust, odors, or direct sunlight. There was even a rule forbidding a surgeon to speak during an operation, as his breath might contaminate the wound (Green and Krieger 238).

Bettman (433) provided a detailed translation analyzing forty-eight surgical cases. Therefore, the Smith papyrus is evidence that medical treatment without magic or prayer existed as early as five thousand years ago. Another papyrus, known as the Ebers, includes a dialogue between patient and physician. The

questions and answers of this conversation outline the examination for symptoms in the same basic order that doctors use today. Egyptian physicians made careful physical examinations: sizes of abnormalities, textures, smells, pulse, temperature and functional tests were all recorded and taken into account. They prescribed many medicines still used today. Castor oil was prescribed for bedsores, for scalp lesions, and for catharsis. The Ebers and Smith papyri alone indicate that orderly, scientific medical procedures were better established than we supposed before the relatively new science of archaeology revealed practical realities of our earlier ancestors everyday lives (Galbraith 187; Grossman 144).

From the first century of Christianity, hospitality was given to travelers, the poor, the sick, orphans, and those handicapped in any way. Almost all of these places of refuge were connected to monasteries and religious orders and it is out of these that the hospitals of the Middle Ages developed (Green and Krieger 130).

Before the rise of monasteries of men and women however, there were several notable houses which furnished public assistance to the sick. The first was founded in Rome in A.D. 390 by the matron Fabiola, who personally went out into the streets to find the most neglected and nurse them. Also, in the

fourth century Basil the Great founded a type of hospice in Caesaria, and it is reported that there were even resident physicians and nurses. Basil's sister Macrina (330-379), who founded a religious community of women, is known to have managed three hundred forty-seven such houses for the care of the sick in Constantinople (Green and Kreiger 25; Lane and Lindquist 6).

The first truly monastic order of the West, the Benedictines, originated in the sixth century in Italy. Hospitality and the care of the sick were always an important part of the Benedictine life. Benedictines were directed by their rule that "before and above all things, care must be taken of the sick" (France and Rajiv 32). Benedictine abbeys of men and women spread rapidly throughout Europe between the sixth and tenth centuries (France and Rajiv 32).

By the year 800 every important city in the Moslem world had its own medical hospital with trained physicians and substantial endowments. But, Christian Europe accomplished this feat only in the thirteenth century, when almost every hospital was administered by religious orders of hospitallers (Green and Krieger 25; Lane and Lindquist 6).

Orders of hospitallers were established to give care to

pilgrims, the poor, and the sick, they could be found in all the important cities of Europe. The Gilbertines, a group of religious women, worked mainly in England. Both the Antonines and the Order of the Holy Spirit began in France in the thirteenth century and spread throughout Europe in the following years. The Knights of Malta were founded in 1108 to help the sick and tend pilgrims in the Holy Land during the Crusades (Green and Krieger 25; Lane and Lindquist 7).

By 1200 the medieval hospitallers were working under physicians trained at Salerno and Montpelier. When the orders of sister hospitallers came into being, the sick were treated as "masters of the house," and medical care in the Middle Ages was free to the patient (Lane and Lindquist 10).

The Renaissance brought renewed interest in the natural sciences, but had a negative effect on society by placing pleasure, leisure, and wealth above work, service, and devotion. The less fortunate were considered inferior and treated accordingly. During the Reformation in the sixteenth century Christianity was split, church properties confiscated, religious driven out, and the sick and poor were left untended. With the dissolution of monasteries in England under Henry VIII the English hospital system virtually disappeared (Green and Krieger 26; Lane

and Lindquist 11).

Gradually during the next century hospitals under municipal management appeared in London, Paris, and several German speaking cities. A trend toward the study and teaching of medicine centered in the hospitals of this period was initiated in Holland with the introduction of bedside teaching at Leiden in 1626. Later, under the leadership of Dutch physician Herman Boerhaave (1668-1738), this trend was consolidated and influenced other medical centers, especially Edinburgh. By the beginning of the eighteenth century the character and concept of the hospital was changing, and there was a growing emphasis on its function of treating illness (Green and Krieger 26; Lane and Lindquist 13).

The development of hospitals in the "new world" began in the sixteenth century. The Spanish conquistadors established a hospital in Santo Domingo in 1503, and in 1524 Cortez founded the Hospital of Jesus in Mexico City, the oldest existing hospital on the American Continent. In Canada, the Hotel Dieu De Precieux Sang was founded in Quebec in 1639. In the same century there were several hospitals for wounded and sick soldiers built by Dutch settlers in what was then New Amsterdam (present day New York) (Green and Krieger 27; Lane and

7 Lindquist 12).

The Beginning of Hospitals in America

There had been little structured provision for the needs of the sick on the American continent during colonial times. British Canada and French holdings in Louisiana provided minor exceptions to this reality. The New York and Pennsylvania colonies alone found means to respond to certain emergencies. The first quasi hospitals were actually those set up to care for the sick and wounded soldiers in service to European kings and queens. One hospital was founded by the Dutch of the East India Company on Manhattan Island in 1658. During the seventeenth century almshouses were established by municipal officials in New York, Pennsylvania, and New Orleans. Philadelphia's almshouse, erected in 1731, was affectionately know as Old Blockley. New York's Bellevue began functioning as an almshouse in 1736. There was also a health facility for New York's French colony begun the same year (Berki 589).

In 1737 New Orleans had begun the operation of St. John's. It admitted the poor but received payment from patients as well, although most almshouses served primarily as institutions to care

for the indigent of these cities. Also, almshouses usually provided multiple services, doubling sometimes as orphanages and sometimes for the confinement of criminals or the mentally ill. Gradually almshouses were separated from hospitals so that they could be used to isolate from the community those who were clearly undesirable. At the typical almshouse the quality of care remained poor; there were often shocking abuses, especially involving those considered to be "insane." The "voluntary" hospitals provided better care because they were financed by contributions and by patients fees (Berki 589; Ettenson and Wagner 86; Lane and Lindquist 15).

During the Revolutionary War (1776-1783) health care took on another dimension. The wounded could anticipate care from a variety of sources, and for the first time some colonists came into contact with a corps of Catholic women whose religious inspiration motivated them to care for the sick. Protected by religious liberty in British Canada, these Catholic sisters were able to respond to the needs of the revolutionaries. Thus New England soldiers serving under Benedict Arnold and ravaged by epidemics of smallpox and scarlet fever were nursed back to health by the sisters at the Hotel Dieu Hospital in Quebec. Later that same year members of both the British and Colonial forces

who were involved in the Battle of Three Rivers (Vermont) were taken to a convent run by the Ursuline Sisters, where members of both armies were treated with compassion (Thompson and Rao 17).

Many changes in the provision of health services occurred as the eighteenth century began. For one thing, the United States Public Health Service began to function; it operated a marine hospital as early as 1798. Also an 1804 act of Congress made every seaman in the merchant service entitled to health care. New Medical strategies such as the use of morphine and the practice of isolation to prevent exposure to disease were employed for the first time (Green and Richardson 58).

In 1800 America's population was 5,308,483. Only 322,000 lived in communities larger than twenty-five hundred. A person who felt sick was ordinarily treated by a neighbor or relative. If the illness persisted he or she would consult a physician. The physicians credentials were usually limited to apprenticeships with a local practitioner. Normally the physician knew his patients personally and treated them in their homes (Moustafa 125).

When Thomas Jefferson was inaugurated as President in 1800 there were only two American hospitals, one in Philadelphia and the other in New York. Most Americans in 1800 had

probably not heard that such things as hospitals existed, and only a minority would have ever had occasion to see one. Philadelphia's Pennsylvania Hospital had been founded in 1752 New York Hospital, although organized in 1771, did not receive patients until the 1790's, while Boston's Massachusetts General Hospital did not open until 1821. If few Americans had encountered one of these institutions or visited the hospital wards of an almshouse, fewer still would have been treated in one. Most hospital patients were urban workers or seamen; only occasionally did the member of a prosperous and respectable family find his or her way into a hospital bed (Fishbein 24; Moustafa 130).

Even among the working poor, sickness and dependence meant institutional care in an almshouse ward. The concept of a hospital was little more than an embryo in the era of President Adams and Jefferson. Although hospitals increased in scale and numbers with the growth of America's urban population, they were to remain insignificant in the provision of medical care in America. Yet to that handful of elite urban physicians who staffed them and those philanthropists who supported and administered them, these pioneer hospitals were significant indeed (Fishbein 24; Moustafa 131).

Bettman (422) found that the origins of the American hospital began as much with ideas of dependence and class as with the unavoidable incidence of sickness and accident. If most philanthropists were a trifle uncertain about the internal working of a hospital, they knew with certainty what they did not want, and that was an almshouse. One of the fundamental motivations in founding American first hospitals was an unquestioned distinction between the worthy and unworthy poor, between the prudent and industrious objects of a benign stewardship and those less deserving Americans whose own failings justified their almshouse incarceration. Thus, it was only natural that the Pennsylvania Hospital should, in the late eighteenth century, have demanded a written testimonial from a "respectable" person attesting to the moral worth of an applicant before he or she could be admitted to a bed. Bettman (432) states that Philadelphia's Lying-In-Charity Hospital assured potential supporters in 1834, for example, that great care would be taken to:

> Discriminate between the deserving and the undeserving. Our object is not to encourage inactivity and improvidence, but to mitigate the unavoidable suffering incident by nature to the feebler portion of the human family, and to furnish some of the cheering comforts required, and

which the individual cannot possibly procure. (432)

Bettman (433) also found that in every city there were young men adrift from family and community, mechanics and hard working artisans stricken with incapacitating illness or aged widows of irreproachable character who had spent a lifetime in piety and hard work. There were the insane as well, helpless by definition and drawn, as did not seem to be the case with most other ills, from every social class. To help such unfortunates was no less than demanded by the responsibilities of Christian stewardship.

The hospital was something Americans of the better sort did for their less fortunate countrymen; it was hardly a refuge they contemplated entering themselves. Nevertheless, all conceded the hospital's benefits extended well beyond the immediate recipients of its care. The hospital's wards and amphitheater would serve as a school of clinical medicine, and some physicians at least would have the advantage of seeing and treating a broad variety of patients. And although a few American medical schools had come into being by 1810, Pennsylvania, Harvard, Dartmouth and New York's College of Physicians formal curriculum was entirely didactic. The aspiring

medical student was required to sit through two "courses" of such lectures before becoming eligible for his degree. Clinical training as yet had no part in the medical school's responsibilities. Yet as thoughtful observers had been aware of for at least a century, not even the busiest doctor could boast a practice approximating the number and variety of cases a young man would see in the hospital's wards (Lane and Lindquist 14; Forgionne 25; Thompson and Rao 16).

Advocates of America's first hospitals all emphasized the institutions educational function. It was an argument that appealed to municipal pride as well. To found a hospital was to keep ones eager and ambitious young physicians at home for their training. To Philadelphians in mid-eighteenth century it meant avoiding the expense, moral temptation, and danger of an ocean voyage and residence in London or Edinburgh. To New Yorkers it meant that their young men would not have to voyage south to rival Philadelphia for clinical experience (Javalgi and Rao 14).

The advantages of hospital work for established clinicians were even more immediate. To the prominent physicians and surgeons who walked its wards and treated its patients, hospital appointments meant both honor and profit. The hospital was from its very origins inextricably linked to the careers of

successful and ambitious medical men. Christianity, intellectual curiosity, and a laudable ambition were consistent in underlining the centrality of the hospital to such leaders of the medical community. It is hardly surprising that prominent clinicians played a pivotal role in the founding of all our early voluntary hospitals. The Quaker physician Thomas Bond enlisted Benjamin Franklin in lobbying for establishment of the Pennsylvania Hospital, while a similar role was played by Amuel Bard in New York and James C. Jackson and John Collins Warren in Boston. It was a pattern to be followed in American cities both large and small throughout the nineteenth century (Nisbett and Wilson 232; Scotti and Booner 8).

The benefits of the hospital would be distributed among every social class. The worthy poor would find an opportunity to recover outside the almshouse's demeaning walls, while society would profit from the productive skills of each worker restored to health. The insane of every class would find an appropriate haven and perhaps in time clarity of mind. The established urban physician would be allowed to exercise his benevolence and clinical acumen, while younger clinicians could improve those skills that might eventually allow them to replace their teachers as leaders in their city's medical profession (Hisrich and

Peters 55; Scotti and Bonner 8; Thompson and Rao 18).

Thompson and Rao (18) found that hospital reality began with admissions. Formal criteria in all the early voluntary hospitals were similar. None admitted those with contagious diseases or with chronic ills. These people endangered the hospital's staff and patients, and undermined its limited ability to provide beds for the potentially curable. As the chronicler of Philadelphia's Pennsylvania Hospital explained in 1831, "the institution was not intended to be an asylum for poverty" (18), "no incurable cases would be admitted" (18). Thompson and Rao (19) also found that the editor of the Boston Medical and Surgical Journal defended a similar policy of the Massachusetts General Hospital (MGH):

> For our own part we cannot conceive why any one should suppose it an act of inhumanity to reject patients of this description. The reception of them into an institution designed for the cure of diseases which are within the power of medical and surgical skill, would be the surest of all modes of defeating the objects of such an establishment. (19)

Both hospitals had only a limited number of free beds. If chronic cases were admitted, MGH attending physician James Jackson argued, these beds would be soon filled and "the hospital would become an asylum for the sick poor, like an

almshouse, instead of being a place for the relief of disease" (Thompson and Rao 20).

Life On The Ward

In the spring of 1874 the Board of Managers of Philadelphia's Pennsylvania Hospital appointed an Officer of Hygiene, a young physician whose task it would be to inspect the building from basement to attic and report his findings. The building through which the Officer of Hygiene walked in 1874 had in many ways changed little since the beginning of the century. Nurses were often absent from assigned wards and servants insolent or evasive. Chamber pots remained full for hours under wooden bedsteads, and mattresses were still made of coarse straw packed tightly inside rough ticking. Vermin continued to be almost a condition of life among the poor and working people who populated the hospital's beds, and lice, bedbugs, flies, and even rats were realities of hospital life (Green and Krieger 28).

The bylaws of the New Haven Hospital specified that patients take off their hats in the wards and their boots or shoes before lying down. All patients able to leave their bed will wash themselves in the ward bath rooms and comb their hair,

immediately upon getting up in the morning, and every patient is expected to bathe once a week" (Lane and Lindquist 15). Philadelphia's Jewish Hospital similarly warned its patients in 1874 that they had to remove all their outer clothing before getting into bed and refrain from "using tobacco, spitting, or throwing anything upon the floors or steps, and throwing or hanging anything whatever from the windows, balconies, or verandas" (Green and Krieger 25; Lane and Lindquist 16).

In every hospital, both private and municipal, ambulatory patients would, as they had since the eighteenth century, be expected to help with the cleaning, serving, and mending. The superintendent of one large city hospital suggested in 1883 that recovered patients be made to work for two weeks after they would normally have been discharged. It was only right that they pay with their labor for the care that had helped them recuperate. Social position, not sickness, was still the primary determinant of a patient's hospital identity (Green and Krieger 26).

As the American population expanded in the 1840's beyond seventeen million Americans to include hundred of thousands of recent immigrants, especially those from Ireland and Germany, many aspects of American life changed. For one thing, procedures and practices concerning health issues changed

dramatically. In particular, modern inventions and discoveries provided better health opportunities for Americans. Practicable coal furnaces and indoor facilities such as flush toilets, bathtubs, and efficient kitchens meant more healthful and sanitary conditions, even for recent immigrants and the urban poor. These improvements in the quality of life transformed the concept of establishing hospitals which would be equipped for specialized care, especially at times of epidemics and crises, and which would be staffed by trained personnel. Communicable diseases were isolated in certain wards; the mentally ill received special forms of treatment, as when Pennsylvania Hospital set up a separate department in 1841. Surgery could be performed with the use of pain killing drugs and anesthesia, and the sterilization of instruments made full recovery from surgery more certain (Fox 701).

In 1847 the American Medical Association was founded as the national organization which was to make the first important and necessary changes in health care. Under its auspices, stricter educational and licensing practices were developed; it became effective in reducing and eventually eliminating "self made" doctors. The Association of Hospital Superintendents, founded in 1889, was a second organization established to be a charitable

and educational association to improve the care supplied by hospitals and hospital personnel. Under a new title, the American Hospital Association took the initiative concerning the unregulated increase in hospitals: the one hundred seventy eight hospitals of 1873 had grown to an astounding figure of more than twenty five hundred by the turn of the century (Fox 702; Shepherd 110).

The Death of Charity

For decades voluntary hospitals had been seeking governmental responsibility for the poor and socially dependent. Medicare and Medicaid, apparently assuming responsibility for these groups, might be seen as a vindication of the hospitals long held position. With cost reimbursement, giving services free to patients through "hospital charity" seemed dead; new hospitals were merely and clearly vendors (Thomas 651; Whitaker 220).

Indeed, so strong was the shift away from local responsibility that it had major spill over effects on the behavior of local government hospitals, in cities with a heterogeneous hospital system. Viewing the high cost of their tax supported hospitals, city governments refused to argue that the new federal programs

had made the public hospital outmoded and unnecessary, since the elderly and poor now had the right to care in "private" hospitals. As an unanticipated by product, Medicare and Medicaid thus promoted a doctrine of institutional irresponsibility for the poor among both voluntary and city owned institutions (Warner and Lapp 88; Wayne and Nason 145).

Hussman (33) found that in the 1960's many suggested that the largest city hospitals either be abolished or upgraded. City hospitals in the major cities were described by a New York medical school dean in 1967, one year after Medicare was implemented, as "badly run, impoverished, long neglected fleabags" (33). City hospitals, wrote the New York City health commissioner, would be inferior as long as they remained the residual system for the voluntary hospitals. The director of the University of Michigan Hospital, foreseeing a loss in the traditional clientele, remarked, "Even if the patient feared he would be used for teaching and experimentation, he had no alternative but to come anyway or stay home and suffer" (Hussman 34). Meanwhile, in Philadelphia, controversy over policemen and firemen treated at the city hospital led to charges that at least four city employees had died because of the wrong diagnosis (Hussman 34).

By the late 1960's tax supported hospitals which were the heritage of the old almshouse tradition were in crisis in Chicago, Boston, New York, and Minneapolis, and their role has continued to be ambivalent. Harlem Hospital staff severely curtailed services for a month, protesting hospital conditions. Cook County house staff bought a full page advertisement in the Chicago Sun Times, proclaiming, "The Hospitals are dying and the doctors are helpless" (Fox 702). The faculty council of Louisiana State University Medical School predicted medical disaster unless more funds were made available for the state's Charity Hospital in New Orleans, and St. Louis City Hospital lost its accreditation.

Doctors revolted at Boston City Hospital in the summer of 1968, while 200 of Kansas City (Missouri) General hospital's 500 beds were slated to be closed and 150 employees dismissed. Meanwhile rising property taxes, competing city services, and high employment made hospitals less useful political vehicles for city administrations. With high employment there was less call for hospitals as employers of last resort and as sources of political patronage (Fox 703; Tawney 312).

In theory, government hospitals are unnecessary in a "contract state." Government agencies specify what needs to be bought, as a mater of public policy. Where they buy goods and

services is irrelevant, provided the contract conditions are met. Thus the old almshouse hospitals were left in limbo. Did they have a social mission at all? Did they have a function outside of being teaching institutions? If they are successful as entrepreneurs in the stakes for patient payments, why not "privatize" them, that is, reorganize them as private nonprofit or for profit agencies? From the late 1960's to the present these hospitals have existed in a climate of tension. Some have closed; some have chosen management by outside firms, usually for profit companies; some have sought to strengthen their "public" mission. There were difficult philosophical, ethical, and economic questions enmeshed in the relative futures of all kinds of hospitals under the immediate impact of federal spending (Tawney 315).

Conflicting legal theories of what constitutes a "charitable institution" muddied the waters further. Hospitals seemed an undifferentiated mass of vendors, with little charitable or public intent, and little to choose between voluntary, investor owned, and governmental institutions (Tawney 316). Are any of them charitable at all? Even tax supported hospitals playing the game as if they too were businesses, came under increasing criticism from the courts. A notable example was when government hospitals traditional exclusion from tort liability for negligence was

overturned in a key Michigan case in 1979, in Parker vs. Highland Park. This case reiterated earlier criticisms about the doctrine of charitable immunity for voluntary hospitals. The facts were that all hospitals were charging and receiving money for their services and seeking profits. The Parker case was quite specific: " The modern hospital, whether operated by a city, a church, or a group of private investors, is essentially a business" (Tawney 317).

Payments

As the proportion of paying patients rapidly increased, so did acceptance of payment in principle; by 1900 payment was the "true scientific plan" for hospital charity. Patients who could afford to pay more were often charged at rates above cost to help subsidize the poor, while additional funds were sought through private donations and government subsidy. Assumptions about paying for care were folded into the prevailing language and expectations of the practice of charity, with its strong focus on the work ethic. The relatively well endowed Presbyterian Hospital in Chicago is a good example. This hospital, designed for both paying and nonpaying patients from its beginnings in the 1880's, labeled those patients "productive" and "unproductive"

respectively. Nevertheless, hospital spokesmen had no difficulty in describing Presbyterian as a "monument of charitable purpose and action" because it represented an "immense investment of capital and good will" (Warner and Lapp 145).

Another change that confronted the hospital providers after the 1940's came about as a result of the Hill-Burton Federal Grant which allowed patients access to certain kinds of hospital treatments never before affordable. This federal law was meant to be a means of providing equal access to hospital care. The program also prompted the construction and expansion of hospitals through massive grants and subsidies for increases in hospital capacity. Expansion resulted in an increased patient census and greater access to newer therapeutic measures (Fox 702; Shepherd 55).

As new technologies continued to increase, new specialists in health care were required and new equipment and facilities had to be added. No longer was the aim of hospitals simply to serve the acutely ill. By the late 1940's and early 1950's, not only were patients suffering from chronic illnesses coming to the hospital for treatment, surgery, or relief of pain, but for the first time patients were also being admitted to hospitals in order to prevent or forestall disease or illness. The focus of hospitals

became one of preventive medicine, and outpatient service centers were added to acute care facilities. At this point new skills had to be acquired and educational services had to be updated in order to provide specialized information for both physicians and nurses. In some facilities, research departments were needed to further health care delivery. This change in the scope of health care was confirmed by the ready response of the general public to the new directions (Thomas 652).

During the 1960's new advances in medical science and techniques occurred. Major strides in plastic and reconstructive surgery during World War II and the Korean War contributed to corrective and rehabilitative procedures; the therapeutic aspect of medical care became an important part of overall medical care. So too did such drugs as cortisone, steroids, tranquilizers, antihistamines, and antimicrobial agents that contributed to the management, control, and, in some instances, prevention of health problems. Studies to combat heart disease, cancer, and strokes also yielded beneficial results and required specialized training. Federal funds were allocated for further research as consumer groups became more vocal in their demand for improved health care (Thomas 653; Whitaker 225).

As the public pursued a better quality of health care, most

hospitals joined public agencies in the utilization of federal funds, particularly those that enabled the construction and expansion of facilities which were designed for the new medical advances. In turn the public, especially those aided by new health care insurance, turned to hospitals in increasing numbers in order to take advantage of new possibilities. Still another change occurred as hospitals expanded their services; they became major employers in their respective locations (Whitaker 228).

Following World War II in particular, entire families began to participate in a variety of voluntary health care insurance programs. Third-parties (health insurance and government health programs) were thought to cover 88 percent of American families in 1995 to some degree. Coverage of the total health care cost for America in 1995 country (9.1 percent of the Gross National Product) however, varies from including only a part of hospitalization cost for a limited period of time, to including every conceivable medical, dental, drug, appliance and nursing cost. Hospitalization for acute illnesses is the most usual benefit provided to almost everyone, with the consequence that in-patient acute hospital revenues are usually derived from third-party sources to a degree over 90 percent. Today the hospital's financial health depends principally on their local third-party

environment, with their losses mostly depending on their management of the small but precarious mixture of cash payments, bad debts and charity. The central problem revolves around their inability to generate a profit on government sponsored patients. Therefore, hospital revenues were divided into two general categories, the retrospective cost-reimbursement third-parties (Medicare, Medicaid and Blue Cross), and the cost-plus-profit sources (Forgionne 25; Hisrich and Peters 78).

Medicare

Warner & Lapp (34) found that after leaving office Former President Harry Truman said:

> I have had some bitter disappointments as President, but the one that had troubled me most, in a personal way, has been the failure to defeat organized opposition to a national compulsory health insurance program. (34)

Truman had promoted enactment of such a program throughout nearly two full terms as president only to find bills incorporating the scheme bottled up in congressional committees. Trumans advocacy of health security labeled socialistic and un-American by

forces led by the country's richest and most influential post World War II lobby, the American Medical Association. But although nearly sixty-nine years old when he retired from public life in 1953, Harry Truman lived to see inauguration of Medicare twelve years later, during the Johnson administration (Warner and Lapp 35).

In Independence, Missouri, July 30, 1965 was a momentous day, a day that signaled the signing of the Medicare bill into law. Medicare was the most significant addition to the nation's old age insurance system since passage of the Social Security Act thirty years before. Former President Harry Truman was eighty one years old and a bit unsteady afoot but he was still able to recall the prolonged and heated debate that had been generated over his national health insurance proposals back in the forties and early fifties. Truman had been, after all, the first president to endorse publicly the government health insurance idea. Truman had repeatedly asked Congress to enact it into law and had boldly carried the issue to the American people in the presidential election campaign of 1948. When organized opposition led by the American Medical Association proved too strong and his comprehensive insurance program suffered defeat in Congress, it had been Harry Truman who shifted in early 1951 to a hospital

insurance plan for the aged under social security, the precursor to medicare (Warner and Lapp 40).

Medicare became effective (under PL 89-97) in 1966 and provided members of the population sixty five years and over with substantial hospital and medical benefits; in 1972 the disabled and kidney dialysis and transplant patients were also included. Basic benefits initially included up to ninety days of inpatient hospital care per illness, outpatient care, post hospital care in a skilled nursing home of up to a hundred days per illness, home health services, and physician services, with various deductibles and coinsurance imposed upon patients. Hospitals were guaranteed payment by the program on the basis of "reasonable costs" (Fox 702; Warner and Lapp 40)

Nationally, the program was administered by the federal department of the Social Security Administration. However, payment of hospitals on behalf of medicare patients was organized through fiscal intermediaries. These third parties provided a buffer mechanism between the government and voluntary, for profit, and local government hospitals. In the negotiations surrounding the legislation the AHA fought for the concept of intermediaries, arguing that the hospitals "needed protection" from the potential iron hand of government agencies.

The ideal intermediary, from the hospital perspective, was Blue Cross, with its commitment to the strength and goodwill of the voluntary approach. Under Medicare, hospitals were allowed the privilege of picking their own intermediary; 90 percent chose Blue Cross. In another bow to the existing system, hospitals were guaranteed participation in the federal program by virtue of accreditation by the Joint Commission Accreditation of Hospitals, (JCAH) government certification (Warner and Lapp 45).

Medicare is divided into Part A, which reimburses hospitals at cost, and Part B which pays doctors and out-patient services their charges. Whatever its population coverage, the financial impact of Medicare is great because of the increased illness experience of the elderly. Scotti and Booner (8) found that in 1996 the number of persons reaching age 65 is now increasing 5 percent per year. Medicare carries a deductible and coinsurance feature to involve the patients in a sense of responsibility for their costs, but sometimes this leads to bad debts which are then reimbursable. A great many persons have purchased supplemental insurance to cover these "gaps" in coverage. However, the effect of such supplemental insurance obviously defeats the usage restraints of deductibles and coinsurance, so it is a type of insurance which is difficult to defend as a concept.

It is also difficult to challenge the freedom of people to respond to their problems with such supplemental insurance (Nisbett and Wilson 235; Scotti and Bonner 8; Thompson and Rao 29).

Medicare gave hospitals a license to spend. The more expenditures they incurred the more income they received, until the system was changed in the early 1980's. Medicare tax funds flowed into hospitals in a golden stream, more than doubling between 1970 and 1975, and doubling again by 1980. One major result of Medicare was to distinguish further the role of government as purchaser from that of hospitals as sellers of services in the marketplace. Another was a great increase in government power, through recognition of the power of the purse. Later there was recognition of similar power vested in major, nongovernmental purchasers, that is, employers (Davis and Sturges 3011; Ross 520).

Nonprofit hospitals were dramatically changed by governmental oversight in many ways. In particular, the immunity of nonprofit hospitals from litigation on the basis of their charitable donation to society was slowly eliminated. Religious congregations had to face the implications of becoming indebted to the federal government. Also, the recent changes in reimbursement methods and regulations have decreased inpatient

utilization of acute care facilities significantly and increased outpatient activity. The severity of acute care patients in acute care hospitals has also increased, with the majority of these patients being elderly and having complex health problems. The needs of these frail elderly, especially their home care needs, are among the most serious issues of this time. The increased life span of the population must be addressed in relation to its impact on society's health care systems (Bettman 425; Ettenson and Wagner 88; Lane and Lindquist 18).

From the beginning Medicare expenditures grossly outran federal estimates. Although hospital utilization by the elderly increased more rapidly than expected, these figures could not be attributed entirely, or even in the main, to increased inpatient admissions. One study of factors contributing to the increase in total hospital costs between the mid 1960's and early 1970's attributed less than 10 percent of the increases to expanded utilization and growth of population. Another 23 percent was attributed to the rapid inflation in the economy in this period. The remaining two thirds represented massive expansions in hospital payroll and nonpayroll expenses including profits. The average cost per patient day more than doubled, in real terms, between 1966 and 1976, that is, even after allowing for inflation. The

total assets of short term hospitals rose from $16.4 billion in 1965 to $47.3 billion ten years later (Bradley 415; Ross 520; Shepherd 122).

Medicare made hospital managers and entrepreneurs acutely aware of the games that could be played to maximize hospital income by including the costs of borrowing money in third party reimbursement rates. The availability of Medicare reimbursement accelerated the preexisting trends toward borrowing funds for hospital capital projects and the decrease in government grants and private gifts as the base funding for new buildings. Voluntary hospital administrators, as well as for profit hospital managers began to view their budgets in terms of the institutions entire financial requirements, including operating expenses and capital as one package. Demands for capital were increasing from the working capital necessary to keep an institution going pending delays in reimbursement through funding for the development and start up costs of new projects, and money to replace buildings and equipment. Far from making hospitals more "socialized," Medicare encouraged them to be more "capitalistic," in the most fundamental sense of this word (Ketchom 28; Daniel 236; Ross 521).

Medicaid

Medicaid for the indigent became Title XIX of the Social Security Act in 1966, but there are appreciable differences between Medicaid and Medicare. The Medicare program is directly financed out of the Social Security Trust Fund, while Medicaid is a federal 50 percent matching program. The federal half of the Medicaid money comes from tax revenues and is administered by the states in their welfare programs. A separate agency of HEW supervised the program at first, but so much bureaucratic infighting took place that the Medicare and Medicaid programs were consolidated in the Health Care Financing Administration (Berki and Ashcraft 589; Bettman 422; Gaeth 62).

Green and Krieger (28) cite that the problems were alleviated somewhat by the reorganization, but Medicaid continues to be difficult to administer because of its different source of federal revenue, and the need to yield to the prerogatives of 50 different state welfare agencies. The federal government would obviously like to make the program more manageable by taking it over, but fears the prospect of providing the remaining 50 percent of the funds. The states have lately become the most powerful effective

lobbyists in Washington, and the state bureaucracies which would be threatened by a federal takeover are strongly urging the advantages of local administration. Green and Krieger (29) found that if one cuts through the cross-accusations of incompetence, waste, and confusion of authority, there is one central truth about Medicaid: the states cannot afford to supply their 50 percent of the money, and unlike the Federal Treasury, cannot print money.

Blue Cross and Blue Shield

The Blue plans (Blue Cross for hospital costs, Blue Shield for physician charges) were created in the depression years by hospitals and physicians, in response to such widespread inability of the public to meet medical bills that payment of a discounted bill seemed a vast improvement over no payment at all. It can plausibly be argued that these volunteer community efforts prevented the collapse of the private medical system or the creation of a government run health system of the Scandinavian or British variety. Most of the problems now posed by the Blue plans grew out of failure to modify the premises which were appropriate to the 1930's. Payment on a discounted basis, rather than full payment, persists as a principle in both Blue Cross and

Blue Shield. Retrospective cost reimbursement remains the predominant method of Blue Cross payment and their non-profit corporate structures have persisted even though the larger plans approach a billion dollars in annual turnover (Green and Krieger 28; Javalgi and Rao 20).

As a result, although Blue Cross became a national movement, it was also one which was geographically skewed. The concentration of voluntary nonprofit hospitals (relative to their types of hospitals in different areas) obviously affected the environments in which prepayment plans were established. In industrial states like Illinois, Massachusetts, New York, Pennsylvania, and Ohio, where more than 60 percent of all general hospitals were nonprofit in 1939, unified voluntary policies for prepayment were easier to achieve than in states where there were relatively more government or proprietary institutions (Bradley 422; Ross 532).

For any group hospitalization plan that developed in Georgia, Nebraska, Oklahoma, or Texas, where proprietary hospitals comprised more than half of all hospitals in the state, it had to be decided whether to include proprietary institutions, assuming it was possible to get a scheme going to all. In the south and west, multi hospital voluntary prepayment schemes tended to be limited

to the few cities that had both an established pattern of interhospital cooperation, at some level, and a predominance of voluntary institutions (Green 1346; Ross 536).

Texas, in particular, remained a slow and reluctant participant in the Blue Cross movement. In Dallas, for example, where the Baylor plan had begun, two other competing hospital plans soon arose, including a commercial plan, the National Hospitalization System. This firm also worked with hospitals in Forth Worth, Texas, Louisville, Kentucky, and Shreveport, Louisiana. Memphis reported four separate plans in the late 1930's, each promoted by a different hospital. Two of the plans employed a private promoter who worked on a commission, receiving one third of the enrollment fees. However, for the most part commercial insurance companies expressed little interest in the uncertainties of hospital insurance in the 1930's, while hospitals usually found paid solicitors unsatisfactory and unnecessary (Daniel 236; Ross 528).

Group hospitalization plans were businesslike from the beginning, targeted to the budgets of the voluntary hospitals and designed for the technology conscious working population. The men subscribing to Blue Cross plans in 1940 were predominantly in clerical work or sales (40 percent), in business or professional

jobs (27 percent), or blue collar occupations (30 percent). Women subscribers were generally professional and clerical workers or in sales (66 percent and 18 percent respectively). They were attracted to the plans by upbeat publicity campaigns in newspapers and by radio spots in music programs and variety shows. Monthly enrollment fees were compared to the cost of a pair of silk stockings every other month or of a package of cigarettes a week. Posters and newspaper advertisements featured storks carrying babies labeled "Prepaid," or advising in cartoon form: "You never know what it is around the corner." Thus the technology of hospitals was linked to the expectations of middle class workers (Warner and Lapp 157).

The model preferred by the hospital establishment within the American Hospital Association was the multi hospital (noncompetitive) prepayments scheme, organized as a nonprofit corporation and supported by local voluntary hospitals. The first such plan in Sacramento (1932) was soon overtaken in scope by rapidly successful undertakings in St. Paul, New York, and Cleveland, each a city with a strong voluntary hospital presence. It was from St. Paul that the Blue Cross insignia was taken as a symbol of the entire prepayment movement. Multi hospital support encouraged voluntary hospitals not to compete with each

other for patients and consolidated their interests at the local level (Warner and Lapp 110).

Blue Cross plans, like their supporting hospitals, lacked endowments to give free or subsidized care. They were designed to alleviate workers budgets at times of sickness and to produce more paying patients, not to provide hospital access to everyone. It was quite the reverse, for plan executives took pains not to make their members second class citizens in a hospital system that was already multiclass. Benefits were designed to give members access to patterns of private, high technology care, with reimbursement to hospitals providing a similar operating margin to that of self pay private and semiprivate patients. They avoid any criticism that Blue Cross was a "Class proposition," carrying the odor of charity or philanthropy (Warner and Lapp 112).

Nor did any plan want its initial membership flooded with expensive hospitalizations. Eligibility for obstetrics usually began ten to twelve months after initial enrollment. Mental health was almost universally excluded, and coverage for chronic diseases was rare. Enrollment was targeted, as far as possible, on groups of workers who formed a relatively healthy population, in order to avoid "adverse selection" or "bad risks", as well as to tap into a

ready market niche and to reduce the administrative costs involved in enrollment. In twenty eight of thirty seven Blue Cross plans surveyed in 1940, members were asked to sign a health pledge before receiving their membership certificate. Structurally, the Blue Cross schemes were corporations founded by corporations (the voluntary hospitals) which responded to the needs of other corporations (employers). As a result, Blue Cross was a "community" scheme but not a "social welfare" scheme; notably, it excluded the unemployed, the elderly and the disabled, as well as agricultural, domestic, and other part time workers who had no affiliations with the organized workplace (Daniel 236; Bradley 415).

As new (typically nonprofit) corporations, prepayment schemes were a potential threat to local physicians, suggesting hospital control at one remove. However, the physicians were able, in large part, to mold the structure and direction of the plans in ways that served physician interests and encouraged a sense of solidarity between voluntary hospitals and physicians. The question was, what should be covered? Were the new plans to cover, for example, outpatient care, the services of attending physicians, or even the services of the hospital based specialists in radiology, anesthesia, and pathology? Doctors rallied initially

to oppose repayment. However, as the success of local hospital medical negotiations rapidly indicated, the plans as written actually enhanced physician autonomy and reduced the danger of hospital dominated medicine (Thomas 654).

Each local plan negotiated its own menu of services to be covered, depending on local custom and medical power structures. Subscribers generally received twenty one days of acute hospital care in any contract year, laboratory services, drugs and dressings, X-rays, and anesthetics. Plans paid, on average, three fourths of the entire hospital bill. Following the established custom of separate hospital and medical bills, the plans excluded the service of attending physicians. By this move hospitals effectively ruled out the alternative of hiring their own staff physicians to provide complete medical care (Thomas 652).

Blue Cross plans usually escape premium taxes which are typically two percent, and this advantage plus the existence of contractual discounts from hospitals has allowed aggressive plans to become virtual health insurance monopolies in some areas like the east coast. If the hospitals and physicians who initially provide the seed capital, discounts and management had been less selfless in forming non-profit corporations, the Blue plans

would have sold shares to stock holders and there might now be less competitive advantage. Instead, states are increasingly prodded by the Federal Trade Commission to pass laws forbidding hospitals and doctors to sit on the boards of directors of corporations they founded (Nisbet and Wilson 238).

Blue plan share of the entire market even in the East was considerably diminished by the advent of Medicare, which took away large numbers of subscribers with a heavy illness experience. On the other hand, Medicare and Medicaid copied the Blue Cross system of retrospective cost reimbursement. Since the government merely supervises Medicare and Medicaid and the actual administration is conducted by contract with private organizations acting as intermediaries, it was fairly natural for the great majority of these lucrative contracts to go to Blue plans. Since the non-profit corporations never had profitability at risk, it has made very little difference to Blue plan intermediaries whether the business was governmental or their own (Nisbet and Wilson 239).

Health Maintenance Organizations

The great recent concern about rising health care cost among

Fourth-party employers and government has led to the development of public discussion panels on the subject. Such panels typically include a labor leader, a businessman, an economist, and a hospital representative. No matter what constituency or political coloration is represented, such panels typically take only about twenty minutes to agree that the moral hazard of widespread health insurance is the major cause of the recent escalation of medical cost. Naturally it follows that the solution must be some modification of the insurance mechanism. For a while, prepaid salaried group practice arrangements were proposed, but government quickly lost interest when it became clear that such groups could anticipate a high start up cost. The federal government subsidizing the seed money for a thousand of those did not sound like a good way to save money (Ettenson and Wagner 89).

Attention then began to turn to certain prepaid insurance arrangements created in central California by groups of physicians who wished to compete, but who also wanted to preserve independent fee-for-service practice. In small towns, the entire medical society might join the arrangement and practice as before, with two changes. The doctor would bill the insurance carrier instead of the patient, and the patient (or his employer)

would pay an annual lump-sum premium. On examination, it was found that such arrangements did result in a reduction of hospitalization rates for the subscribers; the doctors and the patients seemed happy, and start-up costs were small. Because clients of the prepaid arrangements were intermingled with the fee-for-service patients in the doctor's practice, the scheme could start small and grow as fast or slowly as it pleased. If the Fee-for-service clients began to find that the pre-paid premium was cheaper, they might switch . If the reverse was true, the thing would die and no great harm would be done (Ettenson and Wagner 90; Forgionne 30).

If several competitive pre-paid schemes started up in the same locality with different alliances of doctors, maybe this was a way of re-introducing competition into the health field. Competition over the price of the pre-paid premium rather than the price of the service was the goal, and it was lined to the concept of the physician group responding to risk. It would mean more money for them if they were careful of patient expenses, and less money if they got careless (Forgionne 31; Green and Krieger 28; Hisrich and Peters 75).

All of this sounded like a feasible proposal, so the concept of the Health Maintenance Organization (HMO) was born, and

federal grants became available to assist with planning and start-up. The California concept was modified somewhat, An HMO was to be a nonprofit insurance company with a mandated majority of non-physicians on the board of directors, but it would negotiate with an Independent Practice Association (IPA) which could well consist totally of physicians. Each had the freedom to become dissatisfied with the other and seek alternative relationships. In 1979 there were eight million subscribers to prepaid groups (four million of them in California), and there was considerable interest among both physicians and employers in learning more about HMO's (Hisrich and Peters 76).

HMO's justify their claim of "health maintenance" because failure to maintain subscriber health would theoretically be expensive for doctors instead of lucrative for them. The potential risks are greater than the potential rewards for those physicians whose practice income is already adequate. An underwriting loss of 30 percent might wipe out a year's net income, but a gain of 30 percent more gross revenue means more taxes and overhead. The public is thus often put in the position of switching to non-established physicians, since HMO marginal economics work in favor of a non-established doctor, but work against established ones. Indeed, the awkwardness develops that an HMO could not

afford to accept an established busy physician anyway, because he would bring along his patients. Such sorted-out subscribers would be considerably more unhealthy, hence more expensive, than the healthy bulk of the population who are not currently seeing a doctor (Hisrich and Peters 980; Javalgi and Rao 20; Lane and Lindquist 16).

The incentives for the fourth party paying the premium go quite the other way. An employer, of course, has whatever employees he has, sick or well. The premium is mostly experienced-adjusted in the present employee group health insurance. However, the HMO system does nothing to mitigate the present employer incentive to refuse employment to sickly people, and it may well consolidate the data about the employees' health in such a way as to intensify this antisocial incentive (Green and Krieger 28).

Medicare and Medicaid have a worse problem. They have tried to help the HMO program along by exploring the idea of offering to pay a fee equal to an HMO which accepts their clients, a fee equal to 95 percent of medicare's average client cost. Superficially that would sound like a five percent bargain until you consider that the HMO has an incentive to select out only healthy clients. Such a process would eventually raise the

total government cost quite a bit. Inexpensive well people would likely develop cost below average, while the patients with above average cost who remained behind in the present system would continue to be just as expensive (Thompson and Rao 36).

HMOs have the potential to reduce health care spending, but many HMOs fail to realize this potential. Half of the employers responding to Higgins found in 1996 that HMO rates were as high or higher than their non-managed care plan costs. On average, the research found that HMOs save employers 14.7 percent against traditional fee for service plans, but many individual HMOs, PPOs, and point of service plans do not. Research results show substantial variations in cost savings by geographic region. In some cities the average cost per employee for HMO coverage is actually higher than the average per employee cost for indemnity plan coverage. The Congressional Budget Office (18) research found that enrolling Medicare patients in HMOs "had little or no effect on hospital use and cost" (Higgins 24).

Statement of Purpose

American hospitals are regarded as the best in the world. But one out of every eight Americans has no hospital insurance.

Collectively, hospitals have become one of the largest enterprises the United States, spending $180 billion in 1987, employing 3.7 million people, and providing 34 million inpatient treatments and 311 million outpatient visits. Investor owned hospitals have begun to establish a strong presence, and the idea that hospitals are charities, or even elements of a welfare state, has diminished almost to extinction (Higgins 28).

After decades of growth hospital admissions and occupancy rates declined in the early 1980's. Hospital administrators and boards have counted a tightening market by being aggressively competitive and profit oriented by forming alliances among hospitals and with physicians, and by extending the hospital's "products" through diversifying into such activities as nursing homes, rehabilitation centers, medical equipment firms, and management consulting companies (Higgins 28; Thompson and Rao 35).

As the percentage of private patients rose rapidly in hospitals everywhere in the United States, the poor increasingly became a nuisance, even though if a "free" patient could be charged to the government, even partially, the patient was no longer "free" as far as the hospital was concerned. Therefore, the authors interest in this area has led to the initiation of this study to

examine the social changes of the American hospital as it relates to the patients ability to pay.

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Chapter 2

The 20th Century American Hospital

By the first decade of the twentieth century, the average patient's experience had become something very different from that which had been the lot of his predecessor a half century before. One source of change grew out of scientific and technological innovation. The germ theory and related public health practices reshaped not only the incidence of infectious disease, but the status and prerogatives of the doctor limited to apprenticeships with a local practitioner, but who normally knew his patients personally and treated them in their homes (Moustafa 154).

Moustafa (157) found that between 1870 and 1917 the American hospital was transformed from an asylum for the indigent into a modern scientific institution. Hundreds of new hospitals sprang up under the aegis of religious orders, clerics, industrialists, women's groups, ethnic associations, and committees of established and aspiring elites in communities across the United States. Hospitals were built in small towns across New England, in trade and industrial centers in the West,

in cities like Milwaukee and St. Louis that were expanding rapidly under an influx of immigration, in market centers for farmers in Georgia and Illinois and for lumber workers in Wisconsin and Washington, and in the railroad depots of great companies like the Santa Fe joining the older, usually larger hospitals in the more settled, established cities. Even small hospitals boasted well equipped, marble walled operating rooms, disciplined nursing schools providing willing workers to staff the wards, and a cadre of private attending physicians. The hospital, like the hotel, the factory, the club, and the symphony, was a manifestation of modern America (Moustafa 158; Woolhandler 18).

Patterns of influence, financial and political incentives, and expectations about the hospital's function were created that we still see today, both at the local and national levels. The medical profession was gaining a new identity and prestige through the successes and brilliance of surgery, through claims of expertise based on science, and through the strength of professional organizations. For the first time, The American Medical Association became a powerful national force after it reorganized in 1901 as the federated representative of state and local associations. Inside the hospitals authority was gradually being reshaped around the growing involvement of doctors in hospital

routine, from patient admissions through authority over nursing procedures, to decisions about autopsies. In turn, the relative balance of power shifted from hospital trustees to medical decision makers (Moustafa 159).

There was no standard definition of a "hospital" in 1900. American hospitals were a heterogenous group of institutions in terms of both function and size. They fell into three categories of ownership: proprietary, charitable, religious (catholic), and governmental. The most prestigious hospitals were organized as charities, by individuals who were usually not medical practitioners and who had agendas of their own (Woolhandler 18).

Proprietary

Proprietary hospitals operated by proprietors or owners were nearest to the day to day routine of many private practitioners, scattered across the country, who set up a few beds for the convenience of paying patients, sometimes in their own homes. Proprietary hospitals flourished in particular where other types of hospitals were unavailable, notably in the South and West. In North Carolina fifty-four of the sixty-five hospitals existing in

1916 were "proprietary hospitals," virtually all of them new hospitals opened by surgeons (Vayda Mindell and Rutkow 464; Woolhandler 19).

There may have been as many as 1,500 to 2,000 proprietary hospitals in 1910 out of a total of over 4,000 hospitals of all kinds. Eminent surgeons established their own small hospitals for private patients who preferred not to go to large institutions. Small town doctors set up small units where no other hospital existed, and profit oriented city specialists designed their own exclusive treatment centers, chiefly for women's surgery as this became a fashionable and lucrative field. Some of the profit making medical schools also owned hospitals as a sideline. In Louisville, Kentucky, for example, medical school professors ran a hospital as a profit making venture. Such hospitals were essentially small businesses in character, intents, and methods (Vayda, Mindell, and Rutkow 465).

Bettman (440) found that proprietary hospitals sought to admit only the morally worthy. The prostitute and alcoholic like the victim of typhus fever, smallpox, or cancer would be excluded and left to the almshouse, that residuary legatee of a city's misery. Thus maternity patients were often admitted to private charities if married, rebuffed if unwed. Some institutions would

admit an unmarried woman with her first pregnancy, but reject her subsequent indiscretions. Such early hospitals were hard-pressed for income. The Pennsylvania Hospital, for example, would admit incurable cases if they paid their way. The rate for smallpox victims was five dollars a week in 1840's, for venereal and alcoholic cases four dollars. The original building of the Pennsylvania Hospital maintained an average census of 150 patients from 1755 to 1965. In all probability, the building was completely paid for during the eighteenth century, and it can be estimated that during the following years it housed ten or eleven million days of patients care without any capital cost or debt service (Bettman 441; Hisrich and Peters 210).

Especially in the early years of the century personal ties often dictated admission decisions. In some institutions, no patient could be received without the "recommendation" of a subscriber. In out-patient dispensaries, similarly, a signed certificate from a contributor might be necessary before a poor man could receive medical attention. At the New York dispensary, for example, annual subscribers of five dollars had the privilege of "recommending" two patients at a time; anyone donating fifty dollars was awarded the privilege for life. However, no patient was to be treated without a certificate from one such

subscriber. Where individual philanthropists supported free inpatient beds, they often retained the right to approve the beds occupants (Louviere and Woodworth 360; Scotti and Bonner 14).

Thus the patients hospital experience was determined, first, by his or her location in society, which defined the likelihood of applying for admission; and second, by the natural course of the illness from which he or she suffered. Most patients were simply not that sick; the critically ill could not be kept alive by "extraordinary means" and most hospital patients were, in fact, not even bedridden (Nisbett and Wilson 240; Scotti and Booner 15).

Charitable Hospital

The private charitable hospital, organized under nonsectarian auspices and run by a voluntary board of trustees was the most prominent type of hospital in the early twentieth century. Not only were charitable hospitals socially useful as instruments of charitable impulse, they were valued for their role as modern, "progressive" institutions. It was in society's interest to promote medicine, including medical education and laboratory research in order to improve general levels of efficiency and skill in the

population. Hospitals also made economic sense in a technological, consumer oriented culture. Income from paying patients, a major drive and rationale for widespread institutional expansion, represented almost half of the budgets of nonsectarian private charities in 1904 and almost three fourths that of the "ecclesiastical" institutions (Andreopoulos 144).

The average length of a hospital stay was twenty-five days in 1904, but only nineteen days in nonsectarian charitable institutions. Hospitals were complex, expensive, and particularly attractive to paying patients. All charities charged where they could. However, the rise of surgery created a new market of services to relatively well off individuals who were not otherwise disabled or socially dependent (Andreopoulos 145).

Income from paying patients was particularly strong in the western states. Hospitals in thirteen U.S. states and territories drew 70 percent or more of their operating income from patients in 1903. In Utah and Oregon, government and private charitable hospitals together earned more from paying patients than they actually spent on hospital operations. Certainly, charitable hospitals benefitted from paying patients. In San Francisco, for example, the six charitable hospitals which took in more money from paying patients than their entire operating expenses in 1903

included the Lane Hospital (the teaching hospital for Cooper Medical College), Pacific Hospital (a private charitable corporation), St. Thomas Hospital (a private charitable corporation), the Protestant St. Luke's Hospital, and the Roman Catholic St. Joseph's and St. Mary's. The University of California even did quite well on outpatient services in 1905, receiving income from patients equivalent to two-thirds of its operating expenses (Evans and Stoddart 122).

Charitable hospitals were also exempt from local property taxes in many states in 1900, even though the hospitals made profits on at least some patients or services. Peoria County, Illinois, for example, unsuccessfully brought suit to tax a hospital run by the Sisters of the Third order of St. Francis where only 5 percent of the hospitals patients were charity patients in 1907. Through the courts, the private charitable hospital, nurturing its increasing market of paying patients, was given public sanction to expand its plant, services, equipment, and endowments (Andreopoulos 140; Evans and Stoddart 155).

The courts supported the principle of private benevolence as a public good. Trustees did not have to offer services necessarily, or even primarily, to serve the poor; nor did they have to demonstrate that the hospital's services were actually

needed. It was assumed rather, that the act of benevolence itself, the administration of wealth to create social ties across the community, should be recognized. It was also assumed that trustees knew what they were doing, and that what they were doing was for the public's general benefit (Andreopoulos 148).

Yet at the same time the charitable hospitals were vulnerable to criticism. The rush to construct charitable hospitals in 1910 led to a substantial and recognized oversupply of beds. At this point nearly half of all charitable hospitals lay vacant in Pennsylvania alone. The economic structure of charitable hospitals meant that available beds were not routinely made available for free patients. Neither doctors nor charity givers wished to engage in "indiscriminate charity," with the dual risks of establishing a permanent underclass of paupers and having people who could afford to pay cheat the system. These two activities were called "pauperization" and "charity abuse." The problem was that the shift of surgery to hospitals created a new category of obviously "worthy" patients; this is people who were medically needy but not necessarily indigent in other respects. The largest single occupational group supplying inpatients to the Pennsylvania Hospital in 1910 was of schoolchildren (22 percent of all admissions), typically admitted for tonsillectomies,

followed by housewives (19 percent) and laborers (17 percent) (Andropoulos 158; Evans and Stoddart 162).

Besides establishing the hospital itself, hospital boards and associated women's committees commonly established their own nursing schools as well, whose pupils provided basic staff for the hospital. Upon graduating, the nurses went on to nurse patients in their homes or to work in public health. By 1912 there were more than 1,100 nursing schools run by charitable hospitals, with over 30,000 students. Even the smallest charitable hospitals, those with under twenty five beds, had training schools. Nursing schools were important attributes of hospitals in the northeast, and somewhat less common in the west (Evans and Stoddart 170).

Governmental

France and Grover (89) found that no matter how poor you might be, it was hoped that no curable patients of good character need ever find themselves in an almshouse. One of the universal anxieties of respectable Americans throughout the nineteenth century lay in the fear of social decline and the polluting mixture of classes. When the New York Dispensary found itself in need

of larger quarters for example, it could appeal by invoking the vision of its one room, "where those who are still respectable, but misfortune are reduced to the necessity of asking for relief of this charity, are obliged to mingle with the most loathsome objects of wretchedness" (90). Similar motives lay behind the establishment of New York's Society for the Asylum for Lying-In Women. France and Grover (90) also found that when the New York Hospital closed its lying-in ward, the society's managers explained:

> There now remained no refuge for patients of this class but the Almshouse, where the virtuous and the vicious were indiscriminately treated. The visitors (of the Society) could not conscientiously advise a virtuous wife, to seek a home and companionship among degraded, unmarried mothers, And it was found, that, worthy females would suffer want, and even hazard life, before subjecting themselves to such association. (90)

The admission process was no simple exercise in differential diagnosis. Nor was it entirely controlled by medical men and medical criteria. Throughout the first half of the nineteenth century, the laymen who bore ultimate legal and moral responsibility for American hospitals sought to maintain practical control of admissions. Inevitably, particular decisions reflected

both medical and social criteria. In the early years of the Massachusetts General Hospital, for example, patients had to first make written application, then be seen by a physician, then be approved by the visiting committee of the Board of Trustees. Cases of "sudden accident" could be admitted at any time, but even such trauma cases had to be approved retroactively by formal action of the lay board's subcommittee. No physician could unilaterally control access to even the beds he himself attended (Louviere and Woodworth 365).

Since government hospitals provided a necessary support structure for the success of private charity in major cities, the number of local government hospitals did not diminish when other hospitals opened. Instead, government's role became even more important in the early twentieth century than it had been in the nineteenth. The two sets of institutions were interdependent. They still are, to some extent. although "patient dumping" from voluntary hospitals to governmental hospital is now regarded as unacceptable. There were seventy-eight city and county general hospitals in 1910, some in the almshouse tradition, some attracting patients across a broader social spectrum. Over half had been established in the previous twenty years (McRae and Tapon 254).

Local government control did not, however, inevitably mean restriction to the poor. In isolated rural towns hospitals set up under local government auspices served much the same functions as religious and private charitable hospitals in other areas, drawing a substantial proportion of paying patients; they have continued to do so throughout the century. But the hospitals which are out of the old city poorhouses (almshouses) were vital charitable institutions in major cities such as the huge hospitals like Bellevue in New York, Charity in New Orleans, and Cook County in Chicago (McRae and Tapon 256).

A few large city owned hospitals did charge all patients who could pay, as a mater of policy. Boston City Hospital was a case in point. However, it was also regarded as the only municipal hospital where standards of work equaled or excelled those in privately endowed institutions. Even in Boston there were class differences between the clientele in different types of hospitals, charitable and governmental. The largest almshouse hospitals, with their locked wards and punishment cells were sometimes persisted well into the twentieth century. Many of these government hospitals had syphilis, alcoholic, tuberculosis wards, unmarried pregnant mothers, mentally disturbed old people, and repressive rules and regulations. Sometimes they even had their

own special smell. Bellevue Hospital's first woman house physician (1902) remembered it as a "never to be forgotten mixture of carbolic, soapsuds, dust, and musty wood" (Fulda and Dikens 87; MaRae and Tapon 265).

Religious (Catholic) Hospitals

At the beginning of the nineteenth century, MacRae and Tapon (289) found a growing number of congregations of religious women providing services to the sick and poor, principally among the Catholics of their respective areas, they included: the Sisters of Charity of St. Joseph, in Emmitsburg (1809), who were later known as the Daughters of Charity of St. Vincent de Paul; the Sisters of Charity of Nazareth (1812); and the Sisters of Loretto at the Foot of the Cross, in Kentucky (1812). These native sisterhoods included other American religious groups, such as the Congregation of St. Catherine of Siena, in Springfield, Kentucky (1822), and the Oblates of Providence, founded by black Catholic women in Baltimore (1829). But soon they embraced such European based congregations as the Sisters of St. Joseph of Carondelet, established in Missouri (1836); the Sisters of mercy, whose early

foundations were in Pittsburgh, Chicago, and San Francisco, as well as other immigrant communities whose members originally came to serve the needs of Catholics from France, Germany, and Ireland (McRae and Tapon 289; Louviere and Woodworth 365).

During the year that they had begun work at the Baltimore clinic, members of this congregation of the Sisters of Charity were asked to consider opening a hospital in St. Louis, Missouri, on land explicitly donated for that purpose by a catholic benefactor, John Mullanphy. In 1828, four of the group would be the first of hundreds of nineteenth century nursing sisters to serve in Catholic hospitals. Completed in 1832, St. Louis Mullanphy (now DePaul) Hospital was not only the first of its kind west of the Mississippi. Only eight years after its opening the number of patients had already exceeded one thousand and the first addition was completed. By 1834, the same sisters had also been asked to take charge of the Charity Hospital in New Orleans at the request of the governors of that state hospital. Wrecked by twin disasters of hurricane and fire, the desperate directors of that hospital acknowledged that they could gain expert and devoted care for leprosy victims of all races from these committed sisters (Louviere and Woodworth 366).

When cholera hit Louisville, Kentucky in 1832-1833 the

Sisters of Charity of Nazareth found another way to prove their commitment to their fellow Americans. As death ravaged the adult population they quickly sought provisions and beds for the newly orphaned; they expanded their own building for the sick children under their care. Their expertise was duly noticed. As the sisters good reputation as nurses spread, the enterprise was again forced to move into larger quarters where, after 1853, their hospital became known as the St. Joseph Infirmary (McRae and Tapon 225).

Another community founded in 1829 in Charleston, South Carolina, to educate Catholic children soon turned to health care because of the great need in this center of immigration. From the start, the Sisters of Charity of Our Lady of Mercy were drawn into the work of nursing, providing medical care for homeless immigrants, aiding those suffering illnesses associated with joblessness, and nursing back to health those recently made victims of the epidemics of the 1830's. By 1839 these sisters had, in fact, been put in charge of a hospital financed by a lay brotherhood also established by the bishop to supply the needs of newcomers (McRae and Tapon 298; Louviere and Woodworth 360).

Given the general poverty of the Catholics to whom the

various congregations of sisters ministered, the early success of these various communities is all the more remarkable. To be sure, the sisters were constantly plagued by poverty and insufficient funds to fulfill their religious goals. What made their endeavors possible was the constant encouragement and support of the bishops and priests who relied upon their assistance and of the Catholic poor who both needed and found ways to make their service possible. Yet even this was not enough to avoid the scrutiny of those suspicious of their motives. Thus, if the sisters managed either to work or pay or to charge for their services, criticism was sometimes directed toward them. When the Sisters of Charity of Nazareth elected to be paid they found it necessary to justify their decision (McRae and Tapon 210).

McRae and Tapon (211) also found that when ever possible the services of nursing sisters were given freely. In fact, in order to keep the expenses of patients to a minimum, sisters often attempted to do all of the hospital work themselves. The first of the European based communities to serve during this early period, the Sisters of St. Joseph of Carondelet, discovered this almost immediately, When these sisters did have to find ways to sustain themselves and their ministry, they had to take on a second work.

Fortunately, as health care needs expanded and new medical

procedures created some positive improvements in the quality of American life, the problem of discovering ways to support the ministry of nursing became less acute. Besides, there was seldom a want of benefactors who understood the sisters freely given commitment to God's people. More crucial during this early period of health care were questions involving the new areas of nursing into which the sisters should move as the nation underwent industrialization and modernization and as Catholic immigration rapidly increased (Louviere and Woodworth 365).

Chapter 3

Health Care In Other Countries

Health Care in Great Britain

Cooper (189) found that the National Health Service, established in 1948, was not a radically new policy of the British welfare state. Behind it lay centuries of tradition in the provision of health care and the organization of medical practitioners. It was preceded by the National Health Insurance Act of 1911, which provided a form of health insurance for low and lower middle income workers, and by the infamous Poor law, which governed public welfare policies for centuries.

Cooper (190) found that national concern with the problem of poverty was reflected in the much maligned "Act for the Relief of the Poor", legislated in 1598 during the reign of Elizabeth I. Enacted in 1601, it remained, with some modifications, the law of England until 1948. The Poor Law provided for relief for the elderly and those unable to work by empowering local parishes to collect taxes and to appoint "overseers of the poor." Several provisions of the Law as amended by 1834, ensured that only

those who had no alternative sources of aid sought public relief. The first of these provisions was the means test. The family of an applicant for relief was held to have a legal liability for the care and relief of that person if the family possessed adequate financial resources. Beyond the family, the liability fell to the local community in which the applicant lived (Cooper 190; Walsh 330; Fisher 668).

Overall, the poor law system was quite successful in providing food and shelter for millions of poverty stricken individuals. Medical care of some sort existed in the public relief houses, and by the end of the eighteenth century most parishes provided some medical services for the poor in their own homes. But the effectiveness of the poor law system varied greatly from parish to parish, and the burden of local taxation was often resented. Concern over taxes was not greatly lessened when an independent Central Board replace the local parish administration in 1834 (Culyer 125; Robinson 200).

In addition to public relief, private charity provided medical services to the poor, usually through voluntary hospitals first established by religious institutions. Although such hospitals had existed in previous centuries, their number expanded greatly in the eighteenth century. Between 1720 and 1745, five hospitals

were founded in London. The first, Guy's Hospital, was endowed entirely by one individual. In time, a tradition developed whereby prominent members of the medical profession provided their services free of charge to the voluntary hospitals (Robinson 201; Walsh 333).

A third option existed for the working class poor, many of whom feared that illness might force them to accept shelter in the poorhouse. Mutual aid groups called "friendly" societies developed, particularly among workers employed in the same occupation. These organizations, which were the forerunners of modern insurance companies, provided sick pay, medical care, and death benefit to their members in return for weekly contributions (Walsh 338).

The friendly societies ensured their members some measure of financial independence and were immensely popular. An estimated four and a half million people belonged to friendly societies in the late nineteenth century. But membership was not open to all; in general, only skilled workers were eligible. Some societies accepted only teetotalers, others only members of a certain religious sect. And none provided medical care for women or children (Cooper 190; Fisher 668).

As the Victorian Age drew to a close, friendly society

enrollment remained high, but the organizations were in trouble. The fraternal spirit which had originally characterized such societies vanished as they grew larger. Their most serious difficulties were financial: contribution and benefit rates were based on rapidly outdated actuarial information. Due largely to better living conditions, people were simply living longer. Many societies, not anticipating the large number of sickness claims among their members, found themselves in desperate straits. Some were near bankruptcy. Nonetheless, the friendly societies wielded a great deal of political power, even in their declining years. Their role in shaping the National Health Insurance Act of 1911 was especially important (Fisher 669; Walsh 335).

In 1911 national health insurance for low and lower middle income workers came to Britain. The legislation is usually regarded as the brainchild of David Lloyd George, chancellor of the Exchequer under the Liberal Government. Lloyd George was primarily concerned with sickness as a cause of poverty, not for its own sake. His proposal sought to provide medical care for the breadwinner, but not his family, so that he could return to work (Fisher 670).

The plan was financed by a weekly tax of fourpence paid by the insured worker, a tax of threepence on the worker's

employer, and an additional twopence contribution from the state. In return, insured workers were entitled to receive medical treatment and cash benefits for sickness and disability. The plan also provided for institutional care in sanatoria for cases of tuberculosis and, in some cases additional benefits for dental and ophthalmic care (Robinson 200; Walsh 333).

In the 1920's and the 1930's there were numerous recommendations to alter the national health insurance scheme. They included recommendations to extend benefits to the dependents of the insured workers, and to expand benefits to the dependents of the insured workers, and to expand the system to cover hospital treatment and other specialist care. Ultimately these proposals were rejected in favor of a full fledged, universal scheme of "free" medical care. Many people saw reform of national health insurance as patchwork on a scheme that was fatally flawed in any event. Health care, they argued, should be available to everyone as a matter of "right" (Culyer 125; Fisher 670).

By 1947 some 23 million people were covered by national health insurance for medical benefits. The indigent, who were generally not covered by national health insurance, continued to rely on poor law relief. Moreover the services of hospitals,

which were not covered under the Lloyd George scheme, were becoming increasingly available to the working class through a booming market in private hospital insurance (Walsh 339).

One source of complaint was from the doctors participating in the national health insurance plan. Between 1913 and 1945, the standard fee paid to a doctor for attending each patient on his "panel" increased by 50 percent. Over the same time period, the average number of physician visits per patient per year also increased by 50 percent. So the average doctor was doing about 50 percent more work for 50 percent more pay. Yet from 1913 to 1945, consumer prices increased by more than 100 percent (Lee 235; Walsh 339).

Bevan (125) found that doctors also complained about the fact that they had little incentive to maintain the quality of their services under the plan. In general doctors were paid the same fee regardless of what service was performed. So each doctor had an incentive to provide the bare minimum of service to his patients. They also had an incentive to shuttle their patients off to the hospital sector whenever possible, and to expand the number of patients on their panel in order to increase their total income. Moreover since medical treatment was "free" to the patients at the same time it was received, each patient had an

incentive to place exorbitant demands on his doctor. These demands included excessive numbers of prescriptions and requests for sickness certificates which entitled the patient to cash sickness benefits. Bevan's (127) investigation into the conditions of general practice summarized its findings this way:

> Excessive numbers of panel patients and excessive demands for certificates and returns, quickly reduce the general practitioner to an agent for making out prescriptions and for operating something more like a sickness licensing and registration service. (127)

Owen (46) and Swartz (558) found a more widespread complaint, however, stemming from perceived inequalities that persisted under national health insurance. Since insurance was organized through approved societies, and since these approved societies could select their membership, some inevitably provided better services than others. For example, by carefully screening out the "bad risks," some societies could offer a better deal to its members than others in return for the weekly "premiums." Those groups composed of "good risks" could offer more services, including dental, ophthalmic and even hospital care. Those groups primarily composed of "bad risks" not only offered the bare minimum of services, but many of them were also nearing

bankruptcy. The system, therefore, tended to ensure that those workers with the greatest health needs were participating in insurance groups offering the smallest range of medical benefits (Owen 46; Robinson 20; Swartz 558).

Another source of inequality arose from the distinction between "panel" patients and "private" patients. A common belief was that panel patients received medical care which was inferior to the care received by those who paid directly for medical treatment themselves. This perception was in no way diminished by a political reorganization which consolidated national health insurance and poor law services under the same ministry (Owen 48; Robinson 202).

Cooper (191) found that the British health care system is basically a hospital based system. Hospitals absorb about two-thirds of the National Health Service budget and despite the recent emergence of community health centers, the hospitals share of the N.H.S., spending seems unlikely to decline in the near future (192).

As stated by Owen (46) in 1996, about 24 percent of the population attends hospitals as out patients, and another 10 percent are admitted as inpatients. Those who do attend hospitals as out patients average about 2.7 attendances per year.

So on the average, individuals attend hospitals as out patients about once every one and one half years. Over a lifetime, the average British citizen can expect o be an inpatient in a hospital about eight times and spend about three and one half weeks in the hospital for each episode (Cooper 192; Owen 47).

The central problem of the hospital sector remains the same as the problem faced by general practitioners with medical services free to the patient at the time they are consumed, the quantity of services demanded far exceeds the quantity supplied. However, in the hospital sector the rationing problem is far greater and the effects on health far more serious, than the rationing problem encountered by general practitioners (Robinson 203; Swartz 560).

The Waiting Lists

Bevan (129) found that by the end of the first year of operation of the N.H.S., it was painfully obvious that the demand for hospital services far exceeded the supply. In December of 1949, 460,000 people were on waiting lists to get into British hospitals. Twenty years later, in December of 1969, the number of people on waiting lists stood at 561,000, and by 1979 they

totaled about 750,000 (130).

In 1976 about 82 percent of those waiting were surgical cases. On the average, patients can expect to wait a little over three months before they are admitted. It is apparently not uncommon for patients to wait up to three years for simple ear, nose and throat operations. Patients often wait two to three years for gall bladder operations, and an elderly arthritic can wait up to two years for a hip replacement (Bevan 129; Himmelstein 441; Thomas 652).

Patients are generally classified into one of three groups: "emergency", "urgent", and 'non urgent". Emergency patients have top priority and are treated immediately. Urgent cases receive next priority, followed by non urgent. Patients in need of orthopedic or gall bladder surgery, or nose, eye and throat operations are generally considered to be non-urgent patients. Ministers of Health routinely have defended the N.H.S. waiting lists by stating that all patients on waiting lists were non urgent cases. Patients may suffer some inconveniences, but no one's life is threatened by waiting (Bevan 128; Thomas 654).

Throughout most of the history of the N.H.S., the number of people on hospital waiting lists has been regarded as a measure of "excess demand." The number of people waiting to gain

hospital admission was regarded as that part of the total demand of hospital services that could not be immediately satisfied. A consequence of this attitude was that a succession of Ministers of Health tried to "get the waiting lists down" (Himmelstein 445; Owen 46; Robinson 204).

Summary

Chakraborty (46) found that there are many differences among the patients ability to pay in health care systems around the world. In Canada the people have decided to assure high quality health care to everyone in their society as a matter of right. Granted, the people still continue to debate how to better organize their health care system and how to better pay for the services provided. This debate however takes place in the context of the decision that good health care should be available to everyone, Moreover Canada has succeeded in assuring high quality health care for their entire nation at a lower cost to its citizens (Doherty 31; Himmelstein 445).

Himmelstein (445) found that in the United Kingdom the total expenditure for health services in 1990 was approximately 3.6 billion pounds. If this figure is converted to U.S. Dollars and

corrected for the disparity in population size GNP between America and Britain, it is equivalent to 82 billion in the United States. America, by comparison, spent over 140 billion on health care in 1990. Bunker (225) found that Americans spent 163 billion for health care in 1996 which was almost 9 percent of the Gross National Product. These figures strongly suggest that with reform of the delivery system in the United States, more health services of higher quality could be offered at less cost (Bunker 226).

Himmelstein (444) found that most Americans have been led to believe that health care is a disaster in Europe. We tend to believe that the people in England and other countries cannot get health care and are unhappy with their system. We believe that the people do not get to choose their doctors and that the government tells their doctors what to do. We believe that costs are out of control in Europe, worse than in America. We believe that the people are treated coldly by big organizations and have lost the doctor patient relationship we have cherished in America. McNeil and Weichselbaum (1399) found that these are myths that we have been taught by those who fear they will lose their high incomes or their freedom of choice if America were to change its health care system.

According to McNeil and Weichselbaum (1399), Moloney and Paul (150), and Thomas (655) it would appear that most Americans are angry and frustrated about health care, most Englishmen, Danes, Swedes, and Israelis are not. The vast majority of citizens in these countries describe their health care system with pride, and no major political party in these countries would dream of trying to repeal the system. Many Europeans were horrified to learn that Americans have to worry about whether they can afford health care.

Chapter 4

Comparison of American Health Care to British Health Care

Bunker (18) found that President Bill Clinton's speech on health reform to the joint session of the Congress in September of 1993 was an unprecedented departure. No other chief executive had ever addressed the Congress on the subject of health reform. The Health Security Plan Clinton proposed was, however, anything but new. The issue of national health insurance first surfaced at the presidential level in the 1912 election campaign, when Theodore Roosevelt, ran a three-cornered race for the White House against William Howard Taft and Woodrow Wilson. Roosevelt's advocacy of national health insurance was farsighted, coming eight decades before Clinton put the matter directly before Congress with a strong recommendation for prompt action (19).

A number of other stops along the way between 1912 and 1994 in the legislative journey of national health insurance or universal coverage for medical care in the United States warrant at least brief notice. Starting in 1929 and growing slowly during the depressed 1930's, regional Blue Cross plans offered

Americans an opportunity for protection against the prospective high costs of hospitalization by enrolling in a prepayment plan that was usually open to everyone at a uniform community based premium. This private, non profit health insurance system underwent rapid growth during World Was II when the federal government agreed that unions could bargain for health care benefits without violating the prevailing wage freeze. Its expansion was stimulated by the federal tax code; employer premium payments for health insurance benefits were treated as a nontaxable business expense, and the value of the benefits was exempted from the income tax liability of the recipient (Grossman 188; Louviere and Woodworth 366; Whitaker 187).

Warner (113) reported that the next important program was the New Deal. Although Franklin Delano Roosevelt considered writing national health insurance into the Social Security legislation of 1935, he decided that it was the better part of wisdom not to. FDR concluded that the introduction of national health insurance coverage could jeopardize the passage of the rest of his reforms, a risk he decided not to take (113).

President Harry Truman sent a message to congress urging the enactment of national health insurance. And in the late 1940's several liberal Democratic members of the House and

Senate sought to advance the legislation but failed to elicit any broad based support (Malenbaaum 118; Whitaker 25).

When John F. Kennedy ran for the presidency in 1960, one plank in his platform was the early enactment of Medicare. Confronted by the unyielding resistance of the AMA to a federally funded health insurance system and the ideological antagonism of fiscal conservatives in the Democratic party, Kennedy was unable to persuade Congress on his proposal. After his resounding victory over Senator Barry Goldwater in 1964, Lyndon Baines Johnson, however, succeeded in getting Medicare and Medicaid passed. Despite the scale of the scope of the Great Society programs, President Johnson gave no serious consideration to the enactment of national health insurance. The public recognized the urgent need to ensure continuing coverage for persons who were no longer in the labor force (Grossman 75; Kessel 50).

The early to mid 1970's saw a renewed interest in health reform and national health insurance by three successive presidents: Nixon, Ford, and Carter. Both the White House and the Congress has come to appreciate within a few years of the implementation of Medicare and Medicaid that cost projections for both programs had been seriously understated. With the passage of time it also became clear that to provide health insurance plus

Medicare plus Medicaid still left substantial numbers of persons without any form of coverage for shorter or longer periods of time (Grossman 122; Letsch, Levit, and Waldo 110; Kessel 25; Ketchum 136).

Had it not been for the distraction of Watergate and the inflexibility of the southern Democrats, the United States might have passed in the early 1970's a system of universal coverage consisting of expanded employer coverage, supplemented by government financed coverage for those not insured through employment, a compromise between the alternative proposals of President Nixon and Senator Ted Kennedy. By the time that President Ford first recommended the enactment of national health insurance, the federal budget and inflation added powerful new disincentives that persuaded him not to resubmit his recommendation (Lave 381; Letsch, Levit, and Waldo 118).

Jimmy Carter included a plank in his 1976 presidential campaign platform favoring national health insurance, but once again money came between social commitment and legislative realities. Shortly after he took office, his advisers persuaded him that there was no possible way for him to obtain the necessary congressional support. The tens of billions of additional dollars required to turn national health insurance from a goal into an

operative program could not be drawn from the American taxpayer (Letsch, Levit, and Waldo 120; Ross 540).

Both Presidents Reagan and Bush had to respond to a great number of specific challenges growing out of the need of the federal government to slow its steeply rising expenditures for Medicare and Medicaid. The twelve years of Republican leadership in Washington were marked by a studied avoidance of any large scale national health reform (Javalgi, Ravalio and Rao 20).

The most sweeping initiative by a state occurred in 1982 in Massachusetts, where hospitals were mandated to slow the growth of spending by adhering to a strict, predetermined formula. Over a five year period a successful program of this sort could well reduce expenditures by some 35 to 40 percent below what otherwise would be expected. Also in 1982 California implemented a program to control medicaid costs that required hospitals to bid for a contract under which the hospital provides all services to medicaid patients at a flat daily rate (Nisbet and Wilson 250; Scotti and Boner 12).

In 1983 Congress established a dramatically new plan that uses prospective reimbursement for all medicare payments. Under this program the payment to a hospital would be

predetermined for each of many diagnostic related groupings (DRGs). The hospital would be at risk for any expenditure greater than that authorized for the particular illness (Bettman 425; France 35).

DRG's provide the payment of a fixed amount per admission according to the categories into which a patient falls. Payment is based on several cost indicators, including the primary diagnosis, the secondary diagnosis, the age of the patient, and such aspects of care as surgical procedures. The system encourages surgery and other procedures that lead to higher payments. DRG's encourage hospitals to manipulate the sequence of diagnoses or otherwise classify an illness in the most financially advantageous way. Limitations on expenditures per admission, such as those imposed by DRG's, encourage admissions of easy cases previously handled on an outpatient basis. They also encourage hospitals to shorten lengths of stay and to release and readmit patients for further therapy. Limitations on payments per patient day, rather than per admission, would also encourage admissions of easy cases but would induce hospitals to lengthen rather than shorten stays, because the last days of care are usually the cheapest (Berger 440; Chakraborty 52; Kessel 29).

British Experience

The cost of health care in the United States will continue growing for the foreseeable future. The technological revolution that helped boost real per capita medical expenditures 5 percent a year from 1965 to 1980 shows no sign of abating. During the next two decades the population aged seventy-five and older will rise 70 percent. And health care is what economists call a superior good, one that claims an increasing part of the consumer's dollar as his or her income rises. Economic growth, therefore, will tend to boost the share of national income devoted to health care. According to actuarial projections, the cost of hospital insurance under Medicare, 2.97 percent of the social security wage base in 1982, will more than double by 2005, to 6.29 percent , and nearly quadruple by 2035, to over 11 percent (Bettman 440; Inman 224; France 332; Jones 842).

Four factors explain rising hospital expenditures: rising incomes, third party coverage, technological advances, and the aging of the population. The spread of third party coverage through private insurance and public programs has freed more patients and physicians from the need to worry about the cost at

the time of care. Growth of the population, in general, and of the elderly has contributed to an increase in hospital admissions. However, the most important factor has been technological change, which has increased the number of beneficial services (Lave 382; Letsch, Levit, and Waldo 118; Lane and Lindquist 20).

Cooper (195) and Himmelstein (440) stated that the British experience with rising health care costs suggests that budget limits would gradually cause accepted standards of practice to change, even though the incentives of fee-for-service medicine would slow such adjustments. Good medicine would call for few tests when the gain in information is slight and for less surgery and less use of costly drugs when the advantage of expensive over inexpensive therapies is small. In short, U.S. doctors would begin to build into their own norms of good practice a sense of the relation between the costs of care and the value of the benefits. Himmelstein (441) indicated that physicians would be led to weigh not only the medical aspects of diagnosis and treatment but also the peculiar circumstances of each patient: his age, his underlying health, his family responsibilities, and his chance of recovering enough to resume a normal life (Cooper 190; Himmelstein 443).

Himmelstein (444) also stated that this process would require

a far reaching change in attitude for the many American doctors who believe it unprofessional, if not immoral, for doctors to consider costs in deciding what actions to take on behalf of patients. Himmelstein (442) summed up this view as follows:

> Optimization of survival and not optimization of cost effectiveness is the only ethical imperative. Ethical physicians do not base their practices on their patients ability to pay or choose diagnostic or therapeutic procedures on the basis of their cost. Of late an increasing number of articles in this and other journals have been concerned with "cost effectiveness" of diagnostic and therapeutic procedures. Inherent in these articles is the view that choices will be predicted not only on the basis of strictly clinical considerations but also on the basis of economic considerations as they may affect the patient, the hospital and society. It is my contention that such considerations are not germane to ethical medical practice, that they occupy space in journals that would be better occupied by substantive matter, and that they occupy space in journals that would be better occupied by substantive matter, and that they serve to orient physicians toward consideration of such factors may eventually lead to considerations of age, social usefulness, and other matters irrelevant to ethical practice. The example of medicine in Nazi Germany is too close to need further elucidation. (442)

Cooper (196) suggests that, to try to maintain the belief that they are doing everything of value, American physicians, like their British counterparts, will simply redefine what care is

"appropriate." Such rationalization is probably essential to the morale of the physician who finds that he must often say no to the patient.

The task of saying no will become increasingly difficult as resource constraints become tighter. British experience indicates however, that the care most easily denied is that dependent on costly capital goods for its provision. If the authorities do not buy the capital goods CT scanners, diagnostic x-ray and ultrasound equipment, or operating rooms equipped for coronary surgery, then the services cannot be provided. If staffing is carefully controlled, doctors, nurses, and other providers are placed in the position of simply doing all they can in the time available. In both cases providers are spared the psychologically insupportable burden of denying care because it is too expensive (Bevan 130; Fox 700).

Controlling expenditures on drugs, blood, and other expendable supplies in the United States will pose one of the most difficult problems in cost containment. Limiting such expenditures by monitoring day to day clinical decisions would be almost impossible. Because that mechanism is not practical, a physician might be constrained only if his use of resources was so excessive that, as in Britain, his colleagues forced a change in

behavior (Fox 701).

Although drawing parallels between two different countries is risky. Yet it is impossible not to be impressed by striking similarities between the politics of health in the United States today and the politics of health in Britain in 1948. One need only compare the public statements of many of our leading politicians with the public pronouncements of Churchill, Beveridge, and Bevan over 30 years ago. Indeed, if speeches could be copyrighted, a good case for copyright infringement might be made (Cooper 196).

Like the British in 1948, America now has a form of national health insurance, that is , Medicaid and Medicare, which covers a large portion of low-income patients. And, like middle class Britains in 1948, our middle class is feeling the financial squeeze. Not only are taxpayers bearing the ever increasing financial burden of these programs through the taxes they pay, they are also watching medical prices rise precisely because of the programs. Enacted in 1965, Medicaid and Medicare produced a surge in the demand for medical care with no corresponding increase in supply. The result has been a dramatic increase in market prices. An early University of Michigan study concluded that between 1967 and 1968, physicians fees increased by

almost seven percent more than they would have without the two programs. In addition, the price of hospital care rose by more than 14 percent as a result of their impact (Cooper 196; McNeil and Weichselbaum 1399; Robinson 200).

McNeil and Weichselbaum (1399) cite that, unlike the British experience it appears that if a full blown system of socialized medicine is adopted in America, it will be adopted in stages. Stage 1 involves government controls over hospitals sending a necessary precondition for any program which removes all restraints on demand. This has been evident in American hospitals because many could not expand their bed capacity or buy certain pieces of equipment without prior government approval (McNeil and Weichselbaum 1399).

McNeil and Weichselbaum (1400) found that Stage 2 involves a limited program of national health insurance. One proposal made by the Carter Administration provided unlimited hospital and physician services to existing Medicaid patients plus an estimated 10.6 million additional low income individuals. This proposal would clearly place additional financial pressures on the middle class, and encourage the demand for a fully universal program covering the entire population (Nisbet and Wilson 258).

Ettenson and Wagner (88) and Wayne and Nason (158)

suggest that strong pressures are building for socialized medicine in the United States. Although socialized medicine in this country would not be identical to Britains National Health Service, certain fundamentals would be the same, that is we could expect a lower quantity and quality of health care.

Wayne and Nason (166) also indicated that if health care were provided free of charge to patients at the time of treatment, the demand for medical services would soar and would far exceed the quantity that could conceivably be supplied. If American patients responded as British patients have, they would attempt to see their general practitioners four times as often as they do now.

Green and Krieger (1348) believe that with this scenario the quality of medical treatment rendered would inevitably deteriorate. Doctors would spend less time with patients and they would offer fewer services. In order for British physicians to meet their heavy caseloads, they have all but eliminated the general check up, and vaccination rates against major childhood diseases are at alarmingly low levels.

Ross (540) and Kessel (47) both cite that political pressures would inevitably dictate the allocation of health care spending. Political pressures would also induce government officials to skimp on capital expenditures for the sake of spending

which produces more immediate results. Kessel (48) states that it is no accident that over 50 percent of all British hospital beds are in buildings built before the turn of the century. Also Ross (1988) believes that government ownership or tight regulation and control of hospitals would be inevitable and costly bureaucratic inefficiencies would abound.

Louviere and Woodworth (365) believe that perhaps the most important thing that Americans can expect will occur, not after the introduction of socialized medicine but before. Most people in this country probably believe that the medical profession will go all out in opposition to any form of socialized medicine, but do not count on it. The reader will recall that in 1948 the majority of British doctors did not oppose the national health system on principle. In fact, they favored the idea of comprehensive, universal medical care financed by the state. Their only objections were to the particulars of the scheme.

Nisbet and Wilson (259), Scotti and Bonner (15), and Shepherd (169) believe that even in this country the political position of the medical profession has been ambivalent. After World War 1 it looked for a while as though compulsory national health insurance was going to become a reality in this country; High officials of The American Medical Association praised the

idea. Editorialists for The Journal of the American Medical Association called it "pregnant with benefit to the public" (Davis and Struges 3015). Shepherd (169) found that only after they took a closer look at the particulars of the scheme did A.M.A. officials reverse their position. Particularly persuasive was the expectation that doctor incomes might be lowered, not raised.

Chapter 5

Discussion

Berki (591) stated that if the hospital in Thomas Jefferson's America had been a microcosm of the community that nurtured it, so is the hospital of the 1990's. Ettenson and Wagner (87) cites that although we live in a very different sort of world, the hospital remains both product and prisoner of its own history, and of the more general trends that have characterized our society. Bettman (443) found that class, ethnicity, and gender have all shaped and continue to shape medical care. National policies and priorities have come to play a significant role in affairs that had been long thought of as entirely and appropriately local.

Lane and Lindquist (16) state that the goals of American hospitals have been ambiguous throughout the century for basically four reasons: the lack of a unified social welfare policy; the social agendas of hospitals; the dual role of hospitals as both "charities" and "businesses"; and the symbolic value placed on hospitals as instruments of the wider culture.

Green and Richardson (59) believe that throughout the century U.S. hospitals have been motivated to be expensive not only to

encourage the admission of paying patients but also to enhance their role as cultural icons. Today's hospital system is extravagant, visible, flamboyant, exclusive, and money oriented, just as it was at the beginning of the century. Success in the hospital has helped to balance failures elsewhere in American society. Hence in the 1930's hospitals could be described as "depression cures". Large hospitals continue to be cultural palaces, lavish embodiments of the latest in American architecture, wealth, and engineering, even as their role changes and their structure is diversifying.

Moustafa (126) found that there is a widespread feeling in America that expenditures for health care are too high and growing rapidly. This feeling has stimulated numerous policy proposals for cost containment, including more competition, more government involvement, and national health insurance. The growing cost of medical care frightens people and results in many frantic efforts on the part of policymakers and administrators to get some handle on the system. The financial issues have become so acute that they tend to push all other matters into the background as policymakers search for mechanisms to contain costs.

Scotti and Booner (9) believe that containing costs is only part

of the problem. The challenge is to do so while providing reasonable access to medical care that is effective and humane. If the issue were simply cost, the solution would be simple, because all we would need to do is reduce budgets. In short, the problem of the costs of medical care is here to stay in one form or another. The problem is not simply an issue of greedy practitioners, to many hospital beds, or inefficient practices. The problem more basically arises from the public's rising demands and expectations, the growth of knowledge, and the development of new technologies. There is no sign that these influences are likely to diminish in the future.

As this research has shown health care is an elaborate social system affected by attitudes, values, and ideologies as much as by profiles of illness, economics, and technology. How the patient perceives and uses the medical care system and how professionals mobilize to perform their tasks are in part consequences of social and cultural trends, modes of child rearing, and patterns of professional socialization. If patient and physician behavior are formed by sociocultural processes as well as by medical factors, then these must be considered in developing policies in health care.

This research has also show that the containment of the

increasing costs of medical care has become the highest priority to presidents in America as well as in many other nations. As discussed Bunker (225) found that Americans spent 163 billion on health care in 1990, and all the projections for the future suggest that health care expenditures will require increasing proportions of both the Gross National Product and governmental budgets. There is no absolute ceiling on how much expenditure for medical care the nation can afford.

Although the concept of rationing medical care offends people, it has been practiced for centuries. History has shown us that no community has ever provided all the care that its population might be willing to consume. An important change in recent years, is the extent to which services are free of cost to the recipient at the point of consumption. As government and third parties cover an increasing proportion of medical care cost, there are fewer financial inhibitions on the use of services.

A major way to reduce expenditures for medical care and the requirement for developing more facilities and personnel is to limit the needs and desires among patients for medical care. Reducing needs involves the prevention of illness or diminishing patients psychological dependence on the medical encounter for social support or other secondary advantages. Reducing desire for

services requires changing people's views of the value of different types of medical care, making them more aware of the real costs of service in relation to the benefits received, and legitimizing alternatives for dealing with many problems that physicians increasingly deal with as the boundaries of medical care expand.

Prevention involves clearly identifying risk factors and structuring the environment or motivating people to minimize them. Although the examples of cigarette smoking, alcohol and drug dependence, and inactivity and obesity are most recently cited, these are complex behavioral problems that do not yield simply to exhortation or educational approaches. Often these behaviors are deeply rooted in personality and are related to other serious problems that re intractable to change. There is no reason to be excessively pessimistic about changing the population's habits, since there has been some progress, the forces working against change, and the depths of ignorance concerning the origins of these behaviors and the ways in which they can best be modified. It may be that the greatest potential in changing health behavior lies in focusing on the young before these behavioral patterns become well established. Overcoming the influence of peer groups and other incentives to dangerous habits remains a difficult task.

Moreover, daily routine patterns of healthful behavior such as exercise can be introduced into social environments in which persons spend much of their time sitting at the work place. Also, we need to continue developing primary prevention programs such as immunization and early screening and treatment of diseases and disabilities. In such areas as control of hypertension, effective diagnosis and treatment are available, but overcoming the behavioral problem of achieving continuing cooperation still constitutes a major arise. Early detection of vision and hearing difficulties also limits later problems and costs and does not involve major behavioral barriers. Appropriate treatment of common childhood ailments can avoid secondary problems that may result in the consumption of considerable services in adult life.

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