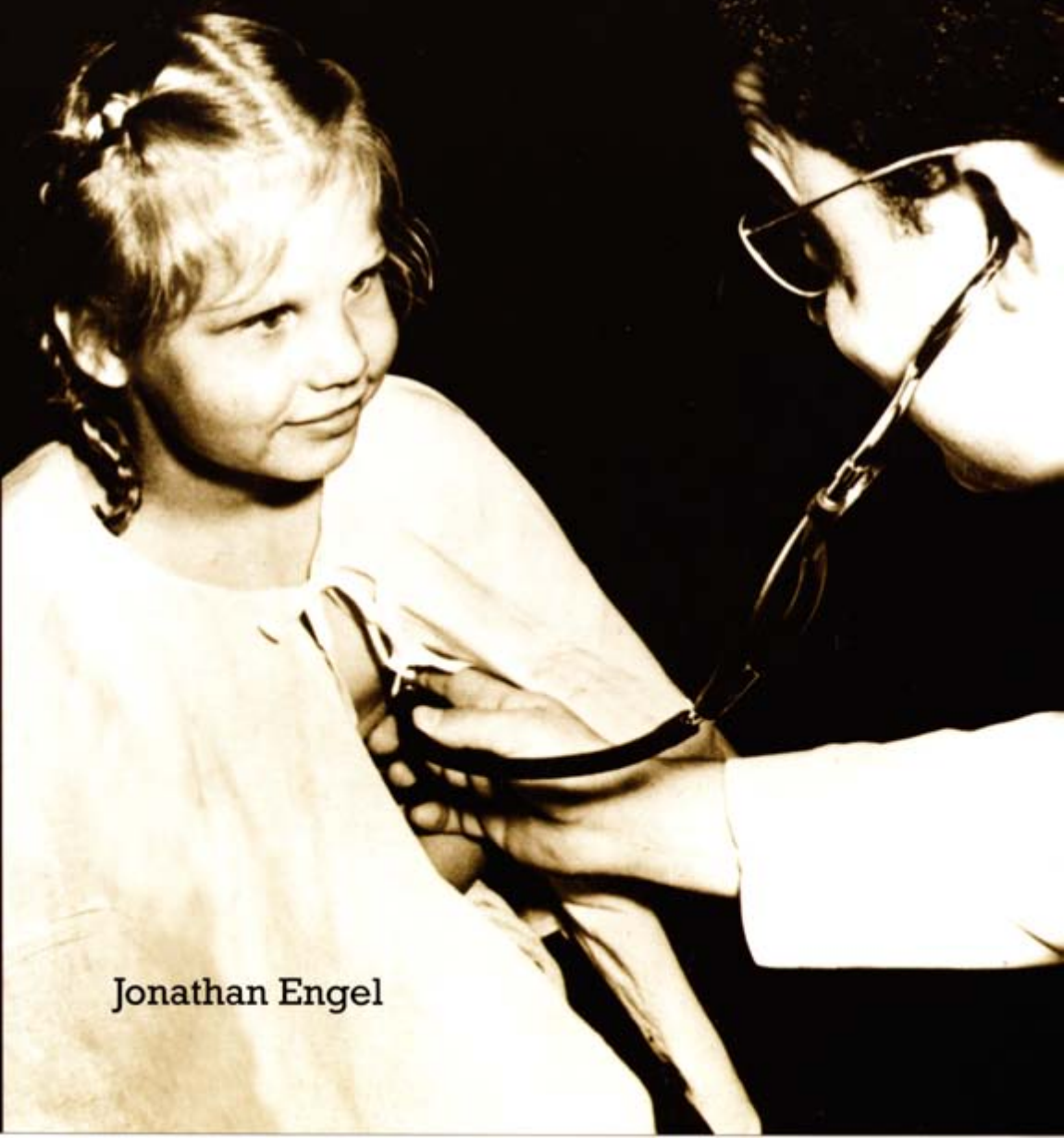


# Poor People's Medicine

Medicaid and  
American Charity Care  
since 1965

Jonathan Engel



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JONATHAN ENGEL

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IN MEMORY OF MY FATHER



# Contents

Preface ix

<b>1</b>	Antecedents: Poverty and Early Poverty Care Programs	1
<b>2</b>	Precursors to Medicare and Medicaid	28
<b>3</b>	War on Poverty and the Genesis of Medicaid	44
<b>4</b>	Hard-to-Reach Groups	69
<b>5</b>	Redefining Health	92
<b>6</b>	Charity Care and Comprehensive Reform under Nixon	107
<b>7</b>	Health Planning and Community Medicine in the 1970s	123
<b>8</b>	Health and Welfare Reform in the Carter White House	144
<b>9</b>	Block Grants and the New Federalism	163
<b>10</b>	Recovering the Cuts, Managed Care, and Comprehensive Reform	184
<b>11</b>	Managed Medicaid, AIDS, and the Clinton Health Bill	209
<b>12</b>	Afterword	244
	Notes	253
	Bibliography	289
	Index	303





## **Preface**

This is a story of ambivalence, for no other word better describes efforts at charity medical care in the United States over the past half-century. Unwilling to wholly abandon the poor to private charities and municipal relief efforts, but at the same time unwilling to provide full access to the private health system through a fully funded state insurance program, the nation has provided health insurance to the poor, coupled with an array of loosely coordinated community health centers, public hospitals, and neighborhood health clinics. The result has been imperfect, and frequently unsatisfactory, yet the effort has also produced startling successes. America's poor today live nearly as long as the nonpoor, survive infancy at rates approaching those of the population at large, and use private physicians and hospitals at least as much as the privately insured do. Even as they complain, accurately, of being shunted to a second-tier medical system, the poor are granted access to some of the best hospitals and physicians in the country.

Moreover, by most any measure the system has improved continuously for forty years. Starting with the legislation which created the modern Medicaid program in 1965, the nation has increased federal subsidies to the states which administer the Medicaid programs, implemented new early screening and care programs, expanded eligibility, and subsidized services unimaginable at the time of the program's construction. Dental,

prenatal, and nutritional benefits were added at various points, along with innovative managed-care programs to ensure access to primary-care physicians. With the widespread move toward managed care in the private insurance sector, Medicaid recipients found themselves, paradoxically, fought over by private hospitals and outpatient treatment facilities. Indeed, in half a dozen states Medicaid recipients brought to their physicians more generous reimbursements than Medicare or privately insured patients did.

Yet even as federal and state governments continually fine-tuned eligibility levels and benefit packages under Medicaid, they rarely funded the program adequately to compete with private insurers. Thus, rather than wholly supersede the existing system of public hospitals and clinics, Medicaid actually strengthened that system by bringing federal funds to institutions which had hitherto existed solely on state and municipal largesse. In this the program failed badly, as for most of its history its recipients disproportionately sought care from doctors with exclusive or near exclusive Medicaid practices, and checked themselves into public hospitals which cared almost exclusively for Medicaid patients or self-payers. Medicaid, unintentionally, opened a new tier of American medicine: one populated by foreign medical graduates with urban practices, who treated patients in small “Hill-Burton” rural hospitals or aging municipal or Catholic hospitals in downtown precincts. At the same time, it brought funds to experimental community and neighborhood health centers, and community mental health centers, none of which were intended to treat the full economic spectrum of patients. Medicaid, in short, further locked America’s poor into a separate and inferior tier of medical care, even as it aimed to obviate entirely just such a tier.

In maintaining this lukewarm commitment to charity care, the United States is exceptional. No other industrialized nation has been as reluctant to federalize or nationalize its system of medical care or medical payment. The United States alone allows a large number of its citizens to live without health insurance, even as it maintains coverage for the poorest and most vulnerable. Yet it has been unwilling to allow medical care and medical products to simply fall to the vagaries of the markets as well. Without committing itself to universal coverage, the United States has committed itself to rigorous review and standardization of medical prac-

tice, hospital organization, drug development and marketing, professional licensing, and insurance sales. A health care professional in America can scarcely speak to a patient without appropriate licensure and accreditation, yet the government has been unwilling to guarantee its citizens, even many of the poorest citizens, funds to exploit those professionals' services. It is a strange picture.

Yet in a larger sense, this nation's ambivalence toward charity medical care mirrors its historically ambivalent commitment to poor relief generally. While other nations developed comprehensive and generous social welfare systems in the early decades of the twentieth century, the United States proved strangely reluctant to adopt similar ones. Old-age pensions, disability insurance, unemployment insurance ("the dole"), widows' pensions, and child welfare services, all of which undergirded the great social welfare projects of Western European democracies through the twentieth century, have all proven contentious here. Americans have looked askance at most every one of these programs and products, and have adopted them in small, incremental measures when they adopted them at all. Sometimes the country has taken substantial steps back, terminating existing programs in a flurry of tax-cutting devolution and states' rights rhetoric. And the sentiment continues to this day. As this preface is being written, the federal government is attempting to impose an increasing share of the costs of Medicaid on state governments, even as those states face looming budget shortfalls and expanding populations of indigent residents.<sup>1</sup> America has proven itself consistent, if not compassionate.

### **Charity Medicine?**

The medical profession has incorporated eleemosynary efforts into its enterprise for as long as we have records. The Hippocratic Oath demands that physicians heal when able to, regardless of a patient's ability to pay, and archival records suggest that both physicians and whole communities have made substantial efforts to provide care to the impoverished sick since at least the Middle Ages. Public health agencies and offices are some of the oldest extant bureaucracies in Europe, and almshouses which house the sick as well as the poor rank among the longest-lasting of civic

institutions. Of the two great publicly provided human services, public health care preceded public education by at least half a millennium.

Early Americans made efforts to care for the poor through philanthropy and community largesse. David Rothman writes that colonial efforts at alleviating poverty grew naturally from Protestant dictates of charity and self-improvement. A minister in Boston, Samuel Cooper, wrote: “[Relief of the needy] ennobles our nature, by conforming us to the best, the most glorious patterns. . . . Charity conforms us to the Son of God himself.”<sup>2</sup> This Christian and community-minded spirit began to express itself in the form of institution building in the Jacksonian era, during which America began to construct—along with prisons—almshouses, orphanages, and asylums. Although Rothman warns us that this spree of institution building was impelled as much by a yearning for social order as it was by charity, these efforts at communal largesse were mirrored in the development of the general hospital, which civic-minded citizens began constructing as early as the eighteenth century.<sup>3</sup> A century later, immigrant ethnic groups and religious denominations established hospitals intended in large part to serve the poor among them. These efforts in turn were followed by a spate of municipally funded public hospital building at the beginning of the twentieth century.

The history of these early efforts at hospital building and care of the poor is well documented.<sup>4</sup> For present purposes the reader should appreciate that providing charity medical and hospital care to the destitute has been an omnipresent and essential civic endeavor since the earliest days of this country, and that until relatively recently most of the work has been done by private groups, with some state and municipal money donated to build municipal hospitals and state lunatic asylums.

Thus far, the American story parallels the European one with some minor divergences. But as of the beginning of the twentieth century America went in its own direction. While most Western European states began to develop comprehensive national health plans, hospital systems, and health payment systems, the United States almost singly left the production, distribution, and payment of medical care in private hands, with government efforts limited to public hospitals, hospital care for war veterans, and sporadic school-based immunization programs.<sup>5</sup> This decision created fundamentally different charity care systems. While the Eu-

ropean nations, along with New Zealand, Australia, and Japan, folded their poor into the health payment platforms they had devised for the general populations, the United States incrementally expanded and enriched its charity care programs to create a health system parallel to the main one. That system, made of public hospitals, physicians with lesser or foreign training, community and neighborhood health clinics, and discount pharmacies and treatment centers, remains with us today.

### **Stumbling toward Social Welfare**

America's tepid efforts at charity health care have been consistent with its tepid efforts at social welfare provision in general. Emerging scholarship points to a constant American ambivalence toward funding social welfare programs along European lines. Whether in disability payments, old age and survivors' insurance, emergency food supplements, unemployment insurance, or general poverty relief, the United States has stumbled rather than marched toward the social welfare state.

According to the classic explanation of how social welfare programs developed, the federalist tradition in the United States precluded the growth of much of a social safety net until the New Deal programs of the early 1930s—most particularly those inaugurated with the Social Security Act in 1935. Those programs, particularly old age and survivors' insurance, disability insurance, and state-administered unemployment insurance, were thrown to a restive population demanding significant change in the role which government would play in its life. The deprivations of the Great Depression had forced millions of working Americans to reassess their basic contract with America: one which stipulated that in exchange for hard work and individual initiative, they would live a reasonable middle-class life and achieve consistent upward mobility. Now these millions, led by activist farm and labor organizations, had realized that the system was fundamentally broken, and could only be fixed by broad government intervention in commerce, employment, insurance, and markets.

This classic description of the growth of American welfare makes two further claims. The first is that social insurance was demanded most vociferously by organized farm and labor groups, who under the pres-

sures of a developing industrial society continued to safeguard the programs in succeeding decades, even as they were repeatedly attacked by social conservatives and laissez-faire market theorists. The second is that once the programs were implemented, Americans quickly cleaved to them and supported both their continued existence and their constant growth. In this historical account, the new social welfare protections created under President Kennedy's "New Frontier" and President Johnson's "Great Society" agendas were natural responses to a continued demand for expanding social welfare programs. Medicare, and to a lesser extent Medicaid, were simply Social Security applied to the medical sphere.

But several prominent scholars dispute these notions. The sociologist and social historian Theda Skocpol persuasively argues that industrialization did not lead to bureaucratic centralization. The half-century gap between the first wave of industrial development in the decades after the Civil War and the enactment of New Deal reforms is too wide to be bridged by this weak hypothesis.<sup>6</sup> Buttressing Skocpol, the political scientist Charles Noble argues that despite the popular image of a unified working class, labor has always organized more along racial and ethnic than class demarcations, and thus has always exhibited tepid support for government-sponsored social welfare programs, if not outright hostility. He notes that American workers tended "not to vote their economic interests, as did workers in most other capitalist democracies, but their cultural identities instead."<sup>7</sup>

But more damning to the classic vision of an ever-progressing American welfare state is Skocpol's innovative study of the rise and decline of the Civil War pension system in America. Skocpol argues that through Civil War pensions, America had already achieved an extensive national welfare system by the 1890s, during which time over a third of elderly American men received government assistance. And yet, even as progressive fervor reached its height in the decade between 1911 and 1920, the nation refused to renew this pension system, or develop a replacement system to ease the plight of the elderly and destitute. Of all the many progressive legislative goals envisioned during that decade, the only policies finding their way into law were those addressing industrial accidents, enacted by forty-two states.<sup>8</sup>

In fact, Skocpol argues, programs to alleviate poverty in the United

States became “feminized” over the ensuing decades, as women organized and fought for a tighter social safety net for children, widows, and single and abandoned mothers. This movement, exemplified by the creation of the U.S. Children’s Bureau in 1912 and the passage of the Sheppard-Towner Act in 1921, reflected a “maternalist welfare effort,” in Skocpol’s terms, in which the nation committed itself to safeguarding the keepers of moral rectitude and familial structure.<sup>9</sup> Although Sheppard-Towner was allowed to lapse after seven years, during the time it was in force the government had distributed millions of pamphlets, conducted hundreds of health conferences, and funded tens of thousands of home visits, improving the lot of up to half of all babies born during that period.<sup>10</sup>

Succeeding years have only reinforced the feminine nature of both poverty and efforts to alleviate poverty in the United States. The poor have disproportionately been single mothers since the beginning of the twentieth century, and this group has only grown in its dominance of the poor rolls since 1959. Indeed, various studies of the past two decades indicate that the best single prediction of poverty is unwed motherhood at too young an age, and that a mother’s chance of being impoverished is cut by almost half if she can wed before or while raising children.<sup>11</sup> In light of this, social welfare policy has been skewed toward protecting mothers and children since the onset of the New Deal programs. Aid to Families with Dependent Children (AFDC, colloquially “welfare”), the government’s best-known poverty alleviation program, effectively precluded any able-bodied man, with or without children, from being classified as poor after 1935, and thirty years later the original Medicaid eligibility standards perpetuated this pattern. Americans seemed, and seem, most comfortable limiting both the definition of poverty and efforts to alleviate it to those deserving women who struggle to raise children as they fight for economic survival. Two-parent families and childless men need not apply.

## **American Exceptionalism**

But why has America, alone among the industrialized nations, been so reluctant to embrace a broader social safety net? Different scholars answer the question differently. Noble offers a three-pronged explanation,



according to which decentralized governmental institutions, an anemic labor base, and a unified business sector all combine to make radical reform all but impossible in American government. Unions, which at their apex never managed to attract more than one fourth of the American work force to their ranks, were never able to overcome the schisms created by differing immigrant ethnic groups and northwardly migrating African Americans. Thus to make themselves attractive to the broadest member base possible, they tended to eschew radical political positions (such as demanding broad social insurance reform) in favor of incremental improvement of their members' lots. In this mold, unions worked not toward national health insurance but toward providing better private policies for their individual members.<sup>12</sup>

Noble also postulates that the decentralized nature of American political institutions, as well as the winner-takes-all election process of congressional seats, has forced politicians with radical agendas to the margins. In a two-party system, both parties work toward moderation to attract a broad base, even as the elected members of those parties confront structural barriers to any comprehensive social reform.<sup>13</sup> Politicians elected in such a system cleave to pork-barrel politics rather than broad redistributive efforts. At the same time, the federal system of devolved legislative power encourages businesses to relocate to the most business-friendly (and frequently labor-unfriendly) states. The combined effect is to squelch debate on fundamental reforms and pressure legislative bodies to appease business and the political mainstream of the population.<sup>14</sup>

Skocpol offers not so much an explanation of American exceptionalism as a vigorous claim for its existence. Americans were never acclimated to a government-sponsored social safety net in the manner in which Europeans were, and the broadest program that the nation was able to adopt (before 1965) was low-level mandatory retirement insurance. In contrast to the almost plebeian "dole" in England, the United States had "welfare," which always carried with it pejorative undertones. "It refers," writes Skocpol, "to unearned public assistance benefits, possibly undeserved and certainly demeaning, to be avoided if at all possible by all 'independent,' self-respecting citizens."<sup>15</sup> Nevertheless, Skocpol argues, many traditional arguments, particularly those which focus on a unique national "character," are unpersuasive.

The truth is some amalgam of these arguments. The United States has remained uniquely open to immigration for most of its history, has facilitated access to land and capital for the credit-unworthy, and has leveraged technology and capital-intensive production techniques in the presence of constant labor shortages. Together these three characteristics of American life have led most Americans, most of the time, to believe that government is best when kept small, and that people ought to be held responsible for their own failings. In a land of abundant land, capital, know-how, and opportunity, people should be allowed to rise, and fall, as far as they deserve.

### **Medical Charity**

Exceptionalism in social welfare in the United States has been mirrored in aberrant health policy. The United States, whether by fate, design, or strange luck, remains the only industrialized nation in the world which relies on the private sector to distribute health care, and health insurance.<sup>16</sup> Although debated fiercely and frequently, the dozens of comprehensive health reform bills submitted to Congress since 1912 have virtually all come to naught. The latest such measure, the Clinton health bill of 1993, was so costly in political capital for President Clinton's administration that it all but immobilized other domestic legislation for the remainder of his first term.

The political scientist Jacob Hacker struggles to understand the reasons for the uniqueness of the American health care system. Besides its dovetailing with the larger social welfare system, he cites the powerful interest groups created once most industrial workers began to receive health insurance from their employers.<sup>17</sup> Unions, pleased with the generous benefit packages already garnered by their members, viewed national health reform as detrimental to their members' interests, while employers, pleased with the stability of the arrangement, eschewed federal or state involvement with a system which seemed to work. Moreover, as private insurance companies grew to accommodate the huge demand for their health products, they created a powerful lobbying force, capable of winning the public to their side.<sup>18</sup>

Accompanying this unique profile of a health care system, or non-

system, is the most porous charity health care network in the world. Again the United States is alone among the world's industrial nations in having a substantial number of uninsured citizens, most of whom fall into a "gap," too wealthy to qualify for Medicaid yet too poor to afford private health insurance. Alone among those nations, the United States maintains a *de facto* separate tier of health care for the poor (other nations maintain a separate tier for the rich). And alone among those nations, the United States continues to maintain high rates of infant mortality—one of the single best indicators of how deeply basic medical care has penetrated into a population.

Despite these dire pronouncements, the position of the poor in the American health care system has markedly improved in the past four decades. Starting with the passage in 1965 of Title XIX of the Social Security Act (Medicaid), America's poor have increasingly availed themselves of modern medicine. Medicaid, although imperfect, has eased access, provided prophylaxis, and delivered procedures. Despite its underfunding and large eligibility gaps, Medicaid has brought the rates of poor people's interactions with private doctors and hospitals up to, and sometimes beyond, the rates posted by the middle class. And despite bizarrely inconsistent reimbursement rates among the various states, Medicaid has improved life expectancy for all of America's poor, regardless of residence.

This book is a study of why and how Medicaid came into being, and how it grew. It seeks to present the vagaries of the charity care system as they existed in the United States up to 1965, and the paths which the different components of that system then took. Three main themes recur throughout the story: the ambivalence with which Americans attempted to bring the poor into the mainstream health system; the inability of Americans to reach consensus on fundamental reform within that system; and the debate surrounding broader welfare reform which paralleled and coincided with the debate over welfare medicine. Several smaller themes appear from time to time, sometimes running tangentially to the broader themes and sometimes flowing directly from them. They include the running debate over federalism in the design of poor-care programs, the tensions between the states over designing their poor-

care systems, and the unpredictable relationships between the many poor-care programs, Medicare, and private insurers. Further complicating the story are the inconsistent stances on these issues taken by organized labor, the medical profession, and professional poor-care advocates.

The story is complicated because several narratives concerning poor care progressed concurrently. For example, even as American welfare policy changed dramatically in the 1990s, so too did understanding in the private sector of cost controls in health insurance. Furthermore, a usually obstinate medical profession abruptly moderated its opposition to government-sponsored payment reform in the late 1990s as a result of declining professional control wrought by managed care.

The evolution of poor care over the past half century, although a distinct story, is closely intertwined with broader developments in the health care delivery system, as well as debates over the still larger social welfare system. This book places that story within the context of those two other stories, while examining the internal debates and decisions made in poor care during that time. There is no easy thematic summary of the story. Ambivalence pervades, as do multiple small failures and large successes.

Thank you to various family members—my wife Rozlyn, brothers and sisters-in-law Andrew, Karen, Samuel, and Anne, and my mother Diana, for indulging my fiction of the writing life. None of them are quite sure of exactly how I earn a living, but so long as the kids are fed and the roof shingled, they seem content to let well enough alone. On a more practical note, thank you to various friends and relations who have hosted me in my research travels—Steve and Dale Sonnenberg in Austin, Michael and Janice Rosenberg in Chicago, and Noah and Andrea Jussim in Los Angeles. Suzanne Smith-Jablonsky assisted me in tracking down obscure journal articles, and saved my eyesight by doing virtually all of my micro-film work for me. Valerie Milholland shepherded the manuscript through the acquisitions and review process at Duke University Press, where Fred Kameny edited it. The project was supported by travel grants from Seton Hall University's faculty research fund and from the foundations associated with the Lyndon Johnson and George Bush presidential libraries. A

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This book is dedicated to the memory of my father, Milton Engel, who died in August 2002. A kind and generous man who often romanticized the academic life, my father supported me unconditionally through the early years of my career, taking it on faith that scholarship had value in and of itself, regardless of its marginal place in society. To paraphrase the Hebrew, his memory is a constant blessing.

# 1

## Antecedents: Poverty and Early Poverty Care Programs

### **Health and Health Care in the United States in the Early 1960s**

By 1964 America was in the throes of its “golden days” of medicine.<sup>1</sup> Death rates due to infection, heart disease, and stroke had fallen rapidly since the 1940s, and even such intractable problems as cancer and severe mental illness were viewed as potentially treatable by an optimistic medical community. Tranquilizers without severe side effects were promising to salve the tension and anomie inherent in a competitive society, and nascent hormone therapies offered the promise of new treatments for congenital abnormalities and growth deficiencies. New surgical techniques were being developed to transplant organs, reattach limbs, and excise brain tumors. *Life* magazine wrote at the time, “With ingenious substitutes for human organs and bold experiments in transplants, man becomes master mechanic, on himself.”<sup>2</sup> The promise of scientific medicine, as envisioned by medical soothsayers such as Abraham Flexner, William Osler, and Harvey Cushing in the early decades of the century, was being fulfilled.

Medicine had grown tremendously in the two decades since the end of the Second World War. By 1964 health care exceeded the nation’s transportation sector both in its number of employees and in raw revenues generated, which at \$33 billion were triple their level in 1949, representing almost 6 percent of gross national product and ranking health care sixth or seventh among the nation’s industries (depending on accounting techniques). Investment in the nation’s hospital infrastructure alone was well

over \$20 billion. Over the previous five years, 1,700 hospital construction projects had been approved, adding 72,000 beds to hospitals and health clinics. The nation's biomedical research budget had grown from \$88 million in 1947 to \$1.6 *billion* in 1964, an increase of nearly twentyfold.<sup>3</sup>

The increase in medical efficacy had saved the nation millions of dollars in lost labor and productivity. The federal government estimated that the annual cost of malaria to the thirteen southern states had dropped from the pre-war level of half a billion dollars to \$50,000. Similarly, the Public Health Service recorded a decline in the incidence of polio from 1,000 cases a week to fewer than a dozen. Inoculation programs and pharmaceutical regimens had halved the man-hours lost to industry over the past decade, and reductions in sickness and accident payments ranged from 25 to 60 percent. "Health is our best investment," the surgeon general, Luther Terry, proclaimed to an audience in Detroit that May. "Thus we will increasingly charge the debits of premature death, prolonged disability, and high costs of care to the assets of improved health, greater economic efficiency, and enjoyment of life."<sup>4</sup>

The miracle of modern health care did not come cheap. The combined cost of physician and hospital services, prescription drugs, medical devices, research, and convalescence was over \$170 per year per capita. A fourth of this was paid for by government—particularly research costs, medical care for the elderly poor, and hospitalization costs for the mentally ill—but three fourths of it was born by private individuals, corporate employers, and unions. For some services, such as hospital care, government paid for a bit more, while for other services, such as primary physician care, the burden fell more to the private sector, but the result in any event was the need for a substantial commitment by private citizens to fund their own care through cash payments, insurance premiums, wage reductions, or membership fees in prepaid health plans. While this health care balance between government and private citizen had existed for decades, the increasing efficiency of medicine made the opportunity cost of forfeiting private care greater, while the increasing cost of providing medical care made the cash sacrifice of obtaining it more acute.<sup>5</sup>

More than any other sector of health care, hospital care had grown in importance and cost, from 18 percent of the nation's health expenditures in 1929 to 33 percent by 1962, while almost all other health expenditures

had declined as fractions of total health care expenditures. New surgical techniques, breakthroughs in trauma care, wound stabilization, transplants, and new life-sustaining therapies for chronic patients demanded financial commitments far greater than what most hospitals could hope to raise through traditional sources of philanthropy and government largesse. Philanthropy had declined to 3 percent of the nation's hospital budget, and state and federal hospital subsidy programs could make up less than a third of the remainder; 67 percent of all funds spent on hospitalization, whether for capital investment or operating reimbursement, needed to come directly from patient billings, and this share was growing.<sup>6</sup>

Hospital costs, unlike physician costs, were highly volatile for any given individual. While in any one year the majority of Americans would spend no money at all on hospital costs, for those who did the bill could run to thousands of dollars. The hospital bill for a significant surgical procedure such as a transplant or removal of a brain tumor exceeded the annual income of most American families. To distribute the risk of a catastrophic hospital bill over many years, or even over an entire lifetime, an increasing number of Americans had turned to private hospital insurance (and to physician insurance as well) in the decades after the Second World War. Insurance allowed for more predictable financial planning as well as a distribution of catastrophic risk over an entire labor force or community. And because a high proportion of all hospital insurance was provided by employers in the 1960s, its cost was psychologically easier to bear, as most American workers believed that more generous fringe benefits did not bring about a commensurate reduction in salary.

Private hospital insurance had existed in the United States since the late 1920s (when the first mutual Blue Cross plans were established) but had not become popular until the war years, when companies began looking for alternative forms of compensation to lure qualified workers during the tight wartime labor markets. When GIs returned from the fighting, American companies had enthusiastically expanded their insurance offerings, pleased with the benefit's lure to the most dependable and sought-after workers—stable family men. In the decade and a half after the war's end, the portion of Americans holding some type of hospital insurance policy grew from 22 to 74 percent—the fastest penetration of



any type of financial instrument in the nation's history.<sup>7</sup> By 1965 over 80 percent of Americans in the prime of their working lives (ages 35 to 65) were covered, and over 70 percent of all children were covered as well. The single group with the lowest incidence of coverage, the elderly, still claimed a 63 percent coverage rate, and the poorest of the elderly, those least likely to be covered under a corporate pension plan and least able to afford private coverage, had benefited from the recently passed Kerr-Mills legislation, which offered medical subsidies for the impoverished aged.<sup>8</sup>

Studies conducted in the 1950s and 1960s indicated that hospital insurance coverage resulted in significantly better access to care and more successful outcomes from illness and trauma. As far back as 1952, the President's Commission on the Health Needs of the Nation reported that uninsured Americans entered the hospital in significantly higher numbers than insured Americans did, and once admitted stayed for substantially longer periods. Those covered by the most comprehensive policies, such as those of the Kaiser Foundation, the Group Health Association in Washington, and the Group Health Cooperative in Seattle, posted hospital admission rates of 80 to 90 per 1,000 per year, as compared to the general population's rate of 110 admissions per 1,000. Members of the cooperative plan stayed in the hospital an average of 6.4 days, while the general population stayed for 10.6. While Blue Cross patients were admitted at a slightly higher rate (122 per thousand), their lengths of stay were much closer to those of the cooperative plan members—7.4 days per admission. As a result, cooperative plan members stayed in the hospital for fewer than 600 days per thousand members per year, while the general population stayed for 1,165. Enrollees in the Blue Cross plan were in between, with 888 days per thousand per year.<sup>9</sup> While all these numbers had risen modestly by 1961, the magnitude of the discrepancy remained.

As hospital insurance became more important to Americans in planning for and financing their health care, those who lacked insurance lagged behind their fellow citizens in their ability to gain access to the best physicians and hospitals and to maintain their state of health. In 1932 the Committee on the Costs of Medical Care (CCMC) had reported that access to quality medical care was highly correlated with income, but the truly poor had always managed to find alternative means of gaining entry to the system. Public hospitals and clinics, pro bono service by doctors and

dentists, and community-based philanthropy had historically minimized the disparity in access to health care between rich and poor. (The ccmc had found, oddly, that the very poorest group of Americans used doctors and hospitals as frequently as the wealthiest group, because of the availability of charity care. For all other groups, income dictated medical purchasing.) But the rise of hospital insurance undermined the existing mechanisms for equalizing access to medical care. By 1965 the discrepancies were obvious and stark. While only 13 percent of households with an annual income of \$5,000 or more lacked hospital insurance, almost 40 percent of households earning under \$5,000 so lacked. And for children of the poor, the situation was worse. In a nation in which over 80 percent of the actively employed had hospital insurance by 1965, only 22 percent of children living in households with an annual income under \$3,000 had the same.<sup>10</sup> “Will the health system touch all, and not just the solvent and initiative-takers?” asked the public health scholar Charlotte Muller that spring.<sup>11</sup> Given the already described health advantages associated with hospital coverage, the wealth gap in health insurance loomed ominously over a nation which was becoming more concerned with social inequity and the persistence of endemic poverty.

## **The Poor**

Who were the poor in 1965? One common sociological index was that families or households had “inadequate income” if their current earnings left them unable to meet at least 90 percent of their basic budget requirements (food, housing, clothing, health care, transportation). By this criterion 20 percent of American households were poor. But the line was hazy, and needed to be adjusted for regional cost-of-living differences, habits of living, unique expenses, and household standards. Another approach was to look at median family income. The median after-tax family income in 1965 was \$5,906, of which \$5,390 was spent on current consumption; 12 percent of households had incomes under \$2,000, and another 8.5 percent had incomes between \$2,000 and \$3,000, leaving just over a fifth of American families below the poverty line of \$3,000 set somewhat arbitrarily by the U.S. Department of Labor. A third approach was based on family food expenses, which the Department of Agriculture

suggested should consume no more than a third of household income. By this measure, again, about a fifth of American households lived in poverty.<sup>12</sup> According to still another measure, the poor were the one sixth of American households which owed no income tax in 1963 because their household income fell below the mandated standard deduction—\$1,325 for a mother and child, \$2,675 for a married couple with two children. Among the elderly, half of those living alone lived on less than \$1,000 a year, although their expenses (apart from medical care) were considerably less than those for the rest of the population, while among children, seventeen million (one in four) lived in families with inadequate income.<sup>13</sup>

Lack of income translated directly into lower use of medical care, even while ensuring higher rates of both acute and chronic illness. A person living in a family with under \$2,000 in income, for example, could expect to lose twenty-eight days of productivity a year to illness, while one from a household earning over \$7,000 would lose only thirteen. Yet at the same time, the member of the lower-income group would consult a physician only five times a year, while the one from the higher-income family would consult one six times. Differences in dental care were even wider: nearly 80 percent of people in the poorer group failed to visit a dentist in any given year (as opposed to 40 percent from the wealthier group), and when a poor person finally did go to the dentist, the visit resulted in an extraction 37 percent of the time (versus 10 percent for the wealthier group). Young bodies ordinarily recuperated on their own, and this minimized the consequences of inadequate care to some degree, but for the elderly poor the inability to consult a physician truly undermined the quality of life. A senior citizen from the poorer group, for example, would experience 50 percent more days of immobility and loss of functioning due to illness than would his counterpart in the wealthier group. And since loss of functioning, at all ages, translated into lost work days and diminished wages, the tendency of the poor to get sicker exacerbated their poverty. "These poor people who get sick and who go to the hospital are statistics," wrote the assistant secretary of health, education and welfare Wilbur Cohen. "But, they live among us; and their misery, buried in the statistics, is very real."<sup>14</sup>

Not only did poverty and illness tend to reinforce each other—the

poor got sicker, the sick got poorer—but medical breakthroughs in the postwar years paradoxically made the problem worse. Where once all people, regardless of income, could count on a certain equity in the distribution of physical fortitude (in the nineteenth century infant mortality rates were actually higher among the wealthy in Europe, who would subject themselves to pernicious obstetrical techniques and unhealthy fashions), now money could buy better health. New drugs were capable of curing (rather than merely alleviating pain), and their very existence challenged prevailing notions of social equity. “I am 80 years old and for ten years I have been living on a bare nothing, two meals a day, one egg, a soup, because I want to be independent,” a witness testified at a congressional hearing in 1959. “I have pernicious anemia, \$9.95 for a little bottle of liquid shots, wholesale, I couldn’t pay for it.”<sup>15</sup> Illness and poverty were inseparable, and becoming more so. Traditional hallmarks of poverty, such as lack of education and adequate nutrition, unhealthy and unhygienic home environments, and poor social and psychological support structures, increasingly seemed like failures of the medical system rather than social pathologies. Governor Nelson Rockefeller of New York emphasized the bond between these two great social challenges when he reminded an assembled audience in 1965 that one of every six American adults was unable to hold employment or engage in the quotidian activities of life because of chronic disease or handicap, mental retardation, senescence, or alcoholism. Certainly access to private insurance did not cure all these ills, but it invariably salved and assuaged, speeded recovery, and retarded demise.<sup>16</sup>

### **The Genesis of Charity Care**

Although formal charitable institutions did not appear in the United States en masse until after the Civil War, Americans of modest means living in farming villages and small towns could rely on informal community commitment for staples, shelter, and rudimentary medical care during difficult times, while America’s few urban dwellers could turn to the almshouse, or even the prison, if desperate. Mass immigration after the potato famine in Ireland in the late 1840s, and then again after the political insurgencies and ensuing economic depressions in central Eu-

rope a decade later, shifted the American population from rural to urban and the work force from agricultural to industrial, and resulted in demand for more structured charitable institutions. Informal bonds of kin, church, and neighbor which functioned well in rural New England and tidewater Virginia were woefully inadequate in the Atlantic and Great Lakes industrial cities, which experienced explosive growth in mid-century. Many American cities quadrupled in population between 1830 and 1865; by the end of the Civil War, New York City claimed a population of nearly a million, Philadelphia of half a million, and the relatively new metropolises of Chicago, Buffalo, Cleveland, Cincinnati, and St. Louis of well over 100,000 each. Cities of this size, teeming with immigrants often isolated from family and *landsman*, required a more systematic approach to charity care.<sup>17</sup>

The sectarian, nonprofit, community hospital emerged to fill this role. Although civic leaders had been establishing private hospitals since the mid-eighteenth century, there were only 150 of these institutions by 1873. Almost exclusively Episcopalian in affiliation, these prestigious early arrivals—Pennsylvania Hospital, New York Hospital, Massachusetts General Hospital, and St. Luke's in New York among them—existed as much to serve the physician community as to serve the sick. Few people of means, or even of middle-class status, would consider obtaining care in the wards. No better equipped than the average middle-class living room for sick care, these early hospitals sheltered those patients who were cursed with attenuated family connections or distant kin, and who required bed, food, rudimentary nursing care, religious counseling, and weekly visits by a local physician who could frequently diagnose but rarely intervene. The physician's services were given gratis; possessing hospital privileges was its own reward for the doctor—an imprimatur of community standing, medical accomplishment, and often financial success. While his hospital service might occasionally lead to the referral of a patient, more likely it was an opportunity for him to dispense his civic obligation, meet young doctors in training, and assert authority within the community.

By 1920 the United States had over six thousand private hospitals. Slavic and Jewish immigrants from Central and Eastern Europe, Catholics from Italy and Ireland, Lutherans from Germany and Scandinavia,

Scottish Presbyterians, Methodists, and northwardly migrating African Americans followed the Episcopalian example of community largesse. Each group, eager to care for its own, established hospitals in cities with a critical mass of coreligionists and sought funds, nurses, doctors, and board members from within its own sect. Hospitals continued to provide little more than room, board, and succor to their unfortunate tenants, and most patients continued to avoid them when possible. Open wards prevailed, medical care was minimal and rudimentary, and prognoses were usually pessimistic upon admission. Nevertheless, groups placed a high priority on building these institutions, providing a locus for the medical training of kith, and the wherewithal to preserve indigenous culture if admission should be necessary. While a sick German could theoretically go to any hospital with little chance of being turned away, it was only at the local German or Lutheran hospital that he could be assured of finding familiar food, German-speaking nurses and staff, appropriate clergy, compatriot physicians, and a familiar milieu in which to either convalesce or die. Jewish hospitals offered the added attraction of kosher food; at Catholic hospitals there was daily mass, communion, and omnipresent crucifixes.

From the beginning these sectarian institutions defined their missions quite specifically. They were to provide community service and charity care to those in need, but only those who met minimal community standards of worthiness.<sup>18</sup> The “deserving poor” was a protean term, but throughout the late Victorian era it generally defined those who had fallen on hard times despite moral rectitude. The abandoned mother, the war widow, the orphan—these were society’s downtrodden who maintained the promise of salvation. By contrast, the drunkard and the sloth either had failed to achieve grace from the outset, or had forfeited it through depraved acts of self-pollution. Various communities parsed the groupings differently, but all accepted the division to some degree. The wards, of course, were intended to serve the former group.<sup>19</sup>

Those deemed worthy entered an institution driven as much spiritually as medically. Since the majority of patients would die before discharge, hospitals defined their purposes broadly as salvation and succor. Nurses lent comfort to the suffering; clergy strove for absolution and repentance. “Many have heard the good news of salvation for the first

time while lying on their beds of suffering,” wrote one hospital superintendent in 1892.<sup>20</sup> Medical staffing was closed, insofar as a patient’s private physicians could not follow him into the hospital. Care was instead turned over to a select group of hospital physicians who were frequently medical leaders in the community, and who donated one or two mornings a week to observe patients, make recommendations, study the afflicted, and issue orders. The hospital was mission-driven (in today’s parlance), and both workers and patients were preselected to comply with its ulterior goals. Few with alternatives chose to cede control over their lives to such a tightly ordered place; the regimen was of too little benefit to justify the surrender of domestic comfort.

Communities rallied round the institutions, however, often bestowing upon them philanthropic aid unparalleled by any other community association. In many neighborhoods fund-raising dinners, dances, and events were yearly social highlights. Membership on the board of trustees was highly prestigious and sought-after, and often culminated a lifetime of community service and civic involvement. Wives’ groups, women’s auxiliaries, volunteer brigades, and fund-raising committees grew up around the hospitals, drawing broad participation and helping to bind immigrant and religious communities undergoing the pressures of assimilation. The hospital was often the most generously endowed institution in any community, and its edifice the most impressive (particularly after the building spree from 1910 to 1930). It was neither the church steeple nor the local priory school which overshadowed the modest architecture of many urban neighborhoods, but rather the domed or vaulted cupola crowning the new *beaux arts* hospital building.

## **Public Hospitals**

For patients who failed to meet the criteria of hospital admission, American cities began to establish public or municipal hospitals toward the end of the nineteenth century. These hospitals, which drew on the examples of a few early arrivals such as Bellevue in New York, were tax-funded and lacked the spiritual dimension of the sectarian institutions. Across the Northeast and the Midwest, cities constructed great holding pens for the disestablished. City Hospital in Boston, Martland in Newark, General

Hospital in Washington, Cook County in Chicago, and Kings County in Brooklyn all evolved from the earlier example of the public almshouse, whose goal was primarily to maintain public order by removing vagrants, shelterless migrants, seamen, and travelers from the streets. These were people who lacked the community ties and upstanding reputation sought by the private hospitals, and for one reason or another lacked family and friends to care for them when they fell ill. Income was not a significant factor in deciding who went to which type of hospital. Rather, community ties and reputation were the tickets for admission or denial.

One significant difference between the two types of institutions was billing. Municipal hospitals were free, as one would expect of an institution modeled on the almshouse. By contrast, the private hospitals charged a bed fee, even if nominally so. The fees helped to offset operating costs, but perhaps more importantly they established a precedent for self-help even among the poorest patients. Nineteenth-century philanthropists were keenly aware of the dangers which charity posed to beneficiaries; paupers could easily slide into vice and criminality if allowed to abrogate responsibility to themselves and their dependants, and the eleemosynary urge of the benefactor needed to be carefully tempered by the moral requirements of the beneficiary. "If a man will not work, neither shall he eat," the social theorist C. R. Henderson wrote in 1896.<sup>21</sup> Students of scientific charity recognized the distinction between poverty and pauperism, the latter being a moral affliction as well as a financial condition, and one which required philanthropic vigilance to thwart. "In nearly all cases, he who continually asks aid becomes a craven, abject creature with a lust for gratuitous maintenance," the reformer R. Hunter warned in 1904.<sup>22</sup> The setting of mandatory hospital fees, however modest, prevented this inevitable decline.

After 1910 both the mission and the operations of sectarian hospitals shifted toward the clinical. The impulse underlying the shift was the growing effectiveness of therapeutics. Analgesic and antiseptic surgery, first discovered in the latter half of the nineteenth century, came into broader use. Techniques first pioneered at the nation's research hospitals such as Johns Hopkins, Massachusetts General, and Presbyterian were disseminated to the medical hinterland, as surgical residents graduated from the most prestigious programs and went forth to establish their own



practices. A revolutionary diagnostic tool, the x-ray, brought many middle-class patients to hospitals to use a technology rarely found in private offices, while new obstetrical approaches including use of the forceps, general anesthesia (“twilight sleep”), and cauterization promised safer and less painful deliveries. For the first time, many Americans began to view the hospital as not so much a spiritual venue but a medical one—the domain of the priest and minister had become the doctor’s workshop.

Demographic changes accelerated this transformation. A wartime economy prompted greater internal migration within the United States, meaning that a substantial number of middle-class burghers lived distant from extended family. An expanding manufacturing sector and an increase in the money supply created economic growth and ended the decades-long deflation which had begun in the 1870s. More Americans had more money, but fewer community ties, on which to draw during a time of illness, and the existing sectarian hospitals became a natural refuge for the moneyed sick. The sectarian hospitals in turn upgraded their facilities from open wards to semi-private and private rooms, in the hope of attracting wealthier patients who could shoulder a larger portion of the hospital’s operating budget. The hospital became associated with cure rather than death, and an institution founded under the guise of community service and spiritual elevation adapted itself naturally to the principles of medical procedure and professionalism. One satisfied customer explained at the time, “I can go to St. Luke’s and for \$21 a week I can have a private room with board, medicines, medical and surgical attendance and a trained nurse constantly with me.”<sup>23</sup> Hospitals reinforced this perception by taking out advertisements in newspapers and serials touting their sophisticated equipment, highly trained nurses, and aesthetic attractions, in the hope of further increasing the ranks of the moneyed hospitalized.

Such developments spelled a fundamental shift in mission for sectarian hospitals. Born as glorified poorhouses whose fundamental client was the community, they had become medical workshops whose most important clientele were the skilled doctors practicing in that community. Pleasing local doctors became paramount for both trustees and administrators, since it was through the medical staff that prestige and import were garnered and billings earned. Trustees liked having well-

regarded doctors on the medical staff; their reputations enhanced the reputation of the institution, and ultimately the social influence of the trustee. Likewise, administrators were eager to please the medical staff with professional nurses, sophisticated equipment, and modern facilities, as a way of both appeasing their own bosses (the trustees) and expanding their own purview. A prestigious hospital was a wealthy hospital, for prestige designated pride of place and attracted ever more philanthropy. As is common, the rich got richer.

But commitment to charity care was lost in this transformation. Private patients were now expected to bear larger hospital bills, and potential patients unable (or unwilling) to do so were now more frequently referred to the local municipal hospital. The distinction between the deserving and the undeserving poor was lost; now there were simply those who could pay, and those who couldn't. Although private hospitals did continue to provide substantial amounts of uncompensated care, this was now seen as an ancillary goal of the hospital rather than the central goal in and of itself. Also attenuated was the close identification which sectarian hospitals had previously held with a specific church, immigrant group, or sect. A Lutheran might now choose to seek care at the local Presbyterian hospital, as medical impetus overrode social inertia. Although boards continued to be drawn almost exclusively from the founding community, they now saw their primary commitment as one toward medical excellence, with commitment to the community at large or to the specific ethnic group which had founded the institution as secondary. The ties disintegrated gradually over the following half-century, until by the 1990s Swedish and Methodist hospitals began to merge with little cultural conflict, formerly Episcopalian hospitals advertised themselves as nonsectarian, and Jewish hospitals closed their kosher kitchens because of lack of demand for kosher food. Scientific medicine had proven itself a more compelling organizational foundation than parochial identity.<sup>24</sup>

### **Physician Charity**

Charity care never had the institutional structure of the sectarian hospital. Rather, most doctors took it upon themselves to care for patients who sought their help, regardless of ability to pay. By the end of the nineteenth