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# "CHICAGO HOSPITALS' PROVISION OF CHARITABLE CARE, 1910 - 1960"

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# Community Hospitals' Institutional Change to High Technology Care: Chicago Hospitals, 1910 to 1960

**Abstract** Social historians have done little work which considers hospitals' provision of charitable care, and, for the most part, the work that has been done only considers hospitals before the twentieth century. An exception is the work of Rosner on New York and Brooklyn hospitals. Rosner argues that hospitals moved away from being charitable institutions in the 1910s. The findings of this study on Chicago hospitals show that hospitals remained charitable community institutions into the 1940s.

Research findings include: 1) Only about half of Chicago's hospitals were charitable community institutions at the turn of the century; 2) Charitable hospitals continued to provide charitable care for a few decades following the 1910s; 3) Hospitals responded to heightened community health care needs during the Influenza epidemic of 1918 and the Depression, and 4) Hospital's provision of charity declined, especially in the inpatient setting, from the 1940s through the 1950s.

Overall, the research shows that changes in the U.S. hospital industry from 1910 to 1960 are directly applicable to institutional theories of organization. In particular, institutional theory's emphasis on societal forces, as opposed to organization ecology or organization adaptation, appears to have substantial explanatory power regarding hospitals transition from a community care to a high technology care orientation in the 1940s.

This paper also contributes to institutional theory on two levels. First, the research illustrates how legitimacy can also come from local, community sources. This is shown by describing how hospitals competed among each other to provide the most charitable care. Hospitals' publicized their provisions of charitable care to their communities to maintain a community interdependence and to encourage further philanthropic support.

Second, the research documents how institutional change was promoted, both directly and indirectly, by the actions of key actors in an organizations environment. In the case of hospitals, these direct actions include: 1) the American Medical Association's promotion of specialist education over general practioners education starting in the 1930s, and 2) the federal government's movement to centralize health care around medical education directly legitimated a high technology based hospital system in the 1940s. But more importantly, I argue that the indirect changes that came about from the implementation of hospital insurance in the 1940s and 1950s, led to a health care system based on research and development and a 'no cost is too much' orientation. The heightened cost increases that came about overwhelmed the philanthopic support for charitable care, thus minimizing hospital's traditional charitable orientation.

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# Hospitals' Institutional Change from Community to High Technology Care: Chicago Hospitals, 1910 to 1960

Hospitals in the United States have traditionally been steeped in a community orientation: volunteers, charity, and philanthropy are "giving" activities which characterize an organization which has a strong interdependence with its community (Stevens, 1989). However, in the last few decades, this tradition has seemingly been replaced by a profit orientation (Gray, 1991). Former locally-controlled hospitals have become part of multihospital systems; and large numbers of not-for-profit hospitals are now part of hybrid organizations that include profit and nonprofit elements. The new institutionalism school of organizations[1] points researchers to considering this transition in terms of changes in broad societal belief systems which are external to the community. For example, DiMaggio and Powell (1991), in their recently published book introducing the "neoinstitutionalism", write

> Neoinstitutionalism's emphasis on such standardized cultural forms as accounts, typifications, and cognitive models leads neoinstitutionalists to find the environment at the level of industries, professions, and nation-states rather than in the local communities that the old institutionalists studied (page 27).

Neoinstitutionalists' promotion of non-community, structure-level forces is theoretically based on their contention that legitimacy comes primarily from such sources as the state and the professions (DiMaggio and Powell 1983: 147) or the more general worldwide forces of "rationalization" of society (Meyer and Rowan 1977).

This paper, however, presents evidence that institutional legitimacy also may come from an organization's local community. A community source of legitimation is evidenced in how

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[1] Powell and DiMaggio (1991:12) contend that neoinstitutionalism differs from the "old institutionalism" analysis of Selznick (1949), and the like, because of neoinstitutionalism's cognitive orientation. Using Parson's theory of social action, Selznick grounds human behavior in morality and commitment. This is seen in how Selznick emphasizes the processes involved in forming and coopting values, norms, and attitudes of organization members.

hospitals from the late nineteenth century through at least the 1930s enhanced their community interdependence by publicizing their provision of charitable care. For example, charitable hospitals competed publically among themselves in their ability to provide the highest percentage of charitable care. I argue that the provision of charitable care served these hospitals as a legitimating device which garnered further community support for the hospital as an institution.

Neoinsitutionalist's also suggest that the new institutional theory of organizations is limited to theoretical versions of organizational change which "suggest a static, constrained, and oversocialized view of organizations" (Powell, 1991: 183). To counter this orientation, DiMaggio (1988) contends that without more explicit attention to interest and agency, institutional theorists will be unable to develop predictive and persuasive accounts of the origin, reproduction, and erosion of institutionalized practices and organizational forms: "Institutionalization as a *process* is profoundly political and reflects the relative power of organized interests and the actors who mobilize around them" (page 13).

This paper presents evidence in line with DiMaggio's contention regarding actors/interests and their roles in institutional change. Evidence is presented which documents how key actors -- such as the American Medical Association and the federal government -- initiated changes which led to the institutional change of hospitals away from a community care orientation and toward a high technology orientation in the 1940s. However, this paper also presents evidence that this institutional change was also the result of unintentional social and structural changes. I argue, for example, that the retrospective payment system that was initiated with the introduction and heightened growth of hospital insurance in the 1930s and 1940s, led hospitals toward competition that was based more on fitting with technological care than with community-based care (footnote - on medicine). Thus, in addition to DiMaggio's agency argument, I contend that institutional change is a product of both actors intentions and unintentional social and structural changes. Unintentional changes implies that institutional change has a random, historical component that should be addressed in accompaniment with theoretical inquiries.

The paper is divided into four sections. The first section is a historical portrayal of the community nature of hospitals as charitable institutions. The second section introduces data and provides analysis results regarding Chicago hospitals' provision of charitable care from 1910 to 1960. The third section is a discussion regarding possible explanations for the decline in hospitals' provision of charitable care. The final section highlights how this research contributes to institutional theories of organizations.

## COMMUNITY INSTITUTIONS: HOSPITALS PROVISION OF CHARITY

By the late nineteenth century, a proliferation of community hospitals developed in the cities of the United States as a response to diverse social and medical needs generated by urbanization and industrialization. Very often the elites of an urban neighborhood, such as members of the clergy, local business leaders, or a group of enterprising doctors who, more often than not, had been excluded from privileges at other hospitals, developed these charitable, and generally small, community hospitals. Historians argue that these early institutions were built to serve the health care needs of the whole community, not just certain classes. Earlier hospitals were essentially regional almshouses for paupers, the insane and the chronically ill.

The provision of charitable care was the primary benchmark which hospitals used to legitimate and substantiate their community health care orientation. Community hospitals took special pride in their ability to provide charitable care. For example, Grant Hospital, a hospital in Chicago's Lincoln Park neighborhood, was described in the following way in its 1928 annual report:

> The hospital is a non-sectarian, charitable organization endorsed by the Chicago Association of Commerce and is not intended as a money-making institution. It is operated without profit to anyone; it renders its services free to the worthy poor. During the last 15 years a total of 134,085 days absolutely free service was rendered to patients who were found worthy by our Social Service Department. This does not include Outpatients and babies who were treated in the Free Clinic (page 9).

Grant Hospital's self-description was repeated by virtually all the other community hospitals of Chicago at this time. In essence, these hospitals defined their community nature in terms of the

Charitable care was not indiscriminately given by hospitals. Unlike almshouses in the eighteenth and nineteenth centuries, hospitals differentiated the "worthy poor" from others. By the end of the nineteenth century, differentiating between the poor who were deserving of care because of infirmity or high unemployment, and the undeserving, became a serious issue. For example, in an 1896 paper entitled "How to Care for the Poor without Creating Pauperism," Charles Henderson, a sociologist at the University of Chicago, described five social classes: the social, whose class members "seek to promote the welfare of the community," and four other classes, the unsocial, the pseudo-social, the anti-social, and the sub-social, whose members were all debased and even dangerous. A more accepted--and lenient--model[1] was developed in 1904 by Robert Hunter, a well known progressive of the time. He demarcated three categories of dependents: (1) the absolutely dependent, including the aged and children, the crippled, blind, deaf, dumb, and insane - for whom care in institutions should be provided by the community, and (2) the temporary dependent including the sick, inebriates, and drug addicts for whom charitable support was recommended until they had recovered, and (3) those capable of self-support, including vagrants, beggars, and "the morally insane."

Social historians have done little work that considers hospitals' provision of charitable care, and, for the most part, the work that has been done only considers hospitals before the twentieth century. An exception is the work of David Rosner (1982) who studied New York and Brooklyn hospitals at the turn of the century. Rosner argues that hospitals at the turn of the century were

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[1] What is noteworthy about the practice of limiting charitable care to worthy poor and dependent populations, such as the elderly, children, blind, deaf, dumb, and the insane, is how this charitable population parallels todays eligibility requirements for Medicaid coverage. Eligibility for Medicaid is linked to eligibility for welfare. To be eligible for welfare, families must have incomes falling below a standard of need established by each state. Also, States must cover all families covered by the aid to families with dependent children (AFDC) program, along with the aged, blind, and disabled recipients of supplemental security income (SSI).

classless, community-based charitable institutions[4] . For example, for the time period of 1885 to 1915, he describes New York and Brooklyn's hospitals this way: "The overwhelming majority were privately organized 'charity' or 'voluntary' hospital, which though large in number, were generally small in size" (page --).

Rosner further argues that by the 1910s hospitals turned away from their charitable community responsibilities. He writes:

> By the end of the Progressive Era, the health care system had undergone tremendous change both internally and externally...locally based charity facilities were replaced by a system of health care built around the newly arising medical profession and hospital. Gone were the large rooms, the atmosphere of moral reform, and paternalism of charity care (1982: 3).

Rosner's findings fit with historians' views that community hospitals changed into physicians' workshops by the 1910s and were guided by the notions of scientific medicine (Rosenberg, 1988; Stevens, 1989; Vogel, 1980). For example, physicians affiliated with Brooklyn hospitals increased from 15 percent of all Brooklyn physicians in 1900 to 42 percent in 1910. By 1928 almost two-thirds of all physicians in the nation held hospital staff appointments (Starr, 1982: --).

Numerous historians and sociologists, also, have pointed out how, internally, physicians gained professional control of the hospitals. For example, physicians persuaded hospitals to "open" their staff to all admitting physicians, and forced hospitals to maximize physician payments by limiting charity abuse. Paying patients were needed because hospitals increasingly came to rely on these revenues so that they could continue to build their physical plants and attract more patients, physicians, and philanthropy (Kingsdale, 1981). Furthermore, historians note how medicine as a profession gained in power and focus by the 1910s as evidenced by the Flexner report of 1910 on medical education, and by the introduction of hospital standards by the late 1910s (Starr, 1980). This growth in the cultural authority of physicians led to the demise of the

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[4] Historians of the U.S. hospital industry generally characterize this industry as being class-based by the 1920s. For example, see Stevens chapter, "Hospitals in the 1920s: The Flowering of Consumerism" (1989: 105-140) or Starr (1982: 169-180).

The evidence that I have seen fully supports historical depictions of the beginnings of the physician workshop hospital in the early years of the century. However, my evidence also indicates that the physician workshop hospital did not replace the charitable community hospital. I suggest, alternatively, that until the 1940s hospitals embodied both community- and physician-oriented missions. Thus, a question that needs to be investigated is what factors led the transformation of the hospital away from being a community institution by the 1940s. Before I develop a possible explanation to this inquiry, it is necessary to identify how the hospital had been a community institution and for what period of time.

## PRELIMINARY DATA ANALYSIS

**Data.** A primary source of information on hospitals' provision of charitable care that I analyze is annual reports from hospitals in Chicago from 1910 to 1960. The two sets of numbers that were almost universally covered in hospital annual reports of this period was the number of "free days" the hospital provided and the number of patients admitted. Numbers on charitable care and total patients admitted were evidence that a hospital was living up to its mission of providing care to the community and that a hospital provided good quality care.

All existing hospitals in Chicago were approached to determine whether they have archive materials of use to this study. Comprehensive historical information was collected on thirteen different hospitals in Chicago (Chicago Lying-In, Children's Memorial, St. Ann's, St. Elizabeth, Presbyterian, St. Luke's, Wesley Memorial, Alexian Brothers, Englewood, Lutheran Deaconness, Cook County, Passavant, and Grant Hospitals), and supplemental information was obtained on a number of other hospitals (including Augustana, Provident, St. Anthony, University of Illinois, St. Mary of Nazareth, Mercy, Hannemann, and Isolation Hospitals). These hospitals represent a variety of hospital types, from small, ethnic and religious hospitals, to speciality care hospitals, and large university hospital systems. Also, they represent different areas of Chicago, both

geographically and economically. Of the listed hospitals, data for Passavant, Grant, Englewood, St. Elizabeth's, Wesley, and Presbyterian Hospitals will be described in this paper.

Other data used include data from the Chicago Medical Society's *Blue Book* and my dissertation data. The *Blue Book* was a survey conducted that was conducted sporadically, but often on a biannual basis, from 1905 to 1952. The survey is a collection of self-reported information from hospitals, including whether they offered charitable care or not. Also, my dissertation data is a data base of all hospitals in Chicago historically. This data base was initiated with a biannual collection of hospital data from Chicago phone books and business directories. These primary data were checked and appended from numerous sources of information on Chicago's hospitals. (Names of these sources are too numerous to reproduce here.) Overall, the quality of the hospital database for Chicago's hospitals is excellent and much better than any other hospital database in existence, especially for the period prior to 1931.

## RESULTS

### 1. Only about half of Chicago's hospitals were charitable community institutions at the turn of the century.

Tables 1 and 2 combine information from my dissertation data on when hospitals began, and Chicago Medical Society *Blue Book* information regarding whether a hospital self-reported as providing charitable care. Although the *Blue Book* started in 1905, 1910 was the first year that charitable care data were gathered from the Chicago hospitals.

Table 1 shows that many of the hospitals that existed in 1900 were private. Also, Table 1 shows that Cook County Hospital's 2000 beds were a significant proportion (i.e., 44%) of all general care hospital beds in Chicago at this time. Cook County Hospital provided free health care to all Cook County residents. Table 2 shows a "reply" and an "adjusted" column. The reply column is for what hospitals reported in the *Blue Book* ; the adjusted column is what I have developed in light of the various historical sources that I have used. It was necessary for me to make an adjusted column because it was clear that some hospitals incorrectly answered the

question of whether they provided charitable care of not. For example, Michael Reese Hospital consistently replied that it did not provide charitable care. Yet records indicate that Michael Reese probably provided a higher proportion of charitable care then any other nongovernmental, general care hospitals in Chicago during the period of this study.

Possibly, Michael Reese, and other hospitals, by answering "no" to the charitable care question, was trying to lessen its charitable provider burden or alter perceptions regarding the hospital's image as one of being a care taker of indigent patients. Another possible explanation is that since the *Blue Book's* audience was Chicago Medical Society member physicians, charitable hospitals may have not felt as compelled to legitimate their community charitable orientation. After all, physicians gained greater financial rewards for the services they provided to paying rather than non-paying patients.

Table 2 shows that at most, only half of Chicago's non-governmental hospitals provided charitable care from 1910 on. Also, Table 2 shows that a hospital's likelihood of providing charitable care was independent of the hospital's age. This is an important point because differing hospital types were built at different periods of time. For example, large charitable hospitals were built first (1870s and before), followed by the religious/ethnic institutions (1880s and 1890s), the small private, doctor run hospitals (1890s and 1900s), and the community hospitals (1900s and 1910s).

Overall, Tables 1 and 2 indicate that the characterization of urban hospitals as charitable community institutions at the turn of the century is too narrow (Rosner, 1982). Many of these hospitals were proprietary, having been founded and run by physicians. However, many religious and ethnic hospitals also did not show any tendency toward attending to the charitable, health care needs of their local communities. Furthermore, governmental hospitals in Chicago, especially Cook County Hospital, have always provided a major proportion of indigent care in Chicago.

These findings suggest that health care delivery in Chicago at the turn of the century should not be classified as a homogeneous environment of charitable community institutions . A more appropriate classification would be to say that the hospital system in Chicago was, and remains,

class based between hospitals that only provide for paying patients, hospitals that combine charity and revenues, and governmental hospitals that regularly offer free services.

**2. Charitable hospitals continued to provide charitable care for a few decades following the 1910s.**

Rosner argues that by the 1910s hospitals had turned away from being charitable institutions (1982: 3). Instead these hospitals became voluntary enterprises; that is, hospitals which catered to paying patients (Stevens, 1989). What evidence I have seen regarding Chicago's hospitals at this time supports the notion that hospitals did become voluntaristic by the 1910s. However, my data on Chicago's charitable hospitals indicates that these hospitals maintained a charitable, community care orientation for a few decades subsequent to the full development of the voluntary hospital.

Tables 3 and 4 show that Chicago's hospitals did maintain a charitable orientation into the 1940s. Table 3 shows that Chicago's hospitals in 1917 provided free care to 20% and part pay care to 11% of their patients. Hospitals' definition of charity patients both include and excluded part-pay patients, thus it is not clear whether one can say that 31% or 20% of all patients in the surveyed Chicago hospitals received charitable care. Furthermore, one should use caution in interpreting these results since only half of the hospitals provided information, and there is no way of knowing which hospitals these were[5]. Table 4 shows that 21% of the patient days provided by nongovernmental hospitals in Chicago in 1931 were charity days. Again, there is no way to ascertain whether charity days encompassed both free and part-pay days, or whether the 39 reporting hospitals are representative of the city as a whole. Also, patient days is not an equivalent measure with number of patients which received charitable care. [6]

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[5] One must be cautious when interpreting these data. The 1917 survey included 35 of Chicago's hospital, which was about half of all Chicago hospitals. I suggest that charitable hospitals were more likely to respond to this survey and thus the charitable care numbers may be higher than they actually were.

[6] Charity patients were typically sicker than pay patients and they thus required a longer length of stay. Accordingly, the 21% charity days (Table 4) would have to be adjusted downwards if it is to be compared with the charity patients information of Table 3.

Overall, it is clear that Chicago's hospitals were still providing a significant amount of charitable care in 1931. Furthermore, if one includes the governmental hospitals (i.e., Cook County and the Research and Education Hospital of the University of Illinois), then over 50% of all patient days in Chicago were charity days; which is strong evidence that hospitals continued to provide charitable care in Chicago after the 1910s.

### 3. Hospitals responded to heightened community health care needs during the influenza epidemic of 1918 and the Depression.

Historical trends in Chicago hospitals' provision of charitable care can be open to different interpretations than the one I suggest: that some hospitals continued to be charitable after the 1910s. This is especially true when the data, as presented in Tables 3 and 4 has to be qualified by the lack of survey respondents. Thus, to add support to my interpretation, I offer an alternative test of hospitals' community orientation. That is, did Chicago's charitable hospitals respond at times of heightened community health care needs? To test this research question I have drawn evidence regarding two significant periods of heightened health care needs in Chicago. These periods are the influenza epidemic of 1918 and the Depression years from 1929 through the 1930s. Following descriptions of these periods, I provide evidence regarding hospitals' responses to them.

The exceptional virulence of the influenza strain of 1918 first became apparent during August outbreaks in Africa, Europe, and North America. No other modern strain of influenza led so frequently to deadly pneumonia. Young adults were most susceptible, and general good health provided no defense against the disease. Wartime mobilization of soldiers and civilians created optimal conditions for the spread of the virus. Global fatalities exceeded twenty million and may have approached forty million. Influenza and pneumonia deaths in excess of the annual average surpassed half a million in the United States.

In Chicago influenza took a terrible toll. More than fourteen thousand people succumbed between mid-September of 1918 and March of 1919. The annualized weekly death rate leaped

from 10.8 per thousand in early September to 63.0 per thousand (i.e., one of sixteen people) in late October 1918. Influenza and pneumonia deaths exceeded 8,500 between September 22 and November 16, which city officials considered to be the peak epidemic period. During that period the Department of Health received reports of 37,921 influenza cases and 13,109 pneumonia cases. Officials acknowledged, however, that sickness was far more widespread than their statistics indicated. Thousands of cases went unreported (Ruth, 1991).

The information that I have collected suggests that hospitals in Chicago were heroic in their response to their community's dire health problems during the 1918 influenza epidemic. For example, Passavant Hospital, a medium size emergency hospital located just north of Chicago's downtown business district, stated in its 1918 annual report:

> All the physical parts of the hospital were overtaxed....that there should be a deficit -- and that, a large one -- will be no surprise....all epidemic patients were admitted, irrespective of their ability to pay (page 5).

Another hospital, St. Elizabeth's, a medium size Catholic hospital in a northwest side community, also responded in a dramatic fashion. A nurse dramatically described the hospital's response in the hospital chronicles: "at present, the congestion is so great that the accident emergency room has to be used as a private room, also beds had to be installed in the private booths."

Evidence of hospitals' response to their community needs is also indicated in hospitals' provision of free days for charity care. For example, Figure 1 shows how Grant Hospital increased the percentage of inpatient free days to almost 30% in 1918 compared to 24% in 1914 and 13% in 1909. Further, Figure 2 shows how the percent of charity patients at Englewood Hospital climbed to over 15% in 1919 compared to less than 10% in 1912. In Englewood's case, this was an especially heroic response since the hospital had no endowment monies from which to cover the costs of charitable care.

The Depression years also were especially difficult for nongovernmental hospitals. With costs being a major concern of would-be patients during the Depression, there was a clear shift toward government-based hospitals and away from voluntary hospitals during the depression.

This is illustrated in data compiled by the American Medical Association (JAMA, 1934). These data show that from 1929 to 1933 there was an increased patient census of 21% in all governmental hospitals nationally, while nongovernmental hospitals had an average patient census decrease of 12% (JAMA, 1934). My dissertation data indicates that nongovernmental hospitals in Chicago may have had a patient census decline that was greater than the national average. For example, the occupancy rate of the eight nongovernmental hospitals in and around the Lincoln Park neighborhood on Chicago's North Side fell from an average of 84% in 1920 to 58% in 1931. This average rose to only 64% by 1940.

The loss of paying patients in the early thirties is reflected in a memo that was sent in 1935 to all the staff of Grant Hospital, a mid size hospital in Chicago's Lincoln Park neighborhood. The memo, whose author was not identified, described how the number of days of service in private rooms had declined by 46% from 1930 to 1934; the decline in the wards was 19%. Overall, revenues had declined by 42% at Grant Hospital from 1930 to 1934.

Despite these ongoing losses, Chicago's hospitals provided a heroic response to their community's heightened health care cost concerns. For example, the 1938 annual report of Passavant Hospital states:

> The serious Depression greatly curtailed (Passavant's) normal activities. Income from paying patients was reduced while charity work was naturally increased. The result was that the hospital had difficulty in meeting its mortgage obligations (page 3).

A more dramatic example of community charity is represented in the case of St. Elizabeth's Hospital. This hospital had the unfortunate timing to build a large addition in 1929, which was financed via an $800,000 construction loan. Despite the austerity measures that St. Elizabeth's went through during the early 1930s, the hospital managed to increase its provision of charitable care during the Depression. This is illustrated in Figure 3, which shows an increase in the number of outpatient visits and charity patients at St. Elizabeth in the 1930s.

Further evidence of Chicago hospitals' heroic response to community health care cost concerns is illustrated in Table 5. This table shows that every hospital in a sample of 14 charitable hospitals in Chicago increased its provision of free care from 1929 to 1934. Overall, the average

percent of free care increased from 18% to 30% for these hospitals during this time. Further, charity was increased whether the hospitals had a Jewish, Catholic, university, Protestant, or Black orientation (Table 5). Overall, the above evidence provides clear proof that even though Chicago's hospitals transformed into voluntaristic, physician workshops by the 1910s, they also maintained their charitable, community orientation through at least the 1930s.

**4. Hospitals' provision of charity declined, especially in the inpatient setting, from the 1940s through the 1950s.**

The Chicago Emergency Relief Administration was created in 1932 to provide social support for victims of the Depression. This support included partial reimbursements (i.e., less than 25% of costs) to hospitals which provided charitable care. This Administration went way over budget in its first year and its responsibilities were moved to a state agency, the Illinois Emergency Relief Administration (IERA) in 1933. In 1934, the Council of Social Agencies was formed by the state of Illinois. One mission of the Council was to provide charitable care reimbursements to qualified hospitals through resources from both the IERA and the Community Fund, the foundation which was part of a recently initiated national movement to centralize and rationalize regional philanthropy.

Besides the start of state and private foundations support for hospital charity by the mid 1930s, various interest groups, such as the American Hospital Association, the American Public Welfare Association, and the Joint Commission for the Accreditation of Hospitals, were suggesting that hospitals move their inpatient charity to an outpatient setting. Outpatient care was provided in clinics (formerly known as dispensaries) and cost about 15% as much as inpatient care. Thus, by moving charitable care to an outpatient setting, hospitals would be able to minimize the high costs of providing charitable care, while still maintaining a publicly acceptable charitable orientation.

Most charitable hospitals in Chicago moved their provision of charitable care from an inpatient to an outpatient clinic setting in the 1940s. For example, in 1938 only 28% of

Presbyterian Hospital's total inpatient days were paid for by full paying patients. In 1943, 80% of inpatient days were paid for by full paying patients. In the interim, Presbyterian had acquired the Central Free Dispensary and moved the majority of its charitable care to that setting. This is reflected by the 160,000 visits to Presbyterian's Central Free Dispensary in 1943, of which 79% were free visits.

Despite the general move to an outpatient setting, Table 6 shows that about 10% of the care provided by responding hospitals in a 1945 survey was inpatient charity care. Thus, it is apparent that some charitable, community hospitals continued to maintain allegiance to the health care needs of their surrounding community. For example, 10 to 15% of Englewood Hospital's inpatients were charity patients throughout the 1940s (Figure 2). Englewood was a small, non-sectarian hospital that was started by community members in 1906. In 1934, the Council of Social Agencies decided to not include Englewood in its group of hospitals that they would partially reimburse for providing charitable care. Plus, Englewood did not have an endowment to cover their charity costs; thus, it had the additional burden of having to provide 100% of its charitable care expenses.

## THE DECLINE OF HOSPITAL CHARITY IN THE 1940s

By the 1940s, Chicago's hospitals began to provide less and less charitable care (e.g., Table 6). I suggest that there are three alternative explanations that drove hospitals away from a charitable, community orientation in the 1940s. These explanations include:

1) increased competition for paying patients forced hospitals to limit their charitable care costs.

2) the hospital industry moved away from a community orientation to a high technology based orientation in the 1940s.

The first explanation points to local considerations including the competitive relations between hospitals, and the relationship between the changing ecology of communities and a hospital's survival. This explanations seems to have some explanatory strength, especially considering the changes that were taking place in Chicago during the 1940s and 1950s (cite

Wilson, etc. movement of middle class to suburbs). However, forthcoming analysis results (i.e., Gifford dissertation) indicate that these conditions also existed in certain areas of the Chicago in the decades before the 1940s. Thus, one has to distinguish how local conditions in the 1940s were such that a systemic transformation away from a charitable orientation could only happen then.

Accordingly, I do not highly endorse the local conditions explanation. I argue, alternatively, that the second explanation, regarding an institutional change in the orientation of hospitals away from community care toward high technology care, is the most plausible explanation regarding the decline in hospital's charitable orientation in the 1940s.

In the mid 1930s, Blue Cross hospital insurance was developed and begin to provide hospitals with the guaranteed payments for care that had become problematic during the Depression years. The percent of Americans covered by hospital insurance soon soared from 9% in 1940 to 48% in 1950 to 71% in 1960. Historians note that private insurance soon became the alternative solution that finally curtailed legislative interests in nationalizing the health care system in the 1940s (Anderson, 1985).

Weisbrod (1990) contends that the private insurance movement, and its retrospective payment orientation, invited a heavy investment in medical care research and development from the 1940s until the recent prospective payment system was introduced for Medicare recipients in 1983[2]

> Much of the growth in health care expenditures during the post-World War II period has resulted not from increased prices for existing technologies, but from the price for new technologies. Newly developed technologies have driven up both costs of care and the demand for insurance, while also expanding the range of services for which consumers demand insurance. At the same time, expanding insurance coverage...has provided an increased incentive to the R & D sector to develop new technologies (page 547).

The development of hospital insurance and the interrelated growth in high cost, new technologies translated into an excessive increase in the costs of hospital care. For example, Table 7 shows that

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[2] The Prospective Payment System (PPS) introduced in 1983 stipulates Diagnosis Related Groups (DRGs) which designate the costs that government will reimburse for each diagnosis for Medicare patients. Costs beyond the allowable are to be assumed by the treating physician and the hospital. Before DRGs were introduced -- as a measure to contain health care cost escalation -- doctors and hospitals submitted bills for reimbursement retrospective to a patients treatment. Thus, there was no incentive for hospitals or physicians to contain costs.

adjusted hospital costs increased 550% between 1929 and 1960, while the Consumer Price Index for all items increased only 170% and medical items such as medical care, physician office visits, and prescriptions increased between 170 and 220%.

The development of a 'no cost is too much' orientation regarding hospital-based medical care is analogous to the logic of defense spending in the United States during this same period. However, such logic does not arbitrarily transcend previous institutional logics. In other words, key actors must set the basis for bringing these institutional changes into motion. In the case of health care, the principal actors appear to be the American Medical Association (AMA) and the federal government, both of whom instrumentally initiated and symbolically legitimated an institutional change toward high technology hospital care. For example, the AMA through a series of actions endorsed the growth of specialist physicians over general practitioners in the 1930s and 1940s. This is evidenced in the growth of specialists as a percentage of all physicians from 17% in 1931 to 23% in 1940 to 36% in 1949 (Stevens, 1971).

At the same time, the Federal government supported specialty care: wartime classification schemes put a premium on specialists, the G.I. Bill provided funding for advanced medical education and post W.W. II Veterans Administration Hospitals were moved away from being free standing to being affiliated with local medical schools. This is evidenced in Chicago by showing how the hospital industry consolidated into larger hospitals that were increasingly affiliated with medical schools (Table 8).

The effect of the transition to technologically-based care in the 1940s is illustrated in the changes in Wesley Hospital's charitable care provisions. Wesley is a medium sized hospital which affiliated with Northwestern University's Medical School and eventually moved its hospital location from the near South Side to Northwestern's near North Side medical campus in 1937. As shown in Figure 4, the adjusted costs per day at Wesley greatly increased from the early 1940s through 1960. (The large increase in Wesley's costs from 1920 to 1931, as shown in Figure 4, was due to unique difficulties the hospital was having at those times and should thus be discounted). Furthermore, Figure 5 shows that there was a direct relationship between Wesley's

decreasing provision of charitable care and the hospital cost increase at Wesley from the early 1940s through 1960.

An important point in the Wesley story is that the decline in charitable care was not due to decreasing philanthropic contributions, which was the usual source for covering the costs of charity. Since the late 1910s, Wesley had a huge charitable care endowment of over 1 and three quarter million dollars. The amount of charitable care that this endowment covered decreased greatly as the costs of care rose at Wesley from the 1940s on.

Overall, I argue that the intentional structural changes in the financing of health care and changing cultural legitimacy of specialty care unintentionally provided the impetus for the transition away from a charitable community hospital system. That is, a community hospital, which relied heavily on the care of general practitioners, transformed into a high technology hospital system, dependent on specialists' care and comparatively devoid of local community interdependence, as measured by charitable care. To date, I have found no evidence that suggests that hospitals of this time wanted to turn away from their community responsibilities. Nor is it clear whether community legitimacy for hospitals declined or became overwhelmed by an increasing need to fit within a high technology-based health care system.

## DISCUSSION

Historians generally contend that nongovernmental, general U.S. hospitals went from charitable institutions at the turn of the century (Rosner, 1982) to voluntaristic institutions based on paying patients in the 1920s (Stevens, 1989) to a profit oriented system by the 1960s (Gray, 1991; Rothman, 1991). These historians argue that hospitals have documented two major transformations in the last century: from asylums to modern hospitals at the turn of the century (Vogel, 1980; Rosenberg, 1988), and from voluntaristic to for-profit hospitals starting in the 1960s (Stevens, 1989; Gray, 1991).

Alternatively, I argue that the nongovernmental, general care U.S. hospital system was class-based by the 1890s, if not earlier, and that there was a profit (non-charitable) sector and a community (charitable) sector through the 1930s. The for-profit hospitals were usually small and run by a single or small group of physicians. The community, charitable hospitals were generally run by community ethnic or religious interests. Although my evidence is limited at this time, I am suggesting that neither sector won out over the other in the 1940s as ecologists might argue, but that structural changes, such as the growth of hospital insurance, reoriented the system toward technologically-based care. This third transformation, to go along with the two transformations that historians generally argue for, essentially made the previous hospital sectors obsolete as medical care delivery became increasingly oriented toward large, tertiary care, university hospital systems.

I argue also that the transition to a technology-based hospital system in the 1940s is best explained by neoinstitutional theories of organization. In particular, institutional theory's emphasis on societal forces, as opposed to organization ecology or organization adaptation, appears to have substantial explanatory power.

Furthermore, This paper contributes to neoinstitutional theory on two levels. First, the research illustrates how legitimacy can also come from local, community sources. This is shown by describing how hospitals competed among each other to provide the most charitable care. Hospitals' publicized their provisions of charitable care to their communities to maintain a community interdependence and to encourage further philanthropic support.

Second, the research documents how institutional change was promoted, both directly and indirectly, by the actions of key actors in an organization's environment. In the case of hospitals, these direct actions include: 1) the American Medical Association's promotion of specialist education over general practitioners education starting in the 1930s, and 2) the federal government's movement to centralize health care around medical education, thereby further legitimating a high technology based hospital system in the 1940s. But more importantly, I argue that the indirect changes that came about from the implementation of hospital insurance led to a

health care system based on research and development and a 'no cost is too much' orientation. The heightened cost increases that came about overwhelmed the philanthropic support for charitable care, thus minimizing hospitals traditional charitable orientation.

Thus, in addition to DiMaggio's argument for understanding how agency and interests promote institutional change, I contend that such change may be a product of both actors intentions and unintentional social and structural changes. Unintentional action implies that institutional change has a random, historical component: a component, which has no place in present organization theory. That is, organization theorists traditionally have limited organization histories to outlying, noise factors. This research suggests that organizational behavior should be a combination of causal theory and history, otherwise our perception of organizational change will have little relation to reality.

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## TABLE 1: GENERAL CARE HOSPITALS IN CHICAGO IN 1900

| Hospital Orientation | Year of Origin | Bedsize |
|---|---|---|
| *Doctor Originated* | | |
| Chicago (Private) | 1894 | 60 |
| Columbia (P) | 1898 | ? |
| Garfield Park (P) | 1893 | 50 |
| Jefferson Park (P) | 1900 | 15 |
| Lakeside (P) | 1894 | 60 |
| Monroe Street (P) | 1896 | 30 |
| Peoples (P) | 1897 | 25 |
| Streeter (P) | 1896 | ? |
| West Side (P) | 1896 | ? |
| *Ethnic Originated* | | |
| Bohemian (Private) | 1896 | 10 |
| German (P) | 1884 | 90 |
| German-American | 1896 | 25 |
| Norwegian Lutheran Deaconness (P) | 1896 | 25 |
| Norwegian Lutheran Tabitha | 1897 | 35 |
| Provident (Black) | 1894 | 65 |
| *Religious Originated* | | |
| Alexian Brothers (Catholic) | 1868 | 250 |
| Augustana (Lutheran) | 1886 | 125 |
| Chicago Baptist | 1896 | 100 |
| Hospital of St. Anthony de Padua (Catholic) | 1896 | 75 |
| Mercy (Catholic) | 1849 | 290 |
| Michael Reese (Jewish) | 1865 | 150 |
| Passavent (Lutheran) | 1888 | 10 |
| Presbyterian | 1886 | 250 |
| St. Anne's (Catholic) | 1896 | ? |
| St. Joseph (P - Catholic) | 1872 | 150 |
| St. Luke's (Episcopalian) | 1863 | 152 |
| St. Elizabeth's (Catholic) | 1887 | 100 |
| St. Mary's of Nazareth (Catholic) | 1896 | 24 |
| Wesley (Methodist) | 1890 | 10 |
| *Medical Schools* | | |
| Bennett Medical College & Hospital | 1878 | ? |
| Chicago Policlinic | 1894 | 50 |
| Chicago PostGraduate Medical College | 1894 | 150 |
| Chicago Charity | 1894 | 20 |
| Hahnemann College & Hospital | 1855 | 140 |
| Queen Victoria Mem'l Hosp. & Coll. | 1896 | ? |
| *Other* | | |
| Chicago Homeopathic | 1886 | 50 |
| Cook County | 1857 | 2,000 |
| Frances Willard Nat'l Temperance | 1888 | 10 |
| Illinois Steel Company (P) | 1896 | ? |
| U.S. Marine | 1852 | 250 |
| **39 Total General Care Hospitals** | | |

Source: Gifford dissertation data

What does "P" mean?

TABLE 2: CHICAGO GENERAL CARE HOSPITALS, PROVISION OF CHARITY IN 1910

| Decade of Origin | Provided Charity 1910 Reply | Adjusted |
|---|---|---|
| **1870s and earlier** | | |
| Alexian Brothers | | Yes |
| Cook County | Yes | Yes |
| Hahnemann College & Hospital | Yes | Yes |
| Mercy | No | No |
| Michael Reese | No | Yes |
| St Joseph | No | No |
| St Lukes | No | Yes |
| U.S. Marine | ? | ? |
| 1870s and earlier totals 8 new hospitals | | 71% Yes |
| **1880s** | | |
| Augustana | Yes | Yes |
| Chicago Homeopathic | Yes | Yes |
| Frances Willard Nat'l Temp. | . | No |
| German | No | No |
| Passavent | Yes | Yes |
| Presbyterian | | Yes |
| St Elizabeth's | No | No |
| 1880s totals 7 new hospitals | | 57% Yes |
| **1890s** | | |
| Bohemian | . | No |
| Chicago Baptist | . | No |
| Chicago Charity | . | Yes |
| Chicago | No | No |
| Chicago Policlinic | Yes | Yes |
| Chi PostGrad Med. Coll | . | ? |
| Columbia | . | No |
| Garfield Park | . | ? |
| German American | Yes | Yes |
| Hospital of St. Anthony de Padua | No | No |
| Illinois Steel Company | . | No |
| Wesley | . | Yes |
| Lakeside | No | No |
| Norwegian Lutheran Deacon. | No | Yes |
| Norwegian Lutheran Tabitha | . | Yes |
| Peoples | No | No |
| Provident | Yes | Yes |
| Streeter | Yes | Yes |
| St. Mary's of Nazareth | . | Yes |
| St Anne's | . | No |
| 1890s totals 20 new hospitals | | 50% Yes |
| **1900s** | | |
| American | Yes | Yes |
| Chicago Union | Yes | Yes |
| North Chicago | Yes | Yes |
| Park Avenue | No | No |
| Robert Burns | . | No |
| Columbus | No | No |
| Englewood | Yes | Yes |
| Evangelical Deaconness | Yes | Yes |
| West Side | No | No |
| Henrotin | . | Yes |
| Jefferson Park | . | No |
| Lake View | . | ? |
| Grace | Yes | Yes |
| Northwest Side | No | No |
| Prospect | . | Yes |
| Ravenswood | . | Yes |
| South Chicago | . | Yes |
| St. Francis | . | No |
| Swedish Covenant | No | No |
| University | No | No |
| Washington Park | . | No |
| 1900s totals 21 new hospitals | | 50% Yes |

Sources: Gifford dissertation data and Chicago Medical Society *Blue Book* 1910.

## Table 3: Charitable Care in Illinois' Hospitals, 1917

| | Hospitals | Total Patients | Percentage of Patients Who Were Pay | Part Pay | Free |
|---|---|---|---|---|---|
| Chicago | 35 | 105,898 | 70 | 11 | 20 |
| Over 10,000 people | 35 | 57,812 | 86 | 6 | 8 |
| Under 10,000 | 36 | 13,532 | 91 | 6 | 3 |
| Total | 106 | 177,242 | 77 | 9 | 15 |

Source: Illinois Health Insurance Commission Report, State of Illinois, 1919.

## Table 4: Charitable Care in Chicago's Hospitals, 1931

| Hospitals | Beds | Total Days | Charitable Days | Average Cost/Day | Admit Blacks | Outpatient |
|---|---|---|---|---|---|---|
| Nongovernment (n = 39) | 7,641 | 1,659,585 | 343,004 (21%) | $7.56* | 15 (39%) | 24 (62%) |
| Government (n = 2) | 3,650 | 1,025,834 | 1,025,834 | $4.04 | 2 | 2 |
| Total (n = 41) | 11,291 | 2,685,419 | 1,368,838 (51%) | $7.32 | 17 (41%) | 26 (63%) |

* 32 of 39 nongovernment hospitals reported average costs

Source: American and Canadian Hospitals: A Reference Book Giving Historical, Statistical and other Information on the Hospitals and Affiliated Institutions of the United States and the Possessions and the Dominions of Canada, edited by J.C. Fifield, 1933.

## Table 5: Specific Chicago Hospitals Provision of Charitable Care in 1929 and 1934

| Hospital | 1929 % Free Care | 1934 % Free Care | 1930 Beds | 1930 Rate of Occupancy | Orientation |
|---|---|---|---|---|---|
| Billings | 25 % | 36 % | 208 beds | 57 % | University |
| Chicago Memorial | 14 | 35 | 111 | 76 | University |
| Wesley | 19 | 30 | 275 | 82 | University |
| Average (n=3) | 19 | 34 | 198 | 72 | |
| Augustana | 6 | 21 | 350 | 71 | Protestant |
| Evangelical Deaconness | 0 | 12 | 87 | 83 | Protestant |
| Presbyterian | 25 | 27 | 425 | 86 | Protestant |
| St. Lukes | 20 | 30 | 675 | 82 | Protestant |
| Average (n=4) | 13 | 23 | 384 | 81 | |
| Alexian Brothers | 21 | 23 | 285 | 77 | Catholic |
| Mercy | 14 | 19 | 400 | 75 | Catholic |
| St. Annes | 3 | 5 | 310 | 45 | Catholic |
| St. Elizabeths | 9 | 39 | 325 | 60 | Catholic |
| Average (n=4) | 12 | 28 | 330 | 64 | |
| Michael Reese | 31 | 53 | 654 | 75 | Jewish |
| Mt. Sinai | 24 | 31 | 160 | 81 | Jewish |
| Average (n=2) | 28 | 42 | 407 | 78 | |
| Provident | 39 (1931) | 64 | 58 | 67 | Black |
| All Hospitals Average (n=14) | **18 %** | **30 %** | **305 beds** | **68 %** | |

Source: Social Service Year Book, Council of Social Agencies of Chicago, 1935

Table 6: Charitable Care in Chicago-Cook County Hospitals, 1949

| Pay Status & Payment Source | Hospitals | # of Patient Discharges | # Days of Care | % Days of Care |
|---|---|---|---|---|
| Full or Part Pay: | | | | |
| -- Patient / Hosp. Plan | 42 | 180,021 | 1,922,022 | 88.1% |
| --Federal Funds | 8 | 749 | 8,150 | .4 |
| -State Funds | 16 | 1,572 | 12,997 | .6 |
| --County Funds | 4 | 147 | 1,122 | .1 |
| --City Funds | 10 | 1,130 | 16,004 | .7 |
| Non Pay: | 32 | 10,864 | 220,360 | 10.1 |
| Totals | 42 | 194,483 | 2,180,835 | 100.0 |

Source: The Cook County Health Survey, U.S. Public Health Service, 1949

## Table 7: Consumer Price Index for Medical Items, Selected Years, 1929 - 1960

| | 1929 | 1940 | 1950 | 1960 | Increase Multiplier |
|---|---|---|---|---|---|
| All Items | 73.3 | 59.9 | 102.8 | 126.5 | 1.7 |
| Medical Care | 73.5 | 70.6 | 107.0 | 162.5 | 2.2 |
| Physician - Office Visit | 75.5 | 73.9 | 103.8 | 143.2 | 1.9 |
| Prescriptions | 76.5 | 76.5 | 106.9 | 134.1 | 1.7 |
| Hospital - Men's Ward | 44.2 | 46.0 | 117.2 | 243.5 | 5.5 |

Note: CPI = 100 in 1947-1949

Source (Tables 2a & 2b): Somers, H.M. & Somers, A.R. 1981. Doctors, Patients and Health Insurance, Brookings Institute, 1961.

## Table 8: General and Maternity Hospitals in Chicago, 1900 through 1960

| Year | Hospitals | Total Beds | Average Size* | % Total Beds Cook County | % Total Beds Med School Hosps |
|---|---|---|---|---|---|
| 1900 | 46 | 4585 | 62 beds | 44 % | 5 % |
| 1910 | 70 | 7524 | 92 | 27 | 11 |
| 1920 | 83 | 11171 | 110 | 24 | 9 |
| 1930 | 95 | 16377 | 148 | 20 | 10 |
| 1940 | 87 | 16140 | 155 | 20 | 12 |
| 1950 | 80 | 17176 | 189 | 20 | 13 |
| 1960 | 71 | 17005 | 219 | 19 | 18 |

* Cook County Hospital beds are not figured into this average

Source: Gifford dissertation data

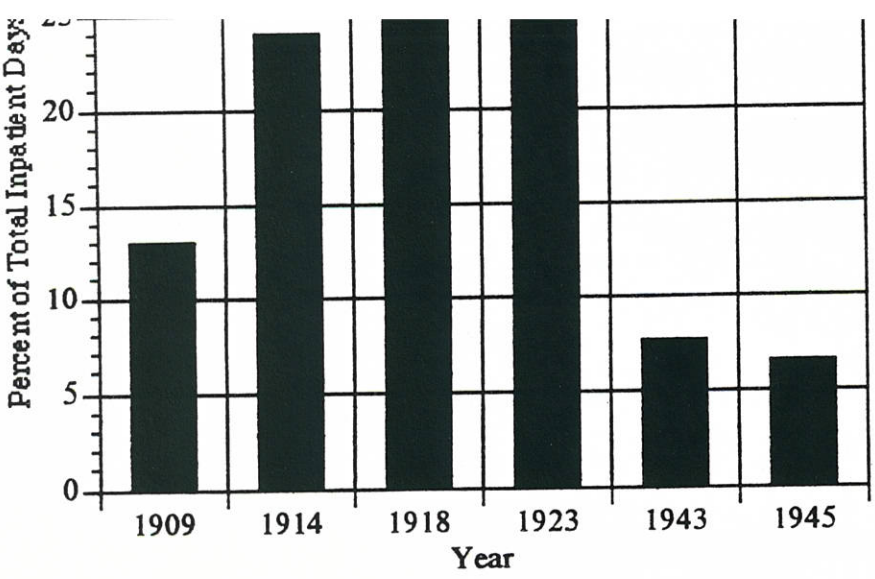



Figure 2: Englewood Hospital. Charity Patients As A Percent of Total Patients, 1912 - 1944

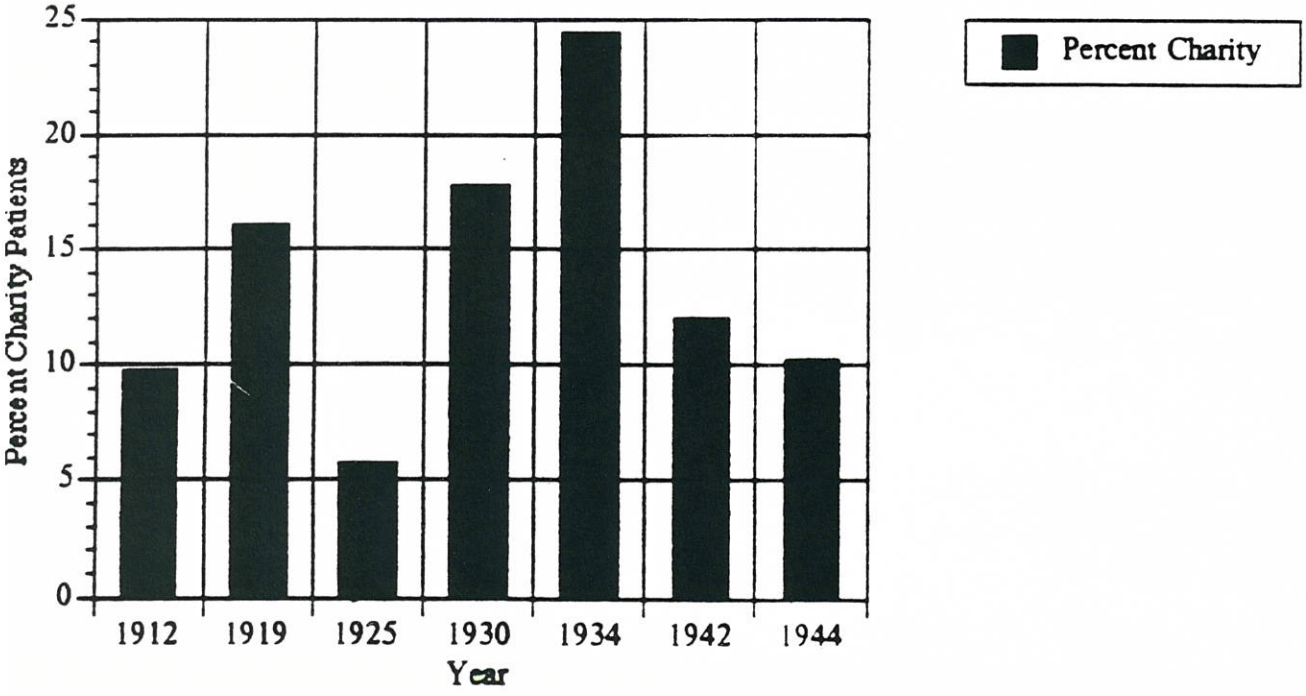
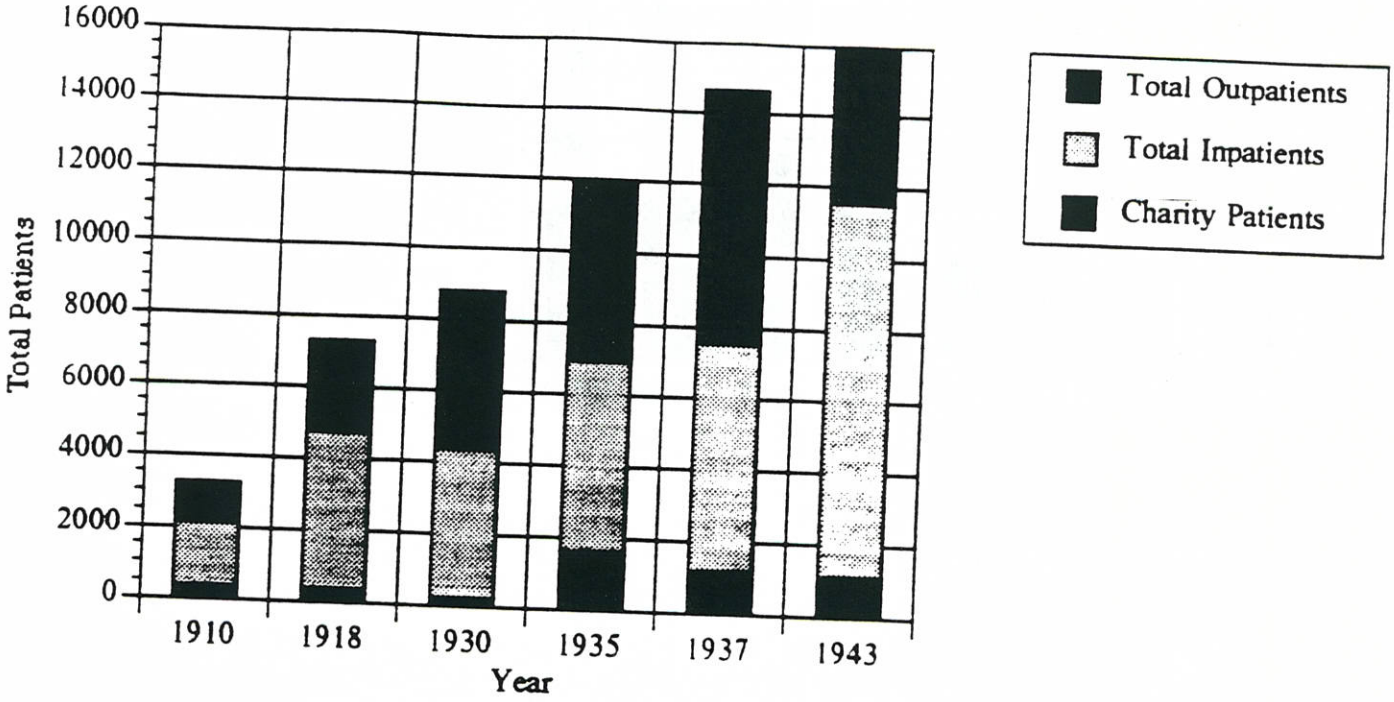
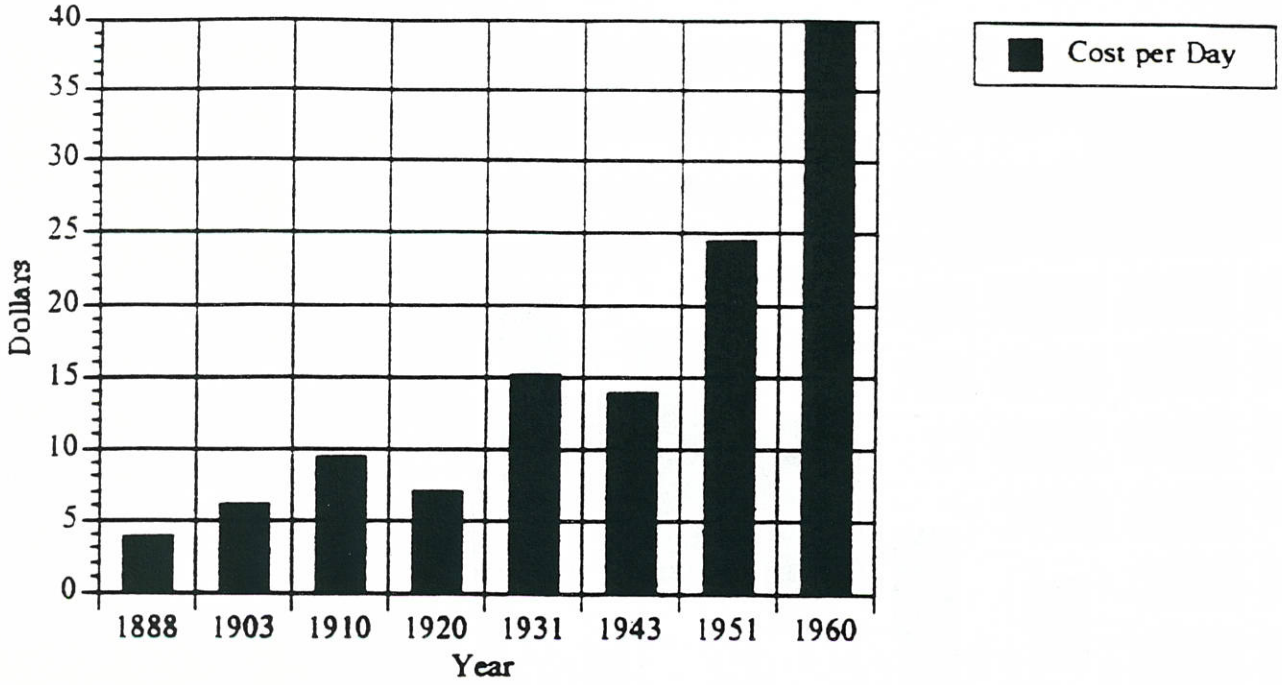


Figure 3: St. Elizabeth Hospital, Patient Type, 1910 - 1943



~~Table~~ 4: Wesley Hospital, Adjusted Patient Costs Per Day, 1888 - 1960




Note: CPI index, 1958 = 100

Figure
~~Table~~ 5: Wesley Hospital, Charity Costs as a Percent of Total Costs, 1915 - 1960