

## CHAPTER 2

# Becoming the Center of the “Healthcare System”: 1900–1945

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### CHAPTER OBJECTIVES

- To trace hospital development and to describe the increasing tendency for many hospitals to become clustered into groupings that would become identified as multihospital systems.
- To review efforts to establish health insurance programs and to highlight the development of the country’s earliest health insurance programs.
- To overview the increasing importance of the hospital and the growing perception of the hospital as the perceived center of the nation’s “healthcare system.”

### KEY TERMS

Diploma programs

“Healthcare system”

## ► Entering the 20th Century

This chapter briefly addresses the significant changes affecting hospitals in the United States from the start of the 20th century to about 1945. Also addressed are some of the societal issues that helped drive hospitals’ proliferation and acceptance and that fostered the public perception of the acute-care hospital as the center of the country’s **“healthcare system.”**

In 1900, the start of the 20th century, the average life expectancy in the United States was approximately 47 years. Surely, this is a rather grim statistic when reckoned in terms of what is known today.

The early years of the 20th century saw a significant proliferation of hospitals established and operated under several different auspices. There were privately supported voluntary hospitals overseen by lay trustees and funded by public support, charitable donations, bequests, and patient fees. There were Catholic institutions in which Catholic sisters and brothers were essentially owners, administrators, and nurses; these relied largely on fundraising and patient fees.

There were public institutions supported largely by taxes and serving charity patients and the aged or infirm. There were proprietary hospitals established and owned and operated by physicians as profit-making enterprises, some developed as specialized institutions devoted to the owners’ medical specialties, obstetrics becoming one of the earliest such specialties.

Specialized ventures aside, at the beginning of the 20th century, it was becoming apparent that the hospital established to serve the sick and injured in general was becoming increasingly more of a public responsibility. For example, it was reported that of all patients admitted to hospitals during 1910, 37% of adults were in publicly operated institutions (U.S. Bureau of the Census, 1910). In terms of financial support, the 1910 Census reported that 45.6% of hospitals received public appropriations, yet most such institutions received the majority of their income from patients who paid for their care (U.S. Bureau of the Census, 1910).

In the United States, during the early years of the 20th century, there were voluntary hospitals, religious-based hospitals, and public and governmental hospitals. By about 1910, approximately half of all hospitals were receiving some form of public or governmental support; however, the majority of their income came from charge-paying patients. It was estimated that about one-third of total hospital income came from public funds.

By about 1925, hospitals were serving increasing numbers of paying patients and were beginning to feel increasing financial pressure and the rise of competition among hospitals. One can say with some justification that this period marked the true beginning of the modern American hospital. Also, during the 1920s and 1930s, the continuing development of nursing as a profession was a prominent force in shaping hospital utilization.

Between 1909 and approximately 1932, the total number of hospital beds in the country increased at a rate nearly six times as fast as the increase in the country’s population. American hospitals at this time included:

- Institutions owned and operated by churches and religious orders
- Tax-supported municipal hospitals dedicated to serving charity patients—the aged, the orphaned, the debilitated, and such
- Voluntary not-for-profit institutions serving specific communities or collective of population
- Proprietary, for-profit institutions generally owned and operated by physicians and primarily serving patients who could pay

In addition, the early stages of the Great Depression brought a marked shift in usage from privately owned hospitals to public institutions.

## ► Interest in Health Coverage Emerges

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In the first decade of the new century, one of the first applications of employee health coverage occurred when railroads began to provide medical programs for employees. In about 1902, the first state workmen’s compensation law was enacted in Maryland; interestingly enough, it was declared unconstitutional barely 2 years later. But by 1908, the federal government had established workmen’s compensation for civilian employees, and hence the issue of unconstitutionality vanished. In a landmark move in 1904, the American Medical Association (AMA) formed the Council on Medical Education to standardize the requirements for doctors of medicine. In 1910, organized medicine became a reality when the AMA brought together half of the country’s physicians.

Also about 1910, President Theodore Roosevelt made national health insurance a major issue during his unsuccessful campaign for re-election. The health insurance idea went nowhere at the federal level, but in the decade of 1910–1920, parts of the country saw localized efforts by a number of employers to protect their employees from financial hardships by creating plans to compensate employees for worktime lost because of illness or injury. Some state legislatures offered model bills for health insurance but all were soundly defeated, opposed by insurance companies that wanted to preserve their accident and burial insurances, organized physicians who feared the possibility of limits on their fees, pharmacists who feared loss of control of their drugs, and organized labor fearing that government insurance would weaken the appeal of unions. Given the apparently unified opposition of these several disparate interests, the push for health insurance did not have much of a chance during this period.

## ► The “Modern” Hospital Takes Its Place

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Between the late 19th century and the mid-1920s, throughout the United States, hospitals were transitioning into increasingly costly modern institutions. They were serving increasing numbers of paying patients, largely middle-class individuals who could afford to pay for their care. And throughout this period, hospitals were starting to experience increasing financial pressure and some degree of competition. There had long been something of a generalized feeling that “competition” in health care was at least marginally undesirable given the noble mission of health care, but as some institutions began to take steps to lure patients away from neighboring facilities, some degree of competition among hospitals could not be denied.

By about 1925, the American hospital had become the sort of human service that most people perceived during much of the 20th century: an institution offering up-to-date medical care by way of the latest in “modern” medicine practiced by specialized personnel.

As nursing became more important to hospital operations, many hospitals became sites for nursing education. Hospital-based schools of nursing were especially prevalent during the middle quarters of the 20th century. Nurses learned under what was essentially an apprenticeship arrangement under which students gained clinical experience while providing actual patient care. Much

nursing education during this period occurred in 3-year hospital-based “**diploma programs**” that were generally known as sources of excellent clinical experience for students.

By the end of the decade of 1910–1920, healthcare spending was noticeably on the increase, and essentially, in parallel, the demand for workmen’s compensation programs and other forms of assistance was increasing. Yet, one 1919 study reported that citizens were losing four times as much in wages as they spent treating their maladies, so many individuals purchased “sickness insurance” rather than health insurance to cover the costs of medical care.

During the same decade, 1910–1920, medicine began to be seen as more of a science than previously, and hospitals became more accepted as treatment centers. Inadequate medical schools closed and overall medical standards increased. The number of trained physicians decreased while fees and overall costs increased. Employer-provided insurance expanded as large companies such as General Motors contracted with insurance companies to cover their employees.

In the decade of the 1920s, the demand for medical care continued to grow and hospitals became more generally accepted. In the first known Presidential referral to American health care as in “crisis,” President Coolidge convened a committee to address increasing concerns for access to and cost of health care. The end of the 1920s brought what was likely the first health maintenance organization (HMO) in the form of a clinic for employees of the Los Angeles Department of Water and Power. The same period saw the establishment of the first group hospital plan (by Baylor University Hospital in Dallas, Texas). Community hospitals organized with each other to offer hospital coverage and to reduce competition for patients, leading the way to the formation of Blue Cross Plans.

The end of the 1920s saw the onset of the Great Depression. During the worst of this period, there was a significant shift of patients from privately owned hospitals to public institutions. In 1932, there were about 6500 registered hospitals in the country, slightly down from the number reported in the previous census. Of 776 general hospitals operated by the government, 77% operated at or near capacity. However, just 56% of nongovernmental general hospitals were operating at or close to capacity (U.S. Bureau of the Census, 1910). Nevertheless, between 1909 and 1932, the number of available hospital beds increased six times faster than the general population. As a result, in 1933, the Council on Medical Education and Hospitals of the AMA asserted that the country was “over-hospitalized”; that is, there were too many hospitals in the United States (American Medical Association, 1933).

During the 1930s, the Depression essentially spurred interest in social programs such as unemployment insurance and senior benefits. Also, during the 1930s, methods of paying for hospital services were proliferating, specifically Blue Cross insurance plans that were becoming popular and accounting for an increasing percentage of hospital income.

In 1932, Blue Cross attained nonprofit status and became free of taxes and insurance regulations. Blue Cross then began to expand to numerous other states where existing laws allowed its presence. About this time, the coverage of some employer insurance plans was expanded to include families, although in most instances, this added coverage was provided at the employees’ expense.

Over the period of 1932 through 1934, healthcare expenditures continued to increase to the point where hospital costs made up nearly 40% of a typical family's medical expenses.

In 1935, President Franklin Roosevelt deferred to the AMA, the insurance industry, and organized business groups and removed national health insurance from his proposed Social Security legislation before presenting it to Congress. To a considerable extent, the health insurance issue passed to the individual states some of which (California, for example) established compulsory health insurance based on income level, and numerous other states which did not address the health insurance issue.

In about 1939, the California Physicians' Service established the first prepayment plan intended to cover physicians' services. Following this, the AMA encouraged the expansion of such plans to other states, marking the establishment of Blue Shield health insurance, a nonprofit entity free from taxes, insurance regulations, and restrictions on personal choice of physician.

The early 1940s saw the beginning of commercial, for-profit insurance plans as commercial insurance companies entered the healthcare market. Labor unions increasingly fought to have health plans included in their contracts with employers. Congress made employer-provided health insurance tax deductible for employers; enrollment in group hospital plans increased from about 7 million in 1940 to about 26 million by 1942.

In 1944, President Roosevelt again called for national health reform. In 1945, President Truman became the first president to publicly support national health insurance through his support of an unsuccessful bill calling for compulsory health insurance to be funded by payroll deductions.

## ► A Highly Informal "System"

At this time when one made reference to the healthcare "system," it was in fact actually reference to the widespread elements of what was essentially a cottage industry. In fact, there were instances in which some providers were organizationally inter-related, such as hospital chains operated by religious orders and those belonging to government, but most providers were individual, freestanding entities.

The acute-care hospital had essentially become the center of the healthcare "system." But in the mid-1940s, government involvement in the business of hospitals would trigger some serious and often irreversible changes in the "system."

## Brief Chapter Summary

During the first half of the 20th century, American hospitals transitioned from what was essentially a cottage industry to a loosely perceived "system" of providers representing a mix of freestanding, government-operated, and sponsored groupings (mainly religious institutions) of providers. Also, during this period, interest in health insurance emerged significantly and health insurance programs began. At this time, the acute-care hospital was generally perceived as the center of the country's healthcare system.

## Questions for Review and Discussion

1. In your own words, define “cottage industry” and state why this term was sometimes applied to health care.
2. How do you believe the acute-care hospital became seen as the “center of the healthcare system?”
3. Why was healthcare legislation not included in the Social Security Act as President Roosevelt intended?
4. What was it that likely boosted the adoption of health insurance program by some employers?
5. Why did the AMA assert in 1933 that the country was “over-hospitalized,” that there were too many hospitals in the United States?

## References

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