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Hospitals and Philanthropy

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Introduction

THE amount and proportion that philanthropy contributes to the income of institutions performing essential community services are likely to change in response to a great number of factors: in particular, alterations in the size and distribution of the national income, the nature of the services and their cost structures, alterations in the mechanisms available for financing various services, changes in the role of government, and shifts in social values. Each of these determinants has altered, to some degree and at some time, the role of philanthropy in the financing of general hospital care in the United States during the past half century.

To set the stage for the analysis which follows it may be helpful to note briefly the order of change which has taken place in the economy at large during the past fifty years. There has been a substantial rise in per capita real income in the United States and there has been a faster than average gain for those at the bottom of the income scale. The amount and proportion of income available for discretionary use beyond expenditures for food, clothing, and rent have likewise increased substantially.

It was not until after World War I that the general hospital became an institution basic to the medical care of the entire community rather than one catering primarily to the indigent poor. It was not until the 1920's that the majority of babies were delivered in hospitals. I personally recall that my sister's tonsils were extracted on the

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kitchen table in 1920 with our family physician acting as the anesthetist. And we lived in New York City!

The trend in hospital costs can be briefly summarized. The per diem cost increased from between \$4 and \$5 in 1929 to \$30 in 1960.¹ Eliminating the inflationary element, per diem costs in real terms advanced in the last thirty years by a factor of two to three.

The Great Depression saw the beginnings of the Blue Cross system, a prepayment insurance device for meeting hospital bills; and some years later Blue Shield made its appearance—a comparable insurance system for the prepayment of physicians' services rendered patients in hospitals. By 1960 the numbers enrolled in these two nonprofit plans, together with those enrolled in related commercial insurance plans, began to approximate the total potential enrollees among the working members of the population and their dependents.

After the Great Depression there was a major shift in the extent to which government was forced to assume financial responsibility in providing for the maintenance and emergency needs of the indigent and near-indigent members of the community. And since the end of World War II, government has entered upon, through the Hill-Burton Act, a large-scale grant program for the construction, and more recently for the remodelling, of hospital and related facilities.

Finally, the public's contributions for philanthropic purposes have fluctuated in amount and more particularly in the way they have been distributed. In 1929–30, income per patient day in voluntary general hospitals in New York State amounted to slightly more than \$4 of which charity contributed \$2. Three years later the contribution of philanthropy had dropped to 84 cents.² But there occurred a substantial increase in government payments for public charges. The Great Depression marked the watershed: before it, philanthropy devoted much of its funds to buying essential commodities and services for those unable to purchase them; after it, meeting the basic budget of the indigent came to be viewed as the primary responsibility of government.³

Some other important and relevant trends are: changes in personal income tax policy with consequences for the proportion of hospital

¹ Eli Ginzberg, *A Pattern for Hospital Care*, New York, 1949, p. 134; American Hospital Association: *Hospital Rates 1959*, Chicago, 1960, p. 15; and *Daily Service Charges in Hospitals, 1960*, Chicago, 1961, p. 4.

² *A Pattern for Hospital Care*, p. 135.

³ Thomas Karter, "Voluntary Agency Expenditures for Health and Welfare from Philanthropic Contributions, 1930–55" in *Social Security Bulletin*, February 1958, p. 2.

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costs carried by the patient; new patterns of community fund raising which have tapped additional sources of philanthropic support; the much deeper involvement of hospitals in educational functions; changes in hospital utilization patterns; and other developments that have altered radically the hospital's cost and income structure. The main purpose in this presentation is to identify and evaluate the major forces that have brought the hospital from the periphery of the market economy into the center. For today, expenditures in *non-federal* hospitals providing short-term care total over \$5 billion annually.

The U.S. Hospital System

The United States has a dual system of hospital care—one that has been long established and that, despite minor alterations, shows every evidence of basic stability. Government hospitals primarily provide care for patients suffering from mental or other chronic diseases; private hospitals, primarily for patients requiring short-term care.

Despite this basic duality there is an indistinct area. The federal government provides a considerable amount of short-term care in its own hospitals for special groups such as military personnel, veterans, Indians, and merchant seamen. State, county, and local governments, particularly the last two, provide considerable short-term care for both paying and indigent patients in hospitals which they own and operate. All units of government also pay for the hospitalization of various individuals for whom they are responsible when such individuals are treated in hospitals other than those which they operate. In recent years a growing number of the larger nonprofit hospitals have begun to provide short-term psychiatric care; and a few major teaching hospitals operate modest tuberculosis services, also for short-term patients. Despite these and other overlappings, the two are distinct systems and are likely to remain so.

The current pattern of hospital care can be briefly summarized by type of hospitals and type of beds. Of a total of approximately 6,800 hospitals (1958) government operated more than 2,200: the federal government 400, state governments about 550, and local government over 1,250.

Of the almost 1.6 million total beds, government hospitals accounted for by far the largest proportion: hospitals operated by the federal and local governments had slightly less than 200,000 each and state governments about 700,000. The nation's 1,000 proprietary hospi-

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tals controlled less than 50,000 beds, and the 3,500 nonprofit hospitals (church and other) were responsible for approximately 460,000 beds.

Disregarding the 65,000 beds for tuberculosis patients and 75,000 beds used for patients with other specialized conditions, the bulk of all hospital beds are divided more or less evenly between those provided for patients requiring general hospital care and those for patients suffering from nervous and mental diseases.⁴

With approximately equal numbers of beds, mental hospitals admit during the course of a year under 300,000 patients, while general hospitals admit over 21 million! The maintenance cost of caring for a mental patient averages about \$4 to \$5 per day. The per diem cost for a patient in a general hospital today approximates \$30. Clearly the two systems differ not only as to ownership and type of patient treated but also with respect to the range of services provided and the costs involved.

In 1956-57 the United States spent approximately \$6.4 billion on all types of hospital care (depreciation and the administrative costs of hospital insurance excluded). Government covered 40 per cent; private sources, including philanthropy, 60 per cent. About 79 per cent of all expenditures were in general short-term hospitals, the remainder primarily in psychiatric (17 per cent) and in tuberculosis hospitals (4 per cent).

Of the approximately \$2.5 billion spent by government, the federal government accounted for slightly more than \$1 billion, three-quarters of which was spent for general hospital care. Of the almost \$1.5 billion spent by state and local governments, half was for the care of patients with mental disease, two-fifths for general hospital care, and the remaining one-tenth for care of patients suffering from tuberculosis.

The almost \$4 billion income from private sources was distributed as follows: about \$3 billion in short-term private hospitals and a half billion in public hospitals for general hospital care. The remainder, slightly under \$300 million, was spent for care of mental, tubercular, and other long-term chronic patients.⁵

Several generalizations can now be made about the role of philanthropy in the financing of hospital care in the United States. Philanthropy plays almost no role in the support of public hospitals, which account for only a little less than half of all expenditures for hospital

⁴ *Statistical Abstract of the United States*, 1960, p. 76.

⁵ "Public and Private Expenditures for Hospital Care in the United States, 1956-57," *Research and Statistics Note No. 19*, July 10, 1959, Social Security Administration, U.S. Department of Health, Education, and Welfare.

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care. Since public hospitals provide most of the care for mental patients, philanthropy makes little contribution to the care of this significant group of patients. Clearly there is no role for philanthropy in proprietary hospitals. The philanthropic effort in the field of hospital care is therefore predominantly concentrated in nonprofit, short-term hospitals. For this reason, this analysis will seek to trace, primarily, the changing relations between philanthropy and short-term nonfederal hospitals.

Philanthropy's Role in Financing Short-Term Nonfederal Hospitals

Reference was made earlier to the fact that philanthropy accounted for almost half of the patient income received by general hospitals in New York State in 1929. This single fact underscores the very considerable role that philanthropy played in hospital financing, at least in one section of the country, as recently as the onset of the Great Depression.

The first reliable national estimate is of a later date, 1935, a year for which the U.S. Public Health Service, making use of Census data, developed the basic data. Dr. Herbert Klarman, Associate Director of the Hospital Council of Greater New York, is responsible for the preparation of comparable data for later years (1950 and 1958) and for incisive analyses of philanthropy's share in the financing of nonprofit general hospitals.

In 1935 the total income of short-term nonfederal hospitals was about \$448 million. Philanthropy contributed \$60 million for roughly 13 per cent of the total. Government's share was over \$106 million or about 24 per cent of the total. Private payments of \$282 million accounted for more than three-fifths of the total.

A review of the 1950 data reveals that the total income of these hospitals had increased almost fivefold—to over \$2.2 billion. The absolute amount contributed by philanthropy had increased substantially, from \$60 to \$155 million, but because of the much greater increase in total income, philanthropy's share had declined by almost half—from 13.4 per cent to 7.0 per cent.

During the fifteen years from 1935 to 1950 there was a decline of 3.0 percentage points in the proportion covered by tax funds which, together with the decline of 6.4 percentage points in philanthropy's proportion, resulted in a 9.4 per cent increase in the proportion covered by private sources. By 1950, private sources had come to account

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for almost three-quarters of the total income of short-term nonfederal hospitals.

The figures for 1958 revealed the continuation of this trend. Total income of nonfederal short-term hospitals had increased to almost \$4.8 billion—more than double that of 1950. Philanthropy's total climbed again, reaching \$226 million, an increase of \$111 million in eight years. But the relative share of philanthropy declined in these years; it now represented only 4.7 per cent of total income, a decline of 2.3 percentage points in eight years. In the 1950's, the relative role of tax funds in the financing of these short-term hospitals dropped strikingly. In 1958 the \$666 million contributed by government accounted for 13.7 per cent of the total—a decline of 6.0 percentage points from 1950.⁶

These selective data indicate that the period since 1935 has witnessed a major revolution in the financing of general hospital care. At the beginning of the period patients paid for only slightly more than three-fifths of the total hospital bill. The remainder was covered by government and philanthropy, the latter accounting for approximately one-seventh of the total. Twenty-three years later the individual patient, either through direct payments or through insurance, was covering almost 82 per cent of the total bill. By 1958, philanthropy paid for only about one-twentieth instead of one-seventh of the cost of general hospital care.

During this period the total income of general hospitals had increased more than tenfold. While philanthropic contributions had climbed from \$60 to \$226 million annually, the rate of increase lagged far behind that in total income.

Further perspective on the significance of philanthropy in financing general hospital care can be obtained by estimating the number of patients whose hospital bill could have been covered by charitable contributions. In 1957 there were just over 21 million patients admitted to general hospitals. Since philanthropy accounted for 4.2 per cent of all general hospital income, the entire cost of the hospitalization of about 900,000 patients might have been covered by charity.

But in point of fact the use of the philanthropic dollar was at once broader and narrower. A considerable part of all charitable contributions was spent as always on important hospital functions that are only indirectly connected with services to inpatients. These in-

⁶ *Geographic Comparison in Financing Hospital Care*, Hospital Council of Greater New York, vol. 15, No. 3, New York, 1960.

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clude the support of education and research; and underpinning the finances of ancillary departments, such as social service, rehabilitation, and home care. Then, too, a considerable number of general hospitals, especially in large metropolitan centers, operate sizeable outpatient departments which frequently run substantial deficits. This suggests that the cost of hospitalizing considerably fewer than 900,000 inpatients was covered by philanthropy.

But there are factors which indicate that much larger numbers profit to some degree from philanthropy's contribution. In terms of the quality of care received, the number can be said to be identical with the sum of all in- and outpatients, for the level of hospital services is always somewhat higher by virtue of the additional dollars made available by philanthropy.

There is a further factor: few hospitals use their philanthropic funds to cover hospitalization costs of individuals who are without financial resources. Those at the bottom of the income scale are most likely to be public charges and, as such, are likely to have their hospital expenses paid for by government. But these government payments seldom cover the hospital's total cost. Many other patients are also able to pay only part of their total bill. Thus, the amount of philanthropic funds enables a hospital to determine how much "free care" it is able to provide; free care here is defined as the hospital's contribution where payment is less than cost.

In 1958 the per diem income from ward patients in nine selected general hospitals in New York City—a community in which philanthropy still looms relatively large in the provision of hospital care—was about \$18. The per diem cost was about \$28—assuming, as is reasonable, that the per diem cost for ward patients was not lower than for most other patients. There was thus a loss of about \$10 per ward patient. Without entering upon refined calculations involving such matters as a greater-than-average length of stay for ward patients and differences between marginal and average costs, we can say that the typical ward patient was subsidized to an amount of approximately \$100. On this basis we can say also that the total philanthropic contribution helped over 2 million patients meet their costs of hospitalization. While this is a significant figure, even more important is the fact that 19 million patients treated in general hospitals thus received no direct financial help from the sums contributed by philanthropy.⁷

⁷ Eli Ginzberg and Peter Rogatz, *Planning for Better Hospital Care*, New York, 1961, p. 64.

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Types of Philanthropic Contributions

The data relating to philanthropy presented above have included only contributions in money to the operating budget of general hospitals and the earnings on unrestricted endowments. While these two categories probably account for most of the philanthropic support which hospitals receive, it would be well to consider the entire range of charitable contributions available to nonprofit hospitals.

Hospitals have long practiced price discrimination in that they have charged different rates for different types of accommodations. Without clear-cut economic justification, they charge noticeably less for ward than for semiprivate accommodations and noticeably more for private than for semiprivate. While the growth of Blue Cross and other forms of hospital insurance has put pressure on hospitals to rationalize their costs and charges—at least to relate their charges for semiprivate accommodations to average costs—many institutions with sizeable sources of philanthropic income have tended to keep their ward rates considerably below average costs and private rates considerably in excess, although presumably a detailed cost analysis would not justify such differentials. If anything, ward costs in a teaching hospital are probably higher than in either semiprivate or private accommodations because of the substantial volume of diagnostic procedures ordered freely by interns and residents and the associated high use of drugs and nursing and other services.

It is not difficult, however, to understand why this practice of price discrimination has been continued. Many voluntary hospitals have long taken pride in providing care for the poor and indigent at no charge or at a charge considerably below cost. Likewise hospitals have had little hesitancy in extracting what is tantamount to a charitable contribution from those sufficiently wealthy to prefer private accommodations.

The nine general hospitals in New York City which were earlier described as losing an average of about \$10 a patient day on the wards averaged a per diem income from private accommodations of about \$17 above their average costs. But the income derived from private patients accounted for only about 15 per cent of all income from inpatients, which indicates that even under a highly discriminatory pricing policy the yield from this forced contribution is modest.⁸

For the country as a whole, private accommodations account for

⁸ *Ibid.*

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only between one-fifth and one-fourth of all beds in nonprofit short-term hospitals. Moreover, a comparison between the average rates for these accommodations and average costs suggests that the pattern prevailing in the New York City voluntary hospitals is atypical; most hospitals did not make a substantial profit from patients in private accommodations.

A review of the percentage changes in daily charges between 1948 and 1960 by type of accommodations—single, two bed and multiple—fails to reveal any significant differences in the rates of increases among these three classes. Apparently nonprofit hospitals did not attempt to charge all that the traffic would bear for private accommodations. They were probably inhibited first by a fear that their charge structure would be out of line with other hospitals. But more importantly, because they were forced to advance their average charges steadily, and by large increments, which in itself resulted in considerable community criticism, there was strong pressure against a further increase in private charges, even though the profit on such charges might have covered the losses on ward patients. Finally, many less affluent patients were frequently forced, because of their medical condition or because of a shortage of semiprivate accommodations, to accept private accommodations. This made it undesirable to extract a forced contribution from this group.

While data are not available to develop a sound estimate of the size of the "forced contribution" that nonprofit hospitals extract from private patients, a first approximation can be ventured. In 1958 voluntary short-term hospitals received in patient payments approximately \$3.1 billion. If between one-fifth and one-fourth of their total accommodations consisted of single bed units, and a profit of around 10 per cent on these accommodations is presumed, their total gain from this source would have been approximately \$65 million. Dr. Klarman's estimates for New York City for 1957-58 show a net gain from private accommodations amounting to about 1.2 per cent of the total income of all nonfederal general care hospitals, a figure which would yield a total sum of over \$57 million for the entire country.⁹ The significance of this sum can best be appreciated when it is placed against "total" philanthropic contributions for operating purposes of about \$200 million for the same year.

The biggest factor in hospital operating expenses has long been wages and salaries; today this segment accounts for about two-thirds

⁹ Herbert Klarman, *Hospital Care in New York City: The Roles of Voluntary and Municipal Hospitals*, New York, 1962.

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of all costs. The overriding importance of personnel expenditures makes it desirable, therefore, to consider developments in this sector that may have a bearing on the role of philanthropy in hospital financing.

There are several points worth noting. First, many hospitals have long been engaged not only in treating the sick and injured but also in training physicians, nurses, and other medical personnel. For several decades hospitals with nurses' training schools made a profit from this facet of their operations. For room, board, and a modest amount of didactic instruction (much of which was provided free of charge by the members of the visiting medical staff), the hospital received the labor of student nurses for three years. After World War II, for many reasons, nursing education was reformed—at least at the better institutions. The primary objective of the revised three- and four-year programs was the education of the student nurse, not the extraction of free labor. As a consequence of this reform many hospitals found that instead of making a gain, or at least breaking even on the operation of a school of nursing, they actually lost money, possibly \$1,000 or more per annum per trainee.

Something else happened on the nursing front. During the depressed 1930's many hospitals, by offering nurses room, board, and a very modest monthly salary, were able to expand their staffs substantially. Not only were nurses willing to work for very little but they put in very long days; it was common practice for them to work split shifts. As happened to many institutional employees, wage and salary adjustments lagged during the war and postwar inflation. For many years, hospitals profited from delays in salary and wage adjustments. The last few years, however, have seen belated corrections and improvements. It could be said that before these occurred, hospitals were able to force a significant "charitable" contribution from their nursing staffs.

To a marked degree this has also been true of other hospital personnel. Outside of the protection of labor legislation, and usually without the help that comes from union organization, many service personnel have worked for wages far below the minimum prevailing in the profit sector of the economy. In fact, the hospitals have long attracted many persons with little skill. Having attracted and hired them, the hospitals failed to help them acquire the range of skills which would justify their being paid at a higher rate. It was little short of scandalous to find employees of major voluntary hospitals

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in New York City in 1959 earning \$32 or \$35 weekly. Here too, many hospitals have succeeded in extracting a "philanthropic" contribution.

The physician is the backbone of the system of hospital care. In addition to training nurses, most of the larger and many of the smaller hospitals have also become involved in the postgraduate training of physicians. For many decades the hospital's responsibility in this regard was limited to the formal training of interns, but in more recent years many institutions have also become engaged in the training of residents. More than half of all young physicians now complete a period of residency which requires a minimum of three and more frequently four or even five years of hospital training beyond internship.

Historically internship was apprentice training. The young physician lived in the hospital and in return for room, board, laundry, and, if lucky, \$25 a month, the hospital had complete command over his time and energies seven days and six nights a week. This was a three-cornered arrangement. The intern learned from the attending staff (and from the nurses). The hospital received his services for very little; the senior staff were able to increase the number of ward and private patients whom they treated.

Since World War II the old pattern of postgraduate education of physicians has been greatly altered, and this has had serious financial consequences for the hospital. Major teaching hospitals have been forced to add a considerable number of full-time senior staff to provide the supervision and instruction required for the training of large numbers of interns and residents. Moreover, young physicians no longer live in the hospital; they are married and are fathers. Because they now work a regular day shift, many hospitals have been forced to hire and pay other physicians to insure coverage at night. Finally, many costly diagnostic and therapeutic procedures are carried out more for the educational advantage of the young physician than for the benefit of the patient with resulting upward pressure on hospital costs.

In brief, the teaching hospital has been forced to accommodate itself to a loss of much free or underpaid labor over the past two decades; and, to make its financial position worse, it has had to incur many additional expenses as a result of its expanded and improved educational efforts. It has compensated for this, in considerable measure, by putting its educational costs into its rate base; thus patients (including those with insurance) assume the cost. Here, then, is another type of forced contribution.

While it is generally true that the patients treated in large teaching

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hospitals are likely to receive better than average care, the fact remains that because of inadequacies in the public and private financing of the education of nurses and physicians, the private patient, with or without Blue Cross or other systems of hospital insurance, is forced to contribute, through the payment of higher charges, what may approximate an "overcharge" of \$150 million. Assuming that one-third of all general hospitalization is provided in institutions with broad teaching programs and assuming that such programs add only 10 per cent to the average bill, a figure in excess of \$150 million per annum would result.

Passing note should be taken of still other types of philanthropic contributions. There are the donated services of sisters, primarily in Catholic hospitals. The United Hospital Fund in New York City estimated that in 1958 the value of these donated services amounted to almost \$1.6 million. While there is no ready basis for calculating the total value of the services donated by Catholic sisters throughout the United States, it is surely a sum many times greater than for New York City alone.

Nonprofit hospitals still rely heavily on the work of volunteers. Not only do volunteers raise considerable sums for operating and capital programs, they also have various managerial and service functions. Moreover, women's auxiliaries frequently devote much time to the supplemental care of patients and to special activities, such as the operation of the gift shop which frequently adds to the hospital's total income.

In addition, in recent years the patient's family has come to serve as an auxiliary labor force in many hospitals, helping to fill the gap resulting from a shortage of nurses and ancillary service personnel. I have pointed out in other connections that, since there is little prospect that this country will ever train or pay for all the nurses needed, we must look forward to relying more on this family-labor reserve. While there is no ready way of calculating the monetary value of the work of volunteers and members of patients' families, there is every reason to believe that it is a substantial sum.¹⁰

Reference must also be made to additional "contributions" even if they cannot be readily subsumed under philanthropy. Nonprofit hospitals continue to receive a considerable amount of donations in kind from pharmaceutical and other medical supply companies; and

¹⁰ *Employment, Growth, and Price Levels*, Hearings before Joint Economic Committee, 86th Congress, 1st session, Part 8, pp. 2661 ff.

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they also benefit from special discounts on many items that they purchase.¹¹

More important, nonprofit hospitals are exempt from taxation. The question has been raised as to the justification of this if hospitals further reduce or eliminate free care to indigent patients—the original basis for their preferred tax status.

Finally, most hospitals have until recently excluded depreciation in their cost accounting. This frequently results in charges to many patients below the total of their true costs. While many who profit from this situation later contribute to the hospital's capital campaign for renovation or expansion, others do not. These last benefit from philanthropy, whether or not they are in need.

The burden of this analysis is clear. The \$200 million estimated as the current philanthropic contribution to voluntary hospitals represents only one segment of a much larger flow of "contributions" in money, kind, and service all of which warrant consideration if the economics of hospital financing is to be properly appraised. Among the most important of these supplementary items are the overcharges to private patients, the unrequited services of physicians, nurses, and volunteers, and the special advantages that flow from tax exemption. Together these items have a net value considerably in excess of the dollar volume of philanthropic contributions.

Regional Variations in Philanthropic Contributions

While it is illuminating to deal with national totals, a fuller understanding of the role of philanthropy in hospital financing requires a consideration of regional and local variations. The philanthropic funds available to one hospital cannot be used to cover the operating deficit of another. And, as we shall see, great variations exist among hospitals in different regions and localities as to the philanthropic sums at their disposal.

Tradition plays an important part in the philanthropic effort devoted to hospitals. Several of the teaching hospitals along the eastern seaboard—in Boston, New York, Philadelphia, Baltimore—have roots that go back to the eighteenth century. Their ability to teach was intimately connected with their philanthropic resources; that is, their free funds enabled them to care for the poor and the indigent, and the ward patient provided, and still largely provides, these institutions

¹¹ *Corporate Contributions to Hospitals*, National Better Business Bureau, Inc., New York, 1955.

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with their basic teaching material.¹² Various religious and ethnic groups have long raised considerable sums for the support of hospitals under their control, originally to take care of their poor confreres, more recently to provide superior hospital services and educational opportunities and to discharge broader communal responsibilities. Finally, there are communities, largely in the east but also in the middle west and the west, where substantial sums are raised locally for the support of voluntary hospitals under nonsectarian auspices.

The New York State Hospital Study, which I directed in 1948, revealed a marked variation in the proportion of funds for general hospital care provided by philanthropy in New York City and in the principal cities of upstate New York. In New York City, philanthropy accounted for just under 9 per cent of total income; in the four major upstate cities the corresponding figure ranged from a low of 2.4 to a high of 3.7. We also discovered at that time that a relatively small number of hospitals in New York City received the bulk of all philanthropic funds.¹³

Recent analyses by Dr. Klarman indicate that the earlier findings have not been significantly altered by the passage of time. Nine out of the sixty-two general-care member hospitals of the United Hospital Fund in New York City received half of all cash contributions. This amounted to about \$14.5 million in 1958, including those contributions made available to hospitals through central collecting agencies. Furthermore, three-quarters of the more than \$7 million income available for general purposes from investments was concentrated in that year among eight of the sixty-two hospitals.¹⁴

So much for the striking variations within one large community in which philanthropy plays a disproportionately large role. What about regional differences? Klarman recently completed (1959) a special questionnaire study which yielded some illuminating new information. He had useful replies from fifteen large cities out of an original sample of seventeen. In contrast to New York City where philanthropy accounted for 7.1 per cent of the estimated income of short-term hospitals, the percentage for the fifteen large cities was only 3.4, less than half of the New York figure. A more detailed analysis revealed that there was a significant regional variation: in the eight east coast cities

¹² Nathaniel W. Faxon (ed.), *The Hospital in Contemporary Life*, Cambridge, Mass., 1949.

¹³ *A Pattern for Hospital Care*, Chapters 6, 7.

¹⁴ Klarman, *Hospital Care in New York City*.

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philanthropy contributed an average of 4.3 per cent; in the seven midwest and far west cities, it averaged 2.8 per cent.

Equally striking were the variations that were found to exist within each region. In one city on the east coast the philanthropic contribution was as low as 1.7 per cent, with two others just one-tenth of a per cent higher; at the upper extreme, one city had a ratio of 7.2 per cent, followed by two others at 4.5 and 3.6 per cent. In the midwest and far west, the city with the highest ratio of philanthropic funds to total income reached the 4.9 mark, followed by those with 3.7 and 3.4 per cent. The lowest contribution ratio of all cities surveyed was in this region; there, philanthropy represented only 1.3 per cent of total income.¹⁵

Klarman went on to investigate whether, as appeared likely, the proportion of philanthropic funds was inversely correlated with the proportion of tax funds to total income. But this was not the case, and he concluded that the key to an understanding of regional and local differences had to be sought in history and tradition.¹⁶

Klarman's detailed analysis of philanthropy's role in the financing of hospital care in New York City disclosed a most interesting fact about the components of the philanthropic contribution that had previously escaped notice. Between 1934 and 1948 centrally raised contributions (United Hospital Fund and Greater New York Fund) increased rapidly—from about \$1.5 to \$6.4 million annually; other contributions (mostly cash) increased from about \$3.0 to \$4.8 million. During these fourteen years there was no change in income from total investments which remained at \$3.6 million. However, in the period 1948 to 1957 there was only a modest increase in centrally raised funds (from \$6.4 to \$8.0 million), a relatively larger increase in other contributions (\$4.8 to \$6.6 million), but a startling advance in income from investments (from \$3.6 to \$11.2 million).¹⁷

With few exceptions hospitals outside of New York City and other large eastern centers must rely on current contributions since they do not have endowments. The last two decades have seen, however, a marked trend toward reliance on centrally raised funds for the support of all major philanthropic institutions within the community. In many localities, hospitals participate in these joint campaigns; in others, they do not.

In 1960 the total sums raised in these community campaigns

¹⁵ Cf. footnote 6.

¹⁶ Klarman, *Hospital Care in New York City*.

¹⁷ *Ibid.*

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amounted to \$458 million—a gain of more than 400 per cent since the outbreak of World War II. Apart from the \$57 million allocated to the Red Cross the three largest recipients of the 1960 distribution were recreation, which received \$133 million; the support of dependents and social adjustment, which received \$115 million; and health, for which \$71 million were allocated. But health covered much more than hospitals and clinics; it included the sums distributed to the five major health appeals, outpatient psychiatric clinics, nursing services, and education and research for health agencies. A total of \$194 million was raised in 118 cities (each of which raised \$500,000 or over). Hospitals, clinics (except psychiatric clinics), and rehabilitation programs received 12.8 per cent of this sum while all health services accounted for 24.8 per cent of the total. Central fund-raising agencies in these larger communities allocated to hospitals a sum of not more than \$25 million, and probably somewhat less. This must be put against the total philanthropic income of general hospitals of \$200 million, as mentioned earlier.

A few trend data are worth noting. Between 1950 and 1960 total moneys raised by these central fund-raising efforts increased from \$193 to \$458 million or by about 137 per cent. During this same period total allocations for health increased from \$26 to \$71 million, or by about 170 per cent. The share received by hospitals and clinics increased by 110 per cent. This indicates that local leadership did not believe that hospitals had special claim to a larger share of the philanthropic dollar; in fact, over the decade they received a somewhat smaller share.¹⁸

Philanthropy and Capital Funds

The analysis so far has focused on the role of philanthropy in relation to the total operating income of voluntary hospitals. There are several reasons for considering also, at least briefly, the part played by philanthropy in meeting the capital needs of voluntary hospitals. The sums provided by philanthropy for this purpose have been and continue to be substantial.

Between 1950 and 1958 the assets of all of our short-term voluntary hospitals increased from approximately \$3.3 billion to \$7.2 billion. Total operating expenses of these hospitals, exclusive of the costs of

¹⁸ 1960 *Allocations*, United Community Funds and Councils of America, Bulletin No. 211.

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new construction, amounted to \$1.5 billion in 1950 and \$3.5 billion in 1958.¹⁹ The juxtaposition of these capital and operating figures underscores the importance of including capital requirements and resources in any review of the hospital situation. Their intimate relation is also manifested by the fact that three years of operating costs of a bed equals or exceeds the cost of new construction; this emphasizes the potential financial dangers inherent in excess capacity. Depreciation, which amounts to at least 6 per cent of operating expenditures, may or may not be included in current costs, depending on how the hospital prefers to secure funds for renovation and expansion. The period since World War II has been characterized by a shortage of general hospital beds in most regions. This is a result of such factors as limited construction during the 1930's and World War II, the steady rise and dispersion of the population, and the increasing use of hospital facilities. This shortage led to the passage of the Hill-Burton Act in 1946 which made federal funds available (if matched by other levels of government and private funds) for the construction of public and nonprofit hospitals and health centers and related facilities.

A survey report as of December 31, 1960, disclosed that 5,390 projects costing \$4.67 billion were aided through this Act, of which \$1.45 billion was the federal share. General hospital projects received about four-fifths of all federal funds expended and accounted for about an equal percentage of all new beds. Fifty-five per cent of all the inpatient beds were added in nonprofit institutions which received just about the same percentage of the total moneys made available by the federal government. During the past few years there have been several interesting shifts in the program in favor of grants to institutions desiring to make additions and alterations. Further, more of the projects approved for support have been in nonprofit institutions and more of the federal funds have been allocated to them, so that their share has now reached about three-fifths of the total.²⁰

Klarman is responsible for the only careful estimate of the distribution of expenditures for construction by source of funds. His data cover the decade 1948-57, during which he estimates that approximately \$8.5 billion was spent on hospital construction. Of this sum, private sources, primarily income from philanthropy but also including mortgages, loans, etc., accounted for 42 per cent of the total, or slightly over \$3.5 billion. The federal government contributed ap-

¹⁹ *Statistical Abstract of the United States*, 1960, p. 78.

²⁰ *Hill-Burton Program, Progress Report*, December 31, 1960, U.S. Department of Health, Education, and Welfare.

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proximately 20 per cent and the remaining 38 per cent was made available by state and local government.²¹

In a brochure issued in 1961 by the American Association of Fund-Raising Counsel, it is estimated that in the last twenty-five years philanthropic support for new construction of nonprofit hospitals totaled about \$2.6 billion, in contrast to \$1.8 billion of charitable contributions for current operations. In addition, nonprofit hospitals received about \$500 million in the form of bequests; thus, these hospitals received a grand total of almost \$4.9 billion during these years.²²

These data substantiate Klarman's findings that the larger share of philanthropy's effort with respect to voluntary hospitals has been devoted to the financing of construction and renovation, not to meeting operating costs; in the 1950's, an average annual contribution of under \$200 million for current operations was made in contrast to approximately \$350 million for capital purposes.

It is worth noting that according to Klarman's data, philanthropy in New York City contributed a greater proportion than in any other large city toward the operating expenses of voluntary hospitals, but provided a smaller share than average for capital purposes. The proportion during the 1950's was 35 per cent; in the rest of the country it was 42 per cent.

Some sense of the magnitude of the postwar construction cycle can be gained by considering developments in New York City. The Hospital Council of Greater New York estimated that about one-third of all voluntary hospital beds today resulted from postwar construction. About half of the large municipal hospital plant is new, and about 30 per cent of the beds in proprietary hospitals came from building which was started after 1945. In the ten hospitals which are supported by the Federation of Jewish Philanthropies, \$70 million of new construction was undertaken after the war, and approximately two-thirds of all the beds in the Federation system are new.²³

While the bulk of capital funds made available to voluntary hospitals is used for new construction, expansion, or renovation of beds for inpatients, attention should be called to one other major purpose for which capital funds have recently been allocated—medical research. The past decade has witnessed a very rapid expansion of medical research. In 1950 total expenditures for this purpose approximated \$150 million, while in 1960 they came to \$715 million. The federal

²¹ Klarman, *Hospital Care in New York City*.

²² *Giving USA*, 1961 edition, pp. 20 ff.

²³ Ginzberg and Rogatz, *Planning for Better Hospital Care*, Chapter VII.

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government has taken the initiative in setting the pace, largely through the instrumentality of the National Institutes of Health, and in 1960 it contributed \$425 of the \$715 million national total.²⁴

Industry and philanthropy, as well as state and local governments, have also increased their contributions to research during recent years. The 1961 edition of *Giving USA* estimates that philanthropy contributes about \$90 million a year to medical research. The complex financial relations which exist between universities, medical schools, and the major teaching hospitals preclude any refined estimates of the full impact of these trends on the financing of medical research in voluntary hospitals. But a few points should be noted. A voluntary hospital that wants to remain in the vanguard must create and maintain a good research and teaching environment. While it can look to government, as well as to industry and the foundations, for most of the operating funds required and even for some construction moneys, it must also seek financing for some of the overhead required to enter into and sustain sound programs in postgraduate training and research. Here is a new and what may be an increasing demand for philanthropic support.

Trends in Medical and Hospital Financing

In 1929 aggregate expenditures for health and medical care totaled approximately \$3.6 billion. By 1959 the total had risen to \$25 billion. In the intervening years, however, population had increased rapidly and the price structure was inflated so that the increase in real per capita terms was less than threefold. In 1959 the per capita expenditures amounted to \$142, compared with about \$50 in 1929.

In 1935, the total outlay in current prices for health and medical care amounted to \$3.26 billion. Private expenditures (including about 2.5 per cent from philanthropy) accounted for 79 per cent of total health and medical expenditures; of the remaining 21 per cent, approximately 17 per cent were state and local and 4 per cent federal. In 1959 when total outlays had risen to above \$25 billion, private expenditures had declined to about 75 per cent; there was no significant change in the philanthropic contribution which remained at around 2.5 per cent. On the governmental side, state and local expenditures declined to about 15 per cent and federal expenditures in-

²⁴ *Coordination of Federal Agencies' Programs in Biomedical Research and in Other Scientific Areas*, 87th Congress, 1st session, Senate Report No. 142, March 30, 1961.

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creased to just under 10 per cent, reflecting in the first instance increased hospital expenditures for the military and veterans and a tremendous acceleration of effort in behalf of medical research.²⁵

These trend data can be summarized thus: in the quarter century between 1935 and 1959 total expenditures for health and medical care advanced very rapidly, almost threefold on a per capita basis after eliminating the inflationary factor. Consumer expenditures accounted for most of this increase, although there had been a modest increase in the governmental share of from 21 to 25 per cent of the total. The relative proportion of philanthropy had not changed significantly from the beginning to the end of this period.

During this period, the outlay for short-term nonfederal hospitalization increased substantially both absolutely and relatively; it accounted for about one-fifth of the total in 1959 compared to one-seventh twenty-five years earlier. At the same time, the philanthropic contribution to the operating income of short-term nonfederal hospitals declined from almost one-seventh to one-twenty-fifth.

A major revolution occurred in the financing of general hospital care, mostly in the period after World War II. At the center of the revolution was the expansion of hospital and medical insurance. In 1948 private expenditures for hospital services, including outpatient services, totaled about \$1.7 billion, of which about one quarter was met by insurance. In 1959, the corresponding figures were over \$5 billion and 53 per cent. The prepayment mechanism for hospital expenditures undoubtedly made possible the vastly increased income of hospitals during this period, and further contributed to the corresponding declines in the share of government and philanthropy in the financing of short-term hospital care.²⁶

Issues in Hospital Financing

An effort will be made in this section to identify some of the more important policy issues that underlie the structure of hospital financing, with particular reference to the role of philanthropy, and to suggest some of the implications of alternative solutions.

Assuming a continued high level of employment and output, there is no reason to question the ability of the American public to pay for short-term hospital care primarily through the mechanism of

²⁵ *Ibid.*

²⁶ Agnes W. Brewster, "Voluntary Health Insurance and Private Medical Care Expenditures, 1948-49," in *Social Security Bulletin*, December, 1960.

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insurance, even if the cost of such care continues to rise rapidly as it undoubtedly will. But a problem does exist with respect to the financing of hospital care for those members of the community who cannot pay insurance premiums because they do not have sufficient income and for those who, because they represent adverse risks (age), cannot obtain insurance under existing plans. It is clearly necessary for government to cover the costs of hospitalization for those who are not insured and who have no resources, especially since the sums made available by philanthropy to nonprofit short-term hospitals are inadequate.

In the past government became responsible for many patients who initially were able to pay for their hospitalization either directly or through insurance but who exhausted their savings or their benefits during the course of a prolonged illness. To reduce the incidence of such indigency, government, together with voluntary leadership in the health field, should strive constantly to secure an improvement in the quality of insurance benefits. For relatively small additions in premiums, it is possible to increase substantially the number of days of coverage. Recent developments in the field of catastrophic medical insurance are a further step in the direction of providing the type of protection that is required.

More difficult is the problem that faces older persons who are not currently enrolled in a hospital insurance program, who are unable to maintain their membership, or who are not permitted to convert their group membership to an individual policy when they leave employment and are forced out of a group plan. Here, too, progress is being made, for many group plans now provide for conversion to individual coverage after retirement. And state governments are constantly restricting the freedom of profit and nonprofit carriers to deny individuals the opportunity for such conversion.

The current agitation in favor of including hospital benefits for individuals over sixty-five under the Social Security system reflects a response to the serious lack of coverage at the present time for many older persons. However, without blanketing in the large numbers who are currently outside of the Social Security system the passage of one of the pending proposals will not solve the problem for the substantial proportion of the older group which is uncovered at present. It would of course insure coverage for all those who are now in the system as well as those who may later be added.

The issue can be formulated thus: is it necessary or desirable to modify the present Social Security system in this major regard or will

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the evolutionary changes in insurance practices currently under way provide a satisfactory alternative for most people who have not yet reached sixty-five years of age? To what extent should the public assistance mechanism continue to be relied upon and to what extent should use be made of the generally preferred mechanism of Social Security? To what extent is easier access to general hospitals crucial for meeting the health needs of older persons?

It should be recognized that payment for hospitalization is not the main problem from the viewpoint of the individual patient though it is of central concern to the hospital. The patient is concerned with the total costs that he must meet—before he enters the hospital, while an inpatient, and after he has been discharged. These costs involve fees to the physician and other essential expenditures. While hospitalization may cost the patient \$40 a day, round-the-clock nursing, if he requires it, will come to almost \$60 a day more; and the fees of the physician who treats him in the hospital may equal or exceed his total hospital bill. For this reason prepayment plans have expanded rapidly in recent years to cover part or all of the fees that the patient must pay to the physician while in the hospital. Little progress has been made, however, with prepayment for nursing services, except under catastrophic insurance. Since 1948 the proportion of all expenditures for services in and out of the hospital covered by insurance increased from 6 to 29 per cent. In 1959, these expenditures came within 10 per cent of total private outlays for hospital services.²⁷ The combined premiums for hospital and physicians' services in the hospital, however, have been advancing rapidly and an important question is the extent to which those in the lower income groups can afford to meet them. The rising public clamor in many communities where Blue Cross has recently advanced its rates substantially is indicative of mounting consumer annoyance, if not resistance. It is questionable whether, without substantial employer participation in the payment of such premiums, many at the lower end of the income scale will be able to afford these mounting premiums. Here is a major threat to hospital financing.

The rapidly mounting premiums make it desirable to consider whether any factors now included in hospital charges could properly be excluded so as to enhance the ability of persons with low incomes to participate or continue to participate in prepayment plans. It was noted earlier that substantial educational and, to a lesser degree, research costs are currently included in hospital cost and charge struc-

²⁷ *Ibid.*

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tures. Their deletion, however, would probably not permit a reduction of more than 5 or 10 per cent in the charges levied by hospitals with comprehensive teaching and research programs. Such relief would not be sufficient to affect the mounting disparity between hospital costs and the consumer's disposable income, especially for those who are at the lower end of the income distribution. Between 1950 and 1957 the percentage of disposable income spent for hospital care increased by almost one-third.²⁸ There are good reasons to rationalize the support of postgraduate medical teaching and research even if it will not do more than make a minor contribution to the specific problem at hand—to help assure the financial solvency of a broadly based prepayment plan. Unless the community rationalizes these costs many hospitals will not be able to establish the range and quality of educational programs that are required to provide the necessary numbers of well-trained medical personnel. Among the many blocks to expanding the number of physicians are the formidable costs involved in operating good teaching hospitals.

There is a clear and urgent need to strengthen the modest controls that are currently exercised by government and voluntary organizations in determining the number and type of hospital beds that a community or an area requires. It is generally acknowledged that the Hill-Burton Act encouraged the construction of too many small hospitals to permit effective staffing. From the viewpoint of controlling costs no action promises more return than sound policies directed toward preventing the unnecessary expansion of hospital facilities or the duplication of expensive services. Excess hospital beds and duplication of specialized services are not only a sure way to waste capital funds but they further insure unnecessarily high operating costs. Hospitals with empty beds are likely to keep patients longer than is medically indicated—especially if their physicians know that insurance will cover their patients' bills.

There is no easy answer as to how more effective controls can be assured. At a minimum, state governments should consider issuing charters to new hospitals only on the basis of certificates of necessity, and they might well consider exercising similar controls over large-scale expansion programs of established hospitals. Most important, all units of government—federal, state, and local—which play such a large role in making funds available for new construction, should restudy and tighten the criteria governing the allocation and use of

²⁸ Ginzberg and Rogatz, *Planning for Better Hospital Care*, p. 69.

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these funds. Similarly, various voluntary groups that are directly or indirectly involved in raising substantial sums for the capital or operating needs of voluntary hospitals should insist upon adequate planning studies as background for their allocations.²⁹ Rugged individualism in hospital operations is an anachronism.³⁰

Among the less desirable consequences of the vast expansion of hospital insurance has been its impact on the manner in which scarce medical resources are used. While the key to such utilization remains the physician and the manner in which he practices his profession, hospital insurance has contributed to the underutilization of specialized hospital resources by limiting insurance benefits primarily to inpatients. This tends to raise hospital costs and insurance premiums. From the community's point of view it would be much more desirable to have the hospital's specialized facilities used by both in- and outpatients. Since room and board loom large in total hospital costs the costs of treating ambulatory patients can be kept much below those for inpatients.

Another axis along which progress can be made is to insure a higher level of planning among the major interest groups—hospitals, government, and insurance systems. Instances have come to light in the last few years where the interlocking directorships of Blue Cross and voluntary hospitals resulted in the absence of countervailing pressures to assure that resources in a noncompetitive market are well allocated and used. Only danger and eventually insolvency for both the voluntary hospital and the prepayment plans can result if the hospital continues to expect Blue Cross to reimburse it on the basis of average costs. To avoid this, the hospital must exercise restraint over policies which tend to raise costs. Moreover, a prepayment plan that acts as nothing more than a conduit for funds which pass from the consumer to the producer has a limited future.

The hospital is a unique institution in that no one person or group of persons has clear cut responsibility for its management. Legally the board of trustees has this responsibility but in fact the trustees have remarkably little influence on the way in which the staff, particularly the medical staff, functions. While it is obviously sensible to leave the treatment of patients to the physician, it should be recognized that

²⁹ Hospital Planning Association of Allegheny County, *Executive Director's Report*, May 23, 1960.

³⁰ Eli Ginzberg, "The Hospital and the Community," in *The Impact of the Antibiotics on Medicine and Society*, Iago Galdston, ed., New York, 1958.

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much of what occurs in the hospital relates more to the convenience of the physician than to the needs of the patient.

The hospital is unique also in that its resources, provided in part by community funds, are essential for the conduct of private medical practice. Years ago it was argued that the physician gave so much free service in caring for charity patients that he returned to the community much more than he received. It is questionable whether a careful application of a cost-benefit calculus would ever have supported this conclusion. It is even more doubtful in recent years which have witnessed a steady decline in the proportion of charity patients.

The basic question, however, is what can be done to establish effective centers of authority and responsibility within each voluntary hospital so that a continuing effort can be made to use the resources of these multimillion dollar institutions efficiently. The answer must be found by those who provide the operating and capital resources. They are the parties of major interest; they are the ones who must devote interest and imagination to this question.

No student of medical economics believes that the trend towards rising hospital costs can be reversed. But the wide range of controls that have been identified above and the many more that might be identified suggest that much can be done to slow the rate of advance, if the community is sufficiently interested and concerned. There is some evidence that the significant gains made since World War II to underpin and strengthen the financing of general hospital care will be jeopardized unless community efforts are accelerated and intensified. The community has a further interest in seeing to it that only hospitals that meet certain minimum standards have the opportunity to participate in governmental grant and nonprofit reimbursement programs.⁸¹

Comparisons with Education

The preceding analysis of the changing role of philanthropy in the financing of short-term hospital care in nonfederal hospitals has delineated the following major trends. The relative significance of philanthropy as a source of general hospital operating income has declined precipitously during the last three decades. The relative share of the government's contribution has also declined. It is the consumer's share, directly and through insurance, which has substantially increased.

⁸¹ Harold M. and Anne R. Somers, *Doctors, Patients and Health Insurance*, Washington, D.C., 1961, *passim*.

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With regard to capital resources the trend has been notably different. Before World War II philanthropy was the primary source of funds for the construction of hospitals providing short-term care. While philanthropy has continued to contribute sizeable sums for capital purposes the most significant postwar development has been the increasing role of government—federal, state, and local—in providing capital funds. To complete the picture reference must be made to the vastly enlarged role of the federal government in providing general hospital care for the large number of men and women on active military duty as well as for the significant number of veterans. In 1935, the total medical and hospital care expenditures for the military and veteran groups amounted to well under \$100 million; in 1959 the corresponding figure was in excess of \$1 billion.

Some gain in perspective may be achieved by considering recent developments in the financing of education. For education, like hospital and medical care, also depends on mixed financing from government, private, and philanthropic funds. In 1930, of the approximately \$2.6 billion of total combined operating and capital expenditures for elementary and secondary education, private funds accounted for \$235 million, or 9 per cent. By 1950, when the total had risen to \$6.7 billion, private expenditures amounted to \$790 million, almost 12 per cent. The comparable data for 1958 are \$15.0 billion total, of which \$2.1 were private funds; that is, the private sector had risen to 14 per cent of the total. These figures reveal that public expenditures had risen about five and one-half times during these three decades, but private expenditures had increased by almost tenfold.

Expenditures for higher education underwent an even more rapid expansion, from \$630 million in 1930 to almost \$4.7 billion in 1958. While private expenditures exceeded public expenditures for the fifteen years preceding 1945, the trend shifted after World War II; in 1958 public funds accounted for roughly 60 per cent of the total.³²

It is not feasible to develop a reliable estimate of the role of philanthropy in the support of private elementary and secondary education but a few observations may be helpful. About five of the seven million pupils in private schools are enrolled in Catholic schools which rely substantially on members of religious orders for staff. Moreover, Catholics also raise substantial funds for capital purposes. It is further general knowledge that parochial schools adjust their fees or waive them in the case of able young people from poor homes.

The larger independent secondary schools have an estimated en-

³² *Health, Education, and Welfare Trends*, 1960 edition, U.S. Department of Health, Education, and Welfare.

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dowment of about \$200 million and the 101 that reported to the American Alumni Council in 1959-60 had total gift income of about \$23 million.³³

Philanthropy has always played a more important role in financing higher than elementary or secondary education. In 1930, the philanthropic share of the total income of institutions of higher learning amounted to 17 per cent; government contributed 31 per cent, student fees accounted for 26 per cent, and income from sales and from auxiliary enterprises accounted for the remainder. These ratios were not significantly affected by the major depression but they were radically altered after World War II. In 1958 philanthropic income, though it had risen from under \$100 million in 1930 to over \$500 million, declined from 17 to 11 per cent of the total income. The governmental share had increased from 31 to 43 per cent. Student fees had actually declined from 26 to 20 per cent.³⁴

From these selective figures it is clear that the pattern of financing education differs markedly from that of general hospitals. In brief, at each level of the educational system, government has always played a larger role than in the financing of general hospital care. In higher education in which the private and the public sectors were more nearly matched than in elementary and secondary education, governmentally supported institutions have grown more rapidly in recent years than private institutions. The consumer's share of total expenditures for elementary and secondary education has increased but today he is actually covering a smaller proportion of the total sum spent for higher education than he did in 1930. Philanthropy has increased its contributions to higher education substantially for both capital and operating purposes but it provides today only \$1 out of every \$9 of current income. This, however, compares very favorably with its contributions to nonprofit hospitals, where it provides only about \$1 in \$25.

There are, however, a few parallels between the two fields that should be noted. Various levels of government have enabled private institutions of higher learning, mostly through loans, to expand their facilities. To date the sums made available fall short of the level of support provided through the Hill-Burton Act but they are nonetheless significant. There has been some interesting experimentation in the postpayment of educational expenditures through the establishment of various systems of student loans. Various banks and insurance companies have developed college savings programs that aim at pre-

³³ *Giving USA*, 1961 edition, pp. 12 ff.

³⁴ *Health, Education and Welfare Trends*.

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accumulation, at least a distant reminder of Blue Cross's prepayment principle.

Many universities are benefiting from large research and special teaching grants made by government, and to a lesser degree the stronger teaching hospitals are also able to draw on this kind of support. Finally various governmental programs which make grants to individuals enable many to cover the high costs of education or medical care.

Broader Perspectives

A detailed consideration of the changing pattern of the financing of general hospital care, which today is a \$5 billion industry, should provide a delineation of some important facets of our changing economy and society. In this concluding section an effort will be made to identify briefly some of those broad implications.

1. Philanthropy has never been able adequately to pay for the products or services required by any substantial segment of the population. Its ability to compensate for skewness in the income distribution has always been limited.

2. In an economy characterized by rapid increases in per capita real income and in disposable income there is no reason for the community to place heavy reliance on philanthropy to provide funds for the production of basic services.

3. In periods of rapid expansion in the demand for services traditionally provided by institutions that derive important support from philanthropy, it has not been possible for philanthropy to maintain its proportionate share of the total income, particularly if the enhanced demand coincides with a period of price inflation.

4. In times of increased demand and inflated prices, there is a serious danger that institutions that have long relied on philanthropy for a significant portion of their total income will be unable to compete successfully for scarce resources, particularly trained personnel, because of the traditional lag in adjusting charges to current costs. As a result of this lag they significantly underpay their staffs, jeopardize future recruitment, and are forced to provide an inferior quality of service.

5. This weakened economic position of many hospitals is likely to be reflected in underinvestment in plant and equipment with serious consequences for the efficiency with which scarce resources are employed and social objectives are met.

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6. The substantial changes in the level of national income and in the distribution of personal income over the past several decades, and the likelihood of further changes in the decades ahead, underscore the importance of potentially radical innovations in the financing of essential services. Such innovations occurred in hospital care during the 1950's and are now under way in higher education.

7. As long as the cold war continues it is questionable whether government alone, regardless of the pattern of federal-state-local fiscal relations, can devote adequate funds to insure services of appropriate quantity and quality for the education, health, and welfare of the public. The country has backed into mixed patterns of financing in many of these fields. It is a major challenge to evaluate existing designs critically in order to improve upon them. By so doing, the sums that consumers can contribute towards the purchase of such services may be enlarged and appropriate levels of capital investment in human resources and facilities may be assured.

8. Philanthropic institutions have long presented a serious challenge from the viewpoint of efficient management. They have been the preferred environments for amateurism, nepotism, and narrow group interests. Now that many of these institutions have become large-scale enterprises there is an urgent need, if valuable resources are not to be poorly utilized and wasted, to improve their management. The fact that it will not be easy is no excuse to back away from the challenge.

9. The best way to improve the internal management of these institutions is through community, regional, and national planning. Here the incentive must come from those who make the funds available, for they are the ones primarily concerned to see that their money goes as far as possible.

10. Finally, economists and other social scientists have a responsibility to develop studies that will lead to the emergence of sounder criteria than now exist to guide investment and pricing policy. Such studies will have to be more than exercises in geometry or calculus for the core values of a democratic society impinge directly on the education, health, and welfare of the public and these are not reducible to mathematical terms. Economists have special capabilities in analyzing problems in the allocation of scarce resources. Until recently the leaders of the profession have been deeply interested in welfare. A renewed interest in welfare problems can result not only in substantial social benefit but will also help to revitalize an academic tradition that is in danger of becoming irrelevant.

