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Book Review

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A Once Charitable Enterprise: Hospitals and Health Care in Brooklyn and New York, 1885–1915, David Rosner. Cambridge, UK: Cambridge University Press, 1982, 1992, 2004; Princeton, NJ: Princeton University Press, 1986

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David Rosner's book, a classic among social historians of medicine, offers insight into the recent history of non-profit hospitals and health plans. In late nineteenth and early twentieth century New York City, as Rosner explains, managerial and medical values eclipsed voluntary hospitals' previous mission of serving people who could not pay for care. The commercialization of these hospitals subsequently accelerated, perhaps most rapidly during the three decades since initial publication of *A Once Charitable Enterprise* in 1982.

Many once charitable enterprises have become – or are becoming – once non-profit as well. "No margin, no mission" has been a cliché among executives and trustees of non-profits in healthcare for a generation. Between 1969, when the Internal Revenue Service began to regulate the community benefits offered by tax-exempt healthcare providers, and 2010, when the Affordable Care Act of 2010 (ACA) required hospitals to assess the health needs of the communities they served, policymakers "almost invariably accepted the hospital industry's view of its history and purpose" (Fox and Schaffer 1991; Internal Revenue Service April 4, 2013). Since 2009, when the Internal Revenue Service began to require non-profits to document how they set executive pay, boards of directors of many organizations in the health sector have benchmarked salaries against those paid by their for-profit as well as non-profit competitors (Fox, confidential sources). Many non-profit health facilities and health plans (Blue Cross/Blue Shield plans in 13 states, for example) have changed their profit status since the 1980s. In some instances, moreover, state officials did not require these former

non-profits to compensate the public for exempting them from income and property taxes and for subsidizing interest rates on the tax-exempt bonds with which they had been built and equipped (Hall and Conover 2006). A headline in *Forbes* heralded, "The Rise of the Charitable For-Profit Entity," two new corporate forms authorized by legislation in a growing number of states (Gomez 2012).

Journalists and academics have usually explained the accelerating commercialization of non-profits as a result of the circumstances that made the health sector the largest American industry by the end of the twentieth century. Beginning in the 1940s, money flowing into the sector has created incentives for both institutions and individuals to prosper. Money to expand and then sustain access to the interventions clinicians order for their patients now comes from private and public employers, Medicare, Medicaid, State Children's Health Insurance, Workers' Compensation, the new subsidies in the ACA, and from direct payments by consumers. Appropriations by states and the federal government, beginning with the Hill-Burton Act of 1946, have financed constructing and equipping new and expanded hospitals, clinics and skilled nursing facilities. From 1946 as well, a new program of extramural research at the National Institutes of Health began to finance grants and contracts under which academic institutions would generate new science and technology. Public subsidy for higher education of health professionals also began at the end of the Second World War, with the G.I. Bill of Rights and new state appropriations, then expanded vastly in the mid-1960s. Simultaneously, manufacturers of prescription drugs and medical equipment developed new interventions, which were frequently based on federally-funded research, and marketed them aggressively to clinicians and patients (Fox 1993, 2010).

This vast increase in money allocated to the health sector created incentives for individuals and organizations to want more of it, thus accelerating commercialization. Physicians, administrators, nurses, allied health professionals and other workers in the sector aspired to higher pay and benefits. Manufacturers sought more profits and rising share prices.

Interest group in health affairs learned that lobbying and contributing to the campaigns of elected officials helped them achieve their aspirations. As a result of these efforts:

- Medicare reimbursed a return on equity for investor-owned hospitals as well as the costs of capital and its depreciation for non-profits;
- members of the American Medical Association – which had threatened to boycott Medicare – learned that its fees markedly increased their incomes;
- medical specialty societies became adept at protecting their members' scope of practice against competition from other physicians, optometrists, physical therapists, clinical psychologists, physicians' assistants and nurse practitioners;

- unions representing health-care workers in public, non-profit and investor-owned organizations mobilized support among elected officials as they negotiated about wages, benefits and work rules;
- hospital and nursing homes trade associations thwarted changes in reimbursement policy that threatened their bottom lines; and
- the Bayh-Dole Act of 1983 awarded universities patents generated by faculty members under grants and contracts from federal agencies.

This explanation for the commercialization of the health sector is, however, incomplete. It neglects the history of beliefs and behaviors that had begun to shape the governance and operations – that is, the culture – of key organizations of the sector before its vast expansion began in the 1940s. Although voluntary hospitals were still incorporated as charities in New York and other states, they were at the forefront of commercialization. In *A Once Charitable Enterprise*, Rosner augments the standard explanation of recent events by explaining how commercial beliefs and behaviors become central aspects of the culture of hospitals between 1885 and 1915.

Rosner's principal subject is the "changes that transformed the hospital from a series of idiosyncratic community institutions into a larger, more bureaucratized system with a focus on medical treatment" (p. 4). He explains these changes as the "effect of social, economic, and political factors on the organization of the hospital and medical practice" (p. 6). The book begins with the social and economic history of the city just before the Depression of the 1890s. In subsequent chapters, Rosner describes how and explains why trustees and physicians changed the socio-economic mix of patients and arrangements of power and authority within hospitals. Then, he shows how these changes influenced negotiations between officials of the city and the state and hospital leaders about financing care for persons who could not pay for it.

By 1915, each voluntary hospital in New York City had been transformed from a "paternalist charity" to a "highly complex bureaucracy in which medical services were bought and sold" (p. 121). Hospital cultures now emphasized financial incentives and disincentives and accorded increasing authority to physicians.

The inhabitants of the city suffered three "losses" from this transformation. The first loss was a "chance to develop a viable set of free-standing ambulatory care centers in poorer neighborhood." The second was the "opportunity to make social services an intrinsic and important part of health-care delivery." Finally, New Yorkers lost an "opportunity to develop health-care services responsive to local community interests" (p. 189).

A fourth loss, which Rosner does not mention, was that the city's voluntary hospitals, like their non-profit counterparts elsewhere, had established

governance and embraced values that would enable them to take advantage of the vast increase in resources allocated to the health sector that occurred during and after the Second World War. The events Rosner describes enabled these once charitable enterprises to take maximum advantage of new funds flowing into the health sector. His book helps to explain why leaders of non-profit hospitals (and residential long-term care facilities) in New York City and elsewhere eagerly embraced every incentive to benefit commercially from that flow. The one incentive denied to managers of non-profit hospitals in New York was the paydays their peers in other states enjoyed because they persuaded boards to sell these institutions to investor-owned corporations (which was effectively prohibited by New York State law).

Rosner's book has been cited by numerous other historians. In 2012, for example, one of them cited *A Once Charitable Enterprise* for evidence that "hospitals increasingly behaved like businesses and sought the kinds of patients who would increase their incomes." But she discusses this behavior as recent, missing Rosner's emphasis on continuity with the past (Hoffman 2012, xxxi, 209). Like other historians who have recognized Rosner's research, she prioritizes the politics of financing hospitals' efforts to accord patients the benefits of advancing medical science and technology (Fox 1991).

A sequel to *A Once Charitable Enterprise* would begin with the story of how the values and principles of governance embraced by leaders of non-profit organizations, and especially of hospitals, have contributed to the growing commercialization of the health sector during the past half-century. It would include the history of policy to resist commercialization; for example, federal legislation enacted in 1986 to inhibit non-profit and investor-owned hospitals from "dumping" indigent patients on public facilities. Then, it would describe notable recent efforts to overcome the historical legacy of these leaders' enthusiasm for commercial incentives. Examples would include the Kaiser Permanente Community Benefits Program and the work of the Ascension Health Alliance (the largest non-profit health system in the country) in improving the quality and safety of care.

Whoever writes such a sequel should emulate David Rosner's distinctive contribution to the historiography of hospitals; he prioritized social, economic and political evidence. A synthesis of such evidence with primary sources about recent efforts to improve the quality and safety of hospital care – and about the advances in research that guide these efforts – could yield new understanding about the history of health care. Such understanding might even inform physicians, managers, trustees, collective purchasers and regulators about the costs and benefits of containing the effects of commercialization on non-profit organizations.

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