Frontiers in Economic History

Paloma Fernández Pérez *Editor*

Business History of Hospitals in the 20th Century

Entrepreneurship, Organization, and Finances

Springer

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Editor
Paloma Fernández Pérez
Department of Economic History
University of Barcelona
Barcelona, Spain

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Preface

This book had its origins in the midst of the COVID pandemic, when in May 2020 I invited Christy Ford Chapin to organize together a session proposal for the World Economic History Congress that took place in July 2022 in Paris. In this proposal, which was accepted, Martin Gorsky (Center for History in Public Health at the London School of Hygiene and Tropical Medicine in London), Pierre-Yves Donzé (Osaka University), Christy Ford Chapin (University of Maryland), Carles Brasó Broggi (UOC), Margarita Vilar (Universidad A Coruña), Jerònia Pons (University of Seville), Sabine Schleiermacher (Charité-Unviersitätsmedizin de Berlin), Jin Xu (China Center for Health Development Studies of Peking University), Guian McKee (Miller Center of Public Affairs University of Virginia), Andrew Simpson (Duquesne University), Laurinda Abreu (Universidade de Evora), and Paloma Fernandez (Universitat de Barcelona) participated in person or virtually. The debates focused on the history of modern hospitals in very different institutional and cultural contexts, trying to make comparisons, find patterns of common change, and the reasons for the different pathways.

Modern hospitals are life-saving infrastructures, very expensive, and complex, that emerged in the late nineteenth century with modern capitalism and developed modern infrastructures and organization after the 1930s and particularly after the 1960s, in most of the regions of the world. They are key infrastructures that have contributed to the increase in life expectancy and well-being in direct contact with their communities. Modern hospitals concentrate their human capital, products, and services in the largest cities of the world in general and specialized healthcare centers, and disseminate their services in primary care centers far from big cities, in middle-sized towns, and in rural areas of the world.

They are critical organizations whose history is plagued with problems of cost efficiency control and chronic financial deficits, with debates about the balance between private and public interest, establishments difficult to change, organizations that are at the very front of struggles about how to improve healthcare policies. International institutions started to pay attention to hospitals since the early twentieth century, though their close connection with local institutions and local conditions have made

very difficult to standardize and converge routines and practices. Hospitals are organizations locally embedded, very connected to their territories. In this book, we study how and why hospitals have become the center of our health system, but pay attention to the historical origins of their current diversity.

In the debates of the session of the Paris conference participants discussed relevant questions such as: what are the driving forces and actors that have shaped the diversity of models of hospital organization and management in the world, and their effficiency? Where and when they started to help improve our life expectancy? Which have been historically the key issues that have determined the degree of efficiency of hospital governance models in the world? Scholarly literature and international organizations have published in the last decades many descriptions about the state of the health care in the world, but very little about the long-term institutional and historical reasons for the current problems of hospitals in the world.

In the context of the COVID pandemic this book started to be designed and planned, the difficulties faced in different hospitals of the world, no matter whether the countries were rich economies or backward economies, were very dramatically revealed. Despite the enormous differences in the history of hospitals of the world, we all were witnesses as to how labor intensive hospitals are, how institutional rules of the game about the access to health care services and products are, how collaboration between general and specialized hospitals can be so relevant in emergency situations, and the enormous differences in morbidity rates between hospitals with efficient organization of their human resources and hospitals without good communication and rules in the sanitary staff.

We all realized the mortality rates in some countries, and in some hospitals, and started to ask us why. The answers combined short-term factors with very long-term historical reasons. Hospitals are big infrastructures difficult to pay, difficult to be maintained, and difficult to change. For this reason, when a large hospital is built, and organized, it creates inertia that is inherited by sanitary staff and patients of the future. The need to know what main historical typologies of hospital organization and management have emerged in the world, that have created different types of inertias for healthcare workers and patients, led to think about expanding the scope of the work to be done. I decided to organize a book, inviting the participants of the 2022 Paris Congress session, and other experts in the history of hospitals in the world such as Daniela Felisini, Fernando Salsano, Josep Barceló, and Grietjie Verhoef who contributed their research on Italy, Spain, and South Africa. We organized two new virtual meetings in which central topics that are the focus of this book were discussed: the sources and criteria to study the history of hospitals, public and private financing of hospitals, instruments to access services and products. healthcare in hospitals, the international transfer of knowledge between healthcare and hospital personnel, the internal organization and management of hospitals, the relationship with public administrations, and primary care as a priority but neglected line of fundamental patient care, which we are all.

This book aims to show the deep roots of the problems when modern hospitals were built and organized, a century and a half ago, and how they have created path dependent rigidities that explain the difficulties to change hospital organization and

management. Large infrastructures difficult to be built, and maintained, like railways, or roads, and bridges, determine in a path dependent way for decades the degree of efficient governance and economic sustainability of future administrators. Large modern hospitals and large health insurance services that emerged in the twentieth century are, also, today, having a difficult relationship with their surrounding communities. From an economic and business history perspective much is still to be known and done, to know how and why, by whom, new hospitals were inspired, designed, built, filled, financed, organized to increase healthcare assistance, improve well-being, and develop a new capital intensive industry with public and private actors interacting with different rules of the game in different territories of the world. Different actors made possible the emergence, in the past century, of a diversity of models of entrepreneurship, organization, and finance to design and sustain new large hospitals in the world. After World War II healthcare systems new large hospitals were built, and pre-existing large ones were reformed, to assist an expanding population concentrated in large cities. This book contributes to know more about how this process took place, how new hospitals designed and imposed new financial systems, to allow the access to health services, and to try to audit and control expenditures often unsuccessfully, under the distant scrutiny of policy makers and interest groups. The book also analyzes the very long-term origin of the problems of the current hospital systems in the world, with chapters that focus on issues related to the reasons behind decline, resilience, or sustainability, through the twentieth century. Finally, the book provides a much necessary historical perspective of the development of modern hospitals, by identifying key periods, models of entrepreneurship, organization and financing, and major agents and drivers of change in some of the hospital systems of the world.

The chapters of this book also present specific studies and bibliography on the different topics and countries addressed. It shows the abundance of books, articles, conferences on the history of hospitals in the United States and Europe, especially monographs of territories or case studies, with few critical analyses of hospital systems or technological change. They show how public spending on health, and the origin and evolution of public and private health systems, have been the great research topics of the last half century. They also show the scarcity of studies that allow contrast and comparison between different hospital systems in historical perspective, with which to see common patterns in problems and possible causes of repeated failures, no matter the country or era of certain strategies of solving these problems. The relevance of primary care, and the abandonment of said care, with an excess of focus on large hospitals in large cities where access to housing is unaffordable and the population lives far from the districts where the large hospitals are located.

The book reveals that, despite undeniable differences in institutional and historical contexts, important issues are shared in all hospital systems addressed in this book. Among them, first, the historical inertias that are difficult to overcome, such as hospital centralism in health care. Second, the existence of short-term institutional obstacles (elections every 4 or 5 years changing policies and priorities) in an area like health that requires long-term vision and investment. Third, the conflict between

progressive and conservative social forces and its impact on the hospital organization. Fourth, the delegation of authority in each hospital center in matters related to internal organization and management. And fifth, among other possible problems shared in the world, the poor incentive and promotion structure to attract and maintain specialized personnel for decentralized primary care in the territory. Chaos dominates, voluntarism, insufficient resources for health centers, excess concentration of resources in large hospitals, scarcity of resources in primary care far from large cities, and a political system that is very short-term in its priorities and ambitions.

Hospitals were born to care for the most vulnerable, to stop the advance of infectious epidemics in the face of the inevitable movement of the population and migrations between territories. They were born to care for the dying, the mentally ill, the poorest. With industrialization, hospitals were also an instrument to maintain the health of factory workers and reduce economic losses due to sick leave. Compulsory health insurance was born to create health and care structures that coordinated the growing supply of professional health personnel who demanded decent remuneration, with the growing demand for industrial and service workers of the commercial and industrial bourgeoisie of cities with growing migration and disease flow. Financing health personnel, machinery, medicines, hospital infrastructure, and regulating instruments that allowed access to these resources by the working population required public-private collaboration: regulations, public subsidies, and investment in capital and knowledge of private initiative.

How and with what results the conversion of hospitals into large infrastructures that were the center of all these changes in health systems around the world was carried out is part of the story explained in this book. The cases studied, of a national or regional nature, include countries in Latin America, Africa and Asia, Europe and the United States. In these works, which bring together experts in hospital and health history from nine countries, central themes and questions are addressed in order to have a comparative knowledge of the models and patterns of evolution and efficiency of hospital systems in 27 countries.

Firstly, the problem of available sources to have reliable very long-term indicators in emerging economies is addressed in which the criteria, data collection methods, and data present enormous variations and limits to their representativeness. This is particularly shown in the chapters about Latin America and China, which offer a quantitative methodology in an effort to offer reliable series and long-term indicators to see main periods of change, and comparisons between countries and periods. The collaboration, coexistence, or plain competition between public and private initiatives in the construction of healthcare systems before and after World War II is a second central theme in many of the chapters, particularly those focusing on the United States, the UK, Germany, Spain, and Italy. In these chapters, some key actors are identified whose interests and objectives seemed to have been well defined and sometimes opposed between them: insurance companies, philanthropic and charity organizations, municipal and central administrations, associations of physicians, associations of patients, political parties with different ideologies, manufacturers and distributors of medical equipment and pharmaceutical products, architects and engineers, and sanitary staff of healthcare centers and their unions. The combination

of path dependent inertias inherited from the past (like the size of the buildings, the location, and internal design of a hospital), and the complexities involved in the changing relationship between the actors mentioned above, have made hospitals organizations very difficult to change. To understand why and how they are today we need to know the history of these institutions, and also the history of the institutional and socioeconomic environment in which they have developed their activities. This is the aim of this book.

Barcelona, Spain Paloma Fernández Pérez

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Editor and Contributors

About the Editor

Paloma Fernández Pérez Professor of Economic History at the Universitat de Barcelona. Ph.D. in History (UC Berkeley 1994), expert in the historical study of networks of entrepreneurship, with particular focus on family networks and professional networks. Author of *The Emergence of Modern Hospital Management and Organisation in the World 1880s–1930s,* Emerald Publishers (2021), and coeditor with P.-Y. Donzé of *The Business of Health.* Abingdon, Routledge (2022). Member of the COST Action CA22159 "Transnational Histories of Healthcare, 1850–2000" (EuroHealthHist).

Contributors

Josep Barceló-Prats URV, Tarragona, Spain

Carles Brasó Broggi Universitat Oberta de Catalunya, Barcelona, Spain

Christy Ford Chapin History Department, Fine Arts Building, University of Maryland Baltimore County (UMBC), Baltimore, MD, United States

Pierre-Yves Donzé Graduate School of Economics, Osaka University, Toyonaka, Osaka, Japan

Barry Doyle Centre for the History of Science, Technology & Medicine (CHSTM), University of Manchester, Manchester, United Kingdom

Daniela Felisini Department of History, Humanities and Society, University of Rome Tor Vergata, Roma, Italy

Alejandro Fernández National University of Luján, Luján, Argentina

Mauricio Matus Dpto. de Economía, Métodos Cuantitativos e Historia Económica, Universidad Pablo de Olavide, Sevilla, Spain

Guian A. McKee Miller Center of Public Affairs, University of Virginia, Charlottesville, VA, USA

Anne Mills Department of Global Health and Development, Faculty of Public Health and Policy, London School of Hygiene & Tropical Medicine, London, UK

Paloma Fernández Pérez Universitat de Barcelona, Facultat d´Economia i Empresa, Barcelona, Spain

Jerònia Pons-Pons Department of Economics and Economic History, Faculty of Economics, Universidad de Sevilla, Sevilla, Spain

Fernando Salsano Department of History, Humanities and Society, University of Rome Tor Vergata, Roma, Italy

Sabine Schleiermacher Charité - Universitätsmedizin Berlin, Berlin, Germany; Institut für Geschichte der Medizin und Ethik in der Medizin, Charité - Universitätsmedizin Berlin, Berlin, Germany

Andrew T. Simpson Duquesne University in Pittsburgh, Pittsburgh, PA, USA

Grietjie Verhoef University of Johannesburg, Johannesburg, South Africa

Margarita Vilar-Rodríguez Department of Economics, Faculty of Economics and Business, Universidade da Coruña, A Coruña, Spain

Jin Xu China Center for Health Development Studies, Peking University, Beijing, China

Cost Efficiency and the Hospital System in the United States

Fuzzy Numbers: U.S. Hospital Accounting Since the 1930s

Christy Ford Chapin

At over 18 percent of 2021 GDP, United States healthcare spending will soon consume one-fifth of the nation's resources. Hospital expenditures—about $1.3 trillion annually—constitute the largest share, almost one-third of these costs (Condon, 2022).

Hospital expenses have reached astronomical heights, but nobody really knows the cost of individual hospital services. Journalists sometimes report the price of a hospital procedure. What they rarely tell the reader is that the published figure was an administrator's best guess and that another administrator—in the same area or even the same hospital—might quote a significantly different price for the same treatment. This situation occurs because U.S. hospitals lack standardized, industry-wide accounting practices and have consistently failed to generate detailed, reliable data about how much it costs to deliver any given service (Carroll & Lord, 2016). The inadequacy of hospital financial systems is astonishing considering the level of resources at stake and considering that, for over a century, American corporations have employed uniform accounting practices and have routinely carried out cost-finding assessments.

This chapter argues that, since the 1930s, U.S. hospitals have manipulated and managed accounting processes to secure generous reimbursements and favorable regulatory terms from third-party financiers, both private insurers and public programs. Turning accounting on its head, hospital leaders have intentionally produced unstandardized, imprecise cost calculations for three reasons: It helped them inflate service prices, justify charging different payers divergent rates, and evade third-party surveillance by concealing internal resource distribution and operational details. The numerical language of accounting imparted a superficial air of objectivity to the bloated and diverse billing rates that administrators quoted institutional

C. F. Chapin (✉)
History Department, Fine Arts Building, University of Maryland Baltimore County (UMBC), 1000 Hilltop Rd., Baltimore, MD 21250, United States
e-mail: cchapin@umbc.edu

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purchasers. By packaging their valuations in accounting terms, hospital leaders could characterize them as neutral products, first, of "voluntary" markets, then—during and after the 1960s—of "competitive" markets.[1] Furthermore, by generating fuzzy figures that obscured internal operations, hospital administrators inhibited third-party information-gathering activities that could aid in designing effective cost containment measures. So important were these objectives that, even after the professionalization of their accounting staffs during the 1960s, hospitals continued—during third-party negotiations and for compensation purposes—producing vague and inaccurate cost calculations.

Demonstrating the propensity of hospital leaders to keep internal operating processes hidden, researchers know remarkably little about the day-to-day accounting practices of American hospitals (Carroll & Lord, 2016).[2] There is a noticeable scarcity of historical studies about hospital accounting in the United States compared to other countries, particularly England, (Hüntelmann & Falk, 2021; Flesher & Pridgen, 2015; Jackson et al., 2013) because the financial practices of American hospitals have been so diverse and concealed. To help fill this historiographical gap, this chapter discusses why accounting became such a valuable device for hospitals seeking higher profits and autonomy within the public-private healthcare system. It then explores—within the boundaries of available evidence—how hospital administrators pursued their goals by directing accounting toward paradoxical ends—toward financial and operational opacity rather than increased financial transparency.

1 Background: The Public–Private Healthcare System and Disciplining Prices

The American Medical Association (AMA) played a significant role in creating the public-private healthcare system. During the 1930s, the AMA designed a distinctive "voluntary" healthcare model that instituted generous but separate compensation for physicians and hospitals, granted service providers complete sovereignty over medical practices, and funneled all financing through insurance companies, both nonprofit and commercial. Because the AMA had significant though informal regulatory power over medicine—including professional influence over state medical licensing boards and economic authority over hospitals—physician leaders were

[1] Historians of accounting frequently contend that accounting is socially constructed or created through the routine practices, customs, and norms of the institutions within which it is embedded. They view accounting not as an "objective, value-free, technical enterprise, representing reality 'as is,'" but instead as an assortment of limited processes capable of characterizing circumstances in myriad ways, depending on practitioner objectives. The case of U.S. hospital accounting illustrates this perspective (Morgan, 1988, quote p. 447; Hüntelmann & Falk, 2021, 6–7, 13–14; Belkauoi, 1978; Tinker, 1991, 2004; McKernan, 2007; Malsch, 2013; Modell, 2017).

[2] Owing to this lack of information, this chapter discusses nonprofit and for-profit hospitals as a single group.

able to impose the *insurance company model* on the entire healthcare system despite its well-recognized tendency to drive up costs.[3] The American Hospital Association (AHA) joined with the AMA to contest government-managed healthcare by championing the insurance company model as the "voluntary" or private solution to the nation's healthcare needs.

The high-cost insurance company model was subsequently embedded in the American healthcare sector through both private market activity and public policy. For example, federal tax benefits that businesses received for supplying employees with healthcare coverage indirectly subsidized the insurance company model (Chapin, 2015, 60–62; Klein, 2003; Hacker, 2002). Similarly, the 1946 Hill-Burton Act directed federal and state money to the "private" healthcare sector through grants and loans to hospitals for construction and remodeling (Hoffman, 2020). To these arrangements, federal policymakers added programs that incorporated the insurance company model and targeted specific groups, like military members (CHAMPUS) and aged citizens (Medicare).

The public-private nature of the healthcare sector created a haze of ambiguity around medical costs and prices. In state-managed sectors, assessing service costs can help hospitals efficiently distribute allocated funds. In predominantly market-based sectors, prices are crucial market-coordinating mechanisms that reflect the costs associated with delivering services. In the former case, government-mandated budgets contain expenses; in the latter case, competition for patients disciplines service providers to hold down costs. However, in the American public-private system, the pressures for regulating costs were weak and brought to bear indirectly, through a diffuse set of "third-party" financiers that purchased health care on behalf of government beneficiaries and employee groups. Federal program officials could only curb service reimbursements with Congressional permission and lacked authority to limit hospital budgets or manage them to prevent "cost shifting," which occurred when service providers increased privately insured patient rates to offset losses associated with caring for government beneficiaries. In private healthcare markets, employer-provided coverage undermined the competition that is so crucial for disciplining prices. Because most workers failed to recognize how employers shifted aggregate employment spending away from monetary compensation and into insurance coverage, they failed to appreciate how rising healthcare costs directly reduced their take-home pay. Even if workers wanted to exert market discipline to contain costs, employers restricted consumer choice by contracting with only one or an extremely small number of insurance companies.

Against this backdrop, U.S. hospitals found that they obtained just as much or more revenue by gaming third-party payment systems as they did by efficiently managing operations to provide competitive prices. Scholars have long noted that third-party insurance drives up healthcare costs. By alleviating concerns that high prices and unwarranted treatments would drive away patients, insurance undermined price-based competition among medical providers (Finkelstein, 2007; Newhouse & Taylor, 1970; Pauly, 1968). Research consistently indicates that when hospitals encounter

[3] This section is largely based on Chapin (2015).

heightened competition or uncertain patient demand, they protect revenue streams by finding ways to increase third-party reimbursements. Accordingly, during the 1950s, researchers discovered that about 30 percent of hospital admissions and 30 percent of patient hospital days were medically unnecessary (Chapin, 2015; Holzhacker et al., 2015; Krishnan, 2005).

By 1960, the cost of insuring workers was eroding the competitive position of U.S. corporations globally. Business and labor groups called for healthcare cost controls. Media coverage about medical bill-padding and procedures performed simply to collect insurance fees—including a 1950s "unnecessary surgery crisis"—finally generated sufficient political pressure to convince insurers and medical providers to pursue cost containment (Chapin, 2015; Tomes, 2016).

Cost containment procedures intensified compensation and supervision disputes between service financiers and service providers. But throughout the period under study, hospital leaders used accounting to gain advantage in these financier-provider disputes. The language of accounting legitimized hospital charges by dressing them in accouterments similar to those of prices generated via truly competitive markets. But accounting also represented an important site of potential third-party surveillance—hospital ledgers provided insurers and government officials an observation point from which to inspect internal operations and resource management. Information delivered power to third-party financiers because as their healthcare knowledge evolved, they could more effectively implement process-specific cost controls. For example, 1950s and 1960s publicity scandals helped insurance companies convince hospitals to install utilization review committees, which evaluated patient treatments to ensure they were medically necessary. Utilization review activities channeled reams of medical information back to insurance companies. Insurers used this data to cultivate their healthcare expertise, which they then applied toward even more provider scrutiny and regulation (Chapin, 2015). Accordingly, hospital administrators attempted to conceal their activities from the supervisory gaze of financial sponsors by employing non-standardized, imprecise accounting methods that obscured internal operational and resource allocation details.

2 Accounting: A Means for Managing Third-Party Relationships

In the first decades of the twentieth century, U.S. hospital accounting practices were rudimentary. Hospitals obtained revenues from a variety of sources: patient billing, municipal and state governments, endowment earnings, individual donations, and charities like community chests. Because hospitals were mostly run on nonprofit bases and were exempt from taxation, administrators saw little need to employ professional accountants. Accounting practices varied from hospital to hospital and primarily revolved around—as they had for centuries—the need to promote "a sense of propriety and transparency among benefactors" (Daniels et al., 2010, p. 39).

Academics, practitioners, and reform-oriented groups—ranging from the United Hospital Fund of New York to the Committee on the Costs of Medical Care (CCMC)—unsuccessfully pressed hospitals to adopt nationally uniform accounting practices (Cole, 1913; Thorne, 1918; Rorem & CCMC, 1930; Sands, 1933; AHA, 1935). While the medical operations of American hospitals were internationally admired, their accounting methods lagged behind the practices of hospitals in other western countries (Fernández-Pérez, 2021; Doyle, 2021) Observers lamented that American hospitals had "all but spurned any attempt" to apply "the techniques and discoveries of business administration" (Carroll, 1936, p.162; Rorem, 1936). In 1922, to create a foundation for uniform industrywide practices, the AHA published its first *Chart of Accounts for Hospitals*—a key organizational tool that defined standard industry accounting terms and categories (AHA, 1976, p. vii). Subsequently, the AHA's Advisory Committee on Accounting issued a 1933 report urging hospitals to regularly prepare balance sheets, categorize patient revenue streams separately from donations, acknowledge equipment and building depreciation costs, and conduct service-specific cost studies (Flesher & Pridgen, 2015).

Well into the 1940s, one could still find large urban hospitals that failed to follow any of the AHA's key accounting recommendations. Hospitals employed their own distinctive accounting and billing systems, and few hospitals—if any—engaged in individual service-cost assessments (Reed, 1947, p. 235; Klarman, 1951; Brennan, 1954).

Hospitals' custom of charging different amounts for the same services—depending on who was purchasing the care—demonstrates the hodgepodge nature of industry accounting practices. Administrators created fee schedules—called "charge-masters" today—for private patients. But prices were largely guessed at and detached from the actual costs of providing patient care, because most hospitals lacked the administrative capacity to conduct cost analyses and because hospital leaders assumed that some portion of service expenses would be covered by municipal funds or donations (Rorem, 1936). Furthermore, hospitals commonly charged commercially insured patients higher rates than Blue Cross patients.[4] Hospitals and local hospital associations began founding nonprofit Blue Cross plans in 1929 to contract with employee groups, exchanging regular paycheck deductions for access to hospital care. Hospital leaders feared jeopardizing their nonprofit status if they charged the insurers with which they were closely affiliated full price for patient care. Thus, Blue Cross plans reimbursed hospitals using either a flat per-diem rate for all hospitals in one service area, negotiated per-diem rates per hospital, or the retail price of rendered services less a percentage. Over the course of the 1950s, however, most Blue Cross plans began compensating hospitals based on some version of "reasonable costs"—that is, the expenses a hospital incurred to care for a patient (Cunningham, 1997, pp. 65–66; Thompson, 1968).

[4] Commercial insurance companies usually sold indemnity benefits, which provided subscribers with set payments according to services rendered. These benefits required hospitals to directly bill patients who were responsible for any portion of the bill that their indemnity payment failed to cover. Nonprofit Blue Cross plans usually sold "service" benefits, which covered the full costs associated with each hospital service, with benefits limited by a stipulated number of hospital days.