Sarsaparilla, ducks, lambs, turkeys, daily groceries, and ten dozen spools of cotton are just a few of the gifts from patrons of one Catholic hospital in 1888. Contributions like these were typical and reflect the kind of relationships on which hospital sisters relied to sustain their institutions. Sisters were enormously successful in creating a network of supporters among New York’s immigrant Catholics. Any image of sisters as passive and sheltered women crumbles when we see the resources they cultivated. Sisters had a keen understanding of their likely supporters.

The simple beginnings of their hospitals—a few sisters moving into a small building—obscure the critical decision sisters made when they chose to open a hospital. While both the Archdiocese of New York and the Diocese of Brooklyn encouraged sisters to open hospitals, neither promised or assumed any permanent financial responsibility for them. Any costs sisters took on—a lease, a mortgage, or daily expenses—belonged, with few exceptions, to them.

Realizing that the ultimate financial responsibility for a hospital was theirs, sisters did not make reckless decisions and simply go wherever they were asked. Because of financial concerns, the Sisters of Charity in 1843 declined Bishop John Hughes’s first suggestion that they open a hospital. Recognizing that sisters would never take on a new hospital without some solid backing, the Brooklyn bishop told residents of Far Rockaway in 1904 that if they wanted a Catholic hospital built there, they would have to come up with some money first; he would not ask sisters to consider the idea otherwise.

In the nineteenth century and for much of the twentieth, Catholic hospitals had a unique relationship with the church hierarchy. The hospitals were not owned by either the Archdiocese of New York or the Diocese of Brooklyn, the Roman Catholic administrative units in
which they were located. In a vague and peculiarly Catholic way, hospitals were always under the supervision of the bishop who headed the diocese, but what that meant in practical terms was never spelled out.

The financial organization of the Roman Catholic Church in the United States is a complicated and thorny affair; it differs among dioceses and is dictated by civil statute as well as canon law. Some dioceses, Chicago for example, were initially organized under an unusual nineteenth-century corporate structure called “corporation sole,” in which the bishop personally became a legal corporation who owned all diocesan property. A more widespread method of church organization and financial management, and the one used in both the Archdiocese of New York and the Diocese of Brooklyn, was the “corporate aggregate” system. Under that method, developed in New York in the 1840s by Bishop Hughes, all Catholic organizations and institutions in the diocese, including hospitals, were organized as separate corporations. The hierarchy frequently controlled the individual corporations as holder of the majority of seats on the corporate boards. 3

In both the corporation sole and the corporation aggregate systems, the corporate structure of the hospitals and related provisions of canon law prohibited the hierarchy from redirecting hospital funds or properties to other purposes. Even in dioceses where the bishop had the very powerful privilege of corporation sole, hospitals remained outside his purview. As Edward Kantowitz explains in his history of the Archdiocese of Chicago, hospitals eluded episcopal control. As far as hospitals went, usually all the bishop could do was “inspect them, and raise hell in Rome if he didn’t like what he saw.” 4 The same was at least literally true in New York, although connections between some hospital communities and the hierarchy were close. At the same time, the hierarchy was not responsible for the financial maintenance of Catholic hospitals, and this corporate arrangement created a formidable distance between the hierarchy and the monetary needs of the hospitals. 5

Hospital boards included members of the hierarchy and other clergy, sisters, and laymen, but the hierarchy did not have majority control of the hospitals’ boards. While the bishop and other clergy were often trustees, sisters had numerical superiority in many hospitals. St. Vincent’s Hospital in Manhattan was originally organized under the Corporation of the Sisters of Charity of New York. That corporation was extended in April 1857 to “purchase land and buildings, and to erect buildings for the purposes of a Hospital in the City of New York.” As directors of the Corporation of the Sisters of Charity of New York, the archdiocesan vicar general and the bishop were also directors at St. Vin-
cent’s, but they were outnumbered on the board of managers by sisters. Similarly, nine Sisters of Charity signed the articles of incorporation for Seton Hospital, a tuberculosis hospital that opened in 1894. At St. Elizabeth’s Hospital, Monsignor Joseph Mooney, vicar general of the New York Archdiocese was president of the boards and all the officers were Franciscan sisters. At St. Joseph’s in Far Rockaway, the directors were Rt. Rev. Joseph McNamee of the Brooklyn diocese and Mary Ann Crummey, Mary Ann Mahoney, Marcella Gill, Mary Ennis, Sarah Boylan, and Mary Pollard—all Sisters of St. Joseph.

The arrangement between sisters and clergy in hospitals was very different from the Catholic parochial schools, which sisters also staffed and managed. Unlike the schools, most Catholic hospitals did not have specific parish affiliations. With two exceptions, St. Francis’ Hospital in Manhattan and St. Catherine’s in Brooklyn, Catholic hospitals were not clearly organized for the benefit of one parish or connected either financially or physically to a parish. (St. Catherine’s connection to Most Holy Trinity parish was reflected in its corporate structure: the pastor of Holy Trinity was the vice-president of the board of managers.)

In contrast, most Catholic elementary schools were organized within individual parishes to serve its parishioners. Sisters came to staff and administer parish schools (and sometimes parish orphanages), after a pastor asked them to. When he did, financial details of the responsibilities of all parties were clearly specified. When Father Lewis, the pastor at St. Mary’s in Manhattan, asked the Sisters of Charity at Mount St. Vincent’s to send a group of sisters to his parish in 1867, he specified to the community’s superior general what the financial arrangements were to be. In order “to prevent misunderstanding,” his memo made it clear that he alone had “the administration of . . . financial affairs. The sisters keep the accounts, provide whatever is necessary and at the end of every month, Father Lewis gives them the amount to their bills, as per the books.”

Financial independence could be a less than desirable situation if money was scarce, and in the early days of Catholic hospital development, it usually was. The individual communities of sisters were all separate corporations, and none were well endowed with either land or accumulated capital. There was also very little incoming money when a group first came to New York. Unlike many earlier European sisterhoods, New York communities did not have the benefit of large dowries, the money and property women brought with them into the convent. Their only source of steady income before they opened hospitals and other institutions, was tuition money, either from parish
schools or from the more expensive female academies almost every community ran. Parish schools could not always be counted on for income; as the Dominican sisters noted in 1858, “more than half of the children are unable to pay tuition, our only source of income, due to the unemployment of their parents.”  

In the academies, where sisters offered a genteel Catholic education to young women with economic means, tuitions were higher and hopefully more reliable, but they could never completely cover what quickly became increasing hospital costs.  

The single most important factor contributing to these rising costs was that almost immediately after opening, sisters saw a need to expand their hospitals, and as a Sister of Charity at St. Vincent’s wryly noted in 1853, “Building . . . in New York is very expensive.” Over the course of fifty years, St. Vincent’s population increased from 299 patients treated annually to more than six thousand. The Sisters of Charity spent $21,109 to maintain 800 patients in 1863; in 1910 it cost $228,776 to treat six thousand patients.  

Sisters were not cavalier about the scope of their efforts. Concerns about how far a community could and should extend itself sometimes limited the size of a venture. The Sisters of Charity originally planned to erect a new building to house St. Vincent’s but instead rented an existing building, presumably at a much lower coast. When the Sisters of St. Joseph bought land for St. John’s Hospital in Long Island City in 1891, they purchased several partially completed buildings on the premises, but without money to renovate them, they could not use all the buildings immediately.  

As hospitals became larger, they would assume a dominant physical place in a neighborhood. St. Vincent’s, just a little house when it opened, grew to be a significant presence in Greenwich Village by the turn of the century. Just three years after the hospital opened, the Sisters of Charity rented a second building on the same street. Soon afterward, in 1856, they moved into larger quarters across town on West 11th Street and rented a building that had earlier housed St. Joseph’s Half Orphan Asylum. It was at this address that the hospital would become a neighborhood fixture. In 1868, they bought the building and started accumulating other properties nearby, purchasing houses on West 12th Street in 1863 and 1874. In 1892, they bought a nearby synagogue. (Expansion often brought internal improvements which could also be costly. The first building had no gas light or internal plumbing; by the 1870s, the hospital had steam heat and hot and cold baths.)  

The Franciscan sisters’ work at St. Francis’ Hospital progressed sim-
ilarly, with the purchase of a nearby house just one year after opening. In 1869, the hospital was enlarged further through the addition of three other buildings; another was added in 1871. By October 1875 when construction and renovation was completed on all existing buildings, St. Francis’ could house 150 patients; by 1884, with yet more additions, its capacity was 280.\textsuperscript{15}

St. Vincent’s expenses in 1863 demonstrate the high cost of enlarging the hospital (Table 4.1). Little of nineteenth-century medical cost was actually spent on medicine: food costs totaled 40 percent of monies spent that year. Other maintenance costs, including rent, repairs, fuel and lighting, amounted to less than 15 percent of the total expenses. Hospital expansion accounted for the most money spent. The largest expense—almost one-third of total expenditures that year—was the $7,500 the sisters put toward the purchase of a new building.\textsuperscript{16}

Sisters worked hard to make the most out of their resources—community records include carefully noted estimates on building and renovation costs—and they made sure to emphasize this frugality in efforts to bolster financial contributions from both private and public sources. At the same time, they were careful to note they did not skimp when it came to patient care. The Sisters of St. Joseph’s at St. John’s Hospital were typically humble but deliberate in the wording of their annual report in 1892 when they noted that “The furnishing of the hospital is simple but durable, in keeping with the uses intended . . . The groceries, meats, liquors, drugs etc., are purchased from first-class firms only, and of best quality, it being deemed wiser to pay for a good article rather than be misled by what might prove false economy.”\textsuperscript{17}

Sisters’ assessment of financial realities was helpful to them as they searched for ways to come up with the money they needed to open and run hospitals. Unlike some other private hospitals in New York, none had the initial support of a wealthy benefactor who financed the initial venture.\textsuperscript{18} The Sisters of Charity supplied all the starting funds for St. Vincent’s in 1849, but that was not always the pattern for their community or others. The initial sources of hospital funding varied among Catholic hospitals. In a few cases, sisters began hospital work with the help of local clergy. More frequently, however, sisters got started in hospital work with significant help from lay Catholics. Catholic men and women contributed small and large amounts of money, services, furnishings, food, and their own time to begin hospitals and, later, to keep them afloat. How sisters garnered this support and why lay Catholics helped them is a story of effective leadership in both health care and community development. Sisters proved themselves remark-
ably skillful persuading would-be contributors that theirs was a cause worth supporting.

A great deal of the initial fundraising work for Catholic hospitals was done by Catholic lay women at fairs organized to support individual hospitals. As Colleen McDannell has illustrated, ladies’ fairs were a frequent fundraising vehicle among Catholic New York lay women in the nineteenth century, and hospital fairs were similar to the parish fairs she describes. More than just fundraisers, they were popular as social events as well. There was music and food and all sorts of items to buy, even for those with little money to spend. Raffles promised even more—a piano, a diamond brooch, or a silver tea set.19 With typical flourish and bravado, the Freeman’s Journal described the first of these hospital fairs, held in 1856 for St. Vincent’s, as “an event in the history of New York.”20 The fair netted approximately $35,000 and provided a nice nest egg for a few years. In 1863, fair proceeds were still being applied to outstanding bills: the $3,600 still remaining was of significant help, covering 17 percent of the approximately $21,000 in hospital expenses that year.21

### Table 4.1 Contributions from the Church of the Most Holy Redeemer to St. Francis’ Hospital, 1865–1868

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collections in the Church of the Most Holy Redeemer</td>
<td>$1,037.00</td>
</tr>
<tr>
<td>Collections by the Fathers in private houses</td>
<td>3,006.52</td>
</tr>
<tr>
<td>Rev. F. Braidstutter extra collection</td>
<td>4,000.00</td>
</tr>
<tr>
<td>Monthly collections by the Women of the Society</td>
<td></td>
</tr>
<tr>
<td>of the Holy Family</td>
<td>2,487.58</td>
</tr>
<tr>
<td>Two excursions under the auspices of the Independent Rifle Company</td>
<td>2,276.00</td>
</tr>
<tr>
<td>Individual donation</td>
<td>2,500.00</td>
</tr>
<tr>
<td>Individual donation</td>
<td>1,000.00</td>
</tr>
<tr>
<td>Appropriation from the state</td>
<td>18,000.00</td>
</tr>
<tr>
<td>Loan from the Societies and from the Church of the Most Holy Redeemer</td>
<td>6,348.84</td>
</tr>
<tr>
<td>Loan from the Societies of St. Alphonsus Church</td>
<td>3,608.00</td>
</tr>
</tbody>
</table>

*Source:* “Claims of the Fathers and the Congregation of the Church of the Most Holy Redeemer, New York, to the St. Francis’ Hospital 5th Street New York,” Archives of the Archdiocese of New York.
The success of these fundraisers was largely due to women’s efforts: women took charge of planning and running most of the events. Their fair responsibilities involved women in tasks and responsibilities outside their homes and family, but this work did not threaten gender boundaries. Charity work fell well within accepted female spheres of influence and involvement. More noteworthy is that Catholic women, religious and lay, worked together to fulfill the sisters’ mission to health care.

Unlike church fairs, hospital fairs transcended the geographic boundaries of parishes. Fairs were joint efforts by several parishes brought together through and by a community of sisters. Women from several Manhattan parishes worked on the 1856 fair for St. Vincent’s. The booths, decorated with needlework and household articles and trinkets, were designated by parish name, and there was probably no small amount of friendly competition. Profits were noted by parish name

Fig. 7. Although only fifteen years apart, the ca. 1897 invitation to a tea at the Waldorf organized by a newly formed Ladies Auxiliary reflects a shift from the fairs (Journals of the Fair, 1882) of the previous decades to more genteel women’s fund-raising events in the twentieth century. Sisters of Charity of New York
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and ranged from the $750 raised at St. Columba’s booth to nearly $2,500 from St. Patrick’s. (St. Patrick’s had not yet moved to Fifth Avenue but was still the seat of the diocese.) Ethnicity was the critical factor in terms of involvement. All the parishes involved with St. Vincent’s were Manhattan’s Irish ones. German-Catholic women supported their own hospitals with similar efforts. Fairs for St. Catherine’s Hospital raised almost $23,000 between 1869 and 1873.22

Personal ties between sisters who ran hospitals and the Catholic community also helped determine who would support a particular hospital once it opened. Some hospitals had special patrons who made sizeable and frequent contributions. In these cases too, a close relationship between the donor and the hospital sisters often precipitated the gift. Eugene Kelly, related by marriage to both the hospital’s founder Ellen Hughes and her brother Archbishop John Hughes, was a close “friend and advisor” to St. Vincent’s. He endowed several beds for the use of charity patients and also made cash donations, including $10,000 in 1893, the year before he died.23 Like Kelly, other large contributors had family connections to the sisters. The father of one of the Dominican sisters at St. Catherine’s made one of the few hefty ($5,000) individual donations to their hospital. When St. John’s in Long Island City opened, the father of a Sister of St. Joseph donated a building for the sisters to use as a convent.24

Physicians were also financial supporters of Catholic hospitals, but for different reasons. As in other nineteenth-century hospitals, physicians in Catholic hospitals did not receive any payment for their services. This was not entirely a charitable contribution on their part. As historian Morris Vogel explains, this system worked to the physician’s ultimate financial benefit. While nineteenth-century physicians earned their living from payments received from private (as opposed to hospital) patients, hospital work and experience contributed to the reputation that brought paying patients to their offices. “Without this gratuitous service,” Vogel notes, “it was difficult for a young doctor to begin a practice in a city where paying patients had a wide choice among practitioners and would choose experience.”25

In addition to their gratuitous services, physicians made other contributions. In 1904, one doctor helped the Dominican sisters with the rent on the building that first housed Mary Immaculate Hospital. John A. Harrigan, a physician and president of the board of trustees at St. Mary’s Hospital, made several substantial gifts to that hospital over the course of his thirty years there. In addition to cash gifts of $10,000 and
$6,000, he contributed more personal and more visible gifts, supplying patients and staff with special holiday dinners, for example.26

Priests, parish organizations and individual lay people were all early contributors and fundraisers at St. Francis’ Hospital (Table 4.2). Between 1865 and 1868, two churches, Most Holy Redeemer and St. Alphonsus, loaned the Franciscan sisters almost $10,000. Male and female parish organizations, like the Holy Name Society, contributed separate amounts totaling almost $5,000. Two parishioners made significant individual donations: one $1,000 and the other $2,500. Another $8,000 was raised by special collections held in church and through clerical solicitations. By 1868, when the hospital’s total yearly expenses were approximately $36,000, Most Holy Redeemer had raised over $40,000 for St. Francis’.27

St. Francis’ was unusual in its specific parish support and also in its specifically German affiliations. Like the parish of the Most Holy Redeemer, the hospital was organized to meet what were perceived to be the unique needs—notably language—of German Catholics in New York. St. Catherine’s Hospital in Brooklyn was similarly connected to one German parish: Most Holy Trinity. The majority of hospitals, however, were organized by sisters with connections to a number of different parishes—most of which were Irish ones.

Many hospitals tried to set up systems of guaranteed support through a program of endowed beds. Individuals or organizations could pay in advance for a bed, which would be filled by a patient of their choice when necessary. Potential donors were asked to contribute to a collective fund where members each paid a part of the cost. In 1863, St. Vincent’s invited patrons to “form clubs of twelve persons each—each member subscribing ten dollars; and each club thus formed securing one free bed for a year at the reduced price of $120.00 per annum,” suggesting this procedure to “Benevolent Societies who . . . are obliged to take care of their members during their illness.”28 As one of the hospital’s annual reports explained, not only did membership entitle subscribers to the use of a hospital bed, but the members of the “Beneficial Association of St. Vincent’s Hospital” also received the added benefit of “the prayers of the sisters and the sick poor.”29 But subscription fees did not increase much over time and were never a major source of hospital income. In 1867, St. Vincent’s raised only fifty dollars through subscription; in 1895, annual subscriber fees totaled $1,044.75.30 When St. John’s Hospital in Long Island City opened in 1890, the local St. Vincent de Paul Society, Exempt Firemen’s Association, and Ancient Order of Foresters all bought hospital subscriptions at fifty dollars each, but none established a major precedent.31
At the end of the century, St. Vincent’s did better with perpetually endowed beds, which were much more expensive. Some were endowed for the life of the donor, some provided free care for just one year, and others were noted as on account. St. Vincent’s first perpetually endowed bed had been established in 1893, but there were seventeen by 1900 and forty-one by 1907.32

The increase in individually endowed beds at the end of the century reflects the ability of at least some Catholic New Yorkers to make significant contributions. Catholics expressed their support in other ways, too, frequently by more personal means and often in much smaller
amounts. Donor lists at St. Vincent’s note contributions ranging from five to five thousand dollars. Other contributions, like Dr. Harrigan’s at St. Mary’s, were in goods rather than cash. They included small amounts of food and household supplies, as well as larger gifts of horses, wagons, and personal services. These donors were also listed in annual reports, which often specified gifts. In 1863 the sisters at St. Vincent’s in Manhattan noted, “Besides voluntary contributions in money, acknowledgements are also due to several friends for donations in stores, and various articles; for all which the sisters return their sincere thanks, and will ever gratefully remember the donors.”

St. Mary’s annual report in 1886 listed gifts of carpets, linens, coffee, and bananas, remarking in particular that “in our capacious kitchen the excellent range and boiler was donated by the late Mr. William Beard.” In addition to recognizing patrons, donor lists were also intended to encourage others to contribute. The sisters hoped that some, like Mr. Beard, might make provisions for the hospitals after their deaths, and bequest forms were often included in the reports.

Donors’ choices of gifts suggest the place a hospital and its sisters inhabited in the lives of many Catholic New Yorkers. Sometimes gifts were seasonal and celebratory. A benefactor at St. Mary’s Hospital in 1886 provided the hospital staff and patients with a traditional Thanksgiving dinner; another at St. Vincent’s (future Sister of Charity Euphemia Van Rensselaer) treated patients to ice cream. In 1892, the sisters at St. Vincent’s thanked a woman who “made Christmas week especially bright and pleasant for our patients by providing for them a Musical Entertainment . . . followed by a feast of cake and ice-cream for all at her expense.”

Large contributors often donated gifts that made a statement about who they were. The largest gifts often reflected a donor’s specific interest or occupation or gender. In donations for St. Vincent’s new wing in 1891, women took charge of furnishing the wards, a man contributed what was needed for the parlor, and a physician and his wife outfitted the operating room. Each gift reflected appropriate nineteenth-century decorum and social place. The wards were the charity beds and, as such, the appropriate focus for benevolent women. The parlor was the most public of the hospital’s rooms, where business was conducted and where the hospital put on a public face—in other words, a suitable location for a man’s contribution. The operating room was more than an interest of a generous physician; it was also the place in the nineteenth-century hospital where a doctor’s authority was strongest.

Unlike large and small gifts acknowledged in annual reports, many
Hospital Finances

contributions were anonymous. Their neighbors might not know who these donors were, but the sisters who took their contributions certainly would. These contributions, monies that went literally from the hand of the donor to that of a sister, suggest more than anything else the place and power of sisters among the city’s immigrant Catholics. Sisters were very successful in their ability to tap into all kinds of Catholic pockets, even ones that were not very deep.

The Franciscan sisters, the Dominicans, and the Sisters of St. Joseph all sent sisters out on missions to solicit contributions. Sisters visited and asked for contributions at places—like police stations and the docks—where they knew they would find Catholics. While these spontaneous contributions the sisters garnered were, for the most part, small, they added up. Between 1873 and 1875, the Dominican sisters who ran St. Catherine’s Hospital collected $26,000 through solicitations. By 1892, their success began to alarm Rev. Michael May, the pastor at Most Holy Trinity, whose parish had helped found St. Catherine’s. May worried that the Dominicans, who had other charity work in addition to St. Catherine’s, might not have been using the money exclusively for the hospital, and they probably were not. Unlike May, the Dominicans viewed all their work as related and did not concern themselves with territorial issues. Also, these donations went from the public directly to the sisters, not to Holy Trinity.37

Lay Catholic men supported the sisters through their affiliations with Catholic organizations too. Both the St. Vincent de Paul Society and the Ancient Order of Hibernians furnished wards at St. Mary’s.38 Overall, however, in the nineteenth century, lay men tended to be more influential as advisers, whether as members of the hospital corporation or, as in the case of St. Vincent’s, as members of a special advisory board. In many cases these individuals were large donors as well. Eugene Kelly, who gave generously to St. Vincent’s, was a member of hospital’s advisory board until his death. Others also made frequent contributions and could be relied on for emergency funds. In 1893, for example, board member William Iselin covered the expenses “to care for and to bury a child whose back was broken.”39

These advisers were also at the forefront of efforts to secure public funding for Catholic hospitals. Advisers were solicited for their political connections as well as their ability to make donations.40 Many privately organized hospitals in New York, including many Catholic hospitals, received public funding in the nineteenth century. Unlike Catholic schools, which were for the most part denied public financial assistance after 1842, Catholic hospitals received funds from both state
and local purses. After the Civil War, when the number of private charity institutions receiving public aid increased, the issue of public funding of Catholic institutions, including hospitals, became a frequent focus of political debate.

New York State’s financial involvement with Catholic hospitals began early in the nineteenth century when the state legislature granted funds to private hospitals as reimbursement for the care of indigent patients. The first Catholic hospitals in New York State received appropriations under this system. In 1849, for example, the legislature appropriated nine thousand dollars for the Sisters of Charity’s hospital in Buffalo. However, St. Vincent’s, the Sisters of Charity’s hospital in New York City, which opened at the end of 1849, did not receive any state funding until after the Civil War. Unlike the situation in Buffalo, where the sisters ran the only hospital in the city, New York had several charity hospitals maintained by public authorities.41

During the war the amount of public funds appropriated to private hospitals, including sectarian ones, increased as the state paid those institutions for their care and treatment of wounded and sick New York soldiers.42 After the war, as the number of private hospitals grew across the state, state grants to private charities, including hospitals, continued to increase in size and proportion.43

The procedure for state funding was unsystematic and most often based on political connections. Catholic hospitals were eligible as charities, and those in New York City and Brooklyn began to receive public monies when the infamous Boss Tweed of Tammany Hall gained power in state politics. Tammany politicians used their influence to obtain state grants for a variety of favorite charity organizations and institutions, hospitals among them. The first Catholic hospital in New York or Brooklyn to receive a legislative appropriation was St. Francis’ Hospital in Manhattan, which received $3,735.52 in 1868. Between 1868 and 1870, all the Catholic hospitals in New York and Brooklyn received legislative grants. They ranged from $713 for St. Mary’s Female Hospital in 1870 to $9,950 for St. Francis’ in 1869.44

For most of the century, New York City aid to private hospitals was no less unsystematic or political than the state procedure. There were two different sources of public funds available to private hospitals. Both the Common Council and the Board of Supervisors could allot funds, but both were ultimately dependent on state authorities since the state legislature had to approve the city’s budget. The earliest city appropriation to a Catholic hospital was a thousand-dollar grant to St. Vincent’s by the Common Council in 1863.45
The question of public aid to private charities became a major public issue at the New York State Constitutional Convention in 1867. Opponents argued that since there were public charity institutions, these private ones duplicated services and any appropriations to them wasted money. There was also mention that public funding of sectarian institutions violated the sacred American principle of the separation of church and state. Some voices were particularly opposed to funding of Catholic institutions—an editorial in the *New York Observer* was entitled “Our State Religion: Is It Roman Catholic?”

Unlike the controversy surrounding state aid to New York City private schools in the 1840s, attempts to reform the state procedure for charity appropriations put the Catholic Church on the defensive. Because the church was already receiving public funds for hospitals, it was not looking to break the monopoly of another private group receiving all public money as had been the case with Catholic schools. As early as 1850, the church had warned that an attempt to discontinue state appropriations to the Sisters of Charity’s hospital in Buffalo could have serious consequences for legislators at the next election. New York’s Catholic newspaper vowed to print the names of all state legislators who opposed the appropriation for this hospital, the first Catholic hospital in the state, urging their readers to take note for election day.

Catholics moved quickly to prevent changes in the system. An editorial in the *Metropolitan Record* cautioned the paper’s Catholic readership that the convention might discontinue further state appropriations to sectarian charities. The editorial dismissed accusations that Catholic institutions received an unfair proportion of funds, noting that “gross misrepresentations on this subject have been made.”

The debate continued throughout the convention. One proposal attempted to limit public appropriations to private charities that were not “religious or sectarian in character, and that a majority of its managers are not members of one religious denomination.” Such a qualification would have all but rendered Catholic institutions, including hospitals, ineligible for aid. Although Catholic hospitals emphasized that their doors were open to patients of any religious persuasion, they were clearly managed by members of one religious denomination: the female religious communities.

Catholic delegates opposed the amendment, and so did other delegates with more practical concerns. Their opinion, which would surface again and again in the debates that followed, was that the money the state appropriated to these sectarian institutions amounted to substantially less than funds required to maintain public institutions for
the same purposes. If the private organizations could not continue their work, public institutions might need to provide more services, and that would be a very expensive proposition indeed.

At the 1867 convention, the issue died when Democrats and Republicans realized that to continue the fight could mean political damage to both parties. However, the issue was soon resurrected when, in 1872, the notorious Tweed ring was voted out of office and a new Republican reform legislature refused to pass the annual charity appropriations bill in 1873. The newly elected legislatures were anxious to change the existing system and established a Constitutional Committee to propose a constitutional amendment prohibiting all public grants to sectarian institutions. The reformers were not entirely successful: a change in New York State policy was implemented in 1874, but the amendment enacted did not go as far as its backers had hoped. It only prohibited some appropriations and still allowed those institutions denied legislative grants to receive public funds through local governments. This change did, however, end direct state appropriations to Catholic hospitals. Still, although the Catholic hospitals in New York City and Brooklyn no longer received direct funding from the legislature, they could receive public aid through local authorities. When, in 1894, a new Constitutional Convention rehashed the debate of 1867, the arguments on both sides remained the same. Critics of the system, for example, objected to what they felt was a high proportion of state funds allotted to Roman Catholic charity institutions.50

Indeed, many of the sectarian institutions that received state grants were Roman Catholic. Catholic hospitals throughout the state, including those in New York City and Brooklyn, had fared well under the new laws of 1868. Between 1868 and 1870, the legislature appropriated $288,699.27 to private hospitals. Of the 28 hospitals receiving these monies, 8 were Roman Catholic and received approximately 32 percent of the total funds. However, the percentage of funds granted to Roman Catholic hospitals was actually declining. In 1868, Catholic hospitals received 46 percent of the total grants; in 1869, 34 percent; and in 1870, 26 percent. This decline reflected the growing number of all kinds of private hospitals throughout the state after the war.51

From the Catholic point of view, many of the seemingly nonsectarian private institutions receiving funds were clearly Protestant in nature, although not officially affiliated with any one particular Protestant group or church. In this sense, the circumstances were not unlike those surrounding the school controversy in the 1840s, when the Catholic Church protested that the private organization that held a
monopoly on state funds for education in New York City was really a Protestant organization. Catholics complained that education in New York public schools was clearly Protestant and often anti-Catholic. Similarly, Catholics complained that private hospitals were often Protestant institutions and that the religious orientation of the hospitals was very apparent and often offensive to Catholic patients. When the issue was debated again in 1894, opponents of all public aid to sectarian charities once more rallied their forces, but with less than satisfactory results. In a compromise agreed to by the New York archbishop Michael Corrigan, the Catholic Church promised to end agitation for public aid to parochial schools in exchange for continued public support of sectarian charities. The defeat of Democratic candidates in the election for constitutional delegates made compromise a difficult prospect for the church to ignore. Despite opposition, public aid to Catholic hospitals continued for a number of reasons. The power of the Catholic vote in New York State, particularly New York City, gave the church a significant political voice, but the bottom line was cost efficiency. As the Catholic Church was quick to remind public authorities, it was cheaper to minimally aid sectarian charities than to maintain public ones. Many public officials also considered this system to be the most efficient way to avoid even greater public expenditures. They recognized that the neediest people were often reluctant to confine themselves to public-run hospitals because of their reputations. If left unattended, these patients would very likely become completely destitute and, ultimately, costly state dependents in the poorhouse. Even reluctant supporters of public aid to Catholic hospitals concluded that those institutions might have a good chance of attending to the needy sick before they were likely to become a permanent public burden. Still, legislators wanted to keep amount granted to Catholic institutions as low as possible. The state’s perspective was that “public contributions . . . should be within such limits as will encourage private charity.” The New York State Board of Charities, in which Catholics were very deliberately included as members after 1894, kept a lookout for waste and extravagance. The history of New York City appropriations to Catholic hospitals is as tied to political circumstances as economic ones. Until 1898, New York City appropriations to private hospitals was an unsystematic procedure of flat grants, and the disbursement of funds was part and parcel of the ward boss politics in New York. Other than the promise of political support, there were no strings attached to these grants.
hospitals receiving funds were not required to make any reports or justify how this money was spent. Concluding that this system was inefficient and corrupt, turn-of-the-century reformers instead initiated a per diem, per capita system of reimbursement to hospitals. After 1898, hospitals were not granted funds unless they reported them to the City Charities department and proved that the appropriations were legitimately earned. Hospitals receiving funds were required to submit data indicating patients’ social class and medical condition and to submit to inspections by city authorities. They had to show that they were providing city-established levels of hospital care, and the city only reimbursed for patient care that fit its criteria.\(^{58}\)

In true progressive style, the reformers who initiated this new system were convinced they had maximized efficiency and raised standards. As David Rosner has shown, the progress was not as clearly defined from the perspective of the hospitals receiving the monies. Under the old flat grant system, hospitals did not have to worry about how many patients they treated. Since under the new system they were paid on a per patient basis, smaller hospitals could look forward to receiving less city funding than they had in the past. Furthermore, many hospitals did not conform to the model of hospital care that reformers prescribed. Under the revised system, for example, elderly patients might not all be considered appropriate hospital patients if they were not clearly ill.\(^{59}\)

Catholics complained about the uncertainty of the public funding system. The percentage of public funds relative to the maintenance of individual Catholic hospitals varied tremendously among hospitals and from year to year (Table 4.3). In 1873, for example, 80 percent of St. Peter’s revenue was from public sources while St. Vincent’s received less than 8 percent. Still, that figure was high for St. Peter’s: in 1870 and 1903, public revenue accounted for 49 percent and 42 percent of its total income.

Overall, public revenue was inconsistent. Public funding for St. Francis’ fluctuated tremendously too, ranging from 88 percent of income in 1873 to 2 percent in 1892. There was some consistency, however, as to which hospitals received the most public funding. Year after year the same institutions received large amounts (relative to their expenses) while others continually received proportionately smaller sums. St. Vincent’s public funds, for example, were always a significantly lower percentage of total hospital income than St. Francis’ or St. Peter’s. Given the inconsistencies from year to year and the sporadic nature of allotments, public money never entirely supported a Catholic hospital but was one of several ways it survived.
By the turn of the century a number of New York hospitals that had been founded as charity hospitals began to rely more on revenue from paying patients to meet expenses. Most Catholic hospitals had charged patients a fee from the time they first opened, however. While willing to offer free service to those who could not pay, Catholic hos-
pitals almost always expected patients to make some kind of payment. St. Vincent’s, for example, attempted to attract paying patients as soon as it opened. The *Freeman’s Journal* described services at the cost of three dollars a week and also noted that private rooms were available. In 1851, another notice for the hospital said, “Patients desiring it can be accommodated with well ventilated and private apartments.”\(^{61}\) A majority of patients treated at St. Vincent’s Hospital before the turn of the century paid something toward their care though there were proportionately more paying patients in the hospital’s earlier years. In eleven of the years between 1863 and 1900 where such figures are available, about half the patients at St. Vincent’s paid something toward their care; at least 30 percent paid in full.\(^{62}\)

Payment was never a requirement, however, and the procedure was not standardized or regulated. Furthermore, fees varied among Catholic hospitals, reflecting the different patient population at each institution. Sisters determined what their patients would be able to pay based on what they knew about them. In 1897, St. Francis’ charged five to ten dollars a week, depending on services and ability to pay; St. Elizabeth’s, eight to ten dollars; and St. Vincent’s, fifteen dollars a week.\(^{63}\)

Historians have different interpretations of the trend to charge patients for their hospital care. David Rosner explains how after the changes made in the disbursement of public funds to private hospitals in New York in the 1890s, those of very meager means were required to pay for care they once could receive free.\(^{64}\) Charles Rosenberg suggests that constant financial worries may actually have actually promoted a comparatively favorable image of Catholic hospitals in the eyes of immigrants. Referring to the “dignity of pay” in Catholic hospitals, he notes how even partial payment might lessen the humiliation attached to the need for hospitalization. Catholic hospital patients who paid something toward the cost of their care could view themselves differently from other hospital patients entirely dependent on the institution’s charity. The long-term result was that hospital care lost some of the stigma of pauperization that opened up the possibilities of hospitalization to a broader segment of the population.\(^{65}\)

Even though many patients at Catholic hospitals were paying for their treatment, named donors still liked to refer to their contributions in terms of charity and stressed a class distinction between patients and donors. At the turn of the century when a majority of patients paid something toward the cost of their care at St. Vincent’s and a third paid the entire cost, the Ladies Aid Society still described their work as being “towards the comfort of the destitute sick,” and a patron’s gift of
dinner and fruit for “her ward” in 1906 deliberately conveys an air of benevolent paternalism.\textsuperscript{66}

Sisters were raising money in new ways too, for several different, but related, reasons. First of all, sisters recognized that they needed to publicize their hospitals outside the Catholic community to obtain public funds. Fairs continued but not to the same extent that they had in the nineteenth century. While earlier fairs were touted for their financial success, later ones were considered successful public relations efforts. A fair held for St. Vincent’s in 1906 was praised because of the money raised but also because it was “distinctly useful in bringing the Hospital prominently before the public.”\textsuperscript{67}

Second, the Catholic community was changing; it was not exclusively or overwhelmingly poor or even working-class. Fundraising efforts reflected this change. Lay women continued to be involved in hospital fundraising—in fact their numbers grew—but they were organized more formally in hospital auxiliaries, which numbered members in the hundreds by the turn of the century. More genteel events like card parties, teas, and luncheons supplanted the fairs as the primary functions organized by women and reveal the changing class composition among Catholic New Yorkers. An invitation to a tea sponsored by St. Vincent’s Ladies Auxiliary at the Waldorf Astoria is a significant change from the boisterous, fun-for-all fair women organized in 1856.\textsuperscript{68}

Lay women’s hospital work remained gender specific. Publicity surrounding the opening of Mary Immaculate in 1904 noted that its women’s auxiliary was organized to raise money for general purposes but also specifically to furnish women’s wards for the new hospital. There was another change as well in a stronger emphasis on the religious component of women’s participation in hospital fundraising. While hospital administrators had always stressed the benevolent effect of gift-giving on donors, the theme of personal spiritual fulfillment was increasingly incorporated into the activities of the ladies’ auxiliaries. St. Vincent’s Ladies Auxiliary in 1906, for example, conducted a retreat for members to arouse “the noblest impulses of the soul” and acquire the strength “to attempt better things for God and his Beloved Poor.”\textsuperscript{69}

In 1905, St. Joseph’s Hospital in Far Rockaway opened in startling contrast to the earlier and quieter foundations that reflected the routine, domestic qualities sisters sought to impart to Catholic hospital care when they first began. St. Joseph’s was christened with a celebration even before the hospital was ready to receive patients. Music, speakers, and refreshments on the hospital grounds heralded the occa-
sion, and donations were presented and eagerly accepted. In the midst of the festivities a patient presented for admittance was sent off to another hospital for treatment—clearly other requirements had priority that day. This was a public occasion in a way earlier hospital openings were not.70

Fundraising efforts and support for St. Joseph’s came from beyond the surrounding Roman Catholic community. St. Joseph’s supporters continued Catholic hospital tradition and organized a fundraising fair in 1907, but unlike the Crystal Palace Fair organized for St. Vincent’s in Manhattan in 1856, most of the booths at St. Joseph’s fair were organized by town, not parish. Fairgoers saw town names on banners instead of parish ones—Far Rockaway, Lawrence, Cedarhurst, Woodmere, and Edgemere—and attended a community, rather than a church, event.71

St. Joseph’s origins differ from other hospitals founded for a particular Catholic group. Still, its history shows how hospital funding had changed. In terms of their finances and fundraising techniques, Catholic hospitals were moving way from their immigrant roots.

Throughout the late nineteenth and early twentieth centuries, individual and group contributions were sporadic, dramatically different in individual amounts, and rarely fixed or guaranteed in any way. At some hospitals, pay patients were an important source of support, at others less so. Public funding varied among hospitals and was particularly crucial to some. Overall, Catholic hospitals survived because of the commitment of the sisters and their remarkable ability to sustain support for their work.

As Catholics liked to point out, even church critics recognized that the sisters did not receive salaries. Almost all literature about Catholic hospitals noted that “Sisters serve for life, with no expense to the Institution save board, the Motherhouse . . . furnishing their apparel.”72 The Catholic press often reminded readers that “sisters receive no compensation” and compared this to the cost of maintaining a staff at other hospitals.73 Catholic World, for example, noted in 1868 that the orderlies at Bellevue Hospital received fourteen dollars a month while Sisters of Charity served for free.74

But this focus on the sisters’ relatively low labor costs overshadowed the fact that the religious communities that ran hospitals were also responsible for the sisters who staffed it. Although nonsalaried sisters saved a hospital money on its expense sheet, their religious communities supported them and the hospitals out of the same resources, which also went toward other institutions and sisters as well. Other hospitals

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did not pay much in the way of nursing staff salaries anyway. As noted in chapter 3, until the last part of the century, lay nurses in other hospitals were often patients themselves and were, at best, miserably paid. By 1900, nonsalaried student nurses staffed hospital wards in most hospitals, including Catholic ones.75

Hospital sisters were, of course, much more than cheap available labor. Comments that emphasized the sisters’ frugality, their service without compensation, or even their saintliness, which put them beyond such mundane concerns as money, failed to recognize the deliberateness of their efforts and the skill and expertise that went into their hospital work, including fundraising. Their financial ability did not surprise those who knew them best. When Sister Mary David, founder and superior at St. John’s Hospital, paid off the hospital’s mortgage in 1901, the bishop wrote her that bank “officials have asked several times when the hospital was going to draw on them for the rest of the amount the bank agreed to advance” and noted that he himself was “no less surprised to have this indebtedness paid off.”76 His astonishment was probably overstated; he knew how capable the sisters were.

Since little hospital support was ever fixed or guaranteed, hospital sisters always characterized their finances as precarious. The message the sisters sent out in annual reports, in the Catholic press, and throughout the immigrant world of New York was that their hospitals teetered on the edge of financial insolvency. It was an efficacious tactic. While they did struggle at times for lack of money, their pleas solicited responses: the public clearly wanted these hospitals to continue and were willing to help financially, either as contributors or paying patients. Sisters’ fundraising reflected enormous skill; it would not be an overstatement to say that it rivaled their nursing as the critical factor in their success. That skill was rarely discussed in the same glowing terms that usually described their nursing—in fact, it was hardly mentioned at all—but that was of no consequence to sisters. Their concerns were about expanding and improving their hospitals.