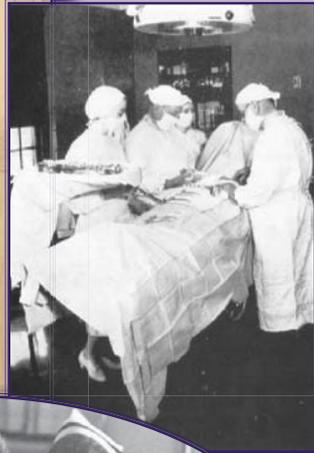


# MAINE HOSPITAL ASSOCIATION



**CARING FOR OUR COMMUNITIES  
FOR 75 YEARS**



**MHA**



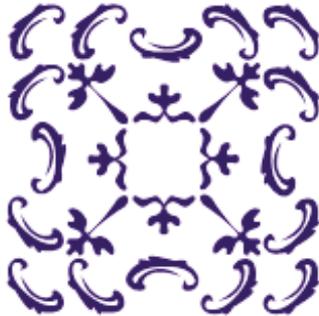
**Maine Hospital  
Association**

## Acknowledgements

June, 2012

This remembrance would not have been possible without *The First 50 Years, 1937-1987*, a Maine Hospital Association history written 25 years ago by Leann R. Diehl. As she correctly noted at the time, "Memorabilia is discarded in the guise of house cleaning. Records, brochures, presentations, letters are tossed in the wastebasket, lost to all who follow." Thankfully, her anniversary book survived the purges and now lives on the MHA Web site at [www.themha.org](http://www.themha.org).

We also would like to thank the hospital public relations directors and archivists who graciously submitted photographs for inclusion in this publication. We wish we had room for all of the historic photos.



### On the Cover

Clockwise:

- Nurse at the china closet at Waldo County General Hospital.
- Operating room in the late 1920s or early 1930s at Goodall Hospital.
- Carolyn Grant and Blanch Arnold in the hydro room at Eastern Maine General Hospital, 1927.



# 1937

The year was 1937 and the country was still struggling to get out of the grip of the Depression. Unemployment continued to drop, but it still remained distressingly high at 14.3 percent. The recovery brought about by the New Deal was sputtering.

As Franklin D. Roosevelt was about to begin his second term as president, employers and employees became subject to a tax of one percent of wages on up to \$3,000 a year for old age insurance. Lump-sum payments were first made payable to eligible workers, their survivors or their estates. The Federal unemployment tax payable by employers of eight or more was increased to two percent of payroll.

1937 was the year the flying ship Hindenburg exploded while attempting to hook itself to a mooring post in New Jersey. It was also the year that aviator Amelia Earhart disappeared.

And, in a grim prelude of the carnage to come, the Buchenwald concentration camp opened in Germany.

In Maine, the FBI shot and killed members of the infamous Brady Gang on Center Street in Bangor after the gangsters tried to buy a machine gun at a

## PRICES IN THE 1930s

Average cost of new house:	\$4,100.00
Average wages per year:	\$1,780.00
Price of a gallon of gas:	10 cents
Average monthly rent:	\$26.00
Price of a loaf of bread:	9 cents
Price of a pound of hamburger:	12 cents
Average price for new car	\$760.00
Toothpaste	35 cents



local sporting goods store. The gang was wanted for multiple murders and robberies in the Midwest.

And 1937 was the year when a group of hospital administrators began meeting formally to discuss dismal rumors about a decrease in state funding for indigent care.

Although Maine had quite a few hospitals by the early 1900s, most were housed in cottages on the main streets of small towns. With only a few beds and limited equipment, the expectation was that only the sickest patients would be admitted and only as a last resort. Everyone else would stay home, send for the doctor, and, if the illness were severe, hire a round-the-clock nurse.



*Presque Isle's first hospital, on Second Street next to what is now City Hall. The hospital opened on April 8, 1912. During its first year of operation, the hospital served 359 patients. The hospital, now The Aroostook Medical Center, is celebrating its 100th anniversary this year.*



Impoverished people who couldn't afford the luxury of a nurse had no choice but to go to the hospital. In those times, the status symbol was to convalesce at home. Hospital stays marked a person as poor.



*Henrietta D. Goodall*

When hospitals were first established, local communities and wealthy patrons provided much of the money both for the buildings and the expense of caring for charity patients. Goodall Hospital in Sanford and CA Dean Memorial Hospital in Greenville still bear the surnames of the early benefactors who established the hospitals in part to care for their workers.

These early hospitals were founded on the premise that care should be provided to all, regardless of their ability to pay. If a patient didn't have cash, he or she was encouraged to negotiate or barter. It wasn't unusual for a hospital administrator to accept a basket of potatoes or a couple of chickens in lieu of payment. Patients set up payment plans, paying a little each week until they paid their debt.

But by the 1930s, treating patients who couldn't pay was becoming a hardship. Hospital costs were increasing—staff expected higher wages, new equipment was available, hospital space was getting cramped and new buildings were needed. And, the stock market crash and the Depression that followed meant there were many more people who couldn't afford to pay their bills.

And so, in the 1930s, hospital leaders in Maine began to look to each other for a solution to the growing problem of indigent care. In 1930, the Portland Press Herald reported that an informal hospital association had been formed in Maine because of the “inadequacy of the state's annual appropriation to hospitals for charity care.”



Although the state had been appropriating funds for hospitals for decades, the money was usually for the maintenance of buildings.

As early as 1913, the Maine Legislature enacted laws to regulate charity care. In 1917, many hospitals in the state were given a lump sum for “Care, Support and Medical or Surgical Treatment of Indigent Persons.” Bath City Hospital received \$2,250; Bar Harbor Hospital, \$2,000; Augusta General, \$6,500; and York Hospital, \$1,200. The law stipulated that hospitals had to secure additional funds from municipalities or private donations to remain eligible for state aid.



*The surgical ward at Maine General Hospital in Portland, circa 1895.*

*Photo courtesy Maine Medical Center Archives*

In 1931, the state appropriated an annual lump sum of \$160,000 to be distributed to hospitals on a per-case basis, not to exceed \$2.50 a day. The sum of \$160,000 was the allocation for several years. By 1938, 42 hospitals were dipping into the state aid fund.



Although hospital leaders had been meeting since 1930 to discuss their concerns, formal meetings were not held until August 18, 1937. The focus of this first recorded meeting was to discuss rumors of a threatened decrease in the state budget. Because of poor economic conditions, state government was being asked to cut its budget by 5 percent.

The first recorded annual meeting of the Maine Hospital Association was in December 1937 at Central Maine General Hospital. The treasurer's report shows \$57.15 with 12 hospitals as members. Dr. Joelle Hiebert was president. Not surprisingly, the focus of the discussion was indigent care. Also on the agenda were nursing education and group hospital insurance.

Group hospital insurance created the most heated discussion. Blue Cross had been in existence for less than 10 years and was spreading across the nation. Maine hospital leaders were cautious about this new payment system. After much debate, MHA endorsed the plan and decided to assist Blue Cross in its membership drive.

In 1939, MHA developed and approved by-laws to become a member of the American Hospital Association and the New England Hospital Assembly.

By this time, 29 hospitals were MHA members along with 95 individuals. MHA leaders agreed that regional council meetings would provide a more productive way to share information.

Although MHA members agreed on the need for advocacy in the Legislature to increase state aid, the real legislative role of the Association would not take hold until the 1940s.

# 1940s



On April 9, 1940, MHA issued its first call-to-arms: hospitals were urged to talk with their legislators to “enlighten them regarding hospitals and hospital services.” These local conversations with legislators laid the framework for more aggressive campaigns.

Once again hospitals were grappling with the problem of funding indigent care. Financial losses for treating state aid patients were beginning to mount. Hospitals wanted relief. As the first step, hospitals were urged to continue to talk to legislators to tell them the true story regarding state aid.

In 1940, the winds of war were beginning to be felt in the United States. World War II raged in Europe. Although, the United States wouldn’t join the war until after the attack on Pearl Harbor on December 7, 1941, there was growing concern that America would be drawn into the fighting, bringing foreign troops to the United States.

In Maine, the threat of war was felt particularly acutely. The coastline was vulnerable and Loring Air Force Base in Aroostook County was an inviting target.

As the nation prepared for war, MHA prepared for its own battle by hiring its first representative, attorney Carroll Perkins. His responsibility was to prepare a report on the inadequate levels of state aid. The report, to be submitted to the state budget committee, would represent the first organized effort by Maine’s community hospitals to initiate political change.

The Association’s first comprehensive study of hospital finances told a now familiar story:

Patients receiving state aid increased 38.8 percent between 1935 and 1940 but state allocations did not. Hospital costs increased 25 percent per patient day with the average cost per day of \$5.31. Hospitals were losing a total of \$500,000 on state aid patients each year.



By the end of 1941, attention would shift from local charity care problems to more global concerns. Two days after the Japanese attacked Pearl Harbor, MHA received a terse telegram from Washington, D.C., Civil Defense Headquarters. The message? To immediately establish medical field units that would hold weekly drills. Reserve nursing and medical staff were to be organized, community volunteers would be used where necessary. The nation was at war.



*AWaldo County General Hospital nursing graduate, 1941.*

By 1942, Maine's hospitals had their civil defense programs well in hand. When an alert siren sounded, hospital windows were blackened, staff fire brigades manned their posts, head nurses dispensed flashlights, and electric generators stood ready to provide emergency lighting in the operating room.

Travel restrictions and gas rationing forced Americans to stay close to home. Regional hospital councils were postponed. Annual meetings were held by mail.

But the Association was still instrumental in the passage of two important state bills—the Hospital

License Bill, setting minimum standards for hospitals, and the Hospital Survey Bill, as required by the first part of the Hill-Burton Act. The Hill-Burton Act gave hospitals, nursing homes and other health facilities grants and loans for construction and modernization. In return, they agreed to provide a reasonable volume of services to persons unable to pay and to make their services available to all persons residing in a facility's area. Because of this law, the construction of new hospital facilities quadrupled by the end of the 1940s.



As the war drove the cost of raw goods skyward, hospital costs followed suit, increasing about 40 percent during the war years. Contracts that hospitals had with insurance companies were now underfinanced. State aid was paying too little for an increasing welfare patient load.

The war brought both tragedy and triumph. The same miracles of technology that designed new ways to kill also brought new ways to heal. Antibiotics, heart surgery, burn treatments, radiology—all brought home from the battlefields—sparked a revolution in medicine and patterns of care.

But the revolution came with a price and someone had to pay the bill. To combat declining income at a time when costs were climbing, the MHA created a Committee on Review of Charges to Agencies Purchasing Hospital Services. The Committee found that on all fronts—state aid, Veteran’s Administration, Blue Cross and other insurance plans—hospitals were being reimbursed for less than their actual costs.

And indigent care had become an emergency situation. Because smaller hospitals had few options for private endowments, most indigent care had become the burden of the large hospitals.



*Franklin County Memorial Hospital, 1946.*

# 1950s

Compared to the Depression and war years, the 1950s were a golden age. Returning soldiers got jobs, got married, had babies. The economy was booming and the middle class was thriving.



*Nurses tending to babies in the nursery at Mercy Hospital*

Still, hospitals continued to grapple with the problem of caring for indigent patients. In 1950, MHA undertook a major public relations push to influence the Legislature. Under the leadership of MHA President Pearl Fisher, RN, 90,000 booklets explaining the need for increased state aid were published and distributed statewide. The booklets were signed by hospital supporters and sent to legislators.

Not every MHA member agreed with the tactic, but it met with success. State aid appropriations were increased for the first time in years, to \$1.8 million to be distributed over two years.

Along with increased state aid, though, came increased state regulations. New rules created new forms, new accounting methods, new reimbursement ratios. Complexity was the new bottom line.



*Tending to a patient in an iron lung at Maine General Hospital.  
Photo courtesy Maine Medical Center Archives*

MHA responded by becoming even more politically involved. In 1953, the MHA hired its first registered lobbyist—Frank Curran of Eastern Maine General Hospital and chair of the MHA Legislative Committee. Mr. Curran is credited with the success of the state aid bill. Despite a loss of tax revenue, the state had agreed to increase charity care to pay 60 percent of actual costs.

Annual MHA meetings shifted during this time to reflect the complexity of the new health care environment. Gone were the presentations on hospital hospitality. New topics included third-party payers, uniform accounting, state finance and welfare reimbursement.

In 1955, the push by hospitals to increase state aid hit an all-time high. In the first recorded *MHA Information Bulletin*, a predecessor of today's *MHA Friday Report*, hospital trustees, auxiliaries and staff were asked to get involved in the legislative process. Administrators were given scorecards to tabulate how many lawmakers were contacted and what their responses were to increasing state aid.



At this point, the Association still had no paid staff and an annual budget of only \$4,000. The bulletins, lobbying and planning were the sole responsibility of volunteers.

By 1959, MHA leaders realized that hospital complexity was making it difficult to stay on top of legislative action. With the continuing increase in hospital costs, state aid had slipped to paying only 35 percent of actual costs.



*Setting the cornerstone at Calais Regional Hospital in 1954.*

# 1960s



If the 1940s are remembered as the decade when world turmoil drew the country's attention outward, the 1960s would be the time when we looked in the mirror and didn't like what we saw.

In the decade of television and space travel, of sex, drugs and rock 'n' roll, of revolution and revelation, public awareness became an instrument of change.

People rallied for civil rights, against the war in Vietnam and in favor of government cures for poverty. As the middle class prospered, there became a growing awareness that fellow citizens were being left behind. Thus, the Great Society was born.

The pillars of this vast social program were Medicare and Medicaid; Medicare for the disabled or elderly, Medicaid for the poor.

Although these government plans would ease one burden, they would spawn an unprecedented set of complex regulations that bound hospitals to the vagaries of politics. Never again would hospitals know the autonomy that they had in the early 1930s.



*Down East Community Hospital community tour, 1964.*



The 1960s saw a great deal of change for the Maine Hospital Association also. After 10 years of debate, the Association hired its first executive director, Wilfred A. Poirier. He would help hospitals face a growing list of problems.

Because technology was advancing so quickly, finding trained personnel to use the new equipment was getting more and more difficult. Medicare regulations in their infant stage were complex. Hospitals were confused and overwhelmed. And, of course, state aid for charity care continued to be inadequate.

Computers first arrived on the scene in this decade too. And, like many new programs and technology, they would solve one problem but create others. While data collection was important for analysis and planning, just who should be privy to the information was the focus of many heated debates.

Legislative initiatives on health care were exploding in this decade. Where before hospitals addressed three or four bills, in this time of scrutiny the MHA legislative committee reviewed 50 to 100.

With taxpayers now a partner in financing health care, public interest in the size of hospital bills became a media event. Reports of soaring costs made hospitals front page news. The MHA stepped up its public relations campaigns and gathered data about the true cost of treating patients.

A major advertising event was launched by the Association to influence the Legislature to increase state aid by \$4 million. And the workload increased—necessitating the addition of an assistant executive director to the MHA staff.

The buzzword for the final years of the 1960s was planning—health planning to best meet the needs of the community. The goal of quality health care at an affordable price for everyone, was crystallized as a goal worthy of planned attention.



*Mount Desert Island Hospital before 1961.*

Health care had entered a new era. No longer was it assumed to be the privilege of status. Many now believed health care was now a universal right .



*Ambulance outside Franklin Memorial Hospital.*



# 1970s

Described as the "Me Generation," the 1970s marked a turning inward. Perhaps the social conscience of America had been appeased by the giant steps of the Great Society.

Now public attention focused on self. Books to help us "pull our own strings" made the best-seller list look like a psychologist's library.

In Maine, hospitals debated the merits of Certificate of Need versus rate review. At MHA, Wilfred A. Poirier resigned and was replaced by Fletcher Bingham, Ph.D.

The Bennett Amendment in Congress initiated the Professional Standards Review Organization, the forerunner of today's quality improvement organization, and added yet another layer of regulation to the growing maze of Medicare.

The need to maintain the standards of personnel in an era of incredible technological change prompted MHA leadership to create the Research and Education Trust Fund in 1974. The Fund was designed to train hospital personnel, sponsor research for hospital administrative improvements and educate hospital staff about the shifting sands of hospital regulation.

As hospital costs continued to skyrocket, cost containment moved to the front of both state and federal legislative programs. In response,



*Ivie Avery, now Calais Regional Hospital's longest serving employee, pictured here in the 1970s.*



*Surgery at Eastern Maine Medical Center, 1974.*

the Association developed a Cost Containment Program to gather and disseminate ideas for holding down hospital costs.

In this environment, it's easy to understand that finances became one of the major priorities of the Association and prompted the Executive Committee to move quickly to expand the MHA staff.

In the 1970s, efforts to control hospital costs were still voluntary. Congress passed legislation asking hospitals to make a special effort to curb spending. The Maine Legislature enacted the Voluntary Budget Review Organization.

But by the end of the 1970s, voluntary would give way to mandatory.

# 1980s

Cost containment took center stage in the 1980s.

In Maine, the first half of the decade saw the creation of the Maine Health Care Finance Commission—the most rigorous cost control regulations Maine hospitals had ever faced. By the start of the second half of the decade, hospitals began an aggressive, decade-long battle to repeal the Commission and its byzantine rules.

The 1980s saw the creation of the 17-member Blue Ribbon Commission to Study Health Care Cost Controls in Maine. The Commission was tasked with recommending the most appropriate form of health care regulation necessary to ensure that the goals of quality, accessibility and affordability were met.

It would be the first of many such commissions.

The 1980s also saw the first tentative steps toward publicly reporting quality data. The Health Care Financing Administration (HCFA) started issuing mortality statistics in 1986. MHA embarked on a public relations campaign to explain why mortality data wasn't a good way to measure hospital quality.



*The rehab facility at Webber Hospital, now Southern Maine Medical Center, in the 1980s.*

In 1987, MHA celebrated its 50th anniversary. That year, the Board of Directors created a Task Force on Public Information to recommend a comprehensive communications plan to enhance the public's image of hospitals and support the Association's legislative and regulatory agenda.



The late 1980s also saw more Maine hospitals becoming smoke free. Surveys done in 1973 and 1983 reported no smoke-free hospitals. By 1988, two hospitals were completely smoke free, four had strict smoking policies, only allowing certain patients to smoke under specific circumstances, and a fifth was about to implement such a policy. In 1973, 17 hospitals sold tobacco products. In 1983, that number had dropped to three and by the 1988 survey, no hospitals sold tobacco. By 1989, the Legislature passed a law mandating that hospitals become smoke-free, though the law allowed patients to smoke in their rooms if they had a doctor's note. Maine's law was the first of its kind in the country.

As the 1980s drew to a close, MHA was concerned about possible changes to the state's Certificate of Need law, Medicare cuts, and Medicaid cuts.



*York Hospital CEO Jud Knox chatting with MHA charter member Pearl Fisher at MHA's 50th anniversary celebration in 1987.*

# 1990s

The 1990s began with one of the deepest recessions in history, hitting state government coffers and thus the Medicaid program. In fact, 1991 was highlighted with the first, and so far only, state government shutdown, the result of a battle over workers compensation reform between Republican Governor John McKernan and the Democratically controlled Legislature.



*Bumper stickers, like the one above, were part of MHA's legislative campaign against Tax & Match.*

As part of the eventual budget and workers' compensation deal, the first hospital tax and match program was adopted as a way to stave off large-scale Medicaid cuts. The program worked well at first but then, as the federal government began to clamp down on such gimmicks, tax and match came off the tracks. In 1995, hospitals were faced with a potential \$110 million excess tax. Hospitals fought back, embarking on one of their largest legislative campaigns to fight against the "Sick Tax." Over half of the excess tax was relieved as a result of their efforts. More importantly, though, the two-year phase out of the program began.

In the same 1995 legislative session, the Maine Health Care Finance Commission (MHCFC) was repealed, thus ending a dozen years of hospital financial regulation. The combination of MHCFC reforms that were passed in 1989, which loosened the regulatory restrictions, and the advent of managed care, diminished the effectiveness and relevance of the Commission. Many states across the country came to the same conclusion during that period: Regulation wasn't the answer to health care costs.

When MHCFC was eliminated, a new agency to collect health care data, was formed. The Maine Health Data Organization (MHDO) was formed in 1996 to maintain and expand the health information databases of MHCFC. The MHDO was mandated to create and maintain uniform, objective, accurate and comprehensive health care information databases



and to develop and implement data collection policies and procedures for the collection, processing, storage and analysis of clinical, financial and restructuring data.

As the economy turned around through the mid to late 90s so did state budget surpluses. The easing of state cuts to Medicaid followed. Much of the policy and advocacy activities turned to the advent of managed care. As managed care took hold with its promises to keep people well and out of the hospital, it quickly became the villain in the eyes of providers and patients alike. It wasn't long before managed care as we knew it was on the ropes in legislatures across the country and in the Congress itself. Patient Protection Acts were passed in many states to counter many of the practices that accompanied managed care.

As the result of a shift from regulation to other methods of cost containment, such as managed care, hospitals began to collaborate more than ever. It was in the late 90s that hospital and health care systems began to form in earnest, forever changing the way hospital care is delivered in many parts of the state. As the result of these changes, MHA found itself spending more time clearing legislative and bureaucratic hurdles that stood in the way of collaboration and cooperation.

As the 1990s drew to a close, hospitals and other technology-dependent industries were scrambling to make sure their computers wouldn't be confused by the millennium change. Dubbed the Y2K problem, computer programs all over the world were upgraded so that dates had four-digit years, instead of two-digit years. There were gloomy predictions that January 1, 2000 would bring disaster as computers would be unable to handle dates with years ending in 00. Little did anyone know that the disaster would be more than 18 months after the turn of the century.

# 2000s

September 11, 2001 was a beautiful day both in Maine and in New York City when the first plane hit the World Trade Center. As a horrified nation watched the events of that day unfold, hospitals in Maine and elsewhere up and down the East Coast readied themselves for those injured in the attacks. Sadly, the death toll in the towers was so high, there were few injured to treat.

The attacks of September 11 brought home the lesson that unexpected disaster can happen at any time. Hospitals in Maine joined with first responders and other emergency management professionals to work on emergency plans.



*Ambulances outside Penobscot Valley Hospital.*

The first decade of the 21st century also was marked by health care reform in Maine. In 2003, the Maine Legislature passed Governor John Baldacci's Dirigo Health Reform Act. The reform bill sought to address cost, quality and access. Along with DirigoChoice, it created the Maine Quality Forum, a state health plan, and put forth measures supporters said would reduce the growth of health care costs in Maine. Those measures included asking hospitals to voluntarily cap their annual cost increases at 3% per



year and their operating margins at 3.5% per year. The law also further expanded the state's Medicaid program.

Additionally, the law created the Commission to Study Maine's Hospitals, which was supposed to:

- Study the comprehensive role of Maine's hospitals and evaluate them in the context of the State Health Plan priorities;
- Collect and evaluate data on overall hospital expenditures, cost efficiencies, the availability of health care services; and
- Determine opportunities/public policies to advance changes in hospital roles, to encourage collaboration and to improve affordability.

MHA had two hospital representatives on the Commission, and the Association agreed with 14 of the 20 recommendations in the



*MHA's two representatives to the Hospital Study Commission, Scott Bullock (left), president of MaineGeneral Medical Center, and John Welsh (right), CEO of Rumford Hospital, get some good-natured ribbing from MHA President Steven Michaud (center), at MHA's Small or Rural Hospital Conference in 2005.*



majority report. However, MHA strenuously objected to six of the recommendations, saying they were not only inappropriate because they failed to address the primary drivers, but they had the potential to jeopardize access and quality. MHA issued a minority report that proved successful with the Legislature, thus preventing many of the most objectionable recommendations from being enacted.

By the end of the decade it became clear that Dirigo had not lived up to the expectations of its authors. Proponents of the legislation hoped it would cover 31,000 uninsured Mainers in its first year and ultimately cover 120,000 people in five years. However, at its height, Dirigo covered only about 16,000 people and many of those were part of the Medicaid expansion.

It was that Medicaid expansion that led to the great MHA campaign of the decade.

In an effort to provide health insurance coverage to more Mainers, the Legislature began expanding eligibility to Maine's Medicaid program, to the point that more than 1 in 4 Mainers received MaineCare benefits. As the state's Medicaid rolls grew, so did the level of hospital utilization. Unfortunately, the state's monthly prospective interim payments to hospitals to treat these patients fell far short of the actual cost of treating them. At the end of each year, the state owed millions to hospitals—money it could not and would not pay. At the height of the crisis, the state owed hospitals \$550



million going back four years.

To persuade the state to pay hospitals the money they were owed, MHA embarked on a campaign called Settle Up. MHA staff crisscrossed the



state meeting with editorial boards, speaking before civic organization and talking to lawmakers to explain the problem. The campaign worked, and settling the state’s MaineCare debt to hospitals became a budget priority. Gradually, the debt is being paid off.

Hospital quality was also a theme in the 2000s. With the publication of “To Err is Human,” the Institute of Medicine’s seminal report that raised awareness of medical errors, both the federal and state governments became more active in ensuring that hospitals provided high-quality care and pushed for public reporting of quality data. Maine hospitals,



*Pen Bay Medical Center in 2007*

through MHA, took a lead in this area, releasing in 2004 “Caring for Our Communities,” a report that showed each hospital’s performance in quality and patient satisfaction measures. Eventually, the Centers for Medicare & Medicaid Services’ public reporting project “Hospital Compare” rendered “Caring for Our Communities” redundant.



*Southern Maine Medical Center CEO Ed McGeachey and former President George Bush at the the dedication of the Dorothy Walker Bush Emergency Department Pavilion in 2005.*

As the decade ended, it became clear that Dirigo wasn't providing coverage to enough Mainers to justify its cost. Annual squabbles about the payment structure proved costly for insurance companies and state government. As the cost of coverage in the state continued to grow, pricing many individuals and small businesses out of the market, observers fretted about a death spiral in the health insurance industry.

A national solution was needed.

# 2010s



Two years into the 21st century's second decade, it's clear that health care reform will be one of the themes. The passage of the Patient Protection and Affordable Care Act of 2010 made major changes to the nation's health care delivery and insurance system. As of this writing, the Supreme Court has yet to decide on one of the law's most controversial aspects, the requirement that individuals buy health insurance or pay a penalty.

However, even if the law is overturned, it seems likely that certain aspects of it, such as value-based purchasing, will remain part of the system. Whether changes in the health insurance system will make private insurance affordable enough for more workers to purchase it is still unknown.



*The new MaineGeneral Medical Center under construction. The hospital is scheduled to open in 2014.*



The hospital administrators who gathered in 1937 to found the Maine Hospital Association would surely be amazed by the size and scope of modern hospitals. Yet, many of the same problems that prompted them to create the Association—a growing number of people who cannot pay for care, a state government that is unwilling or unable to pay for the full cost of caring for the poor—are still with us and have only been magnified by modern medicine.

One thing is clear: No matter what the future holds, the Maine Hospital Association will continue to be a voice for hospitals, allowing them to continue to care for their communities.



*A young patient at the Donald S. Walker Health Center in Liberty, part of Waldo County General Hospital.*

MHA MEMBERS  
1939



Augusta General Hospital  
Bath Memorial Hospital  
Blue Hill Memorial Hospital  
Brunswick Hospital  
Cary Memorial Hospital, Caribou  
Central Maine General Hospital, Lewiston  
Children's Hospital, Portland  
Eastern Maine General Hospital, Bangor  
Elm City Hospital, Waterville  
Franklin County Hospital, Farmington  
Gardiner General Hospital  
Henrietta D. Goodall Hospital, Sanford  
Knox County Hospital, Rockland  
Leighton's Private Hospital, Portland  
Madigan Memorial Hospital, Houlton  
Maine Eye and Ear Infirmary, Portland  
Mount Desert Island Hospital, Bar Harbor  
Presque Isle General Hospital  
Queen's Hospital, Portland  
Redington Memorial Hospital, Skowhegan  
Rumford Community Hospital  
Sister's Hospital, Waterville  
State Street Hospital, Portland  
St. Mary's Hospital, Lewiston  
Thayer Hospital, Waterville  
Waldo County Hospital, Belfast  
Webber Hospital, Biddford  
York Hospital



# MHA MEMBERS 2012

The Acadia Hospital, Bangor  
The Aroostook Medical Center, Presque Isle  
Blue Hill Memorial Hospital  
Bridgton Hospital  
Calais Regional Hospital  
Cary Medical Center, Caribou  
Central Maine Medical Center, Lewiston  
Charles A. Dean Memorial Hospital, Greenville  
Down East Community Hospital, Machias  
Eastern Maine Medical Center, Bangor  
Franklin Memorial Hospital, Farmington  
Goodall Hospital, Sanford  
Houlton Regional Hospital  
Inland Hospital, Waterville  
Maine Coast Memorial Hospital, Ellsworth  
MaineGeneral Medical Center, Augusta & Waterville  
Maine Medical Center, Portland  
Mayo Regional Hospital, Dover-Foxcroft  
Mercy Hospital, Portland  
Mid Coast Hospital, Brunswick  
Miles Memorial Hospital, Damariscotta  
Millinocket Regional Hospital  
Mount Desert Island Hospital, Bar Harbor  
New England Rehabilitation Hospital of Portland  
Northern Maine Medical Center, Fort Kent  
Parkview Adventist Medical Center, Brunswick  
Pen Bay Medical Center, Rockport  
Penobscot Valley Hospital, Lincoln  
Redington-Fairview General Hospital, Skowhegan  
Rumford Hospital  
St. Andrews Hospital, Boothbay Harbor  
St. Joseph Hospital, Bangor  
St. Mary's Regional Medical Center, Lewiston  
Sebasticook Valley Health, Pittsfield  
Southern Maine Medical Center, Biddeford  
Spring Harbor Hospital, Westbrook  
Stephens Memorial Hospital, Norway  
Waldo County General Hospital, Belfast  
York Hospital

# MAINE HOSPITAL ASSOCIATION



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