BACK TO THE POORHOUSE: CLEVELAND CITY/METROPOLITAN GENERAL HOSPITAL, 1889–1990

City Hospital does not receive the more intelligent American girl who journeys from her native town to the city where she can remain in a safe retreat, but instead gathers largely the less experienced girls of foreign parentage who work up to the last minute in pregnant conditions and then in desperation turn to the city for help.

This comment in a 1914 City Hospital annual report is obviously about unwed mothers, the desperate and “less experienced” mothers delivered at this public facility. The “more intelligent,” although probably no less desperate, women might have found shelter at one of the maternity homes or hospitals. But as these private facilities provided services to fewer and fewer dependent women, the public hospital, once the city poorhouse, again became Cleveland’s largest single provider of medical services to unwed mothers.

Throughout the twentieth century responsibility for poor relief and health care shifted from the private to the public sectors, a change accelerated by the Great Depression. All relief programs were designed to penalize unmarried mothers, but Cleveland’s City Hospital best illustrates the public intolerance for women who were not only sexually delinquent but poor and black.

As the story of Cleveland’s unwed mothers returns to this public institution, all the familiar themes reappear. This hospital’s poorhouse beginnings survived in its continued financial problems and the stigma
attached to its use. Its care for unwed mothers, although publicly funded, retained the intrusive moralism of the private maternity homes. Its few social workers struggled to serve growing numbers of women. Initially the beneficiary of the hospitalization of medicine, City Hospital was the loser after the Depression, when the expense of hospital childbirth compelled once-charitable private maternity homes and hospitals to search for paying clients and to shift indigent patients to City. In the postwar years, growing numbers of black women, denied services by private child-placing agencies and segregated maternity homes, gave birth at this public hospital. And despite increased public spending since the mid-1960s, unwed mothers here received what Harry F. Dowling has called “undercare for the underprivileged.”

The Relief of Motherhood

Their ever-growing numbers in the work place did not prevent women from simultaneously joining the growing number of those in poverty in the late nineteenth and early twentieth centuries. In response, the public sector expanded its welfare role even though private agencies in Cleveland, as elsewhere, still bore considerable responsibility for dependent mothers and children.

Cleveland’s female labor force mirrored national trends. In 1900, almost 30 percent of working women (14,246) were domestic servants; more than 10,000, however, worked in manufacturing, most probably in the clothing industry, and they represented almost 20 percent of the manufacturing work force. A 1912 investigation by the Consumers’ League of Ohio, the local chapter of the National Consumers’ League, provided more detailed information: twice as many women (7,000) worked in garment-making as in the next largest job category, retail stores; 2,500 worked in “knit goods and weaving”; and 2,000 worked in laundries. Light manufacturing like cigar-making and the hardware industry also employed several thousand. (The Consumers’ League did not concern itself with domestic servants.) The best-paid women earned nine dollars a week as milliners; the vast majority earned six dollars to seven dollars a week. All earned less than what the league considered adequate to support a single woman. A working woman who could barely support herself certainly could not support herself and any offspring for whom she was the primary caretaker.

The solution to the growing destitution and dependence of women and children was mothers’ pensions. The first innovation in public outdoor relief since the seventeenth century, the state-funded pensions were
Back to the Poorhouse

initiated during the 1910s by a generation of policymakers, men and women, who revered motherhood above all female roles. The pensions also gathered wide support from some private charities, women's organizations, and settlement house workers, who wished to remedy the obvious failure of local governments to provide for women and children. For example, in 1910, after Cleveland mayor Tom L. Johnson left office, women without husbands (widows and grass widows) and children remained the vast majority of the city's dependents. Since their forced exodus from the Infirmary, they received only outdoor relief—no cash, and only such groceries, shoes, and fuel as officials thought appropriate, always subject to cutbacks when times were bad or when public corruption was unearthed. Such skimpy and uncertain relief meant that mothers entered the work force and their children entered orphanages, for as welfare reformers well knew, many "orphans" had one or two living parents who were simply too poor to support their own children.

State mothers' pensions were small stipends to allow "suitable" mothers deprived of their "natural [male] breadwinners" to stay at home and raise their children. Pensions could thus be rationalized as payment for a mother's services. Echoing the recommendations of the 1909 White House Conference, a U.S. Children's Bureau pamphlet explained that mothers' pensions would preserve the child's "home life[,] . . . the highest and finest product of civilization." Since private orphanages were often subsidized with public monies, mothers' pensions had an added economic advantage: "It is actually cheaper in dollars and cents to maintain children in their own homes than to support them in institutions," the pamphlet pointed out. The intended beneficiaries were widows indigent through no fault of their own, not unwed or otherwise unfit mothers. Only three states specifically authorized aid to unmarried mothers, and according to a U.S. Children's Bureau official, the fitness of the mother became a crucial criterion in most states, with the result that unmarried mothers were seldom accepted. In order to reassure taxpayers that recipients would be deserving and that no male breadwinner would escape his familial obligations, there was supposed to be careful screening of mothers. In Ohio an applicant's home was investigated to ensure that "the mother [was] the proper person morally, physically, and mentally to bring up the children."

The pensions had greater political than economic significance: their recognition of public obligation for the welfare of mothers and children was more important than the amount of monies distributed or the number of recipients. Most states by 1921 had passed mothers' pension laws, but less than half of the counties in the United States actually distributed the stipends, and few women actually received them. The pensions were
too small to allow a woman, married or unmarried, to support herself and her children, and they probably became merely supplements to other forms of outdoor relief. In 1920 the Cleveland Hospital Council Survey judged mothers' pensions "a partial approach... [T]hey are most inadequate... so inadequate that in numbers of cases, the pension must be supplemented by Associated Charities."\textsuperscript{9}

In 1914 Cleveland's Associated Charities (AC), the descendant of the Cleveland charity organization society and a charter member of the Federation, had a bigger and better trained staff than either the mothers' pension program, administered by the juvenile court, or the city outdoor relief department. Although AC spent less on relief—including food, fuel, shoes, and the Wayfarers' lodge (a shelter for men)—than did the mothers' pensions program, the private agency spent almost as much as the city's outdoor relief department did and served three times as many clients.\textsuperscript{10} Like other charity organization societies, AC was committed to stable family life as a way of preventing destitution and was by no means free of moralistic analyses of dependence: its 1921 annual report listed "character defect" among several causes of poverty.\textsuperscript{11} The organization did not condone illegitimate pregnancy and doubtless made energetic efforts to keep unwed mothers from receiving aid. Nevertheless, most recipients of AC relief were husbandless mothers who described themselves as deserted, divorced, separated, and even unmarried.\textsuperscript{12}

**Public Hospitals**

Like public outdoor relief, public hospitals expanded during the first three decades of this century. Yet, like private relief agencies, private hospitals, still charitable enterprises, also played a significant role in the medical care of indigents. Cleveland institutions illustrate these national trends.

From 1873 to 1889, the number of beds in public hospitals more than doubled, responding to rapid urbanization and the growing demand for medical services. Simultaneously, public "hospital units emerged from their poorhouse shells and evolved into general hospitals."\textsuperscript{13} Cleveland City Hospital officially separated from the Infirmary in 1889.

City Hospital, adjoining the poorhouse buildings, shared the inadequacies of the old facility. Not until 1892 were the open drains for sewage in the basement of the Infirmary's main building replaced by flush toilets. The hospital staff was responsible for the inmates of the Infirmary, which in 1901 housed almost nine hundred persons, both indigent and insane.\textsuperscript{14} Only in 1909, when the city moved the dependent populations
of the Infirmary to Warrensville Township, did the hospital unit become a free-standing facility, still located on the site of the old poorhouse.

In the late nineteenth century, public hospitals struggled to medicalize their staffs and services. In 1891 a full staff of physicians and surgeons replaced the one doctor at Cleveland City Hospital who since 1878 had served both the hospital and the Infirmary patients for twelve hundred dollars a year. The hospital opened its own nursing school in 1897, intending that medical expertise should replace the “slip-shod methods derived from an entire lack of proper nursing education in an institution generally referred to as a poorhouse.” Student nurses served without pay, and the senior nurse earned only twenty dollars a month. The nurses lived in the basement of the Infirmary until a nurses’ home was provided in 1909. In 1914 City Hospital affiliated with the Western Reserve University School of Medicine, which then became responsible for staff appointments.

Although public hospitals were, in theory, medical facilities, their patients’ poverty and serious illnesses meant that these facilities could not abandon their original almshouse functions. They still provided medical care for the most indigent urban dwellers, the chronically ill, and the most contagious patients, including those with venereal diseases and tuberculosis. If patients could pay anything, Cleveland City Hospital sent them elsewhere. In 1920 the hospital superintendent claimed that almost half of its patients “have no homes and must be kept in hospital until ready for work, the only alternative being the Warrensville Infirmary.” Almost 30 percent of its patients remained hospitalized for more than two months.

The public facilities could not take private patients whose fees might cover the rising expenses of the new medical technology and professional staff. Moreover, as with the old poorhouse, taxpayers were reluctant to help those who seemingly were too lazy to help themselves, and hospital administrators, like poorhouse superintendents, had to promise that no undeserving pauper would get free medical care. The resident house physician at City Hospital reported in 1911: “There is no justification or excuse in misplacing dispensation of charity. . . [The irresponsible poor] will not prepare for a rainy day if someone else furnishes the umbrella.” The most important job of the hospital’s first social worker was to ensure that patients were eligible for free care.

Public hospitals could spend far less per patient than private hospitals. Consequently, “most [hospitals] were deficient in several or many areas. In a few the buildings were . . . old, dilapidated, and poorly kept, the wards . . . crowded, unkempt, and disorganized, the drugs and supplies . . . scantily provided, the equipment . . . deficient, outmoded, and
outworn, and the doctors, nurses, and attendants . . . overworked." 19 At City, nurses, house physicians, and staff frequently complained about low salaries, and in 1920, the Hospital Council Survey charged that City was so short of nurses that "the conditions amount to a serious neglect by the city of its solemn responsibility for the humane care of sick and helpless citizens." 20 Three smaller Cleveland hospitals had well-organized social service departments, but City Hospital had "a single worker, who without any definite policy or guidance, has endeavored to mitigate personal or other problems for those few patients she could reach among the thousands passing through that institution yearly." 21 In 1924 the hospital opened a social service department with one professionally trained caseworker.

In 1920 City's 785 beds made it by far the largest hospital in Cleveland. 22 Throughout the decade, City Hospital's occupancy rose steadily, and under an innovative director of public welfare, Dudley S. Blossom, the hospital added several new buildings.

Like other public hospitals and like the poorhouse from which it came, City Hospital also served unwed mothers. The hospital belonged to the Federation Conference on Illegitimacy and attempted to follow acceptable social work procedures. In 1914 the social worker complained about the sexual double standard, as rescue workers often had, but also about current Federation policies: "It seems a strange travesty of justice that we force the woman to keep her child, lest she make the same mistake again, nurse the baby, lest it not have a fair physical start in life; work for less than any minimum wage board ever dreamed of lest our institutions become overcrowded with nameless infants; while the man walks away unmolested." Nevertheless, the worker also believed the mothers were ignorant and irresponsible: "These girls have not made preparation for the coming child or considered its future destination or support. Rather, they have a vague idea that they can leave their babies in the hospital and return soon to their former position." 23 The hospital consequently had few qualms about attempting to discipline these patients.

City Hospital was not primarily a maternity facility. Hospital births were more likely to be at private hospitals or at the maternity homes. The largest of the private hospitals was Maternity Hospital, which opened in 1891 as the Maternity Home, a homeopathic teaching institution specializing in obstetrics, and whose first patients were indigent married and unmarried women. The facility had moral and religious as well as medical goals. The matron was required to "exert a religious influence over the inmates and hold some religious service each day." 24 In 1917 the institution, now an allopathic hospital, not a home, formally affiliated
with the Western Reserve University School of Medicine and expanded its twelve maternity beds to sixty. The hospital also operated several outpatient maternity clinics on the city's East Side, and hospital physicians delivered many of the city's home births. Difficult cases or women who could pay part of their medical fees were referred to Maternity Hospital for delivery.

Throughout the 1920s City Hospital and Maternity Hospital delivered about equal numbers of unwed mothers. However, the differences in treatment and cost indicated that City took the poorest women. Maternity Hospital provided prenatal care through its clinics; City Hospital did not. Maternity charged $4 to $8 a day for private patients; City charged $2.90 "if able to pay." Maternity provided a three-week stay after confinement; City, two weeks.

In 1925 Maternity Hospital enhanced its prestige as a teaching facility and its respectability for middle-class patients when it moved to University Circle on Cleveland's far East Side and merged with Lakeside and Babies and Children's hospitals, creating a large, multiple-service university-affiliated hospital. In 1927 its social service department noted that a "greater number of unmarried mothers [had] been given prenatal care and instruction than in any previous years—53 white patients and 73 colored." The department referred a handful to maternity homes (nine to Talbert) and forty-five to City Hospital. These referrals help to explain why 47 percent of City's 801 deliveries in 1928 were of black women, even though the facility was far from East Side black neighborhoods. By the end of the decade, Maternity Hospital's clinics referred more and more women, probably the poorest patients and many probably black, to City Hospital.

Cleveland City Hospital, 1930–1959

The Great Depression revealed that neither private relief nor private hospitals could care for dependents during serious and prolonged economic disaster. Public agencies came to the rescue, and Cleveland City Hospital became a major maternity facility for unwed mothers.

The Depression came as no surprise to private agencies like Cleveland's Associated Charities. The city's heavy-industry economy had begun to sag and the agency's relief rolls had begun to rise in 1927 and 1928. But forewarned was not necessarily forearmed. By the winter of 1929, the organization, despite its professional staff and its long years of dealing with economic downturns, could not keep pace with the rapidly escalating number of unemployed and destitute people. An estimated
forty-one thousand Cleveland workers were jobless in April 1930; by the following January the number was one hundred thousand. The city of Cleveland had stopped distributing outdoor relief altogether in 1922, leaving it to AC and two other private relief agencies. But as endowment incomes fell, annual gifts disappeared, and the Federation fund dried up, private agencies realized that only government had enough resources to provide relief and urged that the city again assume this responsibility. AC declared that its own resources were exhausted and that its debts totaled $600,000.28 Local public efforts at relief were futile. A city public works program was ineffectual, as was a one-mill tax levied in 1932 by Cuyahoga County.29

Like other cities, Cleveland was rescued by the federal government. Public works projects became the major conduit for federal funds, but the assumption that men were primary breadwinners meant that there were few private or public works programs for women. From 1928 to 1934 the number of recipients of mothers’ pensions in Cleveland had more than doubled, and by 1938, 42 percent of all the city’s families on relief were headed by women.30 The hardship of women and their children was acknowledged by the inclusion of Aid to Dependent Children in the 1935 Social Security Act. Like the mothers’ pensions, ADC was inspired by the U.S. Children’s Bureau and was supposed to allow mothers and children to remain together in their homes.

ADC broadened the categories of parents eligible for aid, but the stipulation that homes be “suitable” and the latitude given to states to establish eligibility meant that mothers of illegitimate children were less likely than married women to receive relief, or that the relief came attached with harsh conditions such as the requirement that the putative father be named. In 1938–39, only 5 percent of the children receiving ADC benefits were illegitimate.31

There are no Cleveland figures from this period indicating that unwed mothers got less ADC than other dependent women. But in correspondence with the Cleveland Federation, U.S. Children’s Bureau official Maud Morlock expressed concern that unmarried mothers were being shortchanged. The Federation’s response was not reassuring: funding was short, casework services were practically eliminated, and local staff used their own discretion in determining a mother’s fitness.32

As private hospitals accelerated the change from charitable to for-pay facilities, public hospitals were compelled to provide more health care for growing numbers of medical indigents. In 1930 City Hospital admitted a record 11,066 patients, its occupancy rate was 95.1 percent, and its outpatient clinic recorded more than 50,000 visits. Falling tax revenues exacerbated the hospital’s perennial financial difficulties, and
hospital facilities and equipment deteriorated. An advisory committee investigated charges of political patronage and made administrative changes, but in 1938 six departments had to be closed for lack of funds.33

City Hospital's maternity ward soon felt the Depression's impact. In 1930 City delivered 8 percent of all hospital births, with only 6 percent of all maternity beds. The indigence of its patients is suggested by the hospital's puerperal death rate: 20.3 per 1,000 live births, more than six times that of Maternity Hospital and more than three times the city average of 6.6 per 1,000. The total number of births doubled from 1931 to 1933 34.

City Hospital also delivered growing numbers of unwed mothers. (See Table 6.1.) In 1931 the hospital delivered 8 percent of all institutional births and 14 percent of all illegitimate institutional births; in 1935 it delivered 15 percent of all institutional births and 20 percent of all institutional illegitimate births. In 1935, 10 percent of all City Hospital births but only .048 percent of births in all institutions were illegitimate.35

The maternity homes continued to care for about 45 to 48 percent of unwed mothers during these years, so the increase in illegitimate births at City was probably the result of referrals from private hospitals, especially Maternity Hospital. In 1931 Maternity delivered 12.3 percent of institutional illegitimate births, less than 3 percent of the women delivered at the private facility. In 1935 it delivered only 5.8 percent of institutional illegitimate births, about .015 percent of its total deliveries. That
year, 69 percent of unwed mothers for whom City had any social service records had been referred by Maternity.36 Those referrals probably were black and probably were the most indigent of Maternity Hospital's out-patient clients.

Their poverty is illustrated in a comparison with other maternity facilities. In 1935 City Hospital had the highest infant and maternal mortality rates, the highest rate of venereal patients, the highest rate of unemployed patients, and the largest number of unwed mothers known to the public relief agency. City also had the highest proportion of black women: 55 percent of its unwed mothers whose case files were examined by the Federation were black.37

The number of births at City Hospital dropped during World War II, probably because of a wartime personnel shortage at the hospital and war-induced prosperity, which allowed women to make the more attractive choice of birth at a private facility.38 In the immediate postwar years, both numbers of births and shares of births at City Hospital rose again.39 Probably many were to black women because private hospitals did not welcome either black patients or black doctors.

As had public hospitals elsewhere, City Hospital had integrated its medical staff earlier than private facilities. In 1928 City had appointed a black doctor to its outpatient staff, and in 1930, as the result of political pressure from black councilmen, it admitted three black nurses to its teaching program. The next year the hospital hired a black intern with degrees from Dartmouth and Harvard Medical School, Frederick Douglas Stubbs, the first black to receive an appointment at a major teaching institution. Black staff obviously attracted black patients.40

A 1948 Federation study found that City had a higher-than-average proportion of black unwed patients and that its social service department was "obviously unable to serve all its unmarried mothers." Because of the lack of adoptive homes for black children, the hospital social workers were unable to close cases as rapidly as the private facilities. Although the maternity homes turned down more cases than they took, City Hospital had to take almost all those who applied.41 The social service department conceded that "for a number of months the department did not attempt to know the unmarried pregnant patient."42

During the next decade, as the baby boom peaked, private maternity homes and hospitals filled their beds with paying patients. Of particular significance to City Hospital, so did Mary B. Talbert Home, still the only facility that admitted significant numbers of black unwed mothers. Accordingly, in 1952 the City Hospital annual report noted: "In the past two years our service to obstetrical patients has increased nearly one hundred percent. . . . There is every reason to believe that the restriction of
staff and charity beds by other hospitals in the community has created additional demands on City to accept an increasing responsibility for indigent obstetrical patients.” Although Maternity Hospital was not mentioned by name, it had discontinued its home delivery service, which had been used primarily by blacks, in 1951. According to the 1952 Salvation Army study, most of the “lower and lower middle income non-white maternity patients are admitted to City Hospital.”

During the 1950s City Hospital’s financial woes were worsened by the accelerating flight of middle-class, white taxpayers to the suburbs. In 1958, in an effort to broaden the hospital’s revenue base, Cleveland turned over to Cuyahoga County the administration of the medical facility that the city had maintained for more than a century. City Hospital then became Cleveland Metropolitan General Hospital (CMGH).

Almost simultaneously, the hospital released figures that revealed the growing inability or unwillingness of private homes and hospitals to serve black unwed mothers. In slightly more than a year during 1957–58, the hospital delivered “940 illegitimate births to single women; 665 to separated women; 150 women were divorced and 63 widowed. Of the total 1,818, 168 patients were white and 1,650 [90 percent] were Negro.” In words that echoed City’s 1914 annual report, the hospital social service department expressed its concern: “Most of the patients are admitted to the hospital in labor with little if any prenatal care. . . . Many others are without any exhibited interest from parents, relatives, or friends. . . . Physicians are concerned about the lack of postnatal follow-up as well as prenatal care.” The department was clearly not able to provide casework and had contact in one six-month period with only 170 cases out of 675. The Talbert Home’s closing in 1960 worsened the situation.

**POORHOUSE ENDINGS, 1960–1980**

Public spending on relief and health care continued to rise, but at Cleveland’s public hospital, which became the major provider of services for unmarried mothers, those services remained inadequate.

The first significant expansion of the New Deal welfare state began in the early 1960s. In the wake of Michael Harrington’s publicity about “the other America,” and in the midst of the growing militance of the civil rights movement, federal spending on social welfare rose rapidly, especially under the auspices of Lyndon Johnson’s War on Poverty. The fastest growing program was ADC, now Aid to Families of Dependent Children, as residency requirements were relaxed and families with un-
employed fathers were included. This outdoor relief program, designed in the 1910s to support a modest number of “worthy” widows deprived of their male breadwinners, came in the 1960s to serve huge numbers of widowed, deserted, or never-married women, many of them black. Recipients of AFDC nearly doubled from 3.1 million in 1960 to 6.1 million in 1969, even though the suitable home requirement remained. In Cleveland the number of people on AFDC increased fourfold from 1957 to 1967.

In 1966 the U.S. Commission on Civil Rights found that AFDC payments in Ohio were “grossly inadequate to provide support and care requisite for health and decency,” a judgment seconded by the panel on welfare appointed by Mayor Carl B. Stokes. Despite these realities, taxpayers and politicians responded to AFDC as they had to providing public shelter for unwed mothers in the 1880s—with hostile attempts to provide less service for less money. In 1967 welfare amendments restricted AFDC benefits and added a mandatory work-training program as an incentive.

The delivery of health care services at CMGH dramatized this public unwillingness to provide for dependent and husbandless women. CMGH’s maternity services were so deficient that they were not accredited by the state of Ohio until 1963. The hospital’s own 1962 annual report singled out the department of obstetrics as one of “the most inadequate areas [in the hospital]. Conditions in the labor and delivery suite, built for 1800 deliveries but now taking care of over 3600, are probably the most distressing at [CMGH]. . . . E very year, women labor in beds in corridors. There is constant traffic of maternity patients past the cys toscopy rooms, which is in violation of . . . accreditation requirements. . . . The premature nursery is very poor, and the other nurseries are inadequate.”

The commission also emphasized the negative impact of the city’s segregated residential patterns on health care, pointing out that in 1963 the fetal and infant death rates for nonwhites in Cleveland were 50 percent higher than for whites, at least partly due to the inaccessibility of prenatal care for black women: “In 1963, CMGH delivered more Negro babies than any of the other hospitals serving low-income families, although they [were] close to Cleveland’s ghetto areas.” Black women, most of them living on the East Side, had to travel miles to get prenatal care at CMGH.

Also in 1963, the only year for which these data are available, CMGH was the largest single medical care-giver to black unwed mothers. (See Table 6.2.) The hospital delivered only 10 percent of all births in Cuyahoga County but 36 percent of all black births and 47 percent of
Table 6.2
Resident Birth Statistics
According to Hospital or Institution, Cleveland, 1963

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<th>Hospital</th>
<th>Births</th>
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<tr>
<td>MacDonal House</td>
<td>3544</td>
<td>1780</td>
<td>1764</td>
<td>258</td>
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<tr>
<td>Cleveland Metropolitan General Hospital</td>
<td>3435</td>
<td>764</td>
<td>2671</td>
<td>958</td>
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<tr>
<td>Booth Memorial</td>
<td>768</td>
<td>600</td>
<td>168</td>
<td>162</td>
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<tr>
<td>DePaul Infant and Maternity Home</td>
<td>1810</td>
<td>1584</td>
<td>226</td>
<td>80</td>
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all illegitimate births—958 babies. Twenty-seven percent of all births at CMGH were illegitimate. In contrast, MacDonal House (the former Maternity Hospital) delivered slightly more than 10 percent of all births, 24 percent of all black births, and only 12 percent of illegitimate births—258 babies. DePaul Infant and Maternity Home delivered 80 unwed mothers, and Booth Hospital delivered 162, the vast majority of whom were white.\(^5^1\)

In 1965 CMGH became the primary site for the federal Maternity and Infant Care Project, which provided comprehensive services and medical care to high-risk mothers—teenagers or those in poverty. The descendant of the 1921 Sheppard-Towner Act, the project was funded initially by the U.S. Children’s Bureau and carried on one of the bureau’s chief missions—to lower maternal and infant mortality.\(^5^2\) The project funded pre- and postnatal health care at three clinics in East Side neighborhoods and at the public hospital itself. Other hospitals took project clients, but most were delivered at CMGH. Medicaid, newly established, helped to bear the expense.

Although there were social workers on the staff, the project was almost exclusively a medical service and referred clients to other public and private agencies for casework, primarily adoptive services, which were useful to very few mothers. In 1969 there were only 660 adoptions of the 3,884 out-of-wedlock children born in Cuyahoga County.\(^5^3\) Although by 1969 the project cared for more unwed mothers than did the Booth Hospital, DePaul Infant and Maternity Home, and the Florence Crittenton Home combined, it still delivered only 836 of the city’s 3,019 illegitimate births in that year.\(^5^4\) The project expanded its outpatient programs dur-
ing the 1970s and established several new clinics, most on the city's predominantly black East Side. The number of clients rose steadily, but public subsidies did not keep pace.\textsuperscript{55}

Medicaid initially encouraged private hospitals to take indigent maternity cases, probably accounting for the drop in births at CMGH in the late 1960s. A comparison of comparable private and public hospitals in Boston in 1967–68 suggests that private hospitals provided unwed mothers with better care.\textsuperscript{56} As hospital costs escalated nationally and Ohio's share of Medicaid payments stalled, Cleveland's private hospitals became less enthusiastic about treating the medically indigent. Like the Maternity and Infant Care Project, CMGH had to provide expanded services without commensurately increased funds. By 1972 CMGH was the state's largest Medicaid facility.\textsuperscript{57} Beginning in the mid-1970s, "the hospital increased its out-patient clinics as a result of cutbacks in indigent care in other hospitals."\textsuperscript{58} Throughout the decade, the financially straitened hospital restructured. It became a complex of county health services and facilities, including a chronically ill center, which had once been the tuberculosis unit, a large East Side clinic, and a hospital for the chronically crippled.

**Conclusion**

As at the beginning of the century, social welfare strategies were in flux in the late 1980s. Again, unwed mothers bore the brunt of financial and policy changes.

As deindustrialization and middle-class flight continued, Cleveland's population, disproportionately black and disproportionately female, fell upon harder and harder times. By 1980, one-third of Cleveland's children lived in poverty, and the number continued to climb. In 1981 Cleveland had the second-highest infant mortality rate and the highest black infant mortality rate of any major city.\textsuperscript{59}

Simultaneously, federal policies shifted from the War on Poverty to the war on welfare, and funding for public assistance was slashed.\textsuperscript{60} Although AFDC constituted only a very small proportion of monies spent on public assistance and social insurance programs, it was a special target of the Reagan administration's Omnibus Budget Reconciliation Act of 1981 because the public associated the program with black, illegitimately pregnant women.\textsuperscript{61} A 1987 study done for the Cuyahoga County Department of Human Services (formerly the county welfare department) found that the number of Ohio children who received AFDC rose 30 percent from 1979 to 1986, "with smaller benefits in 1986 than in 1979."\textsuperscript{62}
The new federal policies also boded ill for public hospitals and medical services. In 1980 CMGH’s annual report boasted that the hospital had not changed its “long-standing commitment to accept patients on the basis of their need for medical care . . . regardless of their financial ability. It continued to be the only hospital in this area to have an open-door admissions policy. . . . It is the leading provider for indigent care locally.”63 Two years later, the annual report worried about “the nation’s commitment to quality medical care to its elderly and poor” as the federal government, in an effort to “disengage itself” from providing health care, changed its rates of payment and the state of Ohio threatened further cuts in its share of Medicaid.64 The Maternity and Infant Project received proportionately less funding in 1987 than it had in 1975.65

CMGH became the largest single provider of institutional medical care for unwed mothers: in 1986, 2,419 unmarried women, 1,572 of them nonwhite, gave birth at the former poorhouse.66 Private services for unwed mothers were almost nonexistent. The Florence Crittenton Home did not take unwed mothers after 1970, and the DePaul facility had closed in 1983. Only the eighteen beds at the Army’s Booth Home remained. In 1987 CMGH bought the Booth Memorial Hospital facility, once the Salvation Army Rescue, to complement its East Side outpatient clinic and the Maternity and Infant Project clinics. In 1988 CMGH won an award from the American Hospital Association for its community outreach programs, including its best known, the Maternity and Infant Project.

Yet the future of the old poorhouse and the largest remaining home for unwed mothers remained in doubt. Medicaid cuts and pressures from private health insurance companies continued to make health care for the indigent more costly, and by 1986 CMGH had the largest uncompensated care spending of Cleveland hospitals. Consequently, in 1988 hospital officials considered leasing all or part of the hospital to a for-profit corporation, a trend that was apparent in other cities as well.67 The contemplated privatization was further evidence of the historic public distaste for providing health care for the poor. As Harry F. Dowling has noted, and as this local history has shown, “In good times [voluntary hospitals] have held out a hand to the poor; during hard times, when their help was needed the most, they have tended to close their doors to those who could not pay.”68

In 1990, on the Scranton Road site of the old Infirmary, home to forty inmates in 1855, stood a $40 million, twelve-story building with 558 beds, the central component in a complex of public health facilities now called MetroHealth Services. The public facility was also a significant teaching facility affiliated with a dozen universities and medical
schools. Its Department of Obstetrics and Gynecology alone included twelve M.D.s and four Ph.D.s. This multimillion-dollar building symbolized Cleveland’s growth from a mid-nineteenth-century village to a sprawling postindustrial metropolis.

More important, the hospital symbolized the expanded public commitment to the health and welfare of the American people, the central chapter in American social welfare history. The public hospital has provided care for those about whom the public has cared least—not only the poor, but blacks, females, and the sexually delinquent. It has provided care by overcoming great difficulties: the least staff, the least adequate facilities, the least funding. Cleveland’s public hospital is a reminder that the government has been less concerned about the welfare of some of its citizens than about others. As the country apparently moved away from health and relief provisions created by the New Deal and the War on Poverty, and as public officials discussed returning to the private sector the responsibilities that it had carried during the nineteenth century—and dropped in the 1930s—this home for unwed mothers was a reminder also of the impermanence of the welfare state that we have taken for granted for the last half-century.