payment of either a hospital bill or doctor's bill. The hospital superintendent, therefore, is not able to regard his product as an independent commodity merely to be delivered to and paid for by his customer. Hospital care to paying patients is usually delivered along with an economically competing product, namely, the services of an attending doctor or a special nurse.

Some hospitals are making an effort to co-ordinate to some degree all financial relations with patients. One institution has inaugurated a middle-rate plan by which physicians' fees are limited in amount for patients occupying certain types of room accommodations, and by which special-nursing service is permitted only on recommendation of the attending doctors and the hospital authorities. A number of other hospitals, particularly those connected with universities, have engaged full-time doctors who serve as representatives of the hospital and who attend all patients accepted by the institution. The hospitals thereby tend to become medical centers offering various types of professional services, rather than mere buildings in which independent professional activities are performed. Such policies of co-ordination, if developed more widely, would do much to clarify and aid in the solution of problems of hospital management and economic policy.

II

Most hospitals have been constructed and equipped by the general public, who have contributed funds for the purpose either voluntarily or through taxation. Hospital plant and equipment are usually financed on a non-profit basis, without expectation of repayment of principal to, or the receipt of earnings by, the individual investors. Even in those cases where hospital bonds are issued by a private charitable institution or a government, it is usually expected that the interest payments or ultimate redemption of the debt will be accomplished by voluntary contributors or tax-payers rather than by the hospital's earnings from the sales of its product. The hospital superintendent, therefore, conducts his business with a publicly owned plant and equipment.

The fact that most hospital service is conducted with capital supplied by the community has influenced hospital management in several ways. It has tended to obscure in the minds of some hospital superintendents the existence of the overhead costs of interest and depreciation. In those cases where allowances for interest and depreciation need not be recorded to balance the cash expenditures of the hospital, some hospital directors appear to have forgotten that plant and equipment represent important economic outlays from which the public has a right to expect the greatest possible professional benefit. The ordinary hospital ledger of accounts contains no allowance for depreciation or interest on the investment in plant and equipment.

If this omission had its influence merely upon the ledger, the practice would be of no great importance. It would be a matter of interest only to accountants, who might then argue over the problem. But when a community donates $500,000 or a million dollars to build, equip or endow a hospital, it withdraws that money from other public or private enterprise. The money invested in a hospital, which will last thirty or fifty years, cannot be recalled and subsequently invested in a playground, a church, a milk fund or in a profitable business. Interest and depreciation are actual costs to the community of hospital service, even though these "fixed charges" may be paid in advance through public provision of plant and equipment.

An analysis of the total costs of hospital service reveals that the fixed charges per patient-day may range from fifty cents to $5.00 depending upon the degree to which beds are occupied and upon the relative amounts of investment per bed. It is important that hospital superintendents realize the tremendous waste of public funds when hospital rooms and scientific apparatus remain idle for want of an administrative policy which would bring them into public service. The recognition of fixed charges as costs of hospital care does not mean that patients' fees should necessarily be established at levels sufficient to recover allowances for interest and depreciation. This recognition may, in fact, merely serve as the basis for removing the burden of fixed charges from certain classes of patients. The important thing is to recognize the responsibility for adequate use of the publicly owned plant and equipment. The benefits of the public's investment in hospitals can be realized fully only when the plants are utilized to the greatest degree consistent with good professional care.

The superintendent of a hospital is not always responsible for the inadequate utilization of plant and equipment. He may be in charge of an institution built without regard to the needs of the community, planned without regard to economies in operation, or erected merely as a lavish monument to a wealthy donor. A public awareness of the place of fixed charges in hospital costs, and of the influence of plant and equipment upon other operating costs, would tend

to discourage unnecessary, poorly planned or elaborate hospitals. As a result, existing institutions would reap economies from quantity production, and hospital managers would have access to additional community funds for the payment of operating costs. Some hospital directors and trustees are fully aware of the importance of fixed charges in hospital financing and costs, but the subject still requires careful study and attention.

III

Medical care—including hospital care—is regarded by the public not only as an economic commodity, but also as a philanthropic service. For patients able to purchase and pay for hospital care, the product of a hospital is expected to be supplied at a price equal to its full cost of production, including fixed charges. Other members of the population are expected to receive hospital care free or at fractions of the total costs of the various services they require. The superintendent who delivers hospital care free to patients turns for repayment to the financially able members of the general public. These persons are expected to finance the free care of others through paying fees which yield net surpluses, or through voluntary or tax contributions. As a rule, a hospital finds the revenue from paying patients insufficient to cover the total operating costs of the institution's services (even when fixed charges are excluded from the calculation).

The social policy of attempting to provide hospital care according to a patient's need rather than his pocketbook is the cause of much confusion in the public mind with regard to hospital efficiency. Daily "room-rates" of hospitals are compared with those of hotels, with the implication that if hotels can be managed with profit to the owners, hospitals should at least be self-supporting. There are, of course, very few hotels which could meet their operating costs if from one-third to one-half of the guests paid nothing at all, or amounts substantially below the costs of the services they received. It takes money to pay expenses, and if patients cannot pay the costs of services they require, the superintendent should have authority to do one of two things—to refuse such patients admittance to his hospital or to demand adequate payment by the public for all services rendered to its individual members.

A deficit may result either from excessive expenditures or inadequate receipts. Expenditures are in large part under the superintendent's control and he should be expected to reduce them to the minimum. Receipts are also in large part under the superintendent's control, and he should be expected to keep them at the maximum consistent with the public policy adopted by the trustees and the hospital's supporters. But when the public demands that care be given to its individual members, it should also guarantee adequate payment, and should not place the responsibility of financing such service entirely upon the superintendent's shoulders.

The superintendents of hospitals are in part responsible for misunderstandings of hospital financing methods. They have allowed their need for public support to be referred to as "operating deficits" instead of as "costs of services" rendered to the general public. The difference between operating costs and patients' fees may be regarded merely as a statement of the costs of professional services rendered to the public—a bill which the community should expect to pay promptly and in full. To the extent that such a bill appears unduly large, it should be scrutinized with care. It is the superintendent's obligation to remove from the community any portion of the economic burden resulting from his own inefficiency. But it is the public's responsibility to remove from the superintendent that portion of the economic burden resulting from the community's demands for hospital care or from an unwise investment of that community in plant and equipment.

IV

A carefully planned system of cost analysis would be of immense benefit to a superintendent, not only in the control of hospital expenditures, but also in the enlistment of public support. Hospital service, as has been stated, is not a homogeneous product. Some departments are self-supporting from patients' fees. Some are not. If the total costs of each hospital service were determined separately, such calculations would show clearly the need or opportunity for economies from increased utilization of hospital facilities. Unit costs could be calculated for board-and-room care, X-ray services, laboratory tests, etc., and these costs then compared with existing fees. The comparison would permit the establishment of fees intended to yield the greatest surplus or the minimum loss from certain services. It may prove, for example, that a lowering of the fees for X-ray services would result in such an increased demand that unit costs would be materially reduced.

The public's interest in hospital care requires that some fees be established at levels presumed to cover