can go into the matter of cost analysis with some assurance of results. It may take several years and it is not, of course, for the United Hospital Fund to say that the hospitals must follow any course. They have to help work out the problem and adapt it to their own situations. It is a slow process, but we hope to have something to contribute to the hospital world in a few years.

Since the Taylor Society is devoted to the study of scientific management I have tried to set down the things which these two papers suggest to me as tests of efficiency. They may not be worth much from the engineering viewpoint, but the hospital administrator who could answer affirmatively would have a pretty good institution. They are merely suggestive.

1. Does your hospital budget its income and expenditures and try to stick to the budget? I do not mean that a budget should not be changed, but it should be changed only in accordance with a definite plan.
2. Does your hospital budget its free service? A hospital came to us a few weeks ago for advice because it was running behind. After study of the situation we found they were making no effort to control their free service. We have suggested that this service be budgeted, which of course requires a careful analysis of the costs of that free service. This hospital happens to have those costs and can make its budget.
3. Is there expert control of purchasing and avoidance of waste?
4. Does your hospital have at least a 70 per cent occupancy?
5. Is your hospital properly adapted to the needs of the community as to size and type of service offered?
6. Does the staff personnel function smoothly?
7. Is good credit work combined with social service in making admissions? We find that few hospitals study credit matters scientifically. Many have social-service departments but they should have credit work combined with them in order to determine what the patient is able to pay.
8. Are your medical and surgical standards high? Are you approved by the American College of Surgeons?
9. Are the results of your hospital care satisfactory with reference to mortalities, length of stay of patients, post-operative infections, etc.? Are they commensurate with the amount of technical work, laboratory tests and equipment demanded by the staff doctors?
10. Does your hospital contribute to the prevention of disease in proportion to its opportunity?
11. Does your hospital interpret its responsibility to the community and organize it for adequate financial support?

Perhaps the engineers connected with the Taylor Society can help us work out better hospital efficiency tests.

Dr. Joseph Turner,[5] Chairman. At a meeting which stresses management speakers are tempted to refer to hospital administration as though it were merely a question of finances, budgets and paper plans. While these things are important, they are not all important. The most important thing in hospital administration is not what the patient pays but what he gets, for the most important person in the hospital is not the superintendent or the president of the Board or the head nurse, but the *patient*. Of course, no legitimate source of income should be overlooked, and no economies neglected, but everything that is done must be tested in the light of what the patient gets in his turn.

I hoped that Mr. Rorem would emphasize the importance of including interest charges in calculating costs for service to full-pay patients. In the hospital I know best this is done. From 5 to 6 per cent of the capital investment in that part of the plant devoted to the care of private patients is added to the cost of private-patient care. This income in its turn is utilized for the care of the sick poor. The result is the same as if, instead of investing in facilities for private-patient care, we had put this money into income-producing investments at the usual rate of interest. Mr. Rorem pointed out that hospitals were planned originally for the benefit of the indigent sick, an outgrowth of the universal humanitarian impulse to provide medical care for those who cannot provide it for themselves. Buildings and equipment were provided by the community for this purpose; if now it is used in part for those able to pay, it is only right that these paying patients who are enjoying the benefits of the community's philanthropy should pay for them in a measure sufficient to retain for the poor their benefits in this charity.

Mr. Rorem. There are many things that can be said about the role of fixed charges in hospital costs and the influences they have upon adequate planning and financing.

[5]Director, The Mount Sinai Hospital, New York, N. Y.

I pushed very few of the points to their logical conclusion, but will go back to two of them since they have been raised. One relates to the practical way in which a calculation of fixed charges can be used by the superintendent or the community. I think they can be used to great advantage in justifying what appears superficially to be a high price for private rooms. Usually if per capita costs without fixed charges are compared with prevailing rates for private rooms they are found to be quite a bit below $8.00 or $10.00. When it is recalled, however, that private rooms have the choice locations in the hospital, or the most valuable sections of the property, that it is anticipated that they will not be occupied to the same degree as the remaining space and that the person who elects to use a private room asks and expects no charity, it seems reasonable to add an allowance for fixed charges to the current out-of-pocket expense in arriving at private-room rates.

I have heard superintendents get themselves into trouble by justifying high prices of private rooms on the ground that the patient was making a contribution to free services. The argument carries no conviction with the patient who is himself faced with medical bills which he considers high.

A second practical way in which a calculation of fixed charges can be used is before rather than after the event of low occupancy. Mr. Wickenden's observations are really in support of my point of view rather than against it for this reason: The worry over fixed charges should be before the hospital is built. They should be considered in preventing certain important community costs rather than in reducing something which is irreducible.

The big hospital problem today is not primarily one of internal efficiency. Just as scientific management worked out the problems of production and then went on to problems of distribution, so the hospital administrators need to turn their attention from internal problems, which can be solved by conventional methods worked out in business enterprise, to an understanding of the place of the hospital in the community. This will result in the planning of hospitals to fill a need rather than to satisfy the vanity of an individual. It may be a minor, but it is nevertheless an important, point that people give too lavishly to hospitals.

Mr. Cooke. Mr. Rorem modestly has not referred to his discussion of the last few months on the significance of the capital cost of hospitals. I have gathered from sitting at his feet that he thinks the range of costs should be from $3,000 to $8,000 a bed.

When I was abroad this summer I heard that an architect friend of mine had been given an order for a large hospital. I gave him these figures and asked him how his hospital would compare. He replied that he thought my figures must be wrong because his hospital was going to cost $9,000. It is that sort of thinking before the event that is, I believe, the chief value of Mr. Rorem's work.

J. A. Hagios.[6] The Policyholders Service Bureau of the Metropolitan Life Insurance Company was asked some time ago by one of its policyholders, a manufacturer who was on a hospital board, to furnish some information on the effectiveness of various collection methods.

We made an investigation and prepared a special report as a result. It is called "Credit and Collection Practices of Hospitals" and can be secured by any of you who are interested by a request directed to the Bureau.

We were in touch with practically all the hospitals in New York and perhaps a dozen others, who have reputedly good systems, throughout the country by means of a questionnaire. It describes the various payment policies in force, such as payment in advance, payment at the end of each week or payment upon leaving the hospital. It also describes methods of collecting balances outstanding at the time the patient leaves the hospital and also methods of co-operation between the credit people and the social-service department. I should be glad to know of any other similar studies of which I have not heard.

Charles Vezin, Jr.[7] As an outsider I have always been curious to know whether there was any possibility of minimizing loss through unused capacity by renting unused rooms during slow times—with the understanding that the occupant would give it up when needed. I have never heard of this being done but believe it might be studied as a means of helping to meet free-service costs. I was thinking of renting to well people, a less expensive service than that given a patient and therefore a possible means of minimizing loss on space that must be maintained whether occupied or not.

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[7]Litchfield, Conn.