lem in the nursing profession, early retirement from professional activity, is a significant factor in the supply of other professional health personnel. The high proportion of women in these professions helps to explain the persistent personnel turnover imposed by marriage, child raising, and female attitudes toward employment. The predominant number of women may also help to account for the relatively low pay scales in hospitals and health service employment. However, low wages and salaries are also determined by the institutional arrangements and organization in the health industry, where public institutions depend on tax funds and nonprofit agencies depend on philanthrophy and voluntary donation of services. The voluntary nonprofit hospitals and the general public community hospitals are usually unable to pay fully competitive salaries, even for the professionally trained auxiliary medical personnel. Therefore, these occupations are filled with women whose salary expectations are less optimistic than the expectations of men with similar professional training.

Although the supply of personal health services could be increased by greater use of family services for patients in hospitals and by greater utilization of volunteer workers, there is no clear trend toward increased charitable or volunteer service to ease the foreseeable demand for professional and auxiliary health workers. The supply of such workers is inadequate in almost all fields, and shortages of professional auxiliary health workers appear likely to continue for the foreseeable future.

SUPPLY OF HOSPITAL FACILITIES

Increases and shortages

The supply of hospital facilities has grown by more than 10 percent in the last decade, but rising population and rising hospital utilization continue to put severe pressures on the available supply of hospital facilities.

The American Hospital Association reported 6,786 hospitals in the continental United States with a total of 1,572,000 hospital beds in 1958. In 1948, there were 6,160 hospitals with 1,411,000 beds. In spite of these increases, however, the number of hospital beds per 1,000 population dropped from 9.7 in 1948 to 9.1 in 1958, and hospital utilization rose from 115 to 137 hospital admissions annually per 1,000 population.[42]

The decline in the average length of patient stay in general and other special hospitals tends to counteract pressures on the supply of hospital facilities. These pressures result in earlier discharge of patients and occasionally in refusal to admit patients. However, the average length of stay in general short-term hospitals fell from 15.4 days in 1932 to 11.1 days in 1948 and to 9.6 days in 1957. This would indicate that hospital care is changing so as to enable existing facilities to serve more people more quickly. Among the factors involved in declining length of patient stay are the concentration of expensive and effective diagnosis and treatment in the first few days of a hospital stay, the trend to early ambulation of maternity and surgical patients, and the development of "progressive patient care" which moves patients from intensive care units to intermediate, less intensive and less expensive hospital care units and early transfer to home care status. Increasing reliance on tranquilizing drugs for mental patients enables

[42] Hospitals: Guide Issue, J.A.H.A., Aug. 1, 1959, p. 384.