

Other factors tending to increase hospital costs cited by Brown are also important.

One factor is the nature of hospital costs. The major portion of hospital operations costs are not variable. A hospital is typically fully staffed, at all times ready for a peak load. Therefore, the occupancy rate is a critical factor in average operating cost per bed. In studies cited by Brown, it is shown that in a group of otherwise similar hospitals, those which had a better-than-average occupancy rate had less than half the unrecovered overhead cost per bed than did those hospitals whose occupancy rates were lower than average.

While desirable on other grounds, the tendency toward shorter stays makes synchronization of patient discharge and admissions more difficult; this leads to empty, nonrevenue-producing beds. Again, the population pattern of the United States is best served by an extensive system of smaller hospitals to supplement those in metropolitan centers. Occupancy rates are lower on the average in small hospitals than in large.¹³ Their costs per bed are therefore higher.

A second factor is the increase in number of special diagnostic and therapeutic services provided by hospitals. Brown, quoting from the report of the Commission on Financing Hospital Care, offers this statement, "The relationship between the level of per diem expense and the scope of hospital service was apparent when per diem expense was determined for groups of hospitals classified by number of selected services they offered. * * *"¹⁴

C. PROFESSIONAL SERVICES

Income and employment data with respect to medical practitioners is not easily available. Roberts¹⁵ brings together data on the number of active practicing physicians, dentists, and professional nurses. The table below compares his data with Department of Commerce data on number of persons participating (including active proprietors of unincorporated enterprises) in medical and other health services. The declining proportion of professional personnel in the total illustrates the growing importance of nonprofessional technical and other lesser skilled personnel.

TABLE 20.—*Employment in medical services*

Year	Active physicians, dentists, and nurses	Persons engaged in medical and other health services	Physicians, dentists, and nurses as a percent of total
	<i>Thousands</i>	<i>Thousands</i>	
1930.....	439.2	749	58.6
1940.....	529.3	841	62.9
1950.....	667.8	1,237	54.0
1953.....	706.2	1,413	50.0
1955.....	745.6	1,551	48.0

Sources: Roberts, "Trends in the Supply and Demand of Medical Care," table 8, p. 70; "U.S. Income and Output," table VI-16 and "National Income," table 28.

Income data for physicians and dentists is not regularly published. The Survey of Current Business has conducted surveys of professional income, but none have been published for recent years.¹⁶ Partnership income data has been published by the Internal Revenue Service for the years 1947-48, 1953-54, and for 1957-58, preliminary data. See table 16 above.

These data cannot safely be regarded as representative of average earnings for individual doctors for two reasons:

(1) Data tabulated is for the partnership; if the average number of partners per partnership is not the same in each year, the results will not be strictly comparable between years on a per person basis.

(2) Many doctors, dentists, and other practitioners are not members of partnerships. Sole proprietors and salaried medical practitioners experience different earnings records.¹⁷

¹³ Brown, op. cit. says, "During 1954 those hospitals with less than 25 beds averaged 51.6 percent occupancy while those with over 300 beds averaged 71.8 percent occupancy."

¹⁴ Ibid.

¹⁵ Markly Roberts, "Trends in the Supply and Demand of Medical Care," Study Paper 5 in the "Study of Employment, Growth and Price Levels" (1959).

¹⁶ See William Weinfeld "Income of Dentists, 1929-48" Survey of Current Business, January 1950; "Income of Physicians, 1929-49," ibid, July 1951; "Income of Lawyers in the Postwar Period," ibid, December 1956.

¹⁷ Ibid.