CONSUMER HEALTH PERSPECTIVES

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NATIONAL HEALTH SERVICE IV—
THE PHYSICIAN'S ROLE

In previous issues of *Health Perspectives* (NHS I-III) the Consumer Commission focused on the need for, methods of transition to, and organization of a national health service in the United States. In the fourth issue of this series, we define the roles and functions of physicians within this service. Presented here is a regionalized, institution-based model for physician practice and a discussion of the implications of employing salaried, full-time physicians within a publicly-owned delivery system.

How would doctors fit into a National Health Service? How would their present roles be redefined, and what would these changes mean both for doctors and patients?

Obviously, involvement in an NHS would mean the end for doctors of a long-accustomed way of life: fee-for-service practice in private offices. It would mean their integration into various levels of a regionalized and functionally differentiated health delivery system—composed of primary care centers, community hospitals and tertiary care facilities linked with medical schools. Rather than relating to hospitals and other institutional health facilities as visiting dignitaries or special consultants, most doctors would be salaried employees of the institutions in which they conduct most of their practice.

These changes in modes of payment and institutional structures will profoundly affect the practice of medicine. Recruitment and selection of students, quality review and governance of health institutions would also undergo changes in a National Health Service—and all of these alterations would open the practice of medicine to greater public accountability and social responsiveness.

In the United States today, doctor care lags behind other historical developments in health services. The entry of the government into payment for health on an ever increasing scale, professed federal commitment to equal access for all Americans to health services, moves to regionalize the planning of facilities, and more—all present challenges to doctors which have not and cannot be met by modes of practice which were developed for other times and under other conditions.

Contemporary doctor care—though advanced scientifically beyond what could have been imagined a half-century ago—is nonetheless characterized by fragmentation in services, immunity from public scrutiny, tremendous expense, uneven quality and, often, inaccessibility.

Although private practice is touted as the backbone of American medicine, the advances of which the nation is justly proud were not made in the private office, but more usually by the salaried doctor employed by a research-oriented teaching institution. In the community, that former staple of community medical care—the general practitioner—is a rapidly vanishing species who has been replaced by the office-based specialist. The resulting gap in family care has not been filled.

In all, fee-for-service medicine has offered an unparalleled opportunity for doctors to make a very handsome living, have personal control over their own conduct and working conditions, and, generally, to deliver a vital service unencumbered by public accountability or even effective peer review. While the desire to perpetuate such a lifestyle is understandable, there is an increasing gap between what society needs in the way of medical care and the ability of private practitioners to deliver it.

The changes which would have to come about to integrate physicians into an NHS may seem sweeping and perhaps only achieveable after a protracted battle between organized medicine and the public; however, this issue of CONSUMER HEALTH PERSPECTIVES illustrates that, even from the point of view of physicians, the transition to salaried employment in publicly owned health facilities is beginning to appear increasingly desirable. Many of the conditions necessary for a transition are already present: the trend toward regional planning, government support of medical education, increased coordination of graduate residency training with medical schools and—most important—governmental purchase of health services. For physicians, the necessity for continuing education, the professional stimulation that comes from practicing in a group environment, having reasonable working hours, and a resolution to the malpractice crisis all argue for a change in practice modes.

For consumers, the most obvious advantage of receiving doctor care through an NHS is the ability to receive treatment when needed, regardless of economic status or place of residence. In terms of preventive medicine and early intervention, receiving care through a National Health Service has enormous positive implications. Increased access to physicians and other health personnel, improved quality and continuity of care, and accountability of doctors to the public are other gains the consumer can anticipate with the integration of doctors into an NHS.

NHS AND DOCS: BY REGIONAL REASON

To place doctors within a regionalized system, based on the needs of patients, it is necessary to develop standards and means of identifying physicians by their level of education, training, experience and skills. Each level of care—preventive, primary, secondary, and tertiary—requires a different type of knowledge and judgment. For a regionalized health service to function properly, not only institutions, but medical practitioners must be distinguished by the type of care each may be confidently expected to deliver.

For these reasons, medical schools must be incorporated into the system so that their central role in the recruiting,

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training, and deployment of physician manpower is geared to further public goals (see box—"Medical Education for a National Health Service"). Below, we shall outline the roles of doctors at the three levels of a regionalized system and suggest how this differentiation would change present relationships between doctors, health institutions and patients.

PRIMARY CARE: WHERE?

According to the most recent figures (Congressional Budget Office *Background Paper*, August, 1977), the ratio of physicians to population in the United States (in 1975, 175 per 100,000 persons) is higher than at any time in this century. But trends toward ever narrower specialization have meant a rapid decline in the number of physicians providing general, primary care. Overpeck's study of physicians in family practice (*Public Health Report*, 85:485-494, 1970) showed that in 1940 there were 83 general practitioners (GP's) in private practice per 100,000 population; by 1967, there were only 32. During the same period, the number of pediatricians and internists in private practice increased from 6 to 17 per 100,000. Even assuming that all of the new pediatricians and internists have not sub-specialized and are providing primary care, their increased numbers do not make up for the loss in GP's. The rest of the physician laborforce has spread itself out rather evenly over the remaining specialties. The disappearance of the general practitioner, along with the increased mobility of the population, means that a diminishing number of families and individuals are followed through a significant portion of their lifetime by either a single physician or the same group of practitioners. In spite of the increased proportion of doctors to population, a recently published study by the Robert Wood Johnson Foundation indicates that 24 million people, or 12% of the population, have neither a physician nor a source of regular care, such as a clinic.

While increased specialization has undoubtedly meant better care for a great number of patients with specific conditions, the unplanned growth and inordinate concentration of physician laborpower in specialized areas has resulted in severe losses in primary care and prevention.

The difficulty of finding a primary physician is one deterrent to care. The high cost of office visits exacerbates the problem by creating an economic barrier to obtaining care promptly. Specialists' charges are typically higher than those of general practitioners, and most insurance policies do not fully or even partially cover office visits which are not related to hospitalization or surgery.

As a consequence, many people delay treatment for non-acute conditions, use emergency rooms for routine care, or (usually in cities) sit long hours in the outpatient departments of voluntary hospitals, where they are treated by an ever-shifting spectrum of interns, residents and visiting specialists. In rural areas, 145 counties are without a single physician; hospitals with out-patient departments are few and far between; and the general practitioner who traditionally delivered care to rural populations is disappearing. Under current criteria set by DHEW, there are an estimated 16 million people living in doctor-shortage areas—9 million in rural locations and 7 million in inner cities.

LET'S GET ORGANIZED

Because of the lack of organization and planning in the system, where a person receives primary care is often the result of guesswork or luck. A fairly well-to-do parent may take his feverish child to a pediatrician, someone with fewer financial resources may consult a GP if there is one to be found, still others may end up in an emergency room or hospital clinic. Some will be deterred by the expense and delay seeking treatment until the condition appears to be acute.

The disorganization in the system also affects the behavior of physicians. Specialists may be reluctant to refer patients back to what they believe to be poorly-skilled general practitioners; and a general practitioner may attempt to treat a specialized condition rather than lose income by referring a patient away to a specialist. And both kinds of doctors may not have "privileges" to admit patients to the local hospital and be forced to practice "outside" the acute-care system.

An inappropriate visit to an emergency room, a doctor reluctant to make an out-of-office referral or whose knowledge is out-of-date, and deferral of care caused by the difficulty and expense of finding medical help, have directly negative effects on health and have become entrenched symptoms of our disorganized physician care system.

In addition, the fact than an increasing number of people have only sporadic (and sometimes alienating) primary care contacts means that public health officials are thwarted from concentrating on health maintenance and prevention, which, according to the federally established National Health Priorities, are the primary goals of the American health care system.

In a National Health Service, physicians and other medical laborpower would be redistributed geographically and by training to put renewed emphasis on the preventive and primary care needs of the population. As described in "NHS III—Regionalization" (*Health Perspectives*, Vol. IV, No. 3, May-June, 1977), regionalization of institutions presupposes accessible primary care centers as the entry point—for non-emergency care—into the health system.

PRIMARY CARE PRIMARY

Primary care, that is, diagnosis and treatment for the commonly encountered illnesses and accidents, would be provided by an NHS in community health centers located in neighborhoods, schools and workplaces. Preventive medicine, public health education and outpatient mental health services would also be most logically provided at this level. The number of people served by a community health center might vary significantly depending on the area's population density, but an adequate minimum number of physicians and other health workers would need to be assigned to each center for the system to work properly.

Whether primary care should be delivered by the so-called "primary care specialist"—a recently created category of physician meant to replace the general practitioner with a more highly trained generalist—or by a team of somewhat more narrowly focused medical specialists has been a subject of debate in recent years.

One approach would place in each community health center at least one pediatrician, one internist, an obstetrician-gynecologist and a dentist. The alternate method would place one or more generally trained "primary care practitioners" at the local level, supplemented by ancillary health personnel and other specialists as needed. In populous areas where there is likely to be sufficient demand, community health centers might regularly employ other specialists for outpatients, such as dermatologists and opthalmologists.

Because the necessities of modern medicine always involve a certain amount of specialization, patients could not realistically expect to see the same physician at all times; but continuity of care could be much improved by implementing the concept of a "managing physician" who oversees and coordinates each individual's or family's relationship with the system; and efforts to maintain a stable group of physicians in each community should minimize fragmentation. The staff of health workers at the primary level—in terms of personal knowledge, continuity, and record-keeping—would be the hub of a coordinated patient care system.

When patients of primary care physicians are hospitalized, the primary care physician will arrange for a visit (referral) to a secondary- or tertiary-level specialist. Upon admission to a hospital, the patient will be placed under the care of a specialist. Contact between the referring primary care doctor and the specialist would be maintained upon admission and when needed during the inpatient period; upon discharge, patients would be referred back to their primary care physicians and a complete medical chart summary (showing progress, treatment regimen, and final diagnosis) forwarded to the community health center.

In some areas of the country, and for selected medical con-

ditions, the primary care physician will refer patients to the institution, and on confirmation of need for admission by the institutional specialist, will admit the patient and become part of the team treating the patient during hospitalization.

The "levels" in the regional system refer to the appropriate type of care and are not any indication of increasingly excellence. The care received at a community health center should be as highly developed and qualitatively excellent for its purposes as that in the secondary or tertiary level.

All physicians providing primary care in an NHS would be allotted time for upgrading of skills, perhaps through periodic "sabbaticals" for training at other levels or facilities in the system; and for other courses and seminars given at the expense of the health service. In turn, many community health center physicians would be expected to supervise and train residents in primary care fields. Community health centers located near medical school centers would likely be the sites for a great deal of primary care specialty training. While there is no question that an investment in continuing education would be a significant public expense, one could anticipate that the gains in quality and competence throughout the system would be very great.

SECONDARY CARE: NOT SECOND BEST

Replacing the many types of hospitals which now provide inpatient beds to most communities, and to which the local physicians may or may not have the "privileges" to admit patients, will be the public, community hospital. The community hospital would regularly serve the patients using the community health centers in its designated area. NHS medical staff at nearby community centers would have access to the community hospitals, to refer (and, in some cases, admit) patients for acute, general short-term hospital care. At community hospitals, routine inpatient care, major surgery, diagnostic testing related to hospitalization, and routine obstetrical deliveries would take place.

Practicing in and employed by the community hospital would be the internal medicine sub-specialists, general surgeons, orthopedists, pathologists, radiologists and many other specialists and surgical specialists for whom the inpatient setting is the appropriate practice site. These secondary care practitioners would carry a patient load based on the hospital census and the need for follow up of discharged inpatients. A regular amount of time would be allotted for their own continuing education as well as for supervision of residents and continuing education courses for other doctors. Hospital-based radiologists and pathologists would supervise and monitor related laboratory and diagnostic testing performed for outpatients at the community health centers.

ROLE REVERSAL: NOT QUITE

The present role of doctors in secondary (and to a lesser extent—tertiary) hospitals is very different from that envisioned in a National Health Service. Today, the medical "staff" of hospitals is not really a staff at all in terms of hospital employment. Rather, it is a number of independent practitioners, each of whom has qualified for "staff privileges" at one or more hospitals. Physicians with staff privileges are given the right to admit patients to the hospital to treat them while they are there and to order the use of the various hospital diagnostic and treatment resources and other hospital services (which are financed by government, third-party insurance companies or directly from patient hospital charges). Though there has been a trend in the larger hospitals to employ full-time chiefs for the various clinical services, the somewhat peripheral involvement of doctors in hospitals is still more often the rule than the exception.

In most American hospitals, salaried interns, residents and fellows (known collectively as housestaff) normally provide the only continuous medical coverage. Many smaller facilities cannot draw even on this overworked, apprentice laborforce and have no continuous coverage by medical staff. Surgeons, as well as sub-specialists and obstetrician-gynecologists, usually maintain outside offices and affiliations with several hospitals. Radiologists, anesthesiologists and pathologists may maintain offices in and contracts with more than one hospital.

Thus, most private practitioners in hospitals have the status of visiting dignitaries or artists-in-residence. Although doctors often have a great deal of influence over administrative policy-making (hospitals are dependent upon them for admissions), they have a rather narrowly vested interest in the overall quality of hospitals. Doctors often have more control over hospital policy than is commensurate with their commitment to the facility. This somewhat "loose" relationship of the physician with the hospital has consequences for patient care. A study by Milton Roemer, M.D., in *Doctors in Hospitals*, correlates higher adjusted mortality rates with hospitals with loosely structured staff obligations. Recent court decisions have found hospitals, rather than doctors, responsible for the quality of care received by inpatients. Yet, other judicial findings based principally on the provisions in the Social Security legislation forbidding "corporate interference" in the practice of medicine, make it difficult, if not impossible, for hospitals to enforce staff rules on reluctant physicians. This conflict has impact on patient care and can only be corrected by new doctor-hospital relationships.

FULL-TIME ROLE

In a National Health Service these tensions, barriers and legal disputes between doctors and hospitals would no longer obtain; all hospitals would be staffed by physicians who are full-time employees of the NHS. Interns and residents would be in training at these sites but they would no longer constitute an insecure, undersupervised, harassed and—usually—underpaid housestaff.

The variable relationship between doctors and hospitals under the present system has meant variability in the treatment of patients and in the supervision of housestaff, not only from hospital to hospital, but even among the departments within the same institution. With full-time physicians, inpatient care could be provided more uniformly, and responsibility for quality of care more easily determined and maintained—no matter which service, department or hospital.

As with primary care physicians, secondary care specialists would constantly be maintaining their skills and education under the supervision of tertiary level specialists and rotate for periods of time to tertiary institutions. During such period of advanced training, secondary level specialists will have the freedom to study the clinical and scientific advances pertinent to their fields of practice.

TERTIARY CARE PRACTITIONERS

As at the secondary care level, tertiary care practitioners—those doctors who work in the less frequently consulted specialties and sub-specialties—would find their relationships to hospitals regularized by the establishment of a National Health Service. No longer would specialists maintain private offices either outside or within hospitals or depend on consultative referrals by private attendings.

The tertiary care practitioners in each specialty would be the salaried employees of specialty facilities, which would often be part of major medical centers linked with university medical schools. The tertiary care complex would serve a number of community hospitals and the primary, community health centers in its region, and be the hub of region-wide educational activities. Although the focus of the large medical centers might be tertiary care, it is likely that the separations between secondary and tertiary hospitalization would not be entirely distinct. The tertiary care center might serve several community needs by providing a limited number of beds for routine care.

However, the tertiary center would focus on specialized and intensive care, house extraordinary diagnostic and therapeutic technology, and programs for special categories of illness and accidents (certain cancer therapies, open heart surgery, brain surgery, burn centers, high risk birth and intensive neonatal care, etc.).

At the present time, public monies underwrite about 50% of the costs of operating medical schools in the United States. Beginning with the Health Professions Education Assistance Act of 1963, and continuing with other legislation into the 1970s, the federal government has been deeply committed to supporting medical schools. In 1974, $414 million in federal dollars went to physician education, and $975.5 millions came from the states. In fact, more than 60% of medical schools are public (state or city) institutions. Medicare and Medicaid funds support the residency programs in teaching hospitals; and the Veterans Administration grants many millions of dollars to institutions for health professions education purposes.

In spite of this situation, there are few obligations undertaken by medical schools or medical students that go along with receiving this extraordinary "gift" from society. Most of the legislated subsidies of the last 15 years were enacted in the belief that medical schools are a national resource and in response to the periodically recurring opinion that the United States is suffering from a "doctor shortage." Whether or not the nation has "enough" doctors depends both on defining how many medical needs society wishes to meet and the manner in which physicians and other health personnel will be organized to meet them, but evidence suggests that increasing the number of doctors trained does not necessarily have directly positive outcomes in terms of public availability of care, equitable distribution of doctors, or even on the general health level of the population. The doctor "shortage" has been re-named a "maldistribution" problem, as doctors continue to specialize, subspecialize and to cluster in the affluent sections of cities and suburbs.

Meanwhile medical schools have tended to resist any mandatory requirements (such as changing curriculum, aggressively pursuing affirmative action, accepting transfers from foreign medical schools) that have gone along with accepting public monies. Privately accountable medical educators remain the arbiters of how many physicians shall be trained and in what specialties.

With a National Health Service, the goals of medical education would change profoundly; the health needs of the public would be the primary determining factors. Doctors would be educated to meet agreed-upon national health priorities. A top priority would doubtless involve a shift away from unwarranted super-specialization and towards the provision of primary care, as well as increased effort to geographically distribute practitioners to under-served areas.

Decisions concerning the recruitment, education, training and placement of medical students would

The educational responsibilities of tertiary care specialists would take up a comparatively larger proportion of time than would be the case for primary and secondary care practitioners. Just as society would invest more time and money in the education of the tertiary care physician; these specialists, in turn, have an enlarged educational obligation to train medical students, interns and residents. Teaching responsibilities, rotation elsewhere in the system for consultation and supervision and continuing education, as well as a varying amount of research, would likely be major responsibilities of the tertiary care specialist. In terms of direct delivery, they would perform special surgery, supervise procedures involving extraordinary technology, and diagnose and treat the rarer and more severe illnesses and injuries.

CONTINUING EDUCATION: NOW AND THEN

At this time only Maryland and New Mexico have any requirements for periodic recertification of doctors, and less than 25% of physicians nationwide undertake any further formal training (courses, seminars, etc.) after entering their practice. In a time when medical knowledge is undergoing rapid development, the scientific isolation of a doctor in private practice is an anachronism and an anomaly. Worse yet: it is dangerous to patients. In some cases, it fosters incompetence. Although the American Medical Association has tried to create incentives for continuing education by accrediting post-school courses and giving awards for the completion of a certain amount of post-training courses, it is difficult for many doctors to have contact with the changes in their field.

The expense and inconvenience of traveling to and registering in seminars and courses (which can run as high as $1,000 for 2 days) deter many doctors from updating their education. Since doctor earnings are usually related directly to the number of patients seen, doctors lose money while away from practice. The exigencies and unpredictable nature of private practice also dictate against the solo practitioners' extending their horizons through extra education.

Practice in a National Health Service would radically alter these constraints and open greater opportunities for continuing education to all practitioners. The general level of medical knowledge would be significantly raised. In addition to providing time and opportunity for formal course work and "advanced sabbatical training," the continual rotation of teaching specialists through regions, hospitals and primary sites, and the general exposure to other practitioners reduce the chance of undetected incompetency and increase general acceptability of the need to maintain and upgrade skills.

THE ECONOMICS OF PRIVATE PRACTICE

Fee-for-service, though the time-honored mode of remunerating doctors, has been associated with many problems in the health care system.

The most frequently cited implication for quality of care in the fee-for-service method is the incentive it creates for practitioners to perform unnecessary and/or perfunctory procedures, in order to maximize income. Even the most responsible physicians cannot be completely unaffected by the fact each service performed enhances their lifestyle, and (in the case of surgery) hones skills. The phenomenon of unnecessary surgery has been by now widely accepted and documented, although the exact amount of unnecessary procedures is the subject of some dispute. For the hospital-affiliated or hospital-based physician (usually a pathologist or radiologist) who receives an additional portion of his income in direct relation to the number of laboratory tests or other services generated by the department, there is likewise an incentive to influence policy towards ordering a great number of tests, even in situations where their applicability is in doubt, and where the risk inherent in the procedure may outweigh potential benefits. There is no incentive *not* to perform unnecessary surgery or control unnecessary tests under the present fee system.

Economically speaking, this same phenomenon inflates the cost of in-patient care, by swelling hospital bills. Patients who are insured by third parties do not feel the inflationary effects of extra tests directly, and have little incentive to call them to question. The personal trauma of hospitalization and lack of information about medical procedures further decrease the likelihood that unnecessary in-hospital tests will be questioned by a patient. Conversely, out-of-hospital (where people are rarely insured), the fee-for-service system is a deterrent to patients seeking the appropriate number of visits to a doctor's office and coming back for follow-through checks. And many doctors have noted that they will avoid ordering tests that patients cannot pay for. General practi-

center on questions of public health need. Decision-making (including admissions criteria) in medical schools would no longer be entirely the province of doctors, but would be broadened to include the input of consumers and other public representatives. This change, plus the expected curtailment on the extraordinary earning power of physicians, might be expected to have the effect of selecting (and causing the self-selection of) applicants with a different motivation in entering a medical career. Those with a strong public service orientation might be drawn into medicine in greater numbers than is presently the case; and a broadening of the admission criteria to include more than narrowly academic factors might bring about the increased presence of minorities and women in the profession.

HOW WOULD MEDICAL EDUCATION WORK IN NHS?

Candidates wishing to gain admission to a medical school would be reviewed by a panel of consumers, physicians and other health workers and would be rated according to their ability to meet social and technical (scientific) criteria. Medical schools would be required to ensure that entering class composition would be reflective of the region's demographic characteristics.

Accepted candidates would receive a tuition fee education and subsidy while in medical school. The extent of the subsidy would be based on a number of variables, including other sources of income, dependents and local cost-of-living indices.

THE GRADUATE

In the last year of medical school, students would rank their choice of level of practice and/or specialty. These choices would be matched to openings (based on need), much as is done today in internship and residency programs.

The graduating student, awarded a medical doctor degree, would be placed in an on-the-job training program for an apprenticeship period. The training programs would give exposure to delivery of care at all three levels but each practitioner would receive the bulk of his or her training in the selected specialty and level. (Doctors today average four years of training beyond medical school. One could anticipate slightly less time in an apprenticeship for NHS—especially since the number of super-specialists would be reduced.)

On the completion of training, new practitioners would then be matched with or placed in positions where needed. After an initial two or three year period, physicians could make application to be transferred geographically or to another level of care or specialty. Decisions on these applications would be based on available openings, public need and practitioner ability.

tioners have an incentive *not* to refer a patient from their practices, because referral means loss of income. Either way, it's not good medicine.

Other inflationary factors associated with fee-for-service remuneration are the wide geographical variations in doctors' fees, and third-party reimbursement policies which encourage the rapid increase in doctor charges. First explained at length by Sidney Wolfe and Ted Bogue of the Health Research Group in their 1976 report, "Why Not the Most?" these phenomena are extremely costly to the taxpayer-consumer in terms of federal and state involvement in the payment of doctor fees. The Medicare program pays doctors by reimbursing them for the "reasonable cost" of performing the service in their area. A surgeon's fee for a gall bladder operation can cost $290 in Ohio or as much as $1000 in Manhattan, a variation unexplained by the regional differential in the cost of living, by the varying costs of malpractice insurance, or by the quality of the surgical procedure. Federal (and many other) medical insurance programs, are geared to pay the prevailing fees in the region (whether the $290 or $1000 figure) and thus the amount of money paid out by Medicare for private doctor fees is totally subject to the control of practitioners. In addition to motivating a physician to practice where prevailing fees are highest, the inflationary effect of this lack of federal coordination and control is enormous.

WHAT PHYSICIANS EARN: NOW AND THEN

Since 1950, physician fees have risen at a rate higher than any other item or service and at a rate 43 percent faster per year than non-medical prices. The increase in supply of physicians in recent years has not retarded fee increases or physician incomes. According to the White House Council on Wage and Price Stability, in 1976, the median income, after taxes, of office-based physicians was almost $63,000. In 1975, one out of every four doctors had a net income from practice in excess of $80,000 (*Medical Economics,* Oct. 1976). The median income of physicians is more than *four times* the median income of all families.

In a National Health Service, physicians could be offered salaries comparable to the average net earnings they now report, adjusted for variations in working hours and number of weeks worked per year. In an NHS, the physician could expect a shorter and more regular working week, 48 weeks of work per year and time for continuing education. Other factors affecting NHS salaries would be amount of graduate training, willingness to practice in under-served areas, extra obligations and responsibilities undertaken, and extraordinary patient load.

As physicians are absorbed into the institutions which already pay salaries to four million health workers in the United States, the individual expenses they now report under their gross income—office maintenance, rent, malpractice premiums, individual billing procedures, staff—would be saved or redirected into more efficient modes of providing direct service.

FEE-FOR-SERVICE BUREAUCRACY

Another diseconomy associated with fee-for-service is the mammoth bureaucracy and wasted expenditure of doctor laborpower which comes from billing patients and third parties for every visit and/or procedure. Private and non-profit insurance companies, city, state and federal agencies, patients making co-payments, are all involved in this leviathan of a payment system. A National Health Service almost certainly means significant cost savings in this area of the health industry and the consequent possibility of channeling the savings into more socially beneficial areas.

In sum, the practice of paying doctors by salary, along with other workers in the health system, as would be the case under NHS, can be expected to have the following direct and indirect beneficial effects by:

1. removing incentives to perform unnecessary procedures and surgery—with consequent effects on health and on costs;
2. increasing the involvement of the doctor with the health facility;
3. shrinking of the enormous bureaucracy now employed in the process of countless individual billing claims filed with innumerable health insurers and private persons;
4. enhancing the doctor's opportunities to obtain continued education, with consequent benefits for both patient and doctor; and
5. removing monetary gain as a major factor in the selection of medical personnel and as an incentive to medical fraud.

QUALITY AND ACCOUNTABILITY OF PHYSICIANS

Doctors performing human services, though educated, trained and increasingly reimbursed at the public expense, are like many professionals—virtually exempt from public accountability. The private relationship between doctor and patient, and the technical abstruseness of medical science have both been arguments for screening medical practice from public view.

The almost automatic closeting of abuses that is characteristic of peer review, the apparent failure of PSROs to correct abuses of utilization, public attitudes that doctors are both omniscient and omnipotent—all have meant that the public has adopted a rather passive (or sometimes hostile and avoidant) stance towards physicians. The curb on advertising by doctors is but one more aspect of the professional environment of secrecy. The average person, therefore, when selecting a physician, when judging for competency, much less excellence, is often doing little more than guessing. This diminution of personal "agency" in health, along with the fragmentation associated with specialization and unrealistic expectations of patients, may be a contributing factor in malpractice suits.

According to Victor and Ruth Sidel, in *A Healthy State* (1977), approximately 16,000 physicians, or 5% of the nation's doctors, are incompetent by estimation of the U.S. Federation of State Medical Boards, doubtless a very conservative estimate. At the same time, only about 60 doctors a year have their licenses revoked, usually only for outright criminality or flagrant psychiatric, drug or alcohol problems.

A National Health Service, with its emphasis on education, its bringing the doctor out of the private office and into the view of the public and medical peers, its reliance on quality review procedures which are accountable not only to the medical profession but to the government and lay people, will mean a greater possibility of eliminating inferior medical practice.

TRENDS AND TRANSITION

In an appearance before the Senate during hearings on President Carter's proposals for hospital cost containment, DHEW Secretary Joseph A. Califano, Jr. acknowledged the eventual need for cost controls to be placed on doctor fees, adding that the administration had considered attempting it, but had rejected the idea because "We don't yet know how to handle that [the doctor] problem."

Though the government pussyfoots around the most explosive area of the health care system (doctors), pressures nonetheless mount for some kind of change in this sector. Sec. 1801 of the Social Security Act in Title XVIII (Medicare) prohibits federal interference in the private practice of medicine, but there is no doubt that government has made many moves to alter conditions surrounding and touching on doctor practice.

In an upcoming issue of CONSUMER HEALTH PERSPECTIVES, we shall discuss current trends and signs in contemporary medical practice which facilitate the formation of a National Health Service and a plan for phasing physicians into a regionalized, national system.

WHY IS A FOURTH YEAR MEDICAL STUDENT, A DOCTOR-IN-TRAINING, IN FAVOR OF A NATIONAL HEALTH SERVICE?

To me, there are many favorable aspects associated with the development of a National Health Service as opposed to the continuation of the traditional fee-for-service arrangements or even the development of a National Health Insurance Plan.

First, a National Health Service would remove consideration of a patient's income as a factor in deciding whom to treat and where. Quality health care could be distributed equitably on a per capita basis to all rather than have it preferentially allocated to those who are able to pay immediately or who have third party coverage whose rate of reimbursement exceeds that of Medicaid. This would allow practitioners increased flexibility in determining their role in the health care system without the worry of compromising the quality of care they can offer.

Second, since the government, ideally an organization reflecting the wishes of its constituency, would be the sole provider of health care services, preventive health could become a more acceptable part of health care. Currently, preventive care is seldom a reimbursable expense. Who currently will pay for counseling in the nutritional aspects of managing hypertension? Certainly, no third party payer does. The hope would be that the government would find the prevention of disease of less economic burden than the recurrent management of chronic disease states in highly expensive, highly technological acute care settings.

Third, it is hoped that patients could become much more willing participants in their health care than they currently are. Though the role of "expert" might well remain under a National Health Service, I would anticipate that the lowering of economic class distinctions between patient and doctors, with "more reasonable" salaries legislated, would assist in the process of demystification of health care. Also, I would foresee the NHS as providing a service offering increased consumer satisfaction, as has been proved in Great Britain. This would assist in lessening the current antagonism that exists between doctors and patients and permit patients to participate to a greater extent in their health care.

Fourth, control over health care monitoring could be assumed by the NHS rather than remain the province of fellow providers. Currently, there exists an aura of defensive self-protection in the doctor profession that tolerates degrees of incompetence in its ranks in exchange for immunity from external audit and review. Increased external monitoring could achieve increased competency in the field of practitioners I will relate to as colleagues.

There is one drawback in the NHS, from my standpoint, that would have to be overcome. As a medical student, I've had the opportunity to witness the differential health care available in VA hospitals relative to that of large University medical complexes. In part, some of this is the mere illusion created by the wealth of new, shiny technology present at the University, financed by the "profits" re-invested as capital expenditures. However, there are the qualities of bureaucratic inertia and gross inefficiency, that populate the halls of VA hospitals. These frustrate medical practitioners and impede quality health care and can only be removed by the power of tenacious governmental and consumer monitoring that would have associated powers of control and decision-making.

T.D., Case Western Reserve Univ. School of Medicine

HOW DO YOUNG DOCTORS FEEL ABOUT SALARIES?

JAY DOBKIN, M.D.
President Physicians National Housestaff Association

It is one of the small ironies of contemporary medicine that the traditionally taboo salaried physician has increasingly replaced the revered standard—the entrepreneurial private practitioner—without generating much excitement. This slow transformation is proceeding more with a whimper than with the bang many had feared (or hoped for). Instead of private practitioners being dragged screaming into a Health Service and placed on salary, the medical entrepreneurs themselves have adopted the salaried system in various ways, and in so doing have diffused a previously emotion-laden issue for a new generation of physicians.

With solo private practice a vanishing rarity, more and more physicians find themselves in arrangements where they are "salaried." It may be only the thinnest of disguise for standard private business—the professional corporation—but the fact remains that the physicians are paying themselves a salary. Or the arrangement may be somewhat further along the line toward a standard salaried-employee/employer relationship as it is in the larger group practices, hospital-based practice or government institutions and programs.

The significance of all this is not that it represents progress or is related to improved medical care. The opposite may even be true. What is important is that the simple codeword, "salary," which probably represented (and still may in some quarters) a threat to the basic principles of American medicine, no longer has that symbolic connotation to younger physicians. More specifically, the newer generation of physicians have a much more open, realistic approach to the practice options of the present and future: salaried group practices, HMOs, various approaches to national health insurance and even a national health service.

This impression has emerged over the last several years as I have spent time talking with interns and residents across the country and particularly over the past few months while interviewing young doctors completing training or recently embarked on salaried practice positions. When asked to describe the pros and cons of true salaried practice positions that are available now or may develop in the future, all gave detailed, factual answers; some very positive and others negative. Absent, though, was any evidence of ideological attachment to solo, fee-for-service private practice as the central dogma of medical care.

There are many factors which account for these perceptions. The mushrooming complexity of both medical practice and medical practice management is the key phenomenon. The prospect of being on-call every night, having no backup for illness or vacation, dealing with billing and collection and third-party payers is forbidding to many young physicians. Add to this the tremendous start-up costs necessary to begin a new practice, especially malpractice insurance, and it is not surprising that most of those entering private practice begin as employees of a group or partnership on a "guarantee" or salary basis.

Beyond these negative inducements, there are advantages to the larger-scale, more comprehensive settings in which most salaried physicians are employed. One psychiatrist who works for a publicly-run community mental health center offered the standard reason for choosing a salaried position: "It gets me out of being a businessman." He followed this, however, with several specifically therapeutic considerations, such as the latitude in treatment made possible by a large comprehensive facility—particularly, specialized nursing and aftercare. Other positive aspects cited were the variety of patients and the opportunity for substantial backup and "mutual supervision" by other health care personnel, including physicians. Negative factors were readily cited also: usually excessive bureaucracy. "The last two guys left at the same time—they felt that they were treating more paper than patients."

The ability to enter a setting complete with a functioning system of administration and a broad scope of personnel and resources was cited as an attraction by several residents completing primary care training programs. The elimination of ability to pay as the basic determinant of quality or quantity of medical care was also frequently noted as an inducement toward salaried practice in prepaid or other kinds of fully insured systems. However, for those already one or two years into such a career, there were several compelling reservations. To judge the validity of many of the allegations is difficult if not impossible. What is noteworthy, however, is that the problems seem severe enough to induce many to give up after a few years and seek a more "private" type of practice.

One simple issue is money. There is still a "goldrush" mentality in medicine, and many feel that salaries can never compete with the financial benefits of private practice. As I mentioned before, much is underway which may alter this situation, such as rising malpractice rates and other overhead factors, government cost controls and stricter audit and review procedures. But there is still perceived to be at least a glimmer of truth in this notion. As one doctor half-kiddingly put it: "Full time jobs are the last refuge for incompetents who couldn't hack it in the fee-for-service jungle."

Other issues include the underside of the staff and resources benefits cited before. In any institution large enough to have comprehensive resources and personnel there will be various measures of accountability or review that the salaried physician will be subject to. In some cases this is viewed as an asset, but some physicians are unable or unwilling to share authority with other providers or consumers. "One doctor who left here thought he should be more in charge and supervise everyone," was one example. In other cases there is the feeling of needless involvement with paperwork, an excess of administrators and endless meetings, discussions and committees. In the clinics or HMO's which are subsidized or grant-supported, there may also be the lingering feeling that the extensive range of services, the loose administrative practices and the over-indulgence in self-analysis are major weaknesses. In the worst instances, the bureaucratic hassles generated at a small clinic can recapitulate the experiences from which the young physician may have just escaped in the large urban teaching hospital.

Many additional matters were raised in the course of discussing the salaried practice issue with young physicians. Most of their reservations were just concerns about the financial status of the doctor, but relate directly to the type of setting where salaried physicians are currently in practice. Over-utilization of services is one concern raised several times. Even though the net result is better in terms of health care quality and costs if excess utilization is shifted from in-hospital to outpatient, in an HMO it may be the primary care physician who bears the brunt of excess night and weekend outpatient service demands unless services are structured to avoid this. Similarly, in smaller settings which cannot guarantee a regular work schedule, there may be an understandable lack of enthusiasm for extra weekend and night calls when coupled with a fixed salary and no economic incentives for extra work.

The list of real or perceived advantages and drawbacks of salaried practice is extensive. Some concerns may really have less to do with the central questions of medical care organization and delivery than with the self-image of the physician. "I don't want the typical image of the doctor where you have to wear a suit," one physician told me. "I don't want to go through the garbage you have to do to get referrals." What remains significant is that circumstances and sensibilities have changed significantly. We should not waste energy on such discarded totems as those related to full-time salaried practice. Rather we must develop the best settings and systems possible to maximize the advantages of this kind of practice for both consumers and providers.

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