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FEE-FOR-SERVICE PRIVATE PRACTICE MEDICINE The End Is In Sight

by Steven Jonas, M.D.

Last year in *Consumer Health Perspectives*, I discussed the "Problems and Contradictions" of fee-for-service private medical practice, and predicted its passing as a major form of physician employment.¹ In this issue, I will discuss some ideas on how and possibly when that will take place. Before doing so, I will briefly review the major points of the earlier paper.

Fee-for-service private practice is an idea whose time has gone, but it remains with us because it serves the present perceived needs of the medical profession (for high incomes and non-supervised work) and because the profession is politically powerful. The physician is central to health care delivery system operations and thus is a powerful figure in the delivery system. Private practice is a piece-work system, which rewards entrepreneurship, contributing significantly to many major problems of the health care delivery system, to wit:

- The lack of preventive services
- Sky-rocketing costs
- Over-specialization
- Geographic maldistribution of physicians and services
- Over-hospitalization and excess surgery
- The slow rate of pre-paid group practice growth
- Non-existence of national health care insurance

- Deficits in the quality of care
- The two-class system of medical care
- Distortion of the motivation for working

Central to the problems of private practice are three principal contradictions:

1. The vast majority of health workers, all of whose work is necessary to the health care delivery system, are paid on salary while the physicians and a few other professionals are paid on a fee basis.
2. About two-thirds of the monies needed to pay for personal health services are raised socially.² Fewer than ten percent of all health care workers are paid on a fee basis,³ yet they receive about one-third of all monies paid out for personal

READER INQUIRY

A number of readers have asked us how to obtain a copy of the article "How to Keep Your Mandated Citizen Board Out of Your Hair and Off Your Back: A Guide for Executive Directors" (*American Journal of Public Health*, August, 1979) which was referred to in our issue, "Health Consumers at the Cross-Roads: Which Way to Go?"

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health services.⁴

3. It is convenient and lucrative for physicians to treat diseases of individual patients, but historically, it has been measures applied to the population as a whole which have been the most beneficial to health. There currently happens to be a rapidly reawakening interest in prevention in both our people and our government.⁵

The American Way: Your Money or Your Life

Thus, private practice has deleterious effects on the health care delivery system and is subject to certain serious internal contradictions. Nevertheless, physicians are strongly attached to the private practice of medicine. In some discussions of the matter one gets the distinct impression that some physicians are more strongly attached to private practice than they are to any other aspect of medicine.⁶ These politically powerful physicians have been able to exploit the widely accepted notion that private entrepreneurship is the "American Way." In doing so they downplay reports of physician abuse of private practice and discourage consideration of whether treating the sick and making money should go together. The "one rotten apple in the barrel" defense is commonly used, and seems to work well.

Medical Mystique

Furthermore, although individuals and politicians occasionally rail against the medical profession collectively, it is quite a different matter to confront one's own physician individually. In the final analysis, personal health is the most precious of our possessions. Our physician is its guardian in our thoughts, if not in fact. And he or she guards it in a mystical way. When it comes right down to one's own health, doctor knows best, doctor is consulted and doctor is listened to. This very explainable dichotomy of thinking is the reason a public opinion survey can show similar percentages of respondents satisfied with their own care while thinking that the system as a whole is in a terrible mess.⁷ The Medical Mystique is powerful indeed. It gives the profession a powerful political weapon, which it has used many times in the past, to deal with the threat of legislated change in private practice.

How then will change come about? There are three possible routes that I can identify. There certainly may be others. I will examine revolution, legislation, and health manpower market pressures. The latter seems the most likely road in 20th century America.

Revolution

In the Soviet Union⁸ and China⁹, for example, socialist revolution has led to the substantial end of private practice in those countries. Such an event would surely provide the opportunity for the rapid resolution for the three major contradictions of private practice: social practice vs. individual control, social financing vs. individual payment, and the value of prevention vs.

concentration on disease treatment. However, although I may be wrong as an historical prognosticator, I see little chance of a socialist revolution taking place in this country in the foreseeable future.

Legislation

It is certainly theoretically and constitutionally possible for private practice to be legislated out of existence or severely constrained. Senator Kennedy's various national health insurance proposals already contain incentives for physicians to work in a salaried system. In the 1970's, Federal Administration policy under both parties has already seen increasingly strong encouragement to the development of pre-paid group practice. In the current national planning act, this movement is already strongly supported. It is theoretically possible for amendments to be attached to existing Medicare/Medicaid legislation, creating incentives for salaried practice. The states, which already have the power to regulate private health insurance companies, and exercise it heavily in certain instances (e.g. New York), could theoretically induce a similar pattern in Blue Cross/Blue Shield and commercial insurance.

The Federal government already operates the largest single salaried medical service in the country (the Veterans' Administration Hospital system), and two others of substantial size (the Department of Defense and Public Health Service systems). The states, many counties and some cities also already operate salaried medical services. It is conceivable that these services could be expanded significantly, creating competition with private physicians and gradually drawing them into salaried service.

Controlling Maldistribution

The problem could also be attacked indirectly by the "certificate-of-need" approach to the planning of private doctors' offices. This idea first appeared in Wisconsin in the mid-70's¹⁰, and recently re-appeared on the national scene; certificates-of-need were to be applied to private physicians' offices, the regulations could be written in such a way as to virtually force the end of the expansion of private practice in certain parts of the country. For physicians wishing to settle in those sections, salaried practice in an existing institution would be the only alternative. A concomitant of this approach would be the development of controls on the number of specialists, either through legislation or action by the voluntary agencies controlling residency training in response to the threat of legislation. Another parallel approach is the development of specialty licensure by state medical licensing boards. New Hampshire has already created a limited psychiatry-only license for psychiatrists.¹¹

Closing the Public Purse to the Private Sector

Finally, fee-for-service private practice could be attacked frontally in national health insurance or national health service legislation which, while not outlawing private practice, could refuse to reimburse physicians

for services provided under it. This is essentially what happened in Great Britain when the National Health Service came in there and is the approach taken, for example, under the Dellums national health service bill.¹² It could be made somewhat more palatable to the profession by a "grand-fathering-out" system which would continue to pay presently licensed physicians on a private practice basis forever or for a given number of years, while paying newly licensed physicians only on a salaried basis.¹³ There would be constitutional challenges to approaches of this nature under the due process clauses. In taking this tack, private medicine would once again reveal itself as primarily being a business, as it has done so many times in the past. When its basic economic interests are at stake, private practice does not seem shy about revealing itself in this manner. Such a constitutional challenge would probably be defeated using the general welfare and interstate commerce clauses, pointing out that private practice itself is not being prohibited, simply the payment for it under national health insurance/service.

Thus there are many political routes to change. Unless health care costs become absolutely uncontrollable, it is also unlikely that any of them will be carried through to the point that major change will take place. Some of them may play a complementary role to the main driver of the change-over to salaried medical service, health manpower market pressures. The political process will not work on its own, because of the political power of the profession, which is secured in part by the social and psychological factors discussed in the first part of this paper. Rather, the change-over to salaried service will come when it is in the interest of a significant proportion of the medical profession to work on salary. And that will happen when there are too many doctors, a condition predicted by the Department of Health, Education, and Welfare to occur around 1990.¹⁴

Health Manpower Market Pressures

It has been suggested in a previous issue of *Consumer Health Perspectives* that the increasing supply of physicians could bring about a change-over in the pattern of physician payment, for at least a significant minority of the medical profession.¹⁵ There is a great deal of logic to this supposition. The last major change in the social and economic status of the medical profession occurred at the beginning of this century. At that time there were many people who called themselves "physicians" and who practiced something akin to "regular" or allopathic medicine. There were many competing practitioner groups, including the osteopathic physicians, the homeopathic physicians, the chiropractors, the naturopaths, the Thomsonians, the eclectics, and so forth.

It happened that among all of the disciplines there were available few effective therapeutic interventions. As were the other groups of practitioners, the allopaths were unevenly trained. Many had less than a high-school education to go with their medical school experience, which was often of uncertain quality. There were virtually no quality controls of any kind on medical

practice. This situation, however, was not new. It had been recognized for almost 100 years, and many reform proposals had been made. Nothing happened however, until it came to be in the interests of the profession to allow change. The reasons for this were:

1. With advances in biomedical science allopathy was finally given some effective interventions, so that there was a reason to have some kind of quality control.
2. With the rapidly expanding output of medical schools, as well as the rapidly expanding output of competing practitioners, there was a reason to put a lid on the supply of new allopathic practitioners, and to attempt to freeze out the competitors.

Until the beginning of this century the proposals to reform regular or mainstream or allopathic medical education and institute some kind of quality controls on practice had nothing on their side but goodness and correctness. A century of national meetings, reports, and recommendations meant nothing until it was in the profession's own interest to change, or at least until it was in the interest of the profession's leadership and a significant portion of its membership. Reform did leave out some people, but that made it even better for those who remained inside. Thus, beginning with the opening of Johns Hopkins University Medical School in 1892, going through the founding of the American Medical Association's Council on Medical Education in 1904, and the publication of the Flexner Report in 1910 and concluding around 1920 with the demise of virtually all

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the proprietary medical schools (most of which were of very poor quality) American medical education changed significantly. Its quality improved with the introduction of university relationships, requiring basic science, clinical-patient experience, and a 2-year college prerequisite. Its output dropped markedly, from 5747 in 1906 to 3047 in 1920. The doctor to population ratio, which had been rising at the turn of the century, leveled off and then declined slowly.

At the same time, states were passing and enforcing medical licensing laws which served to improve quality but also served to reduce competition by limiting entry to allopathic medicine and freezing out as direct competitors all of the competing disciplines other than osteopathic medicine. Since in most states, the medical society either owned or controlled the licensing board, it was a simple matter for the profession to insure the adoption of desired policies.

Lifting the Lid on Supply

Through a variety of measures which we do not have space to consider in detail here, the profession was generally able to keep a lid on the supply of physicians until the mid-60's. However, beginning at about that time Federal and state government policies towards medical education, which were to have a major impact on the supply of practitioners, began to change. Over the next 15 years or so, a great deal of money was provided for medical school expansion. There were also policies which encouraged the training of two "mid-level" health professions: physicians' assistants/associates and nurse practitioners. These two new pro-

fessional groups proved particularly adept at providing primary care.¹⁶ It was found that physicians assistants and nurse practitioners could provide primary care that was of as good quality as that provided by physicians, and was cheaper. Medical school output doubled between 1965 and 1980. Beginning in 1976, new Federal legislation did lead to a virtual cut-off of the immigration of foreign-born foreign medical graduates, an important source of competition. However, at the same time, supported in part by favorable licensing legislation adopted by certain states, notably New York, American-born foreign medical graduates were being turned out in increasing numbers by proprietary medical schools in Mexico and the Caribbean.

History Repeats Itself—Almost

The manpower supply situation facing the medical profession in the period 1980-2000 is eerily beginning to look like that which faced the profession in 1880-1900. First, there is a rapidly increasing supply of "regulars" from accredited medical schools of reasonable quality. Second, a virtual explosion in the growth of proprietary medical schools, albeit off-shore, is producing graduates of questionable quality. Third, there are growing competing disciplines, especially in primary care. These disciplines, physicians assistants, nurse practitioners have an advantage over 19th century naturopathy and homeopathy: they share with allopathy the same bio-medical scientific base. By themselves, these factors would lead to increasing competitive pressures, even for a profession which at the present time generates a great deal of the demand for its own services. However, as supply increases, it is highly unlikely that the medical profession will be able to create all the demand it would like. Eli Ginzburg to the contrary notwithstanding, there is no evidence that the public's potential demand for health care services is infinite. In fact, the evidence from "free at the time of use" services indicates that the opposite is true. There are other factors which will probably serve to increase competition: First, there are finally being heard in the land complaints about high physicians' fees and the increasingly common practice of collecting them in advance. Second, for our already under-employed surgeons, there will be even less work as second-opinion programs come into general use.

At the end of the 19th century, the medical profession had several options to deal with competition. It chose to decrease its own output, raise its own quality, and freeze out most of the other disciplines. At the end of the 20th century, the profession will find itself with fewer, less attractive options. It now has little influence on physician supply. Medical school growth will come to a virtual halt, but for reasons of expense and questionable utility. The American medical schools alone will still be producing lots and lots of doctors: at least 17,000 per year for the foreseeable future. Furthermore, in the face of determined political activity by parents of medical students, especially in New York State, it is becoming increasingly difficult to clamp down on the 20th century proprietary medical schools which unlike

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their 19th century equivalents are outside the country but which like them, produce graduates who over-all are of dubious quality (although there certainly are individual exceptions), especially in their clinical abilities. The proprietaries have the potential to produce many graduates, although ultimately the total output of U.S.-licensed physicians will be limited by the availability of approved post-graduate training slots.

Foiled by Competent Competitors

The needed quality assurance measures *within* the profession no longer relate to numbers, as they did at the beginning of this century. It is not the licensing laws that most need beefing up, but the mechanisms of quality control in clinical practice. The major competitors outside the profession, the physicians assistants and the nurse practitioners, and possibly the osteopathic physicians (if they can grow in sufficient numbers, and differentiate their product), can no longer be labelled as "quacks." The physicians assistant/nurse practitioner group is growing and is gaining a limited form of medical licensure in many states. Thus control of numbers and quality are no longer open options for the medical profession. It is my suggestion that physician over-supply, predicted by HEW for 1990,¹² will eventually lead the profession, at least its younger members, to turn to salaried service, for security if nothing else.

Pity the Poor Private Doctor

There are other reasons besides increasing numbers and the difficulty of achieving a secure and stable income, especially for the younger members of the profession, which will impel the profession towards salaried service by the year 2000. The costs of private office practice are increasing. I have been told by friends in private practice that over-head, including rent, office staff costs, lab and x-ray costs, and especially mal-practice insurance, take about one-half of their gross income. Tax shelter opportunities are decreasing, so that extra, highly taxed income becomes less attractive, although not entirely unattractive to be sure. Medical students and house-staff of the 70's and 80's are on less demanding schedules in the course of their training than were their forebears, so that the tough schedule demands of private practice seem even less attractive than they did formerly.

The Balance Sheet

Salaried service has two major disadvantages for a physician who is used to thinking in private practice terms. One is that his/her income will likely be less, (or at least one foregoes the chance of being in that 20 per cent of the physicians who make over \$100,000 per year). The other is that he/she is supervised in terms of quality, productivity, time and schedule. Against these conditions, one must weight the advantages of salaried service: regular hours, regular call-schedule, paid and guaranteed vacation, sick-leave, and continuing medical education time, no office-management responsibilities, fringe benefits, paid mal-practice insurance,

no referral network to worry about, and, of course, the opportunity to practice high-quality medicine as part of a team, if the particular setting is right.

Right now research is needed to attempt to predict the time at which the change-over from physician-generated demand to a position of true excess supply will occur. Using economic forecasting methods with manpower supply data that is readily available, it should be possible to do this. At the same time, political strategies should be undertaken which would "encourage" the physician supply situation to move in this direction: continued expansion of the HMO system, strengthening of the government hospital system at all levels, expansion of primary care practice opportunities under proper quality controls for nurse practitioners and physician assistants. Since the quality of their product is so questionable, I do not view encouragement of maintenance and expansion of the off-shore proprietary medical schools as part of this strategy.

Salaried medical practice will come in the United States. It won't come because it's right or good. It won't come as a result of revolution or direct legislation. As have previous major changes in the economic form of medical practice in the United States, it will come because the physicians want it and need it.

REFERENCES

1. Jonas, S. "Fee-for-Service Practice Medicine: Problems and Contradictions." *Consumer Health Perspectives*. Vol. VI, No. 4, Aug., 1979, p. 1.
2. Gibson, R.M. "National Health Expenditures, 1978." *Health Care Financing Review*. 1, 1, 1979. Table 5.
3. Health Resources Administration. *Health, U.S., 1976-7*. Washington, D.C.: USGPO, 1977, Table 112.
4. Gibson, *op. cit.*, Table 3.
5. Surgeon General. *Healthy People*. Washington, D.C.: USGPO, 1979.
6. Bloom, W.H. "In Defense of Doctors." Letters to the Editor, *Newsday*, Nov. 19, 1979.
7. Robert Wood Johnson Foundation. *Special Report*. No. 1, 1978, p. 13.
8. Navarro, V. *Social Security and Medicine in the USSR*. Lexington, MA.: Lexington Books, 1977.
9. Lampton, D.M. *The Politics of Medicine in China*. Boulder, CO.: Westview Press, 1977.
10. Wisconsin Division of Health Policy and Planning. "Coverage of Organized Forms of Medical Practice under the Capital Expenditure Review Program Established in Wisconsin Pursuant to Section 1122 of the Social Security Act." Madison, WI., 1973.
11. Marano, H. "The New Psychiatry." *Medical World News*, Jan. 21, 1980.
12. H.R. 2969. "Health Service Act." Washington, D.C.: 96th Congress, March 14, 1979.
13. Jonas, S. *Medical Mystery: The Training of Doctors in the United States*. New York: W.W. Norton, 1979, pp. 325-326.
14. Stambler, H.V. "Health Manpower for the Nation—A Look Ahead at the Supply and the Requirements." *Public Health Reports*, 94, 3, 1979.
15. Consumer Commission on the Accreditation of Health Services. "National Health Service V. Building a Medical Staff." *Consumer Health Perspectives*, Vol. V, No. 3 August, 1978, p.1.
16. Jonas, *op. cit.*, pp.341-342.

SALARIED DOCTORS

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The Consumer Commission, rather than supporting an insurance plan through which government consents simply to be the sole financier of the present health system, endorses the formation of a National Health Service in which salaried physicians and other health personnel care for patients in public health facilities.

THE ORGANIZATION OF NHS

The National Health Service which the Consumer Commission has proposed would consist of a regionally organized, three-tiered institutional system, staffed by salaried health personnel, including full-time physicians. Primary care would be delivered in health centers located in neighborhoods and workplaces; routine inpatient (secondary) care in community hospitals; and specialty (tertiary) procedures and/or hospitalization in regional medical centers. The number and size of each region's primary, secondary and tertiary facilities would be determined according to population density and local medical need. (For a more complete discussion of the structure of NHS, see *Health Perspectives*, Vol. IV, No. 3, "NHS III" and Vol. V, No. 1, "NHS IV.")

Persons choosing to be treated within the NHS health system would receive all health services without charge. After NHS is fully established, those wishing to consult non-NHS physicians would be free to do so, but at their own expense.

HOW MANY DOCTORS?

A planned service organized in the manner described above would allot positions for physician staff based on regional needs. The question of how many physicians would be needed by the National Health Service is a complicated one. Evidence in current health planning literature indicates that the United States could be served at least as well as it is now by a system employing fewer doctors, provided that a majority of them were delivering primary, rather than specialized care. Presently, the United States has about 175 doctors per 100,000 people (or about one for every 575 people), with more than three-quarters of doctors limiting their practice to a specialized field.

In the study *Reducing Excess Hospital Capacity* (1976), Walter McClure, concludes that the United States could be quite adequately cared for by 130 doctors per 100,000 people, if 50 percent of those physicians were delivering primary care.

Obviously, any decision on the "necessary" number of physicians for the United States must be based on several factors, including the number of health needs the society chooses to meet, the extent to which ancillary medical personnel are engaged in the direct delivery of health services, the health status, age and socio-economic characteristics of the population and even the geographic features of the country. Presently, we have fewer physicians than the Soviet Union (where there is approximately one doctor for every 300 people), and more than Norway, a country known for its excellent health status, where there is only one doctor for about every 650 persons. Although the optimal number of physicians for the United States cannot easily be determined, we do know that by reorganizing the present supply of physicians along lines which have been outlined previously in this series of articles (See "NHS I" — "NHS IV"), we could be delivering more care, more efficiently, to more people.

THE DOCTOR BOOM: GOOD OR BAD?

According to recent projections, during the next ten years, the United States will experience an enormous increase in the absolute number of physicians and in the ratio of physicians to population (Katz, *et. al.*, *Journal of Health Politics, Policy and Law*, Vol. 2, No. 2, and USDHEW, *Forward Plan for Health*, 1979-83). The number of doctors is growing at a pace three times faster than the general population and the ratio of physicians to population (now circa 175:100,000) is expected to rise by 1990 to a level of about 240:100,000.

This increase ought to augur well for the nation's health status, but does it? Not if medical schools and training programs continue to turn out astronomical numbers of specialists and sub-specialists, a dwindling proportion of whom treat patients at the primary level.

Of all physicians in the United States, 83 percent now limit their practice to specialties (H. Wechsler, *Handbook of Medical Specialties*, 1976), although only 38.8 percent are board-certified, that is, have served in approved training programs and have, usually, passed a competency examination administered by one of the national specialty boards. Of first-year residents in 1976, fully 43% were being trained in the surgical specialties alone (Katz, *op. cit.*); it is expected that by 1985, only seven years from now, the supply of surgeons will have increased to 85% above the present level (*Surgery in the United States*, American College of Surgeons, 1975).

There are other reasons why an increase in the number of doctors will not necessarily have a positive effect on health. It has been frequently pointed out by health economists that in our system the classic laws of supply and demand seem to have little application to physician services. Instead, demand goes up along with increases in supply; physicians' incomes paradoxically are highest in the geographical regions where the supply of physicians is the greatest; and increases in the total number of practitioners have failed to distribute them either geographically or into the fields of practice for which there is a demonstrable need among the population (primary care or physical medicine, for instance).

For this reason, the anticipated increase in surgeons, for example, can be expected to have a drastic effect on the already unacceptable amount of unnecessary surgery being performed in this country. And since under the present system, the entry of each new physician into the market is said to generate anywhere between \$150,000 and \$350,000 in health expenditures per annum (Background Paper: Expenditures for Health Care, Congressional Budget Office 1977), we can expect total national health expenditures to continue to explode indefinitely. Disappointingly, if past experience is an indicator, the increase in labor power will take place without the positive effects of reducing the physician maldistribution problem or decreasing the overproduction of specialists.

If it holds true that physicians can generate their own demand, and government guarantees to pay for each service generated, national health insurance will be a disaster in terms of unnecessary procedures and higher costs.

SURPLUS MAKES CHANGE EASIER

Although the expected greatly increased number of physicians bodes ill for an insurance plan which underwrites the entire fee-for-service system, it would be an advantage for organizing a National Health Service.

Even granting that McClure's ratio of 130 physicians per 100,000 people is not ideal, it is clear that (with 240 doctors per 100,000 by 1990) a NHS would not have to go begging for medical staff, and would be in an excellent position to acquire competent physicians. With more than enough physicians to draw on during the initial phases, NHS could concentrate on training generalists and specialists for primary care—drawing either from the ranks of over-represented specialties or from the pool of recent medical graduates. Since the number of medical staff positions within NHS would be based on regional needs, competition for non-primary specialty positions offered by NHS would have the welcome effect of selecting only those specialists needed for NHS (perhaps with a marginal side effect of diverting some into the primary health centers) and diminishing the number of unnecessary procedures associated with having too many practitioners in a given field.

Fortunately, the rapidly increasing proportion of physicians in the general population presents a unique opportunity to use the market forces of supply and demand to recruit sufficient medical personnel for a National Health Service.

The next decade will see a buyers' market for physician laborpower. Although not all physicians will support NHS, enough should identify their own self-interest with the National Health Service to successfully meet the health care needs of the population. Even if a significant proportion of doctors should decide to strike, or to otherwise withhold services at the onset of NHS, there should be more than enough physicians to begin the gradual phase-in of NHS facilities without serious interruption of services or detriment to quality. Remaining opposition among health professionals will weaken as it becomes apparent that their services are not essential to the provision of medical care within the national system.

Based on projections of medical school enrollments, if a national health services were to begin today, within four years, between 64,000 and 80,000 doctors would have graduated directly from medical school into NHS. Since the total supply of physicians is expected to increase by nearly 60 percent in the next decade, and 30 percent of presently active physicians will have no longer be practicing in 1990, an almost entirely new population of physicians could be staffing an NHS by the end of a ten-year transition period.

Although organized medicine in the United States has traditionally balked at any innovation which circumscribed the physician's economic independence, we do not assume that there will be unanimity among doctors in opposing NHS. Rather, the prospect of participating in a model health system, universally accessible, will be welcomed by the many physicians who are concerned with quality and equity in medicine. Many doctors are distressed by the consequences of the present system, its unevenness, expense, corruptibility and its failure—in comparison with other developed nations—to improve the nation's health status.

It is true that, for some doctors, NHS would mean reduced income. Today, median doctor income, after taxes, is more than \$60,000. One in four physicians in 1976 took home more than \$80,000 after taxes. NHS physician salaries would range upward from \$25,000 to levels above the current median, depending upon years of service, training and responsibilities.

The "Gold Rush" in medicine would come to an end with NHS, but those physicians who remained would doubtless be more than comfortable with their lifestyles and with the knowledge that good medical care was in ready reach of all citizens.

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