

TABLE II
PHYSICIAN HOSPITAL WORK LOADS: 1959

Area	Physicians per 100,000 population	Hospital discharges per physician	Patient hospital days per physician
Northeast	149.0	71.3	728
West	128.2	94.7	729
North Central	103.4	113.6	966
South	91.4	127.5	930

Sources: *Health Manpower Source Book*, Sec. 10, pp. 5-6;
Health Statistics, Series B-No. 32, pp. 18-19.

there is at least the possibility that in higher income areas physicians spent more time taking care of patients in hospitals than in low income areas, which would tend to offset the disparities noted above.

But the opposite is more likely to be the case; that is, in low income regions doctors have probably higher hospital work loads than in high income regions. It was possible to compute the relationships between the number of physicians and the number of hospital discharges and the number of patient hospital days for the four major census divisions of the country. The physicians used for this purpose include all active nonfederal physicians in both private practice and in the hospital service. The results of the computations are presented in Table II, which shows the tendency of higher hospital work loads in areas with low physician-population ratios. The regional unevenness in work loads observed above thus tends to be accentuated when hospital work is taken into account.

We may also conclude that while differences in physical demand for physician services may account in part for the observed regional differences in physician-population ratios, they are not a sufficient explanation of existing disparities in the supply of physicians.

C. Fees for Physician Services

It was shown theoretically that high physician-population ratios in high income areas may be due in part to the fact that

fees are based on per capita income rather than on the supply and demand for physician services. It is not necessary, of course, that there be a complete absence of price competition, as was assumed in the theoretical model. A modest amount of price competition may well exist, which would keep fees from rising as much with increases in regional income as they would otherwise.

Some indication that fees are lower in low income areas is implicit in the data presented above in Table I, unless the relationships between regional physician incomes changed considerably between 1949 and 1959. Table I implies that the average income per visit in New England and the Pacific was between 35 and 40 per cent higher than in the southern areas. The East North Central area income per visit was about 20 per cent higher than in the South.

There are no relevant data available on physician fees,¹⁸ but we can remedy this deficiency in part by using another indirect method. The available data on spending and on number of visits make it possible to compute an index of fee differentials between income groups and regions. For the United States as a whole we have for a twelve-month period in 1957-58 an estimated \$25 spent on physician services per capita by families earning under \$2,000 annually;¹⁹ this income group is reported to have had 4.6 visits per capita during a twelve-month period in 1957-59, which indicates an expenditure of \$5.43 per visit. By the same process we obtain an expenditure of \$6.93 per visit for the \$7,500 and over income

¹⁸ The Bureau of Labor Statistics publishes data on certain types of fees paid by comparable wage and salary earner families in twenty major cities. These data, unfortunately, are not suitable for our purposes, since we are interested in comparisons between income groups.

¹⁹ One third of \$75 spent on all health services. See O. W. Anderson, P. Collette, and J. J. Feldman, *Family Expenditure Patterns for Personal Health Service, 1953 and 1958*, Health Information Foundation Research Series No. 14 (New York: Health Information Foundation, 1960), Table 4a, p. 8.