logic suggests that they should have comparable access to medical care.

If we value health from a social point of view and put the same value on the health of all individuals, the economic problem becomes essentially that of adjusting the available supply of physicians as efficiently as possible to the existing need. In the absence of any data on actual need, let us use expressed need, as represented by the number of visits. On these assumptions it can be argued that the existing pattern of physician distribution involves an inefficient allocation of medical manpower resources.

To the extent that wide disparities in regional work loads involve substantial differences in the amount of time a physician can devote to each patient, there is a tendency toward inefficiency. The assumed social values make the social utility of a comparable visit the same for all individuals. From the medical point of view, it is probably reasonable to assume that the effectiveness of a visit does not increase proportionally with the length of the visit beyond a fairly short minimum period. Physician resources made available for long visits are therefore not employed most efficiently. This does not even take into account the fact that where long visits are possible, the visits themselves may be less urgent. Further, where physicians are overloaded, the pressure of time to accommodate many patients may impair a doctor's ability to function with optimal efficiency. Finally, there may be economic inefficiency involved with regard to patients, who may have to waste a great deal of time in the waiting rooms of overloaded doctors. An efficient spatial allocation of physician manpower would therefore be one which tends to equalize the average allowable time per visit between all areas.

A few brief observations are in order also with regard to lack of mobility, which is clearly an important factor in the existing distribution pattern. It is rather doubtful that the existing distribution would be more equal if physicians were more mobile, in the sense that they would be more inclined to maximize either income or some combination of income and leisure. Many of the poorer areas of the country would undoubtedly be even worse off if all physicians made their location decisions with strict economic rationality.

Economic incentives and the lack of mobility also have implications for the improvement of the geographic distribution of physicians. It is unlikely, at least in the short run, that the distribution can be made significantly more even for the country as a whole by simply increasing the manpower output of our medical schools. It is very doubtful whether an increase, perhaps even a substantial increase, in the supply of physicians would automatically solve the distribution problem, as some medical authorities seem to think.[22] Such a measure might result in an increase in the number of physicians in areas where there is a shortage, but this would tend to be accompanied by an even greater increase in areas where there is already a relative excess supply of doctors. This does not promise to be an economical approach to the problem of distribution. On the other hand, there is good reason to believe that the unevenness in the distribution of physicians will diminish automatically, in the long run, along with the tendency toward regional equalization of per capita income.

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[22] See for instance the statement by Dr. P. R. Hawley in Committee on Medical Care Teaching, *Readings in Medical Care* (Chapel Hill, N. C.: University of North Carolina Press, 1958), p. 27.