REPORT TO THE CONGRESS

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

Recruiting And Retaining Federal Physicians And Dentists: Problems Progress, And Actions Needed For The Future

The Veterans Administration, Department of Defense, and Public Health Service are each experiencing some problems in the recruitment of physicians. Except for certain specialties, GAO found no serious problems in either recruiting or retaining dentists in any of these agencies.

It is difficult to identify and assess retention problems since, in most cases, agencies have not established retention goals against which success, or failure, can be measured. Also, most of the programs established to help alleviate recruitment and retention problems have not been in operation long enough to effectively measure their long-range impact.

Whether recruitment and retention problems continue to exist depends to a great extent on the future supply and demand of physicians and dentists.

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

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To the President of the Senate and the
Speaker of the House of Representatives

We have reviewed the problems facing Federal agencies in recruiting and retaining physicians and dentists and have evaluated the agencies' programs and practices for alleviating the problems.

Our review was made pursuant to the Veterans' Administration Physician and Dentist Pay Comparability Act of 1975 (89 Stat. 669), October 22, 1975.

We are sending copies of this report to the Director, Office of Management and Budget; the Administrator of Veterans Affairs; the Chairman, Civil Service Commission; and the Secretaries of Defense and Health, Education, and Welfare.

ACTING Comptroller General
of the United States

Contents

ABBREVIATIONS

BVA	Board of Veterans Appeals
CDC	Center for Disease Control
CORD	Commissioned Officer Residency Deferment
COSTEP	Commissioned Officer Student Training and Extern Program
DM&S	Department of Medicine and Surgery
DOD	Department of Defense
DVB	Department of Veterans Benefits
FTE	full-time equivalent
GAO	General Accounting Office
GS	general schedule
HEW	Department of Health, Education, and Welfare
HMO	Health Maintenance Organization
HRA	Health Resources Administration
HSA	Health Services Administration
IHS	Indian Health Service
NHSC	National Health Service Corps
NIH	National Institutes of Health

OMB	Office of Management and Budget
PHS	Public Health Service
RMC	regular military compensation
T&E	training and experience
VA	Veterans Administration
VIP	variable incentive pay

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

RECRUITING AND RETAINING FEDERAL PHYSICIANS AND DENTISTS: PROBLEMS, PROGRESS, AND ACTIONS NEEDED FOR THE FUTURE

D I G E S T

The Veterans Administration (VA) Physician and Dentist Pay Comparability Act of 1975 provided for special pay for some VA physicians and dentists. It also required GAO to

--review problems facing all Federal agencies in recruiting and retaining physicians and dentists,

--evaluate agencies' programs and practices used to recruit and retain,

--compare the remuneration of Federal and non-Federal physicians and dentists including those in academic medicine, and

--identify alternatives which might solve recruitment and retention problems.

The Federal Government employs about 39,400 physicians and dentists--the majority of which are in VA, the Department of Defense, and the Public Health Service in the Department of Health, Education, and Welfare (HEW). GAO concentrated its review in these agencies.

WHAT ARE THE PROBLEMS?

VA, Defense, and the Public Health Service are experiencing physician recruitment and retention problems. Except for an undocumented need for certain specialties, GAO found no significant dentist recruitment or retention problem. (See p. 13.)

In VA, factors other than salary--the most frequently cited reason for VA's inability to recruit and retain--also act as barriers. (See p. 16.)

These factors include

--restriction on outside employment,

--degree of affiliation with medical schools, and

--restricted type of practice available to VA physicians.

Authorized Defense physician and dentist manpower levels are generally met and frequently exceeded. The Department of Defense may, however, experience a temporary physician shortage between now and 1980 when its scholarship program has had time to take effect. (See p. 26.)

Much of the data needed for an assessment of Public Health Service recruitment and retention problems is not available. The problems GAO was able to identify were attributable to geographic isolation of some facilities, salary disparities between commissioned corps and general schedule physicians, and the scarcity of certain specialties. (See p. 29.)

WHAT HAS BEEN DONE TO ALLEVIATE PROBLEMS?

VA, Defense, and the Public Health Service have numerous programs and practices to recruit and retain physicians and dentists. Included are special pay, programs to finance a medical education in return for future service, and programs which appeal to individual interests, such as research and affiliation with medical schools. Although the effects of the programs cannot be measured individually, when viewed in total they have been beneficial. (See p. 42.)

Two of the special pay programs used by DOD and Public Health--continuation pay and variable incentive pay--are not being administered within the law and its intent since pay under these programs is offered to virtually all who are administratively eligible. According to the law and legislative histories, these payments were intended

only for those physicians and dentists in critical shortage specialties. Neither Defense nor the Public Health Service have determined critical shortage categories. (See p. 57.)

The scholarship programs of these agencies may result in a surplus of physicians. For example, in Defense an excess of over 3,000 physicians may occur by 1990. By 1980, the Public Health Service agency employing scholarship recipients--the Health Services Administration--may have more physicians than it now employs and an additional 800 entering annually. (See pp. 62 and 71.)

None of the agencies had clearly defined recruitment and retention goals. The absence of goals may result in having too many, or too few, of a particular specialty, as well as an oversupply or undersupply in general. (See p. 106.)

COMPARISON OF REMUNERATION BETWEEN FEDERAL AND NON-FEDERAL SECTORS

Income is only one factor in comparing physicians' and dentists' remuneration. Fringe benefits, retirement programs, working conditions, and other factors also influence career and job choices. A comparison of income--cash and cash benefits--is the most objective comparison that can be made since the other benfits cannot be readily quantified. GAO did, however, compare the non-quantifiable benefits between the Federal and non-Federal sectors. (See p. 75.)

Comparison of incomes between the Federal and non-Federal sectors showed that

--private physicians who have completed their residency training generally earn more than their Federal counterparts,

--private sector physician income varies by medical specialty and geographically while Federal incomes do not,

--incomes for uniformed service dentists after several years exceed dentists in any other group, including the private sector, and

--physicians employed by medical schools earn less than uniformed service physicians but amounts comparable to VA physicians.

Within the Federal sector, uniformed services physicians and dentists generally earn more than their other Federal counterparts.

WHAT NEEDS TO BE DONE?

A uniform compensation plan should be developed for Federal physicians and dentists. Such a plan should be built around the unique characteristics of the physician and dentist occupations and should provide sufficient flexibility to deal with special situations. (See p. 94.)

The 39,400 physicians and dentists in the Federal Government are employed under a number of different pay systems scattered throughout numerous agencies. Under the present systems, similarly qualified physicians and dentists can enter the different systems at different levels, progress at a different pace within the system, establish eligibility for a bonus based on different criteria, receive different fringe benefits and allowances, and thus receive compensation which varies significantly among individuals and systems. (See p. 102.)

Certain changes are needed in the present separate systems. (See p. 104.)

RECOMMENDATIONS TO THE CONGRESS

Before a uniform compensation plan can be developed for all Federal physicians and dentists--civilian and military--much more study is needed. To provide a long-term solution, the Congress should:

--Direct the Director of the Office of Management and Budget to develop a uniform compensation plan for all Federal physicians

and dentists. The plan should include a method, or methods, for comparing and adjusting pay and benefits. The Office of Management and Budget should be charged with developing a uniform personnel management and compensation system applicable to all Federal physicians and dentists. If there are compelling reasons for separate systems, a unified plan should be developed and provisions made for interrelating the systems.

--Require that within 1 year, or earlier, after the direction from the Congress, the Director submit to the Congress a report of the results of Office of Management and Budget's activities, together with its recommendations, including proposed implementing legislation and cost estimates. (See p. 103.)

RECOMMENDATIONS TO AGENCIES

GAO also recommends that:

--The Secretaries of Defense and HEW make in-depth studies to identify and adequately document the critical specialties within their respective departments and modify the continuation pay and variable incentive pay programs so that they are administered in accordance with the legislation. If, after identifying these critical specialties, the Secretaries determine that continuation pay and variable incentive pay should be paid to physicians and dentists in noncritical specialties, legislative changes should be sought to permit such payment.

--The Secretaries of Defense and HEW develop long-range plans on how physicians entering through the scholarship and university programs are to be used. Such a plan should be developed soon so that action can be taken in time to prevent a surplus.

--The Administrator of Veterans Affairs and the Secretaries of Defense and HEW each

develop programs to identify their respective physician and dentist needs, by specialty, and to fulfill these needs. (See p. 107.)

Because of the time constraint of issuing the report by August 31, 1976, GAO asked for informal agency comments. GAO did, however, provide VA, Defense, the Public Health Service, and the Office of Management and Budget an opportunity to informally comment on the draft report, and these comments have been included as appropriate. VA was able to finalize its comments.

CHAPTER 1

INTRODUCTION

The Veterans' Administration Physician and Dentist Pay Comparability Act of 1975, Public Law 94-123 (89 Stat. 669), October 22, 1975, provided for special and incentive pay of up to $13,500 annually for certain physicians and dentists in the Veterans Administration's (VA's) Department of Medicine and Surgery (DM&S). DM&S administers VA's health care delivery system. At the end of fiscal year 1975, this care was being provided primarily through a system of 171 hospitals, 213 outpatient clinics, 86 nursing care units, and 18 domiciliaries.

The additional pay was to help VA recruit and retain physicians and dentists. Section 2(a) of the act stated that (1) the statutory ceiling imposed on Federal salaries had seriously impaired the recruitment and retention of qualified physicians and (2) the compensation provided to these physicians and dentists had been rendered noncompetitive by the special pay of up to $13,500 annually provided to certain medical officers in the uniformed services--the military and the commissioned corps of the Public Health Service.

Section 4(a) of the act directed the Comptroller General and the Director, Office of Management and Budget, each to (1) review the short- and long-term problems faced by all agencies of the Federal Government in recruiting and retaining physicians and dentists and (2) furnish a report to the Congress by August 31, 1976. Specifically, section 4(a) required:

"(1) An investigation of the short-term and long-term problems facing the departments and agencies of the Federal Government (including the uniformed services) in recruiting and retaining qualified physicians and dentists.

"(2) An evaluation of the extent to which the implementation of a uniform system of pay, allowances, and benefits for all physicians and dentists employed in such Federal departments and agencies would alleviate or solve such recruitment and retention problems.

"(3) An investigation and evaluation of such other solutions to such recruitment and retention problems as each deems appropriate.

"(4) On the basis of the investigations and evaluations required to be made under paragraphs (1), (2), and (3) of this subsection, (A) an identification of appropriate alternative suggested courses of legislative or administrative action (including proposed legislation) and cost estimates therefor, which in the judgment of the Comptroller General or Director, as the case may be, will solve such recruitment and retention problems, and (B) a recommendation, and justification therefore, of which such courses should be undertaken.

"(b) The reports required by subsection (a) of this section shall also include--

(1) a comprehensive analysis of--

(A) the existing laws and regulations relating to the employment of physicians and dentists by such departments and agencies of the Government, including an analysis of the various pay systems established pursuant to such laws,

(B) the existing physician and dentist recruitment, selection, utilization, and promotion practices of such departments and agencies, and

(C) the degree to which the various pay systems referred to in subparagraph (A), the practices referred to in subparagraph (B), and other relevant departmental and agency practices are effective in alleviating or solving such recruitment and retention problems; and

(2) a comparison of the remuneration received by physicians and dentists employed by such departments and agencies with the remuneration received by physicians and dentists in private practice or academic medicine who have equivalent professional or administrative qualifications, based upon information available through medical, dental, and health associations and other available sources."

Section 4(d) of the act also required the Comptroller General to review the recruiting and retaining problems in DM&S of medical personnel other than physicians and dentists. A report to the Congress under this section is required by March 1, 1977.

PHYSICIANS AND DENTISTS IN THE FEDERAL GOVERNMENT

Approximately 25 Federal agencies employ physicians and dentists--ranging from as few as one in some agencies to several thousand in others. (See app. VI.) Information available at the time of our review showed that approximately 39,400 physicians and dentists were employed by the Federal Government. This includes residents, interns, consultants, and intermittent physicians and dentists.

Physicians and dentists are employed under a variety of statutory authorities. (See app. VI.) At the time of our review, there were nine separate authorities. Following are the agencies which employ physicians and dentists:

Statutory authority	Agency
2 U.S.C.	Panama Canal Zone
5 U.S.C.	Numerous agencies
16 U.S.C.	Tennessee Valley Authority
22 U.S.C.	Department of State
37 U.S.C.	Uniformed Services (Department of Defense and commissioned corps, Public Health Service)
38 U.S.C.	VA (DM&S)
39 U.S.C.	United States Postal Service
42 U.S.C.	Department of Health, Education, and Welfare; Energy Research and Development Administration; and National Aeronautics and Space Administration
49 U.S.C.	Department of Transportation (Federal Aviation Administration)

Within the Federal Government, VA, the Department of Defense (DOD), and the Public Health Service (PHS)

employ the bulk of physicians and dentists. At the time of our review, these agencies employed over 21,500 physicians and about 6,800 dentists, not including interns, residents, and intermittent physicians and dentists employed by VA and DOD.

Physicians and Dentists
Employed by VA, DOD, and PHS
September 30, 1975

	Physicians	Dentists
VA	8,937	882
DOD (note a)	9,219	5,235
PHS	3,419	656
Total	21,575	6,773

a/As of March 31, 1975, for civilian physicians and as of June 30, 1975, for military physicians and dentists.

We concentrated our review in these agencies because they employ the bulk of physicians and dentists.

PHYSICIANS AND DENTISTS IN VA

VA employs physicians and dentists under two statutory authorities--titles 5 and 38 of the United States Code. As of September 30, 1975, VA employed 126 title 5 physicians, 8,811 title 38 physicians, and 882 title 38 dentists. VA does not employ title 5 dentists. Title 5 physicains are assigned to either the Department of Veterans Benefits (DVB) or the Board of Veterans Appeals (BVA). Physicians employed under title 38 are assigned to DM&S.

DVB and BVA physicians

DVB and BVA physicians are Federal civil service employees, entitled to all benefits and subject to all regulations as other civil service employees. Title 5 physicians in VA, and other agencies, may be paid at special rates. (See app. VI.) Special rates were authorized by 5 U.S.C. 5303 and may be used when pay rates in the private sector are so above the general schedule as to handicap the Government's recruitment and retention of qualified persons. Special rates for physicians have been authorized for over 20 years.

Physicians employed by DVB are involved in determining medical eligibility of applicants for VA benefits, such as disability compensation. BVA physicians review and make decisions on cases where applicants for benefits have been rejected for medical reasons and the applicant appeals to BVA for review.

DM&S physicians and dentists

DM&S was created in 1946 by Public Law 79-293 (38 U.S.C. 4101). According to VA, the act gave the Administrator of Veterans Affairs "full authority and responsibility to establish a separate personnel system free of competitive service restrictions for physicians, dentists, and nurses" in DM&S. Since passage of Public Law 79-293, other occupations have been added to title 38. Title 38 authority extends to all DM&S physicians, dentists, nurses, physician assistants, and expanded-duty dental auxiliaries. The VA central office positions of directors of (1) chaplain service, (2) pharmacy service, (3) dietetic service, and (4) optometry have also been added to title 38 authority.

According to VA, the basis for a separate DM&S personnel system was its inability to recruit an adequate number of qualified professional personnel under competitive service (civil service) procedures. VA stated that the civil service pay system was inadequate to attract physicians and that pay should be geared to professional qualifications and attainments rather than to the position held. It further stated that civil service procedures for examining candidates and establishing registers of qualified professionals were not adequate and that VA needed greater authority for removing employees.

Appointment procedures in DM&S

In general, DM&S seeks to recruit physicians and dentists who are fully trained. As a result, the typical DM&S physician or dentist is somewhat older when appointed than a typically appointed physician or dentist in the uniformed services.

Selection of DM&S physicians and dentists is based upon examination and recommendation of professional standards boards. These boards are composed of from three to five members approved by the Chief Medical Director or his designee. The membership of these boards includes qualified professionals in the occupational field being considered. The boards recommend the grade and pay of an applicant, taking into consideration the applicant's education, experience, competency, and professional stature.

DM&S has a seven-level grade structure. Appointment to the first five grade levels is based upon the individual's qualifications. Persons appointed to the top two grades--executive and director--must hold specific positions.

Salary of DM&S personnel

Physicians and dentists are paid on the basis of their grade. (See app. III.) In addition to regular pay, certain physicians are entitled to additional annual pay of up to $13,500 and certain dentists are entitled to additional pay of up to $6,750.

Full-time physicians and dentists accrue 30 days of annual leave per year and may accumulate as much as 120 days. Sick leave is accrued at an annual rate of 15 days with no limitation on the maximum. Part-time personnel generally earn leave in proportion to the hours worked in DM&S. Annual leave is charged in DM&S--as in the military--for nonduty days (weekends) as well as for duty days.

Personnel in DM&S are subject to and entitled to the same retirement and insurance programs as other Federal civil service employees.

Full-time physicians and dentists are generally prohibited from engaging in outside employment for remuneration, except for teaching, consultative duties, and community service. There are no restrictions on outside employment for part-time personnel.

Promotion of DM&S personnel

DM&S has established a promotion system for physicians and dentists which relies primarily on recommendations of peer groups, the professional standards boards. The boards review candidates who have met the administrative requirements for promotion and, based on the candidate's growth potential, recommend whether a promotion should be made. The administrative requirements are concerned with periodic proficiency ratings and time in grade.

DM&S also has merit programs to advance within grade. Advancement within grade may be made for outstanding achievements or exceptional performance upon approval of the

professional standards boards and the hospital director or, in some cases, the Chief Medical Director or his designee.

DOD PHYSICIANS AND DENTISTS

DOD employs both civilian and military physicians and dentists. On March 31, 1975, there were 688 civilian physicians in DOD. As of June 30, 1975, there were 11,155 military physicians, including residents and interns, and 5,235 military dentists, including residents and interns, in DOD.

Civilian physicians in DOD are civil service employees and are assigned to Armed Forces Entrance and Examining Stations and military hospitals throughout the country. DOD civilian physicians may be paid at special rates which apply for medical officers in the civil service. (See app. IV.) Since DOD employs only a small number of civilian physicians, we limited our review to military physicians and dentists.

Military physicians and dentists, including interns and residents, are commissioned officers and are entitled to the same benefits as other members of the Armed Forces.

The primary purpose of a force of military physicians and dentists is to maintain the health of the members and the fighting strength of the military services. Care is provided for the sick and injured in peacetime, while at the same time preparations are made for health support in time of war.

Appointment procedures in DOD

DOD uses a peer group review board system to assess the quality and fitness of applicants for physician and dentist positions. Qualification standards, based on years of training and experience, are established for each grade. Applicants must meet these standards as well as physical requirements. The boards base appointment recommendations on all available information.

Because of the military's desire for a relatively young work force, physicians and dentists are recruited primarily at the entrance level. Entrance level for physicians and dentists is at pay grade 0-3, e.g., Army Captain.

Compensation of DOD physicians and dentists

Personnel in the uniformed services are compensated according to their rank. (See app. II.) In addition to basic pay, members receive allowances for quarters and subsistence. Several forms of compensation in addition to basic pay and allowances are paid to physicians and dentists. These additional compensation programs are discussed on page 52.

The uniformed services have their own benefits programs. Some of the benefits are similar to those in DM&S and civil service while others are unique to the uniformed services.

One of the most significant differences is the retirement program. Under title 10 of the United States Code, commissioned officers of the uniformed services may retire after 20 years of active service, with no minimum age limits. Civil service and DM&S employees must have a combination of years of service and age--30 years service and age 55--for regular retirement.

Another aspect of the uniformed services' retirement program is that it is noncontributory, i.e., employees do not make financial contributions to their own retirement. In contrast, the retirement program for civil service and DM&S employees is a contributory system. Both the employee and the employing agency make periodic contributions to a retirement fund. Only uniformed service members are subject to social security tax and receive social security benefits.

Active and retired members of the uniformed services are entitled to free medical and dental care for themselves and free medical care for their dependents. Members are also entitled to life insurance for a nominal amount. Uniformed service personnel earn 30 calendar days of annual leave per year and may accumulate as much as 60 days. Similar to DM&S, annual leave is charged for nonduty as well as duty days.

Promotion of DOD physicians and dentists

Although each of the military services has its own promotion policies and procedures, they all follow the same general practices. A service promotion or selection board assesses candidates for promotion on the basis of qualifications, periodic efficiency ratings, and time in grade.

On the basis of the assessments, the board makes recommendations on promotions.

The program for physicians and dentists, discussed on page 63, is different; they are generally promoted much more rapidly than other officers. DOD's regulation on physician and dentist promotion states that professional development and responsibilities of medical officers call for a grade structure that is different from the traditional military grade structure. It also states that it is desirable to offer medical officers in DOD an attractive and predictable career pattern which assures them a career competitive with opportunities in the private sector. As a result of this policy, it is possible for most physicians to predict their progression in DOD with a great deal of accuracy. In July 1976, DOD changed its policy of promoting physicians and dentists. This change will have the effect of gradually slowing promotion of these personnel and of reducing promotion opportunity.

PHYSICIANS AND DENTISTS IN PHS

PHS, the health component of the Department of Health, Education, and Welfare (HEW), is the third largest Federal employer of physicians and dentists. DOD and VA each employ more.

PHS is comprised of six major components:

1. Health Services Administration (HSA),
2. Health Resources Administration (HRA),
3. Food and Drug Administration,
4. Center for Disease Control (CDC),
5. National Institutes of Health (NIH), and
6. Alcohol, Drug Abuse and Mental Health Administration.

These six organizations provide for biomedical research; health professionals in isolated communities, on Indian Reservations, at Federal prisons, and Coast Guard Installations; general medical and surgical hospitals; the National Leprosarium; treatment of mental illness and drug abuse; safeguarding the health of the consuming public; and control and prevention of communicable diseases.

PHS employs physicians and dentists under three different systems--the PHS commissioned corps system, the Federal civil service, and a Federal civil service-related system.

PHS commissioned corps

The commissioned corps of PHS is one of the uniformed services of the United States. Its grade structure is based upon military officer rank. Pay and allowances--including additional compensation to physicians and dentists--are identical to the military system, as is the retirement provision--retirement after 20 years service. Appointment is also similar.

The commissioned corps of PHS was organized along military lines in 1873. According to PHS, organization similar to the military was necessary in order to provide for a mobile force, subject to duty anywhere. The commissioned corps has, on three different occasions--World Wars I and II and the Korean War--been declared a military service by Executive order.

As of September 30, 1975, there were 2,435 physicians and 635 dentists in the commissioned corps.

PHS attempts to meet its physician and dentist needs by recruitment into the commissioned corps program. However, the corps has the same entry requirements as the military, and applicants not qualifying for this program may enter PHS service as civil service employees. Generally, an applicant may not qualify for the commissioned corps for one or more of the following reasons:

--Age. An applicant generally must be 44 years of age or younger since the mandatory retirement age is 64 and 20 years of active service is usually needed to qualify for retirement benefits.

--Physical condition not adequate.

--Conscientious objection.

--No U.S. citizenship.

The PHS promotion system for the commissioned corps is somewhat different from DOD's in that PHS members may be promoted faster. Promotions and appointments are based on years of training and experience (T&E)--as in DOD--and are the same for all health professionals: 6 years of T&E qualifies for pay

grade 0-3, 10 years for 0-4, 15 years for 0-5, and 22 years for 0-6. The difference comes in the number of years T&E granted to the various professions. Physicians (and dentists) get 8 years of training and education for medical or dental school plus 1 more year for a civilian internship.

With no civilian internship, a PHS physician will be an 0-4, 2 years after graduation (enters with 8 years of training and education plus 2 years with PHS = 10 years). It will take a DOD physician 3 years to attain the rank of 0-4. A PHS physician will be an 0-5, 7 years after graduation and an 0-6, 14 years after graduation. Attaining the same ranks in DOD will take 8 years and 15 years, respectively. As noted on page 9, DOD recently modified its accelerated promotion policy for physicians and dentists.

Federal civil service system

The second largest group of physicians and dentists in PHS is employed under title 5 of the United States Code. As of September 27, 1975, PHS had 819 general schedule (GS) physicians and dentists. The grade of these physicians is based on a combination of two factors: the level of assignment and the level of professional development. The interplay between these two factors determines the ultimate grade of the position. GS physicians are authorized to receive special rates (up to the statutory limit of $37,800) since physicians are considered a hard-to-fill, or shortage, category. The general schedule of pay, including the extended range for special rates, is included in appendix IV. GS physicians receive no special pay or allowances.

As of September 27, 1975, only 17 dentists were employed under this authority.

GS dental officers do not receive special pay, nor are they authorized the special or extended rates on the GS pay scale.

Civil service related system

A third system is authorized by title 42 U.S.C. 210g and is a variation of the civil service system. This system authorizes the Secretary of HEW to establish not more than 150 positions in professional, scientific, and executive service within PHS. Under this provision physicians and dentists may be hired into supergrade positions (GS pay grades 16 to 18).

Finally, PHS has civilian interns, residents, staff fellows, and visiting associates and scientists. Their pay, allowances, and retirement, as well as those authorized by 42 U.S.C. 210g, are governed by either civil service or departmental regulations. Neither of these groups receive special pay or incentive pay, such as that provided for eligible members of the commissioned corps. As of September 27, 1975, PHS had 9 dentists and 231 physicians under either the 42 U.S.C. 210g program or serving as interns, residents, fellows, etc.

SCOPE OF REVIEW

Of the approximately 39,400 physicians and dentists employed by the Federal Government at the time of our review, approximately 37,400, or about 95 percent, were employed by VA, DOD, and PHS. We therefore concentrated our review in these agencies. We did, however, contact other agencies employing physicians and dentists regarding any recruitment and retention problems they were experiencing. Their comments have been included as appropriate in this report.

Our review was made at the headquarters of VA, DOD, and PHS in the Washington, D.C., area and at field locations of these agencies in Alabama, Arizona, California, Connecticut, Colorado, Georgia, Maine, Maryland, Massachusetts, Montana, South Dakota, Washington, D.C., and Wyoming. (See app. V.) We also mailed questionnaires to selected physicians, dentists, and residents who

--were employed by these agencies at the time of our review,

--had terminated their employment prior to our review, or

--had declined employment with these agencies.

We coordinated our review with the Office of Management and Budget (OMB). OMB was provided the material we used to plan and conduct the review and much of the statistical material gathered by us during the review.

We also obtained data and discussed the review with representatives of the American Medical Association, the American Dental Association, and the Group Health Association of America, Inc., an organization composed of prepaid health groups located throughout the United States.

CHAPTER 2

PROBLEMS EXPERIENCED IN RECRUITIING AND RETAINING PHYSICIANS AND DENTISTS

The Veterans Administration, Department of Defense, and Public Health Service are each experiencing some problems in recruiting physicians. Except for certain specialties, we found no serious problems in either recruiting or retaining dentists in any of these agencies.

It is difficult to identify and assess retention problems since, in most cases, agencies have not established retention goals against which success or failure can be measured. Also, most of the programs established to help alleviate recruitment and retention problems have not been in operation long enough to effectively measure their long-range impact.

Whether recruitment and retention problems continue depends to a great extent on the future supply and demand of physicians and dentists. Discussed below is the issue of the nationwide supply and demand of physicians and dentists. The recruitment and retention problems faced by VA, DOD, and PHS are discussed on pages 16, 26, and 29.

PHYSICIAN SUPPLY AND DEMAND

There is a good deal of disagreement not only about a current physician shortage but also about whether there is likely to be a future shortage. For example, PHS in 1969 estimated that there was a shortage of 50,000 physicians.

Those who believe that a physician shortage exists cite, as further evidence, the continual demands for admissions to medical schools and the sustained influx of foreign-trained physicians into the United States to fulfill the Nation's medical needs.

The American Medical Association believes that a physician shortage exists and states that both short-range and long-range solutions are needed to alleviate the shortage. In a July 1975 paper prepared for Members of Congress, the Association stated that the best short-range source for obtaining more physicians is to expand enrollments at existing medical schools and the best long-range solution is the development of new medical schools.

The Association estimated in July 1975 that since 1964 the physician population had grown 33.6 percent while the overall population was up 9.1 percent. It further estimated that in 1975 there were about 380,000 medical doctors in the United States. This represented an increase of about 13,300 from the previous year. Of this total, active physicians numbered about 329,000 of whom about 300,000, or 91 percent, were engaged in patient care.

Those who contend that the physician shortage is being alleviated cite a 1975 statement of the Secretary of Health, Education, and Welfare. In his November 1975 letter to the Congress transmitting the proposed Health Professions Education Amendments of 1975 for its consideration, the Secretary of HEW referred to the Comprehensive Health Manpower Training Act of 1971. According to the Secretary, this act was passed to assist health professions schools to increase the number of students enrolled, in order to meet what was then seen as a serious aggregate shortage of health professionals and to attempt to place these schools on a solid financial footing. The Secretary further stated that, in the intervening 4 years, enrollments had increased by 34 percent and graduates by 45 percent, with further increases in graduates forthcoming in the next few years.

The Secretary expressed the belief that, with the maintenance of this training capacity, adequate numbers of health professionals will soon be in practice. Instead of a shortage in the aggregate sense, he stated, two other problems appear to be more pressing--geographic maldistribution and specialty maldistribution. The Secretary concluded that, without Federal efforts to alter institutional and individual incentives, correction of these imbalances is likely to occur slowly, if at all.

Those who believe the supply of physicians is sufficient conclude that, even if there were a shortage of physicians in the aggregate, the shortage will likely be a short-term problem calling for a short-term solution.

They believe that ways to correct this short-term problem would include continuing the liberal policy toward the immigration of foreign-trained physicians and initiating greater efforts to increase physician productivity. Furthermore, they believe that there is an inherent danger in the building or expanding of training facilities since such an approach might result in a long-range problem of physician oversupply.

Determining the existence or absence of a nationwide physician or dentist shortage was beyond the scope of our review. We did, however, review several studies on this matter since it is an important factor and will affect the Federal Government's ability to acquire physicians and dentists.

One of the conclusions to be drawn from an analysis of physician supply is that the shortage may disappear in the 1980s. This conclusion, however, is dependent on the assumption that there will be insufficient increase in demand to offset the increase in the physician-population ratios, both by specialty and overall.

Factors other than population growth, however, may increase physician demand, including having larger percentages of the population in higher age brackets, higher education levels, and higher income levels. Technological changes may also increase physician demand, particularly in some specialties. Institutional changes--changes that tend to divorce the allocation of health resources from ability to pay, such as providing more financial access through third-party and Government financing--could also increase physician demand. On the other hand, increased physician productivity made possible, for example, by increased use of paramedical personnel could tend to prevent an increase, or decrease, in physician demand.

In summary, whether or not there is a continuing shortage depends on the supply and rate of growth in demand. It appears, however, that unless demand grows rather substantially, the overall shortage will be much improved in the future. In some specialties, including those for which VA is experiencing difficulty in recruiting and retaining, the shortage may be eliminated.

DENTIST SUPPLY AND DEMAND

The paucity of data on dentist supply and demand prevents an analysis similar to the one made for physicians. In a study made for VA in 1973 and 1974, however, the future nationwide dentist supply and demand issue was discussed in general terms.

The study reported that the per capita demand for dental services is likely to increase markedly in the future because of

--a continuing emphasis on early detection and treatment of dental problems;

--rising standards of living, which make more people able to buy dental services; and

--probable inclusion of routine dental care benefits for many people if a national health insurance plan is enacted.

The study stated that demand for dental services could increase from 25 to 50 percent by 1990. It reported that projected growth could lead to a 20 to 25 percent increase in the number of active dentists relative to population by 1990. The study added, however, that if recent trends toward dental specialization continue, virtually all of these increases in the number of dentists could occur in dental specialties rather than in general practice where much of the future demand will occur.

The study concluded that the increase in demand for general practice dentists suggested a national need for limiting the growth of graduate medical education opportunities in the dental specialties and responding to the need for general practice dentists.

The study also reported use of dental auxiliaries has been shown to increase dentist productivity by 20 to 40 percent in terms of visits handled. It urged that (1) the exposure of dental students to task delegation be intensified and (2) the supply of dental auxiliaries be increased. It also urged that dental auxiliaries be trained to function in a team practice.

RECRUITMENT AND RETENTION PROBLEMS IN VA

Although inadequate salary has been the most frequently cited reason for causing recruitment and retention problems in DM&S, we believe other factors have also affected its ability to recruit and retain physicians. We do not believe DM&S is experiencing significant problems in recruiting or retaining dentists. Similarly, neither the Department of Veterans Benefits nor the Board of Veterans Appeals appear to be faced with any serious physician recruitment or retention problems.

Recruitment and retention problems for DM&S physicians

The problems identified in recruiting and retaining Department of Medicine and Surgery physicians during our review include salary and salary-related problems and such other problems as location of hospitals and the nature of practice available to VA physicians.

Salary as a problem

The statutory limitation on Federal salaries--$36,000 (now $37,800) annually--was the reason used by VA to justify additional pay for DM&S physicians. VA testified before congressional committees that the salary limitation was causing an increasing number of physicians to terminate, or reject offers of, VA employment. VA also stated that the limitation was making it increasingly difficult to fill vacancies, particularly in certain medical specialties, and was causing it to increasingly rely on foreign medical school graduates to staff its hospitals.

VA's Chief Medical Director testified that physician salaries in DM&S were not comparable to those of the (1) uniformed services, (2) private practice, or (3) physicians in the academic world.

Data submitted by DM&S in support of special pay for its physicians showed that for a selected group of physicians, the military received 48 percent more income than DM&S physicians. In a comparison between a DOD physician at pay grade 0-6 and a counterpart DM&S physician at the grade of chief, the income difference was about $13,000.

	Hospital chief of service or section	
	VA	DOD (0-6 grade)
Base pay	$36,000	$31,417
Special pay		4,200
Tax advantage on special pay		1,428
Special pay (variable incentive pay)		12,000
Total	$36,000	$49,045

DM&S also pointed out that the DOD physician is entitled to free medical care and noncontributory retirement. The DM&S physician shares the cost of both of these benefits.

DM&S also submitted data which showed that the average income of private practitioners--solo practice--and physicians in academic medicine was 33 percent greater than income received by its physicians. The difference rose to 83 percent when compared to private physicians in group practice.

Based on our review of VA studies and on responses to our questionnaires, it is questionable whether salary is the main reason for termination of VA employment. It may, however, be a significant factor for rejection of employment offers. We believe, moreover, that salary comparisons are too limiting in that they do not take into consideration all elements of compensation. In our opinion, a more meaningful comparison is one which accounts for all elements of compensation, including salary and fringe benefits. Such a total compensation comparison for Federal and non-Federal physicians and dentists is discussed in chapter 4, page 75.

As shown below, VA's analysis of exit interviews--held when the physicians terminated their VA employment--shows that the number of VA physicians who have quit has increased only slightly since 1968. Moreover, the information shows that the rate of physicians who claimed they quit for pay reasons had actually declined since 1968.

	Total quits		Quit for pay reasons	
Fiscal year	Number	Percent of VA physician population	Number	Percent of total quits
1968	394	7.68	54	13.00
1969	414	8.21	41	9.90
1970	394	7.76	33	8.37
1971	404	7.80	22	5.44
1972	587	10.91	19	3.23
1973	459	8.63	17	3.70
1974	474	8.94	24	5.06
1975	425	7.90	31	7.29

Salary may be more of a reason for rejection of employment offers than terminations. We asked each of the 171 VA hospitals to provide data on reasons why VA employment offers were rejected. According to the information provided, 430, or about 42 percent, of the 1,013 employment rejections, were for salary reasons. As discussed on page 24, however, other reasons also influence an individual's decision to decline offers of VA employment.

Other problems in recruitment and retention

Several other problems have been claimed to hamper recruitment and retention of physicians in VA. Included are factors such as VA's restriction on outside employment, degree of affiliation with medical schools, geographic locations of hospitals, and types of practice available to VA physicians which were identified in our May 1975 report to the Subcommittee on Hospitals, House Committee on Veterans Affairs. 1/

Except for teaching and teaching-related activities, VA regulations generally prohibit full-time physicians from engaging in non-VA duties for remuneration. There are no restrictions on the activities in which part-time physicians may engage.

The restriction on outside employment has been said to cause the dramatic increase in the number of full-time physicians reverting to part-time status. According to VA records, from July 1, 1974, through August 15, 1975, 205 physicians converted to part-time status. Also, 345 part-time physicians rejected full-time employment during the same period of time.

The degree of affiliation with medical schools was mentioned as a factor affecting recruitment and retention in our May 1975 report. It is said that the stronger the affiliation, the less recrutiment and retention difficulty. The reason fewer problems may be encountered is because in many cases physicians have an opportunity to supplement their VA income by holding faculty appointments at the medical school. Moreover, the affiliation program offers an academic and research atmosphere for those physicians who desire this environment.

The view that affiliated hospitals have fewer recruitment and retention problems is supported somewhat by this review. About 80 percent of the VA hospitals with a physician vacancy rate of 20 percent or more were either not affiliated or were not strongly affiliated with medical schools. Conversely, most hospitals with a vacancy rate of 0.5 to 5 percent were strongly affiliated. Although other

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1/ Adequacy of Medical Staffing in Selected VA Hospitals, MWD 75-83, May 5, 1975 (B-133044)

factors such as geographic location probably have an effect on vacancy rates, it appears that the degree of affiliation acts as a positive recruitment and retention tool.

The restrictive nature of practice available to VA physicians was stated in our aforementioned report to cause recruitment problems. Proponents of this view say that the veteran population, comprised mainly of older males, limits the scope of a physician's practice since it offers no opportunity to treat women and children. Since VA regulations prohibit outside practice, there is little opportunity to acquire this mixed practice, particularly if the employing hospital is not affiliated with a medical school.

Reasons other than pay identified in exit interviews conducted by DM&S with physicians who had quit VA from 1968 to 1975 are shown, as follows:

	Percent of quits							
Reasons	FY-75	FY-74	FY-73	FY-72	FY-71	FY-70	FY-69	FY-68
Military	2.1	2.1	2.2	4.4	3.0	-	5.0	7.0
Working conditions	1.7	0.8	2.0	1.0	1.0	2.0	-	2.0
Nature of work	8.7	7.8	7.4	6.3	9.0	6.0	8.0	6.0
Geographic location	16.0	17.7	15.2	13.1	15.0	13.0	12.0	13.0
Health/ physical condition	2.4	2.1	2.6	2.6	5.0	3.0	3.0	3.0
Personal relation	0.1	0.4	0.4	0.7	1.0	2.0	1.0	1.0
Family	1.2	1.1	0.9	1.9	1.0	2.0	1.0	1.0
Self-development	13.2	14.4	11.8	17.4	17.0	14.0	14.0	13.0
No reason given	47.3	48.5	53.8	48.3	43.0	50.0	46.0	41.0

From the above data, it appears that geographic location and self-development are two factors that strongly influence physicians to leave VA.

In our May 1975 report, we cited geographic location as a factor which affected a hospital's ability to recruit. We reported that certain locations--because of their proximity to cultural centers, metropolitan cities, and resort areas--are more desirable.

Data supplied by all VA facilities showed that hospitals with the highest vacancy rates were generally those located in more remote areas. For example, hospitals like Grand Island, Nebraska; Poplar Bluff, Missouri; and Miles City, Montana, had vacancy rates greater than 20 percent while hospitals like Miami, Florida; Tuscon, Arizona; and San Diego, California, had 5 percent or less vacancy rates.

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A high vacancy rate would be one of the most adverse effects of serious recruitment and retention problems. An analysis of physician vacancy rates, or vacancy rates for any specific occupation, is difficult to assess since VA does not have physician "slots." Instead, each VA hospital is required to operate within manpower ceilings which include all hospital personnel. Thus, if a VA hospital cannot fill a "vacancy" for a physician, it may hire other personnel and still remain within the manpower ceiling.

An indication of the confusion as to what constitutes a vacancy can also be demonstrated by two VA reports which are supposed to report vacancies. One, the filled and vacant positions report--a quarterly report on vacant positions by each hospital--showed 393 vacant physician positions as of September 30, 1975. The other report, the recruiting bulletin, is a monthly publication listing each vacant position and the hospitals where the positions are located. Its purpose is to provide job information to prospective employees. The recruiting bulletin listed 235 vacant physician positions as of September 30, 1975.

Since the definition of a vacancy may be subject to different interpretations, we requested each hospital to provide us with the number of physician vacancies which had been funded and for which they were actively recruiting. This data is shown below by medical specialty as of September 30, 1975.

Medical specialty	Full-time equivalents (FTE)		
		Vacancies	
	Number	Number	Rate
Internal medicine	1,632.7	189.3	10.3%
Psychiatry	1,262.2	157.1	11.1
General medicine	1,364.7	73.0	5.1
General surgery	510.0	53.9	9.6
Radiology	414.4	39.7	8.7
Pathology	406.7	35.6	8.0
Anesthesiology	159.3	22.3	12.3
Physical medicine	197.7	18.5	8.6
Spinal cord	51.4	8.0	13.5
All other	1,356.7	126.8	5.3
Total	7,355.8	724.2	9.0%

For certain medical specialties it is possible to acquire needed physician services by contract. VA actually acquired under contract 146.6 FTE positions during fiscal year 1975 for the specialties shown below.

Medical specialty	Contracted FTE
Radiology	81.1
Pathology	16.3
Anesthesiology	49.2
Total	146.6

Recruitment and retention problems for DM&S dentists

It does not appear that DM&S is experiencing major problems in recruiting dentists. Similar to physicians, retention problems are difficult to assess since retention goals have not been established. However, information available at VA's central office, discussion with DM&S dentistry office staff, and data gathered by us at VA hospitals do not indicate any serious problems in dentist retention.

As of September 30, 1975, there were 819 FTE dentists in DM&S. The following shows the specialty distribution makeup of DM&S dentists and the vacancies in each specialty as of September 30, 1975.

Dental specialty	Full-time equivalents		
		Vacancies	
	Number	Number	Rate
Periodontics	24.5	2	7.5%
Prosthodontics	63.0	2	3.1
Oral surgery	55.0	2	3.5
All others	676.5	11	1.6
Total	1/819.0	17	2.0%

1/Composed of 811 full-time and 16 part-time dentists and excluding 295 residents.

In recent years, the rate at which dentists are terminating DM&S employment has shown a downward trend. For example, the quitting rate for dentists--the ratio of quits to total dentist employment--has declined from 7.55 percent in fiscal year 1972 to 5.25 percent in fiscal year 1975.

Data from all VA hospitals shows that during fiscal year 1975, DM&S made offers of employment to 198 dentists of which 99 accepted the offers. Following are the reasons given by the 99 dentists who rejected the offer.

Reason	Number	Percent of total
Accepted employment with other Government agency	6	5%
Accepted employment elsewhere	17	17
Unsuitable professional environment	8	8
Inadequate salary	27	27
Other reasons	23	23
Reason not given	18	18
Total	99	1/100%

1/Does not total because of rounding.

Satisfaction of physicians and dentists employed by DM&S

We questioned salary matters and future intentions in a questionnaire to physicians and dentists who were employed by VA hospitals which we visited during our review. These hospitals employed 1,722 physicians and 119 dentists at the time we mailed the questionnaire in January 1976. Questionnaires were

sent to 185 physicians and 20 dentists at these locations, and we received 83 responses.

Over 80 percent of the respondents stated they were satisfied with their present salary, about two-thirds stated that they planned to remain in the VA, while less than half of the respondents said they would have remained without special pay.

Reasons for leaving DM&S employment

To identify the reasons for leaving DM&S employment, we sent questionnaires to 65 physicians and dentists who left DM&S during fiscal year 1975. We received 51 responses. Our questionnaire was designed to solicit multiple answers on the reasons for quitting; therefore, we are unable to identify any particular factor as the most important. We believe that the decisions to quit were the result of several factors.

Over two-thirds of the respondents said that the prospect of better opportunities elsewhere played an important role in their decision to leave, while about 60 percent believed that certain job characteristics or working conditions played an important role in this decision. Also about 35 percent believed that salary and benefits were an important factor, while 25 percent stated that an undesirable job location was an important factor in leaving.

Reasons physicians and dentists declined DM&S employment

To determine the reasons for rejection of employment offers, we sent a questionnaire designed to solicit multiple responses to 76 physicians and dentists who had declined employment in fiscal year 1975. We received 32 responses.

Slightly less than half the responses indicated that salary and benefits were factors in their decision, about 60 percent listed certain job characteristics as having an influence, 40 percent stated that the location where they would work was a factor, and almost three-quarters of the respondents believed that the prospect of better opportunities elsewhere played an important role in their decisions to reject employment.

Recruitment and retention of DVB and BVA physicians

Neither DVB or BVA appear to be experiencing any serious problems in recruiting or retaining physicians.

Physicians in DVB

Physicians in DVB are employed as medical rating specialists. Recruitment is decentralized to the VA regional benefits offices. These physicians are obtained through normal procedures for competitive service positions. Applications are usually obtained through the Civil Service Commission job announcements and by word-of-mouth of medical officers presently employed by VA. At the time of our review, all DVB physicians were GS-12 and were paid at the special rate of pay authorized for medical officers. (See app. IV.)

As of September 30, 1975, there were 108 physicians in DVB with four physician positions vacant.

According to DVB officials, the nature of the work and no opportunity for advancements results in attracting physicians who are retired from private practice--about 70 percent are 60 years of age or older--or who are physically disabled and unable to engage in the rigors of private practice.

Physicians in BVA

According to the vice chairman, BVA has no recruitment or retention problems for physician positions. This official told us that most of BVA's recruitment is done by word-of-mouth; it has not had to advertise any vacancies in the last few years. At the time of our review BVA employed 16 physicians and maintained a waiting list of qualified physician applicants.

Similar to DVB, the lack of recruitment and retention problems in BVA may be attributable to the type of physicians attracted to BVA service. About 70 percent of all BVA physicians are 60 years of age or older; 12 percent are 70 years of age or older. As of September 30, 1975, all physicians in BVA were GS-15 although most were recruited at the GS-14 level. As in DVB, BVA physicians are paid at the special rates authorized for medical officers.

RECRUITMENT AND RETENTION PROBLEMS IN DOD

It does not appear that DOD is experiencing significant short-term problems in recruiting or retaining physicians and dentists. Authorized manpower levels are generally met and frequently exceeded.

As of March 31, 1975, the authorized strength in DOD was 12,062 physicians and 5,135 dentists. The number on active duty as of that date was 11,369 physicians--693 less than authorized--and 5,235 dentists--100 more than authorized. Where problems do exist, the reason generally seems to be one of specialty maldistribution rather than gross manpower shortages. The reason for the lack of current problems is probably attributable to the fact that physician and dentist needs have traditionally been met through the draft and draft-related programs. These programs, and other programs and practices DOD has used to alleviate, or preclude, recruitment and retention problems are discussed in chapter 3, page 52.

As a result of the ending of the draft in 1973, however, DOD may be faced with a physician shortage in the late 1970s and early 1980s since the impact of its physician's scholarship program--the program DOD will primarily rely on to acquire its physicians in the future--will not be fully effective until then.

Retention of physicians and dentists in DOD

As in VA, problems associated with retention of physicians and dentists in DOD are difficult to quantify since specific goals have not been established. However, as discussed on page 28, DOD may experience a physician shortage about 1979 or 1980 as a result of physicians leaving the military before replacements can be recruited.

In recent years, according to a Defense Manpower Commission report, turnover of physicians and dentists in DOD has been high. As of June 1973, only about 15 percent of physicians had been in the military for more than 10 years. Even with the various monetary inducements, turnover is still high. However, the retention is slowly improving--DOD loss rates for physicians have decreased from 37.4 percent in fiscal year 1974 to 28.4 percent in 1975 and are expected to be 26.5 percent in 1976.

DOD has stated that a 25 percent long-term retention goal--until retirement--would meet its physician needs. None of the military services, however, have adopted specific retention goals.

In the absence of goals, the financial inducements offered to DOD physicians and dentists to increase retention--discussed on page 52--may act as a means to retain more personnel than is desirable. To a degree this may already be occurring in some specialties. For example, we were informed by an official in the Office of the Assistant Secretary of Defense (Health Affairs) that with the cessation of hostilities in Vietnam, the military's need for surgeons had been greatly reduced. Yet, physicians with surgical specialties are being paid variable incentive pay which encourages them to remain in the service occupying positions which otherwise might be filled by physicians with more needed specialties.

Some degree of retention is obviously beneficial because it is less disruptive and less time is spent in training new personnel. However, retention of everyone until retirement may be uneconomical and undesirable. For example, a study prepared for the Department of the Navy in 1973 on recruitment and retention of physicians concluded that because of the high retirement costs, a high degree of turnover is more desirable than retention until retirement.

The reasons given by physicians and dentists for leaving the military services are similar to those in other Federal agencies--inadequate salary, location of assignment, etc. While the concern about salaries is frequently mentioned, physicians and dentists at the installations we visited also expressed other reasons for leaving the military.

Many individuals expressed concern with certain aspects of the military environment. For instance, frequent transfers and the possibility of remote assignments were viewed as unfavorable because of the disruptions caused. Other persons indicated that there is a lack of independence in practicing military medicine because of the regimentation. Some physicians were discontented because they were not used in their fields but, instead, were used as general medical officers to fill the shortage of such individuals at their installation. Another working condition problem cited by many physicians was the lack of additional training possibilities for further professional development.

Medical and dental chiefs also indicated that the criteria for awarding special pay was proving to be a disincentive for retaining physicians who had an obligated term of service. For example, individuals participating in an obligated program perform the same tasks as nonobligated personnel yet the former is not eligible to receive special pay. For this reason a high rate of attrition is expected among obligated officers. Some dental chiefs were of the opinion that the retention of dentists is also jeopardized because they are excluded from the special pay program.

Physician shortages in future

Although DOD does not appear to be facing any short-term physician recruitment problems, it may face a shortage during the late 1970s and early 1980s. The reason for this, according to a DOD study, is that the supply of physicians obligated through the draft and draft-related programs will be depleted and the scholarship program will not yet be fully effective as a replacement supply source.

In a 1975 report on special pay for DOD medical personnel, the DOD Health Studies Task Force estimated that about 1,000 physicians could be voluntarily recruited annually. However, the Task Force report estimated a shortfall, using fiscal year 1977 authorized positions, of as many as 429 physicians in fiscal year 1977 to 195 in fiscal year 1980.

The estimates assume continuation of the special pay program now authorized. This authority expires on June 30, 1977. The report estimated that if the program is not renewed, only 300 physicians could be voluntarily recruited and the shortfall would continue through fiscal year 1990--the latest year for which projections were made. A shortfall of 1,340 physicians was estimated for fiscal year 1990.

Another DOD report stated that general duty dentists may prove fairly easy to recruit but dental specialists are likely to be more difficult to obtain, partially because of the income disparities between dental specialists in the military and their counterparts in the private sector.

Satisfaction of physicians and dentists employed by DOD

We sent a questionnaire concerning compensation, satisfaction, and future job intentions to about 10 percent of the 2,534 physicians and 304 dentists who were employed by

DOD at locations we visited during our review. We received 121 responses.

Over 70 percent of the respondents expressed satisfaction with their present salary, while about 87 percent were satisfied with the benefits. About 40 percent said they planned on remaining in DOD, while over 80 percent stated that they would not have stayed without the various special pays.

Reasons for leaving DOD employment

To identify the reasons for leaving DOD employment, we sent questionnaires to 124 former DOD physicians who left between June and November 1975. We received 81 responses. Our questionnaire was designed to solicit multiple answers on the reasons for quitting; therefore, we are unable to identify any particular factor as the most important. We believe the decisions were the result of several factors.

About 95 percent of the respondents said that better opportunities elsewhere played an important role in their decision to leave, while 86 percent believed that certain job characteristics or working conditions played an important role in their decision. Also about half indicated that salary, benefits, or compensation was an important factor, while almost 40 percent said that an undesirable job location was an important factor in leaving.

RECRUITMENT AND RETENTION PROBLEMS IN PHS

Much of the data necessary for an effective assessment of physician and dentist recruitment problems in PHS was not available. Information concerning vacancies, recruitment goals, and success in meeting these goals has not been developed by all component organizations of PHS. Retention data was available as of September 1974 and to a limited extent for September 1975.

Because of the lack of much of the data necessary for an effective identification of the problems, we were not able to conclusively determine the severity of PHS's problems and, in some cases, to determine if such problems exist at all. The areas discussed in the following sections should therefore be viewed with the understanding that concrete, incontrovertible data was often not available.

Physician recruitment problems

The recruitment problems identified by us were:

--Much difficulty in recruiting physicians for remote and isolated areas in the National Health Service Corps (NHSC) and some difficulty in Indian Health Service (IHS) programs.

--Some difficulty in recruiting top level employees at the National Institutes of Health (NIH).

--Some problems in recruiting certain specialties.

--Possible problems created because of the continued uncertainty of the future of PHS hospitals.

Problems in recruiting for isolated areas

Two programs of the Health Services Administration--IHS and NHSC--are concerned with providing health care to people in areas which are critically short in health care from the private sector. Most of the areas served by these programs are rural and many are remote and isolated.

PHS officials told us that recruiting physicians for many of these areas is extremely difficult, time consuming, and often unsuccessful.

Although IHS has been fairly successful in overall recruitment, certain areas are experiencing serious problems. For example, the Aberdeen, South Dakota, IHS Area Office has 17 physician vacancies as of September 30, 1975, of 59 positions. Officials told us that isolation of some South Dakota communities and cultural differences are among the reasons that have limited the number of applicants. The Navajo IHS Area in Window Rock, Arizona, had 11 of 124 positions vacant. Officials felt that this problem was caused to some extent by the isolation of Window Rock from a major metropolitan area.

The other two IHS areas we visited had considerably less problems in recruiting physicians. The Billings IHS Area Office in Montana reported 3 of 28 positions vacant, while the Phoenix IHS Area Office reported 1 vacancy out of 95 positions.

While geographical isolation was not the only reason given by officials in attempting to explain the problem, we believe some of the other reasons given--social and cultural isolation, lack of professional activities, etc.--are a factor of the remoteness of the location and become more important when the location is also undesirable.

NHSC program and recruiting officials appear to talk in terms of needs and critical shortage areas, rather than in terms of funded positions and shortages for which persons are actively being recruited. For example, according to NHSC data, approximately 260 of 575 NHSC sites had, for periods from a few months to several years, never been staffed.

An official of the Health Services Administration (the parent organization of NHSC) told us that NHSC had reached its ceiling of 330 physicians for fiscal year 1975. He estimated that 210 physicians will need to be recruited during fiscal year 1976 to fill that year's needs. We were also told that the goal was 310 physicians and that 123 had been recruited as of February 1976. Although this makes it difficult to identify definite recruiting problems and their magnitude, our fieldwork did show that certain areas of the country appear to be having problems in recruiting NHSC physicians.

In PHS Region IV, the southeastern section of the United States, we were told that a severe recruitment problem exists in hiring NHSC physicians. As of September 30, 1975, 135 underserved sites with 231 physician positions had been approved. Region IV reported 179 vacancies for these positions. However, this appears to be based on need rather than on funded positions, since the fiscal year 1976 recruitment goal was only 95 physicians. As of January 22, 1976, 30 physicians had been hired. During fiscal year 1975 the goal was 55 and 35 physicians were hired.

Region IV officials told us that one of the main reasons for the recruitment difficulties was the isolation and remoteness of most medically underserved areas and therefore the lack of medical support services, professional activities, and educational and recreational activities.

PHS Region VIII, which consists of the Northern Mountain and Plains States, also has a physician recruitment problem. As of September 30, 1975, 11 communities with positions for 14 physicians and 1 dentist were not staffed. No information was obtained concerning recruitment goals and the success in meeting them, except that physician and dentist vacancies did decrease by 10 in the 6 months prior to September 1975.

Regional PHS officials told us that a primary reason for difficulty in staffing physicians was the social, professional, and cultural isolation in rural areas. Other reasons given included lack of backup physicians and low pay.

We also visited two other NHSC regions. Region IX (the West Coast) officials were unable to provide us with data on recruitment or vacancies; and officials in Region I (New England) told us they had no real recruitment problem for the program in their area. Officials in Region I attributed this, in part, to the fact that communities participating in the NHSC program were closer to major medical centers than participating communities in other regions.

Problem in recruiting at NIH

NIH is experiencing difficulties in recruiting senior physicians to fill top-level positions in the various institutes. We were told that recruiting from the private sector and the academic world provide NIH with physicians who can give a fresh approach to the problems NIH is endeavoring to solve. However, because of the difficulty in recruiting this type of physician, NIH told us that it is forced to fill these positions by promoting from within. NIH believes this problem to be of crisis proportion and constitutes a potential threat to its reputation for excellence.

During recent years NIH interviewed or approached 366 physicians to fill 37 positions, made 97 offers, and filled 24 of the positions. The time span of the recruitment effort for these positions was from 6 months to 4 years.

According to NIH officials the main reason for rejection was inadequate salary. Because of its research-oriented mission, NIH competes primarily with medical schools and universities for physicians. NIH feels that the responsibilities of its Scientific and Associate Institute Directors should be equated with those of department chairman of medical schools and that its clinical directors, and laboratory and branch chiefs should be equated with full professors. Based on data of full-time facilities in U.S. medical schools, the median annual salary for department chairmen was $52,100 and for full professors was $42,100--excluding benefits. The base salary of commissioned corps officers plus the additional pay authorized is generally comparable to salaries at medical schools and universities. However, for the civil service physicians or physicians being paid on the scientific, expert,

and technical pay scales, the differences could be significant since the salary of these persons is presently limited by law to $37,800 annually and they are not entitled to any additional or special pay.

Many of the senior and top-level physicians NIH is trying to recruit are ineligible to join the commissioned corps because of age (see chapter 1 p. 10) or physical disability. Therefore these personnel are required to accept employment under the civil service system if they still want to work at NIH. This difference between the two systems can create situations like that found at the National Cancer Institute where 141 members of the staff were earning as much or more than the Institute's Director.

The civil service pay structure and ineligibility for bonus pay is a serious drawback to bringing a physician into NIH in midcareer. If candidates are not eligible for the commissioned corps, NIH can offer little to convince them to make the change except the opportunity to enhance their careers by working at a noted research institute.

Problem recruiting certain specialties

PHS officials advised us that it occasionally has difficulties recruiting certain specialties. However, since PHS does not maintain a listing of authorized positions, or a listing of authorized physician positions by specialty, it is not possible to ascertain the severity and magnitude of the problem. Our review at various PHS field locations did show that isolated recruitment problems exist in some specialties.

The Center for Disease Control (CDC), one of PHS's six components, has been unsuccessful in recruiting 12 physicians in the specialty of occupational medicine at its National Institute of Occupational Safety and Health. During fiscal year 1975 about 50 physicians inquired and 1 was hired. CDC officials indicated that the recruiting process used is slow and selective since these positions require highly qualified physicians.

Officials of the PHS personnel office told us that certain specialties were difficult to recruit but that proving an actual vacancy would be difficult. By way of illustration, they presented the following case for NIH:

Authorized manpower for NIH is established for each institute in total without identifying the number of positions for physicians, dentists, scientists, secretaries, clerks, or others. The number of positions in each category is at the discretion of each institute director. In fiscal year 1976, 11,154 positions were authorized for NIH. As of January 1, 1976, over 11,500 persons were actually employed, or about 350 more than the authorized ceiling. Thus, no obvious vacancies exist. However, since a physician, dentist, or specialist could not be recruited, some other person might have been hired instead.

Uncertainty of the future of PHS hospitals

PHS officials advised us that the continued uncertainty of whether to close PHS hospitals will probably result in an increasing number of vacancies. A 1971 HEW study group recommended closure, and the necessary legislation was proposed. However, Public Law 93-155 required that the hospitals be kept open and maintained at current operating levels.

Another period of uncertainty may be beginning for PHS hospitals. According to the Budget of the United States for fiscal year 1977, legislation is to be proposed authorizing either (1) transfer of the PHS hospitals to communities for operation or (2) closing of all PHS hospitals.

PHS officials with whom we discussed this matter expect this action to show itself in the form of increased vacancies because of more rapid turnover and reduced recruitment. The PHS Personnel Director told us this problem is but a manifestation of the long-term problem of instability facing the PHS. He cited past studies recommending abolishment or altering of the commissioned corps and a continuing discussion about changing PHS's mission and personnel systems.

This problem of increased vacancies has not yet materialized. An official in PHS's Bureau of Medical Services--the parent organization of the PHS hospitals--stated that there is little evidence of recruiting problems.

Dentist recruitment problems in PHS

PHS officials in the personnel office, Commissioned Personnel Operations Division, and the Recruitment Service Branch of the Health Services Administration told us that recruiting dentists for the PHS is not a problem. However, a March 1976 status report concerning dental officer recruitment and retention by the Dental Affairs staff of the Office of the Assistant Secretary of Health indicated that a problem does exist and is expected to continue unless retention of dental officers is improved.

The Dental Affairs staff agrees that the total number of applications greatly exceeds the number of available assignments but asserts that the numbers of these applicants who are qualified and interested in serving in specific programs and locations where vacancies exist have closely approximated PHS needs or have been less than the requirements.

In a report prepared on PHS dentists, the Dental Affairs staff stated that, since the end of the draft, applicants have became more selective in the assignments they will accept. The report concluded that the number of applications received in the past 3 years was barely sufficient to meet requirements and has "resulted in a gradual lowering of quality of standards for PHS commissioned officers."

Physician and dentist retention in PHS

The Secretary of HEW, in a letter dated June 26, 1975, to the Director of OMB, stated that increased retention of medical officers is presently a PHS goal. The goal is to reach a 35-percent retention rate--entering a 3d year of PHS service--by 1980.

Although dentist retention was not addressed by the Secretary, an official of the PHS Personnel Office told us that similar goals exist for dental officers.

Although an overall PHS retention goal exists, three component organizations have little or no desire to retain many of their physicians or dentists beyond a minimal tour of duty.

Retention not a goal of some PHS agencies

NHSC, CDC, and NIH do not desire career retention for many of their physicians. About 1,400 of the 3,485 physicians and about 110 of the 661 dentists in PHS as of September 30, 1975, were employed by these agencies. According to PHS officials a high rate of turnover is necessary for accomplishing the missions of these agencies.

The NHSC mission is to locate physicians in medically underserved areas. To do this, NHSC assigns physicians to these areas for an initial tour of duty--usually 2 years--and attempts to persuade the physicians to remain as a private practitioner in the same area when he leaves NHSC.

One of CDC's goals is to return physicians to the private sector after a 2-year tour of duty with an increased awareness of preventive medicine. Thus, CDC's goal is achieved not when the person is retained but when he returns to private practice.

NIH wants to retain only a small percentage of its physicians and dentists in the associate program--a training program. Approximately 60 to 70 percent of the physician and dentist terminations for fiscal year 1975 were in this associate/training program category.

Retention problems in PHS

Although some PHS components do not have long term retention as a goal, retention problems for physicians and, to a lesser extent, dentists do exist. The reasons for low retention--living conditions in isolated areas, salary, and lack of educational activities--are similar to those in VA and DOD.

PHS was not able to provide us with retention data for each of its various components, so our analysis is based on data for all of PHS. Only about 8 percent of the physicians and about 14 percent of the dentists who entered on duty between 1963 and 1971 were still employed as of September 1974. However, retention is slowly improving. Data as of September and November 1975 showed that about 10 percent of the physicians who entered on duty between 1964 and 1972 were still in PHS and about 17 percent of the dentists entering on duty between 1965 and 1973 were still on duty.

Although the data obtained during our study indicates that PHS is having a problem in retaining physicians and dentists, a comprehensive analysis of the problem was not possible because we were not able to obtain retention data or goals for all the components of PHS. Obviously, retention goals should be higher than 35 percent for the components of PHS that want to retain physicians and dentists in order to offset the very low retention rates that would be expected in the components which do not desire to retain many of these personnel. However, because of the lack of necessary data and goals in retention, we could not determine (1) which PHS components are having the most difficulty in retaining these personnel, (2) which components have been successful in retaining personnel, and (3) the reasons for either the difficulties or successes.

Reasons physicians and dentists leave PHS

As discussed on page 36, some PHS organizations do not have long term retention as a goal. In addition to this factor, we identified the following reasons as influencing a physician's or dentist's decision to leave PHS.

--Lack of career opportunities. Some physicians and dentists desire to acquire additional education in a medical or dental specialty and to attend training courses and professional meetings. For example, of the 35 physicians and dentists who left the Navajo Area IHS during fiscal year 1975, 20 indicated they left to further their education or to receive additional training. At the San Francisco PHS hospital, 8 of 40 physicians who left employment during fiscal years 1974 and 1975 did so to obtain further training. Also two of the four dentists who quit at San Francisco in fiscal year 1974 did so to further their training.

--Desire to enter private practices. PHS officials told us that some physicians and dentists enter PHS mainly to acquire experience and proficiency before entering private practice. Of the 16 physicians and dentists who left the Boston PHS hospital in fiscal year 1975, 7 left to enter private practice. We found numerous similar instances in other PHS locations we visited.

--Job and assignment location dissatisfaction. Officials at many of the locations we visited believed that many employment terminations resulted from dissatisfaction, although little documentation was available.

Included in this category are such factors as

--inadequate salary,

--poor housing for persons assigned to Indian reservations,

--isolation and remoteness of facilities from urban areas.

--inadequate schooling for dependents, and

--poor working environment, i.e. inadequate buildings and equipment.

Satisfaction of physicians and dentists employed by PHS

We asked questions concerning salary matters and future intention to about 10 percent of the 1,749 physicians and 216 dentists at the locations we visited during our review. We received 141 responses from members of the commissioned corps and 25 responses from GS physicians and dentists.

Almost 80 percent of the corps respondents were satisfied with their salary and 88 percent were satisfied with their benefits. About 64 percent of the GS respondents expressed some satisfaction with salary and about three-quarters were satisfied with benefits.

Concerning our question on future job intentions about 46 percent of the corps respondents and 55 percent of the GS respondents planned to continue in PHS. Over 75 percent of the corps respondents stated they would not have stayed without special pay.

Reasons for leaving PHS employment

To identify the reasons for leaving PHS employment, we sent questionnaires to 53 former employees, and received 33 responses. Our questionnaire was designed to solicit

multiple answers on the reasons for quitting; therefore, we were unable to identify any particular factor as the most important. We believe the decisions were based on several factors.

About 85 percent of the respondents said that better opportunities elsewhere played an important role in their decisions to leave, while 61 percent stated that certain job characteristics or working conditions were an important factor. Also about one-fourth indicated that salary, benefits, or compensation was an important factor, while about 21 percent said job location was important.

Reasons physicians and dentists declined PHS employment

To determine the reasons for rejection of employment offers, we sent a questionnairie designed to solicit multiple responses to 276 physicians and dentists who had declined employment. We received 73 responses.

About 28 percent of the respondents said that salary and benefits were a factor influencing their decisions, 52 percent believed that certain job characteristics and job location were important factors, and about 70 percent indicated that better opportunities elsewhere played an important role in their decision to reject employment.

RECRUITMENT AND RETENTION PROBLEMS IN OTHER AGENCIES

The problems expressed to us by other Federal agencies employing physicians and dentists--849 physicians and 45 dentists, or about 3 percent of the total--were mainly concerned with what officials perceived as inadequate salaries which can be offered.

An official of the Energy Research and Development Administration--which employed seven physicians at the time of our review--was concerned that the added financial incentives available in VA, DOD, and PHS were not available in other Federal agencies and adversely affected their ability to recruit and retain. An official of the National Aeronautics and Space Administration--which employed 31 physicians--believed that a separate salary schedule for all Federal physicians was needed.

CONCLUSIONS

VA, DOD, and PHS are each experiencing problems in recruiting and retaining physicians. Except for an undocumented problem in certain specialities, no significant problems were being experienced in recruiting or retaining dentists. Quantification of physician retention problems is difficult since retention goals have not been established against which success can be measured. Moreover, most of the programs to enhance recruitment and retention have not been in operation long enough to determine their long-range impact.

Although salary has been the most frequently cited reason for VA's inability to recruit and retain physicians, other reasons may also act as barriers. These factors include restriction on outside employment, degree of affiliation with medical schools, geographic location of VA hospitals, and the restricted type of practice available to VA physicians. Although the magnitude of the problem resulting from these factors cannot be determined individually, we believe that combinations of these factors influence physicians' decisions on whether to accept VA employment.

In DOD, authorized physician and dentist manpower levels are generally met and frequently exceeded. DOD may, however, experience a temporary physician shortage between now and 1980. DOD has traditionally depended on the draft and draft-related (deferred) programs for its physician and dentist needs. However, the draft ended in 1973 and the draft-related programs have lost much of their appeal. DOD estimates that by 1980 less than 1 percent of the physicians recruited will enter as a result of draft-related programs.

The shortage may occur because the supply of physicians obligated through the draft and draft-related programs will be depleted by 1979-80, and physicians entering DOD through the scholarship program--the program which will be relied on for physician needs during the 1980s--will not be enough to serve as a replacement. Whether a shortage will occur will depend on the services' success in recruiting volunteers. In any event, the shortage is not expected to be permanent since it is expected that by the early 1980s, the number of physicians entering through the scholarship program will have increased enough to maintain authorized levels.

In PHS, much of the data necessary for assessment of recruitment and retention problems on an agencywide basis was not available. For example, data on vacancies, recruitment goals, and retention were generally not available. Moreover, retention is not a goal of some PHS organizations. The problems we were able to identify were attributable to geographic isolation of some PHS facilities; inadequate salaries, particularly for GS physicians; and the uncertainty of the future of the PHS hospitals.

CHAPTER 3

RECRUITMENT AND RETENTION PROGRAMS AND PRACTICES AND THEIR EFFECT IN ALLEVIATING PROBLEMS

The Veterans Administration, Department of Defense, and Public Health Service have a variety of programs and practices to enhance recruitment and retention of physicians and dentists. The effects are not always measurable for each separate program or practice, but when viewed in total they seem to have contributed to the agencies' recruitment and retention efforts.

Some of the programs increase the monetary benefits for service. Most of these programs are relatively new, and satisfactory measurement of success is not possible. Other programs and practices offer services that might be unavailable elsewhere, which appeal to an employee's interests, and help an individual get an education.

RECRUITMENT AND RETENTION PROGRAMS AND PRACTICES IN THE DEPARTMENT OF MEDICINE AND SURGERY

The programs and practices used by DM&S to recruit and retain physicians and dentists include

--special pay for certain physicians and dentists,

--a medical school affiliation program,

--a medical research program,

--a career residency program, and

--other programs and practices, such as using part-time employees and foreign medical school graduates, hiring at high grades, and contracting for certain physician services.

Special pay for DM&S physicians and dentists

Public Law 94-123 authorizes special pay up to $13,500 annually to certain DM&S physicians and up to $6,750 for certain dentists. Any special pay, however, is reduced by the increase in regular pay as a result of the raise granted to all Federal white-collar employees in October 1975.

Special pay is authorized for all eligible physicians and dentists who execute a written agreement to remain in VA for 1, 2, 3, or 4 years of service. If the physician or dentist voluntarily, or because of misconduct, fails to complete the first year of service under the agreement, he must refund the total amount of the bonus received, unless the Chief Medical Director determines that the failure is due to circumstances beyond the recipient's control. The special pay is not considered basic pay for retirement or for other benefits related to pay.

Not all DM&S physicians and dentists are eligible for special pay. Exclusions are made by law or administratively. Excluded by law are physicians and dentists who are

--employed less than half time or intermittently,

--interns or residents, or

--reemployed annuitants.

The Chief Medical Director has administratively excluded certain positions for which there is no significant recruitment or retention problem. Among these are individuals who occupy positions not requiring the qualifications of a physician or dentist, medical and clinical investigators, and research associates.

The Chief Medical Director and Deputy Chief Medical Director are entitled to the total special pay. For other recipients, special pay is composed of

--primary special pay, which provides payment of $5,000 annually to eligible full-time physicians and $2,500 to eligible full-time dentists and

--incentive special pay, which provides for payment in several categories up to a total of $8,500 annually for eligible full-time physicians and $4,250 for eligible full-time dentists.

The amount of special pay for employees who work half time or more is computed in the proportion their part-time bears to full-time. Part-time physicians and dentists are not entitled to any part of the $2,000 and $1,000 incentive pay, which may be paid to full-time physicians and dentists, respectively. Moreover, the aggregate total annual pay, including special pay, may not exceed $42,000 for part-time physicians and $37,000 for part-time dentists.

How amounts of special pay are determined

As mentioned previously, all eligible full-time physicians are entitled to primary special pay of $5,000 annually for the length of their agreement to stay in VA service--up to a maximum of 4 years. Eligible full-time dentists are entitled to $2,500. The amount of incentive special pay is determined on the basis of (1) position occupied or (2) tenure in DM&S and (3) specialty.

Incentive special pay based on position ranges from $5,500 for a service chief not in a scarce specialty to $8,500 for an associate deputy or assistant chief medical director. For others, the amount of incentive special pay is based on tenure in DM&S--$1,000 for completion of the lesser of a probationary period or 3 years and $2,000 for completion of 7 years. In addition, incentive pay of $2,000 is authorized for those physicians who are in a scarce medical specialty. A scarce specialty is a field of practice in which the supply of qualified physicians has been, and is projected to be, inadequate to meet the needs of DM&S as determined by the Chief Medical Director. An amount of $500 is authorized for physicians who have a continuing education certificate from the American Medical Association. Dentists, under the same criteria, are entitled to one-half of the amount physicians receive.

Effect of special pay on recruitment and retention

Preliminary indications are that the special pay program of DM&S has had a positive effect on recruiting and may similarly affect retention. However, it is still too soon to measure its full impact.

As of December 5, 1975, over 97 percent of the eligible full-time physicians and almost 98 percent of the eligible full-time dentists had agreed to accept the special pay. About 94 percent and 89 percent of the eligible part-time

physicians and dentists, respectively, agreed to accept special pay. Of those who accepted, about 92 percent of the physicians and 95 percent of the dentists executed a 4-year agreement, the maximum allowed by law. Special pay for full-time physicians averaged $7,000 and for full-time dentists averaged $3,000.

In an April 30, 1976, report to the Congress, VA stated that too little time had passed to permit a comprehensive evaluation of the effects of Public Law 94-123 but that preliminary indications reflected improved recruitment. The report stated, for example, that the number of full-time physicians on duty as of March 31, 1976, totaled 5,815--a new high. There were 5,728 full-time physicians employed as of September 30, 1975. Furthermore, the loss rate during the 6 months following enactment was less than during a comparable period the previous year. Losses for January through March 1976 were reported to be the lowest for any equivalent quarter since 1968.

At some VA hospitals affiliated with medical schools, we found a practice which may negate the effect of the special pay and may, in fact, result in an indirect subsidy to the medical school.

At four hospitals we visited, the payment by the affiliated medical school to VA physicians and dentists who hold faculty appointments is reduced whenever VA pay is increased--by promotion, pay raise, etc. Therefore, total pay--VA's and the university's--is not changed.

At the Birmingham, Alabama, VA hospital, about one-third of the eligible physicians rejected the special pay offer. Many of these physicians said they rejected the offer because of the offset by the affiliated university--the University of Alabama.

An official in DM&S's Education Service told us that he had expected this situation. He explained that some affiliated medical schools began supplementing VA physicians' and dentists' income for teaching and consultation approximately 10 years ago to narrow the disparity between VA and faculty salaries. With the increase in pay for VA physicians and dentists as a result of the special pay, he indicated that some adjustments were necessary to maintain salary comparability.

We understand the rationale for these salary adjustments; however, we believe that the special pay program will have little, if any, effect on recruiting and retaining these physicians or dentists since it will not increase their salaries. Moreover, downward salary adjustments by a medical school could be viewed as a subsidy by VA since the school's payroll costs would be reduced.

Medical school affiliation program

Under a policy established in 1946, VA has participated in the education and training of new health manpower in affiliation with accredited educational institutions. At the end of fiscal year 1975, 122 VA hospitals and 27 VA outpatient clinics were affiliated with 98 medical schools; all 171 VA hospitals were engaged in education or training in affiliated programs with one or more universities, schools, colleges, and junior or community colleges. Since many physicians and dentists are interested in academic medicine, the affiliation program has been an effective recruitment and retention practice. The affiliation program also enables many physicians and dentists to supplement their VA income since teaching is the main activity which full-time physicians or dentists may engage in for remuneration.

As of December 31, 1975, over 5,000 full- and part-time VA physicians and 290 dentists held faculty appointments at affiliated medical schools.

During calendar year 1975, VA records show that 866 full-time physicians received remuneration for teaching and teaching-related activities. The average remuneration was $4,867, ranging from a low of $20 to a high of about $41,000.

For dentists, VA records show that during calendar year 1975, 116 were engaged in teaching and teaching-related activities at an average remuneration of $2,605, ranging from a low of $15 to a high of over $7,400. It should be emphasized that these amounts reflect outside income for full-time personnel only; part-time employees are not required to report outside income.

Effect of affiliation program on recruitment and retention

According to VA, it has pursued a strategy since World War II of establishing a close affiliation with the Nation's medical schools as one means of recruiting physicians for its

hospitals. In keeping with this strategy, both the number of affiliated hospitals and the number of VA-supported intern and resident positions have grown substantially over the years.

In academic year 1975-76, VA was supporting about 6,900 full-time intern and resident positions. About twice that number of house staff will rotate from affiliated teaching programs to VA hospitals during the year. All clinical specialties and subspecialties, with the exception of pediatrics, obstetrics, and gynecology, are represented by residency programs in VA. Interns and residents carry out many patient care functions in VA hospitals as part of their clinical training, thereby supplementing the permanent hospital staff in the delivery of medical care. In addition to augmentation of staff, the affiliated school often serves as a recruitment source.

VA also attributes its affiliation program as upgrading the quality of staff at its hospitals. In testimony before the Senate Committee on Veterans Affairs in May 1975, the Chief Medical Director reported that 52 percent of the full-time physicians at affiliated hospitals were board-certified compared to 39 percent at nonaffiliated hospitals. For part-time physicians, 62 percent were board-certified at affiliated hospitals compared to 47 percent at nonaffiliated installations.

According to information VA submitted to the Office of Management and Budget for its review under Public Law 94-123, the affiliation program may be a contributing factor to a major DM&S problem, the increasing number of part-time physicians. As discussed on page 50, a large number of part-timers is viewed by DM&S as undesirable because of divided loyalty, possible unavailability outside regular duty hours, and possible morale problems.

VA has followed a policy of increasing its affiliation with medical schools and increasing the number of its physicians who have medical school faculty appointments. Between December 1973 and December 1975, the number of medical school faculty appointments increased by about 1,150. About 950 of this increase were part-timers. It appears likely, therefore, that the increase in faculty appointments is linked very closely to the influx of part-timers.

Another indication of the effect of the affiliation program on the number of part-timers is shown by the concentration of part-timers in VA hospitals which are strongly

affiliated with medical schools. As of December 31, 1975, 43 percent of the physicians in strongly affiliated hospitals were part-timers. At loosely affiliated and nonaffiliated hospitals, the percentage of part-timers was 16 and 17 percent, respectively.

A further indication that the large number of part-time physicians stems from the affiliation program is reflected in an analysis made by DM&S in May 1975. The analysis compared physician employment 9 to 12 months before affiliation and 9 to 12 months after affiliation. The comparison showed

--overall physician employment increased 18 percent,

--full-time employment increased 9 percent, and

--part-time employment increased 87 percent.

Apparently, as long as VA continues to expand its affiliations with medical schools, the number of part-time physicians will continue to increase.

Medical research program

VA's rather extensive medical research program has been mentioned by VA officials as a means to recruit and retain research-minded physicians and dentists. During fiscal year 1977, VA estimates its medical research program will cost about $95 million and will employ over 4,200 full-time equivalent personnel, including 213 physicians and 10 dentists.

In addition to the personnel assigned full-time to medical research activities, many physicians devote part of their time to research projects. According to the DM&S Director of Medical Research Service, about 21 percent of DM&S's full-time physicians and about 10 percent of the part-time physicians were engaged in various medical research during fiscal year 1975.

It is not possible to determine to what extent VA's research program influences a physician or dentist to enter DM&S service. For some, it is probably a contributing factor. One indication of its attraction may be shown by the fact that physicians and dentists whose functions are research--medical and clinical investigators and research associates--are not eligible for the special pay authorized by Public Law 94-123. Exclusion for these personnel--157 persons as of September 30, 1975--is based on a finding by the Chief Medical Director that no significant recruiting or retention problem exists.

Career residency program

VA established the career residency program for physicians in 1953 and for dentists in 1955 to aid in recruitment and retention. Except for the dental specialist program, the career residency programs have been, or will be, discontinued. They were discontinued because, among other things (1) they no longer held much of an appeal, (2) retention rates were low, and (3) they cost too much for the benefits received. As of September 30, 1975, the participants in the program included 2 physicians, 11 dentists in the general practice program, and 45 in the dental specialty program.

At the inception of the program, the DM&S salary was significantly higher than the stipend the resident would otherwise have received. Thus, the higher salary acted as an inducement to recruit personnel at a point in their career when their earnings were traditionally low.

Participants in the program incur an obligation to remain in DM&S service for a period of time--ranging from 12 to 24 months--after completion of their training. DM&S may designate the place where this service is to be completed. The obligation may be canceled by repaying--"buying out"--a portion of the funds received while in the program. The repayment amount is 90 percent of the difference between earnings received as a participant and the maximum that would have been received as a nonparticipant.

Physician career residency program

Admission of new participants to the physician career residency program was discontinued in February 1973 because (1) the difference in salaries for DM&S residents had narrowed considerably, (2) costs were too high for the benefits received, (3) a large number were buying out their contracts, and (4) it was not an effective recruitment method.

According to VA records, residents in the program were receiving $17,260 per year compared to about $10,000 VA was paying its regular residents. Thus, for a 3-year residency program, VA was paying a bonus of about $22,000. Moreover, many residents spent only 6 months per year in VA hospitals; the remaining time was spent in training outside of VA. Thus, for VA to have the services of these career residents for 12 months, the total costs would amount to about $34,000.

Through June 1970--the latest date for which data was available--1,745 physicians had entered the program and 1,298 had completed their residency training. The remainder had either failed to complete the program or were still in it. Of those who completed the program, 481, or about 37 percent, failed to complete their obligated service and bought out their contracts. The percentage of those buying out their contracts increased to 40 percent by June 1970. About 47 percent left immediately after completion of their obligation. A VA report showed that for fiscal year 1970, only about 15 percent of the full-time physician gains was the result of the career residency program.

Dentist career residency program

According to officials in the DM&S dentistry office, the general practice career residency program will be discontinued because of low retention rates and because of the difficulty of assigning dentists to nonaffiliated hospitals.

The dental specialty career residency program is to continue since this is the main source of VA's supply of dental specialists. Traditionally, admission to this program has been limited to career individuals who have already demonstrated a high level of performance as staff dentists for at least 1 year and who wish to advance professionally by entering a specialty. This may explain the fact that, historically, a predominant number of these trained specialists have remained in VA service.

Other programs and practices to recruit and retain physicians and dentists

DM&S uses various other programs and practices to acquire physician and dentist services, (1) part-time personnel, (2) foreign medical school graduates, (3) hiring at high grade levels, (4) contracting for certain services, and (5) waiver of the dual compensation law.

Of the 8,811 physicians and 882 dentists in DM&S as of September 30, 1975, 3,083 and 15, respectively, were employed on a part-time basis. Although there are times when part-time employment is advantageous--workload not enough to justify full-time employment--VA generally prefers full-time physicians and dentists. As discussed on page 19, however, the numbers of part-time physicians has shown a dramatic increase in recent years. VA believes that part-time

employment often leads to management problems with split loyalties, and it also fosters conflict for the physician when simultaneous demands for his services are made by VA and his private patients.

As a consequence of not being able to hire enough qualified domestic medical school graduates, VA has been increasingly relying on graduates of foreign medical schools to help staff their hospitals with physicians. DM&S does not employ foreign dental school graduates. As of December 31, 1974, VA reported that of its 5,254 full-time physicians in field stations, 1,643, or about 31 percent, were graduates of foreign medical schools.

VA's Chief Medical Director stated in congressional hearings that the problems associated with having foreign medical school graduates on hospital staffs fall into two broad areas--language difficulty and a cultural gap. He stated that the foreign medical graduates sometimes have difficulties because they cannot communicate with veteran patients nor the veterans with them.

As an inducement to physicians and as a means to narrow the difference in income between VA and the private sector, DM&S has increasingly relied on higher entry grades. As a result of hiring physicians at high entry grades, a large number rapidly reach the statutory salary maximum--now $37,800 annually. DM&S has recognized this as a problem since it offers little opportunity for advancement during tenure in VA service. As of December 31, 1975, salaries of 2,346 of the 5,772 full-time physicians, or about 41 percent, were at the statutory maximum.

Since 1966, DM&S has used contracts to help acquire certain medical specialities, particularly radiology, pathology, and anesthesiology services. For fiscal year 1975, about $10 million was spent for contractual medical services. Both the numbers and costs of these contracts have been increasing gradually during the past several years.

Under normal procedures, retired regular officers of the uniformed services may be reemployed by the Government but their retirement pay must be reduced according to a formula prescribed by the Dual Compensation Act of 1964 (5 U.S.C. 5532). The formula prescribes that the reemployed person may retain a base amount plus one-half of the difference between his regular retirement pay and the base amount. The act authorizes the Civil Service Commission to grant waivers because of special or emergency employment needs which otherwise cannot be readily met.

VA has not requested waivers to any great extent to recruit physicians and dentists. According to VA records, less than 50 requests for waivers have been submitted to the Commission since 1964. Of this total, 43 waivers--42 physicians and 1 dentist--were approved.

RECRUITMENT AND RETENTION PROGRAMS AND PRACTICES IN DOD

DOD uses several programs and practices to recruit and retain physicians and dentists. These include (1) programs to increase income, (2) educational programs, and (3) a rapid promotion policy. These programs and practices have contributed to increased recruitment and retention, although the precise effects of each of the programs individually cannot be determined. Moreover, the DOD actions may not be sufficient to prevent a temporary physician shortage during the late 1970s and early 1980s.

We do not believe that two of the income increasing programs--continuation pay and variable incentive pay--are being administered according to the law and legislative intent. According to the legislative history of these programs, their purpose was to assist in recruiting critical medical specialities. DOD offers pay under these programs to virtually all physicians and dentists, regardless of specialty.

Income-increasing programs used to recruit and retain physicians and dentists

DOD has three programs to increase a physician's or dentist's income with the objective of enhancing recruitment and retention. These programs, in order as they came into operation, are

--special pay,

--continuation pay, and

--variable incentive pay.

Special pay

Special pay for DOD, and PHS, physicians and dentists was initially authorized in 1947 under the provisions of Public Law 80-365, the Army-Navy-Public Health Service Medical Officer Procurement Act of 1947. Initially, this act awarded payment of $100 a month to physicians and dentists

who volunteered for military service. The program was based on income disparity then existing between physicians and dentists in DOD and the private sector. According to the legislative history, the additional pay was to help compensate the individual for the additional educational expenses incurred in pursuing a medical career and for the years of lost earning power. The program has been modified since 1947 generally by including additional types of medical personnel--interns, retired officers recalled to active duty, and veterinarians--and by increasing the amount of the special pay.

In fiscal year 1976, special pay for all medical and dental officers of the uniformed forces was paid according to the following schedule:

	Physicians	
Active duty	Monthly rate	Annual rate
Less than 2 years	$100	$1,200
Over 2 years	$350	$4,200

	Dentists	
Active duty	Monthly rate	Annual rate
Less than 2 years	$100	$1200
Over 2 years	$150	$1800
Over 6 years	$250	$3000
Over 10 years	$350	$4200

DOD estimates that for fiscal year 1976, 11,554 physicians and 5,162 dentists will be receiving special pay. For fiscal year 1977, it estimates that 11,499 physicians and 5,004 dentists will receive this pay. The costs are estimated to be $47.6 million in fiscal years 1976 and 1977.

Continuation pay

In 1967 Public Law 90-207 (37 U.S.C. 311), approved December 16, 1967, authorized the continuation payments--in addition to other pay and allowances--to designated physicians and dentists in the uniformed services. Although the pay was authorized for dentists, they were excluded from the program until September 1972 because dentist retention was not as serious as physician retention.

According to the legislative history of this act, continuation pay was intended as a financial inducement for physicians and dentists in critical shortage categories to

remain in the uniformed services. Critical shortage category was defined by DOD as "a category in which the supply of qualified personnel has been and is projected to be inadequate to meet service requirements as derived from approved force structures."

Generally, to be eligible for continuation pay, the individual must meet the following requirements. He

--must be serving on active duty in a critical specialty designated by the Secretary of the respective service,

--must have completed obligated duty,

--must execute a written agreement to remain on active duty for at least 1 additional year, and

--may not be paid more than 4 months' basic pay at the rate applicable when executing the agreement to remain on active duty.

DOD's designation of critical specialities was such that, in effect, all physicians were in critical specialities. DOD has not determined the shortages in the various specialities.

Since continuation pay was for the purpose of retaining physicians and dentists, a requirement was established that an individual must have completed at least 8 years' active duty to be eligible to receive this pay. This was subsequently reduced to 5 years. The program was changed again when the variable incentive pay program replaced the continuation pay program for physicians in pay grades 0-4 through 0-6.

As presently operating, continuation pay may be made to eligible physicians in grades 0-7 through 0-9 and to eligible dentists in grades 0-4 through 0-8. Payment may also be made to physicians who are in initial residency training and who were on active duty on June 1, 1974.

The amount of continuation pay is based on grade. For each year of active duty agreed to, the individual is paid--usually in annual or semiannual installments during each year of active duty agreed to--according to the following criteria.

Pay grade when agreement is executed	Rate of pay
0-9	2 months' basic pay
0-8	2 months' basic pay
0-7	3 months' basic pay
0-4 through 0-6	4 months' basic pay

Variable incentive pay

Public Law 93-274 (37 U.S.C. 313(e)), May 6, 1974, authorized payment of an additional form of compensation to physicians in the uniformed services. This program--called variable incentive pay (VIP)--was enacted to replace the continuation pay program for physicians. Dentists are not eligible to receive VIP. The program expires June 30, 1977.

According to its legislative history, the program was needed to alleviate recruiting and retaining problems of physicians and dentists in critical specialties. The ending of the draft in 1973, which the uniformed services had depended on to acquire physicians, made recruiting more difficult since it would now be necessary to compete for physician services.

To be eligible for VIP, physicians must

--be below the pay grade of 0-7,

--be qualified in a critical specialty designated by the Secretary concerned,

--be determined, by a board composed of medical officers under criteria prescribed by the Secretary concerned, to be qualified to enter into an active duty agreement for a specified number of years,

--not be serving an initial active duty "obligation" of 4 years or less or not be serving the first 4 years of an initial active duty obligation of more than 4 years, and

--execute a written agreement to serve a specified number of years.

Physicians who meet these requirements are entitled to receive additional pay up to $13,500 annually for each year they agree to remain on active duty beyond their obligated

service--up to a maximum of 4 years. The amount of VIP depends on the years of service completed and the length of the agreement to remain in service. Following are the criteria for establishing the amount of VIP.

Years of service computed under 37 U.S.C. 205	Length of agreement			
	1 yr.	2 yrs.	3 yrs.	4 yrs.
4 to 13 years	$12,000	$12,500	$13,000	$13,500
14 to 19 years	11,500	12,000	12,500	13,000
20 to 25 years	11,000	11,300	11,600	12,000
26 or more years	10,000	10,300	10,600	11,000
Obligated officers (note a)	9,000	9,000	9,000	9,000

a/An obligated officer who has been determined by the Office of the Surgeon General to be qualified for VIP but has an unserved active duty service obligation for participation in military funded medical training of 1 school year or more.

Similar to the situation in the continuation pay program, virtually all eligible physicians in DOD are entitled to VIP despite the requirement that participants be qualified in a designated critical specialty. Neither DOD nor the respective services have defined what critical specialties exist. Consequently, once a physician becomes eligible for VIP, an offer is generally extended.

Effect of special pay, continuation pay, and VIP on recruitment and retention

The precise effects of each of the income-increasing programs on recruiting and retaining physicians and dentists can be measured with only limited reliability. For example, special pay is made to all physicians and dentists and there is no way of comparing this pay with a group not receiving it.

DOD data shows that for fiscal year 1976, 44 percent of its dentists--the group to which the program is mainly directed--were receiving continuation pay. However, when viewed from the perspective of the number of dentists who are eligible for continuation pay--those with at least 5 years of active duty--the percentage receiving the pay would probably rise significantly. Data on the number of dentists with 5 or more years active duty could not be readily obtained from DOD. However, the proportion of dentists receiving continuation pay to the total number of dentists has increased every

year since at least 1973. In fiscal year 1973, about 35 percent of all the dentists were receiving continuation pay; in fiscal year 1976 an estimated 44 percent were receiving it. It appears, therefore, that continuation pay is increasing retention of dentists. However, neither DOD nor the services have established retention goals against which the rate can be compared. Also, as discussed below, the intent of the legislation authorizing continuation pay was not, in our opinion, to offer it to all eligible personnel.

The effect of VIP on recruitment and retention of physicians is also difficult to quantify. However, DOD data indicates that VIP may be having a positive effect on both recruitment and retention. For example, since enactment of the DOD program in 1974, physician loss rates--the rate that the number of physicians who leave bears to the total number of physicians--have been reduced from about 37 percent to an estimated 27 percent in fiscal year 1976. Volunteer recruitment increased from 132 physicians in fiscal year 1974 to an estimated 762 physicians in fiscal year 1976--an over 400-percent increase. It is important to note that prior to 1974, the draft was available and DOD did not have to implement recruiting campaigns to acquire physicians. We believe it is too soon to make any definitive evaluation of the effects of the VIP program.

Continuation pay and VIP programs not being administered according to law and legislative intent

When DOD proposed continuation pay and VIP, it maintained that these would be used as a financial inducement and a responsible management tool to alleviate critical shortages of physicians and, in case of continuation pay, dentists. DOD directives and HEW regulations implementing these laws require that the respective secretaries designate which medical and dental specialties are critically short. A critical shortage category is defined as a category in which the supply of qualified personnel is or is projected to be inadequate.

We requested documentation from officials of both HEW and DOD showing that these designations have been made, but neither agency was able to provide this documentation. Therefore, since DOD and HEW are presently paying continuation pay and VIP to physicians and continuation pay to dentists, regardless of specialty, we believe that DOD and HEW are not complying with either the requirements of the law or their own directives.

DOD and HEW should determine and designate which medical and dental specialties are critical shortage categories in order to comply with the requirements of the law and their own directives.

Educational programs used to recruit and retain

DOD has numerous educationally oriented programs to recruit and retain physicians and dentists. The most significant of these programs are those authorized by the Uniformed Service Health Professions Revitalization Act of 1972 (Public Law 92-426). This act authorized two programs--the Armed Forces Health Professions Scholarship Program and the Uniformed Services University of the Health Services--to procure physicians and dentists, as well as other health professionals. The act was intended to enable DOD to more effectively compete for the services of physicians and dentists after the draft ended in 1973.

Scholarship program

Public Law 92-426 authorized DOD to provide up to 5,000 scholarships (at any one time) at accredited institutions for education leading to degrees in medicine, dentistry, and other health professions.

To be eligible for the scholarship program, a student must be enrolled in, or accepted for enrollment in, an accredited institution. Program participants are commissioned in a reserve component of the services at the pay grade of 0-1 (equivalent to 2d lieutenant), with full pay and allowances of that grade for 45 days active duty during each year of participation in the program. Except when serving on active duty, participants receive a monthly stipend of $400 in addition to funds needed to cover all educational expenses, including tuition, fees, books, and laboratory expenses.

The act requires participants to serve at least 1 year of active duty for each year of participation in the scholarship program. The Secretary of Defense has prescribed a minimum obligation of 2 years, and those in the program who participate for more than 2 years incur a year-for-year obligation with periods of 6 months or more counted as 1 year and periods of less than 6 months counted on a day-for-day basis. The Secretary of Defense may relieve participants of their active duty obligations. In this event, they may be assigned to civilian health manpower shortage areas as designated by the Secretary of Health, Education, and Welfare for the rest of their obligated service.

DOD began awarding scholarships in early 1973. At the end of fiscal year 1975, 4,730 persons were enrolled in the program. About 72 percent of the outstanding scholarships were medical scholarships. Most of the rest were awarded to persons studying dentistry. Medical scholarships have been awarded to students at all 114 medical institutions eligible to participate in the program.

In June 1975 DOD estimated that all 5,000 scholarships would be outstanding in fiscal year 1976 and that the total costs would amount to about $46.3 million (about $9,265 per student year). Of this total $45.5 million represents direct scholarship payments and about $845,000 represents advertising and recruiting costs.

According to DOD, the scholarship program will be a major supplier of physicians and dentists needs during the 1980s. For example, DOD estimates that about 360 of the 2,898 physicians (about 13 percent) it will recruit in fiscal year 1976 will enter through the scholarship program. In fiscal year 1980, 1,015 of the 2,110 (about 47 percent) it plans to recruit will enter through this program. As discussed on page 28, DOD expects to experience a physician shortage until the scholarship program takes full effect.

University program

The 1972 act authorized the establishment of a military medical university and provides that:

--The university is to be a degree-granting Federal institution to educate physicians and other health professionals and is to be located within 25 miles of the District of Columbia.

--Not less than 100 medical students are to be graduated annually, with the first class to graduate no later than 1982.

--The faculty is to consist of military and civilian professors, with the civilians receiving salaries comparable to those paid by accredited schools of the health professions in the District of Columbia vicinity.

--Student selection procedures are to be prescribed by the Secretary of Defense.

--Students are to be officers of a uniformed service, commissioned in pay grade 0-1 with full pay and allowances of that grade.

--Time spent as a student is not creditable toward retirement.

--Graduates are required to serve on active duty for at least 7 years, and not more than 20 percent of the graduates of any one class may perform civilian Federal duty in lieu of military service.

In a report to the Congress dated May 5, 1976, 1/ we stated that the university program will be more costly than the scholarship program. For example, in fiscal year 1984--the first full year of simultaneous operation of both programs--the estimated educational cost will be about $37,000 per graduate of the scholarship program compared to about $190,000 per university graduate. The total cost per staff-year of expected service (including anticipated pay and retirement costs) will be about $21,000 for scholarship program graduates and about $26,000 for university graduates. The report presented alternatives by which DOD could obtain levels of physician services expected in fiscal year 1984 at lower costs.

Draft-related
educational program

Until 1973 the military depended on conscription as its main source for physicians and dentists. While the draft was in operation, a draft-deferment program--the Berry plan--was in widespread use. With the ending of the draft in 1973, the program lost much of its appeal. However, a brief discussion is presented because a diminishing number will enter military services under this program for a few years, since the obligations were incurred prior to the ending of the draft.

Under the Berry plan, medical school graduates benefited by electing to delay their entry into service until the completion of residency training. In this manner students were provided with the opportunity to plan their medical training in advance. By allowing draft deferments for individuals to

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1/Cost-Effectiveness Analysis of Two Military Physician Procurement Programs: The Scholarship Program and the University Program, MWD-76-122, May 5, 1976.

continue their medical training, the military was provided with a large resource of highly skilled personnel.

Since Berry planners were not subsidized at any point during their medical education, the military expended little of its own resources in training these deferred individuals. The only real costs incurred by the military were administrative expenses for operating the program.

Persons interested in becoming participants applied directly to the uniformed services of their choice. Deferments were awarded by the military branches to participants on a year-to-year basis. Normally, the total amount of time deferred was dependent upon the training required. In past years, as draft accessions increased so did the number of Berry planners. However, with the expiration of the draft in July 1973, the Berry plan option lost its appeal to medical school students. The Office of the Assistant Secretary of Defense for Health and Environment projects that, by fiscal year 1980, less than 1 percent of all the medical accessions for the Armed Forces will come from the Berry plan.

Other educational programs

All of the services have programs which are directed toward acquiring physicians and dentists through education-related programs. The programs are similar to the Berry plan but differ in that individuals are commissioned in the services while still students or, in the case of officers, already on active duty, undergo training while on active duty.

Among the programs is the early commission program of the Army. Under the provisions of this program, students are eligible to affiliate themselves before graduation with the Army. Selected participants are appointed officers (2d lieutenant) in the Army Reserves. Once professional education or residency training is complete, individuals are obligated to serve 2 years active duty. A similar program is the Army residency delay option available to medical school graduates. By electing to participate, students are permitted to delay active duty until residency training is accomplished. A minimum active duty obligation of 2 years is incurred by participants of the program.

To qualify for Army sponsorship of a residency program, applicants must be graduated from an approved medical school. While receiving specialty training, physicians will receive privileges and benefits of their active duty rank. Most

residencies are conducted in Army hospitals. Residents must agree to serve 2 years of active duty for completion of residency training. Similar obligations are applicable for participants of the first year graduate medical education program. However, the training period for students in this program is only 1 year. During this time individuals also serve on active duty as commissioned officers.

The Army also offers a dental general practice residency program for graduating dental students. Applicants seeking admission to the program must be in their senior year at an accredited dental school. Students accepted into the program will spend 1 year training in dentistry at the graduate level. At the conclusion of the 1-year residency, participants in the program will be obligated to serve on active duty for a minimum of 2 years.

The other services have programs similar to the ones described above.

Effect of educational programs on recruitment and retention

The effect which the scholarship and university programs will have on recruitment and retention will be long range and cannot be precisely determined at this time. Neither of the programs will be providing DOD with personnel in any substantial numbers until the 1980s.

Preliminary indications are, however, that the scholarship and university programs may be too successful. The maximum number of scholarships which can be awarded--5,000 at any one time--was estimated to be reached in fiscal year 1976. The full complement of graduates will not be entering active duty until the 1980s, which corresponds to the entry date into active duty of the graduates of the university program. When both of these programs start supplying physicians to DOD, the supply may be excessive.

According to DOD projections, effective in fiscal year 1981 the physician supply will begin to exceed the assumed authorized level. If the accessions continue as projected, the physician supply will exceed 15,000 by fiscal year 1990, an excess of over 3,000 physicians. DOD officials advised us, however, that these projections were based on a number of assumptions such as (1) the rate of physicians who remain in the service would stay the same, (2) DOD will be able to recruit 1,000 physician volunteers per year, and (3) the output of the scholarship and university programs will be as

projected. These officials also said that if these assumptions change, the projected surplus would likewise change.

Little future effect is expected from other programs. These programs, for the most part, were attractive because of the draft. With the ending of the draft in 1973, these programs lost most of their appeal. For example, by 1980 DOD estimates that less than 1 percent of its physicians recruited will come through the Berry plan.

Rapid promotion practice

As discussed on page 9, DOD has followed a policy of promoting physicians and dentists more rapidly than other officers. The directive establishing the rapid promotion practices stated that it was necessary in order to assure these personnel an attractive and predictable career pattern that would be competitive with the opportunities available in the private sector. DOD estimates that 90 percent of the physicians and dentists who make a career of the military will attain the rank of 0-6 (Colonel/Captain). For those who do not enter the military immediately after graduation from medical school, the entry grade can be as high as pay grade 0-6, depending on years of experience. DOD recently acted to slow down promotion and to reduce promotion opportunity. Included in this recent action is a maximum entry grade of 0-4, unless othewise authorized.

The VIP program has raised the compensation to medical officers to a point where it is more competitive with opportunities in the private sector without using an accelerated promotion system. This competitive compensation plus the high percentages of medical and dental officers in grade of 0-6 has caused both DOD and the Congress to question the need for continued rapid promotion policies. DOD is currently considering reducing the credit given for civilian education and civilian experience, which will lower the promotion potential to a point more comparable to other officers.

RECRUITMENT AND RETENTION PROGRAMS AND PRACTICES IN PHS

PHS uses a variety of practices to recruit and retain physicians and dentists. These include (1) programs to increase income, (2) educational programs, and (3) use of different personnel systems.

The income-increasing programs are similar to those in DOD. We do not believe that these programs are being

administered according to the law and legislative intent. The educational programs include the PHS scholarship and loan repayment programs and a program similar to DOD's Berry plan. PHS also employs physicians and dentists under Federal civil service to a much greater extent that either VA or DOD. PHS civil service physicians are often used differently than those in VA.

Income-increasing programs used to recruit and retain physicians and dentists

Since the commissioned corps of PHS is part of the uniformed services, it has income-increasing programs identical to DOD's--special pay, continuation pay, and variable incentive pay, which generally operate in the same manner as in DOD.

The number of participants and costs of the various income-increasing programs in PHS are as follows.

Special pay

PHS estimates that for fiscal year 1976, 2,476 commissioned corps physicians and 635 dentists will be receiving special pay. In fiscal year 1977, it estimates that 2,500 and 749, respectively, will be receiving special pay. Costs are estimated to be about $7.4 million in fiscal year 1976 and about $8.2 million in fiscal year 1977.

Continuation pay

As in DOD, continuation pay is authorized to help to recruit and retain for critical specialties. Despite this requirement, PHS has made no determination of what constitutes a critical medical specialty and generally makes payment to those who are otherwise qualified and who execute the agreement to serve a specified period.

For fiscal year 1976, PHS estimates that 31 physicians and 238 dentists were receiving continuation pay at a cost of $244,000 and $1.8 million, respectively. For fiscal year 1977, PHS estimates that the same number will be receiving continuation pay but that the costs will be $269,000 and $2.0 million, respectively.

Variable incentive pay

The eligibility requirements for payment of VIP to PHS physicians are similar to DOD's. The amounts, however, are determined somewhat differently. In DOD, the amounts are based on years of active duty. In PHS the amounts are determined by grade. However, there is usually little difference in the VIP paid by DOD and PHS to officers in identical grades except for those in the grade of 0-6 with 22 to 25 years service. As noted on page 10, however, PHS officers may be promoted more rapidly than those in DOD.

As in DOD, VIP is authorized for PHS physicians who are serving in a critical specialty. Although PHS in a letter to OMB in June 1975 described certain actions it would take to identify those who were to receive VIP, we were informed by an official in PHS's Office of Personnel that no further action has been taken. PHS offers VIP to virtually all physicians, regardless of specialty, who are otherwise qualified.

The amounts which physicians in PHS may receive each year are shown in the following table.

Grade	Length of active duty agreement			
	1 year	2 years	3 years	4 years
0-3 and 0-4	$12,000	$12,500	$13,000	$13,500
0-5	11,500	12,000	12,500	13,000
0-6, less than 22 years	11,000	11,300	11,600	12,000
0-6, 22 to 25 years	10,500	10,800	11,200	11,500
0-6, 26 or more years	10,000	10,300	10,600	11,000
Obligated officers (note a)	9,000			

a/A medical officer who has incurred a period of obligated service as a result of training, who is otherwise eligible and who executes a written agreement to serve for 1 year, is entitled to this amount.

As of September 30, 1975, 1,442 physicians were receiving VIP.

Effect of income-increasing programs in recruiting and retaining physicians and dentists

It is not possible to accurately measure the effect of special pay on recruitment and retention since all PHS commissioned corps physicians and dentists receive it. Continuation pay appears to be a successful retention program for dentists.

An analysis of the VIP program in PHS indicates that VIP may be having a positive effect on both recruitment and retention. For example, from March to September 1975, the number of physicians increased by 120. During the same time the number of physicians in grades 0-3 and 0-4 have decreased slightly, while the number in grades 0-5 and 0-6 increased by over 160. This increase, coupled with the small decrease for the lower grades, indicates that PHS may have had some success in hiring more experienced physicians. Also during this 6-month period, there has been a substantial shift to longer VIP agreement lengths and an increase in the numbers receiving VIP.

While none of these facts can be shown to be directly or completely attributable to VIP, it does appear that VIP probably is at least a factor in these shifts--shifts that indicate increased recruitment of more experienced officers and potentially longer retention because of the shift to longer agreements.

According to a PHS official, DOD analyzed retention of commissioned corps physicians. It compiled the number of corps physicians who had completed their obligatory service or contractual agreement (VIP contract) and were "free" to choose whether or not to continue in PHS. The physicians covered by this analysis became free between March and October 1975. The following table shows the results of this analysis for persons completing 2 to 5 years of service.

Completed years of service	Number free to choose	Percent choosing to stay
2	574	29
3	147	44
4	45	64
5	23	65

The data indicates that a substantial number have agreed to continue in PHS and that the longer the physician has

already served the more likely he is to continue. However, no data from previous years is available for comparison.

As discussed on page 57, we do not believe that PHS is administering either continuation pay or VIP according to the law and legislative intent.

Educational programs used to recruit physicians and dentists

PHS uses two main educational programs to recruit physicians and dentists--the scholarship program and the loan repayment program. In these programs the enrollee is obligated to serve on active duty in PHS for a required time in return for the educational benefit received. Other PHS programs are directed toward attracting students in health-related fields into PHS when they complete their training, and there is a draft-related program.

Scholarship program

PHS's scholarship program was authorized by the Public Health Service Act, Title II, Section 225 (42 U.S.C. 234), for the purpose of obtaining trained physicians, dentists, and other health personnel for the National Health Service Corps and other components of PHS--the Indian Health Service, the Division of Hospitals and Clinics, the Federal Prisons' Medical Facilities, and the U.S. Coast Guard Medical Facilities. All of these component organizations are in PHS's Health Services Administration (HSA).

The scholarship recipient receives a stipend of $6,750 a year (or $750 a month for 9 months) and all tuition and fees. Program participants become obligated for 1 year of service for each year of scholarship support with a minimum obligation of 2 years. The recipient can also defer his active duty with the PHS for a 1-year period to obtain his internship or equivalent training. Additional deferrals may also be obtained for residency training if good cause is shown. However, these periods of training are not creditable toward satisfying the active duty obligation unless served in a PHS facility. Also, scholarship recipients are not eligible to receive VIP since they are considered obligated under the law.

The recipient is liable for repayment of the scholarship payments, tuition, and fees plus interest if he fails

to serve his obligation. Similarily, if the participant fails to complete his training, he is liable for the amount equal to the scholarship payments, tuition, and fees. In both cases, there is a 3-year period for repayment. Also in both cases, repayment may be waived, if collection is impossible or would impose an extreme hardship on the individual.

Scholarship program officials have told us the scholarship recipients probably will not come on active duty immediately upon graduation. Most of these graduates will defer their obligated service to complete their internship and residency training. Thus, a lag of at least 1 year and possibly as many as 5 may be incurred. A PHS official told us that the average deferment for training would probably be about 3 years.

If the 1977 and 1978 graduates become available at approximately the same rate, it will be at least 1979 before substantial numbers of these obligated physicians become available for duty. In a memorandum to the Director of the Office of Personnel Management, PHS, an official of the scholarship program estimated that scholarship participants will be presenting themselves for active duty with PHS at the follwoing rate:

Year	Number
1977	150
1978	300
1979	650
1980 and on	800

According to material obtained from PHS, it expects to increasingly rely on the scholarship program to fill much of its recruitment needs. However, the projected number of scholarship participants presenting themselves for duty is less than the number estimated to be needed to fill recruitment needs until 1979. Therefore, PHS may experience a shortfall until 1979 when the numbers expected to come on duty begin to level off and become fairly constant. However, beginning in 1980 and thereafter, the scholarship program may produce a surplus of physicians, assuming the HSA program remains at the present level.

Loan repayment program

Section 741 (f) of the Public Health Service Act, as amended, provides for the Secretary, HEW, to repay a

portion of an individual's educational loans at a school of medicine, osteopathy, dentistry, or other medical training schools when the individual enters into an agreement to practice his profession for a specified period in an area determined by the Secretary to have a shortage of and need for such health professionals.

The individual may enter into either a 2-year or 3-year agreement. In the 2-year agreement, a minimum of 2 consecutive years must be served in a designated shortage area. In return, the Secretary will pay 60 percent of the qualifying loans outstanding at the time of the agreement. If the individual elects to serve a third consecutive year the Secretary will pay up to 85 percent of the loans outstanding at the time of the original 2-year agreement.

The individual may also enter a 3-year contract from the start. Again, he will get up to 85 percent of his outstanding loans paid by the Secretary for serving 3 consecutive years. Depending on the terms of the loan to to be repaid, this type of agreement may be more advantageous than signing an original 2-year agreement and then extending it.

Program participants do not have to serve in PHS. However, serving in NHSC- or IHS-designated shortage areas satisfies the participant's service requirements. This is not considered obligated service, therefore those persons may be eligible to receive VIP in addition to the base pay and other benefits and remunerations.

According to PHS data, the majority of physicians and about one-third of the dentists participating in the programs have elected to serve in NHSC and IHS shortage areas.

This program has grown rapidly since its inception. Costs for fiscal year 1973 were about $400,000, and about $5.6 million has been estimated for fiscal year 1976.

Other educational programs

The other educational programs PHS uses to recruit and retain physicians are the Commissioned Officer Student Training and Extern Program (COSTEP), the Senior Commissioned Officer Student Training and Extern Program (Sr. COSTEP), and the Commissioned Officer Residency Deferment (CORD) program.

COSTEP's primary objectives is to stimulate the interest of promising students in PHS and to enable them to further

their professional knowledge while on active duty in PHS. To be eligible, a student must have completed a minimum of 3 years of a baccalaureate program in a health-related field or be enrolled in a professional school.

Applicants are screened on the basis of (1) references, (2) educational accomplishment and qualifications, (3) career interest, and (4) program needs. Those selected are commissioned in the inactive reserve component of the commissioned corps and are called to active duty during free periods of their academic year. Enrolled in this program are students in dentistry, dietetics, engineering, medicine, nursing, pharmacy, sanitary science, etc.

A student is paid at the 0-1 pay level (equivalent to a 2d lieutenant in the Army) while on active duty at a PHS installation. Upon satisfactory completion of his COSTEP assignment, the officer is retained in the inactive reserve of the commissioned corps, provided he is in full-time training in a health-related field and maintains his student classification. When he becomes academically qualified for appointment, the officer may request extended active duty in PHS or terminate his reserve commission.

The Sr. COSTEP program was established to provide an introduction of qualified physicians to careers in PHS. Qualified students who are attending accredited schools of medicine or osteopathy may be appointed and placed on active duty as commissioned officers in the reserve corps during their senior year. They receive full pay and allowances as junior assistant health service officers (Pay Grade 0-1) plus tuition, fees, and related expenses.

In return for this financial support, they assume an obligation to serve on active duty as medical officers with PHS for a minimum of 2 years after internship. Active duty as an intern with PHS does not count toward this required duty. Sr. COSTEP Officers are considered to be obligated officers and as such are ineligible to receive VIP until this period of obligatory service is completed.

The CORD program is the PHS counterpart to the DOD Berry plan. It was initiated while the military draft was still in existence to allow physicians to defer their military obligation so they could participate in a medical residency training program before being called to duty. Service as a commissioned officer in PHS for a 2-year period satisfied the selective service obligations.

However, since the termination of the draft on July 1, 1973, PHS has lacked a mechanism to force program participants to fulfill their obligations. Since a CORD obligation has been determined to be an initial active duty obligation as specified in 37 U.S.C. 313, a physician with such an obligation cannot receive VIP. Officials have told us that because of the lack of an enforcement mechanism--such as reporting quitters to the selective service boards for possible induction--some CORD physicians have been resigning even before coming on duty.

Data obtained from PHS's Commissioned Personnel Operations Division shows that the number of physicians with CORD deferments is declining rapidly and that the number resigning is large.

Effect of the educational programs on recruitment and retention

It appears that the scholarship program will provide HSA with a number of obligated officers beginning in the late 1970s. Whether this program will have a positive retention effect is not known since it is not known whether large numbers will stay in HSA after their obligated service.

The loan repayment program is also a tool that HSA can use to fill positions in NHSC's and IHS's unattractive areas. However, whether or not physicians and dentists will remain in PHS after fulfilling their service obligations remains to be seen. It is still much too early to determine retention rates for program recipients. These two recruitment incentives are of little or no direct use in filling vacancies elsewhere in PHS, such as the National Institutes of Health and the Center for Disease Control.

The scholarship program may cause a unique problem--too many physicians and dentists. Scholarship recipients are required by law to serve in the various components of HSA. As of January 31, 1976, HSA employed about 1,325 corps physicians--about 900 of whom were not obligated. An official of the scholarship program has projected that 650 scholarship recipients will report for duty in 1979, and that 800 will report for duty in 1980 and future years.

If the entire group of non-obligated physicians remained through 1980, HSA would have about 2,400 physicians on duty--the 900 nonobligated and the approximately 1,500 scholarship recipients. PHS estimates that about 40 percent of the

nonobligated physicians with 5 years or less of service will stay in PHS. Under this assumption, HSA would have about 1,800 physicians by 1981--about 500 more corps physicians than it employed as of September 1975--and an additional 800 physicians entering HSA annually thereafter.

COSTEP is a fairly minor recruitment program, and its effect seems to be getting smaller. During the years 1963-71, about 39 physicians a year were recruited through this program. The average for the past 4 years--1972-75--has dropped to 21 physicians a year.

Dental officer recruitment is also fairly minor. Through the COSTEP program 179 dentists became active in the commissioned corps from 1963 through 1975. Data was not available on how many remain. As with the physicians, the number actually joining the commissioned corps is becoming even smaller. From 1963 to 1971 an average of 15 entered PHS each year, while from 1971 to 1975, an average of only 10 entered.

PHS officials said that the Sr. COSTEP program had diminished in importance because of the PHS schloarship program. However, since the scholarship program only generates physicians for use in programs of HSA, this program will continue since it can be used to aid in recruiting for the other PHS agencies, such as NIH, CDC, the Health Resources Administration, the Alcohol, Drug Abuse, and Mental Health Administration, and the Food and Drug Administration.

The CORD program is also becoming less effective since the draft ended in 1973. Some CORD physicians have resigned before coming on duty. PHS has no enforcement mechanism to require physicians to complete their obligated service.

Use of Federal civil service to recruit and retain physicians and dentists

As discussed on page 10, PHS uses two main personnel systems for employing physicians and dentists--the civil service, or GS system, and the commissioned corps system. The employing authority for the GS system is title 5 of the United States Code, while the employing authority for the commissioned corps is title 37--the same authority that is used for commissioned officers in the military services.

While VA also uses two personnel systems for physicians and dentists, there are major differences between the duties of the personnel employed within each system. VA assigns its GS physicians to the Department of Veterans Benefits and

Board of Veterans Appeals. In neither case are these physicians usually involved in normal patient care activities.

However, PHS does not make such a distinction between duties. In PHS, both the GS and commissioned corps physicians and dentists perform the same types of work and often work side-by-side. The pay and other employee benefits differ greatly and, thus, create pay inequity.

Officials of PHS told us that both authorities are needed and used for the following reasons.

--The PHS mission requires service in remote or undesirable areas, and the commissioned corps--being part of the uniformed services--provides PHS with the necessary flexibility in staffing these difficult areas.

--Since some physicians and dentists have all the necessary medical or dental skills but are ineligible to join the commissioned corps, PHS feels it should have an opportunity to use these people and that the civil service employment authority provides this opportunity.

PHS officials at headquarters and various field locations told us that this pay disparity is causing a serious morale problem among these GS employees. Superiors sometimes receive less pay than their subordinates. Officials fear that if this continues it may become more difficult to recruit and retain GS physicians and dentists.

Data recently provided by the various PHS components indicates that in fiscal year 1975, separations of GS physicians exceeded accessions by 38. In fiscal year 1974 the reverse was true.

Fiscal year	Accessions	Separations	Difference
1974	82	55	27
1975	88	126	-38

We noted that at CDC, seven GS physicians had transferred to the commissioned corps during fiscal year 1975 in order to receive VIP. We were told other physicians would have switched if they had been eligible. Three of the seven had previously switched from the commissioned corps to civil service appointments prior to the VIP program because the benefits and pay of the GS system were better at that time.

CONCLUSIONS

VA, DOD, and PHS use numerous programs and practices to to recruit and retain physicians and dentists. The effects are not always measurable for each separate program or practice but when viewed in total they seem to have contributed to the agencies' recruitment and retention efforts. The efforts used include programs directed toward increasing monetary benefits for continued service; programs and practices to appeal to an employee's interests, such as research; and programs to help individuals get an education.

We do not believe that two of the monetary programs in DOD and PHS--continuation pay and VIP--are being administered in accordance with the law and intent of the authorizing legislation. The law and legislative history indicates this additional pay was to be for physicians and dentists in critical specialties only. Neither DOD nor PHS have defined critical specialties, and they offer this pay to virtually all administratively eligible physicians and dentists.

The PHS and DOD scholarship programs and DOD's university program may cause a unique problem--too many physicians. It is estimated that by 1980, HSA--the PHS organization which employs scholarship recipients--will have more physicians than it employed as of September 30, 1975, and 800 additional physicians entering HSA annually thereafter. By 1990 DOD may have a surplus of 3,000 physicians. The pay disparity between GS and commissioned corps physicians has caused a problem. Civil service and commission corps physicians in PHS often perform similar functions. Yet, in many cases the GS physician earns considerably less. Often a commissioned corps physician earns more than his superior who is a GS physician.

CHAPTER 4

COMPARISON OF COMPENSATION FOR FEDERAL AND NON-FEDERAL PHYSICIANS AND DENTISTS

Section 4(b)(2) of Public Law 94-123 required that GAO compare the remuneration received by physicians and dentists in the Federal Government with that received by those in private practice or academic medicine "who have equivalent professional or administrative qualifications." A comparison of total compensation is not possible because (1) certain fringe benefits cannot, at this time, be readily quantified, (2) there are major differences in the nature and type of practice; and (3) there is no comprehensive total compensation data for the private sector.

For these reasons, the comparison has been limited to those elements of compensation which can be readily quantified--income, other cash benefits, and income tax advantages on certain cash benefits. We did, however, identify other elements of compensation, such as retirement, insurance, and leave.

INCOME COMPARISONS OF PHYSICIANS AND DENTISTS

A comparison of quantifiable compensation elements show that generally, private physicians have higher incomes than physicians in the Federal Government. The incomes of private physicians vary by medical specialty, as well as geographically, while Federal incomes generally do not. The comparison of incomes showed that the Department of Defense and the Public Health Service commissioned corps (PHS/CC) physicians generally earn more than either Department of Medicine and Surgery or PHS civil service (PHS/GS) physicians. DOD and PHS/CC dentists in the later stages of their careers earn more than their private sector and DM&S counterparts.

Methodology used to make income comparisons

Certain assumptions are necessary when comparing incomes of physicians and dentists because there are numerous variables which affect income. One of the major differences between the Federal sector and the non-Federal sector is the size of

the Federal Government. In such a large organization, it is important to have an objective and systematic way of establishing the relative value of each job and to have associated pay structures. For the most part, experience--and consequently age--is the prime determinant of income for a Federal physician or dentist. Generally there is no difference in compensation between specialties for these personnel. In the private sector, on the other hand, specialty acts as a major income determinant, and income varies greatly among specialties.

A Federal physician or dentist has a different type of practice than those in the private sector. The Federal physician is usually hospital based, generally has a stated 40-hour workweek, and works for a salary. A private physician usually works for himself as a businessman and can increase his income by seeing more patients, adjusting fees, developing a good reputation, or working more hours. The Federal physician has no overhead expenses while the private physician incurs office, staff, malpractice insurance, and miscellaneous other expenses.

Another determinant of income in the private sector is the area of the country in which the physician or dentist practices. As shown on page 81, income varies widely between different geographic regions. Federal salaries generally do not vary by geographic regions.

For these reasons, we believe that the most meaningful income comparison is one in which a physician or dentist is comparing the potential of a career in the Federal Government with the potential of a private practice career. We developed a profile of a typical physician or dentist who is making this comparison. In developing this profile, we assumed that:

--Upon entering practice, the physician or dentist has completed 1 year internship and is 27 years of age.

--The physician will serve a 3-year residency. The dentist will practice general dentistry.

--For Federal physicians and dentists, normal career promotions will be achieved, the existing special pay programs will be continued, and the career ladder will not change.

--The physician or dentist has not incurred any DOD or PHS obligated service.

--The physician or dentist is married and has two children.

Using data from Federal agencies and private sector sources, we compared the incomes for the typical physician or dentist through various stages of a career in the private sector, VA, DOD, PHS/CC and PHS/GS. The only GS physicians used in our comparison were those in PHS since neither VA nor DOD employs a large number of GS physicians. To calculate the incomes of Federal physicians and dentists, we determined the incomes of the various grades assuming normal promotions. Included as income is base pay, special pay, lodging and subsistence allowances, and the related tax advantages.

The source for private sector physicians' income data was mainly the American Medical Association. This data was the only source available which showed incomes by age and specialty--a requirement in our methodology.

The Association's income data was derived from its ninth periodic survey of physicians. The survey questionnaire was sent to 10,169 physicians in patient care, excluding interns, residents, and professors; it yielded a 49.3-percent response rate. The survey sample consisted of a cross section of physicians practicing patient care in the United States.

The AMA income data was estimated for calendar year 1974 and needed to be updated for calendar year 1975. Published data on the increase in physician income in 1975 was not available at the time of our review. However, from discussions with knowledgeable officials in the medical field, we determined 10 percent to be a reasonable estimate for an increase in physician incomes in 1975, and we increased 1974 income by this percentage.

We also compiled data for physicians and dentists engaged in teaching and for physicians employed by several health maintenance organizations (HMOs). The academic income data was obtained from the Association of American Medical Colleges and the American Association of Dental Schools. No income comparisons were possible between Federal physicians and dentists and academic and HMO physicians and dentists because the ages were not specified.

For private sector dentist income, we used data from the American Dental Association's 1973 Survey of Dental Practices.

This data reflected dentist incomes for calendar year 1972. We were unable to locate a reliable source for updating this data to calendar year 1975. We therefore used the rates of increase in physicians' incomes for the applicable years.

Results of income comparisons

The following schedules show the income comparisons between Federal and non-Federal physicians and dentists, as well as the comparisons of incomes between Federal physicians and dentists. It should be emphasized that the data for private sector physicians and dentists does not take into consideration items which may be a deductible business expense but which may be personal in nature, such as a business automobile. Although this data is not available, several physicians suggested that this is frequently an important income consideration.

Similarly, the data for the Federal sector does not include any outside income. In the uniformed services, outside employment occurs but is not widespread and is authorized on an individual basis. However, in VA outside employment is more common; 21 percent of VA full-time physicians earned remuneration for outside professional activities during 1975. No information was available on outside income received by part-time VA physicians.

Comparison of Physicians' Average Net Income by Age Calendar Year 1975

Age	Private Sector: General practice	Internal medicine	Surgery	Obstetrics/ Gynecology	Pediatrics	Psychiatry	Federal Sector: DM&S Salary (note a)	Bonus	Total pay
27 to 29 (note e)	$13,435	$13,435	$13,435	$13,435	$13,435	$13,435	$13,222	$ -	$13,222
30 to 35	59,376	45,022	50,738	f/61,443	f/34,263	f/46,900	32,743	5,964	38,707
36 to 40	54,278	59,318	69,895	67,121	53,755	41,385	33,643	6,727	40,370
41 to 45	56,013	67,813	74,172	72,200	56,834	49,134	34,800	6,727	41,527
46 to 50	59,472	68,659	76,201	75,318	47,931	46,831	35,234	7,468	42,702
51 to 60	48,936	55,492	71,607	63,316	47,874	44,583	35,506	7,470	42,976
61 and over	33,777	45,208	48,210	40,456	f/36,945	33,360	35,379	7,256	42,635

Age	Federal Sector: DOD Pay (note b)	Bonus (note c)	Total pay	PHS/CC Pay (note b)	Bonus (note c)	Total pay	PHS/GS Total pay (note d)
27 to 29 (note e)	$20,916	$ -	$20,916	$21,442	$ -	$21,442	$12,835
30 to 35	25,861	13,818	39,679	26,425	13,676	40,101	29,422
36 to 40	30,553	13,508	44,061	31,178	13,364	44,542	34,526
41 to 45	35,915	12,861	48,776	36,546	12,473	49,019	37,581
46 to 50	39,137	12,031	51,168	39,137	11,871	51,008	37,800
51 to 60	40,124	11,602	51,726	40,124	11,602	51,726	37,800
61 ond over	40,124	11,602	51,726	40,124	11,602	51,726	37,800

a/Actual salary data was unavailable in the form required so we assumed a median point in each salary scale.

b/Include base pay, quarters, subsistence, and physician professional pay, and associated income tax advantages.

c/Includes tax advantage associated with the bonus.

d/GS physicians do not receive the bonus.

e/Residents.

f/Fewer than 30 observations.

Comparison of Dentists' Average Net Income by Age Calendar Year 1975

Age	Private sector net income (note a)	Federal sector								
		VA			DOD			PHS/CC		
		Salary	Bonus	Total income	Pay (note b)	Continuation pay	Total income	Pay (note b)	Continuation pay (note c)	Total income
27 to 29	$22,036	$23,787	$2,650	$26,437	$20,116	$ -	$20,116	$20,642	$ -	$20,642
30 to 34	36,727	28,075	2,650	30,725	23,662	3,660	27,322	24,294	3,753	28,047
35 to 39	42,847	31,535	2,883	34,418	29,267	7,142	36,409	29,466	7,195	36,661
40 to 44	42,847	33,230	2,883	36,113	34,231	8,690	42,921	36,081	9,276	45,357
45 to 49	44,746	34,538	3,150	37,688	38,628	10,124	48,752	38,628	10,124	48,752
50 to 54	42,847	35,258	3,150	38,408	40,126	10,619	50,745	40,126	10,619	50,745
55 to 59	36,421	35,823	3,237	39,060	40,126	10,619	50,745	40,126	10,619	50,745
60 to 64	29,105	35,303	3,237	38,540	40,126	10,619	50,745	40,126	10,619	50,745

a/Incomes are medians.

b/Includes base pay, quarters, subsistence, professional pay, and associated tax advantage.

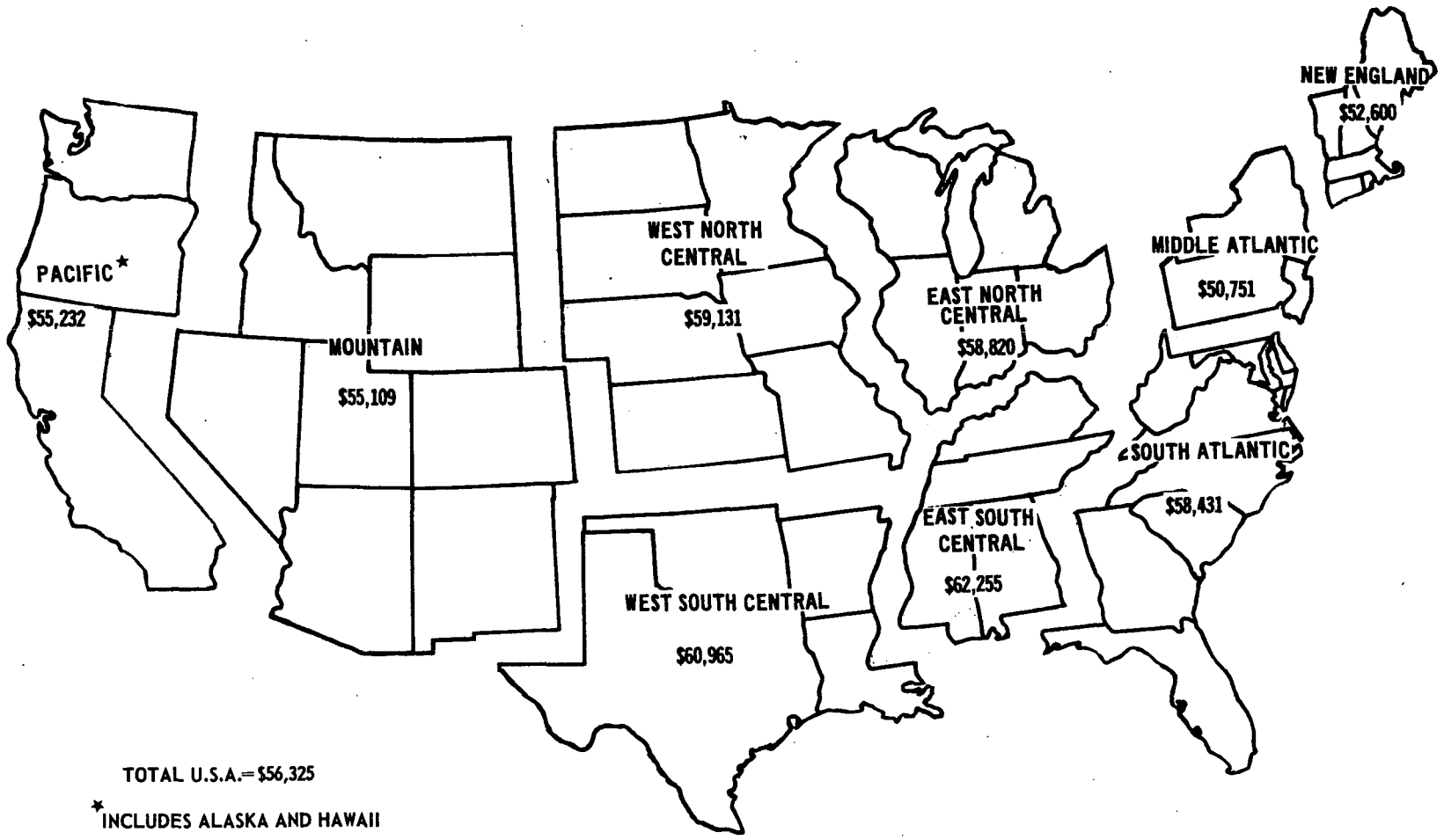
c/Includes the tax advantage associated with continuation pay.

Geographic differences in private sector incomes

In addition to variance by specialty, incomes of private sector physicians and dentists vary by geographic region. This does not generally hold true for Federal physicians and dentists. Therefore, a Federal physician's income may be more comparable with the private sector incomes in some areas than in other regions.

An overall average by geographic region in 1975 showed that the non-Federal physician's average income can vary over $11,000. A physician in the East-South Central United States earned an average of $62,255 from his practice, whereas a physician in the Middle Atlantic States earned an average of $50,751. The following map is based on AMA data and shows the variance of incomes by geographic regions.

PRIVATE PHYSICIANS AVERAGE INCOMES
1975



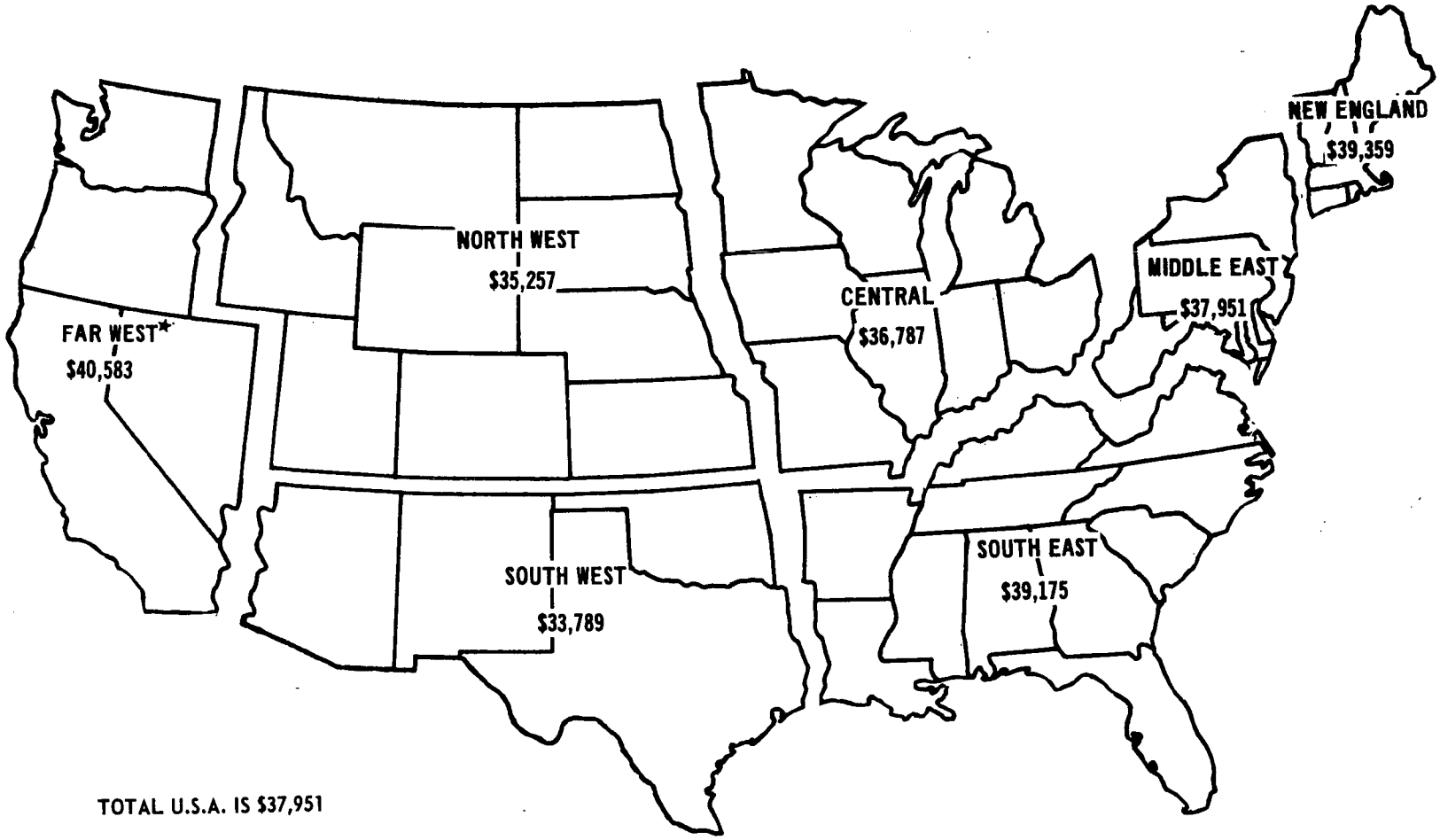
TOTAL U.S.A.=$56,325

*INCLUDES ALASKA AND HAWAII

For dentists, the median private sector income is $37,751. The greatest variance occurs between the Far West and the Southwest. The following map shows the average incomes for all areas of the country.

PRIVATE DENTISTS MEDIAN INCOMES

1975



TOTAL U.S.A. IS $37,951

* INCLUDES ALASKA AND HAWAII

Incomes of other non-Federal physicians and dentists

We compiled income data for physicians and dentists involved in academic-teaching-practice and for physicians employed by HMOs. Comparison to Federal sector incomes was not possible because the data was available only by specialty and specialty is not an income determinant in the Federal sector.

Following are the average salaries for physicians who received their entire professional income from a medical school and devoted full-time to programs for the school. Their professional activities are under the direct auspices of the medical school. The data includes all regions of the United States and is for fiscal year 1976.

Specialty	Instructor	Assistant professor	Associate professor	Professor	Chairman
Family practice	$23,900	$34,300	$39,500	$41,300	$48,900
Internal medicine and medicine (note a)	20,398	31,402	37,889	45,500	54,339
Obstetrics-gynecology	20,000	31,800	41,200	46,700	59,400
Pediatrics	18,100	27,500	34,200	41,800	53,400
Surgery (note b)	20,616	35,689	41,086	49,130	60,391
Psychiatry	18,500	26,900	34,200	42,000	55,500
Radiology	24,600	35,300	43,100	52,600	64,800

a/Includes a weighted average of the clinical science departments of dermatology, medicine, and neurology.

b/Includes a weighted average of the clinical science departments of opthalmology, otolarynology, general surgery, neurosurgery, orthopedic surgery, plastic surgery, thoracic and cardiovascular surgery, and urology.

Another group of physicians for whom income data was compiled were those employed by HMOs. HMO physicians are similar to those in the Federal sector in that both work for a salary rather than being self-employed. They also are similar to Federal physicians in that they work set hours.

HMOs are prepaid group practice health care plans. Most are located in urban or highly populated areas. We were able to obtain income data for several HMOs in the country. The income data is presented below for calendar year 1975. It does not include income from incentive plans or profit sharing. In some HMOs, bonus amounts ranged from $4,000 to $17,000.

Specialty	Starting income	Income after 2 years	Income after 8 to 10 years
General practice	$29,533	$35,500	$49,500
Internal medicine	32,500	37,500	58,000
Obstetrics-gynecology (note a)	38,000	46,000	64,500
Pediatrics	31,750	36,750	49,500
Psychiatry (note a)	35,000	43,000	60,500
Radiology (note a)	36,500	44,500	63,000

a/ Includes only one HMO.

Following are the average salaries for dentists in teaching positions as reported in the 1975-76 salary survey of the American Association of Dental Schools. The data is for full-time faculty.

Position	Salary
Professor	$32,668
Associate professor	26,859
Assistant professor	22,604
Instructor	16,897

IDENTIFICATION OF OTHER BENEFITS

Remuneration includes both salary and benefits, and even though salary is the more visible, benefits have become an increasingly important part of employee compensation in both private and Federal sectors.

Benefits generally consist of (1) employer retirement plans, which may include vesting rights, survivorship provisions, and disability protection, (2) paid holidays, vacations, and sick leave, (3) medical and dental insurance plans, (4) life insurance plans, and (5) severence pay provisions.

We were not able to quantify these benefits since there is no common standard for assigning values. In a report to the Congress in 1975, 1/ we emphasized the importance of fringe benefits and recommended that the Civil Service Commission and the Office of Management and Budget

--develop a policy of total compensation comparability for determining Federal employee's pay and benefits and

--propose legislation to establish the objectives, standards, criteria, and processes for achieving total compensation comparability.

At the time of the present review, these recommendations had not been implemented. OMB officials advised us, however, that the Civil Service Commission was developing a methodology to quantify all elements of compensation.

The retirement program is probably the most significant of all the fringe benefits in the Federal sector. There is a significant difference for this program between the uniformed services, DM&S, and GS. The uniformed services are noncontributory; DM&S and GS are contributory. Members of the uniformed services may retire after 20 years active duty. Assuming the DM&S and GS member retires after 30 years, he

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1/Need for a Comparability Policy for Both Pay and Benefits of Federal Civilian Employees, July 1, 1975, FPCD-75-62.

must work 10 years longer than the uniformed services member and on retirement collects his own contributions for 3 to 4 years before actually receiving any retirement benefits from the Government.

Since the various fringe benefits cannot be readily quantified to any accurate degree, presented below is a comparison of the features of the various retirement plans in the private sector and the Federal Government. Also presented is a comparison of fringe benefits other than retirement.

Comparison of Retirement Plans of Private Sector Physicians and Dentists with Federal Sector

Benefit provision	Private practice	Academic medicine	Selected HMOs	Federal Sector	
				DM&S and GS	DOD and PHS/CC
Normal retirement	(See note) Keogh Plan	(See note) Private plan Employer contribution	(See note) Private plan Employer contributions	Civil service retirement only.	Uniformed service retirement, (see note).
Requirement	-	-	-	Age 55: 30 years service Age 62: 5 years service	No minimum age; 20 years active duty
Benefit calculation	Keogh Plan	Data not provided	Data not provided	Average earnings in 3 consecutive highest paid years, multiplied by 1.5% times first 5 years of service, 1.75% times next 5 years of service, and 2% times all years over 10	2.5 basic pay at time of retirement multiplied by years of creditable service.
Early retirement	Data not provided	Data not provided	Data not provided	None except for involuntary separations. Age 50 and 20 years service or any age with 25 years service.	None if before 20 years.
Benefit calculation	-	-	-	Actual reduction	-
Disability retirement	(See note)	Average of $113 paid by employer	Free, pays $24,000 yearly until age 65	Provided	Provided

Benefit provision	Private practice	Academic medicine	Selected HMOs	Federal Sector	
				DM&S and GS	DOD and PHS/CC
Eligibility requirement	Not applicable	-	-	5 years' service, no age requirement	No age or service requirement, (see note)
Vesting (eligibility) for a retirement benefits:					
Requirements	None	5 years' service	Data not provided	5 years' service; no age requirement	20 years
Survivorship	(See note)	Data not provided	Data not provided	55% of spouse's earned annuity if death occurs before retirement and, depending on election, a maximum of 55% after retirement	Benefits similar to civil service (see note)
Financing	-	Average employer contribution is 9%	Data not provided	Employees contribute 7% of pay. Government pays remaining cost	Government pays entire cost (see note)
Annuity adjustments	(See note)	Data not provided	Data not provided	Annuities are automatically adjusted when the Consumer Price Index goes up by as much as 3% over the last adjustment and stays up for 3 consecutive months. The adjustment equals the percentage increase plus 1%	Similar to civil service (see note)

Note: Except for DM&S and GS, all physicians and dentists are eligible for and subject to Social Security taxes and benefits.

Comparison of Other Annual Benefits between Private and Federal Sectors

Benefit provision	Private practice	Academic medicine	Selected HMOs	Federal sector			
				DM&S	GS	DOD	PHS/CC
Holiday Practice	No data	Data not provided	8 days	9 days	9 days	9 days	9 days
Vacation Practice	No data	Data not provided	4 weeks	30 calendar days per year	13 workdays 20 workdays after 3 years 26 workdays after 15 years	Same as DM&S	Same as DM&S
Salary continuation (sick leave)	None	Data not provided					
Benefit amounts	-	-	2 weeks	15 days each year	13 days each year	As needed	As needed
Health Insurance Medical	None	Average of $211 paid by employer	Provided free	Government and employees share costs on approximately a 60/40 basis	Same as DM&S	Generally no cost to employee (note a)	Generally no cost to employee (note a)
Dental	No data	Data not provided	Sometimes provided	No coverage	No coverage	No cost to employee	No cost to employee
Life Insurance	None	Yes	$50,000 term life	Salary rounded to next highest $1,000 plus $2,000. Additional optional coverage of $10,000 is also available	Same as DM&S	$20,000 term life	$20,000 term life

Benefit provision	Private practice	Academic medicine	Selected HMOs	Federal sector			
				DM&S	GS	DOD	PHS/CC
Financing	-	Average of $95 paid by employer	Provided free or at reduced rate	Employees pay 2/3 of the cost of regular insurance and the full cost of option insurance	Same as DM&S	Employees pay all except Government pays premium for hazardous duty insurance.	
Severance pay	None	Data not provided	Data not provided	Yes	Yes	Yes	Yes
Eligibility requirements	-	Data not provided	Data not provided	1 year's service	Same as DM&S	5 years' service, officers only	
Benefits amounts	-	Data not provided	Data not provided	1 week's pay for each year of service up to 10 years. 2 week's pay for each year of service over 10 years and 10% additional for each year of age over 40	Same as DM&S	Generally $15,000 maximum.	
Tuition for children	Not applicable	Average of $343 paid by employer	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable

a/Members' dependents generally also entitled to health care.

CONCLUSIONS

Income is only one factor in evaluating physicians and dentists remuneration. Fringe benefits, retirement, working conditions, and other factors also influence a career and job choice. However, a comparison of income is the most objective comparison that can be made since the other benefits cannot be readily quantified.

In summarizing the comparison of private physician incomes with those of Federal agencies, we found that private physicians' incomes vary greatly by medical specialties, except in the residency years, whereas Federal physicians' incomes do not vary by medical specialty.

During the years of residency, DOD and PHS/CC physicians earn the highest incomes--over 55 percent higher than private physicians. DM&S and PHS/GS physicians are competitive with private physicians in the residency years. Generally, private physicians out of residency earn more than their Federal counterparts. DOD and PHS/CC physicians generally have higher incomes than either their DM&S or GS counterparts. DOD and PHS/CC dentists in the later stages of their careers also earn more than their private sector and DM&S counterparts.

Physicians employed by HMOs have jobs more similar to Federal physicians than others in the private sector. These physicians are hired on such terms as salary, partnership, contract, incentive plans, and other ownership interests.

HMOs consistently start physicians at a higher income than Federal physicians and reach their income peak much earlier. In all specialties except general practice, HMO incomes stay considerably above the Federal incomes.

Physicians employed by medical schools are paid less than physicians in DOD and PHS/CC. The medical school physicians are paid more at all levels than the PHS/GS physicians. The salary of associate professors is comparable to that of most DM&S physicians.

CHAPTER 5

A UNIFORM COMPENSATION PLAN IS NEEDED

Section 4(a)(2) of Public Law 94-123 required that GAO determine whether a uniform system of pay, allowances, and benefits would alleviate or solve physician and dentist recruitment and retention problems.

There are many factors which affect recruitment and retention, such as compensation, the available supply of physicians and dentists, types of practice, educational commitments, and personnel management policies and systems. An effective compensation plan--encompassing pay, allowances, and benefits--is only one, but an important, factor in assuring that the Government, as an employer, gets a fair share of the Nation's physicians and dentists at a reasonable cost. Physicians and dentists, however, are scattered among various Federal pay systems, the designs of which are generally not appropriate for such occupations.

Compensation plans are generally designed to support the agencies' personnel management systems. To illustrate, because the Department of Defense desires a young and vigorous workforce to carry out its missions, early retirement is provided. However, the policy encourages physicians and dentists to leave at the peak of their careers and makes it necessary for DOD to maintain an intensified recruiting campaign.

A uniform compensation plan should be developed for Federal physicians and dentists built around the occupations' unique characteristics and should provide sufficient flexibility to deal with special situations for all Federal physicians and dentists. Recognizing that the uniformed services' compensation system supports their personnel management policies, we believe that the personnel policies should be evaluated with a view toward eventual adoption of a uniform compensation plan. In the interim, there should be a coordinated approach to providing reasonable parity of compensation for the uniformed services' physicians and dentists with their Federal civilian counterparts.

A plan that results in compensation reasonably competitive to that of non-Federal health professionals and has the flexibility to handle specific occupations and geographic problems should improve the Government's ability to recruit and retain physicians and dentists. However, the extent of

improvement would not be measurable because there are many noncompensation factors which affect recruitment and retention.

Because a uniform compensation plan which includes all of the above elements has not yet been developed, the cost of such a plan cannot be estimated.

WHY A UNIFORM COMPENSATION PLAN IS NEEDED

About 99 percent of the Federal physicians and dentists are under one of three major pay systems--civil service, or GS; VA's Department of Medicine and Surgery; and the uniformed services. The systems' designs are generally not appropriate for such occupations. Furthermore, Federal pay in general has lagged behind non-Federal physician and dentist income, putting the Government at a disadvantage in the labor market. In the absence of a coherent, coordinated Federal pay policy, various special payments and promotion policies have evolved, resulting in Federal physician and dentist compensation varying among agencies and often within an agency, creating internal competition and morale problems.

Physicians in the non-Federal sector are among the highest paid of all professionals. They undergo long periods of training and generally start their careers later than other professionals. Furthermore, the supply of physicians has historically been short of demand. This situation has improved in recent years and is expected to continue to improve as the supply of physicians increases in comparison to population. Compensation of physicians varies widely among the specialized skills and depends upon work disciplines and habits. This environment produces the potential for superior earnings. In the Federal sector, earnings potential is not nearly as great even though the professionals are expected to have similar capabilities and provide the same services.

Civilian pay systems

About 19 percent of the civilian physicians and dentists are under the GS pay system. This system covers about 1.3 million employees in 22 broad occupational groups containing about 430 specific occupations. Each occupation is slotted into one or more of the 18 grades of a single salary schedule based on the job's duties, responsibilities, and required qualifications.

By law, Federal white-collar pay rates should be comparable with private sector pay rates for the same levels of work and should be assessed and adjusted annually. Pay rates for each of the 18 work levels are based on private sector salaries for a selected group of jobs which does not include medical occupations. This process does not provide comparability for every job because the Government classifies many heterogeneous occupations at the same work level or grade regardless of the actual pay relationships among these jobs in the non-Federal sector. As noted earlier, private sector physicians generally earn considerably more than their Federal counterparts at equivalent levels. Maximum consideration is given to internal pay relationships within the GS system and neither the salary levels nor private sector wage movements for physicians and dentists are reflected in the process. The problem was further compounded when the Congress accepted an alternative plan limiting the GS pay increase to 5 percent in 1975 instead of the 8.66 percent "comparability" adjustment.

To deal with this disparity, it was necessary to use the flexibility in the GS system's special rates. These rates, which have been used for over 20 years, are authorized for an occupation whenever the private industry rate in an area is substantially above the Federal rate and significantly handicaps the Government's recruitment or retention of well-qualified personnel.

But special rates did not solve the problem because the main constraint to paying market competitive rates is the legislated pay ceiling--GS salaries cannot exceed the rate for level V of the executive schedule (currently $37,800). Without the ceiling the GS pay schedule calls for rates up to $48,654 a year.

The DM&S pay system covers about 78 percent of civilian physicians and dentists and was established in 1946 basically for DM&S's medical professionals. VA believes that this system is needed for more flexibility in hiring, paying, and removing personnel than is available under the competitive service.

The DM&S system is a rank-in-the-man system based on the philosophy that pay should be geared to a person's professional qualifications and attainments rather than to the position held. Because the DM&S pay rates are based on GS rates, it suffers from the same limitations including being subject to the level V pay ceiling.

VA felt that it was adversely affected by legislation authorizing uniformed services physicians to receive a bonus of up to $13,500 a year. As a result, in October 1975 VA received legislative authority to pay a bonus to physicians and dentists under the DM&S schedule. (Dentists are limited to one-half the bonus received by physicians, or $6,750.) The bonus is not subject to the pay ceiling, nor can it be used in computation of retirement annuities. VA uses the bonus as a retention mechanism. It rewards tenure of service and level of professional responsibility, increasing in amount at the higher levels.

GS and DM&S physicians and dentists have a retirement system which is contributory and encourages a full-length career. For normal retirement, employees must have a combination of years of service and age--generally a minimum of 30 years' service at age 55. Retirement annuities are based on the highest average salary earned during any 3 consecutive years of service multiplied by 1.5 percent for each of the first 5 years, 1.75 percent for the next 5 years, and 2 percent for each year of service thereafter. No constructive longevity credit is given for education and training in the computation of retirement benefits as is done in the case of uniformed service practitioners.

Uniformed services system

About 58 percent of the Federal physicians and dentists are in the uniformed services. Uniformed service physicians and dentists use a rank-in-the-man system modified by fixed waiting periods between ranks which differ between DOD and PHS. Consequently, similarly qualified personnel enter at different levels and progress at different paces and receive different pay. Compensation is paid and received in a variety of ways and is classified into three major categories: regular military compensation (RMC), special and incentive pay, and supplemental benefits.

RMC consists of four elements--basic pay, allowances for quarters and subsistence (both in cash and in-kind), the tax advantage related to the nontaxable quarters, and subsistence allowances. RMC, commonly referred to as the equivalent of a civilian salary, is based on rank, service time, and family size. This system was not designed with the unique characteristics of physician and dentist occupation in mind; rather it was designed to satisfy the diverse compensation requirements of the uniformed services in peace and in war.

The general RMC level is adjusted annually to a percentage of the GS pay increase. The resultant level of compensation suffers from the same limitations as the GS; but only basic pay (about 78 percent of RMC) is subject to the level V pay ceiling.

Since World War II the draft and draft motivations have been the primary source of uniformed service physicians and dentists. The retention rate for physicians and dentists had historically been poor. Over the years, the Congress has authorized the uniformed services to pay these personnel over and above their normal military pay in order to increase retention. Physicians and dentists also have been given constructive longevity credit for their education and training in the computation of their pay, rank, and retirement benefits, and faster promotions than their nonphysician and nondentist contemporaries. The uniformed services follow a policy of encouraging lateral entry of experienced physicians by offering longevity credit and higher rank than the normal entry levels as more competitive compensation with the non-Federal sector. In spite of this, retention has remained low.

In 1974 the variable incentive pay program was enacted because DOD's ability to recruit and retain physicians was threatened by the end of the draft. The purpose of VIP is to retain physicians in critical specialties on active duty beyond their initial tours of duty and to provide an incentive for accession of physicians (volunteers) into the military services. Despite this, VIP is offered to virtually all physicians who are administratively eligible, regardless of specialty. Neither the law nor legislative history indicates that the Congress intended the military services to provide VIP to all medical specialties irrespective of needs. In addition, physicians and dentists are entitled to other forms of additional pay. All service members are eligible for supplemental benefits such as noncontributory retirement, medical care, life insurance, and commissary privileges.

The uniformed services noncontributory retirement system permits retirement after 20 years of active service regardless of age at one-half of base pay. They receive 2.5 percent for each additional year up to 75 percent of base pay. But they have no vested rights prior to 20 years of service. The differences in retirement programs between the uniformed services and civilian plan relates to different mission objectives. The uniformed services retirement was designed

to retain personnel at the early and midcareer levels. This effect, "retirement pull," is pronounced on officer personnel behavior from the 8 to 10 year point of their careers, but it is not as strong on physicians as on most military members. Only 4 percent of the physician accessions retire as compared to 23 percent of other military officers. Even if they decide to stay to become eligible for retirement, they are leaving at the peak of their career which creates replacement problems for the services.

Further, the uniformed services retirement system serves as a barrier for entry into the commissioned corps of PHS later in an individual's career. An applicant generally must be 44 years of age or younger since the mandatory retirement age is 64 and 20 years of active service is needed to qualify for retirement benefits.

We found cases where differences between systems have caused some employees to transfer between systems in an agency. In one PHS installation we visited, seven GS physicians transferred to the commissioned corps during fiscal year 1975 in order to receive VIP. Other GS physicians, who reportedly would have switched, had previously switched from the commissioned corps to the GS prior to the implementation of VIP because the benefits of the GS system were better at that time.

We found numerous instances where physicians who were receiving VIP worked with physicians not receiving VIP because of ineligibility. This has caused bitterness among physicians and resulted in lawsuits being filed against the Federal Government by those physicians not receiving VIP.

LONG-RECOGNIZED NEED: CHANGE PAY PRACTICE FOR PHYSICIANS AND DENTISTS

It has long been recognized by various study groups, such as the President's Panel on Federal Compensation, that certain Federal occupations require separate treatment to assure an equitable alinement of positions and competitive pay. Many of these groups have pointed out that Federal health services professionals are scattered throughout several pay systems and should be brought under a single compensation plan so that each practitioner, regardless of agency affiliation, would be evaluated and paid like the rest of his colleagues in the Federal service. Despite the findings of the study groups, separate systems continue. As discussed previously, many of

the pay systems and ranking practices are incongruous with the unique characteristics of the physician and dentist occupations.

Interagency study of uniform pay plan

The most recent effort aimed at achieving uniformity in the compensation plans for Federal health professionals was that undertaken at the request of the Director of OMB.

In a September 4, 1975, letter, the Director, OMB expressed the Administration's concern about compensation for health professionals and established an interagency study group. The Director stated:

> "As a matter of general personnel policy, the Administration is committed to the goal of equitable and uniform treatment of all Federal personnel systems, and pay and benefit structures. Fundamental and long-term issues concerning the most equitable and uniform treatment of physicians and other health professionals throughout the Federal service should be addressed in developing the 1977 Budget and any Administration legislative recommendations concerning extension of the physician bonus authorities. Accordingly, I am requesting that the Departments of Defense and Health, Education, and Welfare, along with the Veterans Administration, and the Civil Service Commission submit to me a joint report--including coordinated analysis, alternatives, and recommendations--by December 1, 1975, concerning compensation and personnel systems for physicians and other Federal health professionals. Chairman Hampton of the Civil Service Commission has agreed to act as convenor and moderator for the joint agency meetings held to prepare such a report. Representatives of the Office of Management and Budget will also attend such meetings."

In its December 1975 report, the interagency group recommended (1) a long-term solution in the form of a compensation plan for all Federal civilian physicians and (2) a short-term solution to continue the bonus authorities because the long-term solution would require considerable time for development, legislation, and implementation.

The group recommended a "Federal Physicians' Compensation Plan" as the basis for the long-term solution to existing pay problems. The plan would not change other features of existing agency personnel systems.

The descriptive outlines of the plan feature

--a coordinated approach to the compensation of Federal physicians,

--a single compensation plan for all Federal civilian physicians,

--compatible policies, practices, and compensation for use by all agencies,

--the setting and adjusting of compensation rates on a schedule reasonably in line with competitive market rates in non-Federal sectors of the economy and reasonable parity between Federal civilian and commissioned officer physicians, and

--the establishment of special compensation levels or schedules of rates when competitive market rates for specific types of jobs are so far above maximum regular compensation levels that agencies are seriously handicapped in recruiting or retaining well-qualified physicians at the regular compensation levels.

The study group also recommended establishment of a Federal physicians' compensation board which would be responsible for developing the operating details under the plan's descriptive outline and for carrying out the plan.

The long-term plan, in our opinion is a step in the right direction, but it is too limited. The report indicates that the study group took a limited approach for pragmatic reasons, mainly time constraints and failure of other groups to achieve change in agencies' personnel systems.

The recommended plan contemplates a single salary schedule for all civilian physicians with pay rates based on reasonable comparability with the private sector. The uniformed services pay schedule would be linked to the civilian physicians schedule at one or more points and serve as a basis to set and adjust VIP for physicians in

the uniformed services. The plan, however, does not encompass other aspects of compensation, such as fringe benefits. Pay was considered separable from other employment and career matters and something that could be dealt with within the context of the different personnel systems which were designed to meet different agency missions. Also, the plan does not cover dentists, which we believe should be included in a uniform compensation system.

The study group's report pointed out that previous attempts had been made to achieve agreement on a total personnel system. We think this is an important issue which needs to be pursued. Under the systems in existence, similarly qualified physicians and dentists can enter the different systems at differing levels, progress at different paces within the system, establish eligibility for bonuses on different criteria, receive different fringe benefits and allowances, and receive compensation which varies significantly among individuals and systems.

CONCLUSIONS

The development of an effective compensation plan with the pay flexibilities contemplated by the study group demand readdressing the question of whether internal differences in pay and pay-related factors are necessary to the mission and requirements of each agency which has a separate system.

The recommendations of the interagency study are a step in the right direction. We believe it is in the Government's best interest to strive to have all Federal physicians and dentists under one compensation plan which incorporates the necessary flexibilities to meet each agency's needs.

To varying degrees every agency has differing mission requirements and it is a normal tendency for agencies to want the flexibility a separate plan provides. The Government, however, should be concerned with the internal compensation relationships between all groups of employees.

We recognize that before a uniform compensation plan can be developed, considerably more study is needed. For example, an indepth evaluation is needed of PHS's need for two personnel management systems--the commissioned corps and GS. An evaluation by HEW of the commissioned corps in 1971 concluded that the program management structure on which the commissioned corps was once based--along military lines--had largely disappeared, and it did not have an effectively functioning personnel system or a genuine career

service for its major category--the physician. It was concluded that the commissioned corps system should be replaced by a unified career system within the civil service system.

Setting the military physicians and dentists and their civilian counterparts in a personnel management and compensation system designed for the unique characteristics of their professions could overcome the problems noted earlier. However, study is also needed of the problems which may be encountered by removing military physicians and dentists from the personnel management system which is applicable to all other members of the military.

RECOMMENDATIONS TO THE CONGRESS

We recognize that before a uniform compensation plan can be developed for all Federal physicians and dentists--civilian and military--much more study is needed. Accordingly, to provide a long-term solution, we recommend that the Congress:

--Direct the Director of OMB to develop a uniform compensation plan for all Federal physicians and dentists. The plan should include a method or methods for comparing and adjusting pay and benefits. OMB should be charged with developing a uniform personnel management and compensation system applicable to all Federal physicians and dentists. If there are compelling reasons for separate systems, a unified plan should be developed and provisions made for interrelating the systems.

--Require that within 1 year, or earlier, after the direction from the Congress, the Director submit to the Congress a report on the results of OMB's activities, together with its recommendations, including proposed implementing legislation and cost estimates.

CHAPTER 6

ACTIONS NEEDED

As discussed in chapter 5, we believe that a uniform compensation plan should be developed for all Federal physicians and dentists. However, certain actions are presently needed, one of which--changes in the variable incentive pay and continuation pay programs--is an interim measure until a uniform compensation plan is developed and implemented.

CONTINUATION AND VIP PROGRAMS NEED TO BE CHANGED

The continuation and VIP programs in DOD and PHS were established, according to the law and legislative histories, to alleviate recruiting and retaining problems of physicians and dentists in critical specialties. Despite this criteria, neither DOD nor PHS have defined critical specialities, and both offer pay under these programs to virtually all eligible personnel regardless of specialty.

DOD and PHS rationale is that even though there might be an overage in a certain specialty, such physicians could also work as general medical officers when there are shortages. Further, DOD has taken the position that it would be discriminatory and inequitable to exclude otherwise eligible personnel. The present policy is intended to result in a more stable physician and dentist force than if the payments varied and were periodically adjusted by specialty.

Since virtually all physicians and dentists are offered the special payments, they are not bonuses whose objective is to secure additional service to satisfy critical specialty shortages but rather are an income supplement with the objective of raising the pay levels of all uniformed services physicians and dentists. Neither the law nor its legislative history indicates that the Congress intended the military services to provide continuation pay and VIP to all medical specialties irrespective of needs.

With regard to using physicians in specialties where overages exist as general medical officers, we believe that this is not an effective use of manpower and may influence physicians being used in this manner to leave DOD or PHS service.

We believe that both the continuation pay and VIP programs need to be changed to bring them more into line

with their avowed purposes--to recruit and retain critical medical and dental specialties.

EDUCATION PROGRAMS MAY RESULT IN SURPLUS OF PHYSICIANS

The scholarship programs of DOD and PHS and the DOD university program may result in a surplus of physicians in these agencies by the 1980s. The maximum number of scholarships which can be awarded--5,000 at any one time--was estimated by DOD to be reached in fiscal year 1976. The full complement of graduates will not be entering active duty until the 1980s, which approximately corresponds to the entry date into active duty of the graduates of the university program. When both of these programs start supplying physicians to DOD the supply may be excessive.

According to DOD projections, effective in fiscal year 1981, the physician supply will begin to exceed the assumed authorized level. If accessions continue as projected, the physician supply will exceed 15,000 by fiscal year 1990, an excess of over 3,000 physicians. DOD officials advised us that these projections are based on a number of assumptions which, if change materially, would likewise change the projected surplus. Since program changes cannot be made quickly--because of the long period of medical school--DOD should put a high priority on deciding how to deal with this potential surplus of physicians.

As currently operated, the PHS scholarship program may also result in a surplus of physicians by the 1980s. It is uncertain whether the surplus will actually materialize since PHS has not established its future needs.

Scholarship recipients are required by law to serve in the various components of the Health Services Administration. Based on current physician strength, HSA may have about 500 more physicians by 1980 than it had as of September 30, 1975, and 800 additional physicians entering HSA annually thereafter.

HSA officials are aware that this large influx of physicians is imminent but were unable to provide us with a formal long-range program on how HSA plans to use these physicians, other than that they will attempt to seek funding to greatly increase the numbers of physicians in HSA, NHSC, IHS, and Bureau of Medical Services programs.

We believe that PHS needs to identify physician needs in HSA to insure that persons entering through the scholarship program are properly used. If the study shows that HSA cannot

effectively absorb the influx, we believe consideration should be given to either curtailing the program or seeking legislative changes enabling scholarship recipients to serve in other PHS organizations or Government facilities.

NEED FOR RECRUITMENT AND RETENTION GOALS

None of the agencies included in our review had clearly defined recruitment and retention goals for the number and types of physicians and dentists they need. Where goals did exist, such as the 35-percent-retention goal in PHS for physicians, it was unclear how the goals were to be attained. By not knowing the numbers and types of physicians and dentists needed, the absence of goals may result in an agency having too many, or too few, of a particular specialty, as well as oversupply or undersupply in general.

We recognize that merely establishing goals will not solve the problems. We believe, however, that it is an essential first step in identification of the problems. We believe also that the need for goals is essential to insure that the funds being used in the various recruiting and retaining programs--incentive pay and scholarship--are used in the most effective manner.

CONCLUSIONS

We believe that changes need to be made in the present systems to (1) modify the extra pay programs of DOD and PHS, (2) recognize the potential of a surplus of physicians resulting from the educational programs used to recruit in DOD and PHS, and (3) establish recruitment and retention goals.

The purpose of the continuation pay and VIP programs is to assist in recruiting and retaining critical medical specialties. However, neither DOD nor PHS has defined critical specialties and offers pay under these programs to virtually all eligible physicians and dentists. We believe that these programs should be modified to bring them into line with the law and legislative intent.

Both DOD and PHS may experience a surplus of physicians in the future as a result of their educational programs used to recruit--the scholarship and university programs. Some program changes cannot be made quickly--because of the long period of medical school--DOD and PHS need to recognize the potential surplus and put a high priority on how to deal with it.

None of the agencies have clearly defined recruitment and retention goals for physicians and dentists. We believe that such goals are necessary for the design of programs to effectively deal with future recruitment and retention problems.

RECOMMENDATIONS

We recommend that:

--The Secretaries of DOD and HEW make an indepth study to identify, and adequately document, the critical specialties within their respective departments and to modify the continuation pay and VIP programs so that they are administered in accordance with the legislation. We further recommend that, after identifying these critical specialties, if the Secretaries determine that continuation pay and VIP should be paid to physicians and dentists in noncritical specialties, legislative change be sought to permit such payment.

--The Secretaries of DOD and HEW develop long-range plans on how physicians entering through the scholarship and university programs are to be used. Such a plan should be developed soon so that action can be taken in time to prevent a surplus.

--The Administrator of Veterans Affairs and the Secretaries of Defense and HEW each develop programs to identify their respective physician and dentist needs, by specialty, and to initiate programs for fulfilling these needs.

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Because of time constraints we asked VA, DOD, PHS, and OMB for informal comments on the draft report, and the comments provided are included in this report as appropriate. VA was able to finalize its comments and they are included as appendix VII.

The formal agency comments will be forthcoming when they comply with section 236 of the Legislative Reorganization Act of 1970. This act requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the House and Senate Committees on Government Operations not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

APPENDIX I

VETERANS ADMINISTRATION

DEPARTMENT OF MEDICINE AND SURGERY

ANNUAL RATES OF PAY FOR ADMINISTRATIVE POSITIONS

Title	Annual salary (note a)
Chief Medical Director	b/$54,000
Deputy Chief Medical Director	c/ 52,000
Associate Deputy Chief Medical Director	d/ 50,000
Assistant Chief Medical Director	d/ 48,654
Medical Director	d/ 42,066 minimum to 47,674 maximum
Director of Nursing Service	d/ 42,066 minimum to 47,674 maximum
Director of Chaplain Service	d/ 36,338 minimum to 46,026 maximum
Director of Pharmacy Service	d/ 36,338 minimum to 46,026 maximum
Director of Dietetic Service	d/ 36,338 minimum to 46,026 maximum
Director of Optometry	d/ 36,338 minimum to 46,026 maximum

a/Does not include any incentive pay as authorized by Public Law 94-123.

b/May not exceed pay for executive level III as established by 5 U.S.C. 5314 ($42,000).

c/May not exceed pay for executive level IV as established by 5 U.S.C. 5315 ($39,900).

d/May not exceed pay for executive level V as established by 5 U.S.C. 5316 ($37,800).

YEARLY PAY RATE FOR

UNIFORMED SERVICES COMMISSIONED OFFICERS (See note b)

As of October 1, 1975

Grade	PHS	Navy	Army and Air Force	Cumulative years of service: Under 2	Over 2	Over 3	Over 4	Over 6	Over 8	Over 10
0-8	Surgeon General	Rear Admiral (upper half)	Major General	$27,367	$28,188	$28,857	$28,857	$28,857	$31,040	$31,040
0-7	Assistant Surgeon General	Rear Admiral (lower half)	Brigadier General	22,737	24,289	24,289	24,289	25,372	25,372	26,848
0-6	Director	Captain	Colonel	16,855	18,522	19,728	19,728	19,728	19,728	19,728
0-5	Senior	Commander	Lieutenant Colonel	13,478	15,832	16,923	16,923	16,923	16,923	17,442
0-4	Full	Lieutenant Commander	Major	11,365	13,831	14,763	14,763	15,030	15,699	16,765
0-3	Senior Assistant	Lieutenant	Captain	10,562	11,804	12,618	13,964	14,630	15,159	15,969
0-2	Assistant	Lieutenant (junior grade)	1st Lieutenant	9,205	10,058	12,081	12,484	12,747	12,747	12,747
0-1	Junior Assistant	Ensign	2d Lieutenant	7,992	8,319	10,058	10,058	10,058	10,058	10,058

Grade	Cumulative years of service: Over 12	Over 14	Over 16	Over 18	Over 20	Over 22	Over 26	Quarters: With dependent	Without dependent	Subsistence
0-8	$32,472	$32,472	$33,818	$35,362	$36,644	a/$38,113	a/$38,113	$3,830	$3,063	$636
0-7	26,848	28,188	31,010	33,141	33,141	33,141	33,141	3,830	3,063	636
0-6	19,728	20,397	23,626	24,836	25,372	26,848	29,113	3,343	2,815	636
0-5	18,370	19,598	21,070	22,280	22,950	23,756	23,756	3,175	2,635	636
0-4	17,712	18,522	19,328	19,864	19,864	19,864	19,864	2,865	2,376	636
0-3	16,765	17,175	17,175	17,175	17,175	17,175	17,175	2,599	2,106	636
0-2	12,747	12,747	12,747	12,747	12,747	12,747	12,747	2,336	1,843	636
0-1	10,058	10,058	10,058	10,058	10,058	10,058	10,058	1,882	1,447	636

a/Pay is limited to rate of pay for level V of the executive schedule (currently $37,800).

b/Does not include any additional pay authorized for physicians and dentists.

APPENDIX II

VETERANS ADMINISTRATION

DEPARTMENT OF MEDICINE AND SURGERY

ANNUAL RATES OF PAY FOR PHYSICIANS AND DENTISTS (note a)

Grade	Step 1	2	3	4	5	6	7	8	9	10
Associate	16255	16797	17339	17881	18423	18965	19507	20049	20591	21133
Full	19386	20032	20678	21324	21970	22616	23262	23908	24554	25200
Inter-mediate	22906	23670	24434	25198	25962	26726	27490	28254	29018	29782
Senior	26861	27756	28651	29546	30441	31336	32231	33126	34021	34916
Chief	31309	32353	33397	34441	35485	36529	37573	b/38617	b/39661	b/40705
Executive	33736	34861	35986	37111	b/38236	b/39361	b/40486	b/41611	b/42736	b/43861
Director	36338	37549	b/38760	b/39971	b/41182	b/42393	b/43604	b/44815	b/46026	

a/Does not include incentive pay authorized by Public Law 94-123.

b/The rate of basic pay for employees at these rates is limited by section 5308 of title 5 of the United States Code to the rate for level V of the executive schedule ($37,800).

APPENDIX III

ANNUAL RATES OF PAY FOR GENERAL SCHEDULE PHYSICIANS

Title	Grade	Annual salary range
Medical officer	GS-11	$21,133 to 26,011
Medical officer	GS-12	25,200 to 31,014
Medical officer	GS-13	29,782 to 36,658
Medical officer	GS-14	a/33,126 to 41,181
Medical officer	GS-15	a/35,485 to 44,881

a/Rate of pay for these grades is limited to rate for level V of the executive schedule ($37,800).

APPENDIX V

FACILITIES REVIEWED

Organization	Location
Veterans Administration	
VA Central Office	Washington, D.C.
VA Hospital	Dublin, Georgia
VA Hospital	Birmingham, Alabama
VA Hospital	Boston, Massachusetts
VA Hospital	Togus, Maine
VA Hospital	Denver, Colorado
VA Hospital	Cheyene, Wyoming
VA Hospital	Prescott, Arizona
VA Hospital	Los Angeles, California
VA Hospital (Wadsworth)	San Francisco, California
VA Hospital	Fresno, California
VA Hospital	Washington, D.C.
VA Hospital	
Department of Defense	
Headquarters	Washington, D.C.
Air Force Hospital	Robins Air Force Base, Georgia
Martin Army Hospital	Fort Benning, Georgia
Cutler Army Hospital	Fort Devens, Massachusetts
Naval Hospital	New London, Connecticut
Fitzsimmons Army Medical Center	Denver, Colorado
Air Force Academy Hospital	Colorado Spring, Colorado
Air Force Hospital	Luke Air Force Base, Arizona
Camp Pendleton Naval Research Medical Center	Oceanside, California
Letterman Army Medical Center	San Francisco, California
Oakland Naval Research Medical Center	Oakland, California
Walter Reed Army Medical Center	Washington, D.C.
National Naval Medical Center	Bethesda, Maryland
Malcolm Grow Air Force Medical Center	Andrews Air Force Base, Maryland
Public Health Service	
Headquarters	Rockville, Maryland
Center for Disease Control	Atlanta, Georgia
PHS regional headquarters	Atlanta, Georgia
PHS Hospital	Boston, (Brighton) Massachusetts
PHS regional headquarters	Boston, Massachusetts
PHS regional headquarters	Denver, Colorado
Indian Health Service	Billings, Montana

APPENDIX V

Organization	Location
Indian Health Service	Aberdeen, South Dakota
Indian Health Service	Phoenix, Arizona
Indian Health Service, Navajo Area	Window Rock, Arizona
PHS Hospital	San Francisco, California
PHS regional headquarters	San Francisco, California
National Institutes of Health	Bethesda, Maryland

APPENDIX VI

PHYSICIANS AND DENTISTS

EMPLOYED BY THE FEDERAL GOVERNMENT (note a)

Agency	Statutory authority	Physicians	Dentists
Veterans Administration:			
Department of Veterans Benefits	5 U.S.C.	108	-
Board of Veterans Appeals	5 U.S.C.	18	-
Department of Medicine and Surgery	38 U.S.C.	b/8,811	882
Total		8,937	882
Department of Defense:			
Department of the Army	5 U.S.C.	345	-
Department of the Air Force	5 U.S.C.	96	-
Department of the Navy	5 U.S.C.	245	-
Other	5 U.S.C.	2	-
Total DOD 5 U.S.C.		688	-
Department of the Army	37 U.S.C.	3,488	1,974
Department of the Air Force	37 U.S.C.	2,638	1,474
Department of the Navy	37 U.S.C.	2,405	1,787
Total DOD 37 U.S.C.		c/8,531	5,235
Total all DOD		9,219	5,235
Department of Health, Education, and Welfare:			
Public Health Service	5 U.S.C.	819	17
Other	5 U.S.C.	32	-
Public Health Service	37 U.S.C.	2,435	635
Public Health Service	42 U.S.C.	165	4
Total		3,451	656
Other departments and agencies:			
District of Columbia Government	5 U.S.C.	d/453	34

APPENDIX VI

Agency	Statutory authority	Physicians	Dentists
Department of State	5 U.S.C.	8	-
	22 U.S.C.	48	-
Total		56	-
Department of Transportation	5 U.S.C.	51	-
Federal Assistance Administration	49 U.S.C.	4	-
Total		55	-
National Aeronautics and Space Administration	5 U.S.C.	18	1
	42 U.S.C.	13	-
Total		31	1
Panama Canal Zone	2 U.S.C.	d/84	7
U.S. Postal Service	39 U.S.C.	50	-
Department of Justice	5 U.S.C.	42	1
Action	22 U.S.C.	19	-
Tennessee Valley Authority	16 U.S.C.	17	1
Civil Service Commission	5 U.S.C.	13	-
Energy Research and Development Administration	42 U.S.C.	7	-
Environmental Protection Agency	5 U.S.C.	5	-
Other	5 U.S.C.	e/17	1
Total other departments and agencies		849	45

a/The data in this schedule reflects the most recent data available at the time of our review. The VA and PHS data is as of September 1975. The DOD data is as of June 1975 for 37 U.S.C. employees; as of March 1975 for 5 U.S.C. employees of the Army, Air Force, and Navy; and as of March 1976 for other 5 U.S.C. DOD employees.

APPENDIX VI

b/Does not include 7,249 interns, residents, consultants, and intermittent physicians and dentists.

c/Does not include 2,624 interns and residents.

Army	1,008
Air Force	986
Navy	630
Total	2,624

d/Does not include interns, residents, and consultants.

Panama Canal Zone	46
District of Columbia Government	197
Department of Transportation	23

e/Includes physicians in the Departments of Agriculture, Commerce, Interior, Labor, and Treasury; Federal Trade Commission; Library of Congress; Railroad Retirement Board; U.S. Soldiers Home; and the General Accounting Office.

APPENDIX VI

Summary of employment by statutory authority

Statutory authority	Physicians	Dentists
2 U.S.C.	84	7
5 U.S.C.	2,272	54
16 U.S.C.	17	1
22 U.S.C.	67	0
37 U.S.C.	10,966	5,870
38 U.S.C.	8,811	882
39 U.S.C.	50	0
42 U.S.C.	185	4
49 U.S.C.	4	0
	22,456	6,818

APPENDIX VII

VETERANS ADMINISTRATION
OFFICE OF THE ADMINISTRATOR OF VETERANS AFFAIRS
WASHINGTON, D.C. 20420

AUGUST 19 1976

Mr. Gregory J. Ahart
Director, Manpower and
Welfare Division
U. S. General Accounting Office
441 G Street, N.W.
Washington, D. C. 20548

Dear Mr. Ahart:

We are forwarding our comments on your draft report, "Recruiting and Retaining Federal Physicians and Dentists: Problems, Progress, and Actions Needed for the Future," which was delivered Monday, August 2. Since it was necessary for us to review the report before August 10, a thorough analysis was not possible, but we do want to comment on certain points.

The following comments are keyed to draft report pages and section headings.

Pages 6 and 7, DM&S physicians and dentists:

The Veterans Administration (VA) Department of Medicine and Surgery (DM&S) was established in 1946 to permit expansion and improvement in the capability of providing health services to veterans, and to provide a separate authority for employing and paying physicians and dentists. Conditions in 1946 dictated a dynamic reorganization which could attract well-qualified, professional personnel and allow flexibility with which to care for patients 24 hours a day, 7 days a week. The separate Title 38 employment system was authorized after extensive consideration by Congress of what was needed to improve the VA medical program. We have administered this separate flexible system for 30 years, and have been generally successful in meeting the needs of our medical program. The competitive service (civil service) was considered to be the primary deterrent to obtaining and retaining professionals capable of providing quality medical care.

If our medical program is to remain viable, our personnel system must have the flexibility and capability to meet the rapid changes in medical technology and changes in the needs of our clientele. This is particularly true in light of the magnitude and complexity of current problems in meeting needs of veterans within the context of the limited supply of medical talent. It is our view that many physicians and dentists are attracted to the VA by the quality and scope of our medical programs, our affiliations with the nation's medical schools with the

APPENDIX VII

Mr. Gregory J. Ahart
Director, Manpower and Welfare Division

opportunity for teaching and research, and our unique personnel system based almost exclusively on the individual's professional qualifications and attainments.

We suggest that the second paragraph under this heading (first paragraph on page 7), which describes the basis for a separate DM&S personnel system, be redeveloped to reflect the history and rationale described above. For detailed information concerning the legislative history, see "Establishing a Department of Medicine and Surgery in the Veterans Administration," as published in the December 18, 1945, report from the Senate Committee on Finance, and in "Hearings Before the Committee on World War Veterans' Legislation," H.R. 4225, October 9, 10, and 12, 1945.

Page 33:

The matter of vacancies can be interpreted in many ways and the VA would hesitate to adopt a rigid policy of filling "vacancies" per se. Advances in medical technology, or the number of patients requiring the skills of a subspecialty and, therefore, dictating need for full- or part-time coverage, are contributing factors. As a position becomes vacant, or the need for a new position is determined, all pertinent factors are considered and a decision made whether or not to recruit for that position. In other words, we see our approach as management by current need, not vacancy. Also, the variance between the number of vacancies in the two reports cited is based on different reporting criteria established to meet specific management needs.

Page 39, Physicians in DVB and Physicians in BVA:

The Department of Veterans Benefits (DVB), which utilizes physicians primarily in an administrative capacity, would not favor a change in the current compensation plan for Medical Officers, GS-12, serving on Rating Boards in VA regional offices. Creating a wide disparity in the existing compensation plan between Rating Specialists, GS-12, and Medical Officers, GS-12, would not be appropriate because the administrative responsibilities of the positions are parallel.

The Vice Chairman, Board of Veterans Appeals (BVA) is quoted as saying no recruitment or retention problems exist for physician positions in BVA. While that was the case when the data for this report was gathered by interviewing Board members, it is no longer true. Because of salary, BVA has been unable to fill a vacancy with the person selected, and two referrals from the Civil Service Commission register were not acceptable to the Board. We suggest deleting the first paragraph under this heading.

APPENDIX VII

Mr. Gregory J. Ahart
Director, Manpower and Welfare Division

See GAO note 2.

The physicians in DVB and BVA serve primarily in an administrative capacity. A uniform compensation plan should consider and continue to provide for these unique characteristics without creating a wide disparity in the existing compensation plan. (See suggested change for page 144.)

Page 128a:

The statistics, especially those concerning "average salaries," could lead to erroneous conclusions. It would be appropriate for a study group embarking on the development of a plan to achieve pay comparability throughout Federal Government to first validate all statistics used in this report for completeness and accuracy.

See GAO note 2.

Page 157, Recommendations to the Congress:

While the concept of a uniform compensation system is generally acceptable, the VA views its authority to administer a separate personnel system in the other areas of personnel management as vital to the VA medical care, research, education, and training programs. Therefore, we suggest this recommendaton be limited to the development of a uniform compensation system and that it not include as a goal the development of a uniform personnel management system.

We also suggest the following minor word changes:

See GAO note 2.

APPENDIX VII

Mr. Gregory J. Ahart
Director, Manpower and Welfare Division

Page 76: We wish to avoid any implication that our part-time employees are not loyal to the agency. We feel many of our part-time physicians and dentists exhibit an extraordinary degree of loyalty.

Page 144: In recognition of varying conditions in government agencies, we suggest changing the first sentence to read, "A uniform compensation plan should be developed for Federal physicians and dentists built around the occupations' and agencies' unique characteristics ...".

With regard to the discussion on pages 161 and 162 concerning the need for establishing recruitment and retention goals, the Veterans Administration's retention goal for our physicians and dentists is that their employment with the VA become their career.

We recognize the importance of developing programs to identify physician and dentist needs, by specialty, and to initiate programs for fulfilling these needs. We plan to conduct studies to determine ways to implement this recommendation fully.

Thank you for the opportunity to provide our comments.

Sincerely,

RICHARD L. ROUDEBUSH
Administrator

GAO notes:

1. Page references in this appendix refer to our draft and may not correspond to the pages of this final report.

2. Material deleted related to matters which were revised in final report.

APPENDIX VIII

PRINCIPAL OFFICIALS RESPONSIBLE FOR ADMINISTRATION ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office From	To
VETERANS ADMINISTRATION		
ADMINISTRATOR OF VETERANS AFFAIRS:		
R. L. Roudebush	Oct. 1974	Present
DEPUTY ADMINISTRATOR:		
O. W. Vaughn	Nov. 1974	Present
CHIEF MEDICAL DIRECTOR:		
J. D. Chase, M.D.	Apr. 1974	Present
DEPARTMENT OF DEFENSE		
SECRETARY OF DEFENSE:		
D. J. Rumsfield	Nov. 1975	Present
J. R. Schlesinger	July 1973	Nov. 1975
DEPUTY SECRETARY OF DEFENSE:		
W. P. Clements, Jr.	Jan. 1973	Present
SECRETARY OF THE AIR FORCE:		
T. C. Reed	Jan. 1976	Present
J. W. Plummer, acting	Nov. 1975	Jan. 1976
J. L. McLucas	Jan. 1973	Nov. 1975
SECRETARY OF THE ARMY:		
M. R. Hoffman	Aug. 1975	Present
N. R. Augustine, acting	July 1975	Aug. 1975
H. H. Calloway	May 1973	July 1975
SECRETARY OF THE NAVY:		
J. Wm. Middendorf, II	June 1974	Present
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE		
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
D. Mathews	Aug. 1975	Present
C. W. Weinberger	Feb. 1973	Aug. 1975
ASSISTANT SECRETARY FOR HEALTH:		
T. Cooper, M.D.	May 1975	Present
T. Cooper, M.D., acting	Jan. 1975	May 1975
C. C. Edwards	Mar. 1973	Jan. 1975

APPENDIX VIII

	Tenure of office From	To
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE (CONT.)		
COMMISSIONER OF FOOD AND DRUGS:		
A. M. Schmidt, M.D.	July 1973	Present
DIRECTOR OF NATIONAL INSTITUTES OF HEALTH:		
D. S. Fredrickson, M.D.	July 1975	Present
R. Lamont - Havers, M.D., acting	Jan. 1975	July 1975
ADMINISTRATOR OF HEALTH RESOURCES ADMINISTRATION:		
K. M. Endicott, M.D.	Aug. 1973	Present
ADMINISTRATOR OF HEALTH SERVICES ADMINISTRATION:		
L. M. Hellman, M.D.	Mar. 1976	Present
R. Van Hoek, M.D., acting	Feb. 1975	Mar. 1976
H. Buzzell	July 1973	Jan. 1975
DIRECTOR, CENTER FOR DISEASE CONTROL:		
D. J. Sencer, M.D.	Feb. 1966	Present
ADMINISTRATOR OF ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION:		
J. D. Isbister	Aug. 1975	Present
J. D. Isbister, acting	Sept. 1974	Aug. 1975