One of the first concepts that one learns in economics class is the relationship between supply and demand. An excellent illustration of this relationship can be found in the economy of health care.

**Physician Supply and Health Care Utilization**

Research has consistently shown that an increase in the proportion of doctors in a community consistently results in an increase in health care utilization (demand) of all types.

- This indicates that many patients will use or be encouraged to use services when the physicians’ services are made available (Barer, Evans, & Labelle, 1988; Hulka & Wheat, 1985).

U.S. studies on the utilization patterns within the various specialties of medicine have shown that increased utilization of health care services (hospital days, clinic visits and medication) is related to medical specialty (Fylkesnes 1993; Greenfield, Nelson, Zubkoff, Manning, Rogers, Kravitz, et al., 1992).

Higher use of health care services is associated with health status, socioeconomic status, and residence in an area with a specialty care centre (Fylkesnes, 1993).

Variation in the mix of patients (health status and demographics like age, sex, education, ethnicity, country of birth) is also a major determinant in health care utilization (Kravitz, Greenfield, Rogers, Manning, Zubkoff, Nelson, et al., 1992).

**Physician Payment Schemes and Health Care Utilization**

A physician’s provision of health care services is also heavily influenced by the way they are paid. In Canada, most physicians act as independent business people who bill the government for the services they provide. This is known as Fee for Service funding. Recent studies have revealed that Fee for Service funding systems are associated with 41% higher hospitalization rates compared to other physician payment schemes (Greenfield et al., 1992).
Rather than restructure the Fee for Service format in Canada, provincial governments have attempted to contain the cost of physician services indirectly through the manipulation of fee schedules. These schedules are “price lists” for specified health care services provided by physicians. To have a maximum impact, the fee schedule must also be accompanied by billings constraints, otherwise physicians will simply increase the amounts of services billed in order to offset the reductions of payments they receive for individual services (Hughes, 1991).

It has been suggested that the above patterns of behaviour of doctors have been due to the fact that most physicians have restricted themselves to concerns of the individual patient, leaving the problems of overuse or misuse of medical resources to others. It has been argued that in order to incorporate the goals of both quality of health and cost or utilization containment, the medical profession must begin to educate its members about the links between a purported need and the results and outcomes of care (Brook, Lohr, Chassin, Kosecoff, Fink, & Solomon, 1984).

**Alternatives to Physician Supply**

Alternative forms of providing health care must also be considered in order to reduce both the use and cost of health care as currently provided by physicians. An Acute Care Nurse Practitioner (ACNP) is one example of an alternative method of providing medical care. ACNPs are advanced practice nurses who assume delegated medical and nursing functions that enable them to offer comprehensive care to acutely ill patients at a lower cost than the physician counterpart.

When patients cared for by ACNPs are compared with patients cared for by medical residents or family physicians, there are (Sidani, Irvine, O’Brien-Pallas, Porter, DiCenso, McGillis Hall, et al., 1998; Spitzer, Roberts, & Delmore, 1976):

- no significant differences in mortality;
- no significant differences in patient satisfaction and;
- either a decrease in cost for the ACNP patient groups, or no difference in cost.
References
The Influence of Physician Supply, Payment Schemes and Alternative Providers on Health Care Utilization


