As I said in my initial review, these authors are (as we say in the US) “Hell bent” on proving that supplier-induced demand drives health care in Switzerland. And maybe it does. But even with a lot of fancy statistics, they were unable to do so, even to their own satisfaction, and were left to conjecture that it probably is true anyway and that “additional data defining regional health status and the respective medical needs are therefore required.” Yet without all of the fancy statistics and the hoped for studies in the future, what was observed was expected and consistent with a system that is responsive to need.

1. The key finding was that significant correlations were observed between regional mortality, PCP density, specialist density and treatment intensity.

2. Consistent with this, there were small but significant correlations between the density of specialists and treatment intensity. Sick, often older, patients receive more care from specialists (so more specialists gravitate to locales where there is a greater need for their services). Some of the extra care apparently was administered by PCPs, probably under the direction of specialists. In the US, where there are more specialists, more of the added care is provided by specialists. My guess is that in Switzerland, where there are many more PCPs and fewer specialists, more is provided by PCPs, probably with specialist consultation. That is consistent with the observations in this study.

3. It also should be no surprise that there were moderate positive associations between the average age of the patients and the treatment intensity.

4. The authors were surprised that only 63% of Swiss patients saw a PCP in a given year. The same is true in the US. That’s because the great majority of Americans are in good-to-excellent health, and half who are see a physician, most commonly a PCP, less than one visit per year; whereas only 10% are in poor health, but they have 10 or more physician visits a year, mostly to specialists.
The authors summarize their findings as follows: “Significant correlations between density of PCP’s and mortality indicate that areas with high mortality are also characterized by high density of PCP’s and high treatment intensity whereas no association was observed between regional mortality and specialist density; but specialist density was positively associated with higher treatment intensity of PCP’s. Mortality also yielded a positive and significant parameter estimate in the modelling procedures implying higher number of consultations in areas with higher mortality.”

While a bit awkward in phrasing, the message is clear. Sicker patients use more care and die more often, and there are more physicians, both PCPs and specialists, to provide that care..

BUT, this does not fit the authors' preconceived ideas, and so they ramble on about the notion that “there is high supply of primary care in areas with high needs and the results reflect effects of competition between PCP’s and specialists” (There is no evidence that there is competition between PCPs and specialists).

And they continue, “yet, the associations between mortality and treatment frequencies of PCP’s were not consistent across the three language regions and are also coherent with other observations made earlier in the same project showing that utilisation of primary care and care provided by specialists care also differs across language regions [10] (which points out how important culture is in determining attitudes about treatment and, in the US, the availability of family support and other social factors that contribute to maintaining health are assisting with care).

And next, “however, it remains debatable whether mortality rates can be used as a measure of effective medical needs in a health system that is characterized by comprehensive and high density of supply of care.” (While it remains debatable from the authors’ perspective, the current paper supports exactly that).

And now onto the core philosophy: “and furthermore, it can also be criticized that a high physician’s density is not necessarily related to better medical care at the regional level (although that is what the paper concludes). Additional data defining regional health status and the respective medical needs are therefore required before such implications can be made. (Well, maybe that’s true, but the data in this paper suggest the opposite – high physician density is responsive to high needs, as evidenced by age and mortality.)