

the number of visits per capita in urban areas (towns with 2,500 inhabitants or more) was about 39 per cent higher than in rural farm areas, and about eight per cent higher than in remaining rural areas.

Another factor correlated with income is the possession of health insurance,¹⁶ which tends to increase the demand for medical services. People who possess health insurance tend to have a higher number of physician visits, higher hospital admission rates and higher surgical rates than people without insurance at comparable income levels.¹⁷ This is true not only for services that are covered by insurance but also for those that are not covered. People seem to be more inclined to see a physician if at least some of the potential expense is prepaid.

It has been established that both the physician-population ratio and the number of visits per person increase with income. The question now is whether the demand for services and the relative supply of physicians increase in the same proportion, which would mean an uneven distribution of physicians but an even distribution of work loads. The available data indicate that regional differences in use of physician services are of a lower order of magnitude than differences in physician-population ratios. We computed the number of non-hospital visits per private non-hospital physician by multiplying the regional average number of visits per person by total regional population and dividing by the regional number of physicians. This measure can be taken as a reliable index of work load, for the physicians concerned, unless there are

important regional differences in the amount of in-hospital visits per physician. The results, presented in Table I, show a large work load differential between the region with the highest and the lowest number of visits. Physicians in the West South Central area (Arkansas, Louisiana, Oklahoma, Texas) have 74 per cent more visits of all kinds outside of hospitals than those in New England and 37 per cent more than those in the Middle Atlantic region. Although New England may be a special case, there is a general tendency for the number of visits to increase with decreases in the physician-population ratio. Apparently, doctors in areas with low physician-population ratios either work longer hours or work more intensively. Contrary to what seemed to be indicated in the earlier comparison of metropolitan centers, the census area comparison indicates a tendency toward a possible redundancy of physicians in high ratio areas and toward a shortage in low ratio areas. However, census divisions are much less homogeneous than metropolitan areas, and

TABLE I
REGIONAL PHYSICIAN WORK LOADS
IN THE U. S., 1959

Region	Non-hospital visits per physician	Income per capita	Physicians per 100,000 population	Average income of all nonfederal physicians, 1949
New England	3,817	2,396	113	\$ 9,442
Middle Atlantic	4,847	2,543	120	9,574
Pacific	5,284	2,502	112	12,782
East North Central	5,694	2,337	83	12,158
West North Central	5,986	1,978	79	11,961
Mountain	6,042	1,994	84	11,214
East South Central	6,286	1,424	65	11,325
South Atlantic	6,499	1,804	74	11,137
West South Central	6,630	1,764	75	11,794

Sources: *Statistical Abstract of the U.S.*, 1960, Table 6; 1961, Table 419. *Health Manpower Source Book*, Section 10, Table 2; *Health Statistics*, Series C, No. 6, Table 11; *Survey of Current Business*, July 1951, Table 12, p. 19.

¹⁶ Possession of any kind of health insurance is about three times more frequent in families with incomes of \$7,000 and over than in families with incomes of under \$2,000. See U. S. Department of Health, Education, and Welfare, *Medical Care Financing and Utilization*, Health Economics Series No. 1 (Washington, D. C.: U. S. Government Printing Office, 1962), Table 87, p. 99.

¹⁷ O. W. Anderson and J. J. Feldman, *Family Medical Cost and Voluntary Health Insurance: A Nationwide Survey* (New York: McGraw-Hill, 1960), pp. 73, 183, 194.