6.5. Inequalities in doctor consultations

Measuring rates of health care utilisation, such as doctor consultations, is one way of identifying whether there are access problems for certain populations. Difficulties in consulting doctors because of excess cost, long waiting periods or travelling time, and lack of knowledge or incentive may lead to lower utilisation, and in turn to poorer health status and increased health inequalities.

The average number of doctor consultations per capita varies greatly across OECD countries (see Indicator 4.1 "Consultations with doctors"). But there are also significant differences among socio-economic groups within countries, as determined by income, education, or occupation.

Ongoing OECD work is updating an earlier study by van Doorslaer *et al.* (2004) on income-related inequality in visits to doctors in a number of OECD countries. The figures show the horizontal inequity index – a measure of inequality in health care use – for the probability of a doctor, GP and specialist visit. The probability is unequal if the horizontal inequity index is significantly different from zero. It favours low income groups when it is below zero, and high income groups when it is above zero. The index is adjusted for differences in need for health care, because health problems are more frequent and more severe among lower socio-economic groups.

Doctor visits were more likely among higher income persons in 12 of 15 countries (Figure 6.5.1), however most countries have low levels of inequality. Only in the United States was a higher level of inequality apparent. In three OECD countries – the United Kingdom, the Czech Republic and Slovenia – given the same need, high income people were as likely to see a doctor as those with low income. In Korea, a similar study found income-related equality for western doctor visits (Lu *et al.*, 2007).

Regarding the frequency of visits, six countries out of 14 display pro-rich inequalities (Canada, France, Finland, Spain, the United States, and Poland). In the other eight countries, low income people saw a doctor as frequently as high income people (Belgium, Slovenia, New Zealand, the Czech Republic, Hungary, Germany, the Slovak Republic, and Estonia).

There is a difference between GP and specialist visits. The probability of a GP visit was equally distributed in most countries (Figure 6.5.2). When inequality does exist, it is often positive, indicating a pro-rich distribution, but the degree of inequality is small. Lower income people, however, consult a GP more frequently.

A different story emerges for specialist visits – in nearly all countries, high income people are more likely to see a specialist than those with low income (Figure 6.5.3), and also more frequently. In Finland, the relationship is stronger for visits to private specialists because of the size of patient co-payments, a high-income distribution of workplace services which facilitate access to specialist care, and the large private ambulatory care sector (NOMESCO, 2004; OECD, 2005b). It Italy, regional variations in health care access explain most of the pro-rich inequalities in specialist visits (Masseria and Giannoni, 2010).

Consistent with these findings, an earlier study found that people with higher education levels tend to use specialist care more, and the same was true for GP use in several countries (France, Portugal and Hungary) (Or *et al.*, 2008). The study suggests that, beyond the direct cost of care, other health system characteristics are important in reducing social inequalities in health care utilisation, such as the role given to the GP and the organisation of primary care. Social inequalities in specialist use are less in countries with a National Health System and where GPs act as gatekeepers. Countries with established primary care networks may place greater emphasis on deprived populations, and gatekeeping often provides simpler access and better guidance for people in lower socio-economic positions (Or *et al.*, 2008).

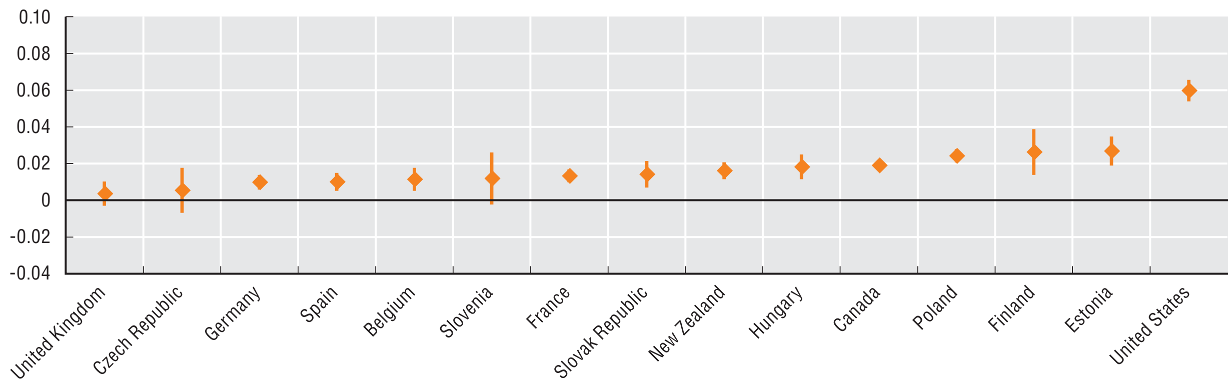
Definition and comparability

Consultations with doctors refer to the probability and frequency of visits with physicians, including both generalists and specialists (except in the United States where this distinction is not possible).

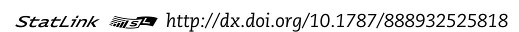
OECD estimates come from health interview or household surveys conducted around 2009, and rely on self-report. Inequalities in doctor consultations are assessed in terms of household income. The number of doctor consultations is adjusted for need, based on self-reported information about health status.

Differing survey questions and response categories may affect cross-national comparisons. Surveyed groups may vary in age range, and the measures used to grade income can also vary. Caution is therefore needed when interpreting inequalities in health care utilisation across countries.

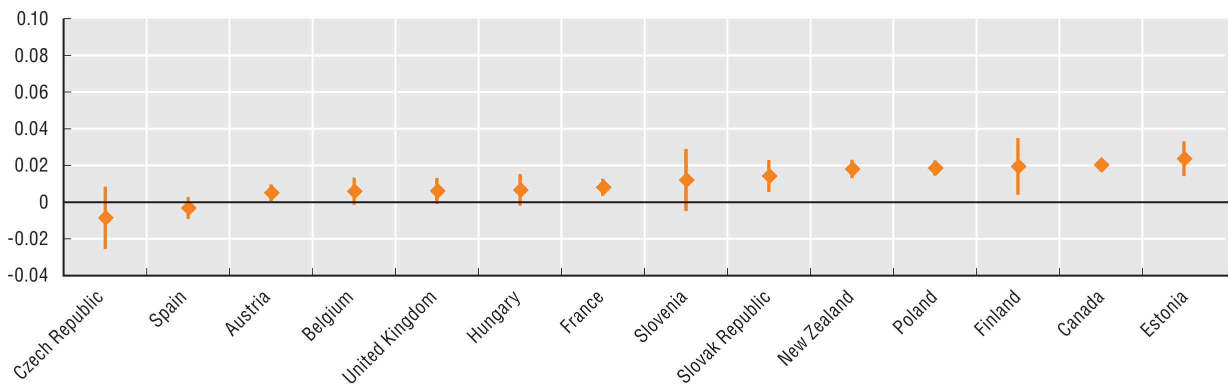
6.5.1 Horizontal inequity indices for probability of a doctor visit (with 95% confidence interval), 15 OECD countries, 2009 (or nearest year)



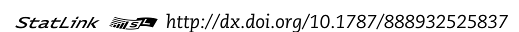
Source: OECD estimates (2011).


StatLink http://dx.doi.org/10.1787/888932525818

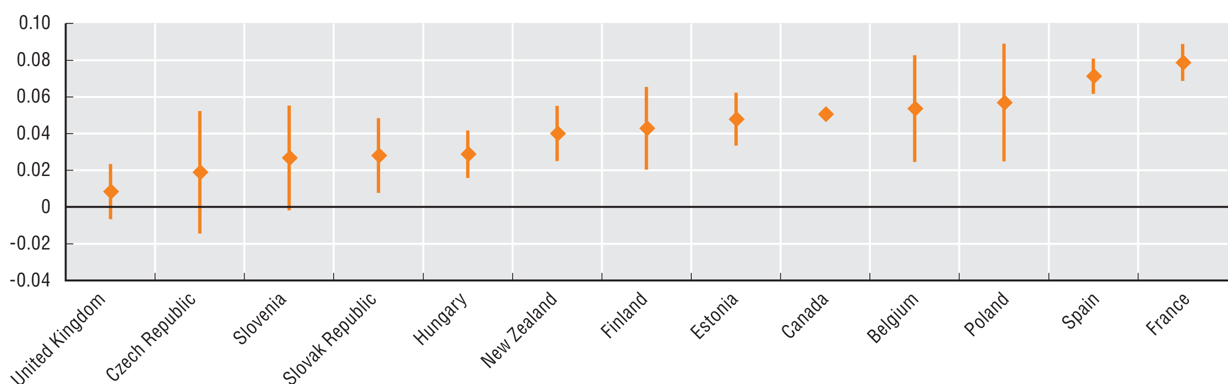
6.5.2 Horizontal inequity indices for probability of a GP visit (with 95% confidence interval), 14 OECD countries, 2009 (or nearest year)



Source: OECD estimates (2011).


StatLink http://dx.doi.org/10.1787/888932525837

6.5.3 Horizontal inequity indices for probability of a specialist visit (with 95% confidence interval), 13 OECD countries, 2009 (or nearest year)



Note: The probability of a doctor, GP or specialist visit is inequitable if the horizontal inequity index is significantly different from zero. It favours low income groups when it is below zero, and high income groups when it is above zero. The index is adjusted for need.

Source: OECD estimates (2011).

StatLink http://dx.doi.org/10.1787/888932525856

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