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, 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 consultations per capita varies greatly across OECD countries (see Indicator 4.1 "Consultations with doctors"). But there are also significant differences among population groups within countries. One dimension that is often used to examine these variations is socio-economic status, as determined by income, education, or occupation.

A study by van Doorslaer *et al.* (2004) examined income-related inequality in visits to doctors in a number of OECD countries around the year 2000. After adjusting for differences in need for health care (since health problems are more frequent and more severe among people from lower socio-economic groups), doctor visits were found to be more frequent among higher income persons in nine out of 21 countries – Canada, Finland, Italy, Mexico, the Netherlands, Norway, Portugal, Sweden and the United States – but the degree of inequity was fairly small. In the other 12 OECD countries, given the same need, high income people were as likely to see a doctor as those with low income. A similar study using 1998 data found income-related equity for doctor visits in Korea (Lu *et al.*, 2007).

For a majority of countries in the study, data were available for both GP and specialist visits. GP visits were equitably distributed in most countries, and when significant inequity existed it was often negative, favouring low income earners (Figure 6.5.1). However, a different story emerged for specialist visits – in nearly all countries, high income people were more likely to see a specialist than those with low income (Figure 6.5.2), and in most countries also more frequently (van Doorslaer *et al.*, 2004; 2008). In Europe, this was especially so in Portugal, Finland, Ireland and Italy, four countries where private insurance and direct private payments played an important role in accessing specialist services. In Finland, the sources of these socio-economic differences in specialist visits include the size of patient co-payments, the pro-high income distribution of workplace services that facilitate access to specialist care, and the large private ambulatory care sector (NOMESCO, 2004; OECD, 2005b).

Consistent with these findings, research in 13 European countries has found that, after controlling for need, people with higher education levels tend to use specialist care more, and the same was true for GP use in several countries (including 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 inequities in health care utilisation, such as the role given to the GP and the organisation of primary care. Social inequalities in specialist use were found to be 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 meeting the care needs of deprived populations, and gatekeeping often provides simpler access and better guidance for people in lower socio-economic positions (Or *et al.*, 2008).

A more recent study from Canada for 2003 confirmed that higher income persons had inequitably higher rates of GP and specialist consultations (Allin, 2006). On the other hand, no significant differences in the use of GP or specialist care was found between people with higher and lower education levels in the Netherlands in 2005 (Westert *et al.*, 2008).

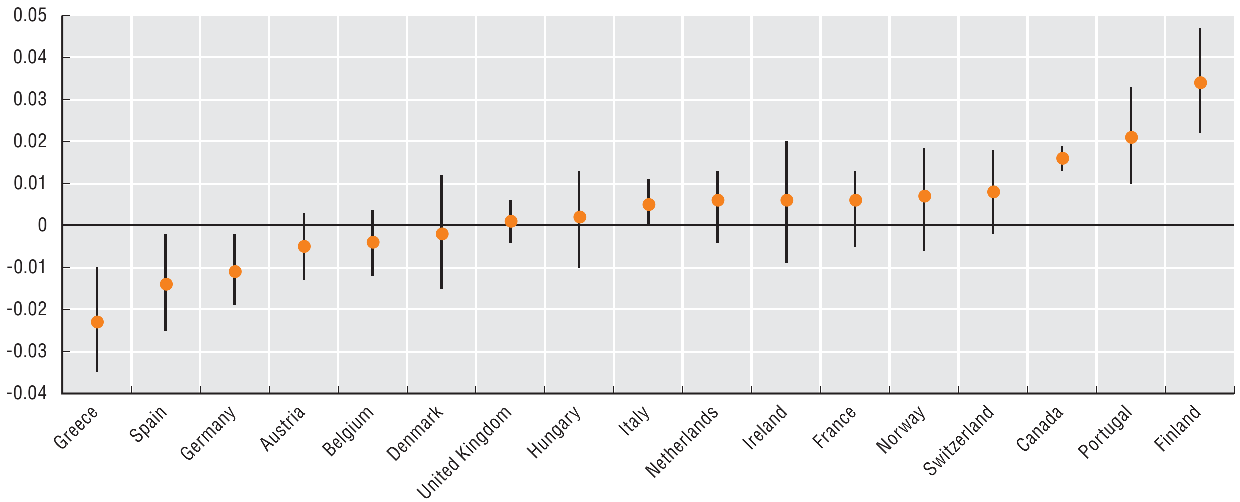
Definition and deviations

Consultations with doctors refer to the number of ambulatory contacts with physicians (both generalists and specialists). For more information, see Indicator 4.1 "Consultations with doctors".

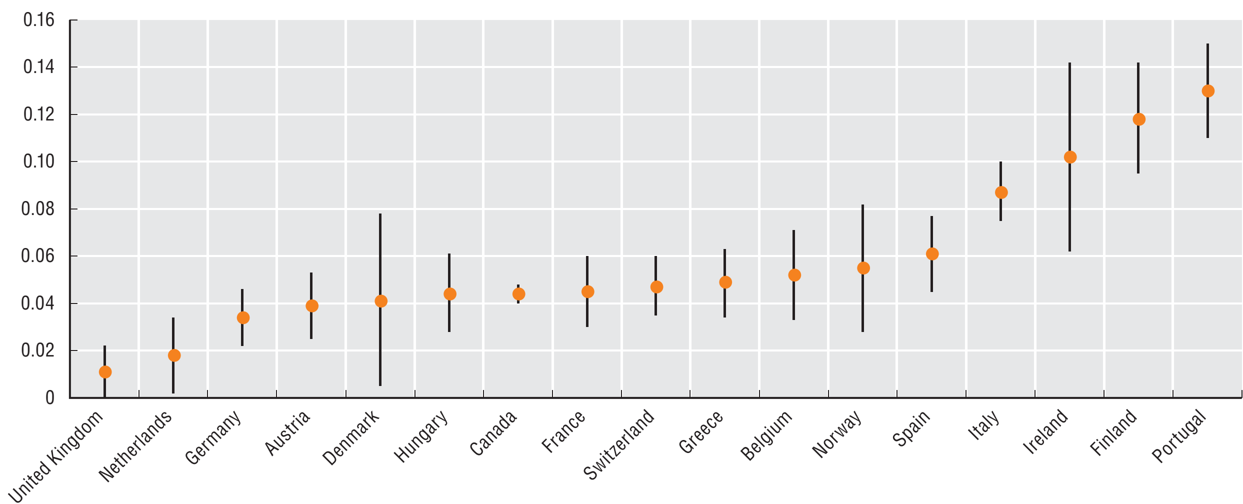
Estimates in studies by van Doorslaer *et al.* (2004) and Or *et al.* (2008) come from health interview or household surveys conducted around 2000, and rely on self-report. Inequalities in doctor consultations are assessed in terms of people's income and educational level. The number of doctor consultations is adjusted for need, based on self-reported information about health status.

Differing survey questions and response categories may affect the ability to make valid cross-national comparisons. Surveyed groups may vary in age range, and the measures used to grade income and education level 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 GP visit (with 95% confidence interval), 17 OECD countries, 2000 (or nearest available year)



6.5.2 Horizontal inequity indices for probability of a specialist visit (with 95% confidence interval), 17 OECD countries, 2000 (or nearest available year)



Note: The probability of a 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: Van Doorslaer *et al.* (2004).

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