

**Equity in the use of physician visits in OECD countries:  
Has equal treatment for equal need been achieved?**

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ABSTRACT

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This paper uses methods proposed by Wagstaff and Van Doorslaer (2000) to generate new international comparative evidence for 1996 on the degree of horizontal equity achieved in health care utilisation in 14 OECD countries. The index of horizontal inequity used measures deviations in the degree to which the use of doctor visits is distributed according to need. The data for the 12 European Union member states are taken from the third wave of the *European Community Household Panel*, the data for Canada are from the second wave *National Population Health Survey* and the US data stem from the first wave of the *Medical Expenditure Panel Survey*. We find that in all countries physician visits tend to be significantly more concentrated among the worse-off. After standardising for need differences across the income distribution, significant horizontal inequity in total physician visits emerges in only 4 of the countries studied: Portugal, the US, Austria and Greece. However, disaggregating by general practitioner and specialist visits reveals that this is the net effect from quite diverging patterns in the type of doctor consulted by income level: in all countries (except Luxemburg) the rich see a medical specialist more often than expected on the basis of need, while the use of GP visits is fairly closely related to need and in several countries even distributed somewhat pro-poor. The degree and distribution of private health insurance coverage and regional disparities seem to have the expected effect on inequity but in most countries their contribution is rather small. Only in the US, the effect of private insurance cover is quite large. The results suggest that even in countries which have long achieved fairly universal and comprehensive degrees of health insurance coverage, some differential patterns of doctor utilization remain: higher income individuals are more likely to receive specialist services whereas lower income individuals are more inclined to use general practitioner care. To the extent that these differential use patterns result in differences of quality of treatment, persons in equal need cannot be said to receive equal treatment at all income levels.