



# INEQUALITIES IN HEALTH CARE SERVICES UTILISATION IN OECD COUNTRIES

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## Background (1/2)

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- Policy objectives: reduction of inequalities in health status and equal access to health care based on need
- Equality and equity in health care use:
  - Inequity: inequalities remaining after adjusting for needs for health care



## Background (2/2)

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- Evidence for inequity in health care use, especially for specialist and dentist visits, but less clear-cut for GP visits.
  - International studies around the years 2000 (van Doorslaer & Masseria, 2004; Or *et al.*, 2008; Bago d'Uva *et al.*, 2008), but no recent update.
- Evidence for inequality in preventive care
  - Two studies aimed at gauging inequalities (Cervical cancer screening: McKinnon *et al.*, 2011; European countries: Carrieri & Wubker, 2012)



## Objective of the study

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1. To update earlier results on inequity in health care use (van Doorslaer and Masseria, 2004) to extend the analysis to new preventive care services and to new OECD countries.
2. To examine inequalities in conjunction with health systems characteristics (with focus on financial barriers)



# Methods

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- Measuring inequities by income level in doctor visits by adjusting for differences in people's need for health care.  
→ Horizontal equity principle
- Measuring income-related inequalities in dentist visits and breast and cervical cancer screening.
- Concentration index to measure the degree of inequality/inequity.



# Data

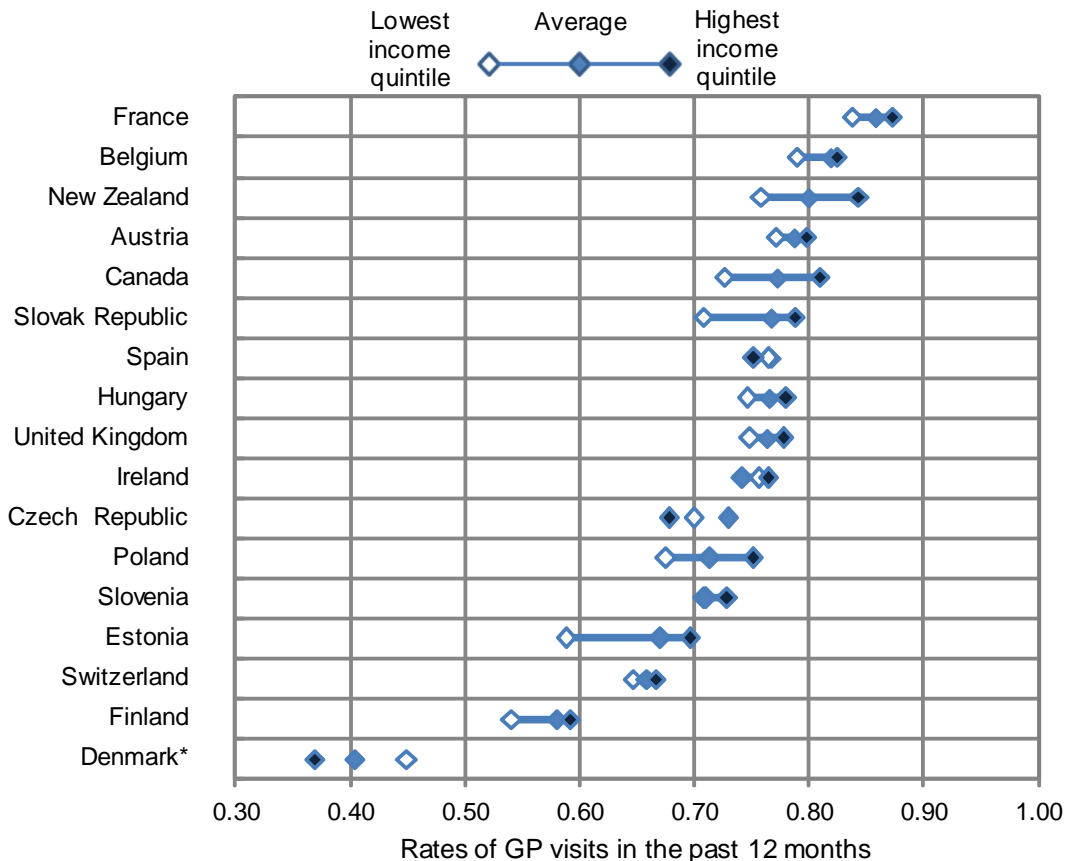
- Latest national health survey data for 19 OECD countries
- Doctor visits in the past 12 months
- Dentist visits
- Breast & cervical cancer screening
- Needs for health care
- Individual characteristics
- Income level of the household.

19 OECD countries
Austria (EHIS 2006/7)
Belgium (EHIS 2008)
Canada 2007/08
Czech republic (EHIS 2008)
Denmark 2005
Estonia (EHIS 2006/7)
Finland 2009
France 2008
Germany 2009
Hungary( EHIS 2009)
Ireland 2007
New Zealand 2006-07
Poland (EHIS 2009)
Slovak republic (EHIS 2009)
Slovenia (EHIS 2007)
Spain 2009
Switzerland 2007
United Kingdom 2009
United States 2008



# GP visits in the past 12 months

Need-adjusted probability of a GP visit in last 12 months by income quintile (age 16-85)

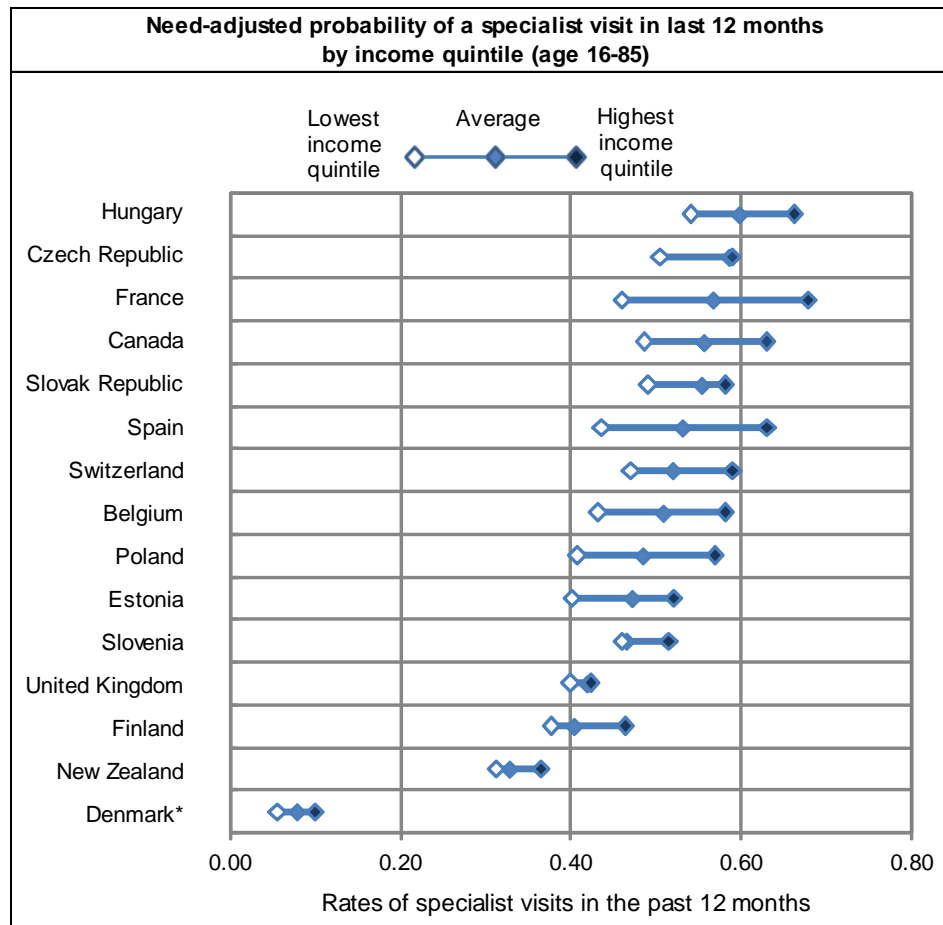


- Small variations across income groups.
- Before need-adjustment, low-income people are more likely to see a GP in 13 of 17 countries.
- After need-adjustment, low-income people are as likely as high-income people to see a GP (in 8 of 17 countries).
- Once they go to visit a GP, low-income people are more likely to consult more often.



# Specialist visits in the past 12 months

- Large variations across income groups, low-income people being less likely to see a specialist in all countries.



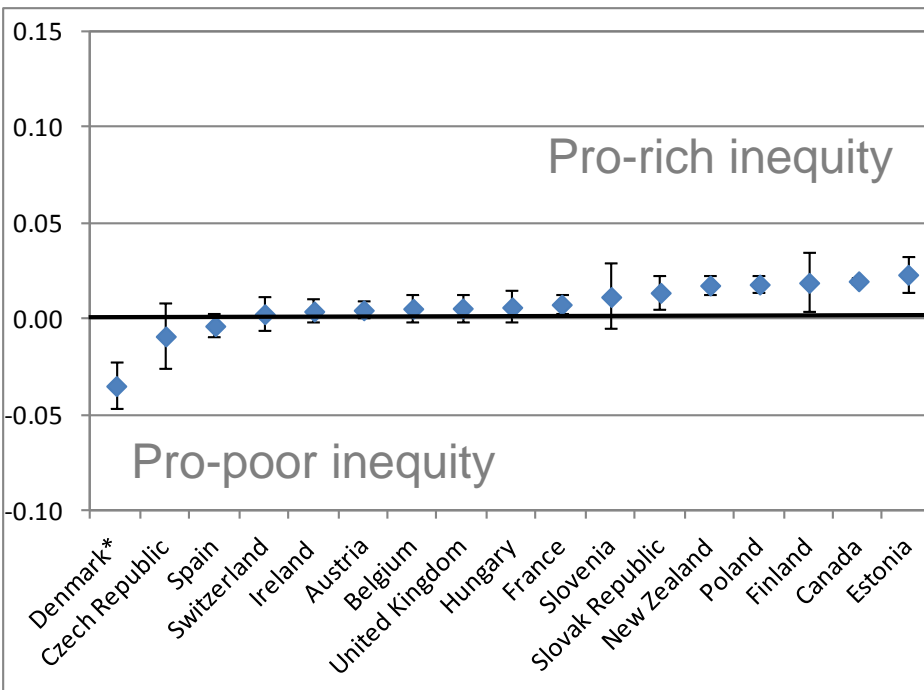
(\*) in past 3 months in Denmark Source: OECD Health Working Paper No 58. Devaux and de Looper, 2012.



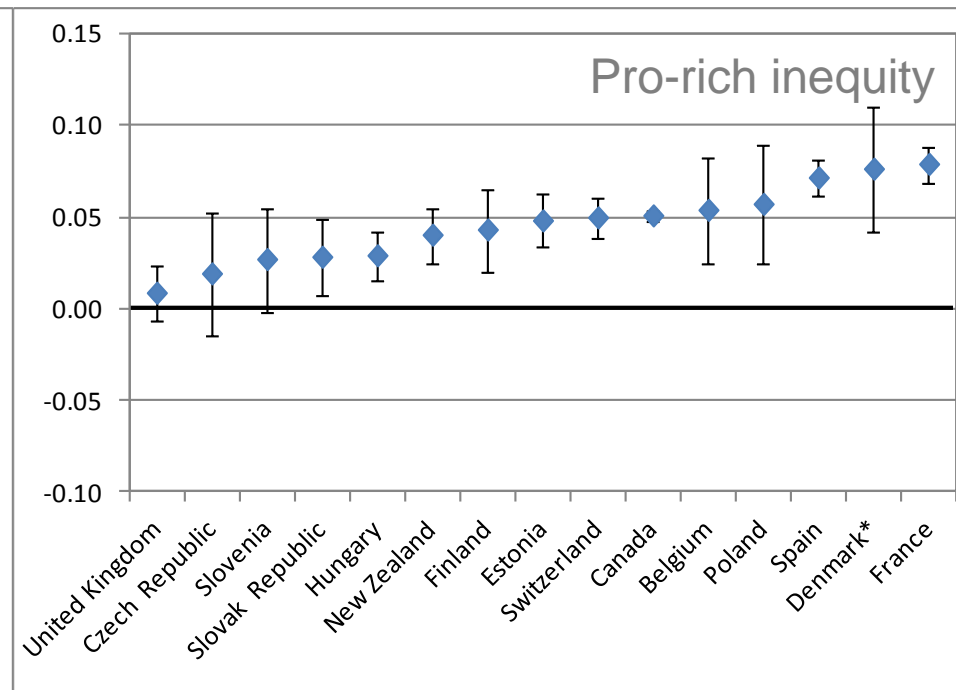


# Inequity Index in GP and Specialist visits

## Inequity in GP visits



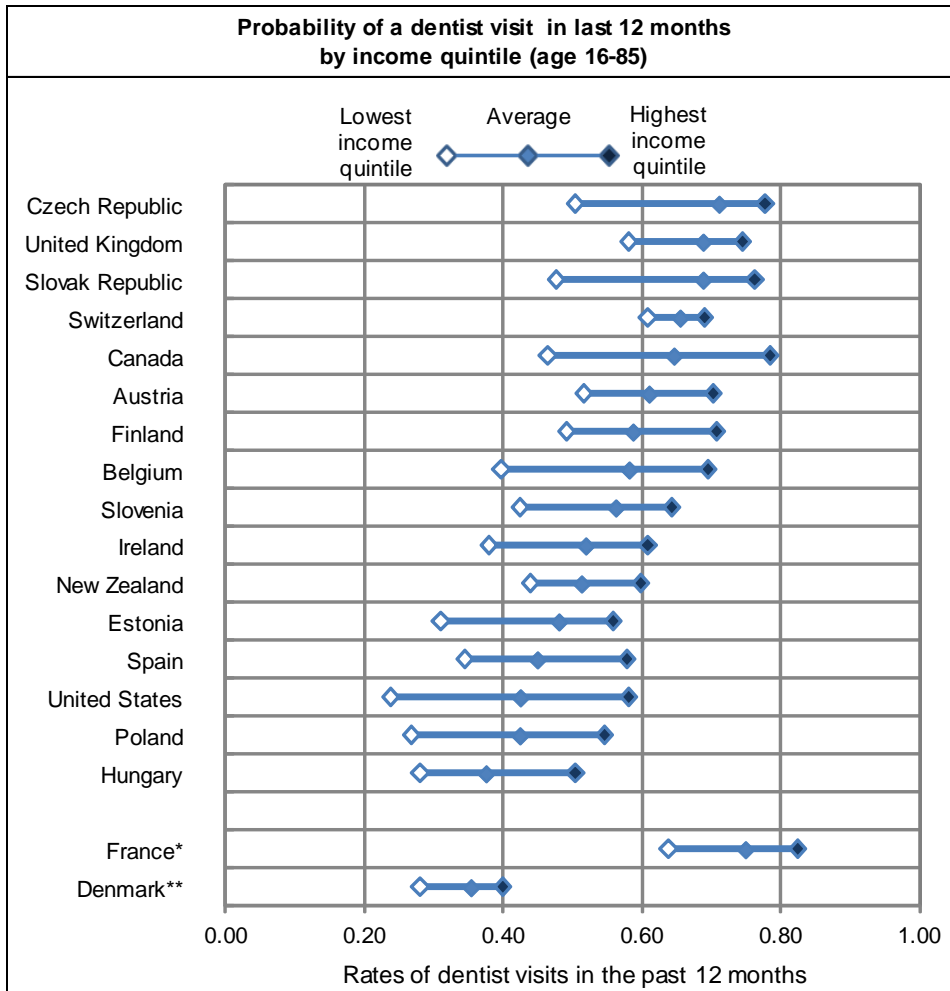
## Inequity in Specialist visits



(\*) in past 3 months in Denmark Source: OECD Health Working Paper No 58. Devaux and de Looper, 2012.



# Dentist visits in the past 12 months



- People with higher incomes are also more likely to visit a dentist
- Main reasons = Financial barriers
- Dental care not -or only partly- reimbursed under health insurance plans

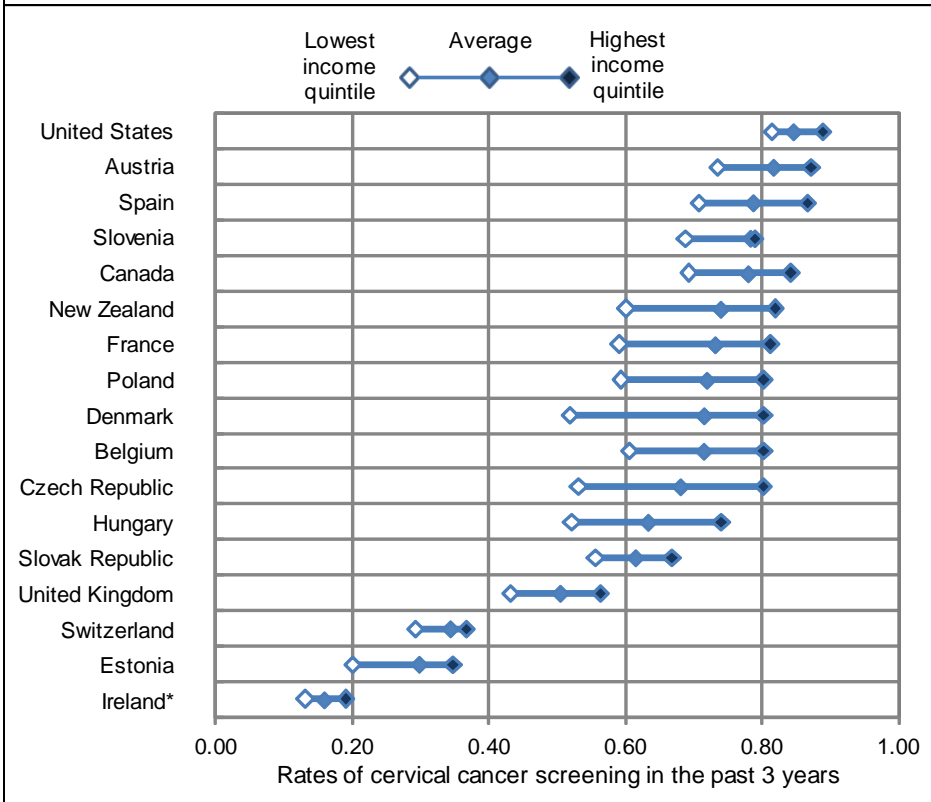
(\*) France past 24 months; (\*\*)Denmark past 3 months.

Source: OECD Health Working Paper No 58. Devaux and de Looper, 2012.



# Pro-rich inequality in cancer screening

Probability of cervical cancer screening in last 3 years by income quintile (age 20-69)



(\*) Ireland: in past 12 months

Source: OECD Health Working Paper No 58.

- In countries with cancer screening programmes, services are made available to all at little or no cost
- Despite this, uptake varies among socioeconomic groups
- Often, geographic reasons such as travelling distance or availability of screening facilities create many barriers
- Lower levels of awareness of programmes, symptoms or risks, especially among women with low incomes or from minority groups



## Comparison with earlier findings

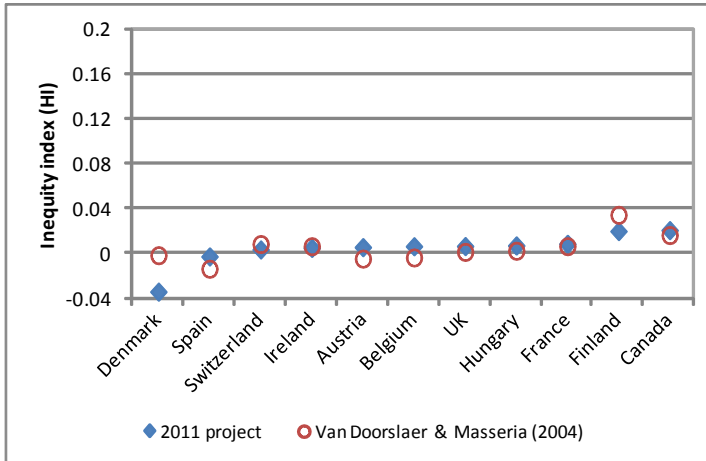
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- Country ranking remained rather stable
- Size of inequality remained very stable for doctor and GP visits.
- Some discrepancies found for specialist (Finland) and dentist visits (Finland and Spain) mainly due to differences in survey methodology and wording of questions.

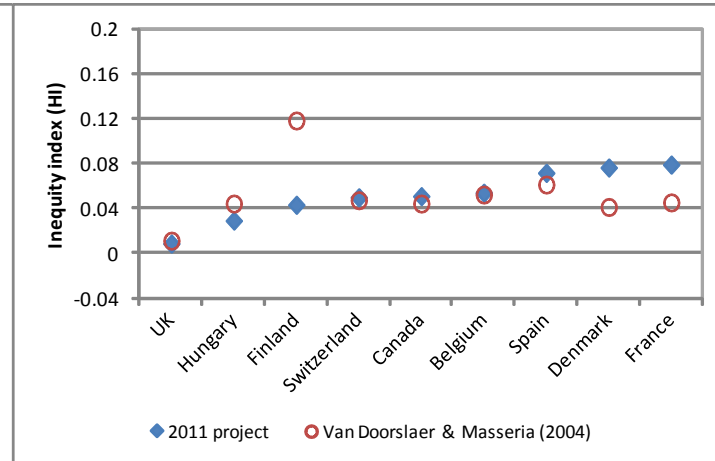


# Comparison with earlier findings

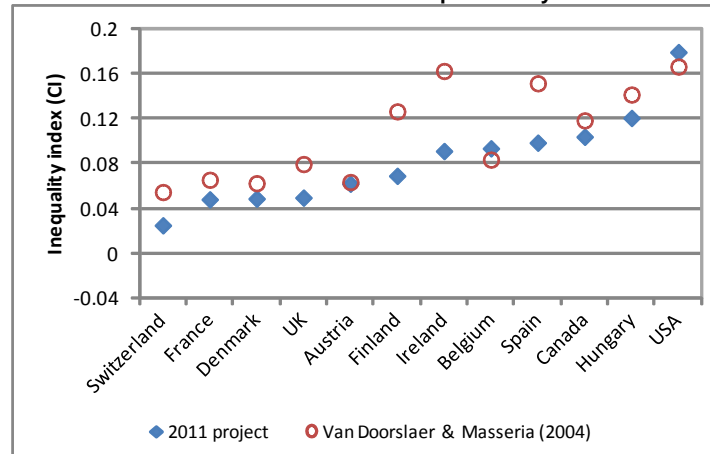
Panel A. GP visits: probability



Panel B. Specialist visits: probability



Panel C. Dentist visits: probability





# Which *health system features* characterise countries with lower levels of inequity?

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- Organisation of health systems
- Financing of health care services
- Cultural and information barriers



# Gatekeeping system --Preliminary data-

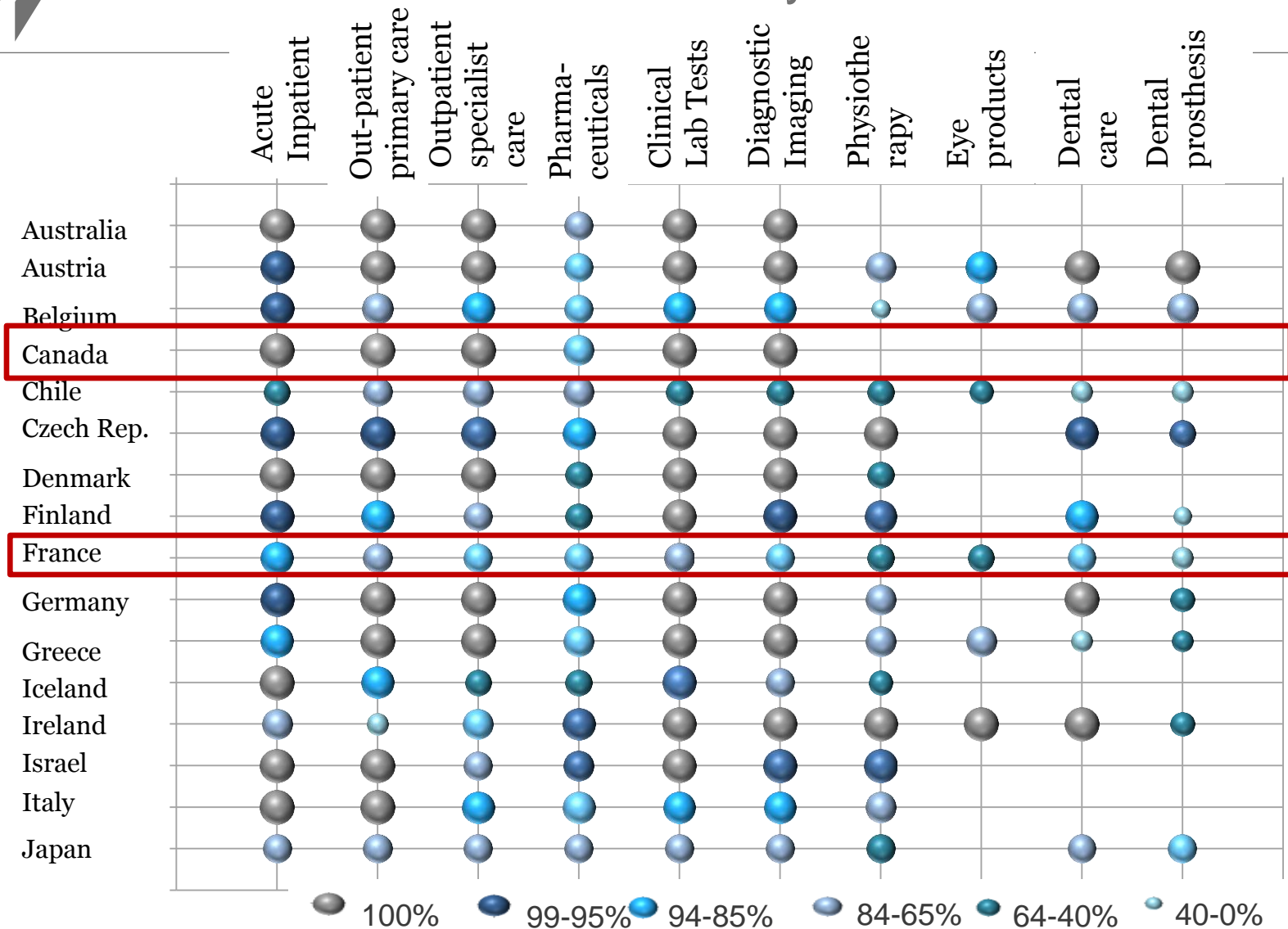
		Primary care physicians referral to access secondary care		
		Required	Incentives	No requirement, no incentive
Register with a primary care physician	Required	Denmark, Finland, Ireland, Italy, Netherlands, Portugal, Slovenia, Spain		Czech Republic,
	Incentives	Australia, New Zealand, Norway, Poland,	Belgium, France, Switzerland	
	No requirement, no incentive	Canada, Chile, United Kingdom	Mexico	Austria, Germany, Greece, Iceland, Israel, Japan, Korea

Source: OECD Health System Characteristics Survey 2012 and Secretariat's estimates.



# Level of coverage for different types of care

--Preliminary data--



Note: coverage for an adult not subject to any exceptions

Source: OECD Health System Characteristics Survey 2012 and Secretariat's estimates





# Cost-sharing arrangements

## --Preliminary data--

Country	Cost-sharing arrangements, 2012
<b>Austria</b>	Mostly free at the point of use for contracted physicians
<b>Belgium</b>	Per-visit co-payments for outpatient care
<b>Canada</b>	Free at the point of care
<b>Czech Republic</b>	Per-visit co-payments for outpatient care
<b>Estonia</b>	<i>n.a.</i>
<b>Finland</b>	Per-visit co-payments for outpatient care
<b>France</b>	Per-visit co-payments for outpatient care
<b>Germany</b>	Free at the point of care
<b>Hungary</b>	Per-visit co-payments for outpatient care
<b>Ireland</b>	Free for medical card holders (40% of pop) and full cost for non-medical card holders.
<b>New Zealand</b>	Cost-sharing for outpatient primary care, no cost-sharing for specialist care
<b>Poland</b>	Free at the point of care
<b>Slovak Republic</b>	<i>n.a.</i>
<b>Slovenia</b>	Cost-sharing
<b>Spain</b>	Free at the point of care
<b>Switzerland</b>	Cost-sharing after general deductible
<b>United Kingdom</b>	Free at the point of care
<b>USA</b>	<i>n.a.</i>



## Health system features likely associated with larger inequalities

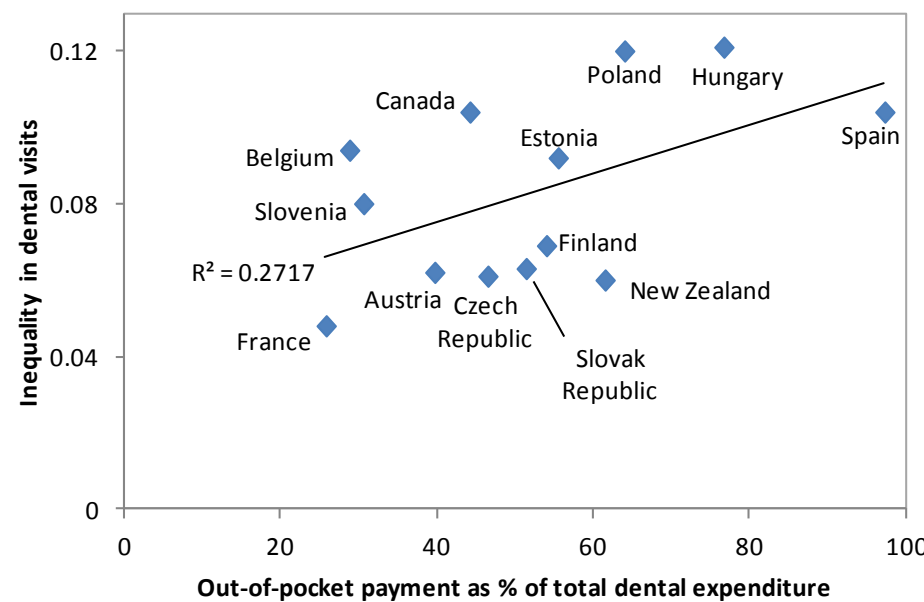
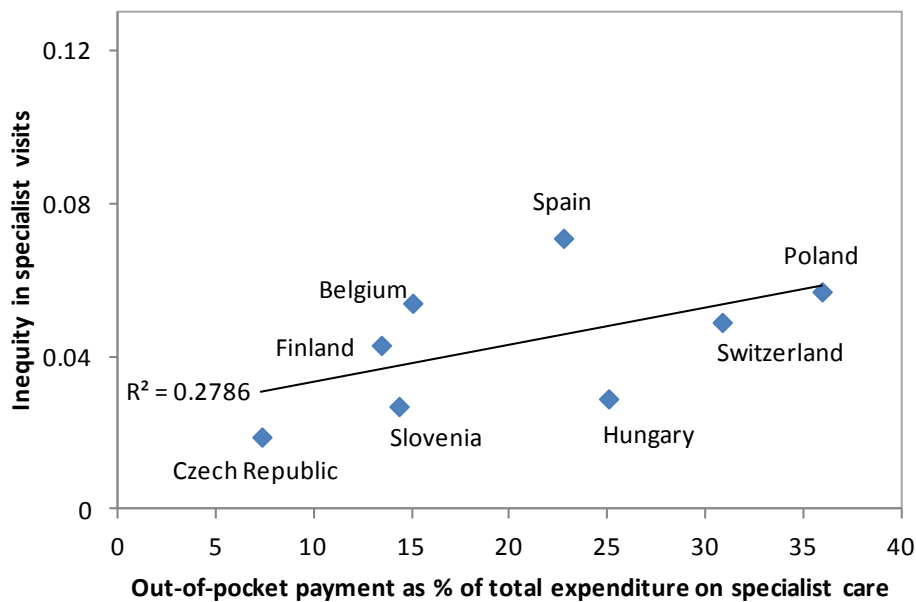
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- Universal health coverage not achieved
- Large share of private financing and out-of-pocket payments
- Care not free at the point of delivery
- No gatekeeping system
- Mostly private provision of health care
- Non-existence of public screening programmes



# Out-of-pocket payments (OOP)

- A greater share of OOP is associated with greater inequity in specialist and dental care.
- Weak correlation possibly because countries with high OOP have introduced measures to offset the negative effects on access



Source: OECD Health Working Paper No 58.



## Concluding remarks

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- Update of previous work
  - Inequities in health care utilisation persist across OECD countries
  - For the same level of needs, the better-off are more likely to visit doctors - especially specialists and dentists - than those with lower incomes.
- Need for strengthening equity



# Possible policy actions to strengthen equal access to care

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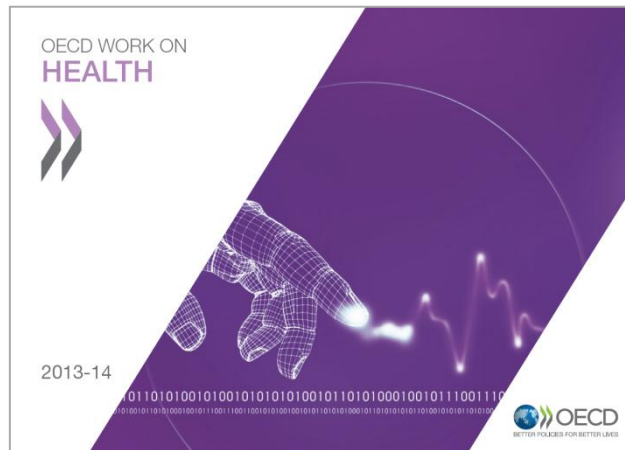
- Reducing financial barriers
  - Targeting population the most at risk (exemptions)
  - Increasing coverage (e.g. dental and eye care)
  - Trade-off with budgetary constraints
- Reducing non-financial barriers
  - Geographic distribution of services
  - Social dimension (education level, ethnic and language)



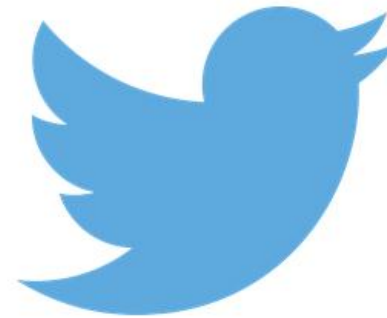
Thank you

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