

# Executive summary

Health is one of the main components of a good life. In addition to having value in itself, good health also translates into a better chance of succeeding in education and in the labour market – ultimately contributing to enhance opportunities for people to improve their standing in life. At the same time, inequalities in income and educational attainment contribute to health inequality. Ensuring that everyone, regardless of socio-economic circumstances, has access to the health system can help make sure that economic prosperity is shared by the entire population.

This publication analyses inequalities in health and health systems and thus provides a key insight for the discussion of how societies can become more inclusive. It looks into socio-economic differences in the exposure to risk factors to health, health status, the utilisation of health services, unmet health care needs and coverage. To assess these inequalities, the report undertakes detailed analyses of micro-level data from a range of national health surveys representing 33 OECD and EU countries, presenting differences between the most and least well-off as well as population-level summary measures of inequalities.

## **Poor health behaviour tends to be more prevalent among the disadvantaged, but the relationship between risk factors and educational level can be complex**

Overall, less educated people are more likely to be overweight and smoke. This applies to both sexes but the extent of these inequalities differs. In all countries, there is a greater risk of women with low education to be obese or overweight. For men, this holds true in about 55% of countries. Regarding tobacco consumption, the less educated men are significantly more likely to smoke in all countries and in 80% of countries in the case of women.

The picture for hazardous alcohol consumption is less clear. For women, there are no significant differences in drinking habits across education levels in around two-thirds of the countries but in 25% of them, alcohol consumption rises with income. Men with a high education level are less likely to be heavy drinkers but the population-level gradient is only significant in around half of the countries.

## **No matter how it is measured, the least educated are more likely to be in bad health**

Across all countries, people in the lowest education category are twice more likely to view their health as poor compared to those with tertiary education (44% vs. 23%). Similar results can be observed for other variables of health status, such as limitations in daily activities and prevalence of multiple chronic conditions.

## **People with low income are less likely to see a doctor while access to preventive services is systematically concentrated among the better off**

For the same level of health care needs, a person in the lowest income quintile is less likely to see a doctor in a year compared to one in the highest income group. Across countries, this difference is 5 percentage points for a visit to a General Practitioner (GP) but much more pronounced for a specialist visit (12 percentage points). At population level, this gradient is significant in around half of the countries in the case of GPs but in nearly all countries for specialists.

Yet, once access to a GP is established, low-income patients have at least as many visits to the GP than the rich in all but one country. The number of visits to specialists is also equally distributed in the majority of countries once a first contact has occurred.

The use of preventive services, such as cancer screening or dental care, is concentrated among higher income groups in the vast majority of OECD and EU countries. For cervical cancer, the difference in screening rates reaches on average 17 percentage points across income groups.

## **Unmet needs for care are systematically concentrated among lower income groups and poor households face more difficulties to afford care when they access the system**

On average in Europe, 26% of people in the lowest income segment did not avail care they needed due to costs compared to 8% of people with the highest income level. Overall, unmet needs for financial reasons are concentrated among lower income groups in all countries.

When accessing the health system, nearly 17% of households in EU countries declare they have difficulties in affording care but the proportion stands at 30% for those below the poverty line. Everywhere, households in the bottom income quintile are more likely to incur catastrophic health spending.

## **There is some consistency when comparing inequalities across various health domains**

Comparing jointly the levels of inequalities across domains and countries shows some consistency. The relatively high inequalities in indicators measuring service utilisation and unmet needs in countries like Bulgaria, Latvia, Croatia, Greece and Finland suggest that when countries struggle to warrant equal health service use across different population groups, they also face problems with inequalities in unmet needs. In some of these countries, this reflects limitations in the level of coverage and financial protection.

## **A range of policy options exists to reduce social inequalities in health**

A wide range of policy options exists for OECD and EU countries to tackle health-related inequalities. This should start with public health interventions that more specifically target disadvantaged population groups helping them to adopt more healthy lifestyles. Measures to improve health literacy –which is less widespread among disadvantaged populations – can also help close the inequality gap on risk factors and access to care.

The health care system can also contribute to redress inequalities. Measures should include the strengthening of primary care and the reconfiguration of service delivery models to ensure that recommended preventive services are also delivered to population groups with lower socio-economic status. This can require improving service availability in rural and disadvantaged urban areas. Making sure

that the entire population has health care coverage and benefit baskets are designed in a way to exempt the most vulnerable population groups from co-payments can also help.

Finally, labour market, education, housing and social policies that benefit the more disadvantaged groups can also contribute to reducing inequalities in health.



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