6.3. Geographic distribution of doctors

Access to medical care requires an adequate number and proper distribution of physicians in all parts of the country. Shortages of physicians in certain regions can increase travel times or waiting times for patients, and result in unmet care needs. The uneven distribution of physicians is an important concern in most OECD countries, especially in those countries with remote and sparsely populated areas, and those with deprived urban regions which may also be underserved.

The overall number of doctors per capita varies across OECD countries from lows of about two per 1 000 population in Chile, Turkey and Korea, to highs of four and more in Greece, Austria and Italy (Indicator 3.1). Beyond these cross-country differences, the number of doctors per capita also often varies widely across regions within the same country (Figure 6.3.1). A common feature in many countries is that there tends to be a concentration of physicians in capital cities. In the Czech Republic, for example, the density of physicians in Prague is almost twice the national average. Austria, Belgium, Greece, Portugal, the Slovak Republic and the United States also have a much higher density of physicians in their national capital region.

The density of physicians is consistently greater in urban regions, reflecting the concentration of specialised services such as surgery and physicians' preferences to practice in urban settings. Differences in the density of doctors between predominantly urban regions and rural regions in 2011 was highest in the Slovak Republic, Czech Republic and Greece, driven to a large extent by the strong concentration of doctors in their national capital region. The distribution of physicians between urban and rural regions was more equal in Japan and Korea (Figure 6.3.2).

Doctors may be reluctant to practice in rural and disadvantaged urban regions due to various concerns about their professional life (e.g. income, working hours, opportunities for career development, isolation from peers) and social amenities (such as educational opportunities for their children and professional opportunities for their spouse).

A range of policy levers may influence the choice of practice location of physicians, including: 1) the provision of financial incentives for doctors to work in underserved areas; 2) increasing enrolments in medical education programmes of students coming from specific social or geographic background, or decentralising medical schools; 3) regulating the choice of practice location of doctors (for all new medical graduates or possibly targeting more specifically international medical graduates); and 4) re-organising health service delivery to improve the working conditions of doctors in underserved areas and find innovative ways to improve access to care for the population.

In many OECD countries, different types of financial incentives have been provided to doctors to attract and retain them in underserved areas, including one-time subsidies to help them set up their practice and recurrent payments such as income guarantees and bonus payments.

In Canada, the province of Ontario provides an example of an attempt to decentralise medical schools. A new medical school was created in the Northern part of the province in 2005, far from the main urban centres, with the objective of increasing access to physician services in rural and remote parts (NOSM, 2012).

In Germany, the number of practice permits for new ambulatory care physicians in each region is regulated, based on a national service delivery quota (Federal Joint Committee, 2012).

In France, new multi-disciplinary medical homes (Maisons de Santé Pluridisciplinaires) were introduced a few years ago as a new form of group practices in underserved areas, allowing physicians and other health professionals to work in the same location while remaining self-employed.

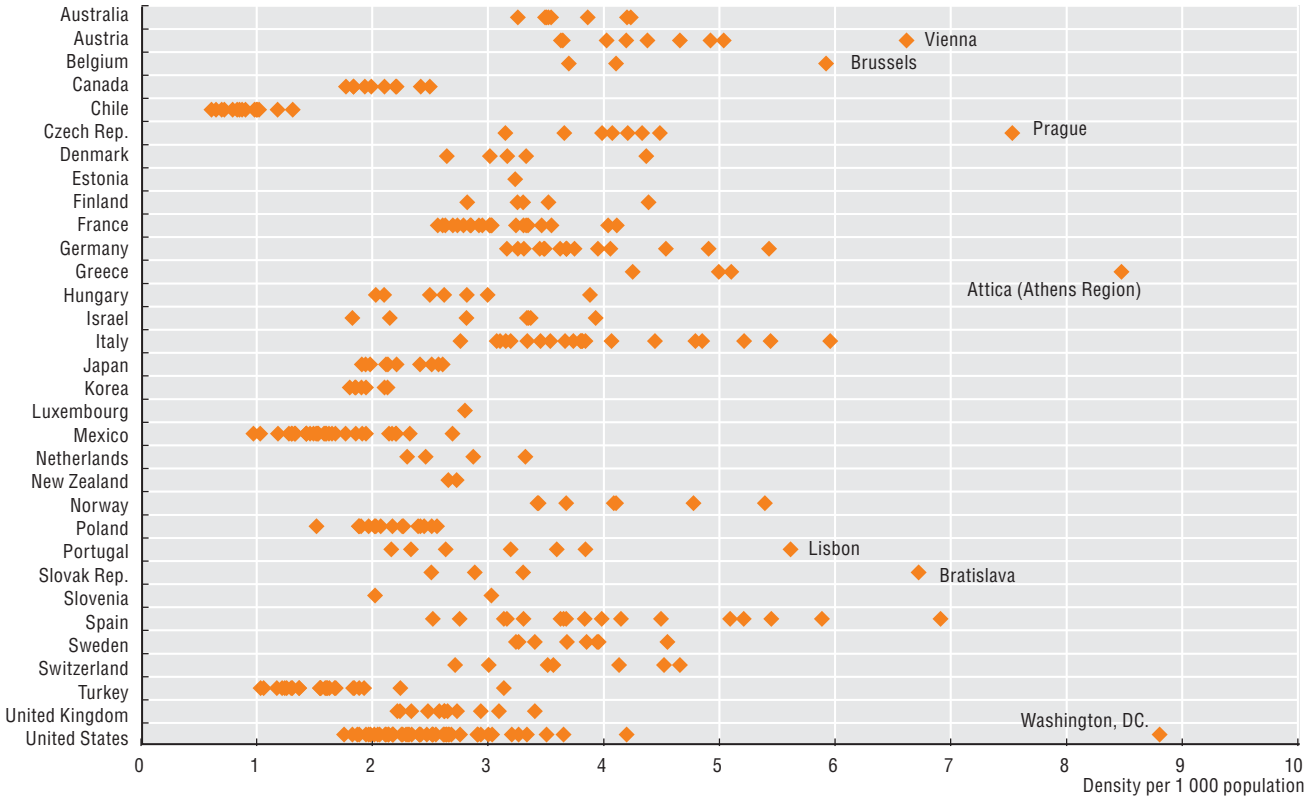
The effectiveness and costs of different policies to promote a better distribution of doctors can vary significantly, with the impact likely to depend on the characteristics of each health system, the geography of the country, physician behaviours, and the specific policy and programme design. Policies should be designed with a clear understanding of the interests of the target group in order to have any significant and lasting impact (Ono et al., forthcoming).

Definition and comparability

Indicators 3.1 provides information on the definition of doctors.

The OECD classifies regions in two territorial levels. The higher level (Territorial Level 2) consists of large regions corresponding generally to national administrative regions. These broad regions may contain a mixture of urban, intermediate and rural areas. The lower level (Territorial level 3) is composed of smaller regions which are classified as predominantly urban, intermediate or predominantly rural regions (OECD, 2011a).

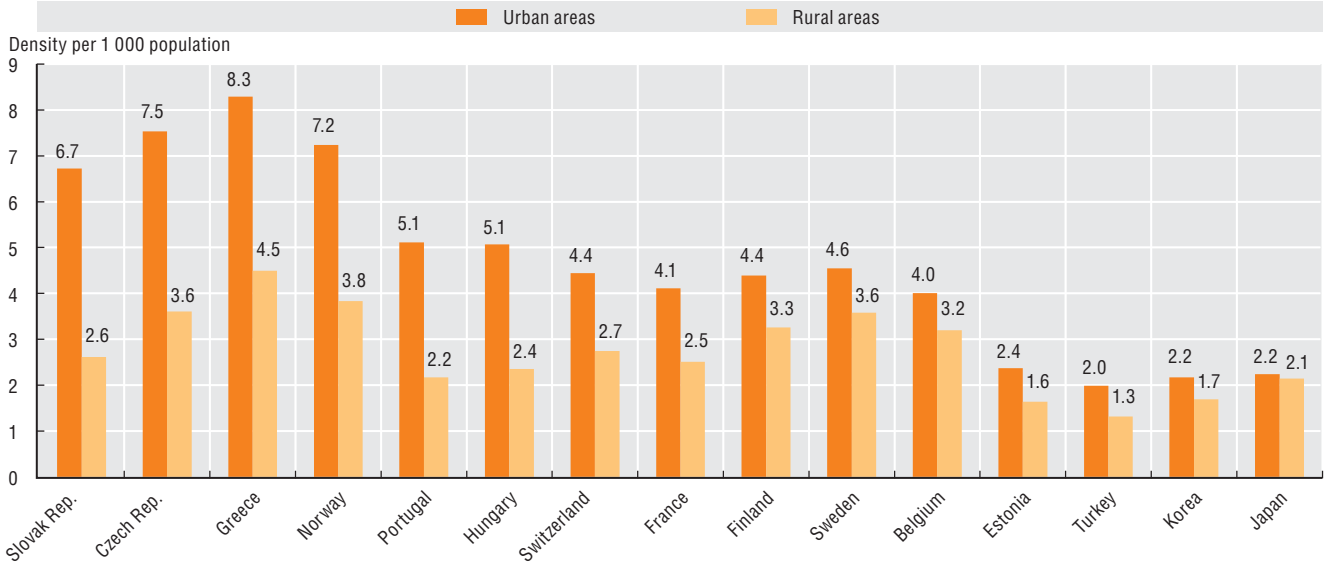
6.3.1. Physician density, by Territorial Level 2 regions, 2011 (or nearest year)



Source: OECD Regions at a Glance 2013.

StatLink http://dx.doi.org/10.1787/888932918586

6.3.2. Physicians density in predominantly urban and rural regions, selected countries, 2011 (or nearest year)



Source: OECD Regions at a Glance 2013.

StatLink http://dx.doi.org/10.1787/888932918605