All European countries endorse equity of access to health care for all people as an important policy objective. One method of gauging to what extent this objective is achieved is through assessing reports of unmet needs for health care. The problems that people report in obtaining care when they are ill or injured often reflect significant barriers to care.

Some common reasons given for not receiving care include excessive costs, having to travel too far to receive care, long waiting times, or not being able to take time off. Differences in the reporting of unmet care needs *across* countries may be partly due to socio-cultural differences. However, these factors play a lesser role in explaining any differences among population groups *within* each country. Self-reported unmet care needs must be seen in conjunction with other indicators of potential barriers to access, such as the extent of health insurance coverage and the amount of out-of-pocket payments (see Indicators 5.1 and 5.2).

In all European countries, a large majority of the population reported no unmet care needs, according to the 2012 EU Statistics on Income and Living Conditions survey (EU-SILC). However, in some countries, significant proportions of people reported having unmet needs. In Latvia, Poland, Romania and Bulgaria, more than 10% of survey respondents had an unmet need for a medical examination, and the burden fell heaviest on low income groups, particularly in Latvia and Bulgaria (Figure 5.4.1). On average across EU member states, more than twice as many people in low income groups reported unmet needs as did people in high income groups. The main reason for people in low income groups to report unmet health care needs was that care was too expensive.

A larger proportion of the population indicates unmet needs for dental care than for medical care (Figure 5.4.2). In many countries, dental care is only partially included, or not included at all in basic health care coverage, and so must either be paid out-of-pocket, or covered through purchasing private health insurance. People in Latvia reported the highest rates of unmet need for a dental examination in 2012 (over 20% of the population), followed by Portugal, Romania, Bulgaria, and Italy (all between 10-15%). There are large inequalities in unmet dental care needs between high and low income groups in most of these countries. People in Slovenia, the Netherlands and Luxembourg reported the lowest rates of unmet dental care needs in 2012 (between 1% and 3% only), according to EU-SILC.

Unmet needs for medical care and dental care due to financial reasons have decreased between 2005 and 2008 on average across EU countries, and have remained fairly stable on average between 2008 and 2012 (Figures 5.4.3 and 5.4.4). The proportion of people in low-income groups reporting some unmet needs for medical care and dental care for financial reasons continues to be two-times greater than among all the population as a whole, and over four-times greater compared with people in high-income groups on average across EU countries.

In Greece, the percentage of people reporting some unmet medical care needs for financial reasons has increased since the beginning of the crisis in 2008, rising from around 4% of the population in 2008 to over 6% in 2011 and 2012, according to EU-SILC. This proportion reached 11% among people in the lowest income quintiles in 2012, up from 7% in 2008.

By contrast, in Portugal, the percentage of people reporting unmet medical care needs for financial reasons was lower in 2011 and 2012 compared with the years before the crisis. These results from EU-SILC have also been found in the European Quality of Life Surveys (EQLS): 34% of Portuguese respondents to this EQLS survey reported having some difficulties accessing care due to cost in 2011, less than the 49% who reported having such difficulties in 2007 (Eurofound, 2013). The MoU that the Portuguese Government signed in May 2011 with the EU Commission, the IMF and the ECB (the "troika") included a series of measures to reduce public spending on health, but it also included certain measures to protect access to care, particularly for low-income groups. For example, while co-payments for a range of health services were increased for most of the population, the number of patients exempted from such co-payments was increased through increasing the income threshold (Eurofound, 2014; see chapter by Rodrigues and Schulmann).

Definition and comparability

Questions on unmet health care needs are included in the European Union Statistics on Income and Living Conditions survey (EU-SILC). To determine unmet medical and dental care, individuals are asked whether there was a time in the previous 12 months when they felt they needed health care or dental care but did not receive it, followed by a question as to why the need for care was unmet. Reasons given include that care was too expensive, the waiting time was too long, or the distance to travel was too far.

Cultural factors may affect responses to questions about unmet care needs. Caution is therefore required in comparing the magnitude of inequalities across countries.

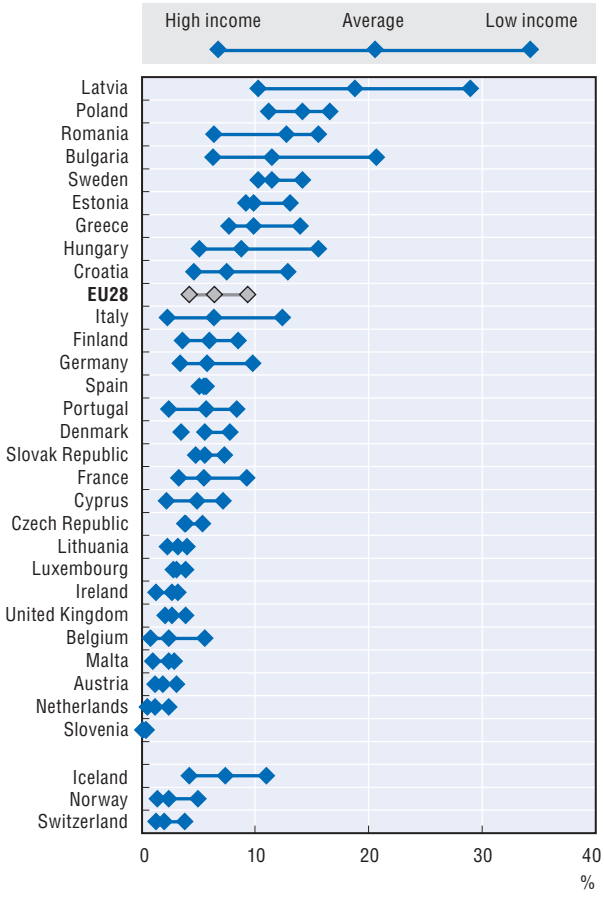
Income quintile groups are computed on the basis of the total equivalised disposable income attributed to each member of the household. The first quintile group represents the 20 % of the population with the lowest income, and the fifth quintile group represents the 20 % of the population with the highest income.

References

Eurofound (2014), *Access to Healthcare in Times of Crisis*, Dublin, including a country report on Portugal by R. Rodrigues and K. Schulmann.

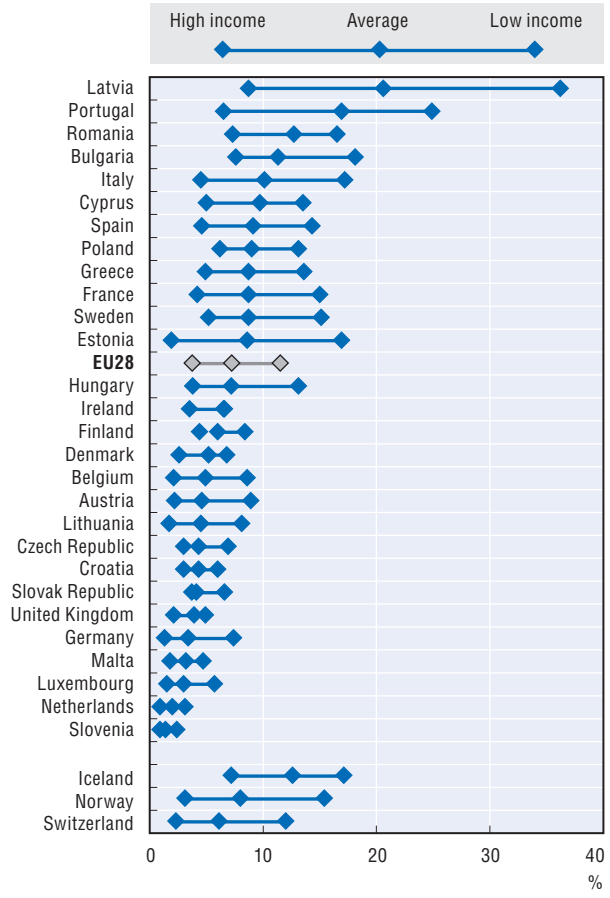
Eurofound (2013), *Impacts of the Crisis on Access to Healthcare Services in the EU*, Dublin.

5.4.1. Unmet need for a medical examination (for financial or other reasons), by income quintile, 2012



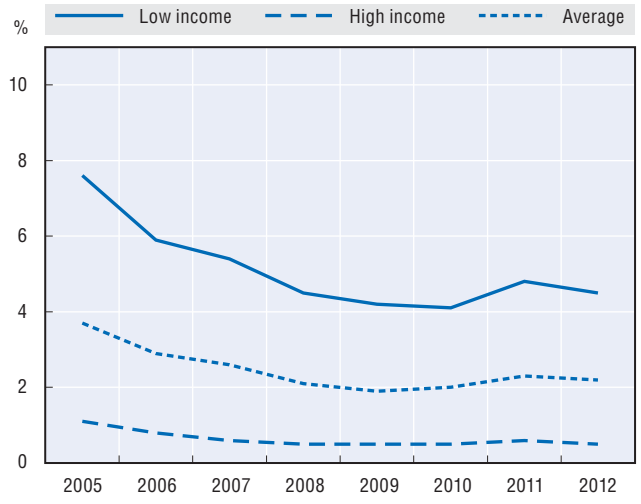
Note: 2011 data for Austria and Ireland.
Source: *Eurostat Statistics Database*, based on EU-SILC.

5.4.2. Unmet need for a dental examination (for financial or other reasons), by income quintile, 2012



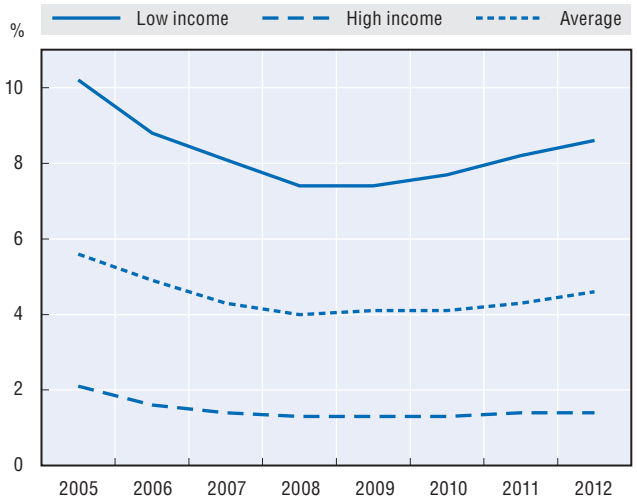
Note: 2011 data for Austria and Ireland.
Source: *Eurostat Statistics Database*, based on EU-SILC.

5.4.3. Change in unmet medical care need for financial reasons, average across EU countries, 2005 to 2012



Source: *Eurostat Statistics Database*, based on EU-SILC.

5.4.4. Change in unmet dental care need for financial reasons, average across EU countries, 2005 to 2012



Source: *Eurostat Statistics Database*, based on EU-SILC.
StatLink http://dx.doi.org/10.1787/888933155793