

UNMET HEALTH CARE NEEDS

Accessibility to health care can be limited for a number of reasons, including cost, distance to the closest health facility and waiting times. Unmet care needs may result in poorer health for people forgoing care and may increase health inequalities if such unmet needs are concentrated among poor people. As noted by the Expert Panel on Effective Ways of Investing in Health, there are many challenges in measuring unmet needs for particular interventions, but the data from the EU Statistics on Income and Living Conditions survey (EU-SILC) are the only timely and comparable source of information available across all Member States (Expert Panel on Effective Ways of Investing in Health, 2018).

In all European countries, most of the population in 2016 reported that they had no unmet care needs for financial reasons, geographic reasons or waiting times, based on EU-SILC (Figure 7.1). However, in Estonia and Greece, at least 10% of the population reported some unmet needs for health care, with the burden falling mostly on low-income groups, particularly in Greece. Nearly one in five Greek people in the lowest income quintile reported going without some medical care when they needed it mainly for financial reasons. In Estonia, the main reason for people to report unmet care needs is because of long waiting times. This can be partly explained by the limited volume of some services (such as specialist consultations) fully reimbursed by public health insurance.

In most countries, a larger proportion of the population indicates some unmet needs for dental care than for medical care (Figure 7.2). This is mainly because dental care in many countries is only partially included (or not included at all) in public schemes and so must either be paid out-of-pocket or covered through purchasing private health insurance (see the indicator Extent of health care coverage). More than one in eight people (13%) in Portugal, Greece and Latvia reported unmet needs for dental care in 2016, mainly for financial reasons. On the other hand, a very small proportion of people reported unmet dental care needs in the Netherlands, Austria, Germany, Slovenia and the Czech Republic in 2016, with very little difference across income groups.

Unmet needs for medical care and dental care have decreased since 2015 on average across EU countries, although part of the reduction in some countries is simply due to a change in the survey question (Figure 7.3 and Figure 7.4). However, the gap in unmet medical and dental care needs between poor people and rich people has remained the same: people in the lowest income quintile are still five times more likely to report unmet medical care needs than those in the highest quintile, and they are six times more likely to report unmet dental care needs.

Indicators of self-reported unmet care needs should be assessed together with other indicators of

affordability and accessibility to care, such as the extent of health care coverage, the amount of out-of-pocket payments, and the actual use of health services. Strategies to improve access to care for poor people and disadvantaged groups need to tackle not only affordability issues, but also effective access to services by promoting an adequate supply and distribution of health workers and services throughout the country.

Definition and comparability

Questions on unmet health care needs are included in the European Union Statistics on Income and Living Conditions survey (EU-SILC). People are asked whether there was a time in the previous 12 months when they felt they needed medical care or dental care but did not receive it, followed by a question as to why the need for care was unmet. The data presented here focus on three reasons: the care was too expensive, the distance to travel too far or waiting times too long.

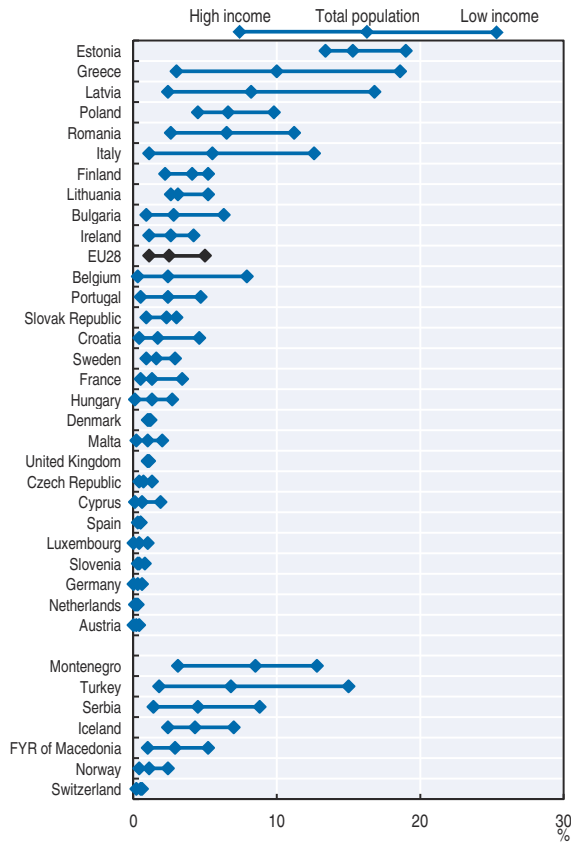
Cultural factors may affect responses to questions about unmet care needs. There are also some variations in the survey question across countries: while most countries refer to both a medical examination and treatment, the question in some countries (e.g. Czech Republic, Slovenia and Spain) only refer to a medical examination or a doctor consultation, resulting in lower rates of unmet needs. The question in Germany refers to unmet needs for “severe” illnesses, also resulting in some under-estimation compared with other countries. Some changes in the survey question in some countries in 2015 and 2016 have also led to substantial reductions. Caution is therefore required in comparing variations across countries and over time.

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 the 20% of the population with the highest income.

Reference

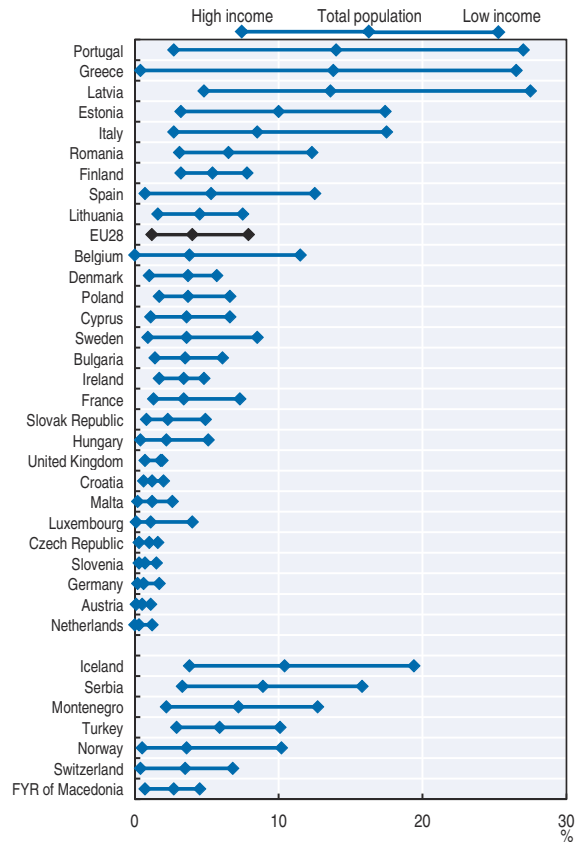
Expert Panel on Effective Ways of Investing in Health (2018), Opinion on Benchmarking Access to Healthcare in the EU, European Union, https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/docsdire/opinion_benchmarking_healthcareaccess_en.pdf.

7.1. Unmet need for medical examination for financial, geographic or waiting times reasons, by income quintile, 2016 (or nearest year)



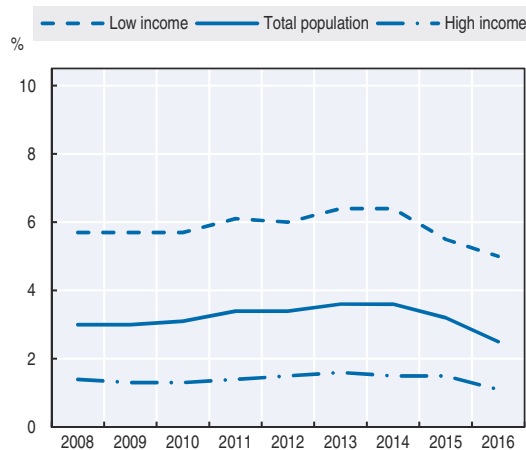
Source: Eurostat Database, based on EU-SILC.
StatLink <http://dx.doi.org/10.1787/888933836200>

7.2. Unmet need for dental examination for financial, geographic or waiting times reasons, by income quintile, 2016 (or nearest year)



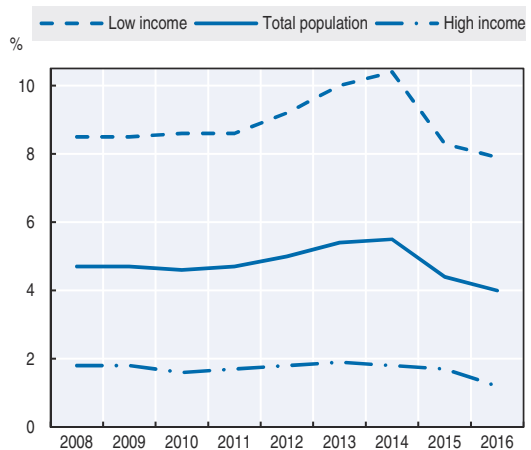
Source: Eurostat Database, based on EU-SILC.
StatLink <http://dx.doi.org/10.1787/888933836219>

7.3. Change in unmet medical care need for financial, geographic or waiting times reasons, by income quintile, all EU countries, 2008 to 2016



Source: Eurostat Database, based on EU-SILC.
StatLink <http://dx.doi.org/10.1787/888933836238>

7.4. Change in unmet dental care need for financial, geographic or waiting times reasons, by income quintile, all EU countries, 2008 to 2016



Source: Eurostat Database, based on EU-SILC.
StatLink <http://dx.doi.org/10.1787/888933836257>



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