6.1. Unmet health care needs

Most OECD countries aim to provide equal access to health care for people in equal need. One method of gauging equity of access to services is through assessing reports of unmet needs for health care for some reason. The problems that patients report in getting care when they are ill or injured often reflect significant barriers to care.

Some common reasons that people give for unmet care include excessive treatment costs, long waiting times in order to receive care, not being able to take time off work or caring for children or others, or that they had to travel too far to receive care. The different levels of self-reported unmet care needs *across* countries could be due to differences in survey questions, socio-cultural reasons, and also because of reactions to current national health care debates. However, these factors should play a lesser role in explaining any differences in unmet care needs among different population groups *within* each country. It is also important to look at indicators of self-reported unmet care needs in conjunction with other indicators of potential barriers to access, such as the extent of health insurance coverage and out-of-pocket payments (Indicators 6.2 and 6.3).

In most OECD countries, a majority of the population report no unmet care needs. However, in a European survey undertaken in 2007, a significant proportion of the population in some countries reported having unmet needs for medical care during the previous year. Generally, more women than men reported not getting the care they needed, as did people in low-income groups.

Three possible reasons that might lead to access problems are presented in Figure 6.1.1. In almost all countries, the most common reason given for unmet medical care is treatment cost. This was especially so in Portugal, Poland, Italy and Greece, and persons in the lowest income quintile were most affected. Waiting times were an issue for respondents in Italy, Poland, Sweden and the United Kingdom, and affected both higher and lower income persons. Travelling distance did not feature as a major problem, except in Norway, where one-third of those indicating that they had an unmet care need said that it was because of the distance they had to travel to receive care.

A larger proportion of the population reports unmet needs for dental care than for medical care. Poland (7.5%), Italy (6.7%) and Iceland (6.5%) reported the highest rates in 2007 (Figure 6.1.2). Large inequalities in unmet dental care needs were evident between high and low income groups in Iceland, Greece, Portugal and Denmark, as well as in Belgium, although in the latter country, average levels of unmet dental care were low.

Inequalities in self-reported unmet medical and dental care needs are also evident in non-European countries, based on the results of another multi-country survey (Figures 6.1.3 and 6.1.4). Again, foregone care due to costs is more prevalent among lower income groups for a number of different treatments. There are large differences in the size of these inequalities across countries, as shown by much lower levels in the Netherlands and United Kingdom than in the United States. In the United States, more than half the adult population with below-average incomes reported having some type of unmet care need due to cost in 2007 (Commonwealth Fund, 2008). Those adults with below-average incomes who have health insurance report significantly less access problems due to cost than do their uninsured counterparts (Blendon *et al.*, 2002).

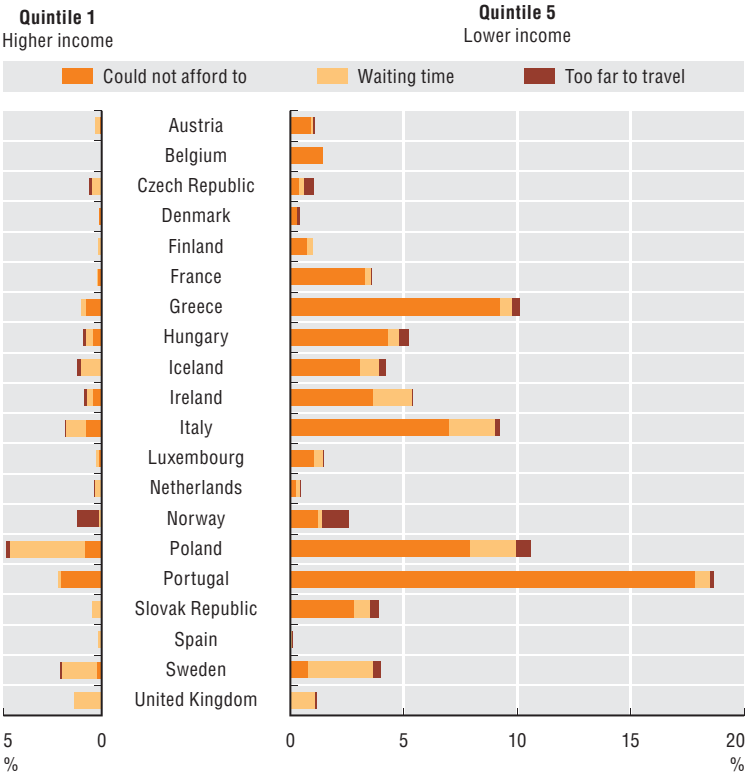
Definition and deviations

Questions on unmet health care needs are a feature of a number of national and cross-national health interview surveys, including the European Union Statistics on Income and Living Conditions survey (EU-SILC) and the international health policy surveys conducted by the Commonwealth Fund. No single survey or study on unmet care needs has been conducted across all OECD countries.

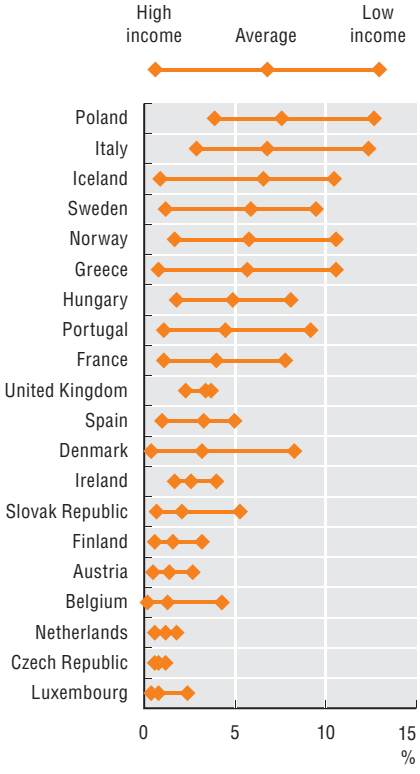
In order to determine unmet medical care, individuals are typically asked questions to determine whether there was a time in the previous 12 months when they felt they needed health care services but did not receive them, followed by a question to determine why the need for care was unmet. Common reasons given include that care was too expensive, the travelling distance to receive care was too far, or that the waiting list for care was too long.

Information on both unmet care and socio-economic status are derived from the same survey, although specific questions and answers, along with age groups surveyed and the measures used to grade socio-economic status can vary across surveys and countries. Cultural factors and changes to national health care systems may also affect attitudes to unmet care. Caution is therefore needed in comparing the magnitude of inequalities across countries.

6.1.1 Unmet need for a medical examination, selected reasons by income quintile, European countries, 2007

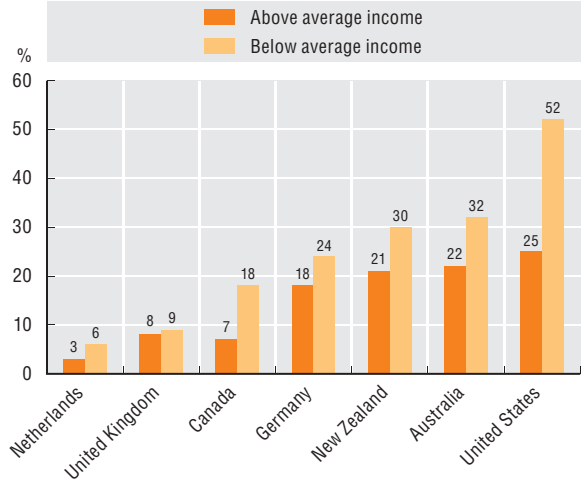


6.1.2 Unmet need for a dental examination, by income quintile, European countries, 2007



Source: EU-SILC.

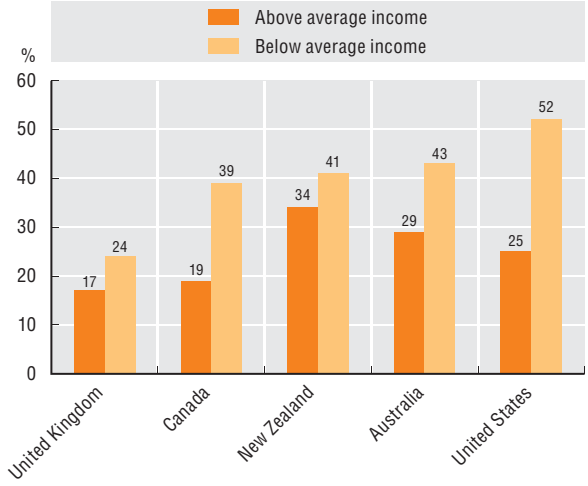
6.1.3 Unmet care need[1] due to costs in seven OECD countries, by income group, 2007



1. Did not get medical care, missed medical test, treatment or follow-up, did not fill prescription or missed doses.

Source: Commonwealth Fund (2008).

6.1.4 Unmet need for a dental examination due to costs in five OECD countries, by income group, 2004



Source: Davis *et al.* (2007).

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