Financial and geographic access to health care

Unmet health care needs, as reported in population-based surveys, are a good way of assessing any access problems for certain population groups. A European-wide survey (EU-SILC), conducted on an annual basis, provides information on the proportion of people reporting unmet care needs for medical examination for financial, geographic or other reasons.

In all European countries covered by this survey, low-income people were more likely in 2013 to report unmet care needs than people with high incomes. The gap was particularly large in Hungary, Italy and Greece. The most common reason reported by low-income people for unmet needs for medical examination is cost while the main reasons reported by high-income people are lack of time and a willingness to see if the problem would go away on its own.

In contrast to publicly funded care which in theory is based on need, direct out-of-pocket (OOP) payments by households rely on people's ability to pay. If the financing of health care becomes more dependent on OOP payments, the burden shifts, in theory, towards those who uses services more and possibly from high to low income households that often have greater health care needs.

In 2012, about 3% of total household consumption was dedicated to medical spending on average in OECD countries. In some countries which have been hit particularly hard by the crisis and where public coverage for certain health services and goods has been reduced, the share of OOP spending has increased in recent years (Hungary and Ireland).

Health systems in OECD countries differ in the degree of coverage for health services and goods. In most countries, public coverage is higher for hospital care and doctor consultations, while direct OOP payments are higher for pharmaceuticals, dental care and eye care (glasses) resulting in a relatively greater proportion of people reporting unmet care needs for the latter group of health services and goods.

Access to medical care also 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 to access medical care and therefore result in greater unmet care needs.

In all OECD countries, the density of physicians is greater in urban regions, reflecting the concentration of specialised services such as surgery and physicians' preferences to practise in urban settings. Differences in the density of doctors between predominantly urban and rural regions in 2011 were highest in the Slovak Republic, Czech Republic and Greece. This was driven to a large extent by the strong concentration of doctors in the national capital region. The geographic distribution of physicians was more equal in Japan and Korea.

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 Germany, the number of practice permits for new ambulatory care physicians providing services to statutory health insurance patients in each region is regulated, based on a national service delivery quota. In France, new multidisciplinary medical homes were introduced in underserved areas, allowing physicians and other health professionals to work in the same location while remaining self-employed.

Methodology and definitions

Data on unmet care needs come from EU-SILC. Survey respondents are asked whether there was a time in the past 12 months when they felt they needed a medical examination but did not receive it, followed by a question as to why the need for care was unmet. Data presented here cover unmet care needs for any reason.

OOP payments are borne directly by a patient where neither public nor private insurance covers the full cost of the health good or service. They include cost-sharing and other expenditures paid directly by private households, and also include estimations of informal payments to health care providers in some countries. Only expenditure for medical spending (i.e. current health spending less expenditure for the health part of long-term care) is presented here.

The data for most countries refer to the number of practising physicians, defined as the number of physicians who are providing care directly to patients. Countries are ranked based on the difference between the density of physicians in urban and rural areas. 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 that are classified as predominantly urban, intermediate or predominantly rural regions (OECD, 2013).

Further reading

OECD (2013), Regions at a Glance, OECD, Paris, *http://dx.doi.org/10.1787/reg_glance-2013-en*.

Figure notes

12.6: Data for Greece, Spain and Turkey are for 2009 rather than 2007. Data for Australia, Canada, Japan, New Zealand, Norway, Portugal and Switzerland are for 2011 rather than 2012. Data for Israel are for 2010 rather than 2012.

Information on data for Israel: *http://dx.doi.org/10.1787/888932315602*.

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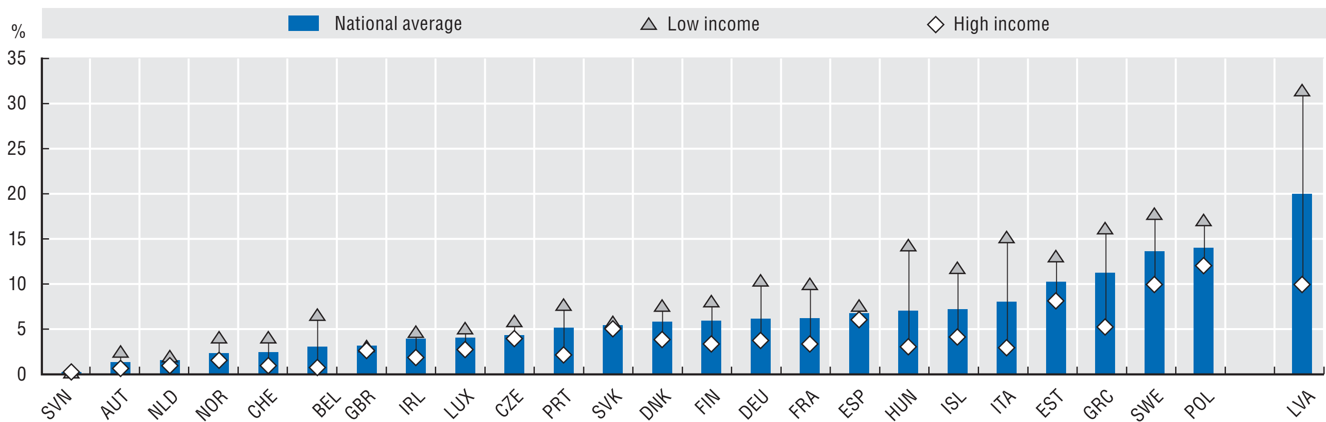
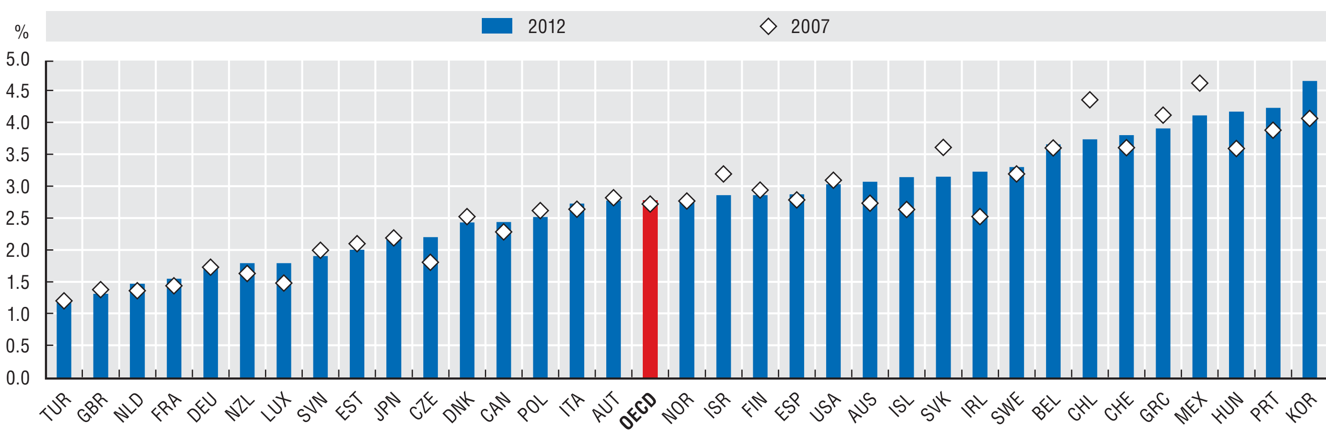
12.5. Unmet care needs for medical examination by income level, 2013



Source: EU Survey on income and living conditions (EU-SILC), 2013.

StatLink http://dx.doi.org/10.1787/888933249388

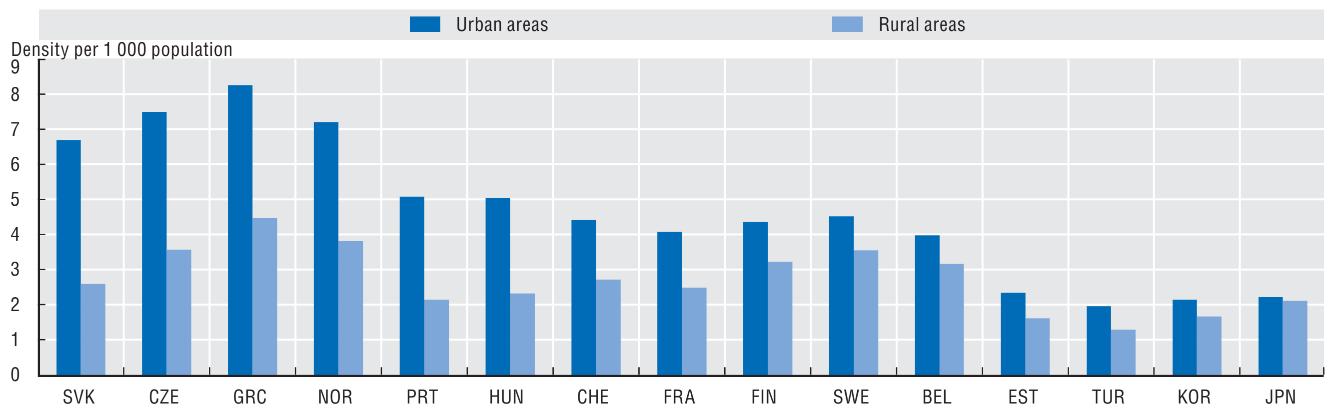
12.6. Out-of-pocket (OOP) medical expenditure as a share of final household consumption, 2007 and 2012



Source: OECD (2014), *Health Statistics.*

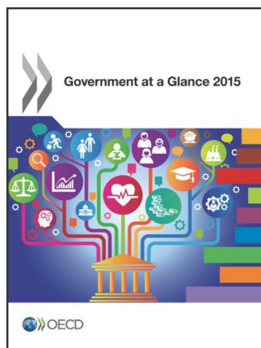
StatLink http://dx.doi.org/10.1787/888933249395

12.7. Physician density in predominantly urban and rural regions, 2011



Source: OECD (2013), *Regions at a Glance 2013*, OECD, Paris.

StatLink http://dx.doi.org/10.1787/888933249403



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