Unmet needs for healthcare

A fundamental principle underpinning all health systems across OECD countries is to provide access to high-quality care for the whole population, irrespective of their socio-economic circumstances. Yet access can be limited for several reasons, including limited availability or affordability of services. Policies therefore need to ensure an adequate supply and distribution of health workers and healthcare services throughout the country, and address any financial barriers to care (OECD, 2019[1]; 2023[2]).

On average across 26 OECD countries with comparable data, only 2.3% of the population reported that they had unmet medical care needs due to cost, distance or waiting times in 2021 (Figure 5.4). However, over 5% of the population reported unmet care needs in Estonia (8.1%) and Greece (6.4%), while in Germany, the Netherlands, Austria and the Czech Republic, fewer than 0.5% of the population reported unmet needs for medical care. Socio-economic disparities are significant: people in the lowest income quintile were three times more likely to report unmet medical care needs than those in the highest quintile in 2021, on average across 26 OECD countries. This income gradient exists in all analysed countries; it was largest in Greece, Latvia and Türkiye (and accession country Romania), with a difference of over 6 percentage points in the population reporting unmet needs between the lowest and highest income quintiles. In Greece and Estonia, more than one in ten people in the lowest income quintile reported unmet medical care needs.

Reported unmet needs are generally larger for dental care than for medical care (Figure 5.5). This reflects the fact that dental care is less well covered by public schemes than medical care in most OECD countries, so people often must pay out of pocket or purchase additional private health insurance (see section on “Extent of healthcare coverage”). More than 7% of people in Portugal, Latvia, Iceland and Greece reported unmet dental care needs in 2021, compared to fewer than 0.5% in the Netherlands, Germany and Austria. In all analysed countries, the burden of unmet needs for dental care falls disproportionately on people on lower incomes. This was most evident in Portugal and Latvia, where more than 16% of people in the lowest income quintile reported forgoing needed dental care in 2021, compared to fewer than 2% in the highest quintile. Recently, Portugal has aimed to improve access to dental care by creating dental health offices within public primary healthcare facilities.

The main reason cited for unmet needs for medical care was typically waiting times, with 1.4% of people reporting this issue in 2021, on average across 26 OECD countries (Figure 5.6). In Estonia, Slovenia and Finland, more than 4% of the population cited waiting times as a barrier. Cost was also cited as an important barrier to access, and was the main reason for unmet needs in Greece, Iceland, Türkiye and Latvia, and accession country Romania. Distance to travel was also cited as a barrier, but less frequently than waiting times or cost.

Unmet medical care needs due to cost have generally fallen in most countries since 2011 (other than in Portugal, Luxembourg and Denmark). However, unmet medical care needs due to waiting times have often increased since 2011 – particularly in Slovenia, Estonia, Ireland and the Slovak Republic. Some of these countries have introduced initiatives to reduce waiting times. In Estonia, for example, the national e-booking system now includes a function where patients can select a treatment service and the system automatically searches for an appointment time that matches their preferences. This system should help the government track which health services have longer waiting lists and analyse the reasons (OECD/European Observatory on Health Systems and Policies, forthcoming[3]).

Definition and comparability

Questions on unmet healthcare needs are included in the EU Statistics on Income and Living Conditions (EU-SILC) survey compiled by Eurostat. People are asked whether in the previous 12 months they ever felt they needed medical care or dental care but did not receive it, followed by a question on why the need for care was unmet. The data presented here focus on three reasons: healthcare was too expensive, the distance to travel was too far, or waiting times were too long. Note that some other surveys of unmet needs (for example, the European Health Interview Survey) report much higher rates of unmet needs. This is because such surveys exclude people without healthcare needs, while the EU-SILC survey considers the total population surveyed.

In comparing across countries, cultural factors may affect responses to questions about unmet healthcare needs. There are also some variations in the survey questions across countries: while most countries refer to both a medical examination and treatment, the question in some countries (the Czech Republic and Spain) only refers to a medical examination or a doctor consultation, resulting in lower rates of unmet needs.

Income quintile groups are computed based on the total equivalised disposable income attributed to each household member. The first quintile represents the 20% of the population with the lowest income, and the fifth quintile the 20% of the population with the highest income. Data for Iceland refer to 2018, data for Norway refer to 2020; for all other countries data refer to 2021.

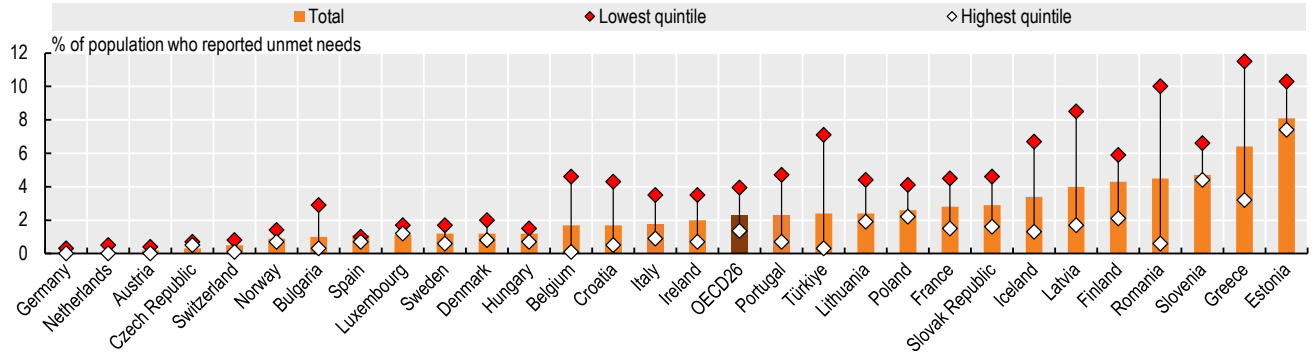
References

OECD (2023), *Ready for the Next Crisis? Investing in Health System Resilience*, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/1e53cf80-en. [2]

OECD (2019), *Health for Everyone?: Social Inequalities in Health and Health Systems*, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/3c8385d0-en. [1]

OECD/European Observatory on Health Systems and Policies (forthcoming), *Estonia: Country Health Profile 2023*, State of Health in the EU, OECD Publishing, Paris. [3]

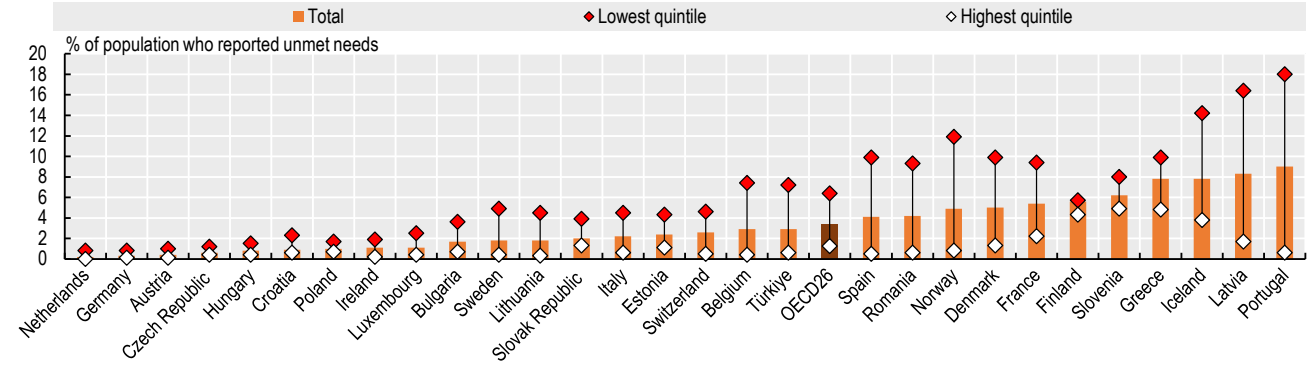
Figure 5.4. Population reporting unmet needs for medical care, by income level, 2021



Note: Data for Iceland refer to 2018 and data for Norway refer to 2020. Source: Eurostat, based on EU-SILC.

StatLink https://stat.link/rpkaci

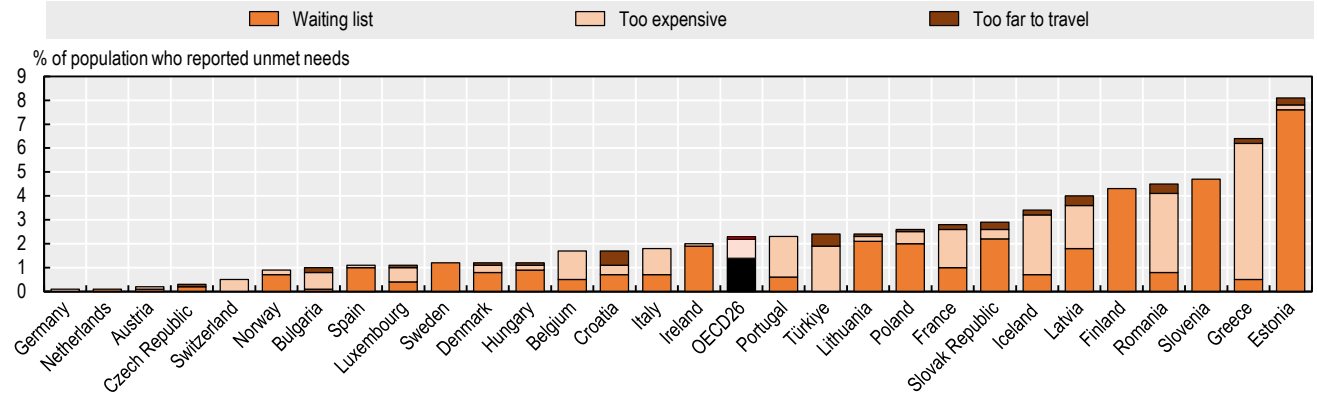
Figure 5.5. Population reporting unmet needs for dental care, by income level, 2021



Note: Data for Iceland refer to 2018 and data for Norway refer to 2020.
Source: Eurostat, based on EU-SILC.

StatLink https://stat.link/rkcp8e

Figure 5.6. Main reason for reporting unmet needs for medical care, 2021



Note: Data for Iceland refer to 2018 and data for Norway refer to 2020.
Source: Eurostat, based on EU-SILC.

StatLink https://stat.link/ujceq3