FOCUS ON

Unmet needs for health care: Comparing approaches and results from international surveys

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The level of unmet needs for health care reported in international surveys varies across countries and surveys – sometimes greatly. This brief explains these differences in the level of unmet needs, by comparing the methods and approaches used across three international surveys. It identifies at least five methodological differences that explain these inconsistencies. Despite differences in the level of unmet needs, the broad picture arising from these surveys is consistent: unmet needs are greater among the poor.

A key objective of any health system is to provide access to care of good quality and thereby meet the health needs of the population. Whether health systems really succeed in doing this is difficult to evaluate, because of the variation in how "needs" are defined and measured.

Current survey instruments generally measure unmet needs by asking people if there was a time during the past year when they did not receive the care they needed, and about the main barriers, including availability (such as waiting times and distance to providers) and affordability (costs). Asking people whether their needs for health care have been met is a pragmatic way of capturing barriers in access to health services from the people's perspective. However, the specific approaches used to measure unmet health care needs vary across national and international surveys, leading to differences in results.

The purpose of this brief is to explain why various international surveys display some differences in levels of unmet health care needs in OECD countries by highlighting differences in the methodologies used, while also pointing out some consistent findings across surveys.

Three international surveys provide data for unmet needs for health care

This brief focusses on three surveys that collect data on unmet health care needs across European and OECD countries:

1) The EU Statistics on Income and Living Conditions (EU-SILC);
2) The European Health Interview Survey (EHIS); and
3) The Commonwealth Fund International Health Policy Survey.

The methods and approaches used to assess unmet needs for health care vary across these three surveys, leading to results that are difficult to compare. The OECD uses the results from these surveys in different reports, reflecting the specific needs of each study, and it is useful for readers to understand these differences (Box 1).

There are at least five differences in the methodology used in these surveys:

1) The population considered: While EU-SILC and the Commonwealth Fund Survey consider all adults, the EHIS questionnaire allows for a distinction between adults who did not have any health care needs in a given year and those who had care needs (Eurostat, 2018). The exclusion of people without health care needs result in higher rates of unmet needs for the rest of the population.

2) The range of health services and goods covered: EU-SILC includes two distinct questions on medical and dental care. In EHIS, the questions first refer to barriers to access to 'health care' in general - this generic term may include any type of care- and then asks more specific questions about financial barriers for medical care, dental care, prescribed medicines, and mental health care. The Commonwealth Fund Survey contains four distinct questions on financial barriers to doctor consultations, medical tests or treatments, prescribed medicines, and dental care.

3) The reasons for unmet needs: In EU-SILC, people who report unmet needs must select only the main reason why they did not receive the care they needed (among a range of health systems reasons including waiting times, distance to services or cost, and some personal reasons). In EHIS, three independent questions refer to three barriers to health care: long waiting times, long distance to travel, and cost. In the Commonwealth Fund Survey, the questions focus only on not receiving care due to cost (there are other questions on waiting times but these are not explicitly related to unmet needs).

Box 1. The use of these international surveys in OECD reports and analyses

Recent OECD reports have used in various ways the three international surveys described in this brief, depending on the country coverage of the analysis of unmet care needs, the breadth of the analysis in terms of the range of health services and goods covered, and the possibilities to carry out some trends analysis to assess whether unmet needs have been growing or diminishing in recent years.

EU-SILC data have been used in Health at a Glance: Europe 2018 (OECD/EU, 2018) and in the EU Country Health Profiles (OECD/European Observatory on Health Systems and Policies, 2019) as this survey provides data for all EU countries and allows comparison over time for a period of about 10 years. However, the Country Health Profiles also used as a complementary data source EHIS data from 2014 to provide a more balanced picture of the level of unmet needs in some countries.

EHIS data from 2014 have been used in a recent OECD publication that looked at social inequalities in health and access to health care as it provides a broader range of information on unmet needs for various health services and goods beyond only medical care (OECD, 2019a). Another advantage of EHIS is that it allows complementing the information on unmet needs with the actual number of medical visits that people in different health state report, which can provide a more accurate measure in inequity in access to care. EHIS data have also been used in Health at a Glance, complemented where possible with comparable national surveys from non-European countries (OECD, 2019b). When the data from the 2019 wave of EHIS will become available, it will be possible to assess the trends over two point in time.

Data from the Commonwealth Fund International Health Policy Survey have been used in previous editions of Health at a Glance (e.g. the 2017 and 2015 editions), as it provides comparisons across a selected group of both European and non-European countries.

4) The wording and the order of the questions: The EHIS questionnaire prompts respondents to recall the barriers in access to care they faced by explicitly citing upfront the type of barriers: long waiting times, long distance to travel, and costs. By contrast, the formulation of the questions in the other two surveys aims to assess first whether the respondents had any episode of not receiving care when needed and only if they respond positively then ask them the reason why (probably resulting in some under-reporting).

5) The inclusion of delayed and forgone care (as opposed to forgone only) in the definition of unmet needs: Unmet needs refer only to forgone care due to any reason in EU-SILC, and to forgone care due to cost in the Commonwealth Fund Survey, but they include both delayed and forgone care due to waiting time and distance in EHIS, as well as forgone care due to cost.

More specifically, in EU-SILC, 'unmet needs' for medical care (or, dental care) is defined as having at least one episode when the person did *not receive* a medical (dental) examination or treatment for a health problem when s/he really needed it. In the Commonwealth Fund Survey, 'unmet needs' for medical care (dental care) refers to at least one episode when the person had a medical problem, but because of the cost, did *not visit* a doctor, *skip* medical test or treatment, or did *not fill a prescription* for medicines (*skipped* dental care or dental check-ups). In EHIS, 'unmet needs' for medical care is defined as having at least one episode when the person did *not receive care soon enough, or not at all,* due to long waiting time or long distance to travel, or an episode when s/he did *not receive* care due to cost. Unmet needs for dental care is defined in EHIS as episodes when the person did *not receive* dental care due to cost.

Box 2 provides the different questions and answer categories offered in these three surveys. The following sections review some of the main results from these three surveys, highlighting the reasons for the differences but also the similarities in key findings about disparities by income group.

European Union Statistics on Income and Living Conditions Survey (EU-SILC)

The EU-SILC survey collects data on the level of unmet needs for medical and dental care yearly since 2008 in all EU countries, Iceland, Norway, and Switzerland and EU candidate countries (Box 2).

In 2018, on average across EU countries, 3.2% of adults reported that they did not receive a medical examination or treatment that they needed in the past 12 months for different reasons (Figure 1). There are large variations across countries. The highest level of unmet needs is found in Estonia (19%), followed by Latvia and Greece, while the lowest levels are in Austria, Spain, Malta, Germany, Netherlands and Luxembourg (less than 1%).

The most often cited reason for unmet needs for medical care is cost. Long waiting time and long distance to travel are also cited as barriers for timely access to health care. Together, these three reasons account for 1.8% of the 3.2% unmet needs in the EU as a whole. Beyond accessibility and affordability barriers, people can also mention personal reasons for unmet needs such as lack of time or fear of doctors.

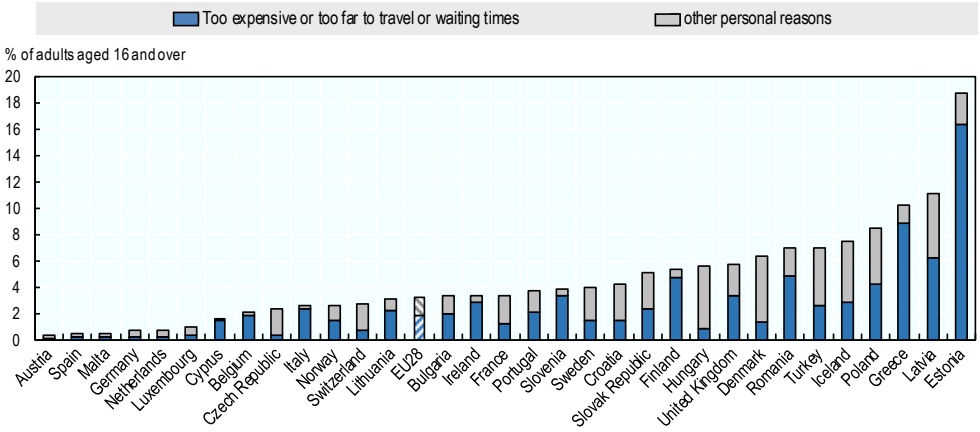
Overall in the EU, unmet needs for medical care have decreased since 2013 (Figure 2), especially among low-income people. This pattern is generally

consistent across countries (with some exceptions, such as Estonia and Slovenia where unmet needs have gone up).

The data also allows for a distinction of unmet needs between different population groups in each country. People in the lowest income quintile have higher unmet needs than the most well-off (Figure 2). Social inequalities in unmet needs generally have a consistent pattern across years, and across countries. However, in countries where the level of unmet needs is very low (e.g. Spain), the inequality is hardly visible.

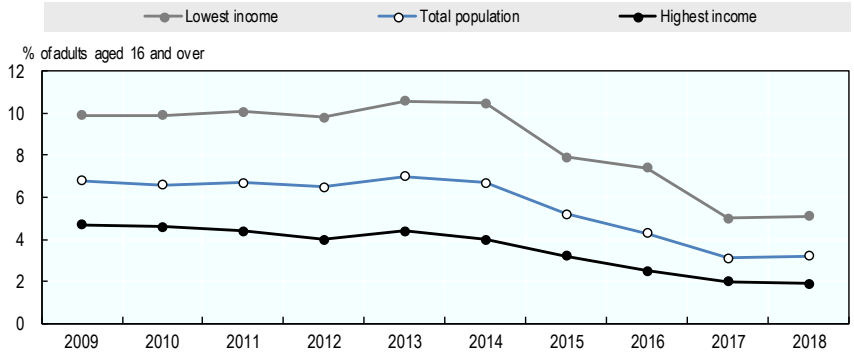
In 2018, around 4% of the Europeans reported unmet needs for dental examination or treatment. This share is greater than for medical care. The main reason given for unmet dental examination and treatment needs was cost in nearly all countries (Eurostat, 2018).

Figure 1. Share of people reporting unmet needs for medical examination or treatment (by reason) in the past 12 months, EU-SILC 2018



Note: Unmet needs for medical examination or treatment (for different reasons).
Source: Eurostat EU-SILC 2018 complemented with 2017 data for Ireland, Slovak Republic, United Kingdom, and Turkey, and 2016 for Iceland.

Figure 2. Evolution in unmet medical care needs, by income level, EU-28 average, EU-SILC 2009-2018



Note: Unmet needs for medical examination or treatment (all reasons included).
Source: Eurostat EU-SILC, several years.

European Health Interview Survey (EHIS)

EHIS gathers information once every five to six years across all EU, Iceland and Norway on whether people did not receive care soon enough, or not at all, because of long waiting time or long distance to travel, and when they did not receive specific types of health services and goods due to cost (Box 2). Explicitly mentioning the barriers to health care may prompt respondents to recall all episodes of unmet needs. EHIS distinguishes between the respondents who had needs for health care and those who did not, thus allowing for an analysis of unmet needs focussing only on people reporting that they had care needs.

According to the latest wave of EHIS in 2014, around 10% of adults in the EU as a whole reported no needs for health care in the year prior to the survey. The estimates of the level of unmet needs based on EHIS –as presented in (Eurostat, 2018) and replicated herein- exclude this population group for health care in a given year. Thus, the reference population considered in EHIS (adults who had needs for care) differs from EU-SILC (all respondents).

On average across EU countries, 26.5% of adults who had needs for care reported in 2014 that they did not receive care soon enough, or not at all, due to long waiting times, distance or cost (Table 1). This proportion ranges from less than 10% in Cyprus and Norway to around or more than 40% in Ireland,

Latvia, Estonia and Portugal, where cost is the main driver of unmet needs, followed by waiting times.

Affordability is a common barrier to health care. On average in EU countries, 15% of adults in 2014 reported that they did not get medical care, dental care, mental health services or prescribed medicines because they could not afford it. This was mainly driven by unmet needs for dental care (12.3%) followed by medical care (5.9%) (Table 1). There are notable differences across countries with 6% of the population or less declaring unmet needs for financial reasons in the Czech Republic, Cyprus and the Netherlands, and more than a quarter in Estonia, Greece, Ireland, Latvia, and Portugal.

Long waiting times and distance to travel are the two other main barriers to access health care. In 2014, on average across EU countries, 19% of adults who had needs for health care, reported having not received care soon enough, or not at all, due to long waiting time and, 4% due to distance or transport problems (Table 1).

Table 1. Share of people reporting unmet needs due to waiting times, distance or transport, or cost, EHIS 2014

% of people who had needs for health care

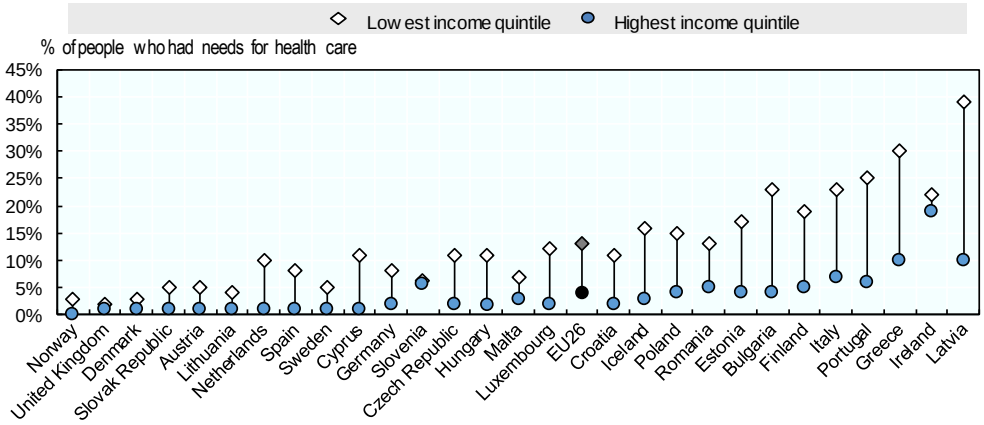
Country	Unmet needs for any reason (combination of (i), (ii) or (iii))	Not receiving care timely, or not at all, due to waiting time (i)	Not receiving care timely, or not at all, due to distance or transport (ii)	Not receiving care due to financial reason (iii)				
				Any type of care (a, b, c or d)	Medical care (a)	Prescribed medicines (b)	Mental health care (c)	Dental care (d)
Austria	17.0	11.1	2.0	9.8	3.4	2.2	6.5	7.5
Bulgaria	17.3	4.3	3.7	17.0	10.7	9.6	2.3	12.6
Croatia	24.4	21.4	4.9	10.8	7.8	5.7	1.7	5.6
Cyprus	9.4	7.4	0.1	4.9	4.2	2.0	7.9	4.5
Czech Republic	17.3	11.2	4.9	6.0	4.3	3.2	1.1	1.4
Denmark	29.8	25.1	3.3	19.7	2.3	4.4	13.3	15.5
Estonia	38.8	18.7	3.4	30.8	10.1	6.6	3.7	31.0
Finland	30.2	20.1	3.7	20.1	11.8	10.6	7.4	15.1
Germany	30.3	24.7	4.3	13.4	4.1	3.7	3.6	10.5
Greece	30.2	15.0	6.9	25.3	18.8	14.9	9.7	20.1
Hungary	22.5	12.8	2.6	13.8	4.9	5.9	1.4	11.9
Iceland	33.7	28.8	4.0	20.7	8.1	9.5	33.1	19.4
Ireland	40.6	27.2	*	35.9	23.0	19.4	*	31.9
Italy	31.0	29.9	9.1	17.2	12.5	7.2	3.6	15.1
Latvia	41.8	23.3	6.8	34.2	22.6	17.3	6.3	29.8
Lithuania	17.5	12.8	2.8	8.5	2.7	3.8	4.7	11.1
Luxembourg	37.3	31.0	3.7	16.5	5.9	6.9	4.7	12.3
Malta	23.0	26.5	2.8	7.1	5.0	3.4	2.1	4.6
Netherlands	12.3	11.4	1.8	5.7	3.3	1.9	2.1	4.2
Norway	9.6	4.0	1.5	6.3	1.1	3.2	0.7	3.3
Poland	32.3	26.2	4.2	17.0	8.5	9.4	4.1	13.0
Portugal	39.8	24.4	2.5	28.1	12.3	10.0	31.1	32.4
Romania	15.5	2.4	1.5	14.8	7.6	6.7	1.8	10.6
Slovak Republic	11.4	6.1	1.3	7.2	1.9	4.3	1.6	6.1
Slovenia	26.1	19.6	3.0	15.3	4.5	5.8	2.5	12.6
Spain	25.7	15.5	1.4	17.2	3.2	3.2	1.6	16.8
Sweden	22.3	17.7	2.7	14.5	3.1	4.5	3.2	10.7
Turkey	33.6	20.5	13.3	21.3	14.7	11.5	6.2	17.2
United Kingdom	20.3	16.1	1.9	6.6	1.5	1.3	0.7	5.1
EU-26	**26.5**	**18.7**	**3.6**	**14.8**	**5.9**	**4.6**	**2.7**	**12.3**

Note: * Data not reliable. Data not available for France and Belgium. The sums per row do not add up since multiple reasons can be mentioned. The share in the column "combination of a, b, c, or d" can be lower than the share in columns (a) to (d) because the denominator of the proportions may differ.

Source: Eurostat indicators hlth_ehis_un1e and hlth_ehis_un2e based on EHIS2014.

Social inequalities in unmet needs exist in virtually all countries. Looking at episodes when people did not receive medical care due to cost (Figure 3), the less well-off are three times more likely to have unmet needs than people with high income due to cost (14% among the lowest income quintile did not receive care due to cost, versus 4% in the highest) (OECD, 2019a). The difference between the lowest and the highest income groups exceeds 10 percentage points in 10 countries.

Figure 3. Unmet needs for medical care due to cost in the past 12 months, by income level, EHIS 2014



Note: Share of people reporting not receiving medical care due to cost, as percentage of those who had needs for health care. Ordered by increasing share of unmet needs for the total population. In Sweden, the proportions are calculated over the total adult population (including both people with and without care needs). The analysis excludes those individuals who did not report income. Note that Figure 3 cannot be directly compared with Figure 1 as the indicators differ as explained in this document, while similarities in country ranking are found in the conclusion.
Source: OECD calculations based on EHIS data.

Commonwealth Fund International Health Policy Survey

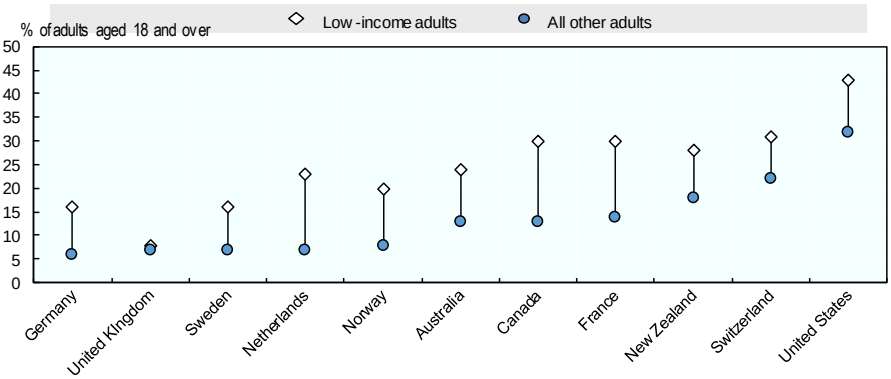
The 11 European and non-European countries participating in the Commonwealth Fund Survey collect data on unmet care needs for doctor visits, medical tests, prescribed pharmaceutical drugs and dental care due to cost.

The average proportion of unmet needs for medical care varies between 7% and 33% of adults across the 11 countries in 2016 (Table 2). The largest proportions of unmet needs were reported by people in the United States, while the shares were the lowest in the United Kingdom and Germany, followed by the Netherlands and Sweden.

Social disparities in unmet needs due to cost are significant in nearly all countries, with the exception of the United Kingdom. The share of unmet needs is significantly higher among low-income people , with the largest gaps observed in France, Canada and the United States (Figure 4).

Unmet needs for dental care are reported by a larger share of the population, because dental care among adults is less covered or not covered by public health insurance in many countries. Unmet needs for dental care range between 11% in the Netherlands and the United Kingdom to more than one quarter of the population in Canada (28%) and the United States (32%) (Table 2).

Figure 4. Unmet needs for doctor consultations, medical test and treatment, or prescribed medicines due to cost, Commonwealth Fund Survey 2016



Note: Unmet needs for doctor consultations, medical test and treatment, or purchasing prescribed medicines (due to financial reason), in the past 12 months. “Low income” defined as household income less than 50% the country median.
Source: Commonwealth Fund International Health Policy Survey, 2016.

Table 2. Share of people reporting unmet care needs due to cost, Commonwealth Fund Survey 2016
% of all respondents

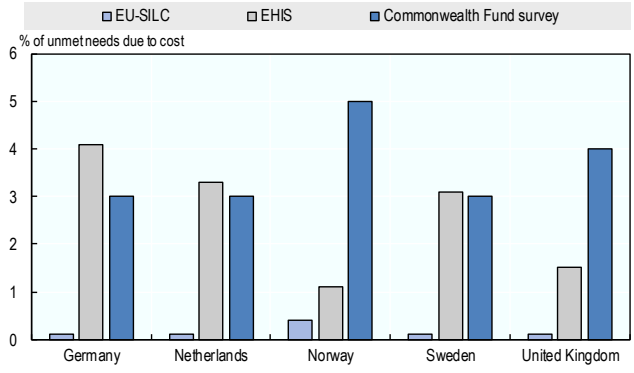
Country	Unmet needs for medical care				Unmet needs for dental care
	Any type of medical care (a, b or c)	Doctor visit (a)	Test or treatment (b)	Prescribed medicines (c)	
Australia	14	9	7	6	21
Canada	16	6	6	10	28
France	17	9	13	4	23
Germany	7	3	5	3	14
Netherlands	8	3	4	4	11
New Zealand	18	14	10	6	22
Norway	10	5	4	3	22
Sweden	8	3	3	6	19
Switzerland	22	16	10	9	21
United Kingdom	7	4	3	2	11
United States	33	22	19	18	32

Note: Unmet needs due to cost (for several types of care).
Source: OECD estimates based on the Commonwealth Fund International Health Policy Survey 2016.

Comparing the results of the three international surveys on unmet needs for health care

The level of comparability of data across the three international surveys is very limited because of differences in approaches and methods (Box 2). Comparing the most detailed level of information across the three surveys is possible by considering unmet needs for medical care due to cost in the five countries that are included in the three surveys (Germany, Netherlands, Norway, Sweden, and the United Kingdom) (Figure 5).

Figure 5. Comparison of unmet needs for medical care due to cost across the three surveys



Note: See the aforementioned differences in the methodology.
Source: EU-SILC 2018; EHIS 2014; Commonwealth Fund International Health Policy Survey, 2016.

The level of unmet needs for medical care in EU-SILC (compared to EHIS and the Commonwealth Fund survey) is systematically lower in all five countries. Beyond this, the level in the Commonwealth Fund Survey is higher compared to EHIS in Norway and the United Kingdom, lower in Germany, and roughly equal in the Netherlands and Sweden. This comparison sheds light on inconsistencies across countries and across surveys that are difficult to explain. Part of these differences in results arise from the aforementioned five differences in the methodology. Specifically, one of the explanations for the low rates using EU-SILC is that in this survey, respondents must select only the main reason when reporting unmet needs. If they select 'waiting time' or 'distance' as the main reason while they also experienced the cost barrier, the data then do not capture the right level of unmet needs due to cost in the overall population.

Conclusion: Despite differences in survey approaches, a consistent picture emerges

Despite the differences in the level of unmet needs across surveys, a few consistent messages can be derived, namely:

- There are important social disparities in unmet needs shown across all three data sources.
- Both European surveys consistently show that levels of unmet needs for financial or other reasons are higher in Estonia, Finland, Greece, Iceland, Latvia, Poland, and Turkey.
- The cost of health care remains one of the main reasons for not receiving care, particularly among people in the lowest-income groups.
- Unmet needs for dental care are generally greater than for medical care, and also deserve policy attention.

While there is certainly room to achieve further harmonisation in the measurement of unmet needs across national and international surveys, this should not divert attention to policy responses to address the barriers in access to care.

Box 2. Methods and approaches to measure unmet care needs vary across surveys

1. EU-SILC approach

The European Union Statistics on Income and Living Conditions (EU-SILC) is a survey carried out every year since 2005 across all EU countries, Iceland, Norway, and Switzerland (European Free Trade Association -EFTA-countries), as well as candidate countries to the EU, under the coordination of Eurostat, with data on unmet needs available since 2008. The module on unmet needs for health care focusses on medical examination or treatment, and offers a number of possible choices for the main reason for such unmet needs, including reasons related to the health system (too expensive, waiting times and distance to services) and more personal reasons.

A first question relates to the episodes when people did not receive care they really needed, and then it asks for the main reason for not receiving care. Two separate questions relate to medical and dental care. Importantly, the EU-SILC questions do not allow for a distinction between people who had or did not have health care needs.

EU-SILC questions related to unmet needs:

Was there any time during the last 12 months when you personally, really needed a medical examination or treatment for a health problem but you did not receive it?

- ► Yes
- ► No

What was the main reason for not receiving the medical examination or treatment?

1. Could not afford to (too expensive)
2. Waiting list
3. Could not take time off work/ from caring for children
4. Too far to travel or no means of transport
5. Fear of doctor/examination/treatment
6. Wanted to wait and see if problem got better on its own
7. Didn't know any good dentist
8. Other reason

Was there any time during the last 12 months when you personally, really needed a dental examination or treatment but did not receive it?

- ► Yes
- ► No

Same question about the main reason as above.

2. EHIS approach

The European Health Interview Survey (EHIS) is conducted once every five to six years by all EU countries, Iceland and Norway, under the coordination of Eurostat. While the first wave in 2008 did not include a module on unmet health care needs, the second wave in 2014 included such a module, and this module has been included again in the third wave in 2019 (with the data expected to become available in 2021).

The way the questions are formulated tends to make respondents think about barriers in access to care and recall better the occasions where they could not receive care. The first two questions deal with 'experiencing a delay' due to waiting times or distance that the interviewer instruction defines as episodes where care was not received soon enough or not at all. The third question relates to not receiving care because of the cost. The term 'health care' is not further defined in the first two questions, while, in the third question, it explicitly refers to medical care, dental care, prescribed medicines, or mental health care.

EHIS questions related to unmet needs:

Have you experienced delay in getting health care in the past 12 months because the time needed to obtain an appointment was too long?

- ► Yes
- ► No
- ► No need for health care

Have you experienced delay in getting health care in the past 12 months due to distance or transport problems?

- ► Yes
- ► No
- ► No need for health care

Was there any time in the past 12 months when you needed the following kinds of health care, but could not afford it?

- ► Yes [for …]
- ► No [for …]
- ► No need [for …]

By type of care

- Medical care
- Dental care
- Prescribed medicines
- Mental health care

Box 2. Methods and approaches to measure unmet care needs vary across surveys (continued)

3. Commonwealth Fund survey approach

The Commonwealth Fund has conducted since 1998 a population-based International Health Policy Survey about once every three years in selected OECD countries, with the most recent survey of the adult population conducted in 2016 in 11 countries (Australia, Canada, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland, United Kingdom and United States). The 2016 Commonwealth Fund survey covers adults aged 18 and over. The module on access to care contains a series of questions related to financial barriers.

Commonwealth Fund survey questions related to access problem related to cost:

During the past 12 months, was there a time when you had a medical problem but did not consult with a doctor because of the cost?

- Yes
- No

During the past 12 months, was there a time when you skipped a medical test, treatment, or follow-up that was recommended by a doctor because of the cost?

- Yes
- No

During the past 12 months, was there a time when you did not fill a prescription for medicine, or you skipped doses of your medicine because of the cost?

- Yes
- No

During the past 12 months, was there a time when you skipped dental care or dental check-ups because of the cost?

- Yes
- No

Disclaimers

Note by Turkey: The information in this document with reference to "Cyprus" relates to the southern part of the Island. There is no single authority representing both Turkish and Greek Cypriot people on the Island. Turkey recognises the Turkish Republic of Northern Cyprus (TRNC). Until a lasting and equitable solution is found within the context of the United Nations, Turkey shall preserve its position concerning the "Cyprus issue".
Note by all the European Union Member States of the OECD and the European Union: The Republic of Cyprus is recognised by all members of the United Nations with the exception of Turkey. The information in this document relates to the area under the effective control of the Government of the Republic of Cyprus.

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Useful Links

OECD Health Inequalities: https://www.oecd.org/health/inequalities-in-health.htm

OECD Health at a Glance: http://www.oecd.org/health/health-systems/health-at-a-glance-19991312.htm

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