

# Unmet need as an indicator of health care access

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*Summary: Ensuring adequate and fair access to health care is a priority objective for European governments. This short paper discusses the measurement, distribution and policy implications of one indicator of access to health care: self-reported unmet need or foregone care. Two international surveys – EU-SILC and SHARE – include questions on unmet need and foregone care respectively, and therefore provide an opportunity for drawing comparisons on access to health care. It appears that, overall, people who report unmet need tend to be in worse health and with lower income. However, from a policy perspective, it is important to separate the causes of unmet need into those that are more relevant to policymakers from those that reflect individuals' preferences and tastes, to view this indicator alongside other access measures such as health care contacts, distance to facilities, waiting times and supply characteristics, and to examine long-term trends in reporting unmet need and health outcomes.*

*Key words: Access, health care, unmet need, comparative research, health inequalities*

Access to safe and effective health care represents an essential determinant of health. In an effort to reduce inequalities in health, many governments have targeted the health system to improve access to health care and to more equitably distribute health services across the population.

The accessibility of health services depends on a multitude of factors that relate to the health system and also to the patients themselves. On the supply side, the design of statutory health care coverage and public benefits packages, the volume and distribution of human resources and capital, waiting times, referral patterns, booking systems, how individuals are treated within the system (continuity of care), and quality of care can affect accessibility.<sup>1-4</sup> Characteristics of patients, such

as their age, socioeconomic status, past experiences with health care, their perceptions of the benefits and quality of care, and level of health literacy may also affect their decisions to seek care.<sup>5-7</sup> Characteristics of providers have also been identified as a determinant of access, over and above indicators of clinical need.<sup>8</sup>

There are many tools that are available to monitor the accessibility of health care, and to assess the extent of inequity in access to and use of services. One relatively simple tool is the direct questioning of individuals as to whether there was a time that they needed health care but did not receive it, or whether they had to forgo health care.

## Measuring unmet need

Self-reported unmet need for health care in the past twelve month period is included in two international surveys: the Survey on Health, Ageing and Retirement in Europe (SHARE) of individuals aged 50 years and older, and the EU Survey of Income and Living Conditions (EU-SILC) of residents of private households aged sixteen years and older. These surveys present opportunities for cross-country comparative research on access to health care. However, the survey questions on unmet need differ,

as do the samples. The phrasing of the question in EU-SILC is as follows: "Was there any time during the last twelve months when, in your opinion, you personally needed a medical examination or treatment for a health problem but you did not receive it?" Follow-up questions include the reasons for unmet need. Among these possible reasons for 'unmet need' are those that are important from a policy perspective, such as the individual could not afford to (costs) and waiting lists, but also those that are less clearly relevant to policymakers, such as that the respondent wanted to wait to see if the problem got better on its own, didn't know any good doctor, fear of doctors, and could not take the time.

In SHARE the question focuses on care forgone either due to costs or unavailability of care. Specifically, the questions are: "During the last twelve months, did you forego any types of care because of the costs you would have to pay?" and "During the last twelve months, did you forego any types of care because they were not available or not easily accessible?" Follow-up questions then focus on the type of care (for example, physician, medicine, dental) that the individual reported to forego.

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### Prevalence of unmet need

Across Europe there is quite a wide range in the proportion of the population who report an unmet need or who report to have foregone care in the past twelve months. For any unmet need, the range is from 1.3% in Denmark to 13% in Sweden (Figure 1); reported foregone care ranges from 2.6% in the Netherlands to 16% in Israel (Figure 2). However, the diverse set of reasons for reporting unmet need (in EU-SILC) necessitates its disaggregation in order to gain meaningful information. For example, as shown in Figure 1, the prevalence of unmet need in 2004 in Sweden was 13% when all reasons are included (and 6% on average across all 15 countries surveyed), but this falls to 1.5% of the population in Sweden (and 2.4% on average across countries) when only costs and availability are included.

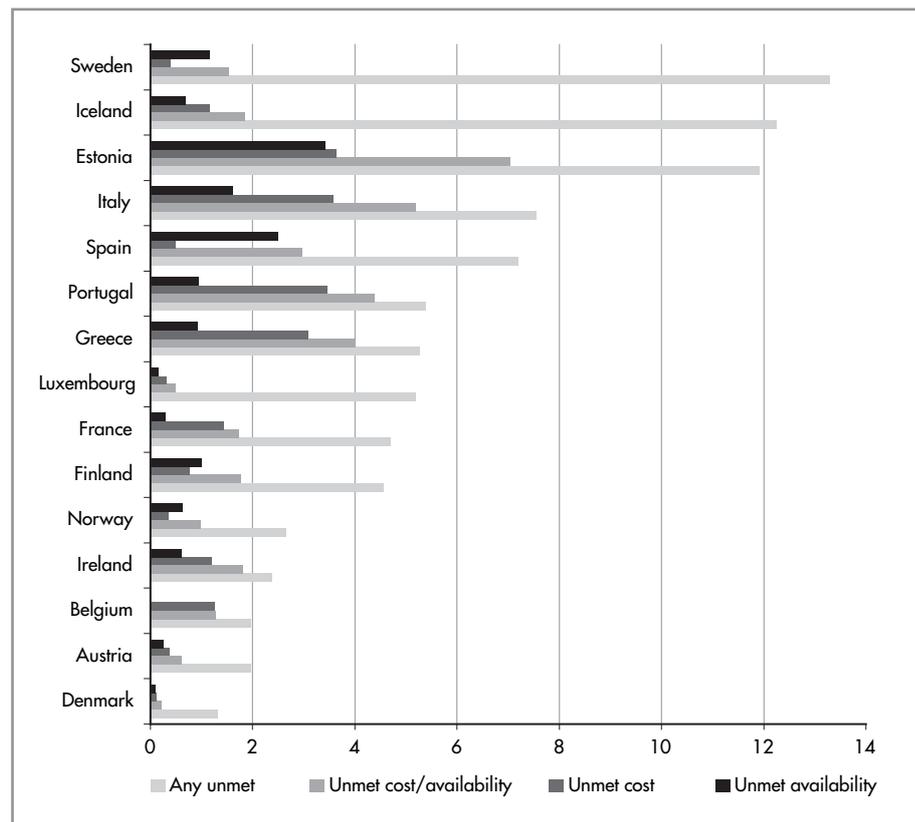
### Who reports unmet need and foregone care?

The few studies of unmet need in Europe have identified a strong association with both income and health whereby people who report unmet need tend to be in worse health and with lower income. For instance, an early study of the EU-SILC found that when reporting any unmet need (i.e. not restricted to the more policy relevant reasons), in all countries it was concentrated among those with lower income, as signaled by a negative concentration index. After adjusting for health (which tends to be worse among those with lower income), the relationship with income persists in all countries except in Luxembourg, Norway and Spain (see Figure 3).<sup>9</sup> Analyses of SHARE also show an association between foregone care and income, whereby the authors found a higher likelihood of care foregone among individuals with lower income in all countries studied,<sup>10</sup> although paradoxically the highest income groups in Sweden and to a lesser extent in Greece, showed a higher prevalence than the middle-income groups.

### Policy implications of unmet need

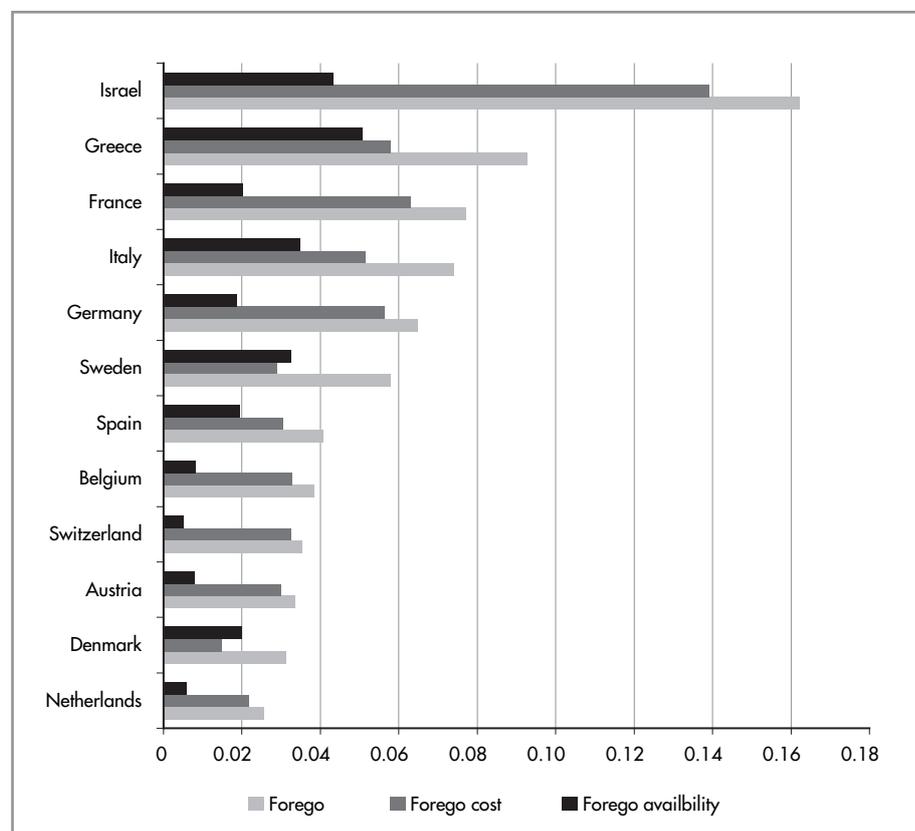
To what extent can analyses of unmet need and foregone care inform the development of policies to reduce inequalities in health and access to health care? With regards to the persistent inequalities in health that are observed between social groups in all countries in the EU, further research is needed to investigate the role that access barriers play in contributing to these inequalities. For instance, longitudinal

**Figure 1: Percentage of the population who report any unmet need, unmet need due to either costs or availability, unmet need due to availability, and unmet need due to cost**

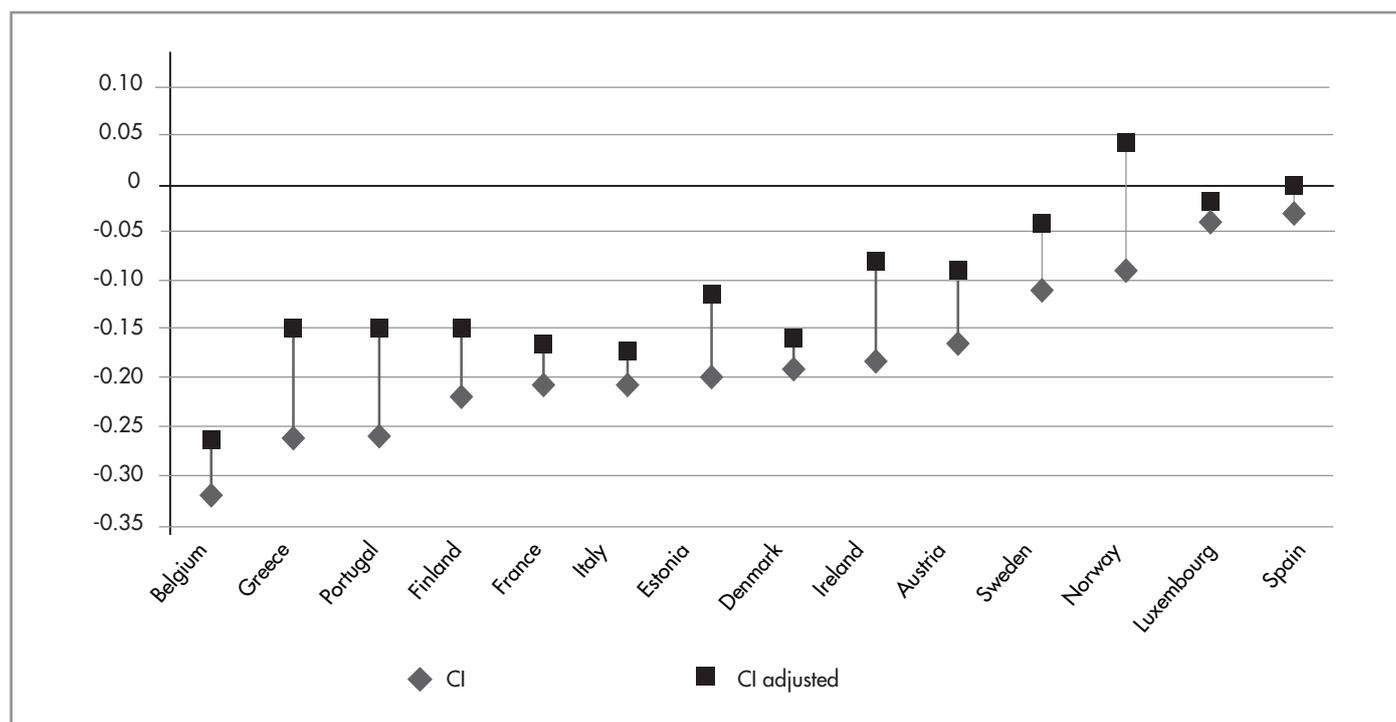


Source: Survey of Income and Living Conditions, 2004

**Figure 2: Self-reported foregone care, foregone care due to costs, and foregone care due to unavailable/inaccessible care**



Source: Survey on Health, Ageing and Retirement in Europe, 2004

**Figure 3: Concentration Indices (CI) of the concentration of unmet need by income, and the CI after adjusting for differences in health status**

Source: Adapted from Koolman X, 2007.<sup>9</sup>

analyses drawing on EU-SILC and SHARE could be undertaken to examine the impact of self-reported access barriers (through reported unmet need and foregone care) on health outcomes and the gradient of social inequalities in health; however, a sufficiently long time period is needed in order to control for the many factors that affect health, such as changes in employment status, and other life events.

Further complicating the reporting of access barriers with self-reported unmet need is the finding from preliminary research from Canada that those who report an unmet need use more than the expected level of health services compared to those who do not report this access problem but have otherwise similar levels of health.<sup>11,12</sup> This implies that unmet need may in part represent dissatisfaction with the health system; this is consistent with the education-gradient in reported unmet need that has also been found in Canada, whereby higher educated individuals are more likely to report unmet need.

Overall, self-reported unmet need and foregone care provide opportunities to examine inequalities in access to health care; however, disaggregation of unmet need by the stated reasons allow for a more meaningful interpretation of the indicator.

Moreover, long-term analyses would permit analyses that link information on access problems, actual use of health services, and health outcomes in order to better understand the meaning and impact of unmet need on health, and health inequalities.

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