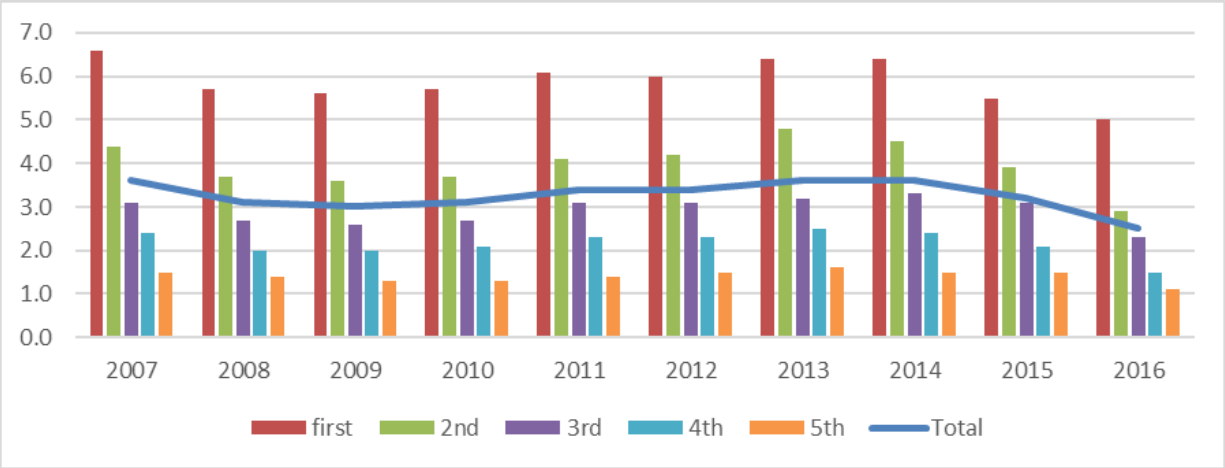
Healthcare

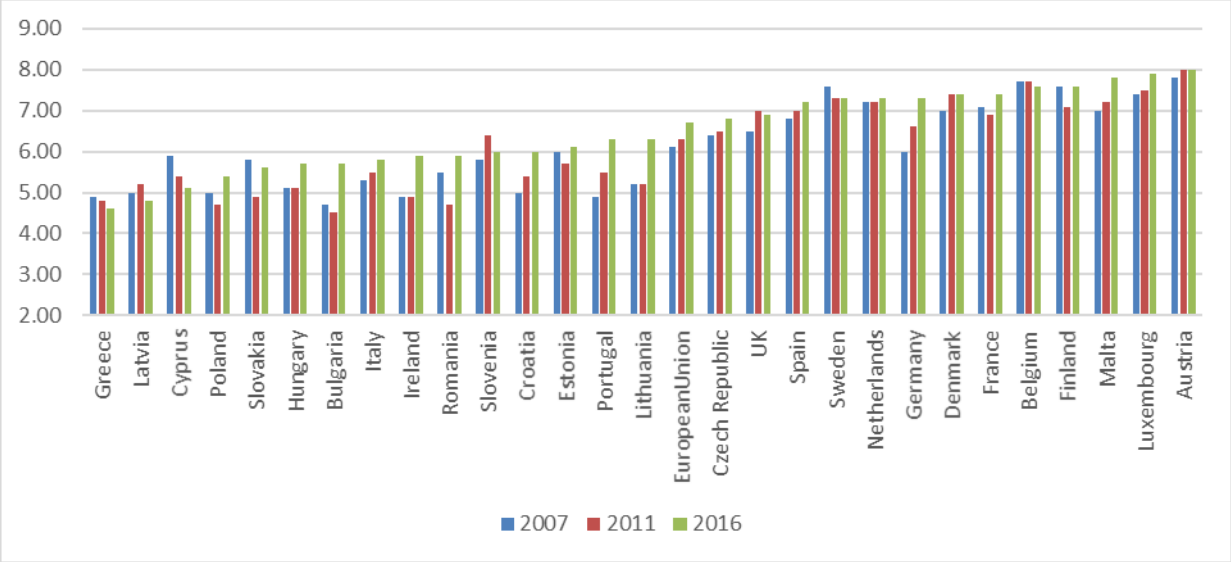
Chart 2.1: Self-Reported Unmet Need for Medical Examination or Treatment due to Problem of Access (%), EU-28. 2007-2016, by Income Quintile



Source: Eurostat, [tsdph270/ hlth_silc_08]

Notes: Reasons associated with problems of access: 'could not afford to, waiting list, too far to travel'.
Rates prior to 2010 refer to EU27.

Chart 2.2: European Quality of Life Survey: Perceived Quality of Health Services, 2007, 2011, 2016



Source: Eurofound 2017f (online database, EQLS, Data visualisation, year 2016) and Eurofound 2017e, Table 12, p 54.

Note: Rating on a scale 1–10, where 1 means very poor quality and 10 means very high quality.

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Eurostat publishes rates of self-reported unmet need defined as the share of the population perceiving an unmet need for medical examination or treatment. This is one of the social protection indicators used in the social protection performance monitor (SPPM) by the EU's Social Protection Committee.

A number of reasons may be given for inability to avail of medical treatment but, in this case, we look at reasons associated with problems of access (could not afford to, waiting list, too far to travel). The average rate of perceived unmet need for medical treatment (due to difficulties with access) was falling up until 2009 when it started to increase again. It rose from 3% (EU27) in 2009 to 3.6% in 2013 and 2014 (EU28). It has fallen since to 2.5% in 2016.

However, as Chart 2.1 shows, the perception is very different between different income quintiles with more perceived unmet need in the poorer quintiles. As in previous years, in 2016, it was least perceived in the top (or 5th) quintile (1.1%) and most in the bottom quintile (5%) (2016). As the EU's Social Protection Committee (2017) notes, there is a clear income gradient as those in the lowest income quintiles more often report an unmet need for medical care, and the gap between the lowest and highest quintiles rose during the crisis years. However, even though the gap remains between the poorest people and the wealthiest, comparison between 2015 and 2016 shows some reduction in the rate across all quintiles: -0.5 percentage points (1st quintile); -1 percentage points (2nd quintile); -0.8 percentage points (3rd quintile); -0.6 (4th quintile); -0.4 percentage points (fifth quintile).

The situation is also different between countries. According to the latest annual report from the EU's Social Protection committee (2017), ten Member States have a key challenge concerning access to health market supports in regional economic policy. care, based on self-reported unmet needs for medical care again due to cost, waiting time, or distance (Estonia, Greece, Finland, Hungary, Ireland, Italy, Lithuania, Latvia, Poland and Romania).

Divergences between countries are highlighted in a recent report from the OECD (2017), evidencing very different waiting times in different countries for different kinds of procedures or elective surgeries. For example, the average waiting time for cataract surgery in the Netherlands is, at one end of the scale, 37 days, but it is 464 days in Poland at the other (looking at EU countries only). Similarly, the Netherlands has the lowest waiting times for hip replacements (42 days) while Estonia (290 days) and Poland (405 days) have the highest.

Another health indicator comes from the European Quality of Life Survey (carried out at the end of 2016), which found that how people rated the quality of public services had improved overall since 2011 (See Chart 2.2). In particular, satisfaction with healthcare and childcare improved in several countries where ratings were previously low. But, unfortunately, in several countries, participants rated the quality of health services less favourably in 2016 than in 2011 (Latvia, Slovenia, Cyprus, Greece, UK and Belgium). Thus, the perceived quality of public services still varies markedly across EU countries.

Policy Priorities

- Invest in community-based healthcare schemes (such as Sláintecare in Ireland) to help alleviate the 'two-tiered' system of healthcare; this would both reduce costs associated with accessing healthcare facilities (e.g. travel) and alleviate waiting lists for acute services.