

Financial and geographic access to care

Most OECD countries have achieved universal (or near-universal) coverage for a core set of health services, which usually include consultations with doctors and hospital care. National health systems or social health insurance are used to achieve universal health coverage, though a few countries (the Netherlands and Switzerland) have done so through compulsory private health insurance. Some affordability or accessibility issues can hinder the use of health services. These are mostly related to out of pocket (OOP) payments, distance to health services or waiting times for appointments.

Unmet needs for health care are a relevant indicator of access barriers. The EU Statistics on Income and Living Conditions (EU-SILC) survey asks respondents whether they forewent a medical examination in the past 12 months for different reasons. In 2018, 2.7% of the population in OECD European countries experienced unmet health care needs due to costs, distance or waiting times. This proportion rose to 4.6% for lower income citizens. On average, 16.4% of respondents in Estonia and 8.8% in Greece reported unmet care needs. Income inequality in access to care is highest in Greece, Latvia, Turkey and Belgium.

Across OECD countries, an average household spent almost 3% directly from its income on medical services in 2017 (a proportion that has remained stable since 2013). OOP spending is highest in Switzerland and Korea where households spend over 6% of their income on health services. In France, Luxembourg and Slovenia, households spend less than one-third than Swiss households spend.

Policies can contribute to lowering the financial burden on households. In the Slovak Republic, the share of OOP has decreased since 2013, following the introduction of policies to limit such payments for people with chronic conditions and vulnerable groups, as well as tightening the rules on additional charges by private providers (OECD and European Observatory, 2017a). In Latvia, the Safety Net and Social Sector Reform Programme reduced OOP payments for low-income households between 2009 and 2011, which exempted them from co-payments and subsidised pharmaceuticals. After 2011 the programme narrowed its scope to target specific patient groups, increasing direct payments and reverting OOP to 2009 levels (OECD and European Observatory, 2017b).

The under-supply of physicians can lead to longer waiting times or patients having to travel far to access services (OECD, 2019). The overall number and geographic distribution of doctors varies across OECD countries. In 2017, there were 2 active physicians per 1 000 population in Korea, Poland and Turkey, whereas this number was much greater in countries like Austria and Greece. In many countries such as Greece, the Czech Republic, the Slovak Republic and the United States, there is a large concentration of physicians in the national capital region.

Methodology and definitions

Data on unmet care needs come from the EU-SILC survey, which asks respondents whether, at any point in the 12 months before the interview, they felt they needed a medical examination and did not receive it. Data only present the number of respondents who could not get it because of distance, waiting times or costs. Low income represents the poorest quintile of the population, while high income is the richest quintile.

OOP payments are costs that patients cover directly from their income when medical services or treatments are not included in the collectively financed benefit package of public or private health insurance schemes or are only partially included (co-payments). They also include estimations of informal payments to health care providers in some countries.

The number of physicians includes general practitioners and specialists actively practicing medicine during the year, in both public and private institutions. The data for Greece and Portugal also include those who are not practicing (resulting in a large over-estimation). Physician density is defined as the ratio between the number of physicians and the population in a region.

Further reading

OECD (forthcoming), *Health at a Glance 2019: OECD Indicators*, OECD Publishing, Paris.

OECD/European Observatory on Health Systems and Policies (2017), *Slovak Republic: Country Health Profile 2017*, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels, <https://doi.org/10.1787/9789264283541-en>.

OECD/European Observatory on Health Systems and Policies (2017), *Latvia: Country Health Profile 2017*, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels, <https://doi.org/10.1787/9789264283466-en>.

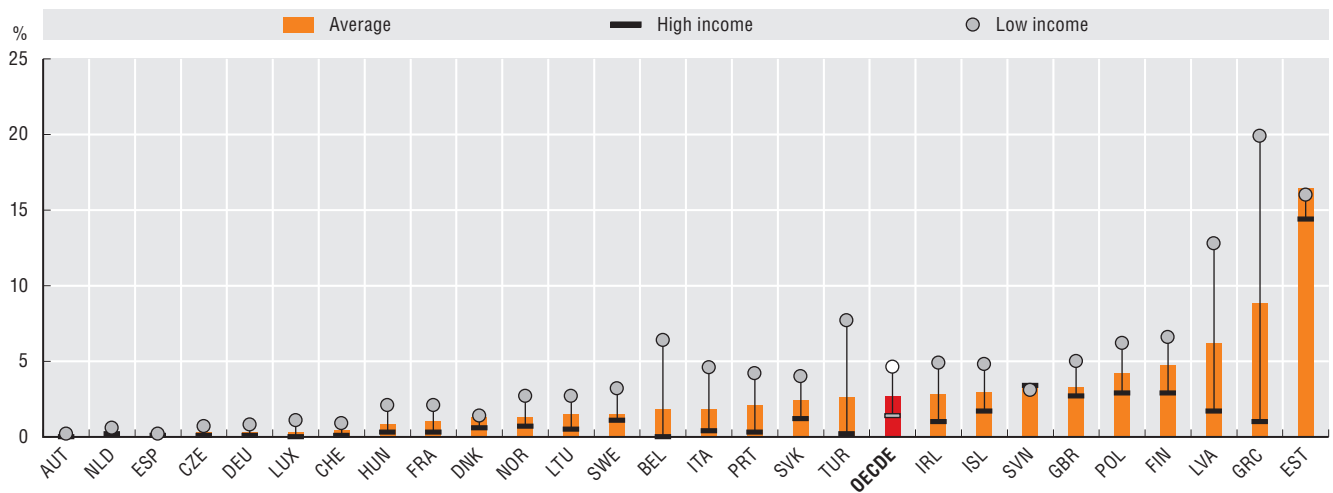
Figure notes

11.5. Data for France, Germany, Ireland Lithuania, Luxembourg, Norway, Switzerland, and the United Kingdom are for 2017; for Iceland are for 2016 instead of 2018.

11.6. Data for Australia, Brazil, Costa Rica and Russia are for 2016 instead of 2017. Data for Chile and Turkey are not displayed On data for Israel, see <http://doi.org/10.1787/888932315602>.

11.7. Data for Estonia, Finland, Greece, Italy, Japan, Lithuania, Slovenia, Sweden, Turkey, the United States. New Zealand and the United Kingdom for 2010 instead of 2015. Data for Russia are for 2014 and China are for 2013. Territorial level 2 consists of macro-regions (e.g. provinces). On data for Israel, see <http://doi.org/10.1787/888932315602>.

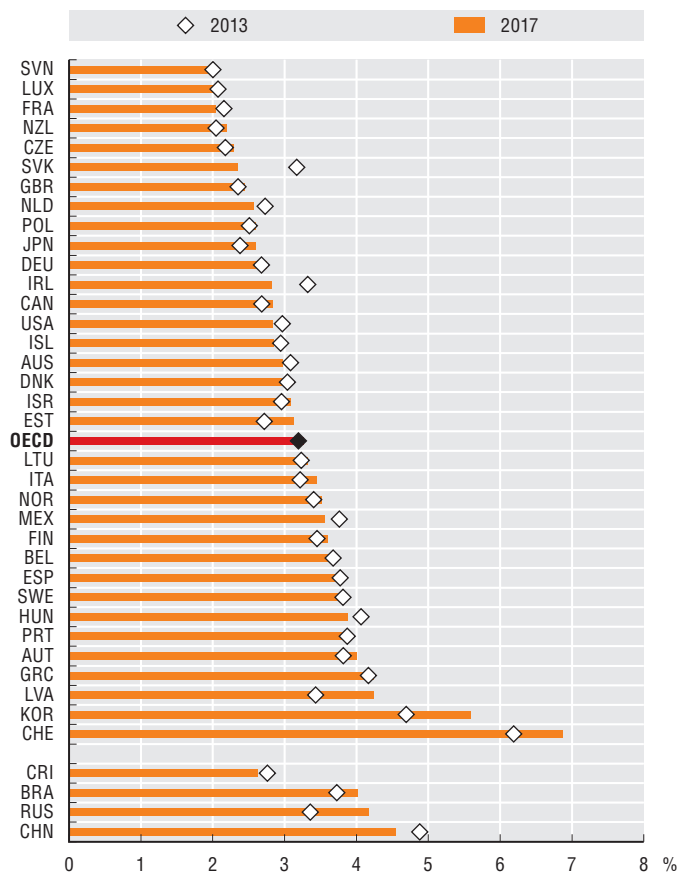
11.5 Unmet care needs for medical examinations by income level, 2017



Source: European Union Statistics on Income and Living Conditions (EU-SILC) (database), 2019

StatLink <https://doi.org/10.1787/888934033498>

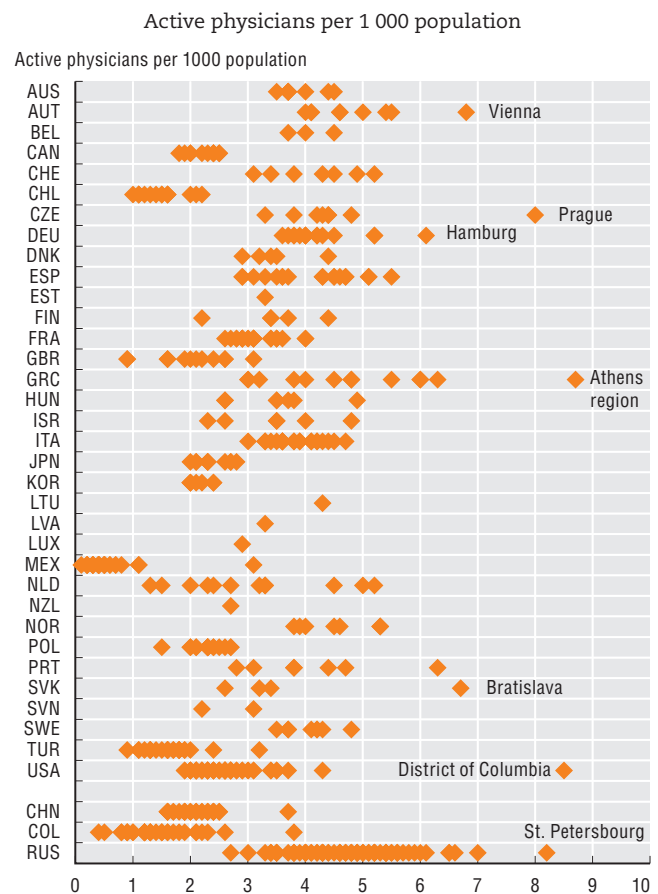
11.6 Out-of-pocket medical expenditure as a share of final household expenditures, 2013 and 2017



Source: OECD (2019) Health Statistics (database) OECD (2019) National Accounts Database, 2019

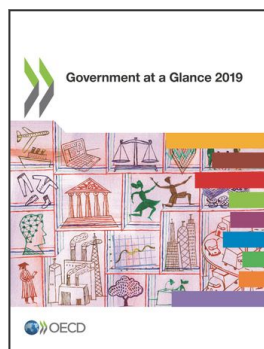
StatLink <https://doi.org/10.1787/888934033517>

11.7 Physician density by Territorial Level 2 regions, 2015 or latest available year



Source: OECD (2019), OECD Health Statistics (database).

StatLink <https://doi.org/10.1787/888934033536>



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