WKC Evidence Summary
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World Health Organization
Centre for Health Development

Inequality in unmet healthcare and social care needs in Europe

OBJECTIVES

This study aims to:

1. measure the prevalence of self-reported unmet healthcare needs in the population and unmet social care needs, only among older people aged 65+ years, across European countries;
2. identify the main reasons for unmet healthcare needs across European countries; and
3. assess country-level correlations between the prevalence of self-reported unmet healthcare needs and social care needs (among older people) and the UHC service coverage index.

Summary

- To ensure universal access to necessary care, measuring the gap between 'the services judged necessary and the services received' or unmet needs is crucial. This study measures the prevalence of self-reported unmet healthcare and social care needs and their correlation with the universal health coverage (UHC) service coverage index across European countries.
- We analysed the European Health Interview Survey (EHIS) Wave 3, conducted in 2019. We studied unmet healthcare needs among individuals aged 15+ years in 27 countries and social care needs among individuals aged 65+ years in 28 countries. Individuals with unmet healthcare needs were defined as individuals facing barriers in accessing healthcare among those with needs, while individuals with unmet social care needs were defined as respondents needing (more) help, irrespective of whether help has actually been received, among those with at least one activities of daily living (ADL) or instrumental activities of daily living (IADL) limitation.
- Overall, 24.4% of persons 15+ years old reported unmet healthcare needs, while the prevalence of unmet social care needs among those 65 and above was 35.4% and 30.8% for ADL and IADL needs, respectively. The age-disaggregated analysis showed no clear pattern of unmet healthcare needs across different age groups in European countries. However, older age groups, 70 and above, had a consistently higher prevalence of unmet ADL and IADL needs in all countries.
- Waiting time was the main reason for unmet healthcare needs in most countries, followed by cost and transportation/distance.
- The findings related to the correlation between the UHC service coverage index and unmet care needs were inconclusive. The strength of association with unmet healthcare needs was weak and the direction of the association was inconsistent across age groups. For unmet social care needs, a consistent negative correlation with the UHC service coverage index was observed, but the strength of association reached a moderate level only for unmet ADL needs.

Measuring unmet healthcare need

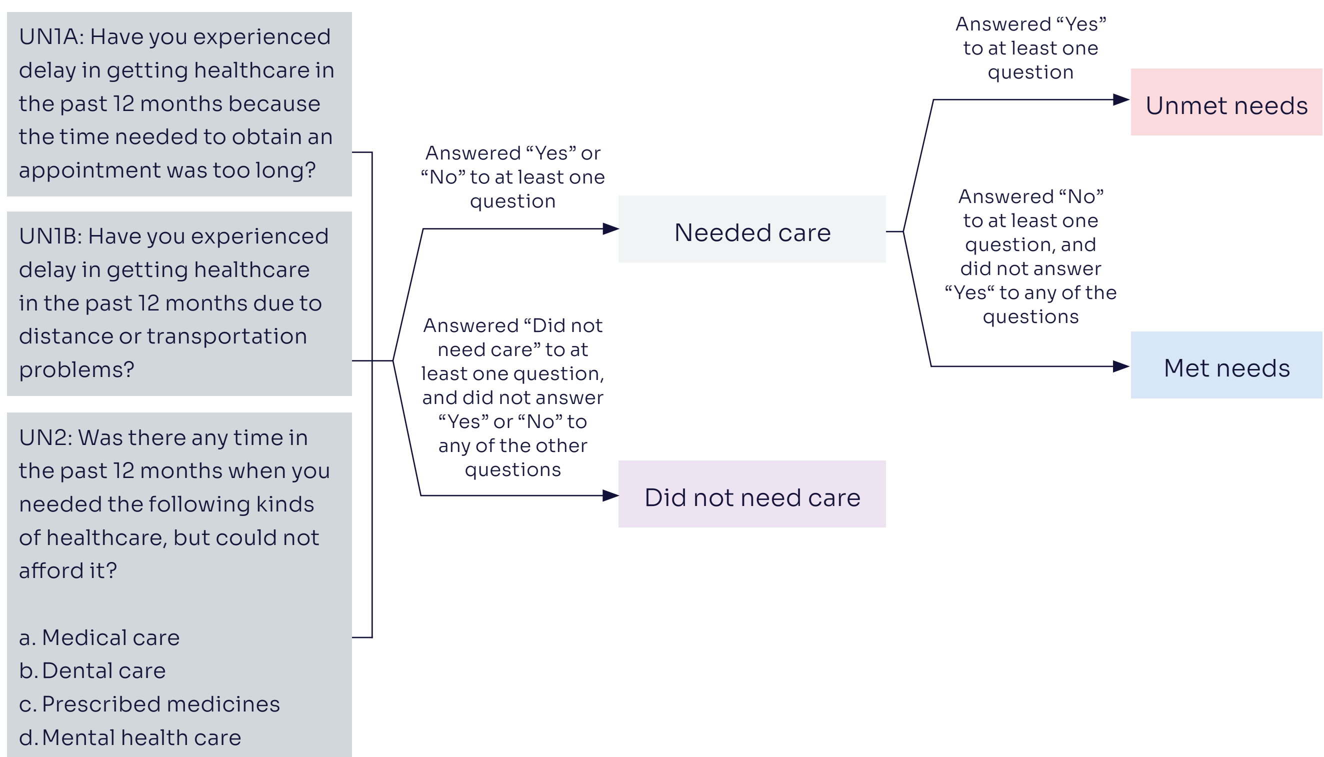
If a respondent reported experiencing at least one instance of delayed or foregone healthcare in the past 12 months, they were defined as having an unmet healthcare need.

Methods

This study utilised data from the European Health Interview Survey (EHIS) Wave 3 collected in 29 countries in 2019, focusing on the population aged 15+ years in private households.[1]

In EHIS, respondents were asked if they experienced any barrier(s) to accessing healthcare, related to long waiting times, distance/transportation, and costs. The prevalence of unmet healthcare needs was defined as the proportion of individuals who reported experiencing at least one barrier in getting healthcare in the past 12 months among those with needs (Figure 1). As the questions on unmet healthcare needs were not asked in Belgium and Serbia, only 27 countries were included in the analysis.

Figure 1. Construction of unmet healthcare needs variable using EHIS Wave 3



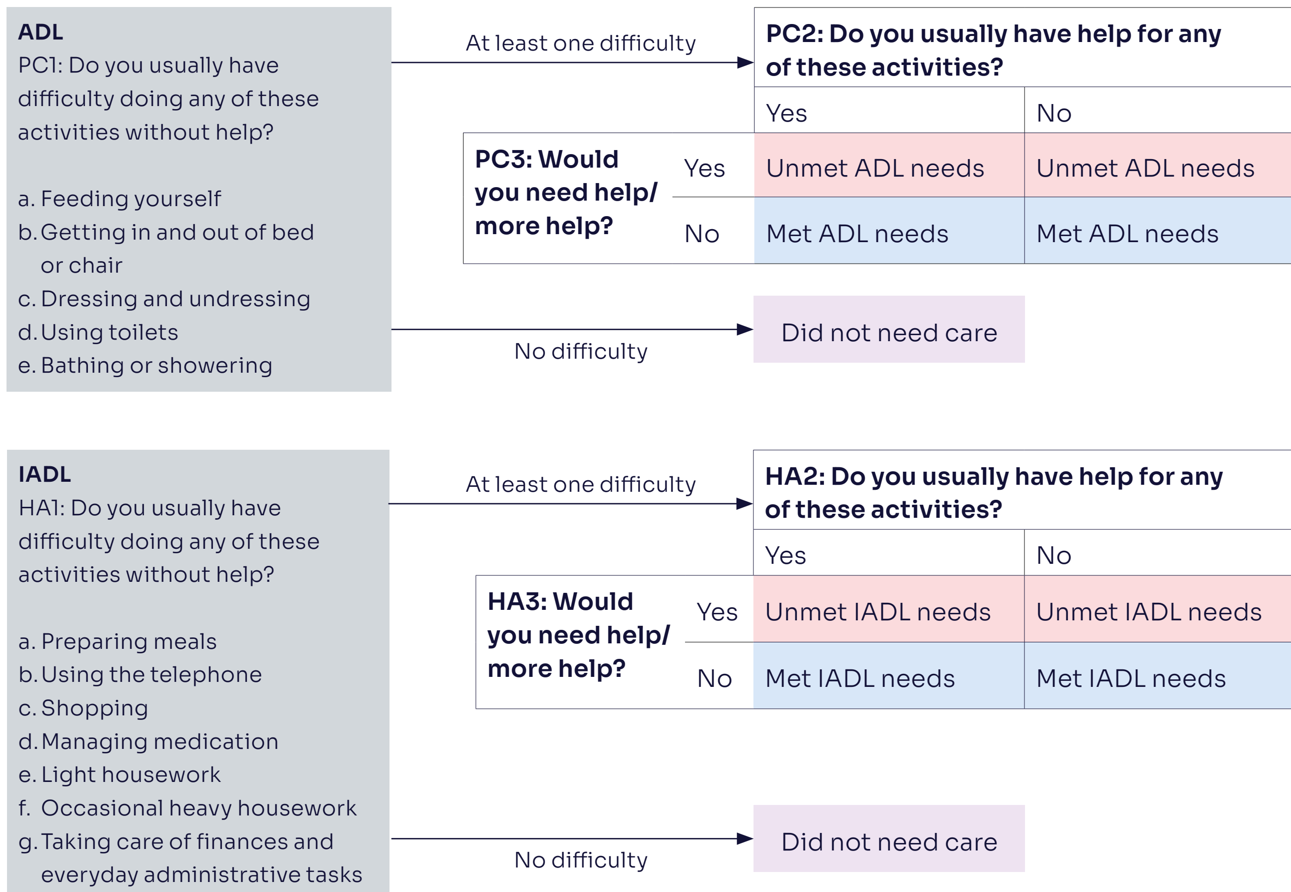
Measuring unmet social care need

If a respondent reported at least one ADL or IADL limitation and said they would need (more) help, they were defined as having an unmet social care need, irrespective of whether they currently receive any help or not.

EHIS also assessed unmet social care needs based on the ADL and IADL assessments among respondents aged 65+ years across 28 countries, excluding Serbia. Those reporting at least one ADL or IADL limitation received two more questions about whether they usually receive help with one or more self-care activities and whether they perceive the need for help or more help (Figure 2). The proportion of unmet social care needs was calculated as the number of respondents who reported needing (more) help among those who reported at least one ADL or IADL limitation, respectively, regardless of their actual receipt of care.

We estimated unmet health care needs across four age groups with more attention to older age groups (<60, 60–64, 65–69, and 70+) and unmet social care needs across two older age groups (65–69, 70+). The study also utilised the 2023 UHC service coverage index, a summary index of 14 tracer indicators of essential health services, published by the World Health Organization, to assess the association between the prevalence of unmet health and social care needs and the UHC service coverage index at the country level.

Figure 2. Construction of unmet social care needs variable in EHIS Wave 3

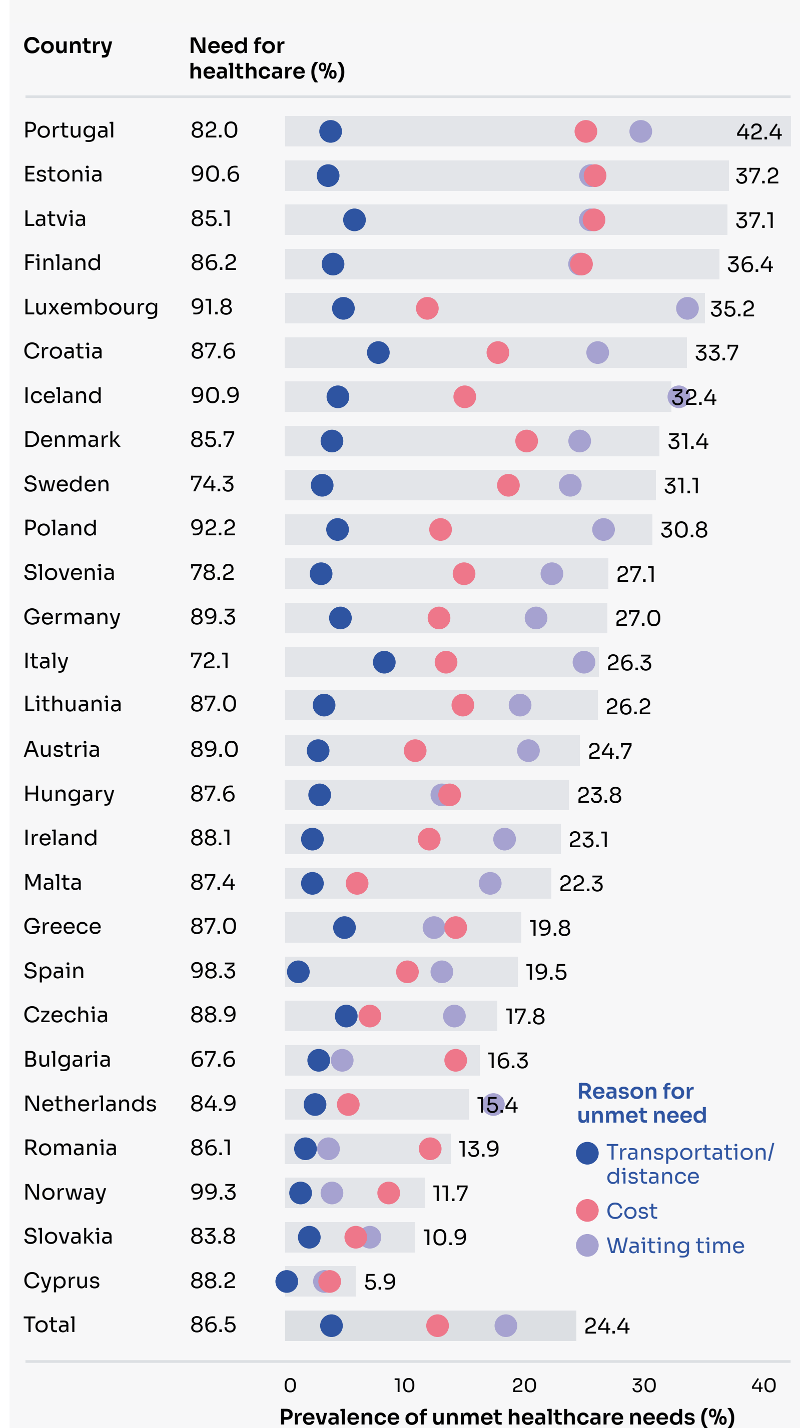


Results

Self-reported unmet healthcare needs in European countries

- The prevalence of unmet healthcare needs ranged from 5.9% (Cyprus) to 42.4% (Portugal), with an overall prevalence of 24.4% (Figure 3).
- While more than 99% of respondents in Norway reported having a need for healthcare in the past 12 months, the prevalence of unmet healthcare needs was relatively low at 11.7%, indicating that most of its population accessed healthcare services when needed.
- A long waiting time was observed as a major barrier to accessing healthcare (availability), followed by cost (affordability) and transportation/distance (accessibility). Long waiting times were noticeable, especially in Luxembourg and Iceland.
- Generally, the pattern of unmet healthcare needs was unclear across different age groups (results not shown). Countries in the Northern and Western regions, for example, Denmark or Germany, reported higher unmet healthcare needs among younger age groups (<60 years and 60–64 years), whereas older age groups (65–60 and 70+ years) were found to have a higher prevalence of unmet needs in the Southern and Eastern regions, for example, Croatia or Romania.

Figure 3. Prevalence of self-reported need and unmet needs for healthcare among the population aged 15+ years in 27 European countries, EHIS Wave 3, 2019

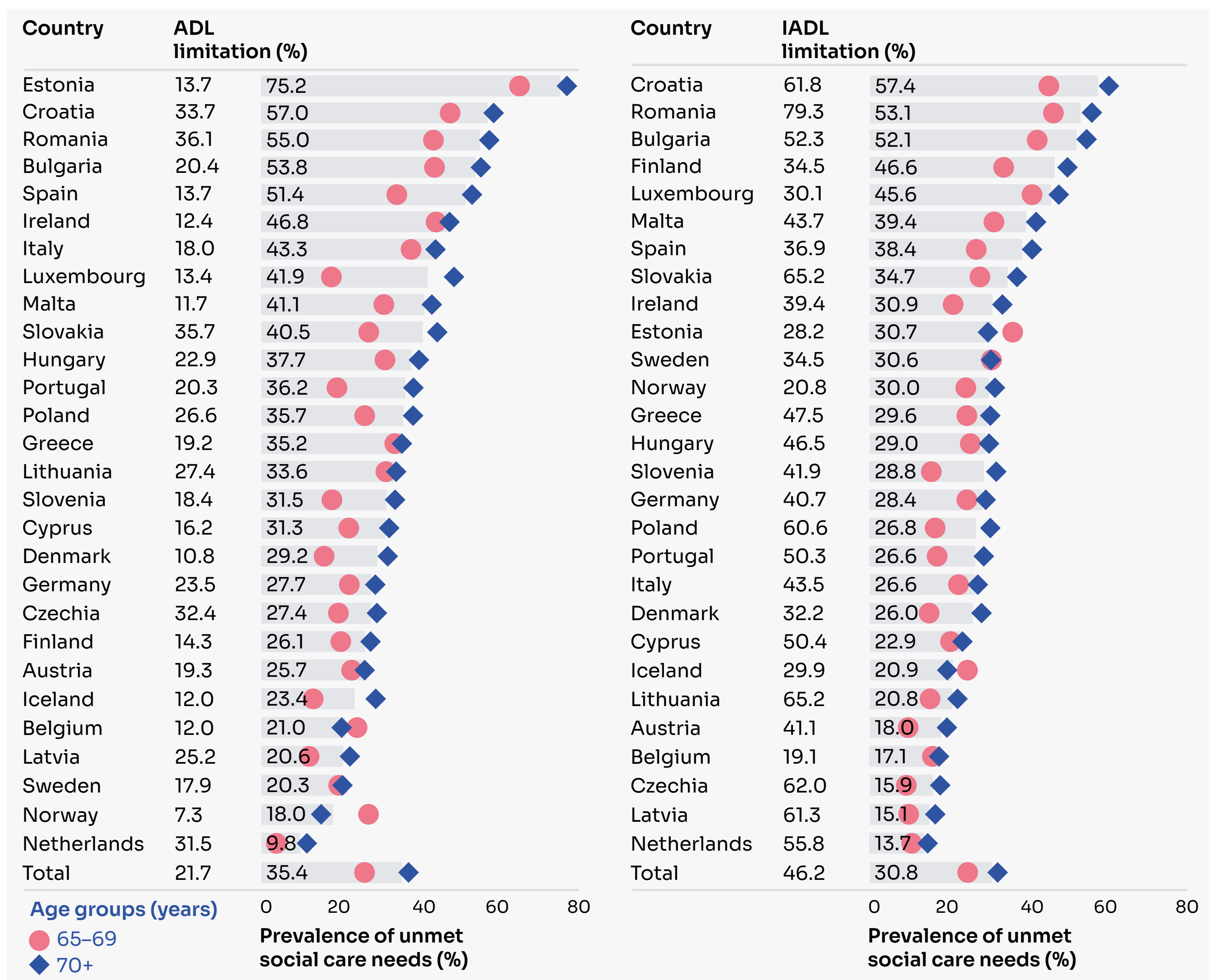


Notes: Unmet healthcare needs is defined as the proportion of respondents who perceived that their need for health care was unmet among respondents with healthcare needs. Dots represent the proportion of those with unmet health care needs who cited that particular barrier as one of the reasons for the unmet need (multiple selection was possible).

Self-reported unmet social care needs in the European countries

- The prevalence of unmet ADL needs among older people aged 65+ years ranged from 9.8% in the Netherlands to 75.2% in Estonia, while unmet IADL needs ranged from 13.7% in the Netherlands to 57.4% in Croatia (Figure 4).
- In general, the prevalence of unmet ADL needs was higher than that reported for IADL needs, with some exceptions.
- In nearly all countries, respondents aged 70+ years perceived higher unmet ADL/IADL needs than those aged 65–69 years. The gap in unmet social care needs between age groups tended to be more pronounced in unmet ADL needs than in unmet IADL needs.

Figure 4. Prevalence of self-reported ADL/IADL limitation and unmet social care needs among the population 65+ in 28 European countries, EHIS Wave 3, 2019

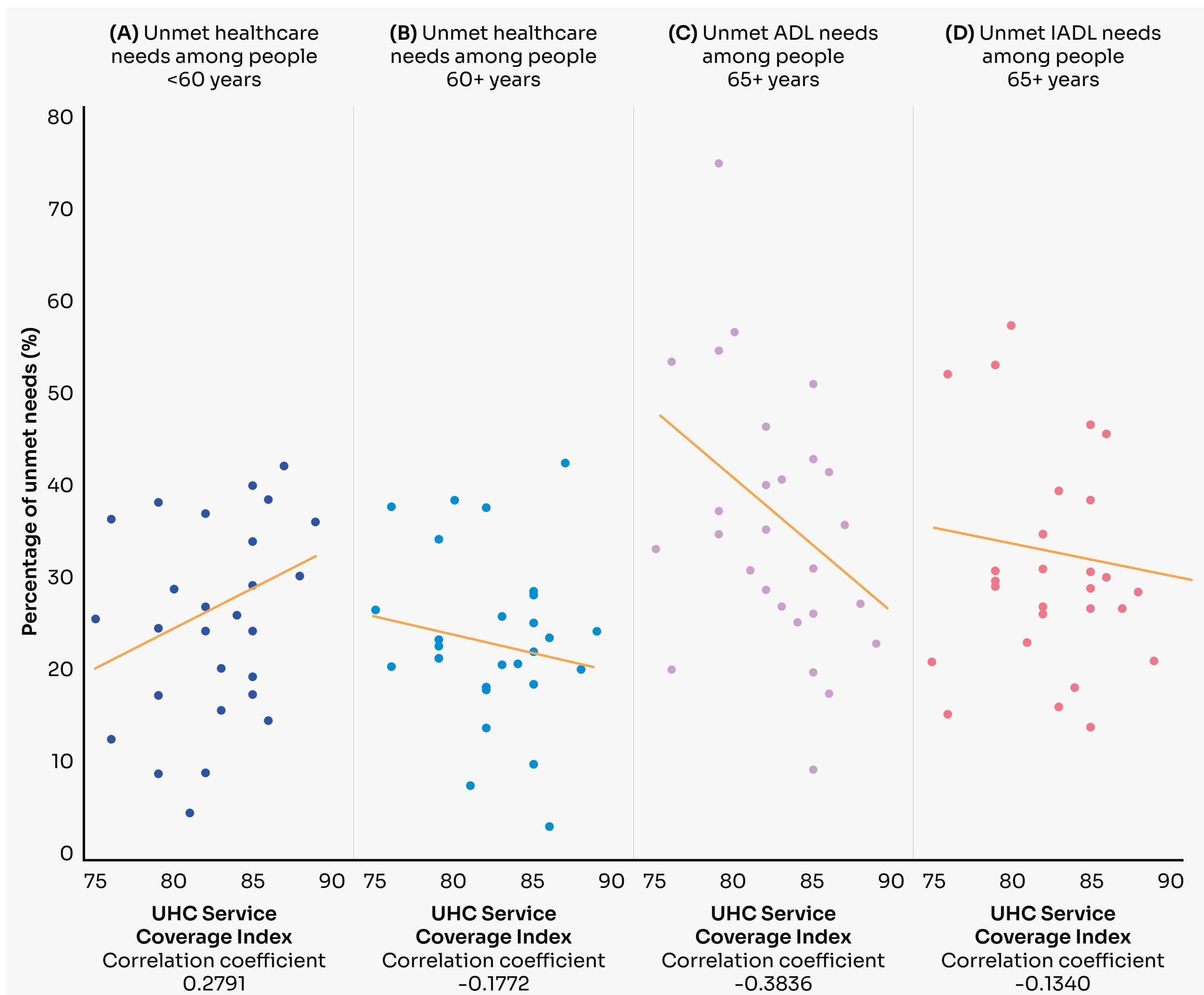


Notes: Unmet ADL/IADL needs is defined as the proportion of respondents who perceived that their need for ADL/IADL care was unmet among respondents who reported at least one limitation with ADL/IADL. Barcharts represent prevalence of unmet ADL/IADL need among those aged 65+.

Self-reported unmet health and social care needs and the UHC service coverage index

- A weak positive correlation exists between the UHC service coverage index and unmet healthcare needs among people less than 60 years old. On the contrary, the correlation between the UHC service coverage index and unmet healthcare needs among people aged 60+ years was negative but also much weaker (Figure 5).
- The correlations between the UHC service coverage index and unmet ADL and IADL needs among people aged 65+ years were negative; the strength of the correlation was moderate with unmet ADL needs but weak with unmet IADL needs.

Figure 5. The correlation of UHC service coverage index and unmet health and social care needs in 27 European countries, EHIS Wave 3, 2019



Notes: Unmet need data are from the European Health Interview Survey (EHIS) Wave 3, 2019. UHC Service Coverage Index data are from 2019 provided by WHO.

35%

of people aged 65+ with an ADL limitation said they needed (more) help (on average across 28 European countries).

Conclusions

- On average, across the 27 European countries studied, one in every four individuals aged 15+ years who had a need for healthcare in the previous 12 months reported that the need was unmet. The most frequently cited reason for unmet healthcare needs was long waiting times followed by cost and transportation/distance. Among older people aged 65+ years across the 28 European countries studied, one-third or more of those with at least one limitation in ADL or IADL expressed that they needed (more) help. The age-specific estimates indicate that perceived unmet ADL/IADL needs were higher among those 70 years old and above.
- The correlation between the prevalence of unmet healthcare needs and the UHC service coverage index was inconclusive. A weak negative correlation was found between the UHC service coverage index and unmet healthcare needs among people aged 60+ years, and a weak positive correlation was observed for people younger than 60 years.
- A moderate negative correlation existed between the UHC service coverage index and unmet ADL needs; the corresponding correlation with IADL was weak. In settings with high UHC service coverage and strong welfare systems such as in the Nordic countries, the unmet ADL needs was much lower, though the patterns were less clear for unmet IADL needs.

Lessons learned for other countries

- The main target of the health system is to ensure equitable access to needed healthcare. However, estimating the need for healthcare and the barriers to accessing health services poses challenges, particularly in low-middle-income countries (LMICs), as such indicators are often unavailable in household survey data. Moreover, even when such data is available, the data collection methods and the questionnaire may not be harmonized, making them less comparable across countries. EHIS is a research tool that allows for standardized measures of health and social care needs and measures of unmet needs to be implemented uniformly across different settings and could be adapted to LMIC settings.
- Our findings, based on high-income settings, highlight that a long waiting list is the most common reason for unmet healthcare needs. However, it is important to note that this may not be the case in LMICs, where healthcare providers and financial protection may be lacking. In such cases, other access barriers such as cost and distance to facilities may be equally or more problematic than long waiting times.

- In LMICs, older people with disabilities are more likely to receive care in their homes, often relying on family caregivers rather than seeking care from formal carers or in institutional settings.[2] The norms related to older person's care may differ from those in high-income countries, and the older person's perceived or expressed needs for social care may be lower than expected based on their assessed ADL/IADL limitations. Evidence suggests that older people receiving care in traditional community housing are at a higher risk of experiencing unmet needs compared to those living in institutional care.[3] Efforts to train and support informal caregivers would be important in these contexts to ensure good care for older persons.

WKC Evidence Summaries are produced by the WHO Centre for Health Development (WHO Kobe Centre – WKC) from academic research it has supported, to make research more accessible to policymakers, health system managers and others. They aim to provide evidence to support policymaking and outline potential future research directions.

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