1.1. People with self-reported unmet needs for medical examination due to financial reasons (% of respondents, EU-SILC) (A-6); People with self-reported unmet needs for dental examination due to financial reasons (% of respondents, EU-SILC) (A-7)

1.1.1. Documentation sheet

Description	**Primary indicators** A-6 People with self-reported unmet needs for medical examination due to financial reasons (% of respondents 16+, EU-SILC); A-7 People with self-reported unmet needs for dental examination due to financial reasons (% of respondents 16+, EU-SILC) **Secondary indicator** Households with self-reported unmet needs for care (medical care, surgery, dental care, prescription medicines, eye glasses or contact lenses, mental healthcare) due to financial reasons (% of responding households, HIS)
Calculation	**Primary indicators** **Numerator**: weighted number of respondents who, according to their own assessment, needed examination or treatment for a specific type of healthcare, but delayed or forewent care with as main reason that they could not afford to pay for care (too expensive) (using EU-SILC survey weights). **Denominator**: total weighted number of respondents (16+) included in the survey (using EU-SILC survey weights). **A-6 – Medical examination or treatment** refers to individual healthcare services provided by or under direct supervision of medical doctors or equivalent professions according to national healthcare systems. Hence, this includes healthcare provided for different purposes (preventive, curative, rehabilitative, mental, long-term healthcare) and by different modes of provision (inpatient, outpatient, day, and home care). Dental care and self-medication are excluded. **A-7 – Dental examination or treatment** refers to individual healthcare services provided by or under direct supervision of dentists, stomatologists, and orthodontists. Hence, it includes diagnostic, preventive and curative dental care and excludes medical care and self-medication. **Secondary indicator** **Numerator**: weighted number of households in which, according to their own assessment, at least one person needed care (medical care, surgery, dental care, prescription medicines, eye glasses or contact lenses, mental healthcare), but delayed or forewent care with as main reason that they could not afford to pay for care (using HIS survey weights). **Denominator**: total weighted number of households included in the survey (using HIS survey weights).

Rationale	Belgium has made a commitment to universal health coverage (UHC), i.e. everyone should be able to obtain the health services that they need, of high quality, without risk of financial hardship in doing so.[1, 2] Ensuring affordable access to healthcare is at the heart of universal health coverage, and was reaffirmed numerous times as main objective of the Belgian healthcare system.[1] Healthcare is generally considered financially inaccessible when people limit or postpone the use of necessary care because of (excessively) high costs, or when they have to relinquish other basic necessities because they need care. Financial accessibility can be undermined by out-of-pocket (OOP) payments for healthcare. All countries use OOP payments to pay for some healthcare, though to varying degrees (see indicators A-2 & A-3). Evidence shows that user charges are not a good instrument for directing people to use resources more efficiently and can have negative effects on equity and efficiency.[3-7] Low-income populations are disproportionately affected by increased cost sharing, as they have higher care needs, are more price sensitive and resource constrained than other income groups. Hence, OOP payments can be a barrier to accessing health services and treatments, resulting in people foregoing or delaying the use of healthcare (unmet need for healthcare) with potential adverse consequences to their health.[1, 8] By shifting healthcare costs on to households, OOP payments can also lead to financial hardship (e.g. impoverishing or catastrophic health spending, see indicator A-4). In this latter case, people can no longer afford to meet basic needs – food, housing, electricity – because they have to pay out of pocket for healthcare.[2, 3] Households with low incomes are consistently most likely to lack affordable access to healthcare, experiencing both catastrophic health spending and unmet need. This deepens poverty, erodes health and well-being and increases social inequalities within and across countries.[7, 9]
Data source	Eurostat, EU-SILC own calculations
Technical definitions	**Primary indicators** A-6 is based on the following questions from the EU-SILC[10, 11]: • **PH040**, identifying individuals with unmet needs for medical examination or treatment in the past 12 months. Question: "*Was there any time during the past 12 months when you really needed a medical examination or treatment, but that this did not occur?*" Response categories (up to 2017): 1. *Yes, there was at least one occasion* 2. *No, there was no occasion* Response categories (from 2018): 1. *Yes, there was at least one occasion* 2. *No, I had a medical examination or treatment each time I needed* 3. *No, I did not need any medical examination or treatment* • **PH050**, identifying the main reason for unmet needs for medical examination or treatment. Question: "*What was the main reason for not having a medical examination or treatment?*

Response categories:

1. *Could not afford to (too expensive or not covered by the insurance fund)*
2. *Waiting list, don't have the referral letter*
3. *Could not take time because of work, care for children or for others*
4. *Too far to travel/no means of transportation*
5. *Fear of doctors/hospitals/examination/treatment*
6. *Wanted to wait and see if problem got better on its own*
7. *Didn't know any good specialist*
8. *Other reason*

A-7 is based on the following questions from the EU-SILC:

- **PH060**, identifying individuals with unmet needs for dental examination or treatment in the past 12 months.

  Question: "*Was there any time during the past 12 months when you really needed a dental examination or treatment, but that this did not occur?*"

  Response categories (up to 2017):

  1. *Yes, there was at least one occasion*
  2. *No, there was no occasion*

  Response categories (from 2018):

  1. *Yes, there was at least one occasion*
  2. *No, I had a dental examination or treatment each time I needed*
  3. *No, I did not need any dental examination or treatment*

- **PH070**, identifying the main reason for unmet needs for dental examination or treatment.

  Question: "*What was the main reason for not having a dental examination or treatment?*

  Response categories:

  1. *Could not afford to (too expensive or not covered by the insurance fund)*
  2. *Waiting list, don't have the referral letter*
  3. *Could not take time because of work, care for children or for others*
  4. *Too far to travel/no means of transportation*
  5. *Fear of doctors/hospitals/examination/treatment*
  6. *Wanted to wait and see if problem got better on its own*
  7. *Didn't know any good specialist*
  8. *Other reason*

	Secondary indicator The HIS research team constructed a household-level indicator that reflects that at least one household member forewent or delayed care (medical care, surgery, dental care, prescription medicines, eye glasses or contact lenses, mental healthcare) due to financial reasons in the past 12 months. More technical details on the methodology are available in the HIS summary report on financial accessibility of care.[12]
International comparability	Data on unmet healthcare needs are available in Eurostat based on the EU-SILC survey.[10, 11]
Limitations	The unmet needs for medical/dental examination and treatment are self-assessed. Hence it is impossible to evaluate whether or not the postponed care was related to an objective need for care (was it necessary or acute?), for how long care was postponed (forgone care or delayed until the receipt of income in the next month?), and whether the postponement is the result of spending money on basic necessities (food, utilities, rent) or on other (non-necessary) consumption. The comparability of the results over time is challenging for the following reasons: 1. There has been a revision of the phrasing of the EU-SILC questions in the Belgian survey in 2011 and in 2018. For this reason the reported time series starts in 2011. In 2018, an additional answer category was added to questions PH040 and PH060 to distinguish between individuals without unmet needs who did and did not need healthcare in the past 12 months (see technical definition). This, however, did not led to a change of the indicator value as reported by Eurostat. Statbel, on the other hand reports a revised indicator on their website, excluding individuals without care needs (PH040=3/PH060=3) from the denominator. This adapted methodology leads to higher values for self-reported unmet needs, given a reduced denominator. 2. There have been two methodological improvements in 2019: (1) the use of administrative information to capture the majority of income concepts; (2) a revision of the survey sampling and the calculation of survey weights (accounting for more variables, including the use of administrative income information). Therefore results before and after 2019 are not comparable. 3. The COVID-19 pandemic affected the 2020 survey in several ways: (1) from mid-March 2020 onwards, fieldwork took place by phone (CATI) instead of through face-to-face interviews (CAPI); (2) lower response rate, in particular in new sampled households; (3) progress of interviews was not equal over the survey period. All this may lead to potential bias in the results compared to other years and call for a cautious interpretation of the results.
Dimension	Accessibility
Related indicators	A-2 Out-of-pocket (OOP) payments (% of current expenditure on health) A-3 Out-of-pocket (OOP) medical spending (% of final household consumption) A-4 Households facing catastrophic out-of-pocket payments (% of respondents, HBS)
Reviewers	Rudi Van Dam (FOD Sociale Zekerheid – SPF Sécurité Sociale), Carine Van de Voorde (KCE)

1.1.2. Results A-6 – unmet needs for medical examination due to financial reasons

Belgium

Table 1 shows that the share of the population aged 16 years and over who report unmet needs for medical examination or treatment due to financial reasons increased from 1.4% in 2011 to reach a high of 2.2% in the years 2014 to 2016 after which it decreased gradually to 0.9% in 2022, the lowest incidence in the considered timeframe. Despite the break in series in 2019 (alterations to survey sampling and use of administrative income information), it seems reasonable to conclude that there has been an important declining trend in self-reported unmet needs over the past 5 years.

Analysis by demographic characteristics and socioeconomic status

In Table 1 the rate of self-reported unmet needs for medical examination or treatment was calculated in different population subgroups based on socioeconomic or sociodemographic characteristics. The most pronounced association was observed between self-reported unmet needs and levels of household income. It can be clearly seen that the likelihood of experiencing unmet needs due to financial reasons was inversely related to household income. Not only do we find the highest rates in the poorest income quintile, but also the largest volatility over time (4.1% in 2011, 7.7% in 2016 and 2.6% in 2022). The deterioration and subsequent improvement in self-reported unmet needs in the population over time is to a large extent driven by what happened in the poorest income quintile, as can be seen in Figure 1. In the richest income quintile, there seemed to be no issue of postponement of care with rates of 0.1% in 2011, 0% in 2016 and in 2022. The rates in income quintiles 3 and 4 were below the population average, whereas the rate observed in income quintile 2 was slightly above the population average.

Furthermore, we find that rates of unmet needs were higher in subgroups with lower educational attainment and among working-age individuals in inactivity or unemployment. Both socioeconomic characteristics are of course correlated with income level. In 2022, rates of unmet needs amount to 2.0%, 2.2% and 1.5% among people with primary degree or no degree, individuals in inactivity and in unemployment, respectively, compared to 0.9% in the general population.

Rates of self-reported unmet needs were relatively lower among retired individuals, i.e. 0.6% in 2022. Despite their higher care needs, they seem better protected against unmet needs for medical examination or treatment due to financial reasons. Individuals in the age groups between 35 and 65 and females were, on the other hand, more likely to forego or postpone medical care.

These socioeconomic and sociodemographic breakdown of the results are in line with the more detailed analysis in KCE report 334[1], where higher incidence rates were found among individuals in a financially precarious situation (low income, poverty risk, material deprivation, inability to cope with unexpected expenses, receipt of welfare support), among working-age individuals without paid work, among single adults below 65 years old, among individuals in the age group 35-49 and among females aged 50-64.

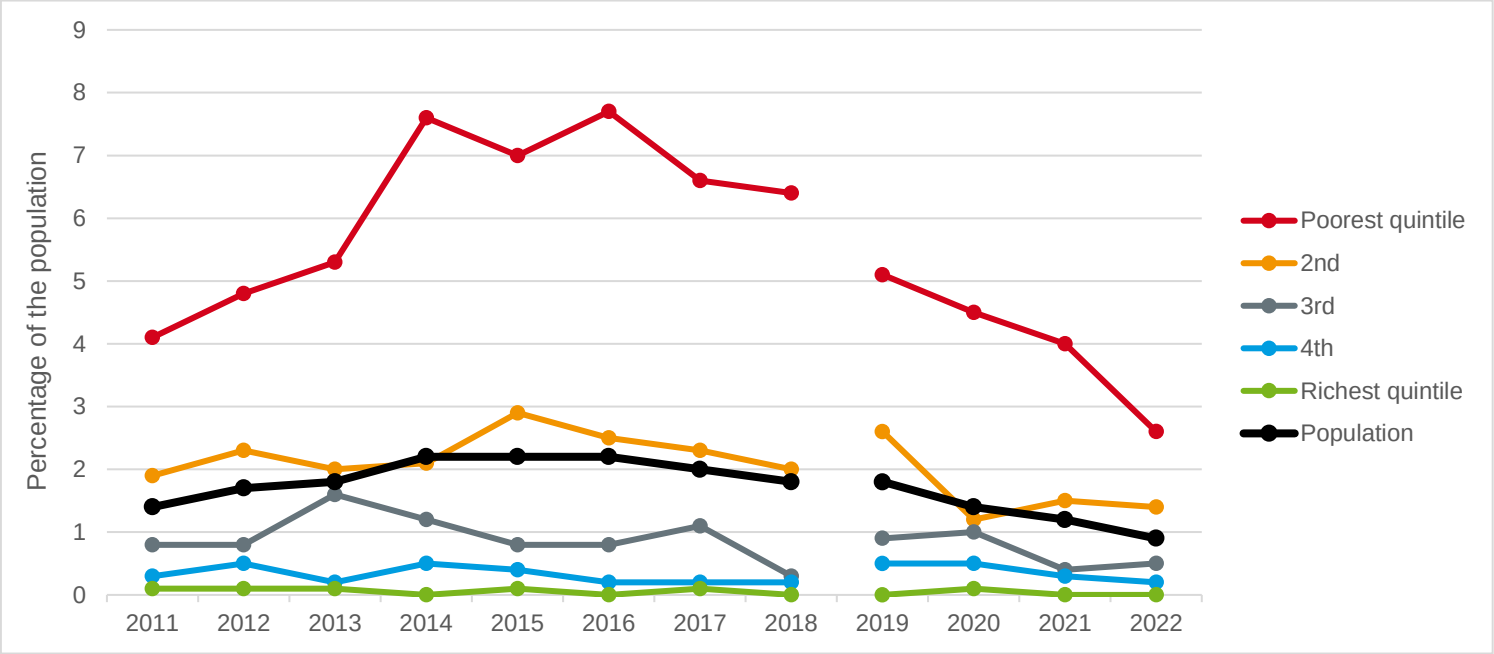
Table 1 – Self-reported unmet needs for medical examination or treatment due to financial reasons in Belgium (2011-2022) (in percentages)

		2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Belgium		1.4	1.7	1.8	2.2	2.2	2.2	2.0	1.8	1.8	1.4	1.2	0.9
Regions	**Flanders**		1.0				0.8		0.8	0.9	0.4	0.7	0.2
	Wallonia		1.6				4.0		3.0	2.8	2.5	1.9	2.0
	Brussels		5.9				4.8		3.5	4.0	3.6	2.1	1.9

		2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Household equivalized income quintiles	**First quintile**	4.1	4.8	5.3	7.6	7.0	7.7	6.6	6.4	5.1	4.5	4.0	2.6
	Second quintile	1.9	2.3	2.0	2.1	2.9	2.5	2.3	2.0	2.6	1.2	1.5	1.4
	Third quintile	0.8	0.8	1.6	1.2	0.8	0.8	1.1	0.3	0.9	1.0	0.4	0.5
	Fourth quintile	0.3	0.5	0.2	0.5	0.4	0.2	0.2	0.2	0.5	0.5	0.3	0.2
	Fifth quintile	0.1	0.1	0.1	0.0	0.1	0.0	0.1	0.0	0.0	0.1	0.0	0.0
Educational attainment	**Primary degree or no degree**	2.2	2.9	3.3	3.7	4.0	4.2	3.2	2.7	2.7	2.4	2.1	2.0
	Secondary degree	1.3	1.4	1.5	2.0	2.0	1.9	2.2	2.1	2.0	1.6	1.5	0.9
	Tertiary degree	0.7	0.6	0.7	1.2	0.9	0.9	0.7	0.6	1.0	0.7	0.5	0.4
Activity status	**Employed**	0.9	0.9	1.1	1.4	1.1	0.7	1.1	0.7	1.0	0.8	0.6	0.5
	Unemployed	4.2	6.3	7.2	7.0	7.6	7.5	7.3	6.8	5.2	5.4	5.2	1.5
	Inactive	2.2	2.5	3.0	4.1	4.7	5.2	4.2	4.1	3.5	3.3	2.7	2.2
	Retired	0.9	0.9	0.9	1.0	0.8	1.5	0.9	0.9	1.3	0.6	0.5	0.6
Gender	**Male**	1.1	1.6	1.4	2.0	1.8	2.0	1.4	1.5	1.5	1.1	1.0	0.7
	Female	1.8	1.7	2.2	2.5	2.6	2.5	2.6	2.0	2.1	1.7	1.4	1.2
Age category	**16-24**	0.7	1.2	1.0	2.4	1.8	2.4	2.4	2.0	1.9	1.7	1.4	1.1
	25-34	1.5	1.7	1.3	2.2	2.2	1.5	2.4	1.9	1.0	1.0	0.9	0.8
	35-44	2.1	2	2.6	2.8	2.6	3.3	3	2.7	2.5	1.5	1.7	0.8
	45-54	2.3	2.6	3.0	2.9	3.2	2.5	2.8	2.7	2.6	2.9	2.3	1.8
	55-64	0.9	1.6	2.1	2.3	2.8	2.7	2.5	1.8	2.1	2.0	1.2	1.3
	65-74	1.5	1.1	1.0	1.2	1.0	1.7	0.9	0.9	1.6	0.8	0.6	0.9
	75 years or over	0.3	0.7	0.5	0.8	0.7	1.3	0.4	0.6	1.2	0.5	0.4	0.2

Note: break in series in 2019 (methodological improvement survey sampling and income information).
Source: Eurostat – EU-SILC

Figure 1 – Self-reported unmet needs for medical examination or treatment due to financial reasons, by income quintile (2011-2022)



Note: break in series in 2019 (methodological improvement survey sampling and income information).

Regional comparison

The results in Table 1 indicate important regional variation with, for example, rates in 2022 of 0.2% in Flanders, 2.0% in Wallonia and 1.9% in Brussels. In the period with available regional data (2018-2022), rates were consistently below the average in Flanders and above the average in Wallonia and Brussels. In Brussels, rates were generally the highest and about twice the level of the national average.

The regional differences should, however, be considered in combination with the socioeconomic and sociodemographic characteristics described above that are associated with unmet needs and differ between the regions. There are for example regional differences in the age structure (Brussels has a younger population), the (in)activity rates (activity rate is higher in Flanders), the unemployment rate (the unemployment rate is lower in Flanders), the poverty risk (lower in Flanders), etc. For example, while Brussels accommodated about 11% of the Belgian population in 2022, about 24% of the individuals at risk of poverty lived in Brussels, contributing to a higher rate of unmet needs.

International comparison

Figure 2, Figure 3 and Figure 4 put the Belgian results in an European context. Figure 2 shows the evolution over time of the rate of self-reported unmet needs for medical examination or treatment in Belgium as well as the

EU-14 and the EU-27 averages. While the Belgian rate closely matched the EU-14 average between 2011 and 2014, it followed the decline of the EU-14 average starting in 2014 with a time lag of about two years. As a result, the Belgian rate was well above the EU-14 and EU-27 average between 2015 and 2021. Since 2020, the decrease in the EU average rates levelled off and was even reversed, whereas the Belgian rate continued to decrease and was below the EU averages in 2022.

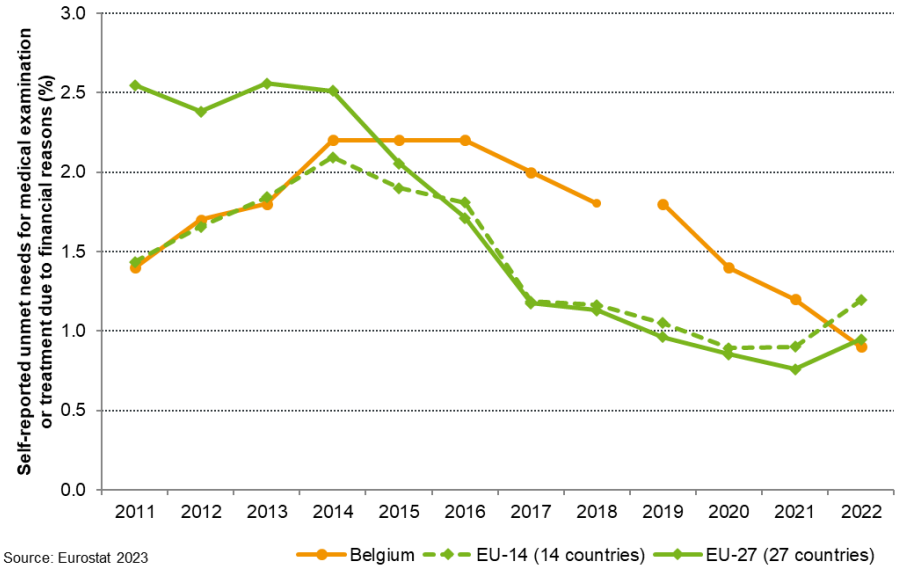
Despite the improving trend, Figure 3 shows that Belgium was not among the best performing countries and only 7 EU countries had a higher rate in 2022. Among our neighbouring countries, only France had a higher rate.

Important distributional discrepancies hide behind the average, in particular income-related differences, as was described above. While this was not only the case in Belgium, the gap between the incidence in the richest and the poorest income quintile has long been (one of) the largest among all western EU countries.[13, 14] In 2022, in spite of a major improvement over time, it was still larger than the EU-27 and EU-14 averages, only exceeded in 5 other EU countries (see Figure 4).

Impact of COVID-19 pandemic

COVID-19 had an impact on postponement of care in general, but not on the downward trend in self-reported unmet needs due to financial reasons. The COVID-19 related measures such as the lockdowns and reduction of non-urgent care had an impact on the access to medical care. The impact is particularly pronounced in the EU-SILC wave 2021, with a substantial higher share of individuals aged 16+ who needed but were unable to receive care in the past 12 months (i.e. during the course of 2020 and early 2021) for all reasons combined: 2.2% in 2020, 3.0% in 2021 and 1.6% in 2022. However, when examining the reasons of unmet needs, not financial reasons, but “other reasons” and “waiting lists” were listed as main reason for inaccessibility of care. While financial reasons were listed as main reason in 64% and 56% of the unmet needs for medical examination or treatment in 2020 and 2022, respectively, this accounted for only 40% in 2021. Other reasons and waiting lists accounted, respectively, for 37% and 17% of the self-reported unmet needs in 2021, illustrating the impact of COVID-19.

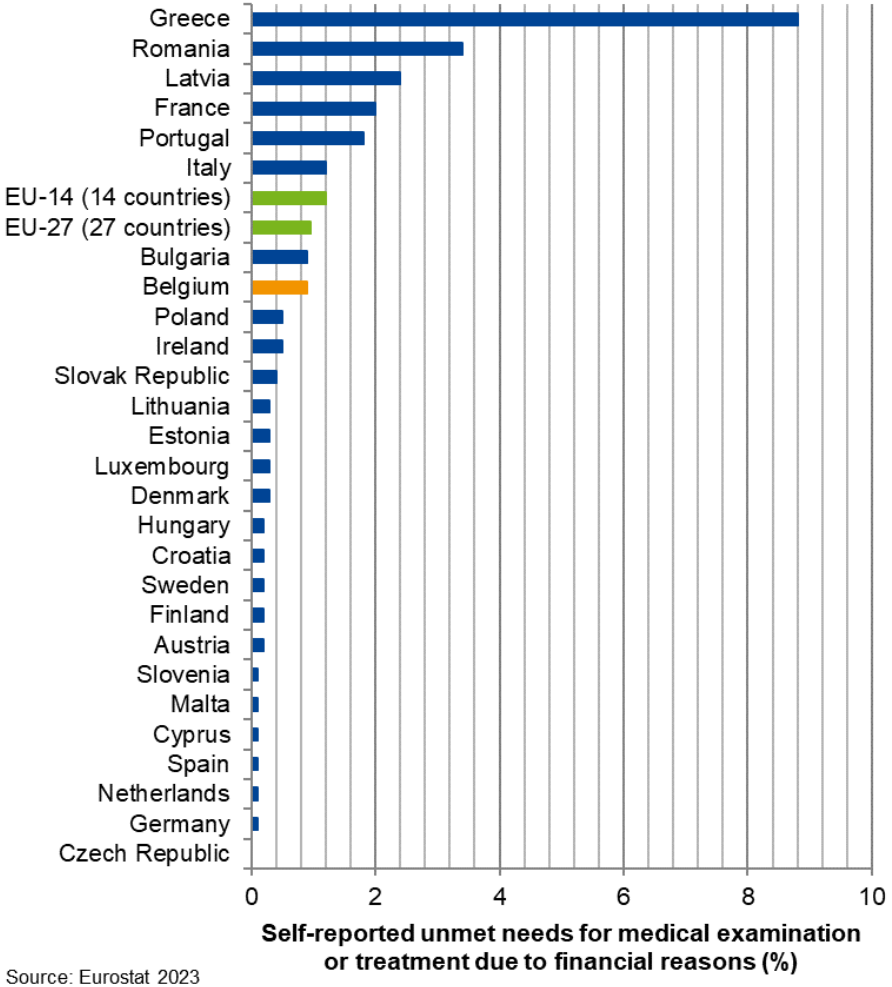
Figure 2 – Self-reported unmet needs for medical care due to financial reasons, evolution Belgium, EU-14 and EU-27 (2011-2022)



Source: Eurostat 2023

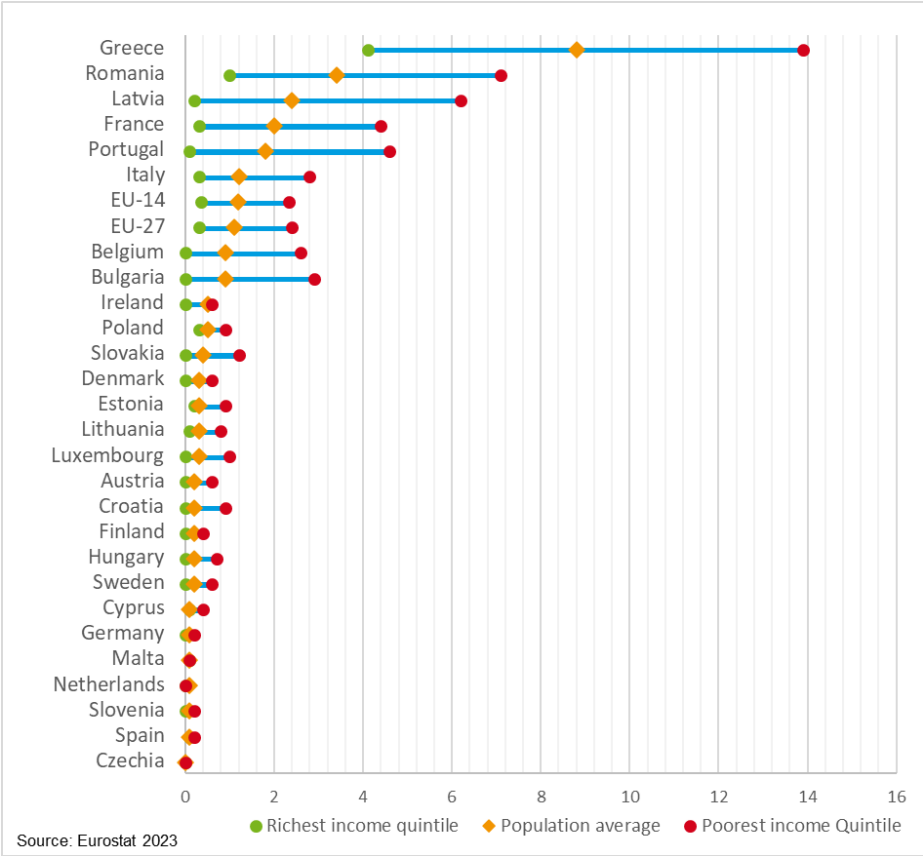
Note: break in series in 2019 (methodological improvement survey sampling and income information).

Figure 3 – Self-reported unmet needs for medical care due to financial reasons in a European perspective (2022)



Source: Eurostat 2023

Figure 4 – Gap in self-reported unmet needs for medical care due to financial reasons between richest and poorest quintile (EU-27, 2022)



Source: Eurostat 2023

Key points

- **The rate of self-reported unmet needs for medical examination and treatment due to financial reasons is an indicator for affordable access to care.**
- **The rate increased from 1.4% in 2011 to reach a high of 2.2% in the years 2014 to 2016 after which it decreased gradually to 0.9% in 2022. There has been a strong declining trend in self-reported unmet needs over the past 5 years.**
- **Important distributional discrepancies hide behind the average. The likelihood of experiencing unmet needs due to financial reasons was inversely related to household income. High rates and volatility were found in the poorest income quintile (4.1% in 2011, 7.7% in 2016 and 2.6% in 2022), while nearly no unmet needs were found in the richest income quintile. Furthermore, rates of unmet needs were higher in subgroups with lower educational attainment and among working-age individuals in inactivity or unemployment, and lower among retired individuals.**
- **There were regional differences in the rate of unmet needs: 1.9% in Brussels, 2.0% in Wallonia and 0.2% in Flanders in 2022. They can be (partly) related to differences in socioeconomic and sociodemographic characteristics in the regions.**
- **In an international perspective, Belgium has performed worse than the European average over a long period of time (2015-2021), but thanks to a persistent declining trend in the past years, the rate of unmet needs in 2022 plunged below the EU-14 and EU-27 average. Nonetheless, Belgium was not among the best performing countries, with only 7 EU countries having a higher rate in 2022 and 5 EU countries having a higher gap between the incidence in the richest and poorest income quintiles.**
- **The lockdowns and reduction of non-urgent care during the COVID-19 pandemic had an impact on postponement of care in general, but did not impact the downward trend in self-reported unmet needs for medical examination or treatment due to financial reasons.**

1.1.3. Results A-7 – unmet needs for dental examination due to financial reasons

Belgium

Table 2 shows that the share of the population aged 16 years and over who report unmet needs for dental examination or treatment due to financial reasons increased from 2.9% in 2011 to reach peaks of 3.8% in 2014 and 3.7% in 2016 after which it decreased gradually to 2.5% in 2022. Despite the break in series in 2019 (alterations to survey sampling and use of administrative income information), it seems reasonable to conclude that there has been an important declining trend in self-reported unmet needs over the past 5 years.

Analysis by demographic characteristics and socioeconomic status

In Table 2 the rate of self-reported unmet needs for dental examination or treatment was calculated in different population subgroups based on socioeconomic or sociodemographic characteristics. The most pronounced association was observed between self-reported unmet needs, on the one hand, and levels of household income and activity status, on the other hand.

It can be clearly seen that the likelihood of experiencing unmet needs due to financial reasons was inversely related to household income. Not only do we find the highest rates in the poorest income quintile, but also the largest volatility over time (7.6% in 2011, 11.5% in 2014 and 2016 and 6.6% in 2022). The deterioration and subsequent improvement in self-reported unmet needs in the population over time was to a large extent driven by what happens in the poorest income quintile, as can be seen in Figure 5. In the richest income quintile, the incidence rates were very low, ranging between 0% and 0.4%. The rates in income quintiles 3 and 4 were below the population average, whereas the rate observed in income quintile 2 was above the population average. Moreover, in quintile 2 we observe an upward trend since 2020 that necessitates future attention.

Particularly high rates of unmet needs for dental care were found among working-age individuals in unemployment (8.6% in 2022), and to a lesser extent individuals in inactivity (4.9% in 2022).

In addition, we find relatively high rates in subgroups with lower educational attainment and in the age groups between 45 and 65. As for medical care, rates were relatively lower among retired individuals.

These socioeconomic and sociodemographic breakdown of the results are in line with the more detailed analysis in KCE report 334[1], where higher incidence rates were found among individuals in a financially precarious situation (low income, poverty risk, material deprivation, inability to cope with unexpected expenses, receipt of welfare support), among working-age individuals without paid work, among single adults below 65 years old, among individuals in the age group 35-49 and among females aged 50-64.

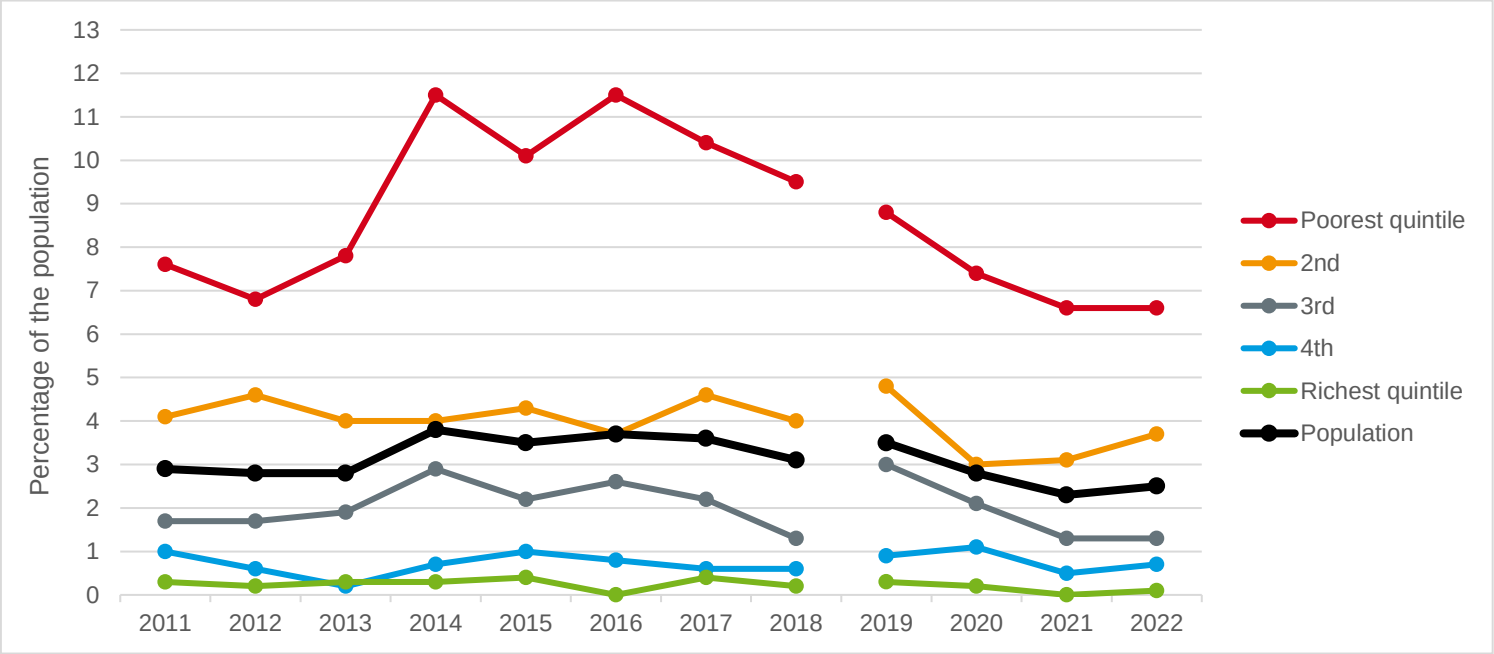
Table 2 – Self-reported unmet needs for dental examination or treatment due to financial reasons in Belgium (2011-2022) (in percentages)

		2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Belgium		2.9	2.8	2.8	3.8	3.5	3.7	3.6	3.1	3.5	2.8	2.3	2.5
Regions	**Flanders**		1.7				2.1		1.9	2.1	1.1	1.3	1.1
	Wallonia		3.0				5.7		4.6	5.3	5.0	3.8	4.7
	Brussels		8.2				6.2		5.3	5.8	5.2	2.7	3.6

		2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Household equivalized income quintiles	First quintile	7.6	6.8	7.8	11.5	10.1	11.5	10.4	9.5	8.8	7.4	6.6	6.6
	Second quintile	4.1	4.6	4.0	4.0	4.3	3.7	4.6	4.0	4.8	3.0	3.1	3.7
	Third quintile	1.7	1.7	1.9	2.9	2.2	2.6	2.2	1.3	3.0	2.1	1.3	1.3
	Fourth quintile	1.0	0.6	0.2	0.7	1.0	0.8	0.6	0.6	0.9	1.1	0.5	0.7
	Fifth quintile	0.3	0.2	0.3	0.3	0.4	0.0	0.4	0.2	0.3	0.2	0.0	0.1
Educational attainment	Primary degree or no degree	4.4	4.2	4.5	6.0	6.4	6.2	5.3	4.9	5.4	4.0	3.2	4.7
	Secondary degree	2.6	2.5	2.3	3.4	3.2	4.1	4.2	3.2	3.9	3.3	2.5	2.7
	Tertiary degree	1.6	1.5	1.8	2.2	1.6	1.4	1.3	1.4	1.7	1.5	1.5	1.2
Activity status	Employed	1.9	1.7	1.8	2.4	2.1	1.9	2.0	1.8	2.2	1.8	1.3	1.4
	Unemployed	8.6	10.3	9.9	12.3	9.5	10.4	12.1	13.1	12.5	9.4	9.6	8.6
	Inactive	4.0	3.9	4.7	6.6	7.2	7.5	6.6	5.6	6.3	5.3	4.5	4.9
	Retired	1.9	1.3	1.4	1.8	1.6	2.3	2.1	1.5	2.4	1.5	1.0	1.6
Gender	Male	2.8	2.6	2.5	3.8	3.1	3.5	3.0	2.7	3.3	2.6	2.2	2.2
	Female	2.9	2.9	3.1	3.8	4.0	4.0	4.1	3.5	3.7	2.9	2.3	2.8
Age category	16-24	2.0	1.9	1.5	3.5	2.2	4.2	4.1	3.6	3.9	3.1	2.6	2.8
	25-34	3.5	3.1	3.1	4.9	3.3	2.6	4.6	3.2	2.6	2.4	1.7	2.0
	35-44	4.2	3.5	3.8	4.5	4.5	5.1	4.8	5.0	5.0	3.6	3.2	2.8
	45-54	3.7	4.9	4.4	4.8	4.9	4.9	4.8	4.5	5.1	4.6	4.0	4.0
	55-64	2.1	1.7	2.5	4.0	5.0	5.1	3.8	3.4	4.4	3.5	2.8	3.4
	65-74	2.2	1.4	2.1	2.3	2.2	2.6	2.8	1.5	2.6	2.1	1.4	2.1
	75 years or over	1.3	1.0	0.9	0.9	1.0	1.5	0.9	1.1	1.7	0.5	0.6	1.3

Note: break in series in 2019 (methodological improvement survey sampling and income information).
Source: Eurostat – EU-SILC

Figure 5 – Self-reported unmet needs for dental examination or treatment due to financial reasons, by income quintile (2011-2022)



Note: break in series in 2019 (methodological improvement survey sampling and income information).

Regional comparison

The results in Table 2 indicate important regional variation with for example in 2021 rates of 1.3% in Flanders, 3.8% in Wallonia and 2.7% in Brussels. In the period with available regional data (2018-2021), rates were consistently below the average in Flanders and above the average in Wallonia and Brussels.

The regional differences should, however, be considered in combination with the socioeconomic and sociodemographic characteristics described above that are associated with unmet needs and differ between the regions. There are for example regional differences in the age structure (Brussels has a younger population), the (in)activity rates (activity rate is higher in Flanders), the unemployment rate (the unemployment rate is lower in Flanders), the poverty risk (lower in Flanders), etc. For example, while Brussels accommodated about 11% of the Belgian population in 2022, about 24% of the individuals at risk of poverty lived in Brussels, contributing to a higher rate of unmet needs.

International comparison

Figure 6, Figure 7 and Figure 8 put the Belgian results in an European context. Figure 6 shows the evolution over time of the rate of self-reported unmet needs for dental examination or treatment in Belgium as well as the EU-14 and the EU-27 averages. Between 2011 and 2016, the Belgian rate

was well below the EU-14 and EU-27 average. Since 2017, the Belgian rate more or less matched the EU averages which started to decline in 2014. The downward trend in the EU average rates levelled off and has even been reversed since 2020. The Belgian rate showed a minor increase between 2021 and 2022, but it is too early to determine whether or not the reversal at the EU level will also set in in Belgium.

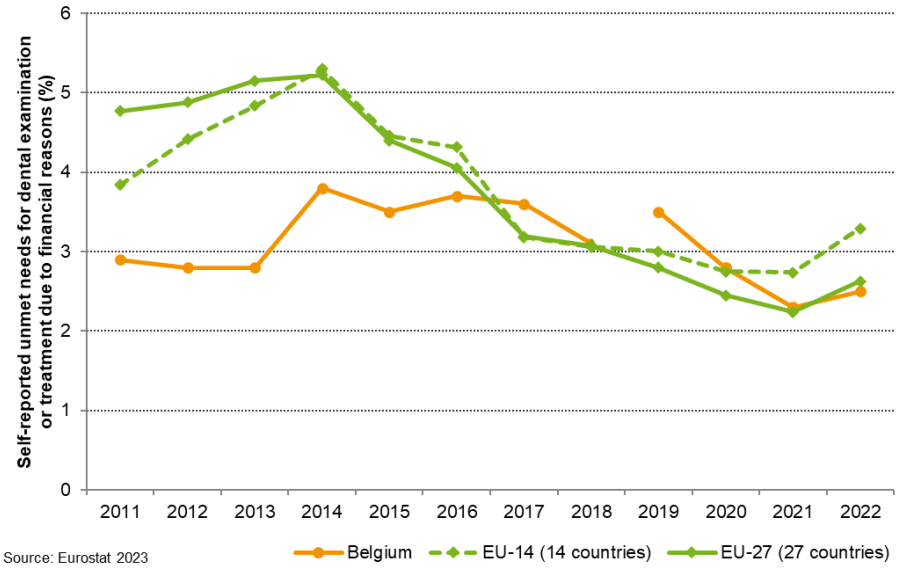
Despite the improving trend in the Belgian rate, Figure 7 shows that Belgium was not among the best performing countries and only 7 EU countries had a higher rate in 2022. Among our neighbouring countries, only France had a higher rate.

The average value obscures important income-related differences, as described above. While this was not only the case in Belgium, the gap between the incidence in the richest and the poorest income quintile has long been (one of) the largest among all western EU countries.[13] In 2022, in spite of a major improvement over time, it was still larger than the EU-27 and EU-14 averages, only exceeded in 7 other EU countries (see Figure 8).

Impact of COVID-19 pandemic

COVID-19 had an impact on postponement of care in general, but not on the downward trend in self-reported unmet needs for dental examination or treatment due to financial reasons. The COVID-19 related measures such as the lockdowns and reduction of non-urgent care had an impact on the access to dental care. The impact was particularly pronounced in the EU-SILC wave 2021, with a substantial higher share of individuals aged 16+ who needed but were unable to receive dental care in the past 12 months (i.e. during the course of 2020 and early 2021) for all reasons combined: 4.8% in 2020, 5.9% in 2021 and 3.9% in 2022. However, when examining the reasons of unmet needs, not financial reasons, but “other reasons” and “waiting lists” were listed as main reason for inaccessibility of dental care. While financial reasons were listed as main reason in 58% and 64% of the unmet needs for dental examination or treatment in 2020 and 2022, respectively, this accounted for only 39% in 2021. Other reasons and waiting lists accounted, respectively, for 44% and 10% of the self-reported unmet needs in 2021, illustrating the impact of COVID-19.

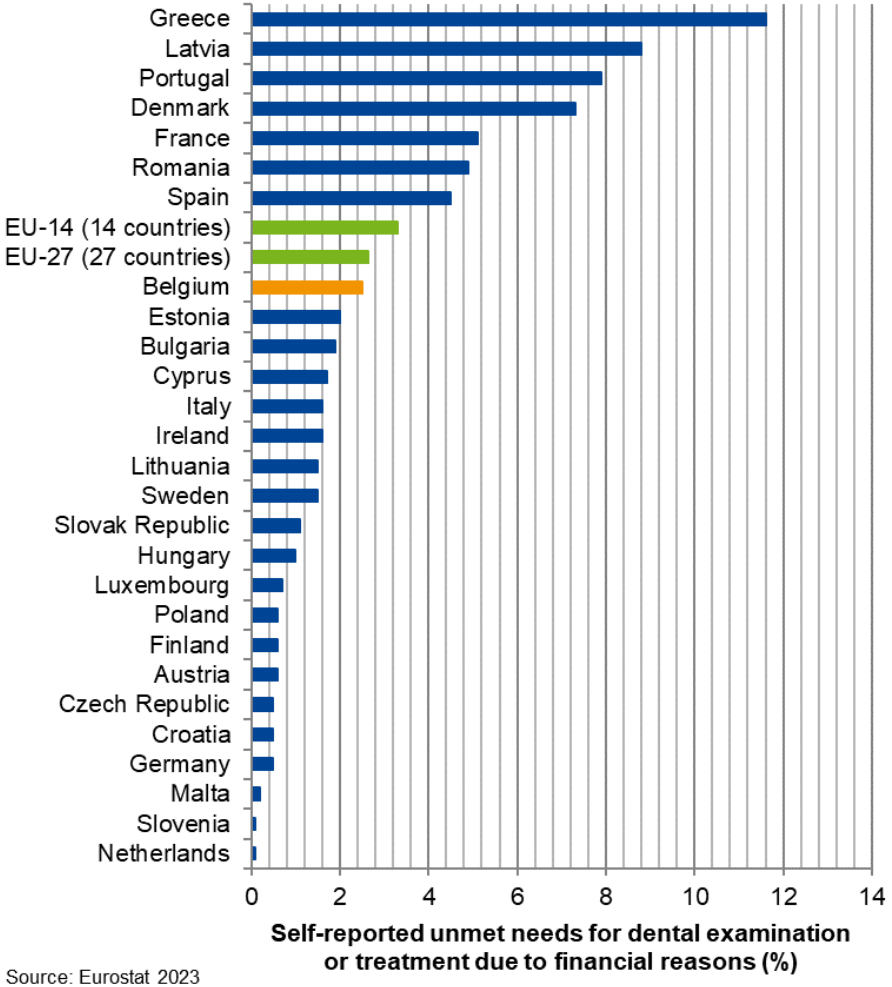
Figure 6 – Self-reported unmet needs for dental care due to financial reasons, evolution Belgium, EU-14 and EU-27 (2011-2022)



Source: Eurostat 2023

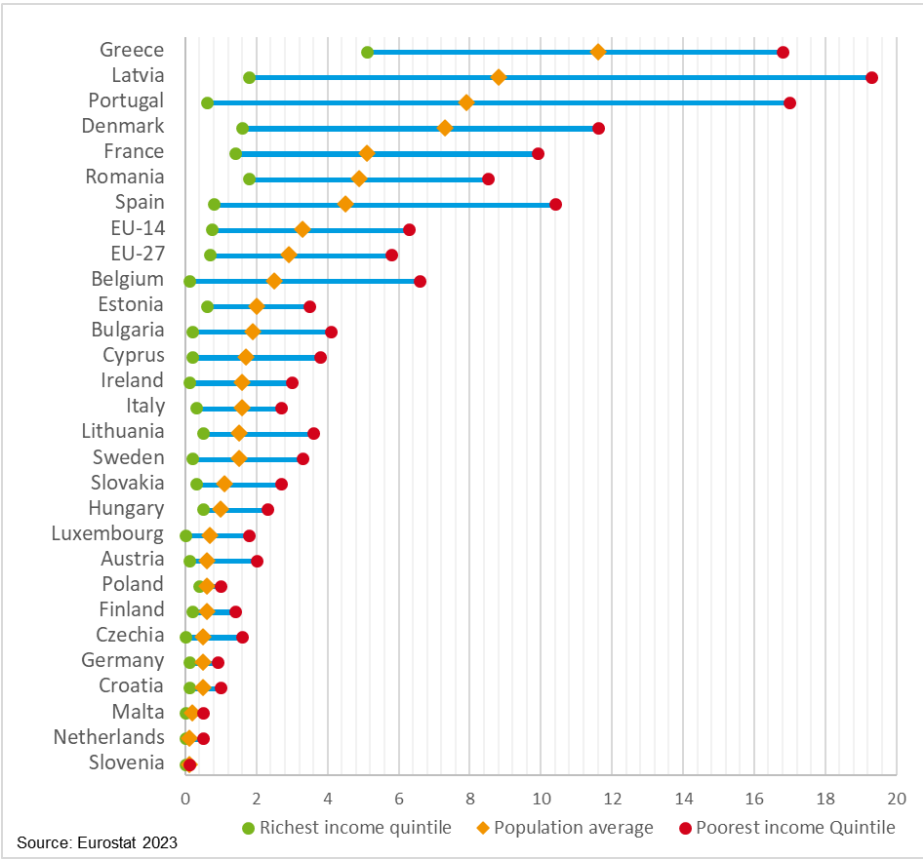
Note: break in series in 2019 (methodological improvement survey sampling and income information).

Figure 7 – Self-reported unmet needs for dental care due to financial reasons in a European perspective (2022)



Source: Eurostat 2023

Figure 8 – Gap in self-reported unmet needs for dental care due to financial reasons between richest and poorest quintile (EU-27, 2022)



Source: Eurostat 2023

Key points

- **The rate of self-reported unmet needs for dental examination or treatment due to financial reasons is an indicator for affordable access to dental care.**
- **The rate increased from 2.9% in 2011 to reach peaks of 3.8% in 2014 and 3.7% in 2016 after which it decreased gradually to 2.5% in 2022. There was a strong declining trend in self-reported unmet needs over the past 5 years.**
- **Important distributional discrepancies hide behind the average. The likelihood of experiencing unmet needs due to financial reasons was inversely related to household income. High rates and volatility were found in the poorest income quintile (7.6% in 2011, 11.5% in 2014 and 2016 and 6.6% in 2022), while low rates were found in the richest income quintile (between 0% and 0.4%). Particularly high rates of unmet needs for dental care were found among working-age individuals in unemployment (8.6% in 2022), and to a lesser extent individuals in inactivity (4.9% in 2022). In addition, relatively higher rates were observed in subgroups with lower educational attainment and in the age groups between 45 and 65 and relatively lower rates among retired individuals.**
- **There were regional differences: the rate of unmet needs for dental examination or treatment in 2021 amounted to 2.7% in Brussels, 3.8% in Wallonia and 1.3% in Flanders. These regional differences can be related to differences in socioeconomic and sociodemographic characteristics of the regions.**
- **In an international perspective, Belgian performed better than the European average between 2011 and 2016 and in line with the European average since 2016. Despite the improving trend in the past 5 years, Belgium was not among the best performing countries, with only 7 EU countries having a higher rate in 2022 and a higher gap between the incidence in the richest and poorest income quintiles.**
- **The lockdowns and reduction of non-urgent care during the COVID-19 pandemic had an impact on postponement of care in general, but did not impact the downward trend in self-reported unmet needs for dental examination or treatment due to financial reasons.**

1.1.4. Results secondary indicator postponement of care due to financial reasons (HIS)

Table 3 – Postponement of care due to financial reasons in Belgium (2001-2018) (in percentages)

		2001	2004	2008	2013	2018
Belgium		10.1	9.7	12.4	8.4	9.1
Regions	**Flanders**	5.7	5	9.6	4.8	5.4
	Wallonia	13.3	14.6	12.9	8.9	12.8
	Brussels	21.9	17.2	23.5	22.5	16.1

Source: Health Interview Survey (HIS)[12]

Belgium

Table 3 shows the share of households in which at least one household member needed care (medical care, surgery, dental care, prescription medicines, eye glasses or contact lenses, mental healthcare), but delayed or forewent care with as main reason that they could not afford to pay for care. In the 2018 Belgian Health Interview Survey, 9.1% of households reported that they had to postpone care for financial reasons, slightly more than in 2013.[12]

Analysis by demographic characteristics and socioeconomic status

The summary reports on financial accessibility of care of the Health Interview Survey report a clear association between postponement of care, on the one hand, and household income, household type and the educational attainment of the household head, on the other hand.[12] A lower household income, being single or living in a single parent household and lower educational attainment of the household head increased the likelihood of postponing care due to financial reasons.

Regional comparison

The results in Table 3 indicate important regional variation with for example rates in 2018 of 5.4% in Flanders, 12.8% in Wallonia and 16.1% in Brussels.

References

1. Bouckaert N, Maertens de Noordhout C, Van de Voorde C. Health System Performance Assessment: how equitable is the Belgian health system? Health Services Research (HSR). Brussel: Belgian Health Care Knowledge Centre (KCE); 2020. KCE Reports 334 Available from: https://doi.org/10.57598/R334C
2. Bouckaert N, Maertens de Noordhout C, Van de Voorde C. Can people afford to pay for health care? New evidence on financial protection in Belgium. Copenhagen: WHO Regional Offce for Europe; 2023. Available from: https://apps.who.int/iris/handle/10665/365978
3. WHO Regional Office for Europe. Can people afford to pay for health care? New evidence on financial protection in Europe. Copenhagen: WHO Regional Office for Europe; 2019. Available from: https://apps.who.int/iris/handle/10665/311654
4. Aron-Dine A, Einav L, Finkelstein A. The RAND Health Insurance Experiment, three decades later. J Econ Perspect. 2013;27(1):197-222.
5. Baicker K, Taubman SL, Allen HL, Bernstein M, Gruber JH, Newhouse JP, et al. The Oregon experiment--effects of Medicaid on clinical outcomes. N Engl J Med. 2013;368(18):1713-22.
6. Swartz K. Cost-sharing: effects on spending and outcomes. Synth Proj Res Synth Rep. 2010(20).
7. Martini J, Fleischmann G, Sabato S, Cylus J, Thomson S, Bouckaert N, et al. Affordable access to health care in the European Union: what are the challenges and how can the EU help to overcome them? Eurohealth. (Forthcoming 2024).
8. Eurostat. Unmet health care needs statistics [Web page].2023. Available from: http://ec.europa.eu/eurostat/statistics-explained/index.php/Unmet_health_care_needs_statistics
9. WHO Regional Office for Europe. Can people afford to pay for health care? Evidence on financial protection in 40 countries in Europe. Copenhagen: World Health Organization. Regional Office for Europe; 2023. Available from: https://iris.who.int/handle/10665/374504
10. Eurostat. Methodological guidelines and description of EU-SILC target variables. 2021.
11. STATBEL. Statistics on Income and Living Conditions [Web page].Brussels: Statistics Belgium;2023. Available from: https://statbel.fgov.be/en/themes/households/poverty-and-living-conditions/risk-poverty-or-social-exclusion
12. Demarest S, Charafeddine R, Drieskens S, Berete F. Gezondheidsenquête 2018: Financiële toegankelijkheid van gezondheidszorgen. Brussel: Sciensano; 2019. Available from: https://www.sciensano.be/nl/biblio/gezondheidsenquete-2018-financiele-toegankelijkheid-van-gezondheidszorgen
13. OECD, European Observatory on Health Systems and Policies. Belgium: Country Health Profile 2021, State of Health in the EU. Paris - Brussels: OECD Publishing - European Observatory on Health Systems and Policies; 2021. Available from: https://health.ec.europa.eu/system/files/2021-12/2021_chp_be_english.pdf
14. Van Dam R, Bastaits S, Laenen S. The evolution of the social situation and social protection in Belgium 2020. Monitoring the social situation in Belgium and the progress towards the social objectives and the priorities of the National Reform Programme. Brussels: Federal Public Service Social Security; 2021.