2. SELF-REPORTED UNMET NEEDS FOR MEDICAL CARE DUE TO FINANCIAL REASONS (% OF INDIVIDUALS AGED 16 OR MORE) (A-4)

2.1. Documentation sheet

Description	Self-reported unmet needs for medical care due to financial reasons (% of individuals aged 16 or more)
Calculation	**Numerator**: weighted number of individuals aged 16 or more who participated in the in the European Union Statistics on Income and Living Conditions (EU-SILC) who answered "yes" to question PH040 (unmet needs for medical care) and who indicated "could not afford to (too expensive)" in question PH050 as main reason for this unmet needs (see below) **Denominator**: weighted number of individuals aged 16 or more who participated in the in the European Union Statistics on Income and Living Conditions (EU-SILC) Calculation is done separately for individuals with chronic condition, using 2 definitions 3. **Individuals entitled to the status for persons with a chronic illness. Entitlement is observed through IMA-AIM variables pp3015, pp3016 or pp3017. If the value for one of these 3 variables is equal to 1 or 2, the individual has an entitlement. Households with at least one member entitled to the chronic illness status, are defined as households entitled to the status.** **4. Individuals self-reporting to suffer from chronic (long-standing) illness or condition. This is identified through EU-SILC variable PH020 equal to "yes". Households with at least one member with a self-reported chronic condition, are defined as households with a self-reported chronic condition (see also indicator CHR-1).**
Rationale	Financial access is a basic condition for a functional healthcare system. Foregoing necessary treatment because of its cost can be detrimental to a person's health. High out-of-pocket payments that affect other necessary expenses are also considered undesirable. 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. Higher rates of unmet needs for financial reasons are therefore considered indicative for the financial accessibility of healthcare. For a detailed analysis of self-reported unmet needs for medical care due to financial reasons, we refer the reader to KCE report 334.[1]
Primary data source	EU Statistics on Income and Living Conditions (EU-SILC) coupled with data from the InterMutualistic Agency (IMA/AIM). Data from 2008, 2012 and 2016 are used. The EU-SILC microdata are the reference source for measuring socioeconomic disparities in Belgium (and Europe). The Belgian data are collected by Statistics Belgium and are representative of the population. The survey format is harmonized across the EU with small national differences. Each wave consists of about 11 000 to 12 000 individuals in about 6 000 households. For every respondent in the EU-SILC, the available information is enriched with additional data from the InterMutualistic Agency. The IMA-AIM data brings together data of the different sickness funds at the individual level in a common format. An advantage is that the data are not self-reported or limited to a certain registration period, but are continuously collected for administrative use and hence less prone to recall bias.

	The available information includes detailed individual-level data on the use and expenditures – further subdivided in co-payments, supplements and expenditures chargeable to the public health insurance – of all care covered by the public health insurance (procedures, services, admissions, prescribed medication, etc.) as well as the take-up and use of protection measures in the public health insurance, such as increased reimbursement status, the chronic illness status and the system of maximum billing.
Technical definitions	**EU-SILC[2-4]** Unmet needs for medical care are recorded at the individual level for respondents aged 16 or more using two questions PH040 and PH050. Medical care refers to individual health services (medical examination or treatment) provided by or under direct supervision of medical doctors; it includes GP, specialist and hospital care, but also mental healthcare and excludes dental care and self-medication There was a revision of the phrasing of the question in 2011, which was accompanied by a significant increase in reported unmet needs.[5] Hence a direct comparison of the results of 2008 on the one hand and 2012/2016 on the other hand should be interpreted with caution. Compared to the 2012/2016 question, the question in 2008 is more restricted in scope and puts emphasis on the presence of a health condition as a preliminary to consult a doctor/dentist and the own responsibility of the interviewed person for not seeking care. **PH040** **Question in 2008 (up to 2010)** (authors' translation from Dutch phrasing): "*During the past 12 months, did you have a health condition or did you need medical treatment (except dental issues) but did you not seek care for one or another reason"* Answer options: ***1. Yes, I had a health condition and did not consult a doctor*** ***2. No, I had a health condition and consulted a doctor*** ***3. No, I did not have a health condition, but consulted a doctor for an annual check-up*** ***4. No, I did not have a health condition and did not consult a doctor*** **Question in 2012/2016 (from 2011 up to 2017)** (authors' translation from Dutch phrasing): "*Was there any time during the past 12 months when you really needed a medical examination or treatment, but that this did not occur?*" Answer options: ***1. Yes, there was at least one occasion*** ***2. No, there was no occasion*** **PH050** There is a follow-up question in which the individuals with unmet needs indicate the main reason for postponing care. In 2008, 2012/2016 the same reasons are available, but with a slightly different wording with respect to affordability: o In 2008: *"I could not afford it due to financial reasons"* o In 2012/2016: *"I could not afford it (too expensive or not covered by the sickness fund or an insurance)"* Other potential reasons for not seeking care include: no time because of work or child care, travel distance was too far, presence of waiting lists, fear of doctor or hospital, wanted to wait and see if problem got better on its own etc.

International comparability	Data on unmet healthcare needs are available in Eurostat based on the EU-SILC survey with subgroup rates by e.g. income quintile, educational attainment, sex, citizenship and age group. However, no distinction in unmet needs is made by self-reported presence of a chronic condition (PH020 variable in EU-SILC). Moreover, no distinction can be made by entitlement to the chronic illness status as the variable is specific to the Belgian public health insurance. For these reasons, no international comparison is presented.
Limitations	For the EU-SILC data, there was a revision of the phrasing of the question in 2011, which was accompanied by a significant increase in reported unmet needs.[5] Hence a direct comparison of the results of 2008 on the one hand and 2012/2016 on the other hand should be interpreted with caution. A general limitation is that unmet needs 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.
Dimension	Accessibility; Equity
Related indicators	Out-of-pocket payments on health (% of current expenditure on health) (A-2), Proportion of households with (further) impoverishing (EQ-4) and catastrophic (EQ-5) out of pocket payments.

2.2. Results

Figure 4 provides an overview of the incidence of unmet needs due to financial reasons in the population (red line) as well as for different subgroups of the population (blue bars) for the three years that were analysed. For a comprehensive analysis of self-reported unmet needs for medical care due to financial reasons, we refer the reader to KCE report 334.[1]

The overall incidence of persons aged 16 and over in Belgium reporting unmet needs for medical examination due to financial reasons increased from 0.5% in 2008 to 1.7% in 2012 and 2.2% in 2016. There are important differences between subgroups in the population.

First, there is regional variation with an incidence above the average in Brussels and Wallonia and below the average in Flanders. Differences by age or sex are small.

Second, unmet needs for financial reasons prevail among individuals in a financially precarious situation, i.e. individuals with low income, on welfare support, with severe material deprivation, in unemployment or inactivity. For example, the incidence among individuals in households at risk of poverty is 3 to 4 times higher than the population average. In 2016, the incidence reached 8.6%. Even more striking, about 1 in 9 individuals receiving welfare support and about 1 in 4 individuals with severe material deprivation indicate to have unmet needs for medical care due to financial reasons in 2016.

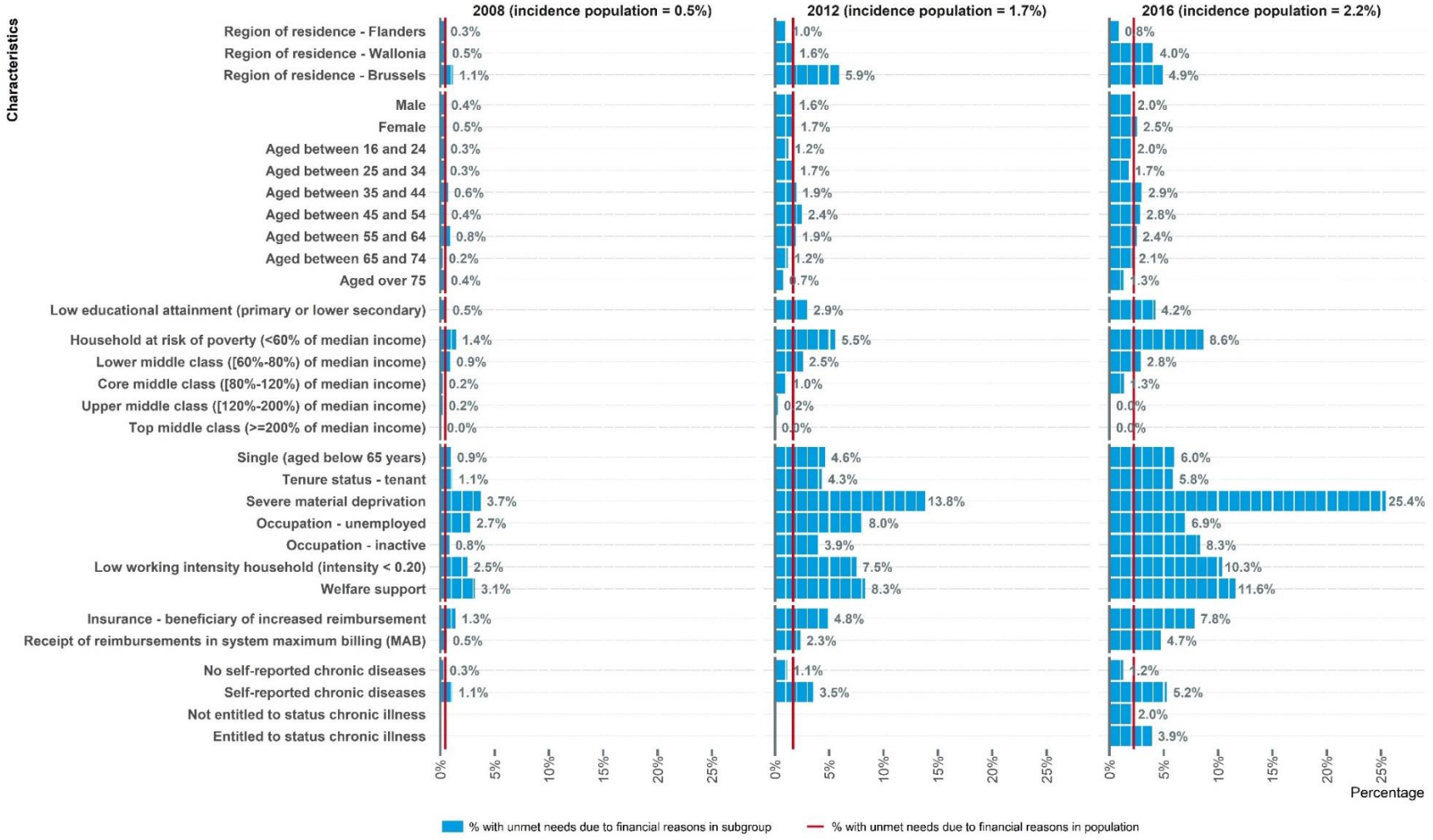
In KCE report 334, it was found that in 2016 95% of the individuals with unmet needs for medical care perceive an **inability to cope with unexpected expenses**, compared to about 22% in the subgroup without unmet needs.[1] The (perceived) inability to cope with unexpected expenses is (at least partially) related to the activity status of the individuals. The majority of the individuals with unmet needs for medical care are **at working age, but without paid work**. The incidence of unmet needs for medical care is high among individuals in households with very low working intensity, i.e. where the household members at working age spend less than 20% of their (combined) available time on paid work.

Third, important protective measures such as the system of maximum billing (MAB) and increased reimbursements status do not prevent postponement of care. Above average incidence rates are found among individuals entitled to increased reimbursement and among individuals living in household benefitting from the MAB.

Higher incidence of unmet needs among individuals with chronic condition

Fourth, the incidence of unmet needs is substantially higher among individuals who report to suffer from a chronic illness. As can be seen in the bottom four lines in Figure 4, the incidence increases from 1.1% in 2008 to 3.5% in 2012 and 5.2% among persons with a self-reported chronic condition relative to 0.3% in 2008, 1.1% in 2012 and 1.2% in 2016 among those without a self-reported chronic condition. When considering the chronic illness status as indicator for a chronic condition, we find that the incidence is nearly twice as high in 2016 among those entitled to the status (3.9%) relative to those not entitled (2.0%).

Figure 4 – Share of individuals with self-reported unmet needs for medical examination due to financial reasons in Belgium for various subgroups (years 2008, 2012 and-2016)



Key points

- **The overall incidence of persons aged 16 and over in Belgium reporting unmet needs for medical examination due to financial reasons increased from 0.5% in 2008 to 1.7% in 2012 and 2.2% in 2016. There are important differences between subgroups in the population.**
- **Unmet needs are substantially higher among individuals who report to suffer from a chronic illness. The incidence increases from 1.1% in 2008 to 3.5% in 2012 and 5.2% among those with a self-reported chronic condition relative to 0.3% in 2008, 1.1% in 2012 and 1.2% in 2016 among those without self-reported chronic condition. When considering the chronic illness status as indicator for a chronic condition, we find that the incidence is nearly twice as high in 2016 among those entitled to the status (3.9%) relative to those not entitled (2.0%).**

References

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