Unmet health care needs

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This article was adapted from "Unmet needs for health care," and "Changes in unmet health care needs" published, respectively, in the January 2002 and March 2002 issues of *Health Reports* 13, 2 and 13, 3 (Statistics Canada Catalogue no. 82-003).

It is said that one of Canada's most cherished accomplishments is its universal health care system, established to ensure reasonable access to health services for all Canadians. While the system has worked well for many years, people are now expressing some concerns about it. In 1999 over 80% of Canadians were satisfied that the health care system could meet their own and their family's needs; however, only 62% felt that it could adequately meet the needs of all residents in their province.[1] In addition, according to public opinion polls, the proportion of people who thought that health care should be the government's top priority grew from 30% to 55% between July 1998 and January 2000, reflecting increased concern about the state of the health care system.[2] In the meantime, the proportion of Canadians reporting that they did not receive the health care they thought they needed increased substantially.

1. Canadian Institute for Health Information. 2001. *National Health Expenditure Trends, 1975–2000*. Ottawa: Canadian Institute for Health Information.

2. ibid.

CST What you should know about this study

Data for the years 1994–95, 1996–97 and 1998–99 come from the National Population Health Survey (NPHS) and for 2000–01 from the Canadian Community Health Survey (CCHS).

The NPHS interviewed Canadians aged 12 or older: over 17,000 in 1994–95, over 73,000 in 1996–97 and over 15,000 in 1998–99. CCHS data were provided by nearly 56,000 respondents aged 12 or older. Information on unmet needs from both surveys is based on self-reported experiences and so is open to interpretation. Respondents may interpret an unmet need as a situation in which they did not receive care for a health problem, or when they received care, but not at the time they felt they needed it. The validity of the data was not checked against clinical or other sources.

Unmet health care needs: The NPHS and CCHS measure self-reported unmet health care needs by asking, "During the past 12 months, was there ever a time when you felt that you needed health care but you didn't receive it?" A "yes" response was tabulated as an unmet need. This question was followed by, "Thinking of the most recent time, why didn't you get care?" and then "Again, thinking of the most recent time, what was the type of care that was needed?" Major response categories were established and the data tabulated.

Because of the wording of the question addressing unmet needs, it is not possible to distinguish situations in which people did not receive services at all from those situations in which they did not receive them in a timely manner.

Access to health care is a dynamic process that involves the person seeking care, the system providing care, and the various factors that facilitate or impede this exchange. People may, therefore, not receive the care they need due to diverse circumstances ranging from the health care delivery system itself to the cost of services to their own personal circumstances and attitudes.

Based on data from the Canadian Community Health Survey (CCHS), and the National Population Health Survey (NPHS), this article focuses on the change in unmet health care needs reported by Canadians between 1998 and 2001. It describes the factors that contribute to unmet needs and explores their relationship to selected socio-demographic characteristics.

Unmet health care needs on the rise

According to the NPHS, the proportion of people aged 12 or older reporting they did not receive the health care they needed rose slightly but steadily from 4% in 1994–95 to 6% in 1998–99. Between 1998–99 and 2000–01, however, the proportion nearly doubled to reach 13%, or 3.2 million individuals. Men and women of all ages reported substantial increases in unmet health care needs.

The main reason for this increase was the large growth in the percentage of Canadians who said they had to wait a long time to get a health care appointment or treatment: the proportion grew from 23% to 30% between 1998–99 and 2000–01. However, it is difficult to determine if actual waiting times did, in fact, increase during these years or if it was only perceived waiting times that changed. According to provincial reports, the elapsed time between making an appointment and seeing the doctor lengthened in some cases, but remained relatively stable in others.

On the other hand, the percentage of individuals who claimed that their health care needs were not met because service was unavailable when or where they needed it stayed virtually the same, at around 21%. In addition, a declining proportion of Canadians attributed their unmet health needs to personal circumstances; for example, the percentage of respondents who did "not get around to it" or were "too busy" fell by several percentage points between 1998–99 and 2000–01. And the share of Canadians who said that they did not seek out care because they felt that "it would be inadequate" dropped from 13% to 5%. Other reasons for ignoring health needs, such as fear or dislike of doctors, not knowing where to go, and cost and transportation problems, did not significantly change.

People with health problems more likely to complain of long waiting times[3]

Health care needs that are not met because of lengthy waiting times or the

3. From this section on, the population covered consists of those 18 years and older, unless otherwise indicated.

CST The proportion of Canadians reporting unmet needs jumped from 23% to 30% in two years

	Population aged 12 or older reporting unmet health care needs	
	1998–99	2000–01
	%	
Reason why health needs not met		
Health care delivery		
Waiting time too long	23	30
Service not available when needed	15	14
Service not available in area	7	7
Cost and transportation		
Cost	11	9
Transportation	2[1]	2
Personal circumstances		
Did not get around to it/didn't bother	14	11
Too busy	14	10
Felt care inadequate	13	5
Decided not to seek care	5	7
Did not know where to go	4[1]	3
Dislikes or is afraid of doctors	2[1]	3
Personal or family responsibility	--	1
Other	7	19

-- Sample too small to provide reliable estimate.

1. High sampling variability.

Note: Because multiple responses were allowed, percentages do not total 100%.

Sources: Statistics Canada, National Population Health Survey, 1998–99 and Canadian Community Health Survey, September 2000 to February 2001.

unavailability of service reflect people's perceived deficiencies in health care delivery. This situation may have been exacerbated in recent years by budget cuts and system reforms, which may place a particular burden on less advantaged groups in society. However, based on analysis of NPHS respondents aged 18 or older, the prevalence of unmet health care needs resulting from inadequate health care delivery did not vary significantly, after taking account of other factors by household income, education, employment, Aboriginal status, immigrant status, age, marital status or place of residence (urban or rural).

Long wait times and the unavailability of service when and where it was needed were, however, strongly associated with an individual's health. Since people with medical problems are most in need of health care services, they are more likely than others to recognize deficiencies in the delivery of those services, particularly if their health problems remain unsolved.

For example, in 1998–99, 7% of people aged 18 or older in poor or fair health reported unmet needs related to health care delivery, compared with just 2% of people in better health. Similarly, individuals with chronic conditions, chronic pain or distress were more likely to report problems with the health care delivery system. Even when the effects of other factors were taken into account, poor or fair health, chronic conditions, and distress were associated with this type of unmet need; however, chronic pain was no longer a significant predictor of having unmet health care needs.

Compared with people who had not consulted a general practitioner or a specialist in the previous year, Canadians who had were more likely to report unmet needs due to long waiting times or service availability. Of course, physician consultations are linked to many other factors that might affect someone's health care needs, notably health status. Yet even when other factors were held constant, consultation with a general practitioner or specialist significantly increased the odds of reporting that needs went unanswered because of problems with waiting times or service availability.

CST Canadians in poor health were more likely to report long waiting times and the unavailability of services

	Population aged 18 or older reporting problems with health care delivery		Odds ratio[1]
	'000	%	
Total	**588**	**3**	
Men	*229*	*2*	*1.00*
Women	358	3	1.17
Self-reported health			
Poor/fair	149	7	1.84*
Good/very good/excellent	*439*	*2*	*1.00*
Chronic condition			
Yes	470	3	1.46*
No	*117*	*1*	*1.00*
Chronic pain			
Yes	187	6	1.45
No	*400*	*2*	*1.00*
Distress			
Yes	146	6	1.71*
No	*441*	*2*	*1.00*
General practitioner consultation in past year			
Yes	545	3	2.24*
No	*43*	*1*	*1.00*
Specialist consultation in past year			
Yes	316	5	2.33*
No	*272*	*2*	*1.00*
Doctor's authority score			
High	72	2	0.42*
Middle	413	3	0.70
Low	*103*	*4*	*1.00*
Self-care score			
High	142	2	1.07
Middle	273	3	1.20
Low	*173*	*3*	*1.00*

* Significantly different from reference group at the 95% confidence level.

1. Presents the odds of individuals with particular characteristics reporting problems with health care delivery relative to the odds of a benchmark group when all other variables in the model are held constant.

Note: Italics denote reference groups.

Source: Statistics Canada, National Population Health Survey, 1998–99.

CST Health Services Access Survey

On July 15, 2002 the first results of the Health Services Access Survey were released. The survey, developed by Statistics Canada, was partly funded by Health Canada and the provinces of Prince Edward Island, Alberta and British Columbia. Among other topics, the survey collected information on the difficulties reported by Canadians in accessing health care. Following are some selected results.

Some 18% (just under 4.3 million) of Canadians who needed routine care, health information and immediate care for a minor health problem encountered a difficulty of some kind. So did 23% (about 1.4 million) of those requiring specialist visits, non-emergency surgery and diagnostic tests. While the type of difficulty varied by type of service, long waits topped the list.

Just over 5% of Canadians who reported needing to see a specialist or to take a diagnostic test had waited 26 weeks or more before receiving these services. Similarly, close to 10% of those who reported needing non-emergency surgery had waited 26 weeks or more and 5% had waited for 35 weeks or longer, but the waiting time varied by type of surgery. People who needed cardiac or cancer related surgery were more likely to receive services within one month (54%) than those requiring a joint replacement or cataract surgery (20%).

Nearly one in five (18% or 900,000) people who visited a specialist reported that waiting affected their lives. The majority (59%) reported worry, anxiety or stress. About 37% said they experienced pain. The situation was similar among individuals waiting for a diagnostic test. Over 20% of those who waited for specialized services felt the length of time was unacceptable.

For more information, see *The Daily*, Monday, July 15, 2002, www.statcan.ca.

A related factor is attitudes toward physicians. People with a high level of trust in doctors were less likely than those with a low level to report that their unmet health care needs stemmed from waiting times or service availability. Even when other factors including health status and physician consultations were considered, a strong tendency to trust doctors was associated with low odds of reporting unmet needs of this kind.

Income affects unmet health needs stemming from cost or transportation difficulties

In 1998–99, slightly less than 1% of Canadians aged 18 or older (about 200,000 people) reported that they had not received the care they needed because of problems related to cost or transportation. The odds of having unmet health care needs due to these reasons were high for people reporting chronic conditions, chronic pain and distress.

Not surprisingly, having cost or transportation difficulties was also related to household income. In 1998–99, over 3% of residents in low-income households reported unmet health care needs due to these concerns, compared with only 0.3% of people in upper-middle and high-income households. Even when other factors were held constant, the odds that low-income households would report these difficulties were about 10 times higher than the odds for upper-middle and high-income households.

These results are consistent with a recent Canadian study in which low-income people, especially the working poor, said their main reason for not obtaining physician services was they believed they would be unable to afford prescribed medications. The same study also showed that lack of transportation was one reason why social assistance recipients did not see a physician.[4]

Personal circumstances and attitudes account for most unmet needs

In 1998–99, over half of individuals aged 18 or older with unmet health care needs (53%) stated that they had not pursued getting health care because they were too busy, decided not to bother, believed that care would be inadequate, did not know where to go, or disliked or feared doctors. Young people were most likely to voice these problems. Even when other factors like health status were taken into account, 18- to 34-year-olds still had significantly higher odds of reporting unmet health care needs due to personal reasons than did people aged 65 or older. Perhaps younger people's busier schedules, and different

4. Williamson, D.L. and J.E. Fast. 1998. "Poverty and medical treatment: When public policy compromises accessibility." *Canadian Journal of Public Health* 89, 2: 120-124.

attitudes toward and knowledge about health care may explain some of these disparities.

A person's attitude toward health care was, in fact, an important factor in predicting unmet health care needs. The more respondents trusted doctors' authority, the lower the prevalence of unmet needs related to personal circumstances. Even when other factors were taken into account, high regard for physician authority lowered the odds of having unmet health care needs for these reasons. Conversely, a strong tendency to rely on self-care raised the odds.

Almost 9% of people in poor or fair health had unmet needs due to personal circumstances, compared with 3% whose health was good to excellent. When taking other factors into account, the odds of reporting unmet needs due to personal circumstances were significantly higher for people in poor of fair health.

Aboriginal people living off-reserve had a higher prevalence of unmet needs due to personal circumstances and attitudes than did non-Aboriginal people: 8% versus 3%. The relationship still held when the effects of factors such as household income and health status were considered.

But although it appeared that people in low-income households were also more likely to have unmet health care needs stemming from personal circumstances than people in upper-middle and high-income households, when other factors were taken into account, the difference was not statistically significant. Similarly, the effects of education, place of residence (urban or rural) and immigrant status were not statistically significant when other characteristics were considered.

Women more likely than men to report unmet health care needs

Women were more likely than men to report that their health needs were not met due to waiting times, service availability (when and where required) and personal circumstances.

The gender gap in unmet needs related to service availability persisted when demographic and socio-economic characteristics were controlled for. However, when health status was taken into account, the difference between the sexes was no longer statistically significant. Health status, it appears, was a key factor linking gender with availability-related unmet needs, since women's self-perceived health tended to be poorer than men's.

The gender difference in having unmet health care needs related to personal circumstance and attitudes was statistically significant when the selected demographic and socio-economic factors were controlled for. But when attitudes toward doctors' authority and self-care were taken into account, the gap between men and women disappeared. Such beliefs may act as mediators linking gender with personal and attitude-related unmet health care needs.

Summary

In 2000–01, one in eight people aged 12 or older reported that they had had health care needs that were not met, up from 1 in every 24 people in 1994–95 and nearly double the rate from 1998–99. Waiting for health care services was the leading reason offered by people reporting unmet needs, and the number of people citing this reason rose substantially between 1998–99 and 2000–01.

In 1998–99, among respondents aged 18 or older, the factors associated with different types of unmet needs tended to vary. Just two factors — chronic conditions and distress — were significantly related to all three types: health care delivery, cost and transportation, and personal circumstances and attitudes. Other measures of health status and physician consultations were associated with unmet needs related to service availability and personal circumstances and attitudes. People who trusted doctors had relatively low odds of reporting unmet needs due to service availability or personal circumstances. It is not clear if this was because such people were less skeptical about health care services or because they had had positive experiences when receiving health care in the past.[5]

5. Ross, C.E. and R.S. Duff. 1982. "Returning to the doctors: The effect of client characteristics, type of practice, and experience with care." *Journal of Health and Social Behaviour* 23: 119-131.

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