Coverage for health care

Most OECD countries have achieved near-universal coverage of health care costs for a core set of services, which usually include consultations with doctors and specialists, tests and examinations, and surgical and therapeutic procedures (Figure 6.10). **Two OECD countries do not have universal health coverage**. In Mexico, the "Seguro Popular" voluntary health insurance scheme was introduced in 2004 to provide coverage for the poor and uninsured, and grew so rapidly that by 2011, nearly 90% of the population was covered. In the United States, coverage is provided mainly through private health insurance, and 53% of the population had this for their basic coverage in 2011. Publicly financed coverage insured 32% of the population (the elderly, people with low income or with disabilities), leaving 15% of the population without health coverage.

Basic primary health coverage, whether provided through public or private insurance, generally covers a defined "basket" of benefits, in many cases with cost-sharing. In some countries, additional health coverage can be purchased through private insurance to cover any cost-sharing left after basic coverage (complementary insurance), add additional services (supplementary insurance) or provide faster access or larger choice to providers (duplicate insurance).

The population covered by private health insurance has increased in some OECD countries over the past decade. It doubled in Belgium between 2000 and 2011 to reach 80%. It also increased in Mexico and Turkey, although it remains at a very low level. On the other hand, private health insurance coverage decreased slightly in Chile and the United States, two countries where it plays a significant role in primary coverage for health care (Figure 6.11).

Problems of access to health care can be measured by the actual utilisation of health care services and reported unmet health care needs. Any inequalities in health care utilisation and unmet care needs may result in poorer health status and increase health inequalities. A European-wide survey, conducted on an annual basis, provides information on the proportion of people reporting having some unmet needs for medical examination for different reasons. **In all countries, people with low incomes are more likely to report unmet care needs than people with high incomes (Figure 6.12)**. **The gap was particularly large in Greece, Hungary and Italy**. Those with low incomes report the most common reason to be cost while high income people report more often that their unmet care needs are due to a lack of time and a willingness to wait and see if the problem may simply go away.

Definition and measurement

Coverage for health care is defined here as the share of the population receiving a core set of health care goods and services under public programmes and through private health insurance. It includes those covered in their own name and their dependents. Public coverage refers both to government programmes, generally financed by taxation, and social health insurance, generally financed by payroll taxes. Take-up of private health insurance is often voluntary, although it may be mandatory by law or compulsory for employees as part of their working conditions. Premiums are generally non-income-related, although the purchase of private coverage can be subsidised by government.

Data on unmet health care needs come from the European Union Statistics on Income and Living Conditions survey (EU-SILC). Survey respondents are asked whether there was a time in the previous 12 months when they felt they needed a medical examination but did not receive it, followed by a question as to why the need for care was unmet. The reasons include that care was too expensive, the waiting time was too long, the travelling distance to receive care was too far, a lack of time, or that they wanted to wait and see if problem got better on its own. Figures presented here cover unmet care needs for any reason.

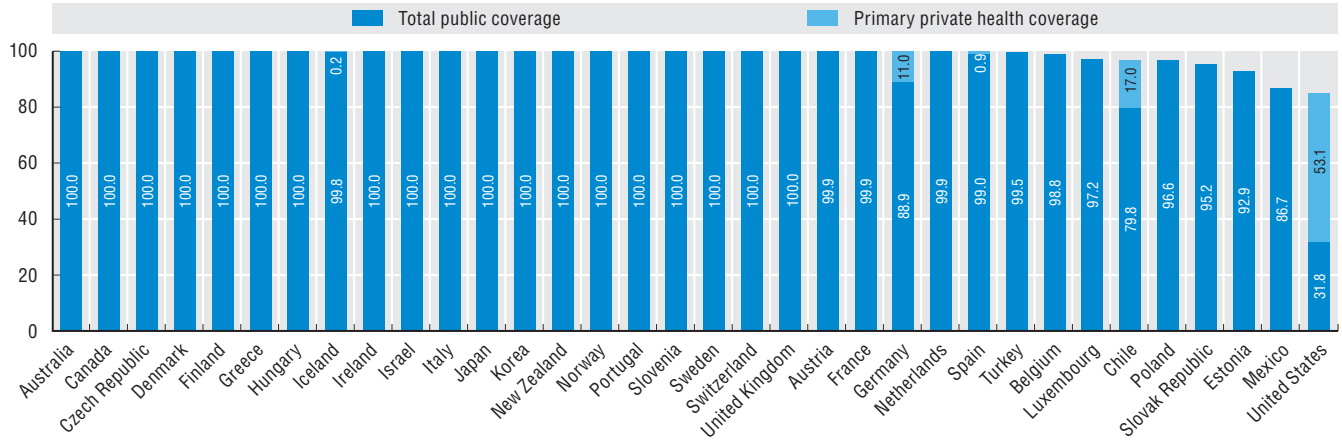
Further reading

OECD (2013), *Health at a Glance 2013: OECD Indicators*, OECD Publishing, Paris, *http://dx.doi.org/10.1787/health_glance-2013-en*.

Information on data for Israel: *http://dx.doi.org/10.1787/888932315602*.

6.10. Most OECD countries have achieved universal coverage for health care

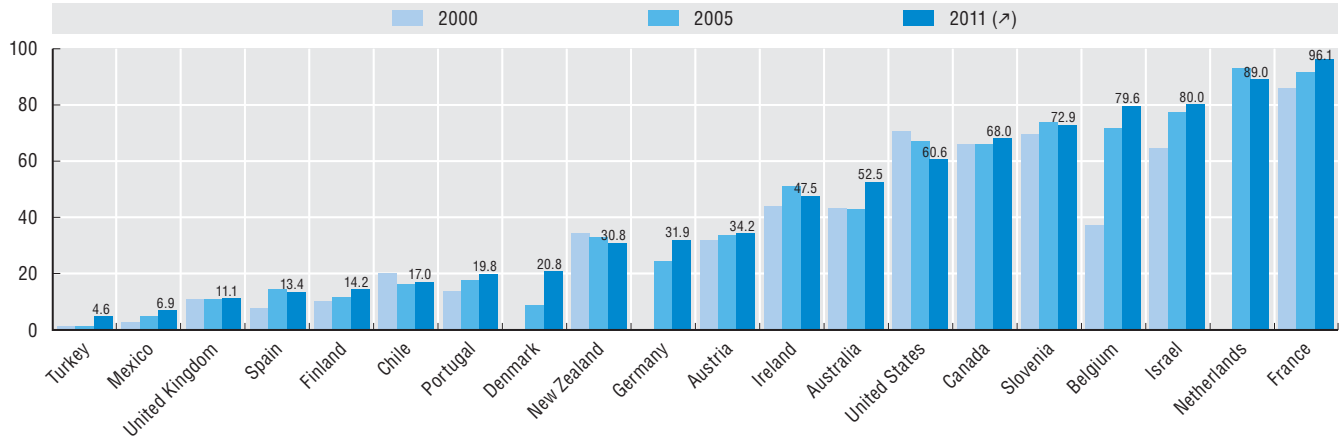
Health insurance coverage for a core set of services, in percentage of total population, in 2011



Source: OECD Health Statistics 2013 (http://dx.doi.org/10.1787/health-data-en).

6.11. The population covered by private health insurance has increased in some OECD countries

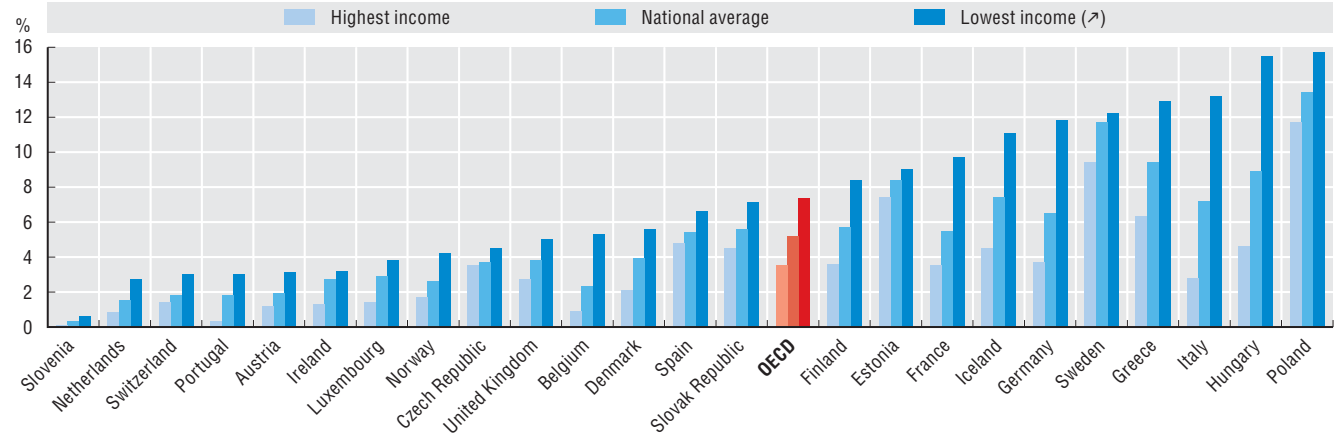
Evolution in private health insurance coverage, in percentage of total population, 2000, 2005 and 2011



Source: OECD Health Statistics 2013 (http://dx.doi.org/10.1787/health-data-en).

6.12. People with low incomes are more likely to report unmet care needs than people with high incomes

Percentage of unmet care needs for medical examination by income level, European countries, 2011



Source: EU-SILC 2011.

StatLink http://dx.doi.org/10.1787/888932966637

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