6.1. Coverage for health care

Health care coverage through public or private health insurance promotes access to medical goods and services, and provides financial security against unexpected or serious illness (OECD, 2004a). However, the percentage of the population covered does not provide a complete indicator of accessibility, since the range of services covered and the degree of cost-sharing applied to those services also affects access to care.

Most OECD countries have achieved universal (or 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 6.1.1). Generally, dental care and pharmaceutical drugs are partially covered, although there are a number of countries where these services are not covered at all (Paris, Devaux and Wei, 2010).

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 has grown rapidly so 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. The problem of persistent un-insurance is a major barrier to receiving health care, and more broadly, to reducing health inequalities among population groups (AHRQ, 2011b). The Affordable Care Act, adopted in 2010, will expand health insurance coverage in the United States, which will become mandatory for nearly all citizens and legal residents from January 2014.

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). Among the 34 OECD countries, ten have private coverage for over half of the population (Figure 6.1.2).

Private health insurance offers 96% of the French population *complementary* insurance to cover cost-sharing in the social security system. The Netherlands has the largest *supplementary* market (89% of the population), followed by Israel (80%), whereby private insurance pays for prescription drugs and dental care that are not publicly reimbursed. *Duplicate* markets, providing faster private-sector access to medical services where there are waiting times in public systems, are largest in Ireland (48%) and Australia (45%).

The population covered by private health insurance has increased in some OECD countries over the past decade. It has doubled in Belgium to reach 80%. It has also increased in Mexico and Turkey, although it remains at a very low level. On the other hand, private health insurance coverage has decreased at least slightly in Chile and the United States, two countries where it plays a significant role in primary coverage for health care (Figure 6.1.3).

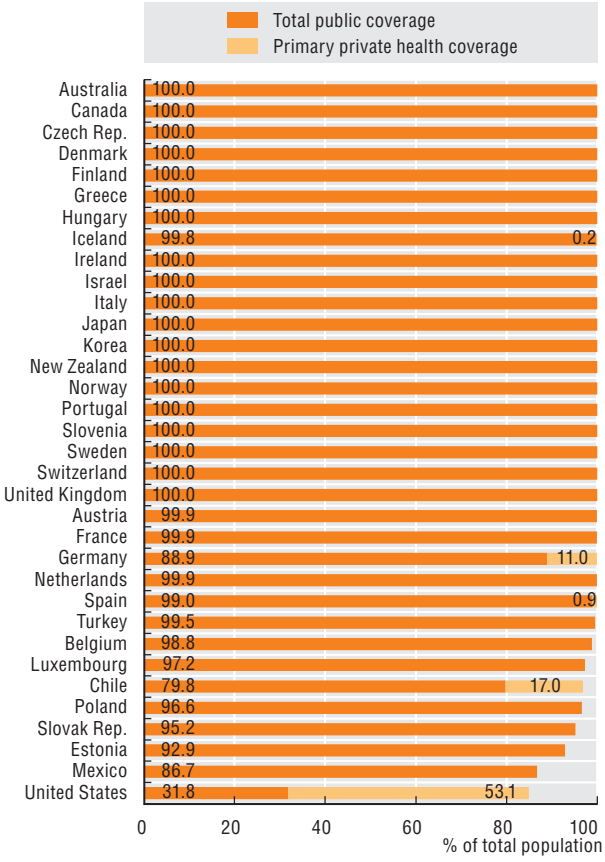
The importance of private health insurance is not linked to a countries' economic development. Other factors are more likely to explain market development, including gaps in access to publicly financed services, the way private providers are financed, government interventions directed at private health insurance markets, and historical development (OECD, 2004b).

Definition and comparability

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.

Private health insurance can be both complementary and supplementary in Denmark, Korea and New Zealand.

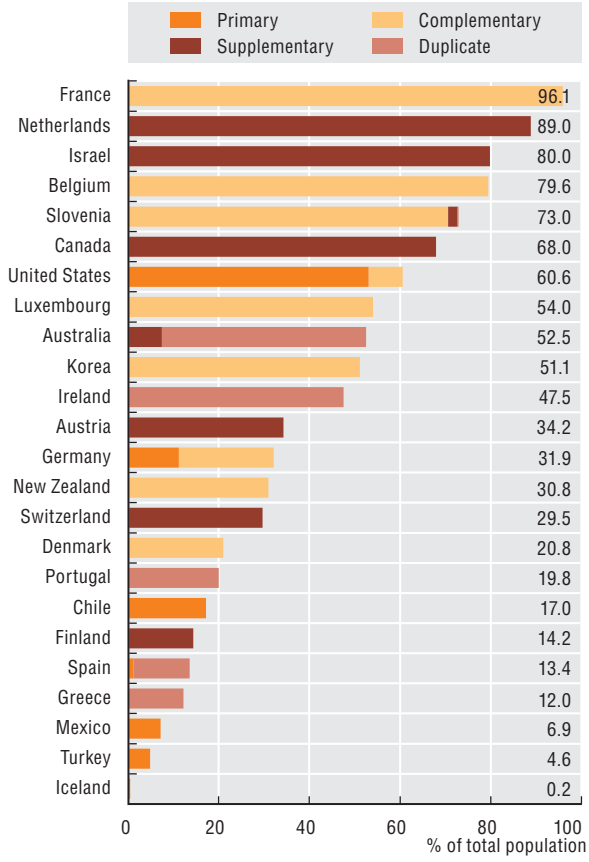
6.1.1. Health insurance coverage for a core set of services, 2011



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

StatLink http://dx.doi.org/10.1787/888932918491

6.1.2. Private health insurance coverage, by type, 2011 (or nearest year)

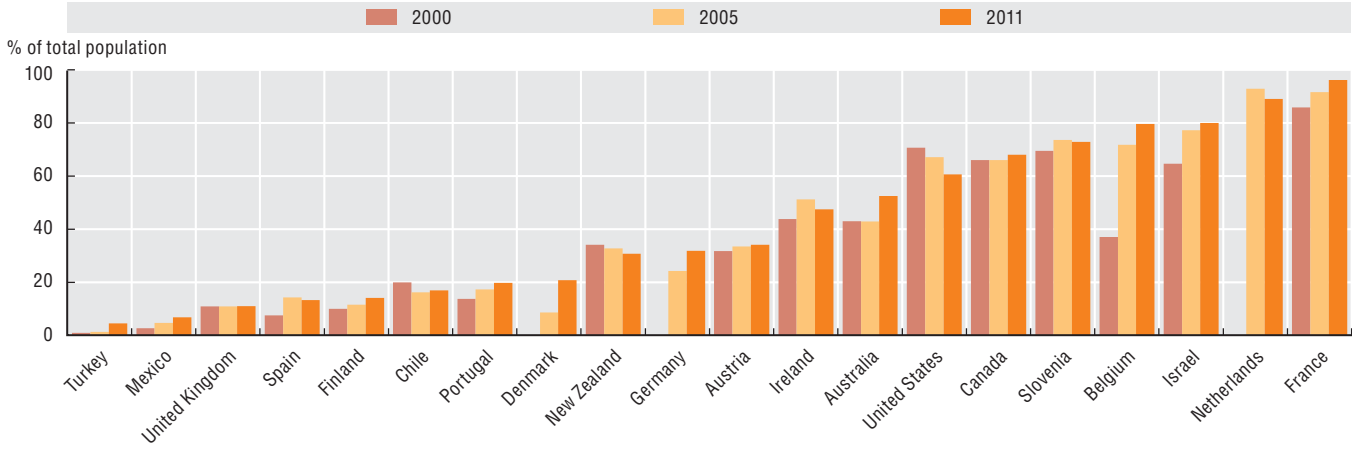


Note: Private health insurance can be both complementary and supplementary in Denmark, Korea and New Zealand; and duplicate, complementary and supplementary in Israel.

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

StatLink http://dx.doi.org/10.1787/888932918510

6.1.3. Evolution in private health insurance coverage, 2000 to 2011



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

StatLink http://dx.doi.org/10.1787/888932918529