Health care coverage enables access to medical goods and services and provides financial protection against unexpected or serious illness. While the share of the population covered by a public or private health insurance provides some indication of financial protection, this is not a complete indicator of accessibility, since the range of services covered and the degree of cost sharing applied to those services vary across countries and will impact on direct out-of-pocket expenditure by patients. Ensuring effective access to health care also requires having a sufficient number of health care providers in different geographic regions in the country and that patients do not have to wait excessively long times to receive services.

Most European countries have achieved universal (or near-universal) coverage of health care costs for a core set of services, which usually include consultations with doctors, tests and examinations and hospital care (Figure 7.1). In most countries, dental care (especially for children) and the purchase of prescribed pharmaceuticals are also at least partially covered (Paris et al., 2016). Four European countries, however, have at least 10% of their population that is not covered for health care costs (Cyprus, Greece, Romania and Bulgaria).

In Bulgaria, Romania and Greece, the share of the population covered has decreased since the onset of the economic crisis. In Bulgaria, a tightening of the law in 2010 made people lose their social health insurance coverage if they fail to pay their contribution (Dimova et al., 2012). However, it is common for uninsured people who need medical care to go to emergency services, where they will be encouraged to get an insurance (without paying any financial penalty for not having had an insurance prior to that).

In Romania, although social health insurance is compulsory, only 86% of the population was covered in 2014. The proportion of the population covered was higher in urban areas (94.9%) than in rural areas (75.8%). The uninsured population include mainly people working in agriculture or those not officially employed in the private sector; self-employed or unemployed who are not registered for unemployment or social security benefits; and Roma people who do not have identity cards, which preclude them from enrolling into the social security system. The uninsured can only access a minimum benefits package, which is strictly enforced. This package covers emergency care, treatment of communicable diseases and care during pregnancy (Vlădescu et al., forthcoming).

In Greece, the economic crisis has reduced health insurance coverage among people who have become long-term unemployed, and many self-employed workers have also decided not to renew their health insurance plan because of reduced disposable income. However, since June 2014, uninsured people are covered for prescribed pharmaceuticals and for free services in primary care and public hospitals, the latter under certain conditions, such as referral by an expert panel (Eurofound, 2014; WHO, 2015). In Cyprus, an estimated 83% of the population were entitled to public health services in 2013, although many are seeking medical care in the private sector and pay out-of-pocket.

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). In most European countries, only a small proportion of the population has an additional private health insurance. But in five countries, half or more of the population had a private health insurance in 2014 (Figure 7.2).

In France, nearly all the population (95%) has a *complementary* private health insurance to cover cost sharing in the social security system. A large proportion of the population in Belgium, Slovenia, Croatia and Luxembourg also make use of complementary health insurance. The Netherlands has the largest *supplementary* market (85% of the population), whereby private insurance pays for prescribed pharmaceuticals and dental care that are not covered in the basic package. *Duplicate* markets, providing faster private-sector access to medical services where there are waiting times in public systems, are largest in Ireland (44%), followed by Portugal and Spain.

While the population covered by private health insurance has grown over the past decade in some countries like France, Belgium, Denmark and Germany, there has been a reduction in private health insurance coverage in recent years in other countries like the Netherlands and Ireland (Figure 7.3).

The importance of private health insurance is linked to several factors, including gaps in access to publicly financed services, government interventions directed at private health insurance markets and historical development.

Definition and comparability

Coverage for health care is defined as the share of the population receiving a defined 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 the government.

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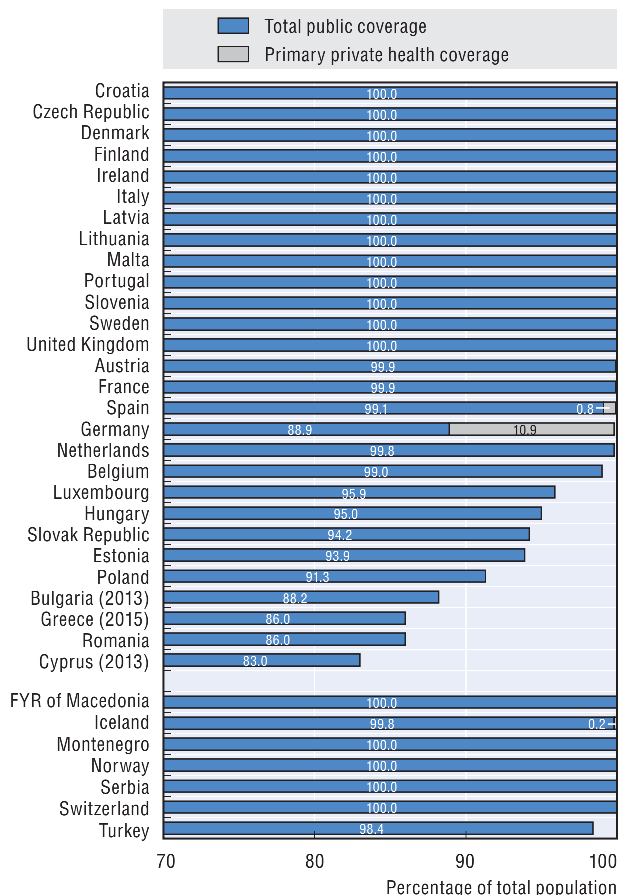
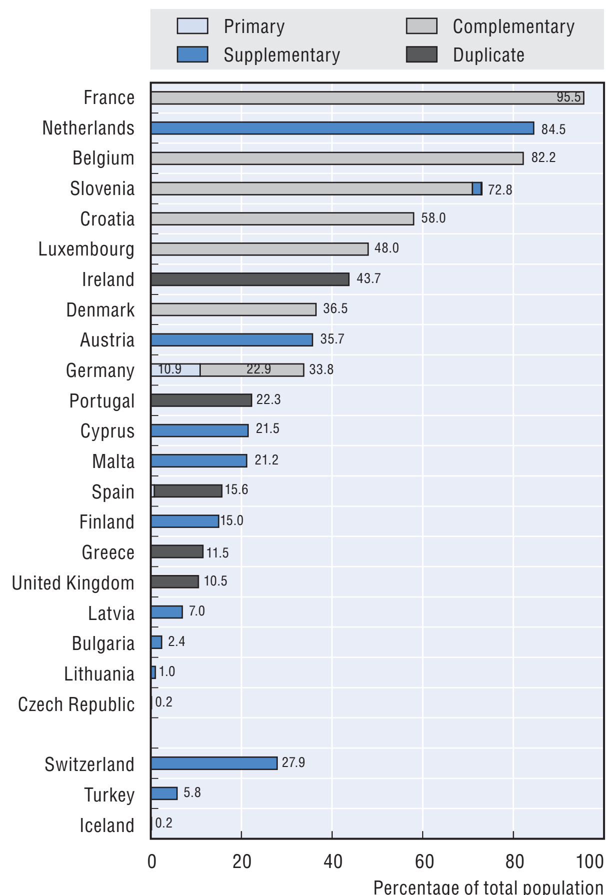
7.1. Health insurance coverage for a core set of services, 2014 (or nearest year)



Source: *OECD Health Statistics 2016*; European Observatory Health Systems in Transition (HiT) Series and Voluntary health insurance in Europe: country experience, Observatory Studies Series, 2016, for non-OECD countries.

StatLink http://dx.doi.org/10.1787/888933429701

7.2. Private health insurance coverage, by type, 2014 (or nearest year)

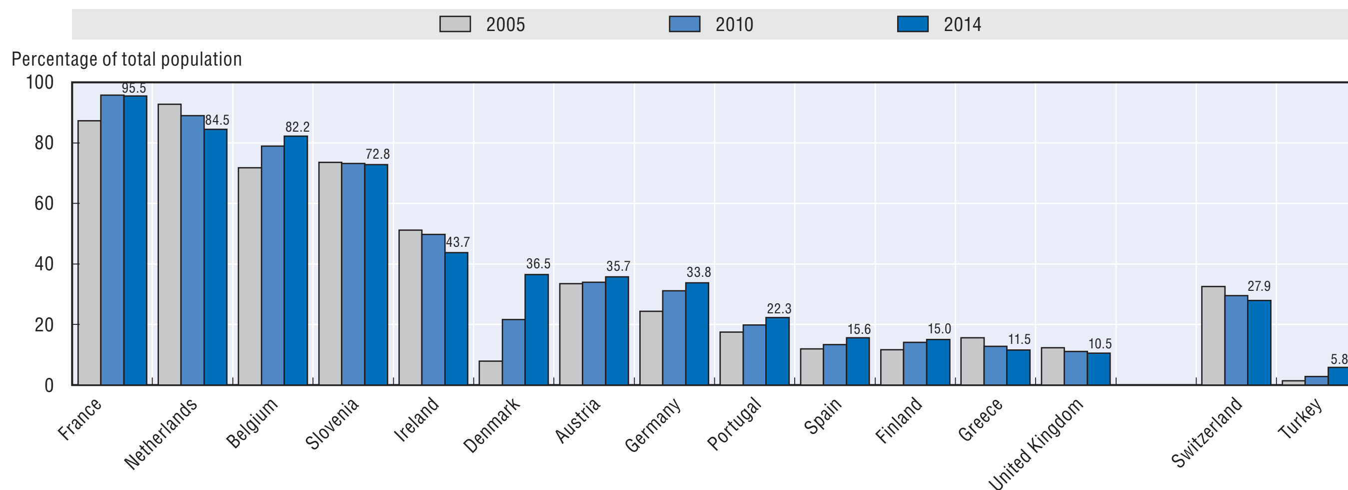


Note: Private health insurance can be both complementary and supplementary in Denmark, Finland and Luxembourg; and duplicate, complementary and supplementary in Slovenia.

Source: *OECD Health Statistics 2016*; European Observatory Health Systems in Transition (HiT) Series and Voluntary health insurance in Europe: country experience, Observatory Studies Series, 2016, for non-OECD countries.

StatLink http://dx.doi.org/10.1787/888933429711

7.3. Evolution in private health insurance coverage, 2005 to 2014



Source: *OECD Health Statistics 2016.*

StatLink http://dx.doi.org/10.1787/888933429727

From:
Health at a Glance: Europe 2016
State of Health in the EU Cycle

Access the complete publication at:
https://doi.org/10.1787/9789264265592-en

Please cite this chapter as:

OECD/European Union (2016), “Coverage for health care”, in *Health at a Glance: Europe 2016: State of Health in the EU Cycle*, OECD Publishing, Paris.

DOI: https://doi.org/10.1787/health_glance_eur-2016-50-en

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