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. However, the percentage of the population covered by such insurance 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 7.1). Generally, dental care and pharmaceutical drugs are partially covered, although there are a number of countries where these services must be purchased separately (OECD, 2015).

Three OECD countries do not have universal (or near-universal) health coverage: Greece, the United States and Poland. 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 services in emergency departments in public hospitals, as well as for non-emergency hospital care under certain conditions (Eurofound, 2014). In the United States, coverage is provided mainly through private health insurance, and 54% of the population had this for their basic coverage in 2014. Publicly financed coverage insured 34.5% of the population (the elderly, people with low income or with disabilities), leaving 11.5% of the population without insurance. The percentage of the population uninsured decreased from 14.4% in 2013 to 11.5% in 2014, following the implementation of the Affordable Care Act which is designed to expand health insurance coverage (Cohen and Martinez, 2015). In Poland, a tightening of the law in 2012 made people lose their social health insurance coverage if they fail to pay their contribution. However, it is common for uninsured people who need medical care to go to emergency services in hospital, where they will be encouraged to get an insurance.

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, nine have private coverage for over half of the population (Figure 7.2).

Private health insurance offers 95% of the French population *complementary* insurance to cover cost-sharing in the social security system. The Netherlands has the largest *supplementary* market (86% of the population), followed by Israel (83%), 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 (45%) and Australia (47%).

The population covered by private health insurance has increased in some OECD countries over the past decade, whereas it has decreased in others. It increased in some Nordic countries such as Denmark where one-third of the population now has a private health insurance (up from less 10% in 2005) and in Finland where the growth has been more modest, but remains almost non-existent in other Nordic countries. Private health insurance coverage has also increased in Australia and Korea, but it has come down in Ireland, New Zealand and the United Kingdom (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 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.

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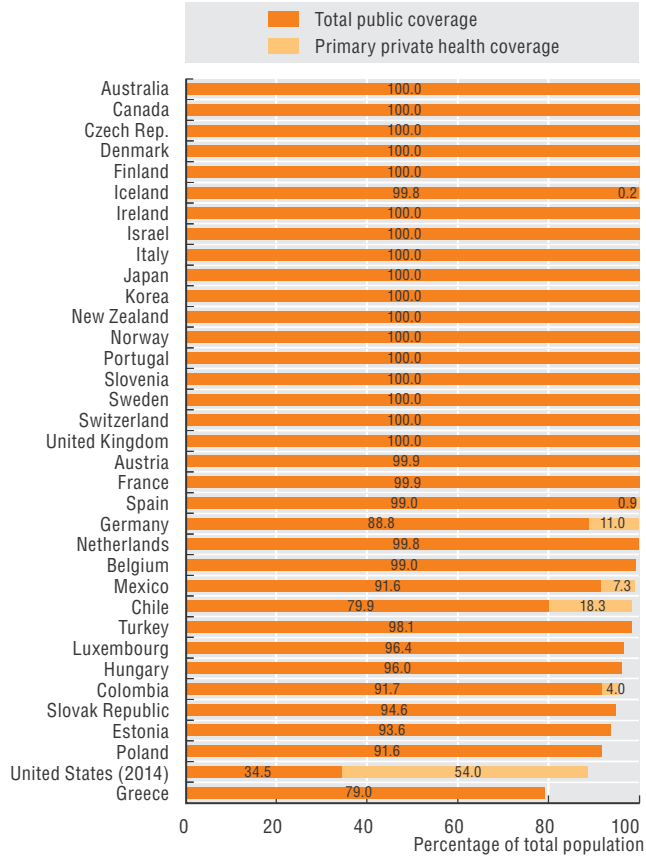
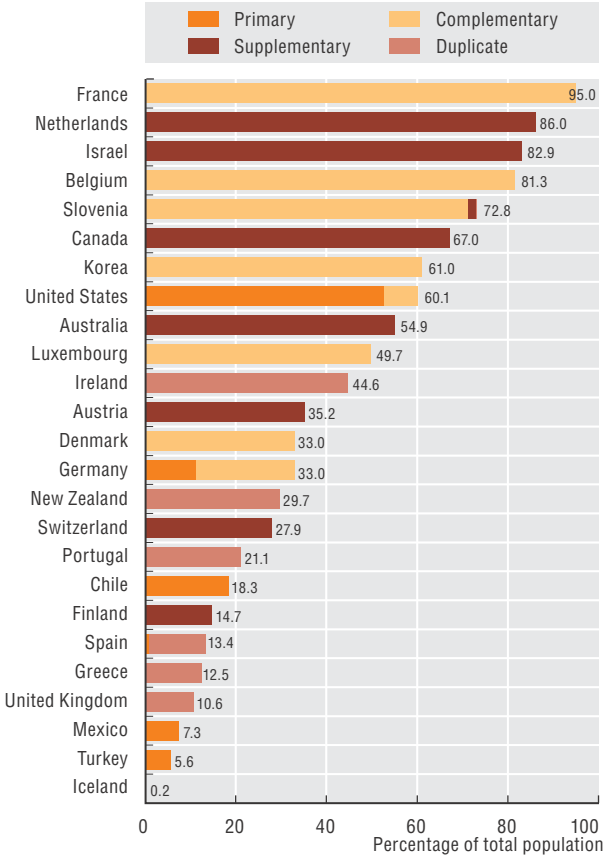
7.1. Health insurance coverage for a core set of services, 2013



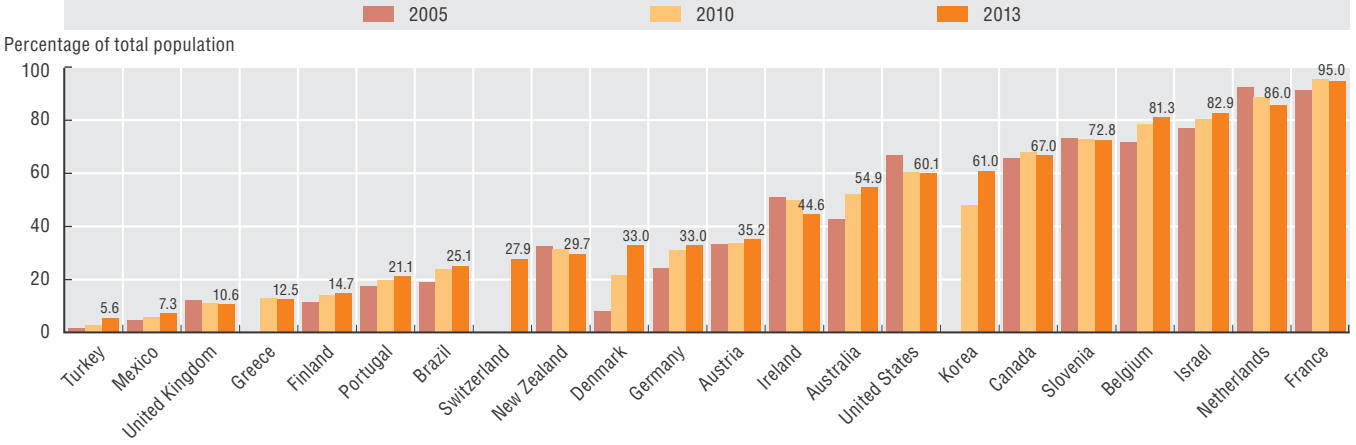
Source: OECD Health Statistics 2015, *http://dx.doi.org/10.1787/health-data-en.*
StatLink http://dx.doi.org/10.1787/888933281052

7.2. Private health insurance coverage, by type, 2013 (or nearest year)



Note: Private health insurance can be both duplicate and supplementary in Australia; both complementary and supplementary in Denmark and Korea; and duplicate, complementary and supplementary in Israel and Slovenia.
Source: OECD Health Statistics 2015, *http://dx.doi.org/10.1787/health-data-en.*
StatLink http://dx.doi.org/10.1787/888933281052

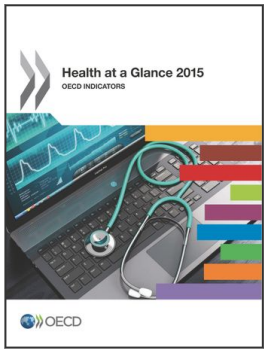
7.3. Evolution in private health insurance coverage, 2005 to 2013



Source: OECD Health Statistics 2015, *http://dx.doi.org/10.1787/health-data-en.*

StatLink http://dx.doi.org/10.1787/888933281052

Information on data for Israel: *http://oe.cd/israel-disclaimer*



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