POPULATION COVERAGE FOR HEALTH CARE

The share of the population covered by a public or private scheme provides some indication of the financial protection against the costs associated with health care, but this is not a complete indicator of affordability as the range of services covered and the degree of cost-sharing applied to those services also matter. These three dimensions – the "breadth", "depth" and "height" of coverage – define how comprehensive health care coverage is in a country. The indicator presented here on population coverage looks at the first dimension only, whereas the next indicator on the extent of health care coverage takes a broader look at these three dimensions together.

Most European countries have achieved universal (or near-universal) coverage for a core set of services, which usually include consultations with doctors, tests and examinations and hospital care (Figure 7.7). Yet, in some countries coverage of these core services may not be universal. In Ireland, for example, only around 50% of the population is covered for the costs of GP visits, although recent reform proposals suggest a gradual roll out of primary care coverage to the entire population (OECD/European Observatory on Health Systems and Policies, 2017). In Greece, a new law in 2016 (Law 4368/2016) provided universal health coverage for the whole population, closing the coverage gap for the 10% of the population that were previously uninsured. These previously uninsured people now have legally-recognised access to a broad range of services and goods (including hospital care and prescribed pharmaceuticals), like any other Greek citizen.

Three European countries (Cyprus, Bulgaria and Romania) still have at least 10% of their population not covered for health services. In Bulgaria, the share of the population covered has decreased since 2010 when a tightening of the law resulted in people losing their social health insurance coverage if they failed to pay their contribution (Dimova et al., 2012). 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 insurance (without paying any financial penalty for not having had an insurance prior to that). In Romania, although social health insurance is compulsory, only 89% of the population was covered in 2017. The uninsured population include mainly people working in agriculture, self-employed or unemployed people who are not registered for unemployment or social security benefits, and Roma people who do not have identity cards (which precludes them from enrolling into the social security system). The uninsured can only access a minimum benefits package, covering emergency care, treatment of communicable diseases and care during pregnancy (Vlădescu et al., 2016).

Basic primary health coverage generally covers a defined set of benefits, but 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 of providers (duplicate insurance). In most European countries, only a small proportion of the population has an additional private health insurance. But in five countries (France, Netherlands, Slovenia, Belgium and Croatia), half or more of the population has private coverage (Figure 7.8).

In France, nearly all the population (96%) has a complementary private health insurance to cover cost sharing in the social security system. The Netherlands has the largest supplementary market (87% of the population), whereby private insurance pays for dental care that is not publicly reimbursed. Duplicate private health insurance, providing faster private-sector access to medical services where there are waiting times in public systems, is largest in Ireland (45%).

The population covered by private health insurance has increased in some countries over the past decade, particularly in Denmark, Slovenia and Belgium (Figure 7.9). The development 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

Population coverage for health care is defined as the share of the population covered for a defined set of health care goods and services under public programmes and through private health insurance. Public coverage refers both to government programmes, generally financed by taxation, and social health insurance, generally financed by payroll taxes. The 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.

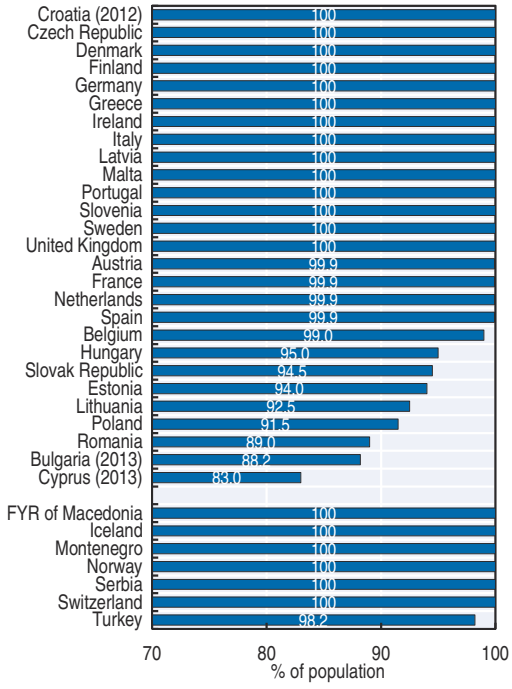
References

Dimova, A. et al. (2012), "Bulgaria: Health System Review", Health Systems in Transition, Vol. 14, No. 3.

OECD/European Observatory on Health Systems and Policies (2017), "Ireland, Country Health Profile 2017", State of Health in the EU, *https://ec.europa.eu/health/state/country_profiles_en*.

Vlădescu, C. et al. (2016), "Romania: Health System Review", Health Systems in Transition, Vol. 18, No. 4.

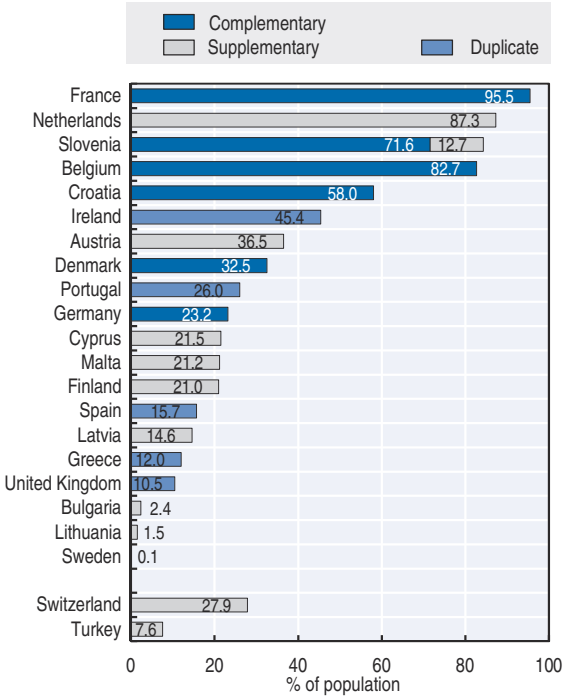
7.7. Population coverage for a core set of services, 2016 (or nearest year)



Note: This includes public coverage and primary private health coverage. Data for Luxembourg is not available.
Source: OECD Health Statistics 2018, *https://doi.org/10.1787/health-data-en*; European Observatory Health Systems in Transition (HiT) Series for non-OECD countries.

StatLink http://dx.doi.org/10.1787/888933836314

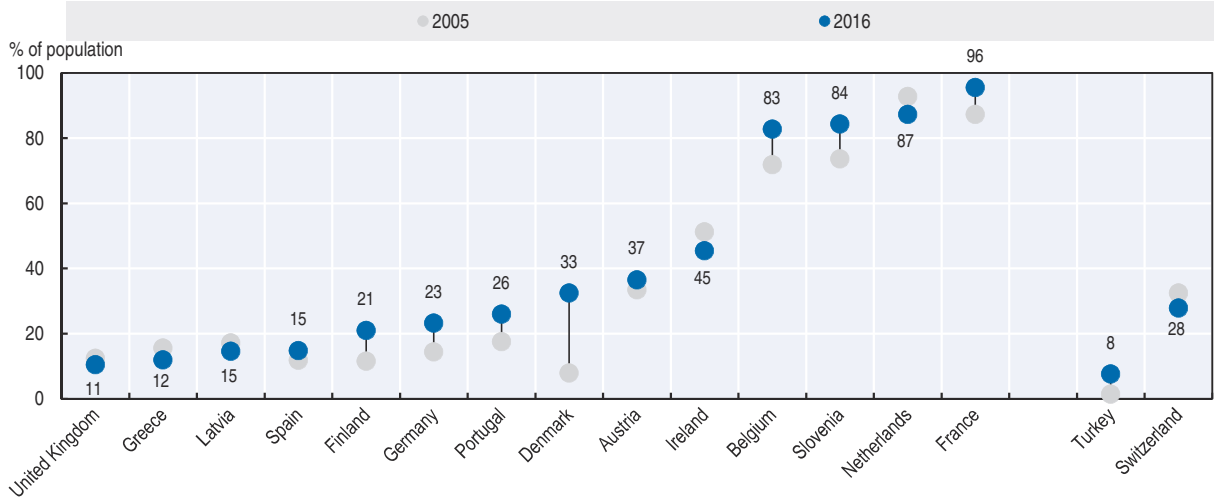
7.8. Private health insurance coverage, 2016 (or nearest year)



Note: This excludes primary PHI. PHI can be both complementary and supplementary in Denmark and Germany.
Source: OECD Health Statistics 2018, *https://doi.org/10.1787/health-data-en*; and Voluntary health insurance in Europe: country experience, Observatory Studies Series, 2016, for non-OECD countries.

StatLink http://dx.doi.org/10.1787/888933836333

7.9. Trends in private health insurance coverage, 2005 to 2016 (or nearest year)



Note: These data exclude primary private health insurance.
Source: OECD Health Statistics 2018, *https://doi.org/10.1787/health-data-en*.

StatLink http://dx.doi.org/10.1787/888933836352

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