Population coverage for health care

Health care coverage, through government schemes and private health insurance, provides financial security against unexpected or serious illness. However, the percentage of the population covered by such schemes 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 5.1). 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). Universal coverage has typically been achieved through government schemes (national health systems or social health insurance), though a few countries (the Netherlands and Switzerland) use compulsory private health insurance to cover some or all of the population.

Population coverage for a core set of services is below 95% in seven OECD countries, and lowest in Greece, the United States and Poland. In Greece, the economic crisis continues to have a significant effect, reducing health insurance coverage among the long-term unemployed. Many self-employed workers have also decided not to renew their health insurance because of reduced disposable income. However, since 2014 uninsured people are covered for prescribed pharmaceuticals, emergency services in public hospitals, and for non-emergency hospital care under certain conditions (Eurofound, 2014). Further, since 2016 new legislation has sought to close remaining coverage gaps. In the United States, coverage is provided mainly through private health insurance. Publicly financed coverage covers the elderly, and people with low income or with disabilities. The share of the population uninsured decreased from 14.4% in 2013 to 9.1% in 2015. This followed implementation of the Affordable Care Act, which was designed to expand health insurance coverage (Cohen and Martinez, 2015). However, this Act is under review by the current United States administration. In Poland, a tightening of the law in 2012 made people lose their social health insurance coverage if they fail to pay their contribution. But uninsured people who need medical care utilise emergency hospital services, where they will be encouraged to obtain insurance. In Ireland, though coverage is universal, most of the population have to pay not insignificant user charges (upwards of EUR50) to access primary care (Burke et al., 2016).

Basic primary health coverage, whether provided through government schemes 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 voluntary 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 OECD countries, nine have private coverage for over half of the population (Figure 5.2).

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 (84% 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 (56%).

The population covered by private health insurance has increased in some OECD countries over the past decade, particularly in Denmark, Korea, Slovenia and Belgium. But private health insurance coverage has come down in other countries, notably Greece, Ireland, New Zealand and the United States (Figure 5.3). 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 to national health systems or social health insurance. 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 not income-related, although the purchase of private coverage can be subsidised by government.

References

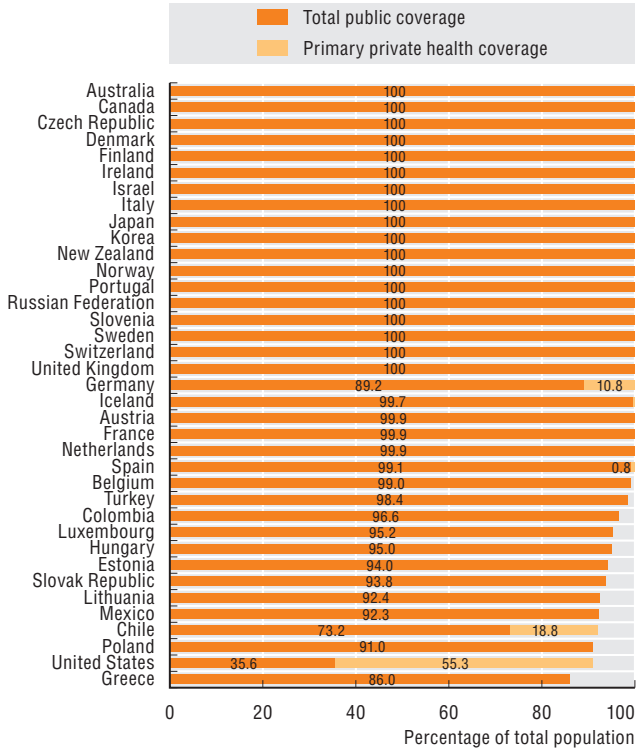
Burke, S. et al. (2016), "From Universal Health Insurance to Universal Healthcare? The Shifting Health Policy Landscape in Ireland since the Economic Crisis", *Health Policy*, Vol. 120, No. 3, pp. 235-240.

Cohen, R.A. and M.E. Martinez (2015), "Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2014", National Center for Health Statistics, June.

Eurofound (2014), *Access to Healthcare in Times of Crisis*, Dublin.

OECD (2015), "Measuring Health Coverage", OECD, Paris, available at: *http://www.oecd.org/els/health-systems/measuring-health-coverage.htm*.

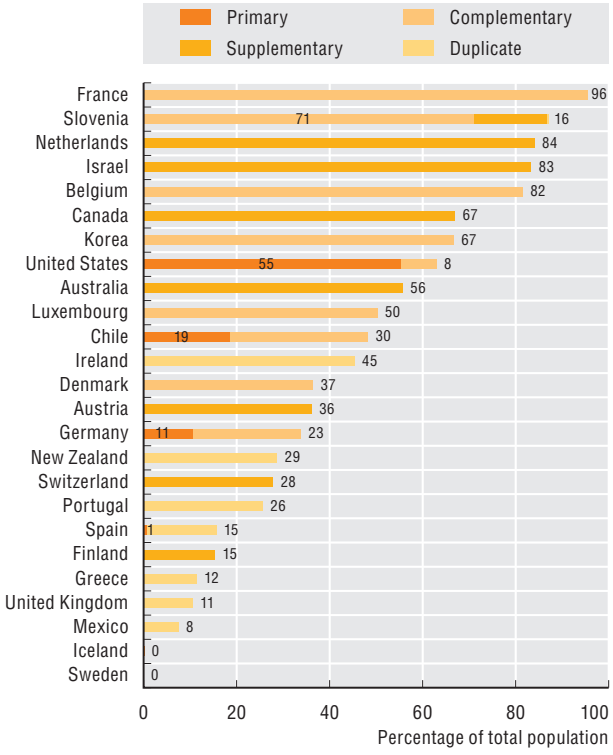
5.1. Population coverage for a core set of services, 2015 (or nearest year)



Source: OECD Health Statistics 2017.

StatLink http://dx.doi.org/10.1787/888933603108

5.2. Private health insurance coverage, by type, 2015 (or nearest year)

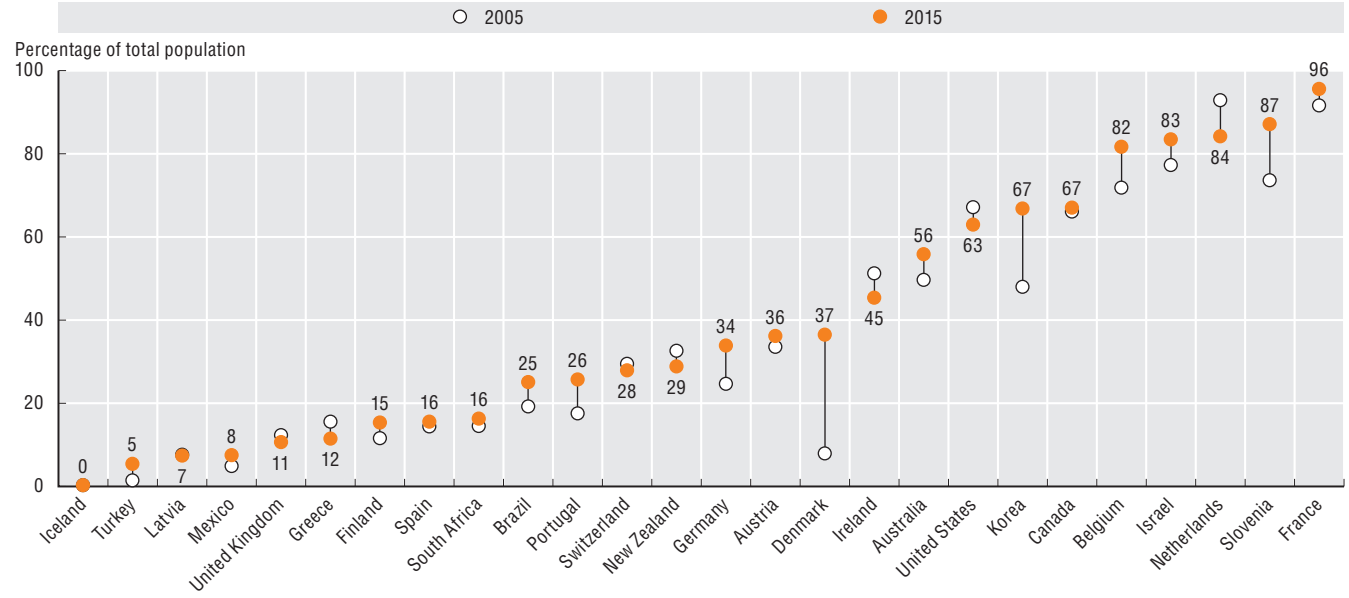


Note: Private health insurance can be both duplicate and supplementary in Australia; both complementary and supplementary in Denmark and Korea; and duplicate, complementary and supplementary in Israel and Slovenia.

Source: OECD Health Statistics 2017.

StatLink http://dx.doi.org/10.1787/888933603127

5.3. Trends in private health insurance coverage, 2005 and 2015 (or nearest year)



Source: OECD Health Statistics 2017.

StatLink http://dx.doi.org/10.1787/888933603146