Population coverage for health care

The share of a population covered for a core set of health services offers an initial assessment of access to care and financial protection. However, it is only a partial measure of accessibility and coverage, focusing on the number of people covered. Universal health coverage also depends on the range of services covered and the degree of cost sharing for these services. Such services also need to be of sufficient quality. Indicators in this chapter focus on access and different dimensions of coverage, while Chapter 6 provides indicators on quality and outcomes of care.

Most OECD countries have achieved universal (or near-universal) coverage for a core set of health services, which usually include consultations with doctors, tests and examinations, and hospital care (Figure 5.1). National health systems or social health insurance have typically been the financing schemes for achieving universal health coverage. A few countries (the Netherlands, Switzerland) have obtained universality through compulsory private health insurance – supported by public subsidies and laws on the scope and depth of coverage. In Greece, a new law in 2016 closed the coverage gap for the 10% of the population who were previously uninsured.

Population coverage for core services remains below 95% in seven OECD countries, and is lowest in Mexico, the United States and Poland. Mexico has expanded coverage since 2004, but gaps remain. In the United States, the uninsured tend to be working-age adults with lower education or income levels – the share of people uninsured decreased sharply from about 13% in 2013 to 9% in 2015 (United States Census Bureau, 2018[1]), but has remained relatively unchanged since then. In Poland, the majority of uninsured are citizens living abroad. In Ireland, though coverage is universal, less than half of the population are covered for the cost of GP visits.

In some countries, citizens can purchase additional health coverage through voluntary private insurance. This can cover any cost sharing left after basic coverage (complementary insurance), add further services (supplementary insurance) or provide faster access or larger choice of providers (duplicate insurance). Eight OECD countries have additional private insurance coverage for over half of the population (Figure 5.2). In France, nearly all of the population (96%) have complementary insurance to cover cost sharing in the social security system – with public subsidies making it free or at reduced rates for poor households. Complementary insurance is also widely used in Belgium, Slovenia and Korea. Israel and the Netherlands have the largest supplementary market (over 80% of the population), whereby private insurance pays for dental care, physiotherapy, certain prescription drugs and other services not publicly reimbursed. Duplicate private health insurance, providing faster private sector access to medical services where there are waiting times in public systems, are largest in Ireland and Australia. In the United States, 8% of the population has complementary private health insurance. This is in addition to the 55% of the population with primary private health insurance.

Over the last decade, the population covered by additional private health insurance has increased in 18 of 27 OECD countries with comparable data, though these increases have often been small. Changes have been most marked in Korea, Denmark, Slovenia and Finland (Figure 5.3). Note that in Slovenia increases were mainly due to one insurance company adding free supplementary health insurance to its insurance portfolio. Several factors determine how additional private health insurance evolves, notably the extent of gaps in access to publicly financed services and government interventions directed at private health insurance markets.

Definition and comparability

Population coverage for health care is defined here as the share of the population eligible for a core set of health care services – whether through public programmes or primary private health insurance. The set of services is country-specific but usually includes consultations with doctors, tests and examinations, and hospital care. Public coverage includes both national health systems and social health insurance. On national health systems, most of the financing comes from general taxation, whereas in social health insurance systems, financing typically comes from a combination of payroll contributions and taxation. Financing is linked to ability-to-pay. Primary private health insurance refers to insurance coverage for a core set of services, and can be voluntary or mandatory by law (for some or all of the population). Additional private health insurance is always voluntary. Private insurance premiums are generally not income-related, although the purchase of private coverage may be subsidised by government.

References

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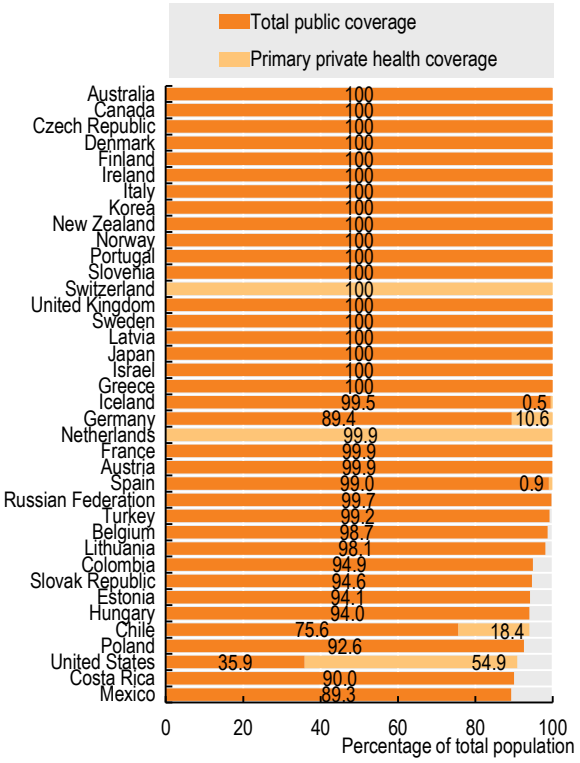
[2] OECD/European Observatory on Health Systems and Policies (forthcoming), *Greece, Ireland, Poland, Country Health Profiles 2019, State of Health in the EU*.

[1] United States Census Bureau (2018), *Health Insurance Coverage in the United States*.

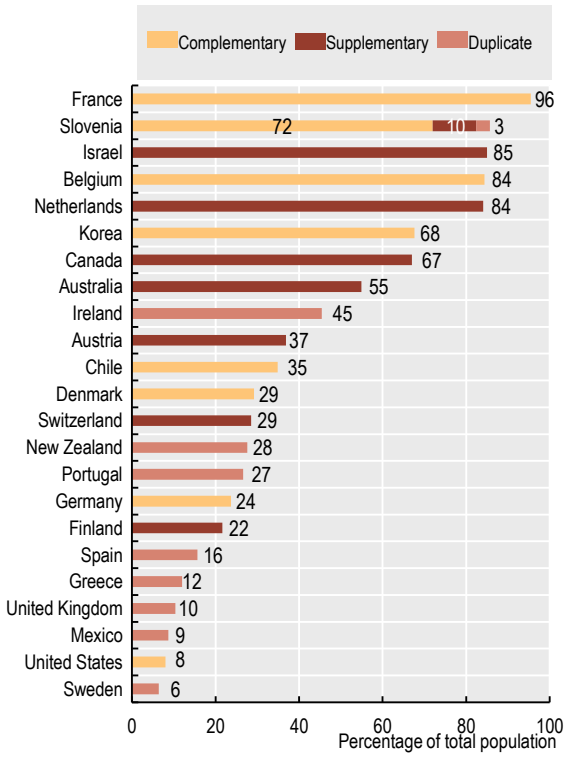
Figure 5.1. **Population coverage for a core set of services, 2017 (or nearest year)**



Source: OECD Health Statistics 2019.

StatLink https://doi.org/10.1787/888934015619

Figure 5.2. **Voluntary private health insurance coverage by type, 2017 (or nearest year)**

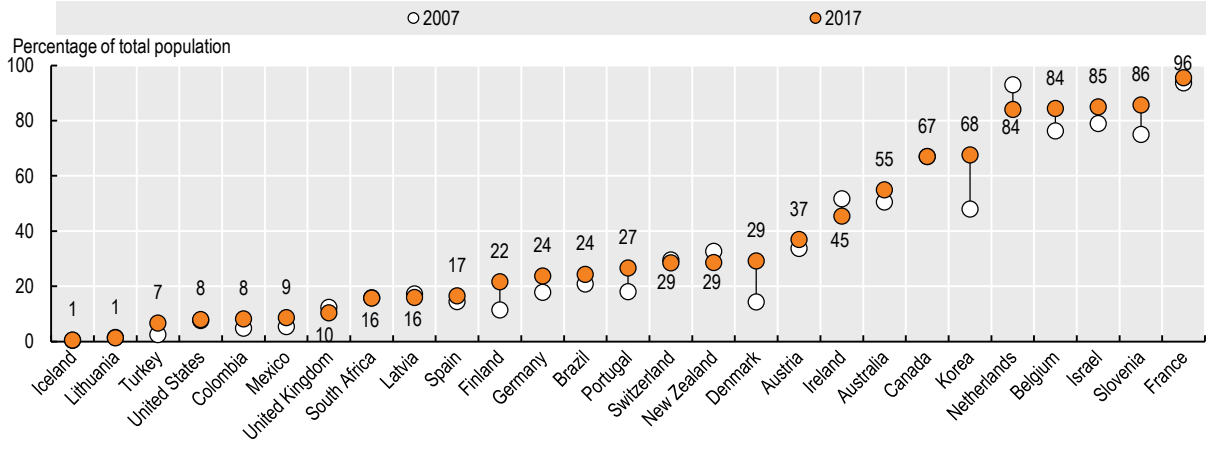


Note: Private health insurance can be both duplicate and supplementary in Australia; complementary and supplementary in Denmark and Korea; and duplicate, complementary and supplementary in Israel and Slovenia. In the United States, 55% of the population also has primary private health insurance.

Source: OECD Health Statistics 2019.

StatLink https://doi.org/10.1787/888934015638

Figure 5.3. **Trends in private health insurance coverage, 2007 and 2017 (or nearest year)**



Source: OECD Health Statistics 2019.

StatLink https://doi.org/10.1787/888934015657