6.2. Coverage for health care

Health care coverage promotes access to medical goods and services, as well as providing financial security against unexpected or serious illness (OECD, 2004a). However, total health insurance coverage – both public and private – is an imperfect indicator of accessibility, since the range of services covered and the degree of cost-sharing applied to those services can vary across countries.

Most OECD countries have achieved 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 6.2.1). Generally, services such as dental care and supply of pharmaceutical drugs are partially covered, although there are a number of countries where these services must be purchased separately (see Annex Table A.5).

Four OECD countries do not have universal health coverage. Chile has a dual health care system with coverage through the public National Health Insurance Fund, or through private health insurance companies and other not-for-profit agencies. A proportion of the population, however, remains without specific coverage. In Mexico, the "Seguro Popular" voluntary health insurance scheme was introduced in 2004 to provide coverage for the poor and uninsured, and has grown rapidly so that by 2009 around three quarters of the population were covered. Public coverage in Turkey has increased rapidly in recent years, reaching over 80% in 2009.

In the United States, coverage is provided mainly through private health insurance, and 55% of the total population had this for their basic coverage in 2009. Publicly-financed coverage insured 26% of the total population (the elderly, people with low income or with disabilities), leaving 19% of the population – mostly under 65 years of age – without health coverage. Most uninsured persons cite the increasing cost of premiums as the reason for their lack of coverage (NCHS, 2009). Employers, particularly smaller ones, are also less likely to offer coverage to workers (OECD, 2008b). The recent rise in the proportion of uninsured can be attributed to the effects of the recession and the loss of employment, accompanied by the loss of health care coverage (KFF, 2010).The problem of persistent uninsurance is a major barrier to receiving health care, and more broadly, to reducing health inequalities among population groups (AHRQ, 2011b; HHS Office of Health Reform, 2009). The 2010 Patient Protection and Affordable Care Act seeks to increase insurance coverage in the United States.

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, ten report private coverage for over half of the population in 2009 (Figure 6.2.2).

Private health insurance offers 94% of the French population *complementary* insurance to cover cost-sharing in the social security system. The Netherlands has the largest *supplementary* market (90% of the population), followed by Israel (81%), 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 (51%) and Australia (45%). The population covered by private health insurance is positively correlated to the share of total health spending accounted for by private health insurance (Figure 6.2.3).

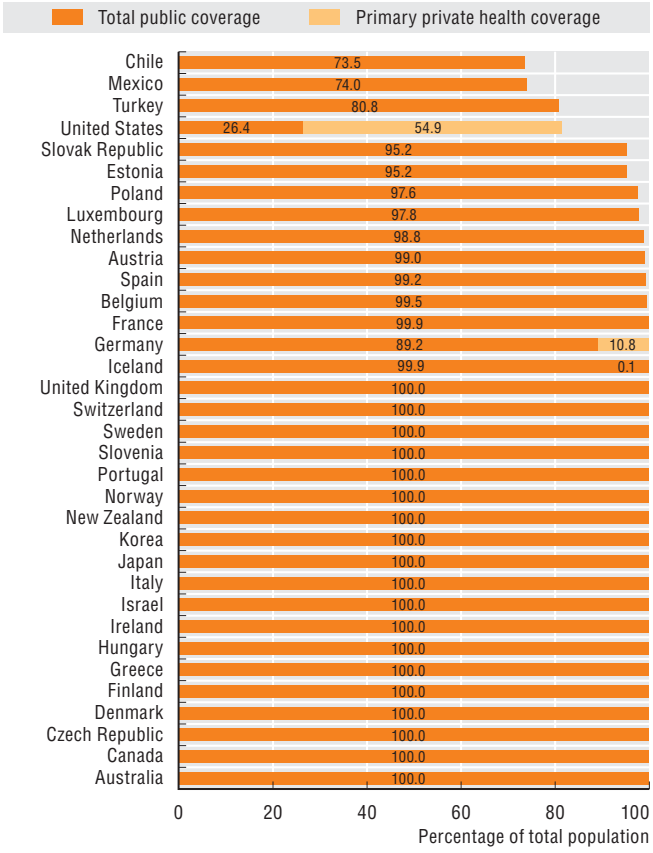
The importance of private health insurance is not linked to a countries' economic development. Other factors are more likely to explain market development, including gaps in access to publicly financed services, the way private providers are financed, government interventions directed at private health insurance markets, and historical development (OECD, 2004b).

Definition and comparability

Coverage for health care is 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 cover can be subsidised by the government.

Information on data for Israel: *http://dx.doi.org/10.1787/888932315602*.

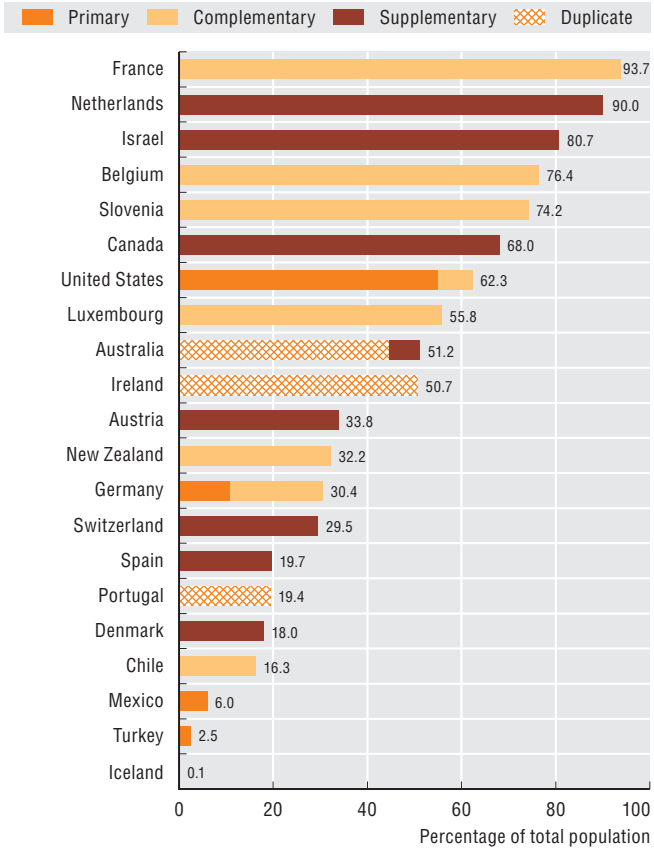
6.2.1 Health insurance coverage for a core set of services, 2009



Source: OECD Health Data 2011.

StatLink http://dx.doi.org/10.1787/888932525685

6.2.2 Private health insurance coverage, by type, 2009

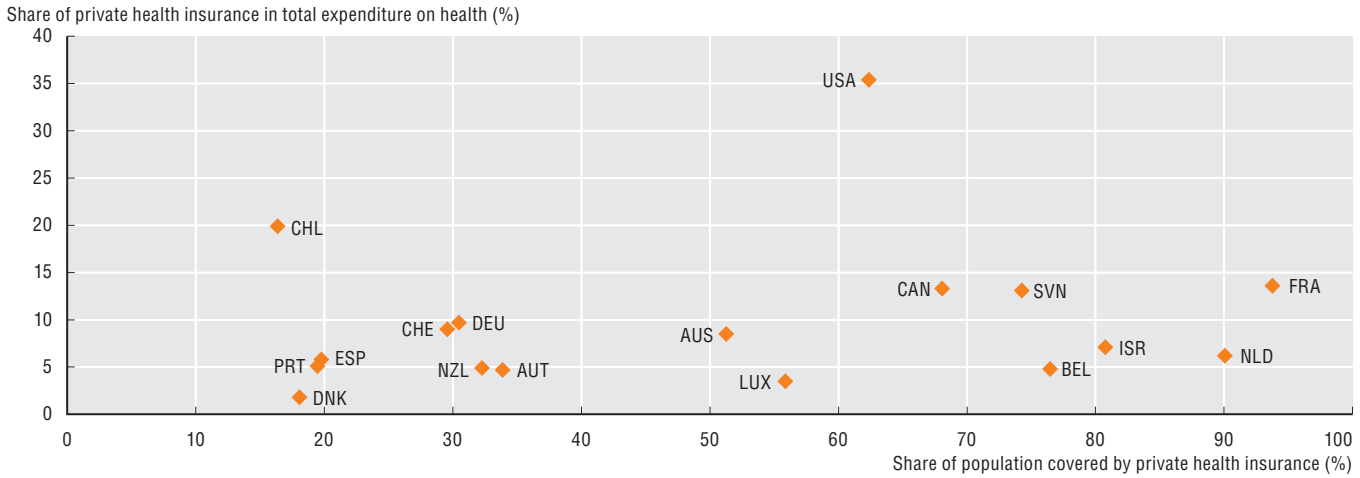


Note: Private health insurance can fulfil several roles. For instance, it can be both duplicate and supplementary in Australia and Israel; and both complementary and supplementary in Denmark, Ireland and New Zealand.

Source: OECD Health Data 2011.

StatLink http://dx.doi.org/10.1787/888932525704

6.2.3 Private health insurance, population covered and share in total health expenditure, 2009



Source: OECD Health Data 2011.

StatLink http://dx.doi.org/10.1787/888932525723

From:
Health at a Glance 2011
OECD Indicators

Access the complete publication at:
https://doi.org/10.1787/health_glance-2011-en

Please cite this chapter as:

OECD (2011), "Coverage for health care", in *Health at a Glance 2011: OECD Indicators*, OECD Publishing, Paris.

DOI: https://doi.org/10.1787/health_glance-2011-53-en