6.2. Coverage for health care

Health care coverage promotes access to medical goods and services, providing financial security against unexpected or serious illness, as well as improved accessibility to treatments and services (OECD, 2004c). Total population coverage (both public and private) is, however, an imperfect indicator of accessibility, since this depends on the services included and on the degree of cost-sharing applied to those services.

By 2007, most OECD countries had achieved universal or near universal coverage of health care costs for a "core" set of services (Figure 6.2.1). Generally, services such as dental care and pharmaceutical drugs are partially covered, but there are a number of countries where these services must be purchased separately (see Annex Table A.5).

Three OECD countries do not have universal health coverage. In Mexico, only half of the population was covered by public health insurance in 2002. 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 2007 over 80% of the population were covered. The Mexican government aims to achieve universal coverage by 2011. Public coverage in Turkey was available for only two-thirds of the population in 2003, although recent legislation has introduced universal coverage (OECD and World Bank, 2008).

In the United States, coverage is provided mainly through private health insurance, and 58% of the total population had this in 2007. Publically financed coverage insured 27% of the total population (the elderly, people with low income or with disabilities), leaving 15% of the population (45 million people under 65 years of age) without health coverage. Of these, more than one-half cite the cost of premiums as the reason for their lack of coverage (NCHS, 2009). Recent rises in the proportion of uninsured persons have been attributed to employers, particularly smaller ones, being less likely to offer coverage to workers, and to the increasing cost of premiums (OECD, 2008c). The problem of persistent uninsurance is seen as a major barrier to receiving health care, and more broadly, to reducing health inequalities among population groups (AHRQ, 2008a; HHS Office of Health Reform, 2009).

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. Among 26 OECD countries, seven (Netherlands, France, Belgium, Canada, United States, Luxembourg and Ireland) report private coverage for over half of the population in 2007 (Figure 6.2.2). In the Netherlands, the government implemented a mandatory universal health insurance scheme in 2006, with regulated competition across private insurers, thereby eliminating the division between public and private insurance for basic population cover.

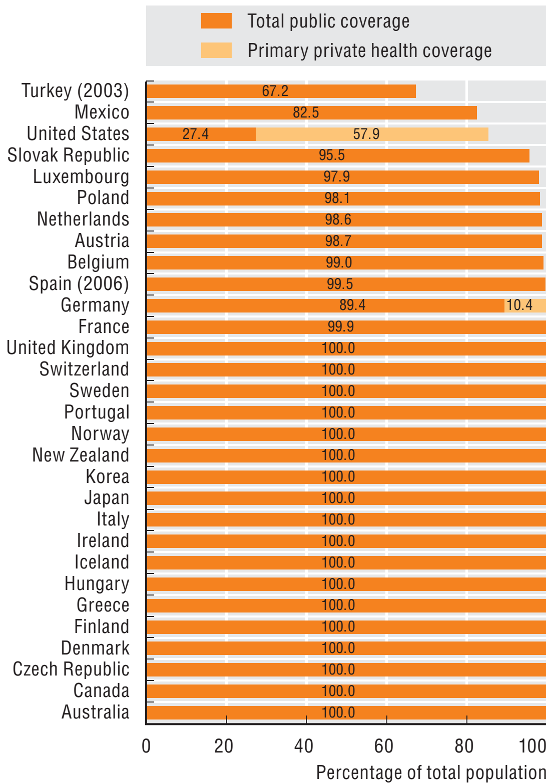
Private health insurance offers 88% of the French population *complementary* insurance to cover cost-sharing in the social security system. The Netherlands has the largest *supplementary* market (92% of the population), followed by Canada (67%) whereby private insurance pays for prescription drugs and dental care that are not publicly reimbursed. Approximately one-third of the Austrian and Swiss populations also have supplementary health insurance. *Duplicate* markets providing faster private-sector access to medical services where there are waiting times in public systems are largest in Ireland (51%), Australia (44%) and New Zealand (33%). 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).

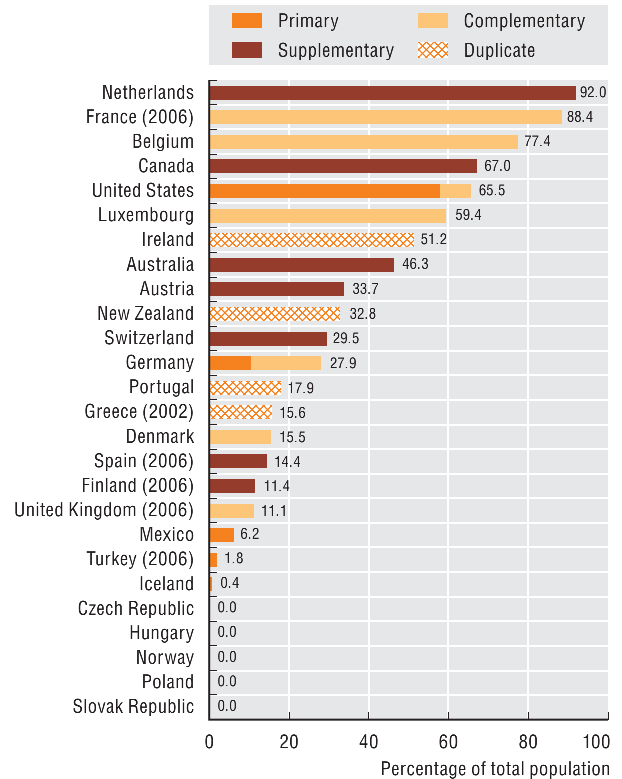
Definition and deviations

Population coverage is the share of the population receiving a defined set of health care goods and services under public programmes and 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.

6.2.1 Health insurance coverage for a core set of services, 2007



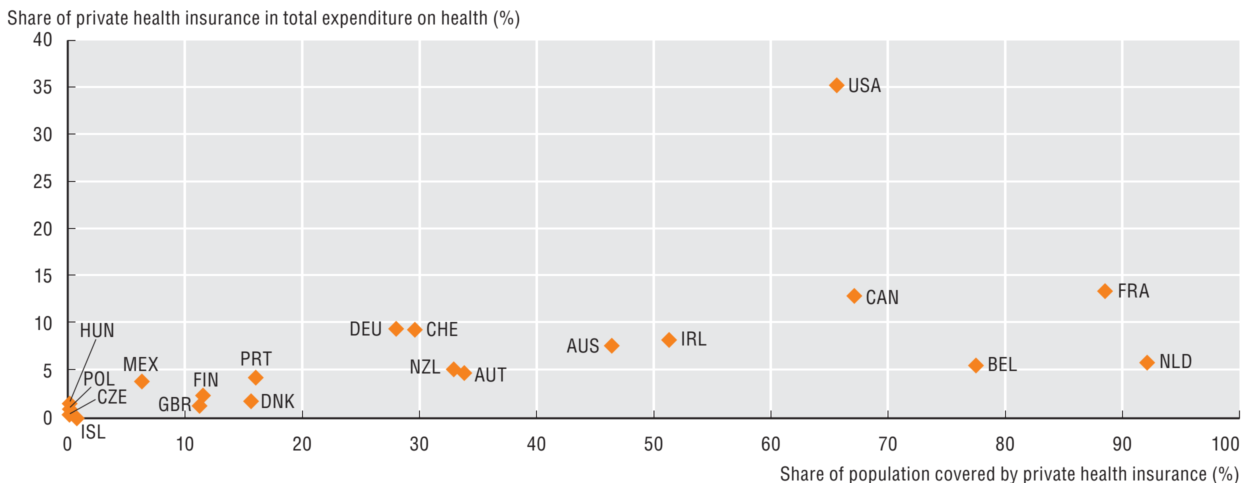
6.2.2 Private health insurance coverage, by type, 2007



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

Source: *OECD Health Data 2009*, OECD Survey of Health System Characteristics 2008-2009.

6.2.3 Private health insurance, population covered and share in total health expenditure, 2007



Source: *OECD Health Data 2009*.

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