Extent of health care coverage

In addition to the share of the population entitled to core health services, the extent of health care coverage is defined by the range of services included in a publicly defined benefit package and the proportion of costs covered. Figure 5.7 assesses the extent of overall coverage, as well as coverage for selected health care services, by computing the share of expenditure covered under government schemes or compulsory health insurance. Differences across countries in the extent of coverage can be the result of specific goods and services being included or excluded in the publicly defined benefit package (such as a particular drug or medical treatment), different cost-sharing arrangements or some services only being covered for specific population groups in a country (such as dental treatment).

On average across OECD countries, around three-quarters of all health care costs were covered by government or compulsory health insurance schemes in 2019 (see indicator "Health expenditure by financing scheme"). This share stood above 80% in ten countries (Norway, Luxembourg, Sweden, Germany, Japan, France, Denmark, Iceland, the Netherlands and the Czech Republic). On the other hand, in Greece, Latvia, Portugal and Korea, only around 60% of all costs were covered by publicly mandated schemes. In Mexico, less than half of all health spending was financed by government or compulsory schemes (49%).

In general, financial protection is not uniform across all types of health care services, and there is considerable variation across countries. In nearly all OECD countries, inpatient services in hospitals are more comprehensively covered than any other type of care. Across OECD countries, 87% of all inpatient costs were borne by government or compulsory insurance schemes in 2019. In many countries, patients have access to free acute inpatient care or only need to make a small co-payment. As a result, coverage rates were near 100% in Sweden, Norway, Iceland and Estonia. In Australia, Mexico, Greece and Korea, financial coverage for the cost of inpatient care was only around two-thirds of total costs. In some of these countries, patients frequently choose treatment in private facilities where coverage is not (fully) included in the public benefit package. In Australia, private insurance may also be used for treatment in public hospitals.

More than three-quarters (77%) of spending on outpatient medical care in OECD countries in 2019 was borne by government and compulsory insurance schemes. Coverage ranged from under 60% in Portugal Latvia and Korea to over 90% in the Slovak Republic, Denmark and Sweden. In some countries, outpatient primary and specialist care are generally free at the point of service, but user charges may still apply for specific services or if non-contracted private providers are consulted. This is, for example, the case in Denmark – where 91% of total costs are covered, but user charges exist for visits to psychologists and physiotherapists or for patients who see a specialist without referral – and in the United Kingdom (89%), where care provision outside National Health Service-commissioned services is not covered.

Public coverage for dental care costs is far more limited across OECD countries due to restricted service packages (frequently limited to children) and higher levels of cost-sharing. On average, less than one-third of dental care costs are borne by government schemes or compulsory insurance. More than half of dental spending is covered in only three OECD countries (Japan, Germany and the Slovak Republic). In Greece and Spain, dental care costs for adults without any specific entitlement are not covered. Voluntary health insurance may play an important role in providing financial protection when dental care is not comprehensively covered in the benefit package – this is the case for adults in the Netherlands, for example.

Coverage for pharmaceuticals is also typically less comprehensive than for inpatient and outpatient care: across OECD countries, around 58% of pharmaceutical costs are financed by government or compulsory insurance schemes. The most generous coverage can be found in Germany (82%), France (80%) and Ireland (79%). On the other hand, this share is less than two-fifths in Canada, Iceland,Poland and Latvia. In Canada, around one-third of all pharmaceutical spending is financed via voluntary private health insurance, which is widespread and accessed mainly through employer-based contracts. Over-the-counter medications – which by their nature are not usually covered by public schemes – play an important role in some countries (see indicator "Pharmaceutical expenditure" in Chapter 9).

During the COVID-19 pandemic, countries have tried to ensure that diagnosis, testing and appropriate care for COVID-19 patients are affordable – notably in countries where segments of the population remain without coverage. In Poland, for example, the National Health Fund covered uninsured as well as insured people for health services combatting COVID-19 (OECD, 2021[6]).

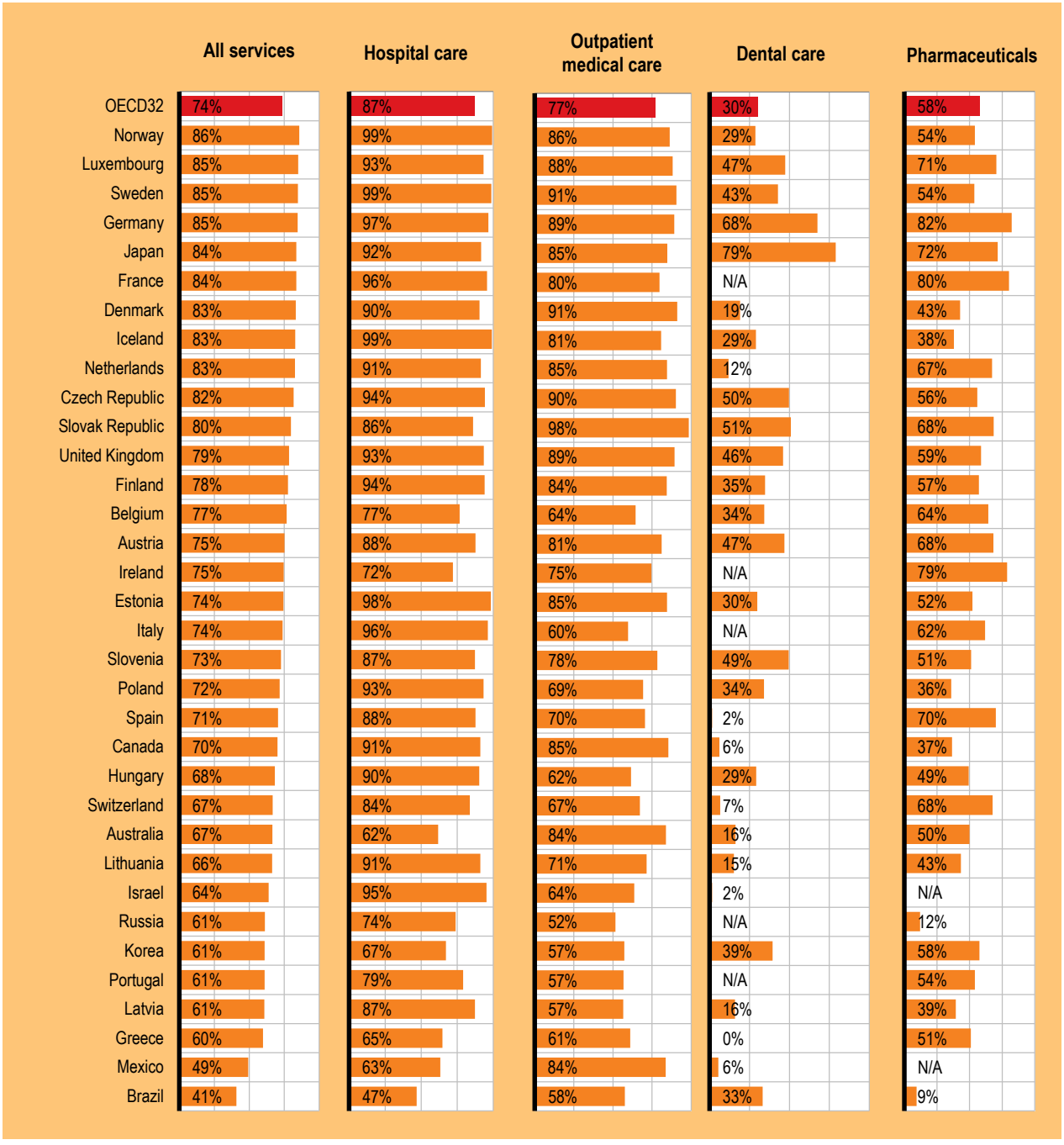
Definition and comparability

Health care coverage is defined by the share of the population entitled to services, the range of services included in a benefit package and the proportion of costs covered by government schemes and compulsory insurance schemes. Coverage provided by voluntary health insurance and other voluntary schemes such as charities or employers is not considered. The core functions analysed here are defined based on definitions in the System of Health Accounts 2011 (OECD/Eurostat/WHO, 2017[7]). Hospital care refers to inpatient curative and rehabilitative care (which is mainly provided in hospitals); outpatient medical care to all outpatient curative and rehabilitative care excluding dental care; and pharmaceuticals to prescribed and over-the-counter medicines, including medical non-durables.

Comparing the shares of the costs covered for different types of services is a simplification. For example, a country with more restricted population coverage but a very generous benefit basket may display a lower share of coverage than a country where the entire population is entitled to services but with a more limited benefit basket.

Figure 5.7. **Extent of coverage, 2019 (or nearest year)**

Government and compulsory insurance spending as proportion of total health spending by type of care



Note: N/A means data not available.
Source: OECD Health Statistics 2021.

StatLink https://stat.link/dqvn2i