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 access and coverage. Universal health coverage also depends on the range of services covered and the degree of cost-sharing for these. Services also need to be of sufficient quality. Indicators in this chapter focus on access in terms of the affordability, availability and use of health care services, 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 and Switzerland) have obtained universality through compulsory private health insurance – supported by public subsidies and laws on the scope and depth of coverage.

Population coverage for core services in 2019 remained below 95% in seven OECD countries, and below 90% in Mexico and the United States. Mexico has expanded coverage since 2004, but gaps remain (OECD, 2016[1]). In the United States, uninsured people tend to be working-age adults with lower education or income levels – the share of uninsured people decreased sharply from about 13% in 2013 to 9% in 2015 (United States Census Bureau, 2018[2]), but has remained relatively unchanged since then. In Ireland, although coverage is universal, less than half of the population are covered for the cost of general practitioner visits. Recent reform proposals suggest a gradual rollout of primary care coverage to the entire population (OECD/European Observatory of Health Systems and Policies, 2019[3]).

Beyond population coverage rates, satisfaction with the availability of quality health services offers further insight into effective coverage. The Gallup World Poll collects data on citizens' satisfaction with health and other public services worldwide. While contextual and cultural factors influence survey responses, the poll allows citizens' opinions to be compared on the basis of the same survey question. Satisfaction with the availability of quality health services averaged 71% across 37 OECD countries in 2020. Citizens in Norway (93%), Belgium and the Netherlands (both 92%) were most likely to be satisfied, while those in Poland (26%), Greece (38%) and Chile (39%) were least likely to be satisfied (Figure 5.2).

In some countries, citizens can purchase additional health coverage through voluntary private health insurance. This can cover any cost-sharing left after basic coverage (complementary insurance), add further services (supplementary insurance) or provide faster access or a wider choice of providers (duplicate insurance). Among 22 OECD countries with recent comparable data, seven had additional private insurance coverage for over half of the population in 2019 (Figure 5.3). Complementary insurance to cover cost-sharing is widely used in Slovenia and Korea (around 70% of the population). Israel and the Netherlands had the largest supplementary health insurance market (over 80% of the population), whereby private insurance pays for dental care, physiotherapy, certain prescription drugs and other services that are not publicly reimbursed. Duplicate private health insurance was most widely used in Ireland and Australia. In the United States, just under 10% of the population had complementary private health insurance. This is in addition to the 52.5% of the American population who had primary private health insurance.

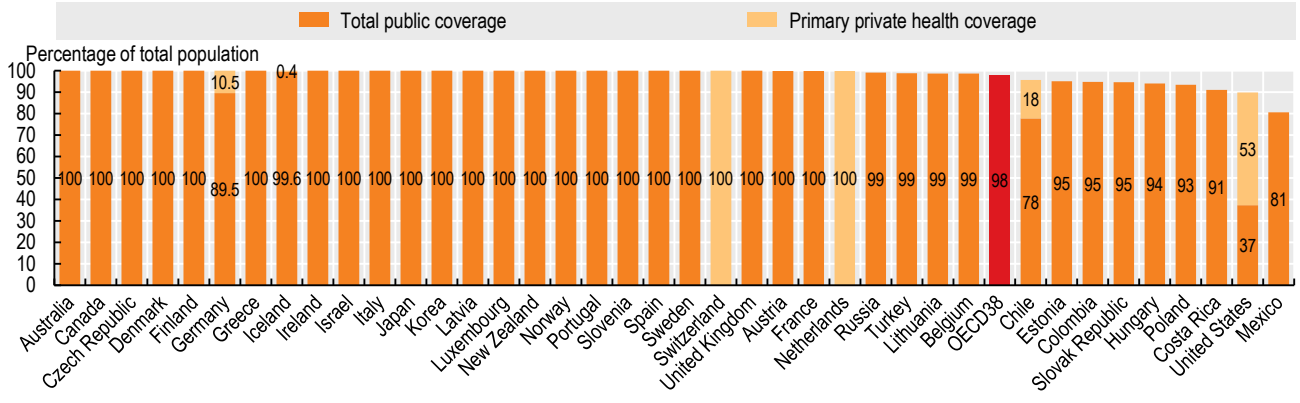
Over the last decade, the population covered by additional private health insurance has increased in 20 of 25 OECD countries with comparable data, although these increases have often been small. Increases have been most marked in Korea (an additional 20% of the total population). Several factors determine 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. In both, 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. Voluntary private insurance premiums are generally not income-related, although the purchase of private coverage may be subsidised by the government.

Data from the Gallup World Poll used in Figure 5.2 are generally based on a representative sample of at least 1 000 citizens in each country aged 15 years and older. For 2020, data were collected from July onwards. Respondents were asked: "In the city or area where you live, are you satisfied or dissatisfied with the availability of quality health care?"

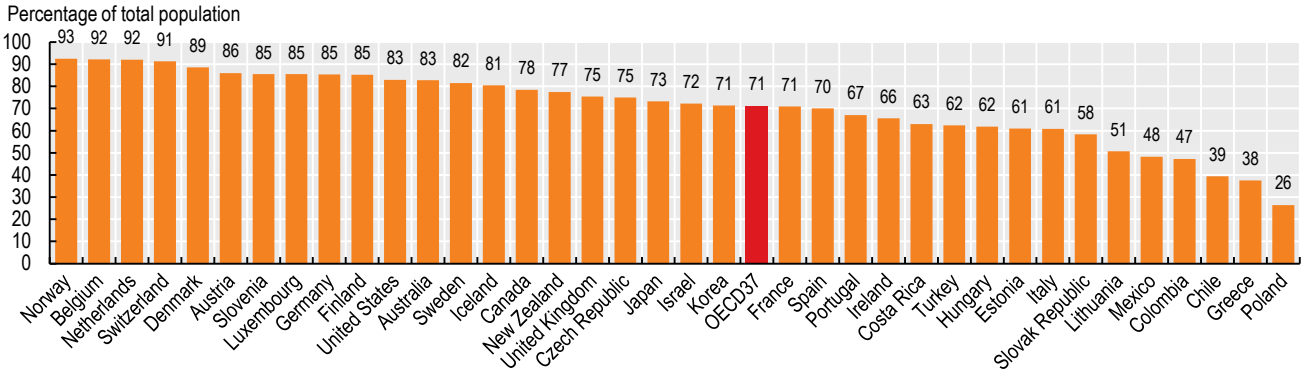
Figure 5.1. **Population coverage for a core set of services, 2019 (or nearest year)**



Source: OECD Health Statistics 2021.

StatLink https://stat.link/q2ysgv

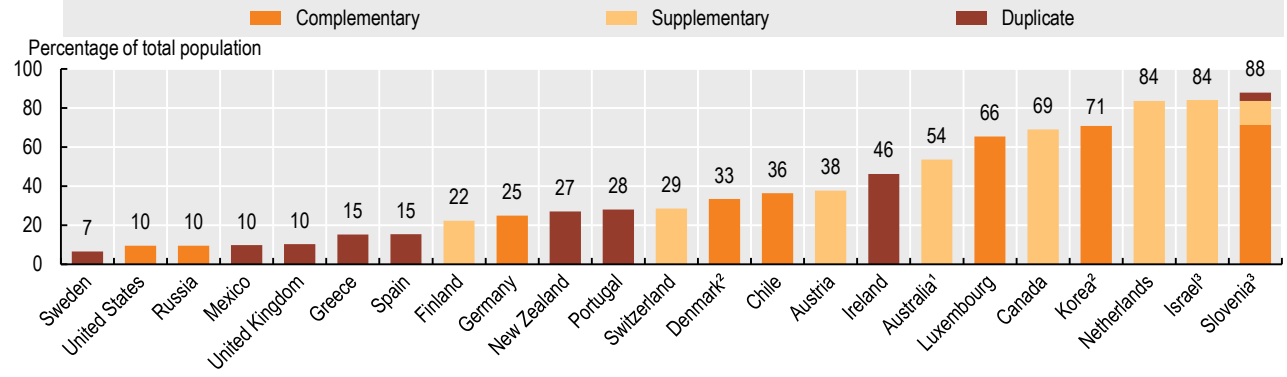
Figure 5.2. **Population satisfied with the availability of quality health care in the area where they live, 2020 (or nearest year)**



Source: Gallup World Poll 2020 (database).

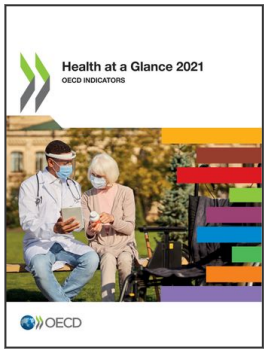
StatLink https://stat.link/n1g468

Figure 5.3. **Voluntary private health insurance coverage by type, 2019 (or nearest year)**



Note: Values here refer to additional voluntary private health insurance. They exclude primary private health insurance coverage, which exists in Chile, Germany, the Netherlands, Switzerland and the United States. 1. Can be duplicate and supplementary. 2. Can be complementary and supplementary. 3. Can be duplicate, complementary and supplementary.
Source: OECD Health Statistics 2021.

StatLink https://stat.link/v8t3bm



From:
Health at a Glance 2021
OECD Indicators

Access the complete publication at:
https://doi.org/10.1787/ae3016b9-en

Please cite this chapter as:

OECD (2021), "Population coverage for health care", in *Health at a Glance 2021: OECD Indicators*, OECD Publishing, Paris.

DOI: https://doi.org/10.1787/ab673b0d-en

This document, as well as any data and map included herein, are without prejudice to the status of or sovereignty over any territory, to the delimitation of international frontiers and boundaries and to the name of any territory, city or area. Extracts from publications may be subject to additional disclaimers, which are set out in the complete version of the publication, available at the link provided.

The use of this work, whether digital or print, is governed by the Terms and Conditions to be found at http://www.oecd.org/termsandconditions.