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First Global Symposium
ON HEALTH SYSTEMS RESEARCH
Science to accelerate universal health coverage

The political economy of universal health coverage

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**Background paper for the global symposium
on health systems research**

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KEY MESSAGES

1. What do we mean when we talk about Universal Health Care?

“Universal Health Care” is understood in a variety of ways. It involves judgements about who the potential recipients are, what is the range of services included within health care, and the quality of that care? The literature on Universal Health Care comes from several disciplinary perspectives and addresses five main themes: accessibility to health care by its intended recipients, broad population coverage, a package of point-of-entry healthcare services, healthcare access based on rights and entitlements, and protection from the social and economic consequences of illness. The term Universal Health Care has most frequently been used in describing policies for care in high-income countries, while Universal Health “Coverage” (UHC) has most often been applied to low- and middle-income countries; hence, the fact that population coverage may not guarantee a sufficient breadth of care services among the poorest countries (merely achieving basic coverage of the populace) is an important consideration that is often overlooked.

2. How do we define a Universal Health Coverage System, and which countries have such a system?

We have defined UHC as the existence of a legal mandate for universal access to health services and evidence that suggests the vast majority of the population has meaningful access to these services. Out of 192 countries studied, 75 had legislation mandating universal access to healthcare services independent of income. Of these, 58 met the criteria based on available measures of coverage (including >90% of the population having access to skilled birth attendance and insurance coverage) which serve as broader proxies for access to care.

3. Why do some countries have Universal Health Coverage while others do not?

Adopting UHC is primarily a political, rather than a technical issue. In states that are able to function effectively (next point) the strength of social democratic parties and labour movements is one main determinant of whether a country uses its available economic resources to achieve UHC and how soon it does so.

4. What are, if any, the social, economic, and political preconditions to establish Universal Health Coverage as a realistic political goal?

The widely held view that low GDP is the main barrier to achieving UHC is likely to be a consequence of poor countries having one or more of the following characteristics: lack of effective control over their entire territory; weak tax-collection capacity; and insufficient human and physical resources to deliver effective health care. Thus, poverty *per se* is likely to be an obstacle to UHC mainly to the extent that it is associated with the lack of a functioning state and health system. However, being poor is not an excuse to reject UHC, and low-income regions in the past have successfully implemented universal systems. Empirical analysis indicates that political commitment (expressed as a legal mandate), higher tax revenues, and greater democracy are associated with a greater share of GDP going to public health spending. Conversely there is evidence that higher private expenditure may crowd out public spending and that UHC is more difficult to achieve in divided societies on ethnic,

religious, linguistic and/or with high income inequalities. Expansion of health care coverage typically occurs as part of a broader process of increasing social welfare programmes.

5. How have countries in the past achieved Universal Health Coverage, and which lessons apply to low- and middle-income countries today?

Most countries have adopted legal commitments to achieve Universal Health Coverage at low- and middle-income stages of development. When they have not, healthcare has tended to expand gradually, leaving many members of the population vulnerable for extended periods of time.

However, a legal commitment is insufficient on its own and must be translated into policies that establish a comprehensive, largely publicly financed system. An over-reliance on partial and private sector-focused care appears to disproportionately benefit richer groups, reducing both efficacy and access to coverage. It also creates groups with strong vested interests in the status quo that can block further progress. Public financing is more equitable and pro-poor, and reflects the shared value of providing care based on need rather than ability to pay.

EXECUTIVE SUMMARY

Universal Health Care is one of the most widely shared goals in global health. The concept of Universal Health Care captures a common set of common values: equity, shared responsibility, and quality healthcare delivery irrespective of ability to pay. This paper focuses on Universal Health Coverage (UHC), which is one aspect of Universal Health Care, unless otherwise specified. Universal Coverage focuses primarily on the achievement of a wide network of health providers and health institutions so that the vast majority of the population can have access to health services; the components that are ‘sufficient’ to be considered adequate coverage are highly contested, as we will show.

Debates about expanding health care within a country involve competing visions about the appropriate roles of the public and private sectors; market and state; local and central government; the duties and entitlements of youth and elderly, sick and healthy, and rich and poor; and the contribution of health to the advancement of society.

Considerations of politics and power shape the decision of a country’s leaders to commit to UHC. Although much has been written about the mechanics of expanding health care coverage and its consequences for levels and distribution of health and financial contributions, much less has been written on the power and politics behind choices to expand healthcare access.

While UHC remains an aspiration for many, there has been little progress in understanding how health ministers and concerned public health advocates should seek to achieve it. This background paper asks a series of basic questions:

1. What do we mean when we talk about Universal Health Care?
2. How do we define a Universal Health Coverage System, and which countries have such a system?
3. Why do some countries have Universal Health Coverage or while others do not?
4. What are, if any, the social, economic, and political preconditions for Universal Health Coverage to be a realistic political goal?
5. How have countries in the past achieved UHC, and does their experience offer lessons that apply to low- and middle-income countries today?

This background paper does not discuss the mechanisms whereby a country implements UHC and this has been examined in detail elsewhere.¹⁻³ Furthermore, readers must bear in mind that every country faces a unique and changing policy context that must be taken into account when applying lessons from elsewhere. However, the extensive work on which this background paper is based, including a systematic review of the literature on UHC, detailed historical case-studies, and an econometric analysis of available data, identifies three main strategies involved in past successes to attain UHC: re-framing the debate, identifying and creating political opportunities, and mobilizing resources.

First, a systematic review was performed of literature on Universal Health Coverage to identify the main themes invoked in existing studies, so as to isolate the meaning of UHC more specifically. Because over 1000 papers were identified addressing the concept of Universal Health Coverage, a random sample of 100 recent papers were selected for detailed analysis and coding. On this basis, a set of measurable criteria of a legislative framework, healthcare coverage and actual access to public health services were developed in order to create a map of countries which did or did not have UHC in the year 2008. Having constructed a comprehensive dataset of indicators of healthcare access and coverage, including all of the available WHO data on health systems, a structured review of the political science, sociology, economics, and health policy literature was performed to identify the

main social, political, economic, and health system factors involved in the political process of expanding UHC. This generated a series of hypotheses, which were explored in a series of detailed historical case studies (focusing on Germany, the United Kingdom and South Korea) and cross-national econometric analysis of coverage indicators of 180 WHO member states. To provide a structural framework for the historical analysis, the Political Process model was selected, as this model moves beyond simplistic pluralist frameworks that isolate individual factors (such as political context, leaders, events, and actors) and offers an integrated account of how social mobilization results in large-scale political change. Here, a summary of main highlights emerging from the cases studied and available quantitative data are described.

Reframing the Debate: Focus on Nation-Building and Investment

A first step in health system change is that the current system falls out of favour with the public, medical profession, political parties, or other key stakeholders. The status quo is deemed illegitimate, and a consensus built among powerful groups that there is a need for change—either reform or restructuring.

Two main arguments affect the potential for change: first, the ‘costs’ are ‘out of control’, and there is a need to reign them in; second, the healthcare system is inequitable or ineffective and failing to deliver appropriate care. The latter may sometimes arise in the presence of events such as political changes enabling popular discontent to be expressed or a visible failure of the existing system to respond to a crisis.

Health ministers, as with other “spending” ministers, typically occupy weak positions in government, so expanding coverage often has low priority among their colleagues. In the literature review and case-studies, there was evidence that ministers can shift the terms of debate to gain support for change by showing that existing, non-universal, systems are failing to address inequalities and control disease, basing their arguments on the availability of evidence and the likely resonance of issues with other key stakeholders (anticipating both what is likely to attract support and what will be opposed in the prevailing political situation). In addition, they can make social, political, and economic arguments for UHC. In low- and middle-income countries, the debate may shift from the perceived expense of coverage to the value of UHC in nation-building, and from concerns about current government expenditure to the value of investment in the country’s future (building on accepted arguments for investing in education, and acknowledging the debilitating costs of chronic disease as well as epidemics to long-term economic growth and social stability).

Recognizing Political Opportunities: Importance of External Events

Choices about how to organize the health system today impact the way it develops tomorrow. The establishment of universal public systems early on will avoid stigma associated with public/private systems and facilitate more equitable provision. Fragmented private systems tend to be more costly and less efficient at achieving public health goals. Leaders of low- and middle-income countries make choices that create and strengthen those with vested interests in the design of healthcare systems and lock those systems into trajectories that become very difficult to change later on (exemplified by the experience of attempts to expand coverage in the USA).

Two main approaches to health system change exist: incremental, gradual reform versus systemic, rapid development. Which takes place depends on many factors, including individuals (political leaders who are visionary and strong may be able to implement change more effectively), institutions (which may facilitate or obstruct rapid change), events (historically, many of the most dramatic changes have been associated with financial crises, wholesale political change, such as the collapse of communism, or national disasters), and

national context (rapid change is much easier where political power is concentrated than where it is dispersed).

Whether a country pursues gradual or rapid health system reforms and development is essentially a political rather than technical choice. Expansion of public health systems has been more common in the presence of governments sympathetic to labour and strong trade unions. While the political spectrum varies in different countries, in general, right-wing politicians have tended to favour gradual expansion of coverage, based on insurance, with measures aiming to de-radicalise opposition movements. Left-wing parties tend to view expansion of coverage as an expression of political ideology, as well as a means to secure support from their natural constituents. The process of debate that normally characterizes coalition governments tends to provide space for a wider range of actors, favouring social insurance, with gradual expansion. It also may provide more space for technical expertise to contribute to the design of reform.

Mobilizing Resources: Building Coalitions and Overcoming Opposition

Public systems tend to expand when there is a strong tax revenue base. Private systems develop incrementally when there is an absence of public financing, a legal or constitutional mandate for UHC, and ethnic divisions and high concentrations of wealth within society.

There is often a coalition (at least informally) of organised medicine, pharmaceutical companies, and insurance systems that tend to resist publicly-financed UHC. Their strength grows under private systems. On the other hand, trade unions as well as nurses and community health workers tend to support public financing. Yet, the power of the medical profession is often overstated. It is mainly negative, based on their ability to boycott reforms, but has often played less of a role in the actual design of health reforms, and opposition to expansion of coverage has been overcome by determined politicians in several cases, such as in Saskatchewan, Canada.

In closing, it is worth reflecting on the challenge this analysis poses to the World Health Organization. It has a mandate to engage in two broad areas of activity. The first is setting norms and, on many occasions, most notably at Alma-Ata, the 2005 World Health Assembly resolution on UHC, and endorsements in regional fora such as the 2008 Tallinn Conference, where member states have endorsed a vision of expanding primary health care as part of fulfilling UHC. However it also supports countries in implementing policies. If it seeks to assist policies favouring UHC in a meaningful way, rather than expounding vague aspirations, it will often stray into highly contested domestic political debates. This will require considerable courage and skill by those involved. The WHO must decide, as an international agency, whether it casts itself as firmly in support of this fundamentally political process.

INTRODUCTION

Since the 1970s, there has been a near consensus among the public health community that Universal Health Care Coverage (UHC) should be a fundamental goal.^{4,5} At the conference in Alma Ata⁶ and, subsequently in Ottawa⁷, commitments were made to pursue equitable systems of healthcare, which would provide access to all for point-of-entry healthcare services, so that no matter what a person's ailment, there is a person or group who can coordinate services. Decades later, progress is elusive. UNICEF, the World Bank, the Rockefeller Foundation, and physician advocacy groups argued that many countries could not afford UHC,^{8,9} instead promoting a Selective Health Care model, based on a limited set of cost-effective technologies (mainly the GOBI interventions) as a first step toward achieving the vision established at Alma-Ata.^{10,11} This partial model, with substantial private-sector involvement, continues to dominate the development of health systems in resource-poor settings.

While the interim selective model prevailed, many countries fell behind on basic indicators of healthcare access. HIV devastated Africa in the 1980s, compounding challenges to control of tuberculosis while driving up child and maternal mortality (a reflection of a selective model that excluded comprehensive prevention as envisaged in the Primary Health Care concept). A tremendous influx of money for global health programmes started around the year 2000, with the UN's launch of the Millennium Development Goals. Yet despite more than \$100 billion subsequently being spent on global development assistance for health¹², many basic goals of Primary Health Care, such as reducing child and maternal mortality, are not on course to be met.¹³

Increasingly, there is recognition that one source of the problem is the weak capacity of health systems in low-income countries. No amount of money can provide effective care when health systems lack functioning infrastructure required to deliver quality healthcare. Such health system resources include a sufficient number of doctors, nurses, and community health workers, who have access to reliable supplies of medicines and surgical equipment and logistical routes of providing care (involving roads and delivery networks, reliable electricity, and sufficient and adequately equipped physical facilities to meet local needs).

Absent these essentials for point-of-entry primary healthcare delivery, it is very difficult for health policymakers and practicing healthcare workers to build a functioning system or implement change effectively (the problem of weak implementation and absorptive capacity). In South Africa, for example, the government attempted to expand public infrastructure during the transition to democracy after 1994, but after a few years it was recognised that deprived geographic regions could not absorb resources effectively. The government returned to a policy of emphasizing health system development in urban centres, as part of an economic growth strategy, which came at the expense of addressing legacies of racial segregation.¹⁴

Compounding the logistical difficulties facing healthcare systems are underlying political and economic problems, such as recurring financial crises. In the 1980s, many countries disinvested in the public sector as part of Structural Adjustment Programmes.^{15,16} More recently, there are also concerns that efforts of donors, however well-intentioned, to bypass the underfunded and underdeveloped public systems will exacerbate the weaknesses of the public sector¹⁷, while creating an unregulated private healthcare market.¹⁸

In view of the failures to achieve basic health goals over the past three decades, there is a renewed interest among health policymakers in returning to the principles of PHC set out at Alma Ata. As set out in the WHO 2008 World Health Report, *PHC: Now more than ever*, the arguments in favour of PHC remain sound: The need for health is universal and health is a human right⁵; fragmented private systems cannot achieve universal coverage; universal care

leads to better health outcomes, is more efficient than fragmented privatized care, and leads to greater economic productivity and growth.¹⁹ Yet, there is an effort to draw lessons from past successes and failures to achieve UHC. One lesson, for example, is that horizontal systems, such as sector-wide approaches (SWAPs), while rhetorically pleasing, create major operational risks because of the difficulty in setting clear quantitative targets and monitoring progress towards them.^{20, 21} SWAPs were an explicit political attempt to capitalise on the backlash against vertical programmes, specified by the World Bank as ‘horizontal interventions’²² (albeit regarded by some as a policy process tool) and contain virtually no targets.

Fundamentally, the decision to implement UHC is a political one; its implementation is a political process.^{23, 24} From the term’s initial appearance in PubMed, as “Universal Health Care: the battle begins”, to more recent publications describing the ongoing process in the USA, there is clear recognition of the contested nature of reform pitting challengers against dominant opposing groups.²⁵ Support from the international community can help tip the balance in favour of domestic stakeholders who wish to implement UHC, but it is insufficient.

Unfortunately, there is little insight from existing studies to inform how the international community can support efforts – which can be characterized as a social movement²⁴ – to expand UHC. Most studies have focused on high-income countries, most especially the USA. Analysis of the politics of health remains very weak and little attention is paid, in the health care literature, to the power and politics involved in decision to implement UHC. Instead, insights are more often obtained from social and economic historians and from political scientists. The political economy analysis, broadly rooted in historical and institutional analysis, focuses on the structural forces driving movement towards UHC. This approach acknowledges the important role of actors but aims to understand the forces that empower or disempower competing groups in the political process. Such a framework integrates pluralist theories (which view the political process like a market, where competing interest groups vie for attention) with elite theories (which view the political process like a country club, determined by the interests of a powerful, limited set of actors, such as the self-proclaimed H8 global health organisations).

One aspect of the difficulty is that the leading organization promoting UHC, the WHO, while passing resolutions about UHC (2005) and writing reports about PHC (2008), has intentionally sidestepped complex political issues that are implicitly necessary to address within countries to promote UHC and action on the social determinants of health. Its normative function enables it to promote universal systems, but roles in country support can create tensions if WHO wishes to engage in political processes – which are crucial to attaining UHC.

Another outstanding challenge is that the definition of UHC is nebulous (argued to be one reason why is it so widely shared²⁶), which makes it difficult to operationalise. There is, for example, no widely available and agreed upon list of countries which do or do not have UHC. Should the recent decision of U.S. policymakers to expand coverage to 94% of its population, with its explicit exclusion of undocumented migrants, qualify as UHC?

Yet, there is a growing emphasis on understanding models of expanding healthcare access to universality in lower-income countries, especially those with legacies of conflict and social (especially ethnic) inequality.²⁷ One example is Rwanda, a desperately poor nation, where national health insurance has existed for 11 years such that 92% of the population is covered with premiums of USD \$2 a year.²⁷ It reflects an ‘out-of-the-box’ model evolving in resource-poor settings with decentralized government decision-making and small patchworks of disintegrated clinics depending on foreign assistance.²⁸ Immediately several questions are raised about Rwanda’s experience: Is this UHC? Does it qualify as

Universal Health Care? Should its model be encouraged to countries in similar economic positions? If so, given its relatively privileged situation as a recipient of development assistance, how replicable is this model in seeking to ‘graduate’ from donor support to independent provision of UHC?

These questions resonate with the growth in interest in comparative health systems performance²⁹, especially since the 2000 World Health Report.⁷ However, there is a recognition that performance assessment will need to apply easily replicated and widely-understood measures that account for people’s daily realities, such as long waiting lines and lack of access to clean water, rather than assembling convoluted indexes of health system strength that fail to provide a clear sense of what has been improved and how well. This background paper seeks to address several of the gaps in the global health systems literature in an effort to understand how countries can accelerate progress toward UHC and define a future agenda for UHC that moves beyond the Alma Ata declaration and Ottawa Charter. First, it reviews the definitions of UHC currently invoked in the literature, and compares them with a theoretical model of health systems and the main WHO definition. This identifies the common understandings in public health about the meaning of UHC. Then, these understandings are integrated with the WHO definition of UHC and available data to provide an initial classification of countries that have UHC, which provide material for in-depth case-studies, selecting countries according to when they implemented UHC and the corresponding level of income. Third, based on a review of the political economy of UHC literature, and the factors that emerge from the qualitative analysis, a cross-national analysis has been undertaken to identify the determinants of UHC.

SECTION 1. WHAT IS UNIVERSAL HEALTH COVERAGE?

A large body of research has attempted to analyse various aspects of Universal Health Care. These studies question, for example, which services should be part of the healthcare package, or whether all members of the population should be covered. This body of work is embedded in a broader literature about improving the effectiveness of health systems financing and delivery.

One weakness in the literature is that while UHC is frequently invoked by health policy analysts, it is unclear what these analysts actually mean by the term. Definitions can vary widely. In general, authors writing about high-income countries refer to ‘Universal Health Care’, while low-income countries are referred to as having ‘Universal Coverage’. Universal Health Care is currently studied in a non-systematic way, and we have been unable to find any systematic review has thus been conducted to assess the key dimensions, approaches, and classifications with which universal health care coverage is studied. Thus, before proceeding, it is necessary to identify the commonly understood meanings of Universal Health Care by performing a systematic review of the literature.

A literature search for the most relevant international Universal Health Coverage literature was conducted on PubMed, Google Scholar, and World Bank Publication. For the PubMed Search, the Mesh term ‘universal coverage’ and the term ‘universal health care’ were used to identify the most relevant peer-reviewed literature on UHC. On PubMed, the applied search limits were ‘Humans, Editorial, Letter, Meta-Analysis, Review, Case Reports, Classical Article, Comment, Comparative Study, Corrected and Republished Article, English Abstract, Evaluation Studies, Government Publications, Guideline, Historical Article, Introductory Journal Article, Journal Article, Legislation, Multicenter Study, Overall, Validation Studies, English, French, German, Abstract available’. This search returned a total of 595 articles. In addition, a Google Scholar search helped us identify an additional 86 relevant articles. These articles were reviewed, and their footnotes searched for immediately relevant articles. This search revealed another 58 articles. These 58 hand-picked articles included articles such as the 2000 WHR, relevant WHO and WB reports on health systems, as well as books on universal health care coverage. The search of the World Wide Political Science Abstracts revealed with the search term “universal health” revealed an additional 148 articles, which were included in our database. These articles constituted the initial library to define UHC definitions and dimensions. Additional relevant articles were drawn from the investigators personal libraries.

In order to investigate the most common definitions in the identified literature, 100 articles were randomly selected from our article database. The articles were reviewed in depth, and 21 included a definition of ‘universal health care’ or ‘universal coverage’. These definitions were divided into 5 common themes using a qualitative approach to ‘factor analysis’ with NVIVO, a qualitative data-analysis program.

Review of Literature about Universal Health Care

Twenty-one of the 100 papers provided an explicit definition of UHC. Of these, there was little consensus, and the meanings were often unclear. The majority referred to UHC as universal coverage, but differed in regard to whether they meant a comprehensive set of healthcare services, whereas others referred to a single intervention.³⁰ Another common definition related to the system’s financing or reimbursement arrangements.³¹ While these terms and notions are invoked, this is done in an unsystematic way (as noted previously, the vast majority provided no definition whatsoever). Thus, the factor analysis did not identify a coherent theoretical framework, but instead revealed the actual usage by scholars and experts

in the existing literature. Acknowledging these limitations, the main five themes emerging from the reviewer suggested that researchers used the term UHC to refer to: access to care or insurance; coverage; an identifiable point-of-entry to the system, a rights-based approach; social and economic risk protection. Clearly, access to care and insurance are different dimensions; insurance is not a healthcare intervention *per se* but a means of financing. Also, the usage of the term ‘coverage’ at times referred to access: a population receiving and utilising particular services such as immunisations. Hence, each definition has a set of limitations, and many of these dimensions are overlapping rather than mutually exclusive. We will now address each of these dimensions in turn.

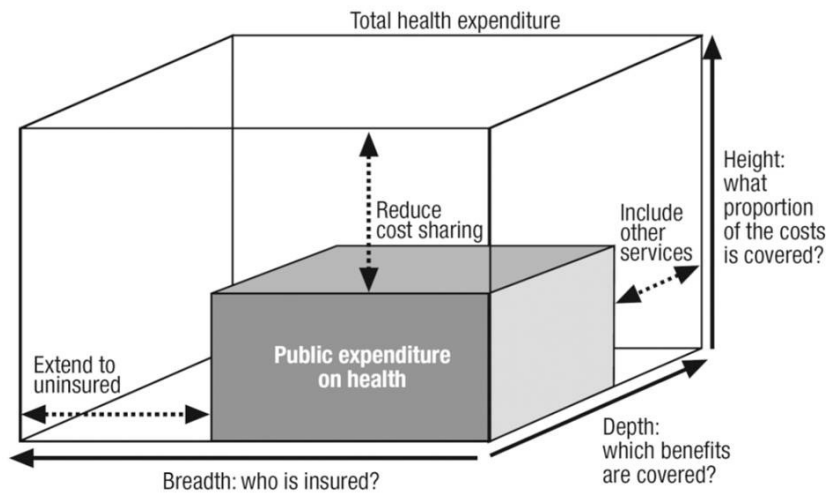
1. Access to care or insurance

An aim of Universal Health Coverage is to provide every citizen or resident access to insurance or a particular (albeit not necessarily universal or comprehensive) set of services. Usage included “Everyone can get insurance”, as well as certain services, such as “Access to essential medicines” and outcomes, “Access to care with financial risk protection”. A broad range of organisations equated UHC with Universal Access, including the OECD and American medical associations. One concern is that persons may achieve the financial, geographic, and legal means of access to health service and protection, but face cultural or social barriers to care.

2. Coverage

Universal coverage was referred to as “100% coverage of the population under the given health plan” or as “comprehensive health coverage without user fees”. However, which services should be fully covered, who should be covered, and what services are considered necessary for coverage to be comprehensive is unclear (dimensions commonly referred to breadth, depth, and height as depicted in figure 1).³² For example, a system has greater height when public spending is higher, so that individuals are less likely to resort to out-of-pocket spending. An ILO study, which compared all available data on access, concluded that based on WHO data, “worldwide, about 1.3 billion people are not in a position to access effective and affordable health care if needed, while 170 million people are forced to spend more than 40 per cent of their household income on medical treatment.”³³

Figure 1: Dimensions of Universal Health Care



Source: WHO 2008

3. Package of Services

Attempting to overcome the difficulties in the definition of coverage, scholars have defined a ‘basket of services’ containing the basic drugs and services set out in the WHO Primary Health Care³². This approach seeks to identify a “universal package of guaranteed benefits or entitlements, comprising a set of essential services applied to all in the world.”³⁴ For example, the WHO Commission on Macroeconomics and Health³⁴ costed the provision of a basket of cost-effective services that would ensure universal population coverage at USD \$34 per capita per year (a highly contested figure, as noted in a critique by Ooms and colleagues^{35, 36}).

On the spectrum from promoting a limited set of basic interventions to a full set of comprehensive services, the one common point for many researchers is the inclusion of primary care within UHC. In this context it typically refers specifically to the care that is provided at the first level point-of-entry to the healthcare system, such as when a provider responds to common primary presenting conditions at the level of a first-responding clinician, rather than via multiple rounds of subsequent referral and specialization to tertiary levels of care. Importantly, this is a more restrictive definition than that employed at Alma-Ata and in subsequent WHO documents, wherein Primary Health Care is viewed as a philosophical approach to health care embracing community participation (community based orientation and services) alongside coverage and affordability (including first line referral hospital to ensure appropriate back up for first line care, rather than only being understood as first line care).³⁷

The literature reviewed here implies that the package would not simply be exclusive to vaccines or other individual interventions, but rather be grounded in the sense of comprehensive point-of-entry services for the ailments common to a population, not specific to a particular vertical program.

4. Rights-based approach of UHC

The rights-based approach starts from the position that health is a human right.⁵ All countries have ratified International Covenant on Economic, Social, and Cultural Rights (ICESCR) and the Convention on the Rights of the Child (CRC), which legally and morally bind their leaders to ensure the “highest attainable standard of health, encompassing medical care, access to safe drinking water, adequate sanitation, education, health-related information, and other underlying determinants of health.” This right to health further is disaggregated into negative liberties, such as the ‘right to be free from discrimination and involuntary medical treatment’, and positive ones, such as ‘the right to essential primary health care.’

One difference in the literature arises in regard to individual versus social rights. The difference is in regard to the duty of provision. In the case of individual rights, the state, market, or community is responsible. However, with regard to social rights, these notions follow the definition put forward by T.H. Marshall, of putting the onus on state institutions for “legislated social provisions aimed at guaranteeing economic welfare and security for every citizen, and the standard of those provisions correspond to the prevailing standards in the society.” However, it is also necessary to recognise that several leading human rights advocates have questioned whether an insistence on social and economic rights that, to some, are clearly unenforceable in conditions of extreme poverty, may detract from the quest for more fundamental political rights³⁸ or whether it is more effective to focus on actions that are arbitrary or discriminatory rather than relate to distributive justice, which key stakeholders may reject.³⁹

5. Social and economic risk protection

Universal social health protection coverage is defined as “effective access to affordable health care of adequate quality and financial protection in case of sickness”.⁴⁰ This view is consonant with the notion that health systems are about more than healthcare. It is associated especially with the International Labour Organisation (ILO), which defines social health protection as a ‘series of public or publicly organized and mandated private measures against social distress and economic loss caused by the reduction of productivity, stoppage or reduction of earnings or the cost of necessary treatment that can result from ill health’.

In sum, the literature reveals that people often mean very different things when they talk about Universal Health Care. Yet, there are important commonalities. For example, those who invoke the rights-based approach also recognise that it requires an “effective, responsive, integrated health system of good quality that is accessible to all⁵.” In capturing these elements of a shared approach and desired outcomes, the WHO has proposed a definition but, as will be shown in the following section, it suffers from certain limitations.

Towards an Integrated Definition of Universal Health Care

The main definition of UHC used by WHO integrates these preceding five notions of Universal Health Care. As set out in the *Lancet* in 2006:

Universal coverage is defined as access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access. The principle of financial-risk protection ensures that the cost of care does not put people at risk of financial catastrophe. A related objective of health-financing policy is equity in financing: households contribute to the health system on the basis of ability to pay. Universal coverage is consistent with WHO’s concepts of Health for All and Primary Health Care.

This definition identifies the health system as a set of widely agreed upon means (e.g. affordability) to achieve desired ends (e.g. financial risk protection).

Limitations to the WHO Definition and Challenges in Implementation

The WHO definition has several limitations. Even among those who are committed to expanding health care to those with limited resources, there is the powerful tradition of Selective Health Care, which focuses mainly on providing a very narrow set of cost-effective interventions, focused on curing avoidable disease at low-cost such as the GOBI program advocated by UNICEF. Furthermore, it cannot be assumed that this vision put forward by the WHO is widely held. There are many individuals and organisations (exemplified by some of those participating in the ongoing debate on health care reform in the USA), who see health care as a matter of individual responsibility and not one for collective action based on solidarity. As historical reviews have shown, including the WHO's SDH reports, despite some views to the contrary, the Rockefeller Foundation contributed to backing the vertical Selective Health Care Approach supported by the World Bank, UNICEF, and some doctors.⁹

Even among those who agree with the WHO's proposed means and outcomes, it is unclear how to attain it. Disparate views exist about how to expand health systems – or even what a health system is in the first place. At the core of the dispute are dimensions of UHC that are implicit, but often unaddressed, that are the nuts and bolts of the healthcare system, such as: Who pays for care and how? What is the appropriate public/private balance of provision in low-income countries?

While the WHO offers an aspirational definition, an outstanding challenge is how to operationalize it. Of course, definitions do not provide blueprints for implementation (although they may impede implementation by setting lofty, intractable and unmeasurable goals). Thus, in order to understand relative success and failure in achieving UHC, a first step is to identify and monitor which countries have or do not have UHC. Creating a dataset to measure the adoption of UHC is necessary for setting out objective criteria and clear policy targets.

SECTION 2. GLOBAL PREVALENCE OF UNIVERSAL HEALTH COVERAGE

There is no single list of countries fulfilling the WHO definition of UHC, based on explicit criteria. However, the ILO has compiled a list of 190 countries, accompanied by an index of social health protection, which combines data on the legal status of coverage and quantitative measures, such as the level of health expenditure, out-of-pocket payments and access indicators.³³ A recent study also provides data on 72 indicators of the right to health, based on information that is available on websites of international organizations or within ‘one mouse-click’ from those sites,⁵ but this lacks longitudinal data that would make it possible to determine when UHC was achieved.

The search expanded upon this previous work in two ways. First, it was ascertained whether a country had a legal framework to provide coverage, in the form of legislation mandating or calling for the health protection of all people the country. Then, these measures were combined with indicators of access and coverage. Together, these provided a complementary set of indicators of what occurs on the books (*de jure*) and on the ground (*de facto*).

To compile this database of countries required a hand search of databases. If a plan included language that indicated that the entire population (note: citizens, residents, or other groups in the population are not distinguished) is covered under the health plan and is granted access to a core set of services, it was determined that the country indeed had a legal mandate for covering the entire population. The second step involved a survey of available measures of access, coverage, inequalities and outcomes from the WHO Statistical Information System. The available data are very limited but some exist in relation to maternal and child health.

In view of the data constraints, the following pragmatic criteria were used to indicate the presence of UHC, combining new and existing data sources on legal and effective access and quality, as well as process of care:

1. Healthcare legislation explicitly states that the entire population is covered under a specified health plan, including a specific package of services is available and identifiable year (and such legislative text can be identified online);
2. The country’s population access to skilled attendance at birth and healthcare insurance (including social health insurance, state coverage, private health insurance, and employer-based insurance based on the ILO data) must be greater than 90%, which serve as broader proxy indicators for access to care, using the latest data available and based on the ILO threshold)^{a,33}

Results

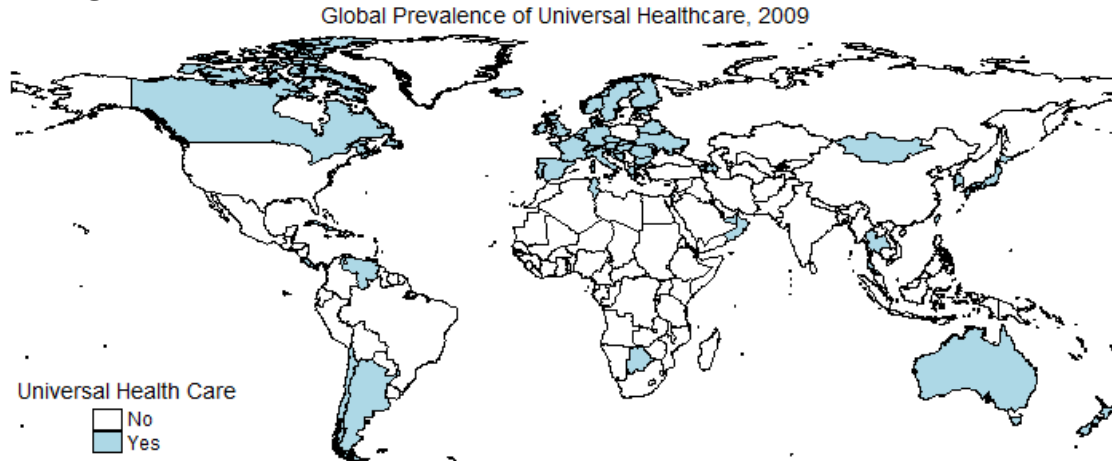
Figure 2 summarises the result of the search. Out of 194 countries in the analysis, 75 countries had legislation that provided a mandate for UHC. Of these, a further 58 met access, quality, and outcome criteria for UHC in the years 2006-2008. Gambia, Bolivia, Congo, and Bhutan were eliminated because skilled birth attendance was below 90% of births. Algeria, Colombia, Ecuador, El Salvador Jordan, Dominican Republic, Brazil, Bosnia, Latvia^b, Moldova, Russia, and Uruguay did not have healthcare insurance among more than 90% of

^a The WHO DOTS treatment success and coverage indicators were considered but are known to suffer from considerable limitations; furthermore most high-income countries did not meet the WHO recommended standards of 75% case-detection and 85% treatment success rates. This would seem to invalidate its use for identifying UHC, despite its widespread recommendation as the standard global TB control package.

^b Although insurance is not universal, those who do not qualify are covered in state facilities.

the population.^c The United States was not included because its current legislation will only achieve >90% insurance coverage by 2014.

Figure 2. Global Prevalence of Universal Health Care, 2009



Of the 58 countries identified which currently can be classified as having attained UHC, data on real gross domestic product per capita (GDP) were available on 44 of them for the year in which the country initiated UHC-legislation.

Figure 3 shows the relationship between GDP per capita and the year of legislative enactment of UHC in constant 2005 US dollars. At the time of the implementation of legislation, country GDP per capita ranged from less than \$5000 (such as the United Kingdom in 1948) to above \$30,000 (Switzerland in 2003). Most countries shown introduced UHC when the real GDP per capita was lower than \$20,000; the mean was about \$13,000 – approximately that of a current middle-income country. Out of the 44 countries which have a legal mandate for UHC and for which GDP data were available at the time of legislation, about one-half would today classify as high income countries, one-quarter as upper middle income countries, and the final quarter as lower middle income countries (based on the World Bank income classification schema). While recognising that the nature and complexity of health care has increased greatly over recent decades, this suggests, in theory, that a country's leaders can choose to adopt UHC and ultimately cover more than 90% of the population with point-of-entry healthcare services, even when the country is at a moderate level of economic development.^d

^c If DPT immunization rates were used as criteria, New Zealand, Cuba, Venezuela, and Greece would be excluded because rates were below 90%. If clean water and sanitation measures were included, Azerbaijan, Mongolia, and Romania would be excluded because above 90% of the population lacked access to clean water among above 90% of the population. Panama would also be removed because more than 90% of the population did not have access to adequate sanitary facilities.

^d It is, however, important to bear in mind that while technology has advanced, making a 'comprehensive' set of services more expensive overall, point-of-entry care services have become more affordable.

SECTION 3. EXPLAINING CROSS-NATIONAL VARIATIONS IN UNIVERSAL HEALTH COVERAGE

After having identified a set of 58 countries which provide a legal mandate for UHC, it was necessary to evaluate the reasons why they had done so, as compared with countries in similar time periods and levels of economic development that had not. As a first step, a review of the existing literature was undertaken, seeking to understand the politics and economics behind the decision to implement UHC followed by three detailed historical case studies of Germany, the United Kingdom, and South Korea and cross-national econometric analysis of the determinants of access and quality of healthcare.

Literature Review of Determinants of Universal Health Coverage

Analysis of UHC has been conducted by many disciplines using a variety of methods, ranging from economics, sociology, political sciences, to public health. Of these traditions, four main theoretical positions have been previously identified to explain the expansion of health coverage (see Box 1). We describe main themes and limitations in the literature on UHC implementation, drawing on illustrative examples of the leading paradigms of thought from a broad literature review.

Main Theoretical Paradigms:

1. Pluralist Theories

In the pluralist framework, so labeled because multiple players are involved in policy-making, groups and individual compete to influence policy, as in a political market. Political outcomes are the result of people's choices, either in the marketplace or through voting and responsive state institutions. This tradition primarily characterizes health economists and political scientists. A limitation of this framework is that, empirically, there is discord between levels of public support for government-sponsored health care and health system outcomes.

2. Institutional Theories

In the politico-institutionalist framework, analysts focus on the main institutions and interest groups (or 'stakeholders') that have varying degrees of power and are impacted by policies. In health systems analysis, these groups typically include the medical profession, hospitals, academic centres, insurance and pharmaceutical companies. This primarily characterises political scientists and sociologists. While this framework often can identify the immediate policy dynamics of a particular outcome, a main limitation is that it does not evaluate where and how these groups attain power in the policymaking process in the first place.

3. Development Theories

In the development framework, it is suggested that "developing" countries will come to resemble "developed" countries over time, as their institutions converge with economic growth and integration into the global economy. This primarily characterises macro- and development- economists, as well as many epidemiologists and public health experts. It draws on the observation that more advanced economies have greater degrees of public involvement in healthcare, and thereby suggests that economic development will lead to the expansion of healthcare access and quality. A strength of this framework is argued to be its

empirical evidence, revealed in correlations of Gross Domestic Product (GDP) and public health spending as a percentage of GDP. The main limitation is that this framework is apolitical, and fails to specify how an increase in economic resources yields a decision to increase the level of resources allocated to healthcare, as well as the type of system that evolves.

4. Class Theories

In the class framework, the power relations between classes determine the nature and extent of what happens to the surplus (i.e., profit) in society. This shapes the development of social welfare, taxation and redistribution in society. In its most general sense, the class analytical framework evaluates the main blocs of economic interests in society, which are determined by a group's relationship to economic production. These two clusters reflect the interests of capital owners versus those of labour. Owners of land (agriculturalists) and factories (industrialists) are main segments of capitalist classes, whereas wage-dependent labourers represent the proletariat, or working classes. These broad groups vie to improve and, in the case of the capitalist classes, reproduce, their class and status positions through the interest groups associated with them (political parties and unions). A strength of this approach is that the class theory can identify the sources of power and its changing distribution in society. A limitation of the class analysis framework is that it is difficult to observe features of the class framework, such as class power, conflict, formation, and consciousness.

In general, the insights of the literature review can be structured as follows:

1. Public Health – most of the existing public health literature provides few insights into the political economy of UHC, for several reasons. First, it tends to underemphasise the significance of political dynamics and processes within countries that result in the expansion of public health coverage. As one leading group characterises their approach, it searches for “control knobs”, seeking ways to inform policymakers about the ways in which the system can be modified, so that policymakers can better achieve their desired outcomes, whatever they may be. As pointed out in Navarro's critique of the 2000 World Health Report, this is an inherently apolitical orientation, and favours incremental tweaks to existing systems (a conservative bias).⁴¹ It is also separated from the lived realities of people's experiences with the healthcare system, which does not involve the analytic construction of health system scorecards or other abstract indexes, but the on-the-ground data related to patient fees, waiting times, access to key medicines, and broader population health concerns like access to piped water that Navarro argues should be recorded regularly and monitored rather than abstract gauges of health system performance.

Second, in general, the public health literature evaluates health care outcomes in relative isolation, instead of examining how the expansion of UHC often coincides with the development of broader social welfare systems. Healthcare movements have generally accompanied broader social movements. As a result, debates that extend beyond the realm of healthcare alone should be included in the analysis.

Third, the dynamics of health system evolution are rarely characterised as a longitudinal process, but instead are analyzed cross-sectionally. This overlooks how the structure of a given system, in terms of its financing and infrastructure, determines the scope for the successive evolution of health systems. As one example, the expansion of user fees has been found to impede the development of public health coverage, because means-testing of services impedes social mobilisation and potential for universal expansion (by fragmenting the ‘deserving’ from the ‘undeserving’ poor), creates stigma of the public sector (as famously

noted, a ‘service for the poor is a poor service’), and establishes vested interests in maintaining the private-based system because care practitioners benefit from direct payments.

Lastly, most public-health policy analysis of health system events, such as the legislative decision to establish Universal Health Care places a considerable emphasis on the power of medical professionals in the health-policy reform process. Part of this bias stems from the differential availability of material written by medical professionals, and the scientific discipline within which these scholars operate. There are also historic tensions between the medical field and public health practitioners, reflected in the identification by some scholarship of the medical profession as an impediment to reform. This does reflect, for example, debates in the UK and US where the medical profession did oppose the expansion of publicly financed, single-payer UHC (to which we return in the case studies).

A second group, mainly development economists, draws insights from cross-national statistical observations relating to two main social determinants of healthcare expansion: economic growth and democracy. In regard to the first, there is a ‘convergence hypothesis’, based on the common observation that social welfare (including healthcare spending) is greater as a percentage of an economy (measured in Gross Domestic Product, GDP) at higher levels of economic development (GDP). Thus, it is argued that if developed countries grow economically, their systems will begin converge with developed countries and provide higher levels of health coverage. The second claim is a pluralist hypothesis, invoking political responsiveness to public attitudes. This argument suggests that there will be a correlation between public opinion and policy outcomes in democracies, because policymakers are responsive to public opinion and their demands for healthcare with effective policy implementation. The validity of this argument has been questioned, for example, in the observation that the majority of the American public expressed support for public provision of UHC for the past three decades, yet a ‘public option’ for financing has remained elusive in American policy debates.⁴²

The third group, mainly of sociologists and political scientists, has focused on power, politics and institutional forces, with a greater reliance on historical case studies and qualitative methods. Representatives of this group are Theda Skocpol, Ted Marmor, Paul Starr, and Vicente Navarro. Their theoretical frameworks differ in regard to their emphasis on immediate and underlying factors of UHC. For example, Marmor’s and Starr’s research focuses on the immediate policy outcomes and the proximal roles of interests groups, largely the medical profession and their capacity to block reforms. Focusing on underlying determinants of policy decisions, Navarro’s analysis reveals the fundamental importance of class forces--that groups of people, their organization and mobilization towards shared goals, enter into conflict. The outcome of the struggles of these groups to achieve their desired goals is the system of social welfare. One main limitation of this body of work is that it is dominated by debate about the USA, the only major industrialised country not to have achieved UHC.

Insights can also be drawn from analysis of the expansion of social welfare (which includes healthcare). One classic analysis of social welfare systems is Esping-Andersen’s categorisation into three types, social democratic, conservative, and liberal, with each having distinctive features and political dynamics.⁴³ As an oversimplification, Esping-Andersen argues that which of these systems emerges is principally determined by:

- 1) Main interest groups have strong leadership over their members
- 2) There is a close tie between interest groups and political parties, creating an entry point into the policy decision-making process
- 3) Parliament must be an effective decision-making arena

Successive work on the varieties of capitalism, by Hall and Soskice, build on Esping-Andersen’s framework.

In our analysis of the literature within each of these main theoretical paradigms, we have identified five main arguments and/or empirical determinants of UHC, as summarised in the table below. These determinants serve as hypotheses to the detailed case-studies and quantitative analysis that follows.

Table 1. Determinants of UHC identified in the Literature Review

Determinant	Description
Left-Labour Coalitions	<p>Left-leaning policymakers tend to prioritise greater state intervention in the economy, redistribution of wealth, and social protection, including healthcare. Navarro, observing the co-occurrence of powerful left leadership in the development of UHC, postulates that strong and well-organised labor unions, with close links to political elites are crucial to establishing UHC.⁴² In empirical work, Navarro and colleagues find that social democratic parties support redistributive policies, which have favourable effects on reducing child mortality rates.</p> <p>A related argument is that UHC expands to quell social discontent arising from high levels of social inequality, thereby enabling elites to maintain high degrees of economic exploitation. One example is how food aid during the 1960s was used to attempt to maintain social stability by preventing riots.</p>
Wealth of Nations	<p>A common notion, drawing on observational data, is that because UHC is more prevalent in high-income countries, it is therefore for rich countries. It is possible that country's need a certain level of economic development as a precondition for meeting UHC. Cutler and colleagues refer to these ideas in two ways: as Wagner's Law, that social insurance is introduced as nation-states become richer, and as a Leviathan theory, that coverage is expanded when governments have budgetary surpluses.</p>
Divided Societies and Types of Political Institutions	<p>Political science literature has identified distinctive consequences of political regime types (parliamentary democracy, congressional democracy, dictatorship, etc) for policy outcomes. Recent work shows that in societies that are highly divided, or fractionalised, on ethnic or linguistic lines, or have high degrees of social inequality, that redistributive public policies are less likely to occur. For example, Alesina and Glaeser's research show that the degree of racial or ethnic fractionalization, geographic factors of proximity, and the ability to unionize are strong predictors of the successful implementation of social redistributive policies.⁴⁴</p>
Initial Social Welfare Conditions	<p>Another view maintains that the initial configuration of a country's health system has implications for the direction of its evolution. It is possible that a health system that involves a high degree of public financing and delivery in a low-income country expands more equitably as a country's wealth increases. Thus, the health systems configuration influences its reform path over time. For example, a healthcare financing system that relies on out-of-pocket payments creates vested interests among providers, who may resist efforts to change the system to involve a greater degree of public payment.</p>

	<p>Similar to this line of argument, Hacker argues that the U.K. developed healthcare as a major redistributive social system, whereas the U.S. focused on access to education as a means of redistribution. This supposes a welfare crowd-out effect, whereby expansion of one system could impede the development of others.</p>
<p>Political Windows of Opportunity</p>	<p>Institutions evolve very slowly, a process referred to as institutional-inertia. Only during periods of exceptional social upheaval or turmoil, such as in response to natural disasters, wars, or financial crisis (so-called ‘events’), do major changes occur (so-called ‘critical conjunctures’). The opportunities created by these shocks are referred to as ‘political windows’.</p> <p>Historical examples of major shocks include the Great Depression of the late 1920s and early 1930s and the post-war reconstruction period. These political windows interact with the preceding factors. For example, studies of the expansion of social policies in U.S. states during the early 1930s found that the greatest rise in social welfare spending occurred in states with left-party (democrats) governors.⁴⁵</p> <p>While these shocks create windows, the policy space, and the kinds of policies they enable, differ. For example, the social unrest following mass impoverishment after the Great Depression in the U.S. is thought to have created political pressure to expand social safety nets (cite Fishback). On the other hand, rising taxes and less competitive businesses can create a backlash among members of the financial elite, who push for pruning government spending.</p> <p>Not only exogenous shocks, but certain periods of political cycles also create windows of change. In the U.S., for example, the newly elected president is thought to have a ‘honeymoon’ period in often, with a presidential mandate, that makes it possible to invest political capital to push through elements of his/her campaign agenda. The importance of such trajectories and events can be seen in the history of U.S. health insurance. Marmor and Oberlander argue that the threat to the U.S. doctors autonomy and salaries posed by UHC were a major factor impeding the expansion of health insurance coverage.²³ Maioni argues that the Social Security reforms of the U.S. in the 1930s established a model of contributory social insurance for one deserving group, the elderly, which paved the way for establishing Medicare for the elderly, but impeded the universal expansion of coverage, like that which occurred in neighbouring country Canada.⁴⁶</p>

Country Case Studies

Theoretical Case-Study Framework

The literature review shows that UHC was typically achieved as part of broader political movements to implement social welfare systems. Thus, we set out a framework to analyse these episodes using the sociological literature on social mobilisation, which has the advantage of moving beyond a set of isolated factors to an integrated theory of policy change. This analytical approach has been previously invoked to describe processes of mass mobilisation to place pressure on government officials to implement UHC. However, social movements, as understood in sociology, have a broader meaning than just in terms of actions of mass mobilization and collective protest. Social movements involve collective actions to effect social change, and involve a set of activities, through both institutional and extra-institutional means, to achieve it (including social protest, awareness and voting campaigns, strikes, etc.).

One framework, developed by sociologist Doug McAdam, to understand the success and failure of the civil rights movement in the U.S., is the Political Process model.⁴⁷ At its core are three simple elements (which are here adapted from the original model, as done previously in analysing the political processes of global health priorities).^{14, 47} These elements are to re-frame the debate, create and identify political opportunities, and mobilise resources.

As well as approaching politics as an interactive and dynamic process, as opposed to an isolated set of factors, the Political Process model integrates theories of resource mobilisation (as groups with low levels resources face difficulty organising and successfully campaigning for change), framing theory (noting how the debate is framed as an individual or collective issue influences the policy response), and windows of opportunity (caused by exogenous forces but also a result of policy decisions). Its disadvantage is that the overlapping categories are difficult to disentangle and endogenous. Thus, a high level of mobilised resources increases the likelihood of political opportunities emerging and vice-versa. Taking account of alternative frameworks, we structure the main findings of our analysis using both the Political Process Model and a commonly applied pluralist framework.

This framework is also consistent with the language of game theory and power structure analysis. Those groups in society who support the development of UHC can be viewed as the ‘challengers’, in a game pitting them against those maintaining the status quo. The main players are the medical profession, organised labour, government officials, political parties, insurance and pharmaceutical companies, leading industrialists, media, and general public. Their relative strength changes over time, often from exogenous changes in the economy and society beyond their group’s immediate control. Their power can be regarded as their ability to achieve their desired outcome; their relative power reflects this ability in response to competition from other groups.

The power of these groups depends on economic, political, and social forces and their interrelations. One is the structure of the economy and the resources it distributes to the main occupational groups (including agricultural workers and land-owners, industrial capitalists and factory workers, intellectuals, unions, etc.). A second is the state and its relationship to these groups in the economy and its functions to tax and redistribute wealth among them. The third is political, involving the main political mechanisms (dictatorship, democracy and their various types, such as parliament, presidency), the rules of the political game (term limits, etc) and the existing checks and balances on policy authorities (including legal institutions and constitutional provisions). A third sphere is social, reflecting the human conditions of groups, their awareness and perceived satisfaction of those experienced conditions, and their solidarity as a group.

Case Selection

One recurring problem in case-studies regards the method used to select cases. The choice can create a selection bias, which can skew the results of a study. Yet, it is often difficult to identify robust criteria, and researchers are limited by the availability of data and source material for investigation. Another caveat is that, in seeking to adopt a comparative structure, there is a risk of conflating the full complexity of historical experience into a tidy narrative. However, the case studies undertaken to inform this background paper involved an extensive review of social histories of the contemporary and prior periods of the expansion of UHC.

Box 1. Reviewed Sources of Case-Study Material

Germany

Abrams L. Bismarck and the German Empire, 1871-1918. London: Routledge; 1995.

Bismarck O. Bismarck, the man and the statesmen: being the reflections and reminiscences of Otto, Prince von Bismarck. London: Smith, Elder; 1898.

Dawson W. Social insurance in Germany, 1883-1911: its history, operation, results and a comparison with the National Insurance Act, 1911. London: Unwin; 1912.

Weindling P. Health, race and German politics between national unification and Nazism, 1870-1945. Cambridge: Cambridge University Press; 1989.

United Kingdom

Abel-Smith B. The N.H.S. the First 30 Years. London: The Stationery Office; 1978.

Bevan A. Aneurin Bevan on the national health service. Oxford: Wellcome Unit for the History of Medicine; 1991. Foot M. Aneurin Bevan, 1897-1960. London: Gollancz; 1997.

Beveridge J. Beveridge and his plan. London: Hodder and Stoughton; 1954.

Doyal L. The National Health Service in Britain. The political economy of health. London: Pluto Press; 1979.

Eckstein H. The English health service: its origins, structure, and achievements. Cambridge, MA: Harvard University Press; 1958.

Klein R. The politics of the National Health Service. 2nd ed. London: Longman; 1989.

Pater J. The making of the National Health Service. London: King Edward's Hospital Fund for London; 1981.

Webster C. The National Health Service: A Political History. Oxford: Oxford University Press; 1998.

Willcocks A. The creation of the National Health Service: A study of pressure groups and a major social policy decision. London: Routledge & Kegan Paul; 1967.

South Korea

Anderson GF. Universal health care coverage in Korea. Health Aff (Millwood). 1989 Jan 1;8(2):24-34.

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- Repetto R, et al. *Economic development, population policy, and demographic transition in the Republic of Korea*. Cambridge, MA: Harvard University Press; 1981.
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- Wells K. *South Korea's minjung movement: the culture and politics of dissidence*. Honolulu: University of Hawaii Press; 1995.
- Yang B. Health insurance in Korea: opportunities and challenges. *Health Policy and Planning*. 1991;6(2):119-29.
- Yang B. The role of health insurance in the growth of the private health sector in Korea. *The International Journal of Health Planning and Management*. 1996;11(3):231-52.

In view of the limitations of existing comparative work on high-income countries, it was decided to revisit the analyses of the expansion of the two main archetypal health systems, the Bismarckian system, dating to 1883 in the German Empire, and the Beveridge system of the United Kingdom in 1948. Since there is a major gap in the literature about low- and middle-income countries, South Korea was chosen as a third case because of its move from a legislative commitment in 1977 to coverage (an employer-based system) to a universal Bismarckian insurance system by 1989, a mere 12 years (Table 1).

The social forces involved in these three case studies, dating from the 1880s in Imperial Germany, the late 1940s in the United Kingdom, to the 1970s when South Korea underwent spectacular economic growth, provide insights that can be applied to a range of situations facing low- and middle-income countries today. Their political contexts varied

greatly. Germany had an authoritarian regime, undergoing early waves of democratization alongside rapid social and economic industrialization. In the United Kingdom, a gradualist, incremental approach advocated by the majority party in the wartime coalition was rejected by a left wing party that swept to power in 1945, based on a wartime report.⁴⁸ The paths these countries followed have been emulated, in various ways, by many other governments subsequently, and the majority of today's population lives with levels of income that characterized Germany and the United Kingdom in this period.

Korea had been influenced by the U.S. after liberation from the Japanese after World War II, and played a key role in the Cold War following the Korean War in the 1950s. After ruling through a period of democracy in the 1960s, Korea's president seized power, implementing authoritarian rule and repression of worker's rights, while achieving growth rates regarded as an 'economic miracle' due to its industrial policy, high exports, and generous foreign investment in the 1970s and 1980s.

Table 2. Three examples of the path to Universal Health Coverage

Dimensions	Germany 1883	United Kingdom 1946	South Korea 1977
Historical Precedents	<ul style="list-style-type: none"> - Voluntary insurance system, formalized in Industrial Code - Poor Laws 	<ul style="list-style-type: none"> - Voluntary insurance, covering about half of the population - Poor Laws, but hospitals being taken over by local authorities - Emergency Medical Health Service established in WW2 	<ul style="list-style-type: none"> - Voluntary Insurance, very limited coverage - Experimental system
Framing	<ul style="list-style-type: none"> - Health as nation-building and unifying - Health as solution to social problems of industrialization (including alcoholism, TB, and STDs as well as overpopulation) - Emphasise the importance of the advancement of social conditions of working class to general society 	<ul style="list-style-type: none"> - Beveridge’s Five Giants: Want, Disease, Idleness, Ignorance, and Squalor; health as part of the commitment to full employment and social security in a ‘New Britain’ - Widespread consensus about providing free and comprehensive care for all members of the community - ‘Universalize the best’, to provide all people with the same level of service 	<ul style="list-style-type: none"> - Health as part of nation-building - Façade of democratic representation to legitimate political authoritarianism - Search for a unique Korean path - Welfare complements growth instead of slowing it down
Political Opportunities	<ul style="list-style-type: none"> - Shift from liberal economic principles to interventionist trade protections to gain support from landed elite (Junkers) - Two assassination attempts on Emperor Wilhelm I - Expansion of democracy (Reichstag), and associated need to contain rising Socialist party beyond Anti-Socialists Laws - Crisis of overpopulation 	<ul style="list-style-type: none"> - First Labour party victory in 1945 with a large majority to break Coalition Labour-Tory government (supermajority of 100 seats) - Wartime propaganda both to strengthen troop morale and undermine Hitler’s new social order - Postwar reconstruction of bombed hospitals and care infrastructure - Typhoid outbreak in 1937 viewed as failure of local authorities to deliver public health 	<ul style="list-style-type: none"> - Repression of democracy and labour movement, with development of authoritarianism - First assassination attempt on President Park Chung-Lee (killing his wife in 1974, a second killing him in 1979) - Anti-Communist Laws and ideology - U.S. military aid to South Korea against North Korea receding in détente between Soviet Union and U.S., and shifting to health aid, with an earmark health system program in 1975 - Component of Industrial Policy needing to redistribute population away from Seoul to regional centres
Mobilising Resources	<ul style="list-style-type: none"> - Rising social discontent from miserable human conditions - Political radicalism - Early eugenics movement (seeking purity of blood and race) out of excess doctors - Anti-semitism and popular imperialism 	<ul style="list-style-type: none"> - Medical profession opposed to state power, but moreso to local authority control 	<ul style="list-style-type: none"> - Increase of extra-parliamentary activity of protest and strikes by a coalition of churches and student-led activists - Park Chung-Hee launching counter social movements (Saemaul) and co-opting unions

The detailed analysis of developments in these three countries will be published later.⁴⁹ However, four key inter-related factors emerge as important (here summarised using a pluralist framework). These are individuals, institutions, events and context. Each shapes the others, so that, for example, individuals are a product of their time and place, shaped by social forces. Individuals can create or destroy institutions. Events can be rendered significant or insignificant by individuals and contexts.

In all cases, individuals emerge as important. They may be politicians, such as Bismarck, the British Prime Minister Atlee and his health minister Bevan, or the Korean President Park but they also include what would now be called policy analysts, such as Beveridge. Their actions are shaped by their beliefs and their personal histories. For example, Bevan, as a trade unionist, believed strongly in industrial democracy and gave the medical profession (who he saw as the main group of workers in the new NHS) a privileged position.

Institutions, defined in its broadest sense to include not only organisations but also formal and informal networks, can facilitate implementation and shape its direction. Thus, the perceived weakness of the Korean government in 1977 shaped President Park's view that insurance should be developed independently. In the United Kingdom, the creation of the wartime Emergency Hospital Service, provided a solid base for the NHS. In Bismarck's Germany, the employers' bodies and trade unions emerging in the industrial revolution provided a natural framework for social insurance.

Events often open windows of opportunity which may or may not be seized. The sense of shared hardship during the war created a solid basis for post-war solidarity in the United Kingdom. Domestic unrest was a stimulus for change in Germany and Korea. Finally, context is important, although. In all three case studies, the political environment favoured the initial change, although in different ways, whether through alignment of political forces, large majorities, or dictatorship. However, subsequent expansion seemed to reflect pressures exerted through democratic processes.

Although it was only possible to undertake detailed case studies of three countries in preparation for this background paper, this framework resonates with evidence from other countries. Thus, it is possible to identify key individuals, such as Tommy Douglas, the architect of the Canadian health system, or Julio Frenk, who introduced Seguro Popular in Mexico, both of whom played visible and symbolic leadership roles. Elsewhere, it is possible to identify the role that institutions play, or in some cases do not. Thus, in France in 1946 the large employers' associations, that would otherwise have opposed de Gaulle's expansion of health care, were neutralised by their history of collaboration with the Nazis. The role of events is apparent in the enactment of the 1941 Dutch Sickness Fund Decree under pressure from the occupying German authorities, making insurance for employees and their families compulsory for the first time. Finally, the roles of context and institutions are apparent in the comparative rapidity with which New Zealand, with its unicameral parliament and centralised power introduced a national health service in 1938 compared with the prolonged process of health care reform in the USA, where power is dispersed between the executive branch and the two legislative chambers at federal level, a situation mirrored at state level, all within a constitutional framework established in 1787.

In summary, the historical evidence suggests that health ministers and others advocating for UHC can make a difference where institutions exist that are supportive (or where those that are opposed can be neutralised), where the political and cultural context is

facilitative, and where it is possible to take advantage of exogenous events such as financial crises, political transitions, and natural disasters.

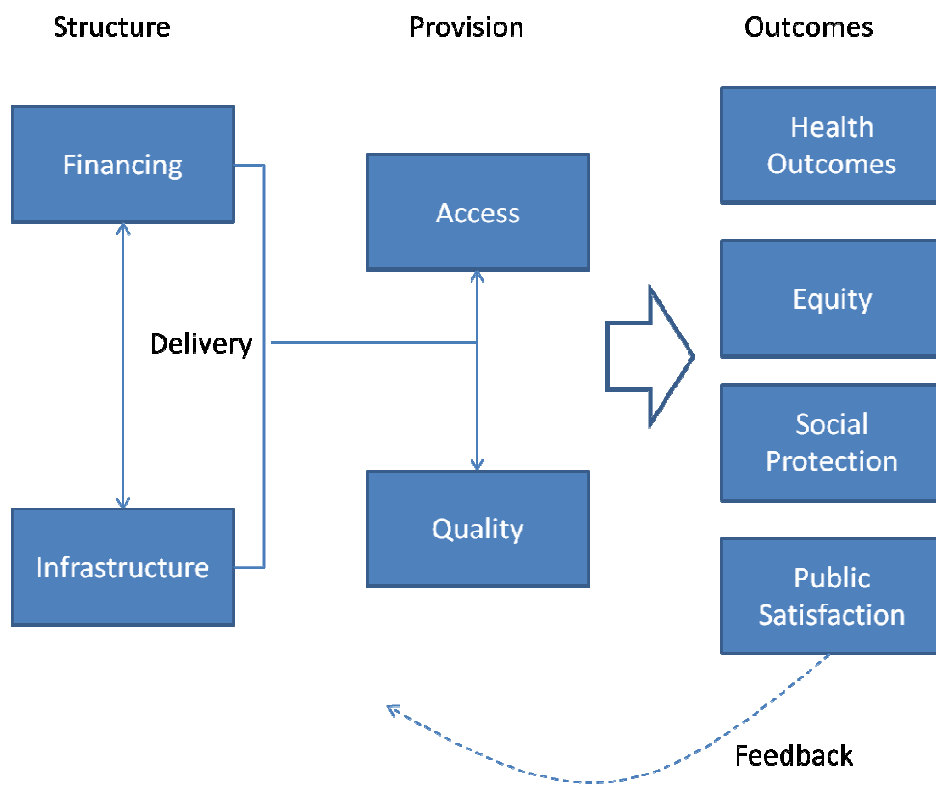
Cross-National Econometric Analysis

The preceding case-studies illustrate the complexity of political dynamics and richness of historical experience in the process of either expanding or reforming health systems. The following section tests some of the basic correlates of health care access and spending (proxies for UHC used in constructing the map of countries with or without UHC) to answer common questions about the key determinants of universal health care.

Here it is necessary to provide a brief review of what a health system is in relation to UHC. Drawing a simplified model from the WHO 2000 Health systems framework, health systems comprise structural aspects (financing and infrastructure) which serve as instruments for policymakers to achieve particular goals (improved health outcomes, equity, and public satisfaction) (Figure 4). Mediating these outcomes are proximal indicators of care delivery, such as access and quality of healthcare. At the point of delivery, financing is converted into infrastructure (physicians, nurses, hospitals, primary care centres) for care provision. Current healthcare institutions and their outcomes influence the potential for change to existing financing and infrastructure arrangements. Hence, our analysis is structured as quantitative case-studies of the determinants of public and private financing, which we treat as underlying factors in a broader analysis of the main components of the health system’s provision of access and quality healthcare, as set out in the figure below.

Figure 4. Simple Model of a Health System

Model of a Health System



Notes: Adapted from Hsiao and colleagues 2010.

However, a caveat is also needed that, while equity is a shared goal, UHC may not be sufficient to achieve it. The 1979 Black Report, from the United Kingdom, revealed that in

spite of three decades of universal health access, there were substantial and widening inequalities in morbidity and mortality between social classes, which required other means to address beyond healthcare coverage.⁵⁰ The effects of financing arrangements on equity necessitate a dedicated analysis and, although we attempted to do so using measures of inequalities in access both within- and between-countries (available upon request), data on the former are lacking.

The data and methods used are summarised in Box 1. The full results summarised briefly here will be published in due course in a peer-reviewed journal.⁴⁹

Box 1 Data and methods used to analyse empirically the determinants of Universal Health Coverage

Health financing, infrastructure, access and quality of care, and outcomes data were taken from the WHO Statistical Information System 2009 edition covering 193 member states between 1995 and 2008. Public and private health spending were based on the WHO National Health Account framework. Union density data were from the OECD Trade Union Density database 2010 edition. Economic data were from the Penn World Tables v6.3 (real gross domestic product per capita), and foreign direct investment, government spending, and savings rates were from the World Bank World Development Indicators 2009 edition. Democratization indices were based on the widely used, Polity2 indicator, developed by the PolityIV project, at the Center for Systemic Peace funded by the U.S. Central Intelligence Agency. Income inequality data were from the World Income Inequality Database 2009 edition. Data on ethnic, linguistic, and religious fractionalization were taken from Alesina and colleagues publicly available datasets.

Regression models were used to evaluate the determinants of healthcare financing and, in subsequent models, the effects of financing on the development of UHC. As GDP is the main underlying source of a society's resources, we sought to model the political process of how these potential funds are applied to achieve UHC. Thus, to account for differences in country income levels, financing data were evaluated as a percentage of GDP. As robustness checks, statistical models also corrected for differences in each country's type of health, accounting and surveillance systems using country fixed effects.

Econometric approaches offer a means to examine statistical determinants of Universal Health Care. It is necessary to avoid the over-simplification of data analysis, recognizing that political situations in different countries can vary widely. The purpose of an empirical analysis, however, is to understand what major determinants can be of differences between locales, e.g., to understand what factors may have led one region or country to develop a more extensive healthcare system than another.

Determinants of Healthcare Financing

Although health systems have varying financial arrangements, in general the two main sources of health financing are tax revenues or private contributions (including those from employers and individuals, as well as out-of-pocket spending on healthcare). These sources are 'proximal' in the sense that they lie closer to the budgetary outcome on a causal chain that traces back to underlying social and political determinants identified in the literature review. Thus, the balance of these two sources, and the levels of funding associated with them, are in turn ultimately determined by political structures, institutions and power groups, legal commitments, and public attitudes for directing the level of economic resources (GDP) available to society. In the analysis, public health spending and private health

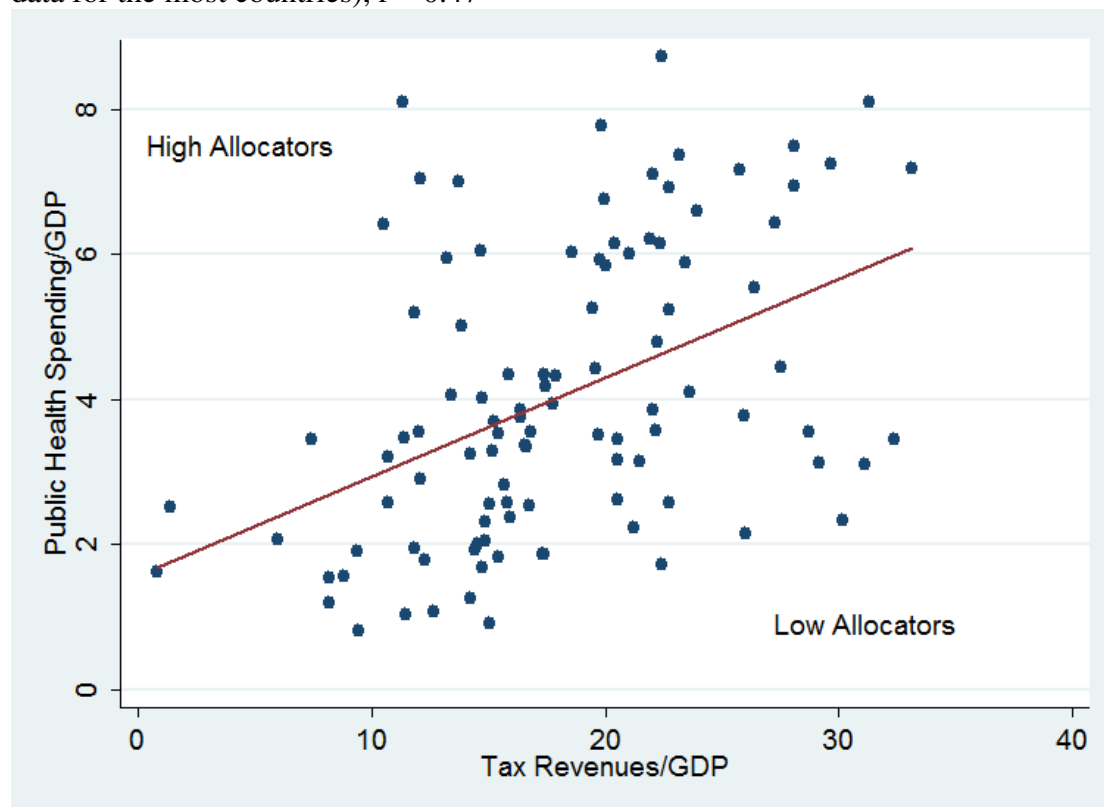
spending are assessed separately, to account for the evidence that a reliance on private expenditure, such as user fees, impedes the development of UHC.

Turning first to the drivers of government public health spending (and addressing next private health spending including out-of-pocket spending – the predominant form of financing in most countries), there are two main pathways by which public health spending comes about: via tax revenues contributing to government spending and via government spending contributing to public health spending.

In investigating the first link in the causal chain, there is a moderate correlation across countries between tax revenues and general government spending as a percentage of GDP ($r = 0.51, p < 0.01$, based on the year 2006). Analyzing the next path in the chain, higher levels of government spending correlate with significantly greater public health spending (again, $r = 0.51, p < 0.01$). Overall, differences in a country's tax revenues base can account for over four-fifths of historical variations across countries in their level of public health spending per capita and a substantial share in terms of the percentage of GDP (see figure 5).

To put these effects into perspective, each additional \$1 USD of tax revenues is associated with an additional \$0.11 is spent on public health, after adjusting for differences in the type of health system (social health insurance, single-payer, and mixed systems) and variations in surveillance across countries. These differences are substantial in terms of health systems financing. As an example, a country like Cote d'Ivoire, with very low tax revenues of 15.0% of GDP, has public health spending of about 0.9% of GDP and about 1 doctor per 10,000 population, compared with neighbouring country Ghana, had greater tax revenues of about 20% of GDP and resultantly higher public health spending of 2.3% of GDP and twice as many doctors in the year 2004. This occurs in spite of Cote d'Ivoire having a stronger economy, with a GDP of about \$533 per capita, whereas Ghana is about \$300 per capita.

Figure 5. Tax Revenues and Public Health Financing in 103 countries, 2006 (latest available data for the most countries), $r = 0.47$



Although the domestic tax base is a crucial determinant of public health spending, there are still considerable variations in how much is allocated to the public health system. As noted above, the correlation of taxes with public health amounts to about \$0.10 for every \$1 raised in tax revenues. But some countries can be viewed as ‘high allocators’, devoting as much as three-quarters of tax revenues to public health in contrast with other areas of government spending, while others allocate as little as 1/15th, as ‘low allocators’. This begs the question of what determines the political decision to allocate tax revenues to public health as opposed to other potential sources of government spending, such as education or military expenditures, and allowing the private-sector to drive health development (through insurance or out-of-pocket/informal payments).

Looking to the case-studies of Germany, the United Kingdom, and South Korea for guidance, one factor determining public health allocations of tax resources seems to be democratic representation. In democratic countries the mass public tends to exert a greater influence on policymakers than in dictatorships. For example, the transition to democracy in South Korea was important in scaling up government financial contributions and, ultimately access to care. A Gallup poll taken in South Korea in 1981, for example, reported that health was the most important issue to people in their lives, and the factor most closely related to their overall happiness. The role of transition to democracy is apparent in many other countries, such as Spain, Portugal, and Taiwan.

Indeed, democratic representation appears to be a significant determinant of public health allocations. Countries with higher levels of democracy scores, tend to be the ‘high allocators’, whereas those with lower levels tend to be ‘low allocators’.

A second potential factor suggested in the course of the prior analysis is that a legal or constitutional mandate to provide UHC can facilitate the expansion of care because it provides a framework for social mobilisation and reflects a re-framing of the debate. The existence of a legal mandate thus could make country leaders more likely to allocate greater portions of tax revenue to public health was examined. There was a significant association between such a mandate and public spending. On average, a legal commitment was associated with about two percentage points of GDP greater public health allocations.

Taken together, these observations raise a key question: why do some countries invest more in public versus private systems? Here it is necessary to reflect on the drivers of redistribution. Based on the existing literature, public redistribution in the form of taxation is expected to be lower when society is highly unequal, such that there is less motivation to redistribute wealth.⁵¹ This social division can occur by income, ethnicity, religion, language, gender, age, and a variety of factors. Conversely, public redistribution tends to be stronger when labour groups and representatives are well-organised, have union representatives that reflect the desires of lower socio-economic groups, and these groups have access to public policy channels, such as through democratic representation.

In general, the evidence is consistent with these propositions (Table 2). Tax revenues, and thereby public health spending (both overall and in terms of public/private mix), are significantly lower in societies that are most divided by income, ethnicity, and language (but not religion). On the other hand, high union density and greater scores on indices of democracy are both strongly linked to higher tax revenues and thereby higher public health spending.

Table 2. Summary of Main Findings on the Social and Political Determinants of Health Financing

Statistical Determinants of Health System Financing	
Public Sector	Private Sector
- High tax revenue base	- Low levels of public sector funding
- Strong left-party organizing (as indicated by unions)	- High foreign direct investment
- Democratic political systems	- Militarization of the economy as competing demand on public funds
- Low levels of social fragmentation, such as income inequality or ethno-linguistic heterogeneity	- No legal mandate of Universal Health Care
- Legal or constitutional mandate of Universal Health Care	- Strong doctors coalition (as indicated by doctors/nurse ratio)
	- Low private savings

SECTION 4. MAKING IT HAPPEN – A RESEARCH AGENDA TO SUPPORT IMPLEMENTATION

As with any sociological study, our analysis has several limitations. First, we undertook a review of major literature through a sociological framework that emphasized a historical and institutional analysis of major structural and political forces that drive UHC implementation. As a result, our analysis may underplay the role of individual actors, and while not coinciding with a ‘great men’ interpretation of history, we did review personal biographies and note the importance and agency of leaders including Bismarck, Bevan, Beveridge, Frenk, Douglas, and De Gaulle within their political contexts. Second, our analysis is based on existing data and literature, which is heavily biased towards wealthier industrialized countries. A major agenda for research on UHC is the experiences (some ongoing) of poorer countries as well as regional blocks that are shaping health system coverage, often without external evaluation or careful data monitoring.

A related concern is that while UHC is a politically convenient term among health analysts, much of what we have discovered during the course of our analysis is that focusing on coverage alone, without also discussing health infrastructure and models of community-oriented primary care, may lead to an artificially myopic conversation. Many health movements relate to UHC – from the drive for primary care expansion to the call for expanded health system financing. Our literature review was limited to articles and research focused on universal coverage, but related fields involving community-oriented ethnographic research and broad health financing research offer insights not reviewed here.

To support the further implementation of UHC, several gaps in the research literature should be addressed, potentially by the WHO. First, we observed that the conflicting definitions employed in the literature lend themselves to misinterpretations of what is being achieved. Researchers should set out clear metrics for what they are defining as part of the UHC package of health services and how they are measuring the extent of coverage. Furthermore, research is needed to determine what are the critical factors that can extend coverage to the hardest-to-reach groups, in the form of operational management techniques and community involvement in health system expansion. Finally, we observed that since UHC is usually achieved in the context of broader social movements, research is needed into how successfully broad social protection mobilization has been achieved in years past.

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