VALUE IN HEALTH 16 (2013) S39–S45

Available online at www.sciencedirect.com

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Universal Health Coverage: A Quest for All Countries But under Threat in Some

Martin McKee, MD[1,*], *Dina Balabanova, PhD*[2], *Sanjay Basu, MD*[3], *Walter Ricciardi, MD*[4], *David Stuckler, PhD*[5]

[1]*London School of Hygiene and Tropical Medicine, London, UK;* [2]*University of California, San Francisco, CA, USA;* [3]*Stanford Prevention Research Center, Department of Medicine, Stanford, Palo Alto, CA, USA;* [4]*Università Cattolica del Sacro Cuore di Roma, Rome, Italy;* [5]*University of Cambridge and London School of Hygiene and Tropical Medicine, London, UK*

ABSTRACT

Over the past 50 years, health care has been making a growing contribution to population health in many countries. Yet its benefits are still denied to many people worldwide. This article describes how many countries, both developed and developing, have pursued the quest to achieve universal health care. This has been an explicitly political process. In Europe, it emerged from a belief in solidarity, a fear of revolution, and a changing view of the role of the state. In developing countries, progress was more erratic, characterized by debates about the affordability of universal health care, until it was realized that functioning health systems were essential to deliver development goals. Throughout, the United States has been an exception. An analysis of progress toward universal health care, combining a review of existing theories and new empirical analysis, identifies five factors as important: the strength of organized labor and left-wing parties, adequate economic resources, absence of societal divisions, weakness of institutions that might oppose it (such as organized medicine), and windows of opportunity. Having noted the substantial benefits accruing from universal health care, the article concludes with an analysis of how universal health care is under threat in some European countries and a warning about the risks posed by current radical austerity policies.

Keywords: global health, health systems, universal coverage.

Introduction

Health care is viewed by some as a fundamental right but by others as a tradable commodity. In the course of just over a century, universal health care (UHC) has gone from being an aspiration to a reality in most industrialized countries, but not yet all. Yet for many, especially in the developing world, it remains no more than a dream. For those who have it, never before has it been so insecure.

Before proceeding further, it is necessary to clarify what is meant by UHC. A previous systematic review of the literature found that UHC and universal health care were often conflated, but the former was invoked more frequently when discussing developing countries [1]. Each term, as used by researchers, was found to express five main themes: access to care, coverage, point of entry to the health system, a rights-based approach, and social and economic risk protection. The definition set out by the World Health Organization (WHO) integrates these themes:

> 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.

It identifies the health system as a widely agreed upon means (e.g., affordability) for achieving desired ends (e.g., financial risk protection).

This article aims to assess the future of UHC in Europe. Our analysis proceeds as follows: in the first section, we first review a chronological history of how UHC came (or did not) to be. In the second section, we assess the global prevalence of UHC and leading theories that can account for its presence. Finally, having evaluated the social, political, and economic drivers of UHC, we evaluate the implications of changes to these forces over time, particularly in light of the recent global economic crisis, to assess challenges and threats to UHC in developing countries and Europe.

A Chronology of UHC

Throughout most of recorded history, the concept of UHC was essentially meaningless because health care had so little to offer.

Conflicts of interest: The authors have indicated that they have no conflicts of interest with regard to the content of this article.

* *Address correspondence to:* Martin McKee, Health Services Research Unit, London School of Hygiene and Tropical Medicine, 15-17 Tavistock Place, London WC1H 9SH, UK

E-mail: Martin.mckee@lshtm.ac.uk.

1098-3015/$36.00 – see front matter

http://dx.doi.org/10.1016/j.jval.2012.10.001

To the extent that care was provided, it was delivered largely by laypeople with no formal training. What care was effective consisted largely of basic first aid or, in some cases, herbal remedies whose efficacy had been established by long experience. Most of what passed for health care was ineffective, or worse, hazardous and unpleasant, such as cupping, bleeding, purges, and similar remedies, so that the treatment was often worse than the disease.

This situation began to change in the late 19th century with advances in biology. The first step was to understand the actual causes of diseases. The development of the germ theory, supplanting the earlier belief in miasma as a cause of disease, paved the way for the identification of the bacteria and viruses causing many common infections. Meanwhile Koch's [2] postulates about causality provided a means to match an infectious agent to a disease process. By the mid-20th century, it was even possible to cure diseases with early antibiotics. Similar advances were apparent with noninfectious diseases. In 1921, the discovery of insulin transformed a rapidly fatal disease of childhood, later to be known as type 1 diabetes, into one compatible with a normal lifespan. The 1950s saw a steady growth in the number of chronic diseases for which there were effective treatments, including hypertension, heart failure, asthma, and chronic obstructive airways disease, and schizophrenia.

By the mid-1960s, health care could make a real difference to the chances that someone would live or die [3]. Since that time Western European countries began to see a steady decline in deaths from conditions considered amenable to timely and effective care (a pattern that was not witnessed in the Soviet Union) [4]. It now mattered whether a population had access to health care or not.

The first system of organized health care emerged in Germany, as part of a series of social reforms introduced by Bismarck, seeking to quell political incursions by the social democrats in the late 19th century. The industrial revolution had led to a rapid expansion in the population living in cities that far outstripped the physical infrastructure, with large numbers living in squalor. Their conditions provided an ideal breeding ground not only for disease but also, as importantly from the perspective of the elite, social revolution. Bismarck also faced pressure from labor unions and social democrats to implement safeguards for people if they became unemployed or fell, ill as well as for their families should they die. These protections included access to health care. The resulting so-called Bismarckian social insurance system was limited to those, largely men, in industrial employment. Women and children benefited to the extent that the family breadwinner was, or had been, in such employment. The system was financed largely by wage-related contributions, reflecting negotiations between employers and trade unions. Over time, governments played an increasing role as investments in health and welfare became a means of addressing social problems of industrialization (alcoholism, tuberculosis, and overcrowding), forging political alliances as well as transferring resources from the rich to the poor, from working ages to children and old people, and from healthy to ill.

A few countries would adopt alternative approaches to UHC, based on either local or national taxation. This often occurred after previously implementing social insurance schemes such as that in Germany. In some, local government took on the responsibility for health care, especially where there was little industrial infrastructure and employers associations and trade unions were poorly developed, as was the case in Scandinavia. Other countries sharing these characteristics, such as Greece and Ireland, were less fortunate, instead patching together composite systems that, collectively, provided coverage for most people but in multiple parallel systems. This was the situation that prevailed in Italy until 1978, although it would take another 14 years to address many of the tensions that the initial reforms left unresolved [5]. In other countries, such as the United Kingdom, it was a political decision by a socialist government, albeit taking advantage of events that created political opportunities for expanding welfare, in this case the creation of a nationwide Emergency Medical Service during the Second World War and the promise to military servicemen of building a better, fairer society for all [6]. Subsequent tax-based systems, such as those in Spain and Portugal, were also the result of political choices, as they made the transition from dictatorship to democracy in the 1970s.

A different form of politics had given rise to the Soviet model of universal care, extending often very basic services to a widely dispersed population. This model, with minor variations, followed the Soviet advance into Eastern Europe after the Second World War.

Similar developments were taking place in other high-income countries. By the mid-20th century, countries such as Australia, Canada, Israel, Japan, and New Zealand had implemented UHC in various forms. In Australia and Canada, it involved a partnership between the federal government and governments in the provinces, states, and territories. In New Zealand, with its small, tightly knit population and constitutional settlement facilitating rapid and wide-ranging legislative change, a universal tax-based system began to be implemented in 1938. In the 1990s, it was the turn of some of the emerging "Asian tiger" economies, such as South Korea [7], Singapore, and Taiwan [8], where investments in social welfare eventually caught up with gains in economic development.

What lessons can be drawn from this wealth of historical experience to provide guidance about how to accelerate progress toward UHC?

Why Do Some Countries Provide UHC and Others Not?

As the preceding examples show, the expansion of health care has long been a political process and one often bound up with the growth of social welfare more generally [9]. It has tended to require a confluence of political opportunities, available financial resources (mainly from a functioning tax revenue base), and the mobilization of strong, left political parties, leaders, and representatives (including trade unions).

In an earlier article [1], three of the current authors reviewed the various concepts informing how we view UHC and the consequent definitions that have been adopted by various sources. We noted how definitions varied considerably, often emphasizing UHC when discussing poor countries but "universal health care" when describing rich ones, but overall there was little consensus about what was meant. Nearly all definitions, however, embraced four components: access to care and/or insurance, coverage, rights, and social and economic protection. These themes could all be identified within the definition put forward by the WHO (Box 1). However, in many ways, its definition was aspirational. The question was what did it mean in practice?

To assess which countries fulfilled the WHO definition of UHC involved a series of pragmatic decisions, influenced in particular by the limited availability of data on health institutions. We adopted criteria on the books (de jure) and on the ground (de facto) to conclude that UHC was in place where there was legislation explicitly stating that the entire population is covered by a defined health plan and where that population has access to at least skilled attendance at birth [21] and 90% of them have insurance coverage [22].

Box 1–Five determinants of universal health care

Left Power: There is extensive evidence linking the strength of organized labor and the electoral power of social democrat parties to the expansion of social welfare, most notably in the work of Esping-Andersen [10], and adapted to health care coverage in the work of Navarro [11]. This research, taken together with other work, has also identified the weakness of organized labor as one factor in the absence of universal care in the United States as well as an explanation for variations in the provision of public investment in health care across Europe [12]. It is notable that in many low- and middle-income countries a powerful labor movement has yet to emerge as in industrialized nations, partly reflecting macroeconomic policies oriented toward attracting foreign investors with a promise of low-wage, tax- and union-free environments.

Economic Resources: There is also evidence linking economic growth to the expansion of coverage. However, the reasons for such a correlation are not clear. Wagner's Law proposes that the scope of social insurance expands as countries become wealthier [13]. The so-called Leviathan theory considers that coverage is increased when countries are running budget surpluses [14]. This is linked to a notion that some countries are "too poor for UHC," lacking a sufficiently functioning tax revenue base to finance public goods. Another view is of "convergence," that as developing countries catch-up with developed countries, so too will their social welfare systems [15].

Societal Division: Societies that are divided on ethnic, linguistic, or religious lines ("status" groups) also tend to contribute fewer funds to public welfare, including health care. Work by Alesina and Glaeser [16] has demonstrated how redistributive policies, of which universal coverage is an example, are less likely to be supported in societies that are more divided. They present a compelling case for the role of race in limiting welfare provision in the United States, with those states where most poor people are black being least generous. Four of the present authors have extended this work globally, showing that countries with greater ethnic and religious heterogeneity have had lesser investment in health care and, as a result, slower progress toward the child and maternal health Millennium Development Goals [17]. The authors also found a significant relationship between income inequality, controlling for income levels, and a lower fraction of spending on health care.

Existing Institutions: When a country reaches a point at which it might pursue universal coverage, such as a particular level of economic development, other factors may constrain the development of the health system. Thus, the existence of powerful vested interests, such as a medical profession dependent on informal payments or a private insurance industry that can call on vast resources to lobby politicians, may be sufficient to block progress. It is generally thought that a reliance on private finance at early stages of health care system development could embed vested interests, making it more difficult subsequently to expand the public sector's role in health care finance and provision. These initial conditions create a situation of "path dependency," whereby future paths are shaped by past choices and present circumstances.

Windows of Opportunity: Windows of opportunity typically involve both an exogenous shock and political leadership to capitalize on it. The shock forces the widespread realization that the status quo is not sustainable; the political leadership suggests an alternative. Examples include the actions of Atlee, in the United Kingdom, and de Gaulle, in France, in the aftermath of the Second World War. For example, de Gaulle was able to deflect criticism from industrialists of his expansion of health insurance by noting how they had collaborated with the occupying Germans [18]. A recent review of the experiences of five low- and middle-income countries that were making progress toward "good health at low costs" (also referred to as "good health in spite of poverty" [19]) identified several such examples, such as the war of independence in Bangladesh, the collapse of the USSR in Kyrgyzstan, and the overthrow of the military government in Ethiopia [20].

On the basis of these two criteria, we concluded that 75 of 194 countries met the first legislative criterion but, of these, only 58 met the access criteria (Figs. 1 and 2). Several things were striking. First, many countries had achieved UHC when they were still quite poor. For example, the United Kingdom did so in 1948 when its gross domestic product, in real 2005 US $, was under US $5000 per capita. Clearly, the scope of health care has increased enormously since then, but this, taken with more recent examples such as Thailand and Rwanda, suggests that countries can achieve universal coverage with at least a basic package at relatively low levels of income. Second, we observed that the presence of the legislative criterion did appear to accelerate progress, likely by providing an organizing platform for advocates so as to strengthen social movements for UHC.

An enormous amount has been written about the factors that give rise to countries pursuing universal coverage, drawing on a wide range of disciplines including economics, political science, and sociology. As summarized by Navarro [11], these can be disaggregated into four broad theories. Pluralist theories see multiple players competing in a political market to influence policy. Institutional theories focus on institutions and interest groups that have differing degrees of power and are impacted by policies in different ways. These institutions typically include the medical profession, health care insurers and providers, and pharmaceutical companies. Development theories suggest that as countries become wealthier, they will adopt many of the characteristics of developed countries, noting in particular the association among gross domestic product, increasing fractions of public health spending in gross domestic product, and progress toward universal coverage. Class theories see the provision of health care as a result of a struggle between those providing capital and those providing labor in the economy. In particular, these theories draw attention to the role played by organized labor in advancing the interests of the population and of elite groups in opposing or supporting their advancement.

The multiplicity of theoretical frameworks, all attracting greater or lesser support from empirical evidence, indicate that there is no single explanation for why a country decides to pursue universal coverage. However, a number of enabling and inhibiting factors can be identified that "load the historical dice" for the development of UHC. Of the many factors, the five most prominent are the strength of organized labor and those left-leaning parties that represent them, the availability of resources (including economic growth), potential for building shared identities and public goals (as seen in more homogenous societies), path dependency (so that the conditions today impact the possibilities for tomorrow), and windows of opportunity (often created by exogenous events such as financial crises, natural disasters or wars, or political transitions), as summarized in Box 1. To varying degrees, these factors affect the scope of UHC in developed and developing countries. For example, limited

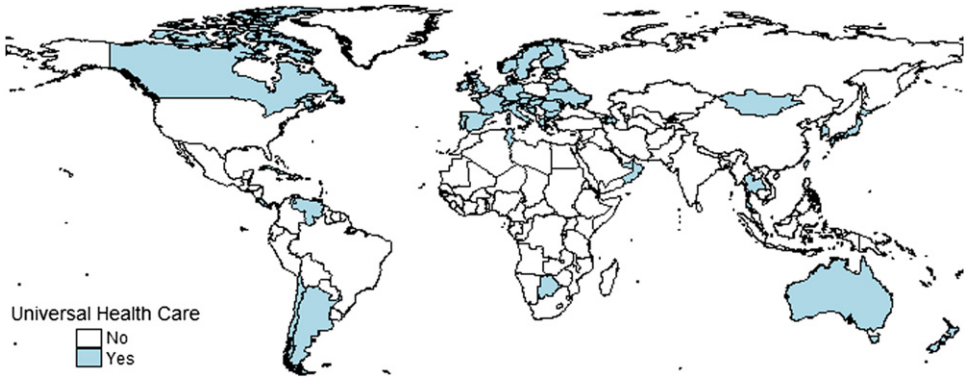

Fig. 1 – Global prevalence of universal health care, 2009.

economic resources (particularly tax revenues) are more likely to be a hindrance to UHC in developing than in developed countries, whereas class conflicts are likely to apply to all countries. As we, and others, have argued elsewhere, these factors can best be understood in a unified framework when viewed together as part of a social movement toward UHC [1,9,23].

Current Challenges and Threats to UHC

The economic crisis that appeared in 2008 has opened a political window of opportunity for those who were hostile to the European postwar welfare state. Apocalyptic predictions appeared in the media describing the purported consequences of aging populations, new technologies, and greater popular expectations. Despite much evidence to the contrary, health care was portrayed as a drain of resources rather than an investment in those whose labors would drive economic growth [24–27]. Politicians began to ask whether their health systems were "sustainable." Few actually called for UHC to be abandoned. Instead, they developed policies that would, in time, encourage those who could afford to do so to opt out by purchasing private insurance. This strategy included limiting publicly funded benefit packages, introducing co-payments, and allowing waiting times to increase. It became clear that the expansion of health care to most or all of the population was not a one-way path toward growth. Here, lessons could have been learned from the experience of Chile, where the welfare state was largely dismantled by General Pinochet following the coup that overthrew Salvador Allende. Yet, there was no excuse for failing to learn this lesson, given how Naomi Klein used Chile as an example of how those opposed to collective action could triumph against the will of the people [28]. Meanwhile, developing countries, particularly India and China, continue to post double-digit growth rates—an expansion of available resources—which creates potential for health care expansion. How will these threats and opportunities affect the evolution of health care systems in developing and developed countries?

The Future of Developing Countries: Political Economy of Welfare Expansion

In developing countries the situation continues to be quite different than that in developed countries [19]. This is despite a commitment by the countries of the world, in Alma-Ata in 1978 [29], to the principle of universal primary health care. The

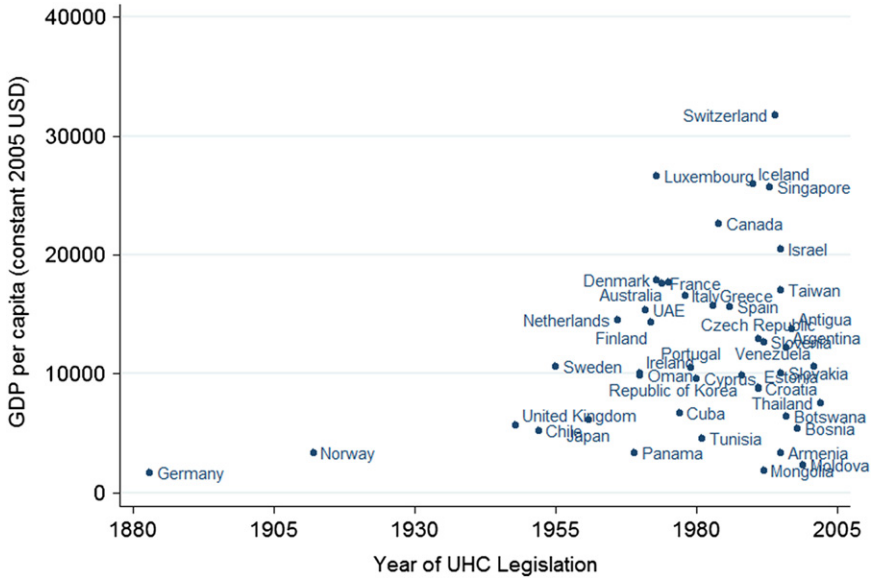

Fig. 2 – Year of UHC legislation and levels of GDP per capita, 44 countries. *Notes*. Real GDP in constant 2005 US dollars is from the University of Pennsylvania world tables series 6.3 and correct for purchasing-power differentials and inflation. Pre-1950 data sources are from Bordo and colleagues using alternative GDP estimation methods. New Zealand not included because of lack of GDP data [1]. GDP, gross domestic product; UHC, universal health coverage; USD, US dollars.

optimism that was generated by this commitment rapidly dissipated, as organizations such as the United Nations International Children's Emergency Fund, the World Bank, the Rockefeller Foundation, and others concluded that universal care was unaffordable and it would be better to focus on a few priority interventions, and in particular the growth monitoring, oral rehydration, breast-feeding, and immunization quartet [30,31]. This approach of minimal public investment in health care resonated with those who wished to limit government spending and open opportunities for private sector development in health ("Washington Consensus" [32]). Nevertheless, growth monitoring, oral rehydration, breast-feeding, and immunization achieved much, with large falls in infant and child mortality, but this began to reverse with the HIV epidemic and by 2000 it was increasingly recognized that these "silver bullet" interventions were no more than a first step; much more was needed to build health systems that could adapt to varied and evolving population needs.

A major stimulus to expanding health service provision in low- and middle-income nations was the adoption of the Millennium Development Goals in the year 2000, whereby all United Nations member states agreed to measurable goals to alleviate poverty by 2015. Among them were a series of health-related goals, involving reductions in infant, child, and maternal mortality, as well as measures to reduce the spread of HIV, tuberculosis, and malaria. The adoption of these goals led to a "Big Push" among rich countries to raise the substantial resources needed if they were to be achieved [33].

Although progress was made in reducing maternal and child mortality, it was highly uneven and most countries of sub-Saharan Africa lagged behind [34]. While there are several underlying reasons for inadequate progress (including general economic underperformance [35], the "Great Recession" of 2007–2009 [36], an evolving burden of chronic noncommunicable diseases [37], and donor displacement of public funding particularly in countries facing international pressure to reduce government spending [38]), it soon became apparent that progress was being constrained by health systems that lacked the capacity to absorb the additional resources (one reason for the well-known "inverse care law," whereby populations with the greatest health care needs tend to receive the least amount of funding and care [39]). An effective response to longstanding health issues needed to go beyond a minimal package of low-cost interventions and address the challenges of expanding primary health care to entire populations [40]. Yet, a few countries showed what could be done. Rwanda viewed health as a nation-building strategy following the genocide. It now offers a basic benefit package to 92% of its population, using contributions of approximately US $2 per person per year [41,42]. Thailand has scaled up its original "50 Baht" scheme to cover its entire population [20]. Several middle-income countries currently are contemplating universal health coverage, including India and South Africa, but, overall, there has been relatively little progress in the past decade. China's dismantling of UHC in the late-1970s led to macroeconomic problems, creating, in turn, a renewed pressure for the reestablishment of UHC, as described further in Box 2.

Future prospects for UHC in emerging economies are mixed, for several reasons. They have less well-developed and poorly mobilized left organizations, which historically played a key role in ensuring that public welfare investment kept pace with economic growth. Their economic models have also relied heavily on extensive foreign investment and integration in global markets, which has constrained their ability to raise taxes and public revenue, a critical precondition for establishing viable UHC.

In addition, there is a strong private-sector alliance of insurance companies, medical associations, and pharmaceutical companies that profits from privatized health care finance and delivery. Aid agencies such as the US Agency for International Development often place conditionalities such as demands to support employer-based coverage or other mechanisms of insurance that create scope for private sector development. Finally, wealthy elites in fast-growing, yet highly unequal countries are able to opt for high-priced, private care, creating a system where they see little benefit in having their tax funds invested. Hence, despite rhetoric by populist political leaders to invoke health as a campaign platform and unifying ideology, the prospect for elites to rally behind UHC is not strong in the absence of strong civil society and dissident movements, of the kind that helped spur UHC in South Korea in response to Park Chung Hee's dictatorship.

Box 2–Macroeconomic factors and UHC in China

In China, the dismantling of the barefoot doctor scheme in the 1970s left large numbers of people, especially in the countryside, without access to care. Not unreasonably, many began to hoard money lest they or their families sustained catastrophic illness. Yet, by not spending this money, they contributed to China's ever-greater trade imbalance with the rest of the world, with global economic consequences as Chinese money underpinned the American subprime lending boom [43,44]. Meanwhile, the microeconomic consequences were also being seen, as ordinary Chinese people protested against what they saw as health providers profiting excessively from their plight. The government had to act, and it did, introducing and extending the scope of a series of new insurance schemes [45].

The Future of Europe: Political Economy of Austerity

Welfare systems are no longer viewed as stable or resilient as they once were thought to be in Europe [12]. Esping-Andersen [10] has argued that the "consolidation" of welfare states after the Second World War depended crucially on the political alliances of the new middle classes. By no means are these alliances stable or secure. In Anglo-Saxon countries, the welfare state predominantly has catered to the working class and poor (with, at the time of writing, the important exception of the National Health Service in the United Kingdom), whereas in Scandinavian countries, these classes were in some cases directly created by state policies. It is now becoming clear that economic change, combined with political cleavages, make possible the reversal and retrenchment of the welfare state, including health.

There are several examples of where UHC was gained and later lost. Examples include Chile, as noted above, but also a number of countries that emerged from the USSR and were plunged into severe economic crises, such as Georgia and Armenia [46]. Yet, even in high-income countries, the welfare state, and thus, potentially, universal coverage, is under threat.

Debates about the future of social welfare in Europe are set against a backdrop of intense pressure for austerity but enduring popularity of welfare programs [47]. Recent debt crises in Europe, resulting from bailouts of the financial sector, have strengthened the arguments of those promoting the case that existing welfare systems are unaffordable [12]. Of course, they fail to explain why they believe the alternative, such as that existing in the United States and costing much more, would save money. Fundamentally, even though many already pay a far smaller share of their income in taxes than do the poor [48], they want to pay less into a system from which they perceive little benefit and resent supporting people with whom they feel they have little or nothing in common

Box 3–American exceptionalism

Throughout the past century, one country has stood out from the rest. This was a country that could clearly afford to provide coverage for its entire population; it was spending almost 18% of its national wealth on health care, or approximately twice that in other industrialized countries. Yet it left a substantial proportion with access only to emergency care and many more at risk of financial ruin should they suffer illnesses that cost more than their often highly restrictive insurance would cover. It is, of course, the United States.

Many previous attempts to extend health coverage in the United States had met with mixed success. The "New Deal" was set to include greater health care protections but succumbed to opposition from clinicians. The creation of Social Security, serving the elderly, established a model of contributory social insurance for one group, but impeded the universal expansion of coverage [49]. The establishment of Medicare and Medicaid by Lyndon Johnson in 1965 built on this system, but attempts at system-wide restructuring, like the Clinton proposals in the 1990s, ended in failure.

Meanwhile, despite spending more than any other industrialized nation, the failings of the American health systems were becoming increasingly apparent. Outcomes from common treatable diseases were lagging ever further behind those in other industrialized countries [50]. Medical expenses had become the main cause of personal insolvency. The cost of paying for a failing system was becoming unsustainable for those employers offering coverage to their staff. The filmmaker Michael Moore graphically illustrated how ludicrous this was in his production "Sicko," which contrasted the health care available to those detained by the American military in Guantanamo Bay with the absence of care for those who had been injured in the rescue operation following the attacks on New York on September 11, 2001. In 2008, newly elected President Obama committed himself to a major expansion of coverage. It would still be far from universal, denying care to illegal migrants and allowing others, such as certain religious groups, to opt out. It would leave about 23 million without cover. But it would extend coverage to about 25 million who currently lack it.

His proposals initially attracted widespread popular support but, influenced by an aggressive political campaign by an increasingly right wing Republican Party, and especially the new Tea Party movement, popular support has rapidly ebbed. However, contrary to what many neoliberal commentators believed, the Supreme Court has rejected a challenge to the legislation on the basis of its impact on interstate trade as it compels people to purchase health coverage. The legislation is now being enacted and although it will continue to face attack from Republicans, it is already being implemented.

[12]. Here it is possible to draw lessons from the experience of American exceptionalism, as described in Box 3 [51].

Those who seek to dismantle the welfare state, however, face at least three significant obstacles: First, as they live in democracies, they must persuade the majority of the population to vote against their own interests, instead supporting the interests of the tiny minority, typically less than 0.1% of the population, at the top. The main channel for achieving this shift in cultural perceptions is through the media. The first step is to create an image of the undeserving poor, something that is increasingly easy in societies that are becoming more heterogeneous as a consequence of migration. Typically, they use labels such as "bogus asylum seekers" or "benefits scroungers," overemphasizing the false-positive "type-1" errors (people who access services who should not) over the much larger "type-2" errors (people who fail to access services even though they should).

Second, critics of welfare must attempt to undermine support from the middle classes who played a key role in past welfare consolidation. To create such cleavages, it is necessary to remove the benefits flowing to the middle classes from welfare, such as free university education, child care, and social care in old age, instead limiting support to the very poor. In this way, the middle classes see the welfare state as being for others, something they pay for but get nothing in return: severing the link between tax euros in and benefits out.

Last, those assaulting welfare must develop their policies insidiously, so that few realize what is happening until it is too late. Those who do are labeled pejoratively as scare mongering. This recalls the scene in Douglas Adams' famous book *The Hitchhiker's Guide to the Galaxy* in which the book's hero Arthur Dent learns, at the same time, that his house is about to be demolished to make way for a new road and the earth is to be demolished to make way for an interstellar expressway [52]. On protesting that no one warned him, he was told, with respect to the former, that the sign was "on display in the bottom of a locked filing cabinet stuck in a disused lavatory with a sign outside the door saying 'Beware of the Leopard,'" while the warning notice of the latter was clearly displayed, but on a nearby planet.

We hope that this overview serves as a warning to everyone now living in countries that enjoy UHC. The safety, security, and reassurance that it has provided cannot be taken for granted. For those who do not, the quest continues, and we hope that by understanding past successes and failures, the quest can be accelerated.

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