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Achieving Universal Health Coverage

Learning from Chile, Japan, Malaysia and Sweden

William D. Savedoff and Amy L. Smith
Social Insight, Bath, Maine USA

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Abstract

Over the last hundred years, most countries have made substantial progress toward universal health coverage. The shared trends includes rising incomes, increasing total health expenditures and an expanding role for government in improving access to health care. Despite this, countries vary significantly in their particular routes to universal health coverage. These routes are shaped by prominent leaders and strong popular movements and framed by particular moral claims and world views. They are affected by unpredictable events related to economic cycles, wars, epidemics and initiatives in other public policy spheres. They are also influenced by a country's own institutional development and experiences in other countries. As a result of these highly contingent paths, countries reach universal health coverage at different income levels and with disparate institutional arrangements for expanding health care access and mitigating financial risk.

This paper examines the histories of attaining universal health coverage in four countries – Sweden, Japan, Chile and Malaysia. It shows that domestic pressures for universalizing access to health care are extremely varied, widespread, and persistent. Secondly, universal health coverage is everywhere accompanied by a large role for government, although that role takes many forms. Third, the path to universal health coverage is contingent, emerging from negotiation rather than design. Finally, universal health coverage is attained incrementally and over long periods of time. These commonalities are shared by all four cases despite substantial differences in income, political regimes, cultures, and health sector institutions. Attention to these commonalities will help countries seeking to expand health coverage today.

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Introduction

How do countries reach universal health coverage? The process looks almost inevitable from a long-term perspective. Despite enormous variation across countries the same broad trends recur. Over time, as incomes rise, total health expenditures and the government share of those health expenditures increase. Successively larger portions of the population gain access to more health care services at less financial risk. This long-term perspective is significant because it suggests that widespread pressures are propelling all countries toward universal access to health care.

Those long-term trends, however, mask substantial variation in the paths taken to reach universal health coverage. Those specific routes are shaped by prominent leaders and strong popular movements and framed by particular moral claims and world views. They are affected by unpredictable events related to economic cycles, wars, epidemics and initiatives in other public policy spheres. They are also influenced by the institutions emerging from a country's own history and the experiences demonstrated by efforts in other countries. As a result of these highly contingent paths, some countries reach universal health coverage at much lower incomes than others. Furthermore, the institutional arrangements by which people access health care and mitigate financial risk end up varying immensely.

The roster of countries that have achieved universal health coverage and the routes they have taken are diverse. A definitive how-to guide cannot be derived from these experiences, but much can be learned from them. This paper examines the route to universal health coverage in four countries: Sweden, Japan, Chile and Malaysia. These cases were selected because their histories encompass a wide range of political, economic and institutional characteristics. The aim of the paper is not to suggest that any of these are ideal types or that any particular route to universal health coverage is correct or replicable. Rather, the goal is to display the range and contingencies of these routes, to identify some key commonalities, and to describe some of the issues and options that arise in pursuit of universal health coverage.

Measuring Universal Health Coverage

Universal health coverage can be defined in many different ways. At its simplest, universal health coverage could be said to be achieved when all persons in a society can get the health care services they need without financial hardship. These three dimensions – who is covered, what services are covered, and how costs are covered – are used by the World Health Organization (WHO) to frame its discussion of universal health coverage in the *2010 World Health Report*. The conceptual clarity is helpful in distinguishing the strategic choices different societies make along these three dimensions.

Applying that definition to actual cases, and particularly to cross-national comparisons, can be tricky. Some countries may affirm a formal right to health care for all, yet lack the means to provide it. Enrollment rates in health insurance plans may be a more feasible means of comparison, yet enrolment does not assure an individual has access to health services. Utilization of health care services may come closest to indicating progress toward universe health coverage, but it also requires qualification. Utilization rates may be low because people lack effective access to needed health services – or because they have little need for health services when their social and environmental conditions promote good health.

Effective coverage is another way to approach the definition of universal health coverage. For any individual, this is the probability that she or he will have access to a particular health care service when needed. The sum of these probabilities over the full range of services is the individual's effective access to health care, while the sum of all these individual probabilities across the entire population is a society's effective access to health care (Shengelia, Murray and Adams, 2003). While this definition has several advantages, it would be daunting to estimate such effective coverage indicators comprehensively because of the number of services and the heterogeneity of individual needs.

In practice, researchers use different indicators as proxies for universal health coverage. Measures like the share of the population affiliated with insurance schemes is one indication of progress toward universal health coverage but requires further evidence that scheme participants actually receive services or benefits. Other measures relate to the supply of health care services, such as the number of doctors per inhabitant, and are imperfect unless further information can be obtained regarding utilization and impact on health. Utilization measures are better proxies for universal health coverage, especially services that are cost-effective and population-wide such as childhood immunizations and skilled birth attendance. Another approach is to compare health care utilization in the population at large to a standard set by utilization among high-income groups. The standard set by privileged groups reflects the feasibility of providing care in a particular context. The degree to which everyone in a society uses services relative to that standard would indicate how far the country has generalized health coverage (Mackenbach et al 1997; Boerma et al 2008; Savedoff 2009).

Since this paper is concerned with the historical path toward universal health coverage, it will utilize a definition corresponding to the common characterization applied to countries, such as Sweden and Japan, which are considered to have achieved universal health coverage in the mid-20th century. The proxy for generalized access to a set of basic health care services used here is a combination of public policy measures and the infant mortality rate. The public policy measures include a range of actions in the legislative, financial and institutional arenas that assure access to health care is generalized and not restricted to those with means to purchase private care. This attention to public policy is balanced by actual infant

mortality rates because when these are reduced below a certain threshold, it indicates that most women have access to skilled birth attendance and emergency obstetric care. This is likely to occur only in societies with generalized access to health care (Jímenez and Romero 2007, p. 459). The level chosen here is 30 infant deaths per 1,000 live births because this corresponds to the periods in which universal coverage was attained in Western European countries.

Three Phases in Achieving Universal Health Coverage

The historical path countries follow toward universal health coverage can be organized with reference to the relative role of governments and civil society. When observed trends are clustered in this way, three phases emerge. The clusters do not imply that there are three necessary stages, nor do they suggest a single correct path or timeframe. Considering even a handful of histories shows that each of these loosely-defined phases has lasted as long as a century or as little as a few decades. Furthermore, the particular political actors and social events that propel or resist the expansion of health coverage differ across countries and over time so that the dominant forces in one period may be absent or have changed their roles in another.¹

Early Phase

In many countries that have achieved universal health coverage, an initial phase is characterized by voluntary actions through multiple efforts. Mutual aid societies, sometimes called sickness funds or friendly societies, appeared in many contexts. They were often based on some form of social affiliation – residential, religious, political, cultural, artisanal, or professional. Some were small and local; others involved larger networks or linkages to national movements such as temperance societies and unions. Even when linked to larger movements, however, early mutual aid societies were rarely coordinated at a national level. For the most part, early mutual aid societies compensated a household for pay lost during illness, although some were directly involved in providing health care by hiring doctors to care for members. Another common form of health coverage in this early phase involved benefits conferred by employers to their employees. Sometimes these were the result of firm-level initiatives; occasionally they were coordinated across firms in particular industries or regions. A further realm of voluntary action included charitable groups, often religious, organized to provide care to the elderly and indigent or to build hospitals.

In this early phase, governments rarely assumed the lead in providing access to health care. Rather, they became involved in subsidizing mutual aid societies and in some cases regulating them (e.g., Sweden, Japan). Governments also were increasingly involved in public health initiatives (e.g., sanitation) with some direct

¹ For a range of historical approaches to understanding health care reform, see Bump 2010, and Campbell and Ikegami 1998, Immergut 1992, and Rothgang et al 2010.

provision of care (e.g., hospitals) but more commonly provided subsidies to the health facilities of charitable societies.

In this early phase, the role of government in ensuring health services was highly contested. Mutual aid societies, employers and unions sometimes sought government support for their programs in the form of subsidies or local monopolies. At other times, these same groups resisted public sector involvement, seeing the government as a competitor for the primary allegiance of their members. Professional associations of medical doctors frequently resisted an expanded government role, fearing that it would undermine their professional autonomy and make them dependent upon the financial and regulatory authority of insurers or the state. Other medical professionals, however, sought an expanded government role – particularly those committed to a vision of public health that entailed building medical education institutions, improving environmental and social conditions, and staffing health facilities with government workers. Very different views could be found among politicians as well, with some endorsing liberal conceptions of limited government with no role to play in health care, while others endorsed a paternalistic role for care of the indigent, and still others sought an expanded role for government as guarantor of citizen rights and well-being, or pursued more instrumental agendas in which the provision of health care might yield a healthy pool of conscripts or coopt combative labor movements.

Expansion Phase

A second major phase generally experienced by countries that have attained universal health care was an expansion phase in which the role of government increased significantly. Voluntary schemes were extended to new segments of the population, often with additional funding from the state. In many places, benefits shifted from compensating for lost income during sickness to paying for medical treatments and hospital stays. In this phase, national governments began to legislate compulsory participation in social insurance schemes, including mandatory contributions and health benefits (often but not solely through the workplace), subsequently extending the mandatory provision to more and more groups. In parallel, most governments established direct provision of care for specific groups like the military or the indigent, or provided high-quality facilities for elites.

The proximate causes of greater government involvement varied. For countries that entered this phase in the late nineteenth or early twentieth centuries during rapid industrialization with strong labor movements, governments often mandated health insurance coverage as part of an effort to manage contentious struggles between workers and employers. By legislating social benefits such as pensions, workers compensation, and health benefits, governments sought to maintain social peace, undermine union mobilization, or steal issues from the platform of the political opposition. After World War II, a broader global consensus emerged

around a prominent role for governments in assuring access to health coverage. Debates nonetheless continued regarding the appropriate role of state and private actors. In later decades, a wave of conservative governments in the United States, Britain and Europe sought to restrict social programs. After 1990, formerly communist countries also severely questioned the role of the state in health policy. Despite these shifting contexts and debates, most countries that lack universal health coverage continue to expand government involvement in this sector, recognizing public action as legitimate and imperative to progress.

Universal Phase

A third period is a universal phase, in which countries attain universal health coverage. Countries which reach this phase establish a coherent national all-inclusive scheme. It may consist of a single national public entity or coordinated multiple private schemes but, regardless of the structure, eligibility is universalized and effective access to health care services becomes widespread. Some countries link multiple insurance entities into a larger comprehensive pool (Japan, France, Netherlands, Chile); some establish a single payer for geographical regions (Canada); some expand direct public provision and

displace formal financial insurance mechanisms (United Kingdom, Sweden, Malaysia). National fee schedules applying to all providers, whether public or private, is another means of coordination and inclusiveness.

In this universal coverage phase, institutional forms vary but the government's role is more settled. The government comes to be seen as the legitimate authority for promoting universal access to health care. Further, the institutional architecture for the health system is more established, building on the institutions that were constructed (and contested) in earlier phases.

Even once universal health coverage is achieved, the historical trajectory does not come to an end. Social debates over the effectiveness, efficiency and fairness of health care systems continue as a result of rising expectations, changing medical technology, social inequities, and increasing costs. Some earlier debates regarding the role of the state may reemerge. Nevertheless, even governments with ideologies that are opposed to large public sector government involvement preserve significant roles for the state as mobilizer of funds, regulator, and direct provider of care to large shares of the population.

The historical phases suggested here are neither tidy nor necessary. Progress toward universal health coverage proceeds through fits and starts, is shaped by uncoordinated and overlapping legislation, adapts to existing public institutions and is affected by the choices and strategies of politicians, private actors, and civic associations. Particular moments of change are highly contingent, subsequent opportunities are constrained by earlier events and even the most well-designed blueprints are rarely achieved as originally envisioned (see Box 1). Further, no

single phase is necessary in order to achieve the goal. Although countries that achieved universal health coverage in the past often began with the predominance of voluntary associations, this is not imperative. Countries pursuing universal health coverage now can avail themselves of an array of demonstrated institutional configurations and benefit from the experiences of other countries.

Box 1: Misinterpretation of historical paradigms: Bismarck and Beveridge

Historical contingency and path dependence are apparent in two of the most widely cited health system reforms, Germany in 1883 and the United Kingdom in 1948. It is not widely known that Bismarck was trying to create a system with a larger government role, including substantial government financing and a government insurance bureaucracy. Blocked from achieving these aims by the political opposition, Bismarck settled for compulsory health insurance financed solely by employers and employee contributions and administered by pre-existing sickness funds. Thus, core features of a social insurance system that was later copied by many other nations were themselves the result of compromises adopted in a specific context and time (see Immergut 1992).

Similarly, the Beveridge Report issued in 1943 is generally cited as the document that envisioned Britain's National Health Service (NHS). While that report made a strong case for universal health coverage for all British citizens, it did not propose a system of direct government provision financed by general taxes (Musgrove 2000; Beveridge 1942). Rather, it was the newly elected Labor Government after World War II that took the opportunity to create a health care system with direct government-provision. This initiative was facilitated by the government's extensive investment and public management of hospitals and specialists during the war. The Labor Government's initial proposals were opposed, however, by general practitioners. Compromises led to the United Kingdom's current pattern of government-employed specialists and independent but government-financed general practitioners.

The financing of the NHS through general taxes was also not in the government's original plans. When the NHS was started, no one knew if the middle class would enroll. When they did, rapidly and in large numbers, the original plan of financing the NHS out of payroll contributions proved inadequate. Demand grew so rapidly that subsequent governments approved larger funding out of general revenues, leading to the current British pattern of primarily financing health care with general revenues. Once again, a design feature that is lauded and imitated by many countries around the world is found, upon inspection, to be the outcome of decisions that responded to contingent events and that were shaped by specific political processes (Digby 1998; Rivett 1997).

Japan, Sweden, Chile and Malaysia

Four countries – Japan, Sweden, Chile, and Malaysia – have been selected for examination here because they cover a range of income levels, regions, and health system structures. Industrialization occurred in Japan and Sweden before they achieved universal health coverage while in Malaysia and Chile the processes were more concurrent. Chile and Malaysia also achieved universal health coverage at lower income levels than Japan and Sweden and continue to have lower health expenditures despite reaching comparable levels of health status. The health systems of Japan and Chile both have prominent roles for insurance institutions which reimburse public and private providers for health care. By contrast, Sweden and Malaysia have health care systems in which integrated public provision is the predominant form of medical care and the key to assuring universal access (See Figure 1).

Figure 1: Four Countries by Income and Health System

Income and health spending	Predominant form of health care access through ...	
	National Insurance	Public Provision
High	Japan	Sweden
Moderate	Chile	Malaysia

Progress toward universal health coverage in these four countries was influenced by different rates of population growth, economic growth, and health care spending (see Table 1).

Population Growth

Japan and Sweden experienced slower population growth during the period of health care expansion than did Chile and Malaysia. In the nineteenth century, Japan was the largest of these four countries, with a population of 34 million in 1870 and growth rates of about 1 percent per year through the following century until it reached a population of 126 million in 2000. Sweden had only 4 million people in 1870 and also grew steadily, doubling its population over the century and reaching about 8 million people in 2000. Chile had 2 million people in 1870 at a time when mortality rates actually exceeded fertility rates. Population growth resumed at average annual rates around 2 percent until Chile reached a population of 15 million in 2000. Malaysia started with the smallest population, only 800,000 people in 1870, but grew much faster at rates around 3 percent in the early twentieth century and 2 percent per year thereafter, surpassing both Chile and

Sweden to reach a population of 22 million people in 2000. Thus, population growth expanded the demand for services more quickly in Chile and Malaysia than in Japan and Sweden. However, Chile and Malaysia also have younger population profiles which offset some of the health care service demand compared with Sweden and Japan which have significantly larger shares of people over age 65.

Economic Growth

Economic growth also varied among these four countries. Sweden was the wealthiest of the four countries in 1900 with per capita income of about I\$2,500, followed by Chile (I\$1,949), Japan (I\$1,180) and Malaysia (which was probably significantly less than I\$1,000).² Swedish economic growth was fairly robust during the early phase of its expanding health care system in the early twentieth century with average growth rates ranging between 1 and 3 percent per year. Sweden's per capita income reached almost I\$4,000 before legislation in the 1930s established compulsory health insurance coverage and about I\$8,700 when universal health coverage was effectively reached in the 1960s. Chile and Japan both passed compulsory insurance legislation in the 1920s when Chile's per capita income was about I\$2,430 and Japan's was only I\$1,696. However, Japan's growth after World War II was so much faster than Chile's that by the time it achieved universal coverage in the 1970s, per capita income had grown to I\$9,700. Chile's slower pace of economic growth meant that when it attained universal coverage in the 1980s, its per capita income was close to I\$6,000. Malaysia began its drive for universal health coverage after attaining independence in 1957 at a time when its per capita income was only I\$1,500. When it effectively attained universal coverage for health services in the 1980s, its per capita income had more than doubled to I\$3,700. Rapid economic growth made it easier for Japan and Malaysia to expand health care services. Yet Malaysia also demonstrates that significant expansions of health care access can be achieved at relatively low income levels.

Health Spending

Health spending is lower in Malaysia and Chile than in Sweden and Japan, but this is a relatively recent situation. In 1960, Sweden, Japan and Chile all appear to have been spending about 3 percent of national income on health compared to 1.5 percent for Malaysia.³ Subsequent growth in health spending, however, caused these countries to diverge, with Sweden eventually spending the largest share of its

² All figures in this section are drawn from Maddison 2003 who calculated historical GDP figures in 1990 international dollars. International dollars reflect differences in purchasing power across countries and thereby depict a clearer measure of consumption possibilities in contexts where nominal exchange rates may not reflect true differences in the cost of living. For a discussion of some limitations of this data, see Riley 2008, pp. 25-27.

³ Early figures on health spending are extremely difficult to obtain and reliable data is only available beginning around 1960.

income on health, followed by Japan, Chile and then Malaysia. Sweden spent about 3.4 percent of its GDP on health care in 1960 and this share grew to 6.1 percent in 1970 and 8.7 percent in 1980 (Freeman 2000). Today, Swedish health spending as a share of GDP is over 9 percent. Japanese spending on health was also 3.4 percent in 1960 but grew more slowly, reaching 4.5 percent in 1970, 6.4 percent in 1980 and 8.5 percent in 2008 (OECD 2011). Chile spent about 3.1 percent of GDP on health in 1963 (Bitrán and Urcullo 2008), rising to 5.5 percent in 1980 and 6.3 percent in 2000 (McGuire 2010). Over four decades, from 1960 to 2000, Malaysian health spending as a share of GDP only doubled, from about 1.5 percent to 3.2 percent, leaving it with the lowest share of all.

All four countries have substantially converged in terms of health status despite very different starting points (see Table 1). Sweden started with much better health in 1900 than the other three countries. Its infant mortality rates were just below 100 per 1,000 live births and life expectancy was 55 years for men and 57 for women. It took four to six decades for the other three countries to surpass these levels. During the 1940s, Swedish infant mortality rates had fallen to 39 per 1,000 live births and life expectancy had reached 68 years for men and 71 years for women. Following the expansion of Sweden's health system, infant mortality rates fell further, dropping to 7 per 1,000 live births in 1980 and 3 in 2000. By contrast, at the time of World War II, life expectancy in Japan was still only 47 years for men and 50 years for women (Riley 2008), and infant mortality rates were about 90 per 1,000 live births. Japan's health gains after World War II were quite rapid, with infant mortality falling to 30 deaths per 1,000 live births in 1960, 7 in 1980 and 3 in 2000. Life expectancy improved so much that Japan is now ranked among the countries with the longest life spans, 81 years in 2000 (OECD 2011). Chile and Malaysia both experienced their greatest health gains after 1960. Life expectancy in both countries was less than 60 years in 1960 but surpassed 75 years by 2000. Infant mortality rates also fell substantially, dropping below 30 per 1,000 live births in 1980 and below 10 per 1,000 live births in 2000. By 2000 all four countries had attained infant mortality rates below 10 per 1,000 live births and life expectancy at birth of over 70 years.

A closer look at each country through each of the three phases of health care service expansion illustrates the themes highlighted earlier. Social pressures to reach universal health coverage vary across countries and across time, yet they are ubiquitous and persistent. The steps toward universal health coverage are not determined or linear; rather they take place at different times depending on a variety of political contingencies and often face setbacks and delays. Each country's history shows how health care debates not only influence the timing of when universal health coverage is achieved but also fundamentally shape the forms and costs of the resulting health care system. Finally, health reform debates do not end with the attainment of universal health coverage. In fact, each country continues to struggle with conditions of costs, equity and quality of care in its own unique way.

Table 1: Income, population and infant mortality in selected countries, 1870-2000

Year	Chile		Japan		Malaysia		Sweden	
GDP per capita (1990 International Dollars and annual change)								
1870			737		663		1,662	
1880			863	1.6%			1,846	1.1%
1890			1,012	1.6%			2,086	1.2%
1900	1,949		1,180	1.5%			2,561	2.1%
1910	2,472	2.4%	1,304	1.0%			2,980	1.5%
1920	2,430	-0.2%	1,696	2.7%	1,110		2,802	-0.6%
1930	3,143	2.6%	1,850	0.9%	1,636	4.0%	3,937	3.5%
1940	3,259	0.4%	2,874	4.5%	1,278	-2.4%	4,857	2.1%
1950	3,821	1.6%	1,921	-4.0%	1,559	2.0%	6,739	3.3%
1960	4,320	1.2%	3,986	7.6%	1,530	-0.2%	8,688	2.6%
1970	5,293	2.1%	9,714	9.3%	2,079	3.1%	12,716	3.9%
1980	5,738	0.8%	13,428	3.3%	3,657	5.8%	14,937	1.6%
1990	6,402	1.1%	18,789	3.4%	5,132	3.4%	17,695	1.7%
2000	9,841	4.4%	21,069	1.2%	7,872	4.4%	20,321	1.4%
Population (1,000s midyear and annual change)								
1870	1,943		34,437		800		4,169	
1880			36,807	0.7%			4,572	0.9%
1890	2,651		40,077	0.9%	1,585		4,780	0.4%
1900	2,974	1.2%	44,103	1.0%	2,232	3.5%	5,117	0.7%
1910	3,364	1.2%	49,518	1.2%	2,893	2.6%	5,449	0.6%
1920	3,827	1.3%	55,818	1.2%	3,545	2.1%	5,876	0.8%
1930	4,370	1.3%	64,203	1.4%	4,413	2.2%	6,131	0.4%
1940	5,093	1.5%	72,967	1.3%	5,434	2.1%	6,356	0.4%
1950	6,091	1.8%	83,805	1.4%	6,434	1.7%	7,014	1.0%
1960	7,585	2.2%	94,092	1.2%	8,428	2.7%	7,480	0.6%
1970	9,369	2.1%	104,345	1.0%	10,910	2.6%	8,043	0.7%
1980	11,094	1.7%	116,807	1.1%	13,764	2.4%	8,310	0.3%
1990	13,128	1.7%	123,537	0.6%	17,504	2.4%	8,559	0.3%
2000	15,154	1.4%	126,700	0.3%	21,793	2.2%	8,873	0.4%
Infant Mortality (deaths per 1,000 live births and annual change)								
1880							121	
1890							103	-1.6%
1900	340						99	-0.4%
1910	267	-2.4%					75	-2.7%
1920	263	-0.2%	166				63	-1.7%
1930	234	-1.2%	125	-2.8%	178		55	-1.3%
1940	217	-0.8%	90	-3.2%	139	-2.4%	39	-3.4%
1950	148	-3.8%	56	-4.7%	102	-3.0%	21	-5.9%
1960	106	-3.3%	30	-6.0%	66	-4.2%	16	-2.8%
1970	76	-3.3%	13	-7.8%	41	-4.7%	11	-3.5%
1980	32	-8.4%	7	-5.7%	26	-4.6%	7	-4.5%
1990	18	-5.3%	5	-4.6%	16	-4.9%	6	-2.3%
2000	9	-6.4%	3	-3.3%	9	-5.2%	3	-5.2%

Sources: Per capita income and population figures are from Maddison 2003. Infant mortality rates are from various sources as compiled by Klara Johannson, Mattias Lindgren and explained at <http://www.gapminder.org/data/documentation/gd002/>.

Notes: Income per capita is measured in 1990 International Geary-Khamis dollars. Changes were calculated as the average annual change over the decade and do not capture intra-decadal fluctuations.

Sweden

Sweden formally enacted universal health coverage in 1955 and effectively achieved it by the end of the 1960s. Although the 1955 legislation envisioned a national health insurance scheme that would reimburse a portion of costs, subsequent reforms transformed this model into one in which local districts manage publicly-employed physicians and facilities, supported primarily through local taxes.

As in other European countries, Sweden had an early phase in the nineteenth century characterized by the growth of voluntary mutual aid associations with gradually increasing involvement of the government through subsidies and regulation; a period after World War I in which these associations were converted into compulsory insurance schemes; and a period after World War II in which the commitment to universal coverage was enacted and the government assumed a dominant role in hospital care and health planning. Sweden also displays a series of particularities, demonstrating a unique set of social pressures for universalizing care; a specific institutional configuration that shaped the arena for debating the extension of health coverage; and a variety of contingencies that sometimes accelerated and at other times diverted progress toward the system Sweden has today.

Sweden's Early Phase – Nineteenth century to the 1930s

Sweden was an agrarian society undergoing rapid industrialization at the end of the nineteenth century when the national government began to expand its role in social protection. In this regard, it was similar to many European countries. Sweden was unique, however, in its age structure. Due to a decrease in infant mortality in the early 1800s and mass emigration of younger people, Sweden in this period had the oldest population in the western world, with 8.4 percent of its population over 65 years of age in 1890 (Edebalk 2000, p. 541). The number of elderly people living in poverty created a burden on rural communities, traditionally responsible for providing poor relief. Pensions for the poor aged thus became the initial focus of demands for national governmental support rather than health care. This contrasts with other countries in Europe, such as Germany, where public debates focused more on the effects of sickness and work-related accidents for laborers than on pensions. It may also be why communities and voluntary associations played a larger role in Sweden's initial steps toward health coverage than did labor unions.⁴

Another of Sweden's distinctive features is the historically dominant role of the executive branch, which greatly affected the adoption of health sector reforms. In Sweden's transition to democracy, the monarchy tried to insulate and conserve its

⁴ Unless otherwise noted, the key points in this section are found in Immergut 1992.

power by creating “Royal Committees,” advisory groups whose function was to consult with collaborative elites and elaborate decrees for later disposition by the monarch. This established a pattern in which, as power was later ceded to the parliament and prime minister, major legislation continued to be negotiated in these circumscribed fora. The committees offered a focus for policy debates that provided continuity through changes in political administrations. They were less susceptible to partisan appeals and were inaccessible to interest groups who could not gain entrance without signaling their willingness to cooperate. Major potential actors (employers, unions, doctors) knew that negotiations in this arena were crucial and signaled their willingness to cooperate as a way to have some influence over policies (Immergut 1992; Bjurulf and Swahn 1980).

From the late nineteenth century through the mid-twentieth century, voluntary associations – variously referred to as sickness funds, friendly societies or mutual aid societies – played a significant role in providing some sort of health coverage in Sweden. These funds varied in origin, affiliation, structure, benefits, and funding. In contrast to Germany, where sickness funds were a crucial organizing tool for unions and for the Social Democratic party, in Sweden these organizations were more closely linked to the widespread Temperance movement, which itself had links across many political parties.⁵ The earliest voluntary funds mainly provided cash benefits to cover income lost during periods of illness. In some cases, they provided coverage for medical treatment as well, for which they attempted to hire physicians on a contractual basis in return for low flat fees. Initially lacking coordination and unevenly distributed throughout Sweden, the sickness funds had overlapping memberships and often were financially incapable of meeting their obligations.

Sweden passed a series of laws in 1891, 1910, and 1931 regarding sickness funds during a period of concern over pensions for the elderly, increasing labor mobilization over pay and working conditions, and social mobilization for universal suffrage. None of the sickness fund laws were considered radical; rather they were compromises negotiated in committees that also considered proposals for national health insurance. They were enacted by different governments, under different parties.

The overall pattern of these successive laws was to increase government subsidies and expand public regulation. The Sickness Fund Laws of 1891 provided public grants to friendly societies without interfering in the funds’ management. While subsidies subsequently increased, the societies continued to determine the content and purpose of their activities and preserved their autonomy. The 1910 law further

⁵ In 1909, 116 local sickness funds were officially linked to the Temperance movement, compared to only 40 that were linked to unions and 27 to the Free Religious movement. The largest national fund was connected to the Temperance movement and was headed by a Liberal Party leader who served as prime minister from 1926 to 1928 and again from 1930 to 32 (Immergut 1992, p. 288).

expanded the public sector role in health benefits. Government financial contributions to sickness funds were increased alongside rules that sought to enhance viability of funds by limiting competition and favoring consolidation into fewer larger funds.

Partly in response to this government involvement, voluntary societies became more coordinated, organizing into larger networks. Two competing umbrella organizations initially held opposite views on national public policy. Smaller sickness funds with local bases created the General Sickness Fund Association in 1907 and favored national health insurance. Larger sickness funds formed the National Sickness Fund's Central Organization in 1916 and opposed national health insurance. Despite their contrasting views on national health insurance, the two groups were united in opposition to a reform that would eliminate competition entirely by permitting only one fund to operate per local area. Nevertheless, by 1928 and in the face of stagnating membership and continuing financial struggles, the two umbrella groups agreed to divide their operations along local and regional lines, opening the way for enacting a comprehensive alignment of national policy in 1931.

Enrolment in sickness funds rose quickly in this period but was concentrated among urban and industrial workers. In 1925, only 13.3 percent of the Swedish population was enrolled in sickness funds. By 1931, this share had risen to 21 percent for the entire population – 26 percent in urban areas and 12 percent in rural areas. Industrial workers were close to 42 percent of all members of sickness funds (Edebalk and Olofsson 1999; Ito 1980).

In this initial phase, proposals to regulate and rationalize voluntary societies gathered enough momentum to reach enactment. Other proposals were elaborated and, though not enacted in this period, remained available for later consideration. In 1919, for example, a government-appointed committee proposed public mandatory sickness funds that would provide cash benefits, drugs, and medical treatment to almost 80 percent of the population (Immergut 1992, p. 195). The proposal was shelved for financial rather than political reasons, and returned in later iterations of the debate.

Sweden's Expansion Phase – 1930s to 1955

From 1931 until 1955, Sweden continued to pursue a number of reforms that knit the earlier voluntary societies into a coherent network. The resulting institutional framework for that network became the basis of a mandatory national system. Disagreements over expanding the role of directly provided public health care continued in this phase but were set aside in favor of a commitment to universal coverage with insurance.

As with previous legislation, the committee process generated the proposal for a 1931 law that rationalized the voluntary societies quite dramatically. The law restricted government subsidies to a single sickness fund in any particular region or area, strengthening the agreement reached by the national associations in 1928 to stop competing and separate their areas of operation. It also set standardized fees for medical services, established a minimum membership size for sickness funds, and provided medical benefits in addition to sick pay.

The law's provision for medical benefits generated objections from groups that opposed a national health system. Doctors objected that the proposed law would compromise their professional autonomy. The central steering board of the Swedish Medical Association overruled its membership and ultimately supported the plan in order to maintain its role in committee discussions and have influence in shaping the plan. As Immergut observes, "The law was made possible, not by a long-standing tradition of government intervention, not by any predisposition of the medical profession to health care programs, but by a long process of political negotiation. Furthermore, the law was prepared not by a conflictual process that pitted the Social Democrats against other parties, but by a multiparty process that, as a result of the committee system, continued uninterrupted through twelve different changes in government" (Immergut 1992, p. 201).

The 1931 law definitively shaped the future development of Sweden's health system. It solidified a shift in the sickness fund movement from a randomly scattered group of voluntary associations to a national network of coordinated insurance funds. This later served as the basis for national health insurance. Following passage of the 1931 law, state subsidies more than doubled within three years and medical benefits were greatly increased. Voluntary membership expanded from 1 million in 1930 to 1.5 million in 1940 and to 2.5 million in 1945 – a shift from 20 percent of the adult population (persons over 15 years of age) to 48 percent.

Although the legislation had initially been motivated by efforts to improve the financial viability of mutual funds and rationalize government subsidies, in the long run it also made it easier to establish a coherent basis for enacting universal coverage. Individuals could be assigned affiliation based on a single characteristic – place of residence – rather than competing forms of membership by location, employment, family relationships, or other categories.

In 1932, just after passage of this landmark legislation, the Social Democrats came to power. They remained in power through World War II and, following the war, led Sweden through a period of change that enlarged the scope of social services and established a welfare state. The committee system was maintained, constituting a distinctive institutional arena for consultation and compromise.

In health care, committee deliberations provided draft legislation for moving toward mandatory national health insurance. This passed in 1947 with the support of all political parties as well as the endorsement of formal organizations representing doctors, employers, and white collar workers. The Swedish Medical Association, employers association, and associations of salaried employees all expressed misgivings, but all agreed to participate. The Swedish Medical Association expressed its preference for voluntary insurance and urged the government instead to focus more on public health measures. Nevertheless, it agreed to support the law, especially as the legislation included a reimbursement mechanism and permitted free choice of doctors rather than creating a system of direct public provision with salaried physicians.

Despite the broad endorsement, events did not favor the implementation of the 1947 law. A balance of payments crisis in 1947 led to an economic downturn, causing the government to delay implementation. Simultaneously, Sweden was reforming local government and consolidating local administrations into larger units, which also delayed action. Disagreements within the labor movement and Social Democratic Party over the cash benefits portion of the law created additional delays.

Though the commitment to universal health coverage had been formally and broadly endorsed, an unusual and heated conflict ensued when the Social Democrats released a new committee report calling for the creation of a national health service in which the public sector would provide all health care through doctors employed by the state. Resistance to this new proposal was widespread – from doctors, employers, local governments (County Councils) and the Conservative Party. Even the labor movement questioned the proposals' financial feasibility. Consequently, the Social Democrats returned to the areas of agreement in the 1947 proposal: universal health coverage through a mandatory national health insurance system. This was enacted in 1953 and went into effect in 1955. The program covered the entire population for medical and cash benefits. These were to be provided through the preexisting national network of sickness funds and paid for by payroll tax contributions from employers and employees as well as subsidies from the government.

Private medical practice in Sweden continued in a variety of forms in this period, benefiting from the subsidies inherent in the national health insurance system. Patients could seek private care and be reimbursed for 75 percent of the official fee schedule. Physicians in public hospitals and working for districts and provincial governments were free to treat private patients. Private practitioners also continued to treat patients in their clinics and offices. Inpatient care was predominantly in publicly-run facilities, but patients frequently sought outpatient care in private practices, especially in urban areas. As late as 1968, private doctors provided 70 percent of outpatient care in Stockholm.

Thus, by the late 1950s, Sweden had established a system for universal health coverage based on mandatory national health insurance, with a growing base of public hospitals and county-run medical facilities, and incorporating private practice.

Sweden's Universal Phase – 1955 to the present

Universal health coverage was made effective over the following years by making the legal commitment to coverage real in terms of health care access. In 1955, one could have expected the Swedish system to evolve, much as it did in France or Germany, into a system with mandatory participation in insurance plans that reimburse a range of publicly and privately managed health providers. However, the government chose instead to shift from an insurance model to one of direct public provision. Through a series of measures, it transformed a system characterized by reimbursements to multiple providers into a system of local government funding, ownership and management of health care.

The Social Democratic governments achieved this transformation over the next two decades by successively limiting opportunities for private medical practice. Though doctors resisted these moves, a combination of strong electoral victories for the Social Democrats and the dominant role of the executive made this transformation to public provision possible.

A significant step in this process was the 1959 hospital law that eliminated private hospital beds and private fees for inpatient care. It also required public hospitals to provide outpatient care, competing directly with more expensive private consultations. A more dramatic step was the “Seven Crowns Reform” undertaken in 1969. This reform eliminated private practice in public hospitals and replaced fee-for-service payments to hospital doctors with full-time salaries. The reform was named for a provision that replaced the practice of being reimbursed for office fees with a system in which patients paid one uniform fee of seven crowns (about US\$1.40 at the time). County Councils that operated the health facilities were paid an additional 31 crowns for each visit directly by the national health insurance authority.

In this phase, the principle of universal health coverage remained intact, but disagreements continued over the forms of financing, management and ownership. Using the power of the executive and overcoming resistance from doctors, Social Democrats effectively transformed the national health insurance system into a national health service. This process also occurred in other countries, notably in the United Kingdom after World War II. However, the Swedish system was structured around local management and local tax funding, in contrast to Britain's national tax base. The current system reflects many features of the proposal that was first put forward by a committee with Conservative Party leadership in 1919; that was flatly rejected in negotiating the 1947 national health insurance law; and that was

rejected again in the early 1950s. Yet events between 1955 and 1969 presented advocates within the Social Democratic Party with opportunities to fully and fundamentally transform the system's structure of payments and provision.

Doctors opposed some of the reforms, but found no opportunities to veto them. The Swedish Employers Association (*Svenska Arbetsgivareföreningen*, SAF), in contrast to their reticence about earlier steps toward universal health coverage, supported restrictions on private practice and the elimination of reimbursement mechanisms as a means of controlling health care costs. Local governments, represented in the Federation of County Councils, also endorsed the reforms, in part due to concern about rising hospital costs. In their view, the increased patient fees would discourage hospitalization and increase revenues, reducing the need to raise local taxes. Some members of the County Councils were also members of parliament, from across the spectrum of parties, and provided support for these reforms in that forum as well.

In subsequent periods, conservative governments have sought to reintroduce space for private practice, restructure payment mechanisms, create an "internal market" with competition among public providers, or transfer hospital management to private administration. But none of these changes have fundamentally restructured the system nor questioned the commitment to universal coverage.

Japan

Japan shares a similar story to other countries in the broad outline of its achievement of universal health coverage. In an early phase, small local associations emerged; in an expansion phase, the government took on larger financial and regulatory roles; and finally in a reform phase these varied insurance mechanisms were bound into a single national system with universal coverage.

Japan also displays a number of characteristics and experienced crucial events which distinguish it from other countries, influencing the particular way it enacted universal health coverage. From an early date, rural communities provided a model for insurance associations that were inclusionary and involved a degree of compulsory membership. Later forms of affiliation emerged with industrialization, but the concept of a community base facilitated extension of coverage to the informal sector, agricultural workers and rural areas. The state was quite strong through the early twentieth century in organizing and modernizing society. The political regime left little room for actors in the policy sphere other than the government and the Japanese Medical Association (JMA). Japan might have transformed its wartime public provision into a national health service after World War II, but the resistance of the JMA and the involvement of the United States during occupation combined with other domestic processes to support the development of a national health insurance system instead. This system retained

thousands of insurance schemes tightly bound in a web of cross-subsidies and designated an affiliation for each individual in society.

Japan's Early Phase – Nineteenth Century to 1920s

The earliest mutual aid societies in Japan were a collective response by villagers to assure the presence of a local doctor. Without such a mechanism, poverty and fluctuating farm income made it difficult and risky for doctors to practice medicine in rural areas. Early sickness funds were built on other well-established village practices of pooling funds for the purpose of constructing and maintaining local irrigation systems and participating in regional cultural and religious festivals. From the outset, the sickness funds were meant to be inclusive and equitable, motivated by a spirit of cohesion and a willingness to pool risks.

The first of these sickness funds, known as Jyorei (literally “giving affordable compensation in a regular manner”) was created in the village of Kamisaigo in the Munakata District in 1835.⁶ The form spread slowly and in 1897, Jyorei could be found in 37 out of 60 villages in Munakata District as well as beyond in nearby districts. Villagers initially made contributions in the form of rice and in proportion to a household’s income. The village head determined which of 34 income levels a household fit and levied contributions that averaged 2.9 percent of annual household income – a range from 7kg to more than 200 kg of rice. Contributions were collected whether or not a household member became ill.

In some respects, the Jyorei was a universal system in miniature. On average 95 percent of villagers participated, excluding only migrants. They were thus highly inclusive, making provision for the vulnerable and poor by means of the progressive contribution schedule. In linking the insurance mechanism directly to service provision, the Jyorei differed from mutual aid societies in other countries. The Jyorei hired doctors, paying them with rice collected from villagers and giving them free housing. In return, villagers gained access to curative medical care and doctors undertook public health measures to control the spread of measles, cholera and other infectious diseases.

In the late nineteenth century during the Meiji Restoration, Japan increasingly adopted western medical practices. Doctors trained in western medicine and their new associations sought to replace the Jyorei arrangements involving a flat annual income with fee-for-service contracts. In 1916, the Japanese Medical Association was formed and became the single voice for doctors to pursue their interests and the most important civil society actor in shaping health policy in the country. By 1926, the practice of contract-based payments in rice was fully replaced by cash payments. Nevertheless, the Jyorei provided an institutional model that was useful for public reforms.

⁶ The discussion of the Jyorei scheme draws mostly from Ogawa et al 2003.

At the same time, Japan was industrializing and urbanizing in ways that created pressures for social reforms. The migration of destitute farmers to Tokyo at the end of the 1900s drew public attention to appalling living conditions. Social reformers denounced urban impoverishment and called on the government to address health and sanitation in the cities. The military, too, sought higher public health standards to ensure a pool of healthy soldiers. Social unrest also occurred, most notably in the Rice Riots of 1918, triggered when women in a fishing village refused to ship scarce rice. The strike spread nationally with demands for better pay and lasted 53 days (Garon 1987).

Japanese governments responded in several ways. In 1911, they passed a Factory Law that established compulsory contributions to a workers' compensation fund. In the 1920s, they passed political reforms that increased the electorate but remained far from reaching universal suffrage. Workplace councils were recognized but unions were not allowed to form or operate with any autonomy (Gordon 2003). In 1922, the government passed a far-reaching Health Insurance Law, partly as a response to labor unrest and partly as an effort to generalize access to health care which was seen as necessary for building both a strong economy and a strong army (Ikegami et al 2011). The government was also aware that similar policies were bringing a degree of stability to Europe in the aftermath of World War I.

The Health Insurance Law of 1922 established mandatory participation in health insurance for formal sector workers and also created, for the first time, a direct role for the government in managing health insurance. The law was compulsory for all workers at firms with 10 or more workers. It set premiums in proportion to earnings and required employers to contribute 50 percent of the cost. Companies with more than 100 workers were required to create their own health insurance associations, known as Society-Managed Health Insurance (SMHI). The compulsory contributions from employers and employees in small firms went to a Government-Managed Health Insurance (GMHI). Though the law was passed in 1922, the 1923 Tokyo earthquake delayed implementation until 1927 (Okimoto and Yoshikawa 1993).

The 1922 health insurance law was passed despite substantial opposition from large employers, workers, and doctors alike. Employers opposed the legislation because of its cost to them; workers opposed it because they wanted employers to pay 100 percent of the contributions; and doctors objected because they feared the plan would lower their fees and reduce their negotiating power. Despite these concerns, the legislation ultimately benefited all three groups in different ways. Employers benefited from workers who became more attached to their firms; workers benefited from expanded access to medical care; and doctors benefited from greater demand for their services (Ikegami et al 2011).

In many respects, Japan's compulsory insurance law for formal sector workers was comparable to similar laws passed in other countries. However, Japan's insurance law differed in one significant regard: it encompassed small firms by creating a government-managed health insurance fund (Ikegami et al 2011). The decision to create this direct government role in managing health insurance distinguishes Japan's experience from most other countries in which the government tends to either coordinate and regulate insurers or directly provide care. This provision for government management of an insurance scheme was not adopted as part of a coherent strategy for the health sector but rather as an almost accidental result of the legislative context at that time. The 1911 workers compensation law had included small firms, establishing this as the standard scope for social protection legislation and making it difficult to exclude them. Then, because small firms were simply too small to administer their own health insurance funds, the available solution was to create the government-administered fund (Campbell and Ikegami 1998, p. 106).

Japan's Expansion Phase – 1920s to 1960s

In the decades following the landmark 1922 Health Law, Japan expanded health care coverage to more and more of its population, relying on institutions formed in its early phase. Some of the steps were incremental, extending existing schemes to more people. In 1934, for example, compulsory health insurance was extended by lowering the minimum threshold for participating firms from ten to five workers. In 1941, the scheme was extended further to white collar workers and non-working family members.

Other steps in expanding health coverage involved creating new institutions. In the 1920s, the government promoted Medical Cooperative Societies in rural areas. More than a thousand of these societies were operating in the mid-1930s when their membership and monetary contributions were sufficient to begin constructing hospitals. The Japanese Medical Association considered these societies a threat to their dominance in bargaining with the government, and successfully pressured the government to disband them.

A longer-lasting effort developed insurance schemes based on residence. The first step involved a new insurance law drafted in 1934 that enabled the government to facilitate and subsidize the creation of insurance groups on the basis of affiliation with cooperatives and trade associations or by place of residence, whether in cities, towns or villages (Garon 1987, p. 205). The second step came in 1938 with passage of the Citizen's Health Insurance (CHI) Act, creating new health insurance schemes based on place of residence and involving municipal governments. The CHI aimed to incorporate the self-employed, farmers and the smallest firms which lacked access to the SMHI and GMHI. The government referred back to the Jyorei model as the basis for the CHI schemes, encouraging the population to participate. The law also dissolved the Medical Cooperative Societies, transferring their

medical facilities to the new CHI schemes. Contributions were levied on a progressive scale and the CHI funds were partially subsidized. Though membership was initially voluntary, it was made compulsory during World War II. The 1938 law also reorganized the government's bureaucracy, creating a separate Ministry of Health and Welfare (MHW) rather than having these issues handled by the broader Home Ministry. By 1943, in the midst of World War II, almost three-quarters of Japan's population was enrolled with some kind of health insurance scheme of which the CHI, GMHI, and SMHI were the most prominent (Garon 1987, p. 274).

With the passage of the 1938 law, all the key institutions of Japan's later universal health coverage system were in existence: the CHI organized to serve people based on their place of residence, the SMHI covering formal sector workers, and the GMHI for small firms (See Box 2).

Box 2: Health Insurance Categories in Japan

Health insurance is mandatory in Japan, with individuals assigned to a particular fund based on their employment status, income or residency. The major categories are:

Society-Managed Health Insurance (SMHI or *Kenpo* in Japanese) covers employees of large private companies and in funds administered by management-labor committees.

Government-Managed Health Insurance (GMHI or *Seikan* in Japanese) covers employees of small companies in a single fund administered by the Ministry of Health and Welfare.

Citizen Health Insurance (CHI or *Kokuho* in Japanese) covers the self-employed, unemployed, retirees and others through funds administered by municipal governments.

During World War II, the Japanese government expanded its role in planning and managing ever larger shares of the country's economy, including the health sector. The war and the economic and political crises following defeat severely damaged the insurance funds and health sector infrastructure. Population enrollment in health insurance schemes fell to 60 percent. At this turning point, the JMA and health funds were both extremely weak and the Japanese government could have chosen to replace the insurance system with one characterized by direct public provision. Instead, during the U.S. occupation, the government chose to rebuild the insurance institutions it had created before the war. This decision was also supported by a key report from an American advisory team on social security in 1947 (Okimoto and Yoshikawa 1993).

As the economy recovered, more and more municipalities set up CHI funds and insurance coverage steadily grew. The system at this point was nearing universality but was still divided between funds with different bases of affiliation – some by employment, and others by residence, age, or firm size. The government thus faced another possible turning point in which it could have channeled all citizens into one or the other of these insurance schemes, the most likely being the CHI. Labor and management, however, did not want to cede their relatively privileged positions in the other schemes. The MHW and the JMA also objected to an approach that would have strengthened local governments at the expense of national authorities. Indeed, the MHW and JMA favored the way the system had developed with a strong role of national authorities in directly managing insurance (GMHI), negotiating national fee schedules, and setting rules for the CHI and SMHI.

Thus, government action in the decade following the war preserved the disparate bases of insurance affiliation while pushing steadily toward universalizing health coverage. Laws in 1948 expanded CHI by giving each municipal government responsibility for organizing and managing its own health insurance fund. A national health insurance tax introduced in 1951 stabilized funding sources and in 1953 the government committed to providing a 20 percent subsidy to national health insurance. The economic boom of the 1950s, during the Korean War, provided resources that facilitated expansion of insurance coverage.

But the 1950s were also tumultuous. The Liberal Democrat Party (LDP), a relatively cautious and conservative party, took office in 1955 but felt threatened by socialist gains in rural areas. In 1957, opposition parties in the Diet rejected requests from Self-Defense Forces and the United States for increased military expenditures. The LDP responded to the political crisis by coopting elements of the opposition platforms, acting on a number of social measures related to health, pensions and minimum wages. It specifically called for legislation to enact “health for all,” knowing that the fundamental interests of the MHW and JMA were aligned in preserving the central role of national authorities in the health sector. Thus, in 1958, the government passed the law that made coverage mandatory and universal. It was implemented in 1961.

By the early 1960s, Japan had a system that was universal but not unified, a system with strong national authorities but multiple insurance schemes based largely on place of employment or residence. The MHW and JMA played central roles in negotiating a uniform national fee schedule. The system incorporated progressive contributions that cross-subsidized poorer and less healthy groups. It favored equality and embodied many of the original principles on which the first Jyorei were established.

Japan’s Universal Phase – 1960s to the present

Once the system was formally and effectively universal, pressures to change the Japanese health system revolved around improving its equity, adjusting the level of copayments, controlling costs, improving the quality of care, and restructuring health care to address a rapidly aging population.

Japan has assured that everyone has health insurance coverage by assigning individuals to a fund based on their occupational status, place of residence, and age. In 2009, those employed in large companies were covered by 1,497 Health Insurance Societies managed by the companies themselves and accounting for 24 percent of the population (about 30 million people).⁷ Employees of small firms are enrolled in a single nationwide plan, the Japanese Health Insurance Association,

⁷ The figures in this paragraph are taken from Ikegami et al, 2011 and a translation of the *Annual Health, Labour and Welfare Report 2009-2010* from Japan’s Ministry of Health, Labour and Welfare accessed at http://www.mhlw.go.jp/english/wp/wp-hw4/dl/health_and_medical_services/P26.pdf on Nov. 29, 2011.

representing another 27 percent of the population (about 35 million people). Some 77 Mutual Assistance Associations cover government and quasi-public employees, representing another 7 percent of the population (about 9 million). Citizen Health Insurance, comprising 1,788 municipal funds and 165 National Health Insurance associations, enroll 31 percent of the population, including the self-employed, unemployed and retirees who are not yet 75 years old. People who are older than 75 are enrolled in a special insurance fund that was created in 2008 and which accounts for 10 percent of the population (13.5 million). The remainder are covered by special programs for the poor and disabled who are on public assistance (less than one percent).

Though the system is characterized by multiple insurers, they do not compete for members nor can they exclude individuals who qualify for affiliation. The contribution rates are set by the government, varying across insurers as well as reflecting differences in member income. The government also negotiates a uniform fee schedule in key biennial negotiations involving the MHW and the Central Social Insurance Medical Care council. The government endeavors to manage contributions, subsidies, and fees so as to preserve the financial viability of all funds. Thus, the insurance system is a hybrid that administers insurance through multiple funds but which acts as a single payer in many ways.

Japan's universal health coverage system has continued to make adjustments since achieving universal coverage, making copayments more uniform across plans, establishing out-of-pocket caps based on income, and establishing a new fund for the elderly. Unlike Sweden, Japan has not undertaken any significant structural changes. Instead, it has established a number of stable arenas for negotiating changes between insurers, providers and the government. Inequities continue to be a focus of current debates, particularly with regard to differences in contributions across insurance schemes (Ikegami et al 2011).

Chile

Like other countries, Chile's path to universal health coverage built on the early emergence of voluntary mutual assistance organizations and public efforts to coordinate and subsidize charity health care. The government's role subsequently expanded through legislation to enact compulsory insurance, complemented by the creation of publicly-managed health services for particular subpopulations. In the 1950s, these programs were merged into a single national health service, contributing to the effective universalization of access to health care by the 1980s. These general historical trends were shaped by dynamics common to other countries: violent struggles between workers and employers and highly polarized debates over the relative roles of government and markets. Medical professionals were prominent on both sides of these debates and international experiences were explicitly incorporated into legislation and planning.

Chile also exhibits a number of distinctive features that influenced the shape and pace of its progress toward universal health coverage. From its experience as a Spanish colony, Chile inherited a high degree of social and economic inequality. This was later reinforced by an economy dependent on mineral exports. Elite groups violently repressed popular movements from the nineteenth century into the 1980s, with the military playing a significant role throughout. Despite a strong liberal tradition opposing expansion of the state, Chileans also demonstrated an early and persistent interest in national government programs to address crises ranging from earthquakes to epidemics and challenges ranging from poor infrastructure to malnutrition.

Chile may differ most markedly from other countries, however, in the way its health system changed *after* achieving universal coverage. Just as Chile was reaching universal health coverage in the 1970s, a military coup overthrew a democratically-elected government and initiated reforms to severely restrict the public sector. In the 1980s, the military government sought to convert Chile's public health system into one predominantly managed by private insurers and health care providers. This vision of a private health care sector, however, was resisted even by elements within the military. When democratic governments returned to power in the 1990s, their policies rebuilt and reformed the public health service and public insurance agency. They also gradually regulated private insurers to function as elements within a coherent system guaranteeing a minimum package of benefits.

Chile's Early Phase – Nineteenth Century to the 1920s

Chile achieved independence in 1818 burdened by a colonial legacy of exploitation, social dislocation, and inequality. The indigenous population was marginalized and labor was exploited in an economy based on extracting and exporting raw materials. Agricultural productivity was low and industrialization occurred relatively late, not until the twentieth century. Nonetheless, the value of export commodities along with a high concentration of income allowed the country's elite to attain living standards on a par with Western Europe.

As in other countries, urban labor groups – comprising artisans and skilled workers – developed mutual aid societies (*Sociedades de Socorro Mutuo*) to provide financial benefits in the event of illness, death and sometimes for retirement. These societies were founded on principles brought to Chile by activists influenced by experiences abroad, including France and Peru (see Gambone 2005). In addition to providing benefits, the societies were a basis for solidarity and support during strikes. The number of mutual aid societies grew steadily from 39 in 1880 to 240 in 1890 and 735 in 1922. They established a national federation, the *Confederación de Trabajadores*, in 1894 (See Scully 1992, p. 72 and footnote 226; Mardones-Restat and Azevedo 2006; Gambone 2005).

Public action in health also started early with specific attention to infectious disease, nutrition and public hygiene. Chile's first public board to vaccinate against small pox was established in 1805, even before the country's independence from Spain (Jimenez and Bossert 1995). The western tradition of medical practice developed during the nineteenth century with the establishment of a medical school at the University of Chile in 1842. Although individualized diagnosis and treatment flourished, many Chilean medical professionals also promoted a public health approach to address the spread of infectious diseases and illness due to malnutrition. These professionals created the Chilean Medical Society in 1873. The government was responsive to many of its proposals. In 1887, faced with a threat of cholera associated with international shipping, the government created Chile's first public authority to deal with infectious diseases, the General Sanitary Bureau.

In the latter part of the nineteenth century, charitable and government programs began to distribute nutritional supplements to the poor, eventually leading to free distribution of milk for infants and children in poor urban areas in a formal program called *Gota de Leche* (Drop of Milk), coordinated by a national public authority called the National Children's Protection Agency (*Patronato Nacional de la Infancia*). Over the same period, private charities established health centers and hospitals that often received government subsidies. These charities gradually came under the coordination of a national institution, first established in 1877, called the *Comisión de Beneficencia Pública*, which comprised 12 groups in the 1870s and 115 by the 1920s (Mardones-Restat and Azevedo 2006).

Despite these initiatives and programs, social policy in Chile – on health as on many other matters – was highly contentious. Political parties were sharply

divided over the role and status of the Church and frequently deadlocked over public policy, including demands for action on health. Labor struggles were a major issue. Workers pushed for a range of rights and benefits, from better working conditions and wages to pensions, government-financed health care, and suffrage. They were often met by violent repression from an elite of landowners, mining interests and business. The military also struggled internally over its own role and positions on public policy, frequently intervening in politics. Sometimes the military intervened in favor of expanding public commitments to health care; at other times it intervened against such public commitments. Even the medical field was divided on the issue of government's role in health care. An important core of medical professionals were committed to strong public health or "social medicine" and advocated for government to work toward universal access to health care. They were opposed by other medical professionals insisting that health was an individual responsibility, outside the realm of public policy.

The role of the state in health policy in Chile was thus openly debated from many different angles in the early 1900s. In 1917, the Beneficencia Pública held its first congress and explicitly discussed whether health care services are the responsibility of the state or of private charity. Workers pushed for government provision of benefits in a series of strikes, including in 1918 when 50,000 participated in demonstrations for social benefits and protections. Political parties responded by seeking ways to control and appease the movement, simultaneously restricting suffrage and limiting public input (Scully 1992, p. 84).

First the Conservative Party in 1919, and then the Liberal Alliance in 1921, submitted social legislation to Congress that included compulsory health insurance modeled on Western European schemes (Scully 1992, p. 80). Congress, however, failed to pass either measure. Congressional inaction was a source of frustration to many. As a sign of changing social views, the Beneficencia Pública held its second national conference in 1922 and this time soundly endorsed state financing of health care for all citizens, declaring that "charity is humiliating." Workers continued to protest but legislation continued to languish (Molina 2008). Elites opposed benefits and legislation that they saw as legitimizing worker organizations, while the workers movement opposed elements of the proposals requiring them to contribute to social security (Jimenez and Bossert 1995). Only when Chilean military officers intervened, in September 1924, was legislation ultimately enacted. This was the first compulsory insurance law benefiting blue-collar workers (*obreros*). It was an explicit commitment at the national level to a government role in assuring access to health care. Subsequent struggles within the military led to several changes in political power between more conservative and more progressive factions. The eventual outcome, however, was that governments in the 1920s and 1930s implemented the 1924 compulsory health insurance law, asserting an expanded role for the state as a funder, regulator and provider of health care services and public health activities.

The legislation of the 1920s reflected a social view that distinguished Chileans by class. According to this viewpoint, employers and land owners could take care of their own needs; literate and salaried employees could save for their own health care and pensions; and manual laborers required the assistance of the state due to their low incomes and poorer education. Although this legislation grew out of the Chilean context, it was also influenced by social security systems in Western Europe, papal encyclicals of the time addressing social conflict, and international public health initiatives associated with the Rockefeller Foundation and the creation of the Pan-American Health Organization. In Chile, the state assumed an important role in guaranteeing access to health care services but the form of its involvement remained contested and its activities were fragmented across population groups and disparate public health initiatives.

Chile's Expansion Phase – 1924 through the 1970s

Although the legislation of 1924 created health insurance only for blue-collar workers in the formal sector, it represented a decisive shift toward governmental leadership in assuring access to health care. Over the next three decades, Chile created and expanded numerous public programs to address different population groups and health problems. In 1952, most of these were brought together in a single national health service. This yielded significant improvements in the population's health and in the 1970s universal access to basic health services was substantially achieved.

At the beginning of this expansion phase, Chile had three major institutions addressing health. First was the *Beneficencia Pública*, originally established as a non-profit private institution. Over time the government provided a larger and larger share of its budget and assumed greater responsibility for its administration. Its network of publicly-subsidized hospitals became a major source of health care for much of the population. Eventually, the hospitals of the *Beneficencia Pública* were subsumed under a semi-independent division of the health ministry.

The second major organization was the *Caja de Seguro Obrero*, created by the 1924 compulsory insurance law. It paid for hospitalization, drugs, six months of sick pay, and insurance for disability and old age for contributing workers. Initially, the *Caja de Seguro Obrero* reimbursed outpatient visits with private doctors, but it shifted toward a system with preferred providers and eventually to providing care in its own clinics (Gutierrez 1976). Other "Cajas" (hereafter Funds) were created for different occupational categories. Foremost of these was the *Servicio Medica Nacional de Empleados* (SERMENA), a health service covering salaried employees in the civil service, railroads, banking and manufacturing that was created in 1942. Each of these Funds differed with regard to contributions, benefits, retirement ages and the degree of subsidy from the government's general revenues. For example, the *Caja de Seguro Obrero* received more state subsidy and provided more benefits

than SERMENA from a presumption that salaried workers were more capable of paying for their own health care needs.

The third organization, the *Ministerio de Higiene, Asistencia y Previsión* created in 1924 and its successors, managed a range of public programs addressing health conditions for the general population and specific problems of disadvantaged groups. For example, the *Consejo Nacional de Alimentación* was established in 1937 to address malnutrition. Publicly-provided services for maternal and child care were also established in another 1937 law. The Preventive Medicine Law of 1938 provided for screening infectious diseases like syphilis and tuberculosis and the *Dirección de Protección de la Infancia y Adolescencia* (PROTINFA) was created in 1942 to promote children's health (Jimenez and Bossert 1995).

This proliferation of government programs followed from the 1920s legislation and its vision of targeting public action and funding on the economically disadvantaged. The inefficiency of overlapping programs and unequal treatment across different health services eventually led to efforts to unify and rationalize public policy. In 1939, then Minister of Health Salvador Allende⁸ elaborated a plan to create a single national health service that would encompass all public health services and activities. Action was postponed until after World War II, but in the process a wide coalition – ranging from the Communist Party to conservatives – coalesced in favor of this approach. The formation of the British National Health Service in 1948 and studies showing large inequities in health in Chile gave further impetus to the reform. Opposition from medical professionals who might have resisted the initiative was overcome by generous salary provisions in the law (Jimenez and Bossert 1995).

Legislation to create a national health service, the *Servicio Nacional de Salud* (SNS), was passed in 1952. It combined most of the government's major health services into a single entity, including the hospitals of the Beneficencia Pública, the health services of PROTINFA, and the facilities of the *Caja de Seguro Obrero*. The SNS strengthened the government's role as the leading provider of health services throughout the country which it divided into thirteen geographical regions (called "zones") for administrative purposes. It invested heavily in training health professionals and, by requiring doctors to serve residencies in rural areas, was able to effectively reach most of the population with basic services by the end of the 1970s.

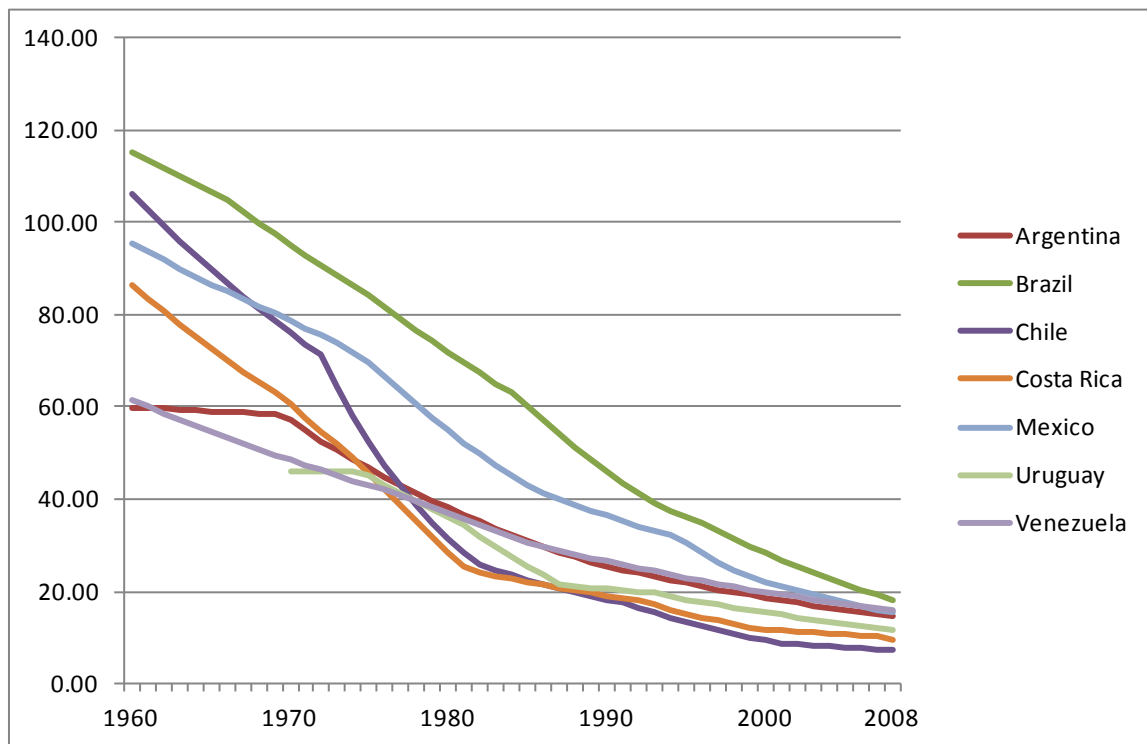
Some groups, such as the military, resisted incorporation of their health service into the SNS and remained independent. The largest category of people excluded from the SNS were white collar workers covered by SERMENA. Under SERMENA, white collar workers received preventive care services but had to pay for

⁸ Allende continued to play a prominent role in Chilean politics, running for President unsuccessfully in 1952, 1958 and 1964 and then successfully in 1970. He committed suicide in 1973 during the military coup that overthrew his government.

consultations and hospitalizations. For those who worked in large companies, this exclusion was offset by access to employer-financed health clinics. However, many white collar workers (30 percent of them according to the Minister of Health in 1966) sought care in SNS facilities despite lacking legal entitlement (Gutierrez 1976). This structure of public subsidies for health services directed towards lower income groups and not for the middle class distinguished Chile from most other countries in Latin America by making its system more progressive and redistributive.

The effectiveness of the SNS can be inferred from dramatic improvements in health status from the 1950s onwards, even though economic growth was not particularly favorable and inflation became problematic. In 1960, Chile's infant mortality rate was among the worst in the region – over 100 per 1,000 live births (see Figure 2) – comparable to that of Brazil, nearly double that of Uruguay and 50 percent higher than Costa Rica. However, by 1980, Chile had surpassed all of these countries, reaching a rate near 30 per 1,000 live births, slightly better even than Costa Rica. Life expectancy also rose steadily as the country reduced the incidence of numerous infectious diseases and even made gains against cardiovascular illnesses.

Figure 2: Infant Mortality Rate 1960-1989 in Selected Latin American Countries
(infant deaths per 1,000 live births)



Source: Klara Johannson, Mattias Lindgren and explained <http://www.gapminder.org/data/documentation/gd002/>.

Debates over the role of government continued and grew more polarized. Demands for more extensive land reforms and redistributive programs sharpened throughout the 1960s. Salaried workers dissatisfied with SERMENA gained access to financial subsidies when seeking care outside of the publicly-administered system in a 1968 reform. Debates continued between those seeking to expand the SNS and incorporate all Chileans in a single unified system and those who wanted to restrict public provision and expand the role of private medical practices. The major actors themselves – including the medical profession, organized labor, political parties and the military – were often split internally on these very questions.

By the 1970s, most Chileans had access to some form of health care through publicly-provided health care services which they accessed directly or via formal affiliation with a subsidized insurance plan. Many also sought private care, paying out-of-pocket, for primary care consultations. The multiplicity of insurance schemes and overlapping bases for affiliation created a chaotic system in which contributions, benefits, copayments, and quality varied substantially from one plan to the next. Still, remarkable gains had been achieved in assuring that most people could obtain basic health care services through most of the country.

Chile's Universal Phase – 1980s to the present

Chile was approaching universal coverage of basic health services just as the country faced one of its most traumatic upheavals, the military coup of 1973 that overthrew the democratically-elected government of President Salvador Allende. The military government led by General Augusto Pinochet violently repressed the popular movements that had agitated for expanding the state's role in public services and the economy. The military not only halted these efforts and repressed democratic action but also reduced the size of government by privatizing a large number of state programs and cutting public budgets.

The military government did not address the health sector until 1979. It then enacted reforms which ironically expanded the structural role of the state even as they created new opportunities for the private sector. In 1979, the regime reorganized public health financing by creating a single national health fund (*Fondo Nacional de Salud* or FONASA). This achieved the Popular Front's original goal of incorporating all Chileans – whether manual laborers, white collar workers, or the self-employed – in the same contributory pool. The same year, it enacted a reform of the SNS, creating the *Sistema Nacional de Servicios de Salud* (SNSS) which decentralized health services to 26 regional entities and expanded the role of municipalities in the management of public health care. Though these two reforms reaffirmed a large role for the state in regulating financing and managing health care services, they were followed by a third reform which created a much larger role for the private sector. In 1981, Chileans were given the option of directing their payroll contributions away from FONASA and toward purchase of private

health insurance coverage. The firms that were created to respond to this demand, largely from higher-income individuals, were called *Instituciones de Salud Previsional* (ISAPREs). As the economy fell into recession in the 1980s and public health services deteriorated under budget cuts, ISAPREs expanded rapidly, eventually covering about one-quarter of the population. With very little public oversight, ISAPREs were able to manipulate the market by attracting lower-risk individuals and cancelling policies when people became ill or retired (Bitrán and Urcullo 2008).

When democratically-elected governments returned to power in the 1990s, they undertook to rebuild public financing and provision of health care but without directly overturning the Pinochet era reforms. In particular, this involved increased funding to FONASA and the SNSS, allowing them to improve the scope and quality of public services. The governments in this period also enacted successively stronger rules to regulate ISAPREs, including provisions for consumer protection and a standardized minimum benefit package. As the quality of public sector services improved and the ISAPREs' ability to manipulate the market diminished, ISAPREs lost market share. Chileans who might have previously opted for private insurance when the price was lower and the limitations of coverage were less transparent began to choose FONASA's coverage as the quality of public health services improved. The number of ISAPREs declined through mergers and their market share declined to about 15 percent of the population, while FONASA has grown to cover about 80 percent of the population. Current reforms are focused on guaranteeing a core package of health care services to all citizens, regardless of insurer chosen, and with special attention to improving the quality of care.

Chile's path to universal health coverage has not been direct. The legislation Chile enacted in the 1920s could have led to a universal health care system based on multiple insurers. Instead, the creation and expansion of publicly-provided health care services, and the merging of many of them into the SNS in 1952, put Chile on a path toward a national health service. However, even as Chile was effectively reaching universal coverage, the Pinochet regime altered the institutional framework for health care financing and provision, equalizing access to some form of health insurance while permitting wealthier citizens to opt out of the public insurance scheme. Today, Chile's health care system contributes to health status indicators that are among the best in the world. The debates that remain focus less on the role of the state or commitments to universal coverage than they do on achieving efficiencies, controlling costs, and reducing inequities.

Malaysia

Malaysia's path toward universal health coverage differs significantly from other countries in a number of ways. British colonial control of the Malay Peninsula from the nineteenth century until 1957 inhibited indigenous social movements that might have promoted access to health care or created mutual aid organizations. The hospitals and health facilities built and operated by the British in this period

were oriented toward providing health care for colonial officers and the civil service rather than the population more broadly.

Nevertheless, as in other countries, Malaysia did experience diverse pressures for public action to expand access to health care. Public health initiatives were initially justified to maintain a healthy workforce and later to coopt popular unrest and address interethnic conflicts. After independence in 1957, expansion of health coverage was promoted by the government as it assumed a commanding role in economic and social development. In parallel with import-substitution policies and large infrastructural investments, the government expanded health services under a model of direct public provision. The political process favored groups that collaborated with the multi-ethnic dominant party and sought to redress inequities by serving the rural Malay population even as it protected and expanded elite privileges. The expansion phase of health care had concluded by the 1980s with most Malaysians gaining access to basic health care services and corresponding improvements in life expectancy.

Malaysia's development model changed in the 1980s when the Mahathir administration began to favor private sector expansion over government-led investment. These new ideological and political commitments led to plans for reforming the health service by introducing competition and private provision. More recently, the government proposed creating a health insurance fund that would allow Malaysians to choose between public and private providers. As in other countries, reaching universal coverage is not the end of the story. Broad popular support exists to maintain a system of government health care provision; however, an alternative model is being promoted by the government in which private health care markets would take the lead and the state would serve only as a provider to the poor.

Malaysia's Early Phase – Nineteenth Century to 1957

Prior to the 1500s, the Malay Peninsula was home to numerous polities. Indigenous groups followed their own medical beliefs and practices. These were influenced by Arab, Hindu, Chinese and European practices, due to the peninsula's strategic location on international trade routes. Beginning in the 1500s, the Portuguese, Dutch and then British dominated the Malay sultanates, controlling trade and promoting export industries. The British assumed more direct control of the peninsula in the 1860s. The basis for expanded colonial power was the establishment of directly administered settlements in Malacca, Penang and Singapore in 1867 and the creation of a federation of Malay States under British authority in 1895. By 1919, the British had consolidated their control over the entire Peninsula, though they preserved a circumscribed role for the Malay sultans who continued to have authority in matters of religion and Malay customs. The British promoted extensive immigration by Chinese and Indian laborers to work for the core export industries in tin mines and rubber plantations. This ostensibly

temporary immigration became permanent and ultimately transformed the Malay Peninsula into a multi-ethnic society, with enormous consequences.

Early British colonial administrations largely neglected investments in public health care, building medical facilities for the exclusive use of colonial employees and military personnel. The few facilities established outside this colonial network, such as paupers' hospitals, were based on philanthropy and social networks within the Chinese community. British colonial policy toward health changed in the late nineteenth century as Britain formalized and extended its power over the Malay Peninsula. Still, the British addressed access to health care services in ways that largely served their colonial interests: preserving the health of workers in export sectors; preventing the spread of infectious diseases that affected trade; and providing health care for colonial administrators and military personnel.

The British began to seriously address public health in 1869, enacting sanitary regulations and establishing sanitary boards in Kuala Lumpur and other large towns. At the time, malaria, beriberi (vitamin B1 deficiency) and cholera were serious threats to health. New regulations set standards for water and sanitation, food safety in processing and retail establishments, and quality of housing (including inspection provisions that could be quite invasive, see Manderson 1999). In 1900, the British founded an institute of medical research in Kuala Lumpur that contributed to advances against a number of tropical diseases, including malaria. In the early twentieth century, the colonial administration implemented campaigns against hookworm, tuberculosis and venereal diseases.

Much of Malaysia's basic health care infrastructure was also started in this period as the British constructed hospitals in major urban areas and established health care programs for specific populations. In the 1870s, the colonial administration built the region's first general hospital and assumed control over pauper hospitals previously operated by philanthropies. Another twenty hospitals were constructed during the next two decades and by 1910 at least one general hospital was operating in the capital city of each Malay state. The British also created an Infant Welfare Advisory Board that oversaw training of midwives and established infant welfare centers to address maternal and child health conditions among the poor. Three of these centers were founded in 1922 and fourteen were in operation by 1937 (Mills 1942, p. 326; Phua n.d.).

Over time, the colonial administration's commitment to health expanded. By the 1920s, a network of health officers (responsible for enforcing sanitary regulations), medical facilities, and public health agencies supported effective public health campaigns that reached even rural areas. Health status for the population improved markedly in this period. Infant mortality fell from 248 deaths per 1,000 live births in 1917 to 147 in 1937 (Chee and Barraclough 2007). Although the overall supply of health care services increased, access was highly inequitable and dependent on class. A system of government-financed and operated hospitals and clinics

provided care to civil servants for free, with their level of entitlement dependent on rank. Services were largely limited to urban areas, but the general population could still seek care at these facilities as outpatients or in subsidized wards.

World War II and the Japanese occupation caused substantial upheaval. With Britain focused on the war in other theaters, military opposition to the Japanese occupation was conducted primarily by the Communist Party, strongly supported by ethnic Chinese and tacitly endorsed by the British. After the war, the Communist Party unsuccessfully fought the reimposition of British colonial rule. This period of insurgency, known as “The Emergency,” lasted from 1948 to 1960. As part of its efforts to defeat the insurgency, the British forcibly resettled rural Chinese populations into “New Villages” so as to restrict their movements and prevent them from providing supplies to guerrillas. As a strategy for winning support, the British provided midwife clinics and primary care in these settlements and extended it also to indigenous Orang Asli peoples (Barraclough 1999; Chee and Barraclough 2007). In 1953, these rural clinics were formally structured in a Rural Health Services scheme, establishing the basis for subsequent extension of government health care throughout the country. This shift in health policy toward expanding access was reinforced by developments in Britain: the National Health Service was created in 1948 with a commitment to assuring universal access to health care through government-financed services.

During the struggle for independence, relations between ethnic groups became a pressing issue. The United Malays National Organization (UMNO) was formed in 1946 to protect the existing Malay hierarchy and oppose a multi-ethnic union. Eventually, the British pressured the Malay nationalists to engage with other ethnic groups, engineering the formation of the Malayan Chinese Association (MCA) in 1949 as an alternative to the Communist Party. UMNO was able to mobilize substantial support not only among Malay elites but also peasants and teachers. It further succeeded in arranging coalitions with the MCA and the Malay Indian Congress, offering them access to power in return for financial support and the ability to claim legitimacy as a multi-ethnic party (Gomez and Jomo 1999).

In 1957, the Federation of Malaya declared independence. In 1963, when Singapore, Sarawak and Sabah joined the country, its name was changed to Malaysia.⁹ The new country inherited a well-structured though limited health care system comprising government-operated hospitals, a government-run rural health service, medical schools and research institutes, all financed from government revenues. Public investments had increased the supply of trained medical professionals and midwives, and government funding supported programs to address public hygiene, sanitary regulations, and control of infectious diseases. The country also had a small number of private charitable hospitals and private primary care physicians in urban areas serving wealthier households able to pay for

⁹ Singapore subsequently left Malaysia in 1965.

services. Health conditions were considerably better than at the beginning of the 1900s, but health care services were limited and inequitably distributed.

Malaysia's Expansion Phase – 1957 to the 1980s

Malaysia's first two decades followed a pattern similar to other newly independent Asian countries in pursuing growth through a strong state role in economic and social investment. Malaysian economic growth benefited from increasing demand for its mineral and agricultural products but also from direct efforts to industrialize, first through import-substitution strategies in the 1960s and later with export-oriented manufacturing. Politically-connected elites preserved their power and benefited financially from control of government offices, public contracts, and access to infrastructure, yet they also sought to foster increased productivity and growth (Gomez and Jomo 1999).

While many policies were highly contested in this period, a number of factors converged to support consensus around universalizing health care access in Malaysia with tax-financed government services. First, expanding health care services was a visible and relatively inexpensive way to benefit the rural Malay population that provided the base of support for the governing coalition. These efforts were strengthened after race riots in 1969 which produced a political shift within UMNO. A new group of leaders became more assertive in promoting Malay interests and affirming a national identity with greater recognition for Islam and the traditional aristocracy (Gomez and Jomo 1999, p. 23)

A second factor that supported expanding government health care services was the prominence of this approach after World War II in many countries and regions, from the Soviet Union and Britain to Western Europe, Latin America and Asia. Models for publicly-funded or administered health services were ideologically favored by a broad political spectrum that fit well with Malaysia's own political trends.

Third, a rapidly growing economy provided an expanding tax base. This permitted the government to put greater resources into health without compromising investments in other higher priority areas such as infrastructure and energy.

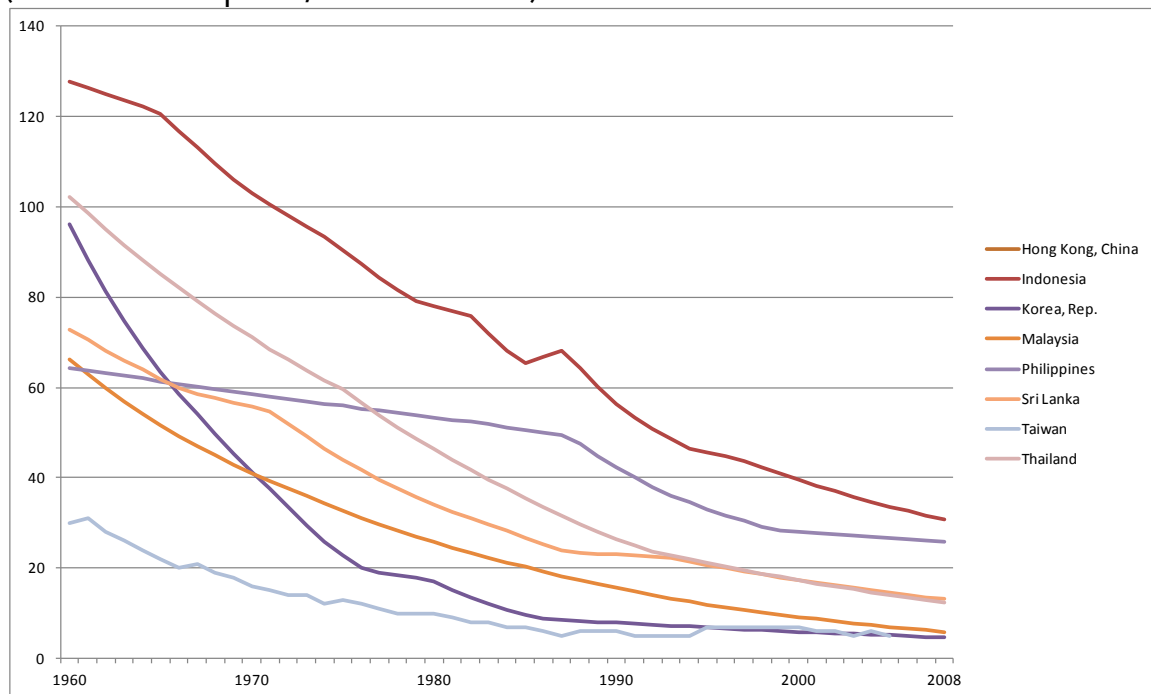
Finally, private sector physicians and non-profit hospitals were allowed to continue operating without interference. Thus, they had little reason to resist expansion of services into rural areas where household incomes were too low to support a private health care market.

The successful efforts to provide tax-financed government health services in this period increased the accessibility of health care throughout the country, even in the sparsely populated and poorer states of Sarawak and Sabah. In 1960, the country had 638,000 rural dwellers per health center. By 1965, the number of

health centers had more than quadrupled and the ratio of rural dwellers to health center had plummeted to 150,000. By 1986, the ratio had fallen further to an estimated 21,697 rural dwellers per health center at which time 89 percent of the population lived within 5 kilometers of a health facility (Chee and Barraclough 2007, p. 6). Over time, the public system grew to encompass some 8,700 doctors, 21,000 nurses, and 120 hospitals, as well as many school-based facilities, rural health service clinics, midwife clinics, and dental offices (Malaysian Ministry of Health 2001). In parallel, effective programs were introduced to reduce infant and child mortality, halt the spread of infectious diseases and improve reproductive health. In part as a consequence of these efforts, infant mortality dropped from 75 per 1,000 in 1957 to under 8 per 1,000 in 2000 (Malaysian Ministry of Health Annual Reports). Over the same period, maternal mortality fell from a rate over 200 to less than 30 deaths per 100,000 live births. Differences in maternal mortality between ethnic groups declined markedly and differences across Malaysia states were almost entirely eliminated (Pathmanathan et al 2003).

The decline in infant mortality rates was quite pronounced during this expansion phase in Malaysia even when compared to its peers (See Figure 3). In 1960, Malaysia's infant mortality rates were comparable to rates in the Philippines and Sri Lanka but fell more rapidly. By 2000, Malaysia had achieved infant mortality rates comparable to Taiwan which, in 1960, had had rates less than half as high as Malaysia. Of the selected countries shown here, only South Korea experienced improvements that surpassed Malaysia's achievement.

Figure 3: Infant Mortality Rate 1960-2008 in Selected Asian Countries (infant deaths per 1,000 live births)



Source: Klara Johannson, Mattias Lindgren and explained <http://www.gapminder.org/data/documentation/gd002/>.

By the 1990s, the government's provision of health care services had effectively universalized access to basic health care in Malaysia. Public provision subsidized two different kinds of care: costly hospital treatments throughout the country and primary care services in rural areas. Private practitioners continued to provide the majority of primary care visits in urban areas on a fee-for-service basis. This mix of public and private services has increased the equity of Malaysia's health system. As one indication, the utilization of government-subsidized services by lower income groups rose from 1.5 to 2.5 consultations per year between 1973 and 1996, while the number of public consultations per year for the richest quintile fell from 1.1 to 1.0 (Chee and Barraclough 2007, p. 110).

Malaysia's Universal Phase – 1980s to the present

Even as Malaysia was attaining universal health coverage in the 1980s, the ruling party's support for direct provision of health care shifted. The major impetus for this shift was an overall reorientation in the government's model of development. It now aimed to reduce the role of the state in the economy, repositioning the state as a regulator and supporter of private sector activity. Prime Minister Mahathir sought to limit the state's role as provider of basic welfare services and increase the responsibility of families, communities and private firms. In 1983, this orientation was explicitly formulated in a Privatization Plan that included the health sector. Arguments for privatizing health care initially reaffirmed the government's commitment to universal and equitable health coverage but claimed that the best strategy for controlling costs and improving access was through increased private sector provision. Though the cost of Malaysia's public health service was modest by international standards, government officials argued that annual increases in the health budget were unsustainable. By the 1990s, the government was promoting a model in which most Malaysians would pay for their own health care through private markets and the public sector would be involved as a regulator and as a provider for those too poor to pay.

The government encouraged the expansion of private or privately-managed care in several ways. It subsidized the creation of private hospitals through tax concessions, exemptions from import duties on medical equipment, and direct investment by state development banks (Barraclough 1997). It created "corporatized" facilities – privately-managed non-profit entities that are compensated by the government on a fee-for-service basis – arguing that this would allow facilities to attract and retain health care providers whose salaries in the civil service would be otherwise highly constrained. The National Heart Institute was the first of these corporatized facilities, established in 1992 (Hussein et al. 2004). It also transferred a number of auxiliary services like drug procurement and hospital laundry services to private firms in the 1990s. It encouraged private hospitals to offer services to the poor and then offered tax offsets to subsidize the creation of low-income wards. Despite actively promoting private investment in hospitals since the early 1980s, the government did not pass applicable regulations

until 1998 and then delayed their implementation for eight years (Chee and Barraclough 2007).

Capital investment in private hospitals grew rapidly over this period, generating profits for politically-connected individuals and corporations who benefited from government subsidies. From 1980 to 2000, the number of private hospitals increased from 50 to 224 and the private share of hospital beds increased from six percent to twenty-seven percent. Nonetheless, private hospitals remain underutilized and most Malaysians (over 70 percent) continue to seek care at public hospitals. As of 2000, even the share of doctors in private practice was largely unchanged from 1980 (46 percent). Rather than serving less affluent Malaysians, private hospitals have invested heavily in advanced technologies to attract wealthier clients and, after the 1997 financial crisis reduced domestic demand, they explicitly sought to attract medical tourists with government endorsement. Thus, the government's strategy of expanding private investment in hospital care has made little impact on overall public health spending or patterns of utilization.

The government has faced significant opposition to its privatization plans from the Malaysia Medical Association, Malaysian Trade Union Congress and consumer groups. A group calling itself the Citizen's Health Initiative issued a manifesto in 1998 to oppose privatization of health care in Malaysia and opposition parties endorsed the manifesto in the 1999 elections (Barraclough 2000). Having delayed corporatization of public health facilities for decades, the government eventually dropped these plans on the eve of the election and committed to increase public spending on health. In 2004, the government introduced more limited proposals to allow private practice in public hospitals and the creation of private wings. This led to the formation of the Coalition Against Health Care Privatization (CAHCP) by many of the same groups that had endorsed the Citizen's Health Initiative (Chee and Barraclough 2007). The CAHCP is a broad multiethnic coalition that has articulated the main opposition to government reform plans and lobbied for support to the existing public health system.

The struggle over the shape of Malaysia's health care system continues. The Ministry of Health has proposed a national health fund that would be financed by compulsory contributions and would permit Malaysians to choose between public and private providers. The consequences of such a scheme are debatable. It could potentially reduce rising out-of-pocket expenditures by channeling contributions into an effective prepaid scheme. Alternatively, it could undermine financing for the network of public facilities which currently assure equitable access.

Today, Malaysia has a health care system that is still fundamentally public, less costly, more equitable and more effective than most countries at its level of income (Chee and Barraclough 2007). The majority of primary care consultations are paid out-of-pocket with private physicians but free or highly-subsidized care of

reasonable quality is available throughout the country at public facilities. The majority of Malaysians still seek treatment at government hospitals which provide highly-subsidized general wards. The incidence of catastrophic spending for households appears to be lower in Malaysia than its peers in Asia, including Hong Kong and South Korea; and falls more heavily on the rich than the poor (van Doorslaer et al 2007, pp. 1173 and 1175).

Nevertheless, considerable dissatisfaction persists. Incomes have grown very rapidly and the promises of advanced medical technology are increasingly visible. Both these trends have raised popular expectations more rapidly than the public system has been able to respond, especially without stronger commitment from the government.

Malaysia's universal health coverage was initially driven by British colonial concerns for a healthy workforce and later to undermine insurgencies. After independence, Malaysia's elites extended services to the population and especially to rural constituents in order to solidify their power. When government policies shifted against public health care provision, civil society groups organized to defend the existing public system. Coalitions of trade unions, nongovernmental organizations and consumer groups are now the primary source of pressure to maintain and extend universal health coverage.

Conclusions

The histories of reaching universal health coverage in Sweden, Japan, Chile and Malaysia are full of unexpected twists and turns. No country today can follow the same path because of cross-national differences and because the political, economic, and technological context has changed. Even the broad phases identified here are not necessary conditions for progress. In fact, most countries already have entered a phase in which the government plays a prominent role in health policy. For those countries which do not yet have strong public action in the health sphere, awaiting the emergence of voluntary schemes would only delay progress without providing substantial advantage.

Nevertheless, these unique histories do reveal significant commonalities that are relevant to strategies for achieving universal health coverage. Four may be highlighted. First, the domestic pressures for universalizing access to health care are varied and widespread. Secondly, universal health coverage is everywhere accompanied by a large role for government, although that role takes many forms. Third, the path to universal health coverage is contingent, emerging from negotiation rather than design. Finally, universal health coverage is attained incrementally and over long periods of time. These commonalities are shared by all of the cases presented above despite their enormous diversity across income levels, political regimes, cultures, and health sector institutions. Attention to these commonalities is useful for countries seeking to expand health coverage today.

Multiple pressures for universal health coverage

Domestic pressures to achieve universal health coverage come from diverse sources and are persistent over time. Many actors are involved for varied reasons, such as health professionals with a commitment to public health, employers seeking government support to maintain a healthy workforce, unions addressing health care within a platform of workers' rights, expansionist regimes with an interest in healthy conscripts, political parties pursuing their political aims or coopting the positions of political opponents, elites seeking to bolster citizens' allegiance to the state, local communities seeking relief from the burden of caring for the aged, and citizen's groups demanding equity.

Each of the cases exhibits a range of groups mobilizing in favor of universal health coverage at different times. In Sweden, the temperance movement played an early and unique role in advocating for expanding health insurance coverage. Labor movements and parts of the medical profession also played significant roles in Sweden, Japan and Chile. The military was an important actor, sometimes favoring and sometimes resisting health reform plans in Japan and Chile. In Malaysia, ethnically identified organizations mobilized to develop institutions for providing health care and colonial administrators initiated public health measures, but it was the developmentalist state that pursued extension of health coverage most strongly.

Countries seeking to universalize health coverage today should not overlook this diversity of potential support for universal health coverage. Most groups are not monolithic and their membership will have factions that support universal health coverage even when their formal associations may be opposed. Views also change over time. As a result, even while countries progress at different rates, no country lacks domestic pressures toward the provision of universal health coverage. Even in countries where universal health coverage has come under attack for its costliness or inefficiency or for being incompatible with changing notions of the proper role for government, underlying pressures for universalizing access to health care persist and seem to always reassert themselves. In the cases reviewed here, this resilience was particularly notable in Chile under General Pinochet and in Malaysia under Prime Minister Mahathir. The resilience of support for public policies to extend health coverage was also apparent in the United Kingdom after Prime Minister Thatcher and in China in response to Deng's market reforms.

Government involvement is essential

Second, all countries that have achieved universal health coverage have done so with extensive government involvement in the financing, regulation, and sometimes the direct provision of health care services. The role of government is significant across a range of schemes – whether public or private providers, non-profit or for-profit insurance funds, integrated provider organizations or separations between financing and provision. Public policies mobilize funds in many ways, including mandatory payroll contributions, general revenues, or earmarked sales taxes. They channel those funds into health through mechanisms as varied as direct government expenditure, independent social security administrations or private insurers. In addition to contributing to the achievement of universal health coverage by mobilizing and channeling funds, governments play a role in structuring the conditions for gaining access to health care through such measures as mandatory enrollment with insurance funds or subsidizing health care providers to serve their citizens. The prominence of public policy in achieving universal health coverage is not an ideological position but is based on both theoretical and empirical grounds. Market failures associated with insurance markets and asymmetric information between providers and patients provide the theoretical explanation for why public policy is necessary to achieve universal health coverage. Studies of household behavior and health care providers, along with comparative health systems research, have demonstrated the advantages of public action in achieving universal health coverage. The character of government involvement varies considerably, but the prominent role of government in countries that have achieved universal health coverage is ubiquitous.

Each historical case demonstrates how critical public sector action was to achieving universal health coverage. In Sweden, the government role evolved from subsidizing sickness funds to enforcing strict regulations and later mandating participation. In Japan, too, the government role expanded beyond public health measures toward mandating health insurance participation and even directly managing a major insurance fund. In Chile, the role of government in health care was fiercely contested yet ultimately expanded through direct provision for the working class and later by mandating health insurance coverage in a mixed public-private system. In Malaysia, colonial policies prior to independence were relatively marginal compared to the concerted effort to achieve universal health coverage after independence through a system of direct public provision.

The question facing countries today is not whether the government will play a role in achieving universal health coverage but rather what form it will take. Countries aiming for universal health coverage need to choose strategies that are suited to their situation and consistent with such factors as the quality of public administration and political accountability, the scope of private medical provision and insurance, existing public health programs and policies, demographics, epidemiology and economics. The range of possibilities is quite large – publicly

provided health care can be highly centralized or decentralized; insurance mechanisms can involve a single payer or multiple funds; private insurers can be promoted within a well-regulated system or restricted to a marginal role. Regardless of the form it takes, collective social action through government appears to be the only way any country has achieved universal health coverage.

Reforms are negotiated, not designed

Third, the institutions created to provide universal health coverage are negotiated rather than designed. They are the outcomes of politics and contestation. While some of the most celebrated health reforms of the past are generally discussed as if they were implemented according to a coherent design, in actuality they emerged from pragmatic compromises or sharp struggles (see Box 1). Sometimes they are enacted as part of a process focused explicitly on health care, yet often they emerge from completely different initiatives such as those that reformed pension systems or decentralized political power. Negotiations over health care reforms are also influenced by political institutions that filter and channel interests, by public discourses that frame debates, and by contests over social legitimacy. This is why, despite the broad trend toward universal health coverage, countries still vary so much in terms of the breadth of health care coverage and its efficiency.

The cases presented above demonstrate that universal health coverage was achieved through long processes of social negotiation and contestation. In Japan and Sweden, health proposals were propelled at times by demographic changes; at other times, delayed by recessions and war. Japan's progress toward universal health coverage was also marked by contingent events: decisions to adopt elements of Germany's social health insurance system; the idiosyncrasy of creating a government-managed health insurance fund for employees in small firms; and the creation of citizen health insurance in response to rural cooperative movements. In Chile, export booms, epidemics, and military coups punctuated the process of reform. The particular features of Malaysia's system of providing universal health coverage was also uniquely influenced by its colonial past, by the political accommodations arranged between ethnic groups by the dominant party, and the particular strategy of state-led development that followed independence.

The lesson for countries striving for universal health coverage today is to design the best possible reforms while recognizing that no design is perfect and implementation is always imperfect. When assessing ideas from other countries, this requires understanding which compromises and domestic pressures may have led them to assume their particular forms. When proposing new plans, it is important to distinguish which elements are most essential from those that can be sacrificed or postponed. Once enacted, the reform process is not over. Cycles of implementation and adjustment to new circumstances will continue, posing both risks and opportunities to further progress.

Change is often incremental and long-term

Finally, a fourth commonality across these cases is that universal health coverage is achieved incrementally and over relatively long periods. In systems characterized by health insurance mechanisms, the incrementalism is evident in who is covered. Different population subgroups tend to be incorporated gradually, sometimes beginning with employees of large firms and then small firms, followed by rural workers, the self-employed, and eventually the unemployed and the indigent. In systems characterized by direct public provision, incrementalism may be evident in expansion of health care facilities to new geographical areas, often starting with urban areas and eventually reaching rural communities, or increases in the capacity of health care services to attend more people so that eventually no one is turned away. The range of health care services that are provided also tends to grow incrementally. In many countries, initial attention to public health measures and hospital care are eventually expanded to include outpatient services and preventive care. While some countries manage to move more quickly than others, the achievement of universal health coverage is never a single event or quick undertaking.

The incremental character of universal health coverage is also apparent in the cases presented here. Initial legislation in Chile, Sweden and Japan envisioned access to health care through a system of employment-based insurance. In each case, the coverage expanded to new population groups largely on the basis of their occupational categories: formal sector employees, informal workers, self-employed, farmers, homemakers or indigent. Access was also extended by reaching people on the basis of where they live. Japan followed this route with its Community Health Insurance schemes managed by municipalities. Malaysia and Chile expanded health care to underserved populations in rural areas through direct government provision in the 1950s and 1960s.

When countries have opportunities to make major advances toward universalizing health coverage, there is no reason to hesitate. But in periods when resistance is strong or resources are limited, small steps can eventually yield substantial gains. Incremental approaches can also provide useful learning about the kinds of approaches and institutions that are appropriate to a specific context.

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No single path guarantees arrival at universal health coverage. No particular political coalition or institutional design will necessarily work for any particular country. Rather, individuals and organizations can look at the commonalities in these case studies and ask how they are manifest in their own countries. Who are the advocates for achieving universal health coverage? What existing institutions can be extended or adapted to expand coverage? What is the debate concerning the role of government and public financing? What specific features and idiosyncrasies

of a country's political system, social composition, epidemiological profile, or economy might favor or hinder progress toward universal coverage? The answers to these questions can inform strategies and choices, though they cannot determine success.

Imitation with adaptation is a good strategy. It allows countries to learn from the successes and mistakes of other countries. But imitation with adaptation will be more successful if it is done with an awareness of differences in context and if the models being imitated are clearly perceived. Compulsory insurance models based on employment will function differently depending on the structure of the economy and the share of formal employment. Geographical forms of administration will operate differently depending on whether governments are strongly centralized or federated and whether settlement patterns are dense or dispersed. Being alert to these kinds of contextual differences can help identify models that are more appropriate to a given country or suggest modifications needed to improve its chances of success.

The overall context for countries trying to achieve universal health coverage today is quite different from the contexts faced by Sweden, Japan, Chile and Malaysia in the past. These differences do not necessarily make it harder or easier to achieve universal health coverage, though they do make it a different endeavor. A wider range of medical technology is available today than when these four countries were achieving significant expansions of coverage. Medical advances increase the demand for services that did not even exist a few decades ago, probably making it more difficult to universalize access to services. However, medical advances have also reduced the costs of many services, making universal access more attainable. Epidemiological trends have raised hurdles to achieving universal health coverage, as with the emergence of HIV/AIDS and increasing risk factors for cardiovascular illness. Yet, general health conditions have improved immensely in most countries, effectively easing the burden on health systems. Though Chile and Malaysia attained universal coverage later than Sweden and Japan, they have reached comparable levels of population health with lower income levels and by spending smaller shares of their income on health services. If some factors for late starters make it more difficult to progress, other factors may facilitate the achievement of universal health coverage. Thus, generalizations about the ease or difficulty of achieving universal health coverage today are not helpful and the true measure of any particular country's challenge is more apparent when a historical perspective informs a realistic vision of what can be attained in the particular context and time frame.

Taking a moment to step out of the fine details of policy debates, gain perspective on the intermediate levels of institutional reforms and return to the broadest levels of historical trends reveals a picture in which most countries are making substantial progress toward universalizing health coverage in diverse contexts, with varied motivations and multiple strategies. It shows that resources for reaching universal

health coverage – in terms of ideas and models, institutions and social pressures – are available in most countries, ready to be mobilized when opportunities arise. A full appreciation of the historical record in other countries can help identify these resources and alert reformers to factors that can hinder or facilitate their success.

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