A Proposed Framework for Understanding the Forces behind Legislation of Universal Health Insurance—Lessons from Ten Countries

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Objective. To understand the forces propelling countries to legislate universal health insurance.

Data Source/Study Design. Descriptive review and exploratory synthesis of historic data on economic, geographic, socio-demographic, and political factors.

Data Extraction Methods. We searched under “insurance, health” on MEDLINE and Google Scholar, and we reviewed relevant books and articles via a snowball approach.

Principal Findings. Ten countries with universal health insurance were studied. For the five countries that passed final universal insurance laws prior to 1958, we found that two forces of “historical context” (i.e., social solidarity and historic patterns), one “ongoing dynamic force” (political pressures), and “one uniqueness of the moment” force (legislative permissiveness) played a major role. For the five countries that passed final legislation between 1967 and 2010, the predominant factors were two “ongoing dynamic forces” (economic pressures and political pressures) and one “uniqueness of the moment” force (leadership). In general, countries in the former group made steady progress, whereas those in the latter group progressed in abrupt leaps.

Conclusions. The lessons of more recent successes—almost all of which were achieved via abrupt leaps—strongly indicate the importance of leadership in taking advantage of generalized economic and political pressures to achieve universal health insurance.

Key Words. Comparative health systems, international health, health care financing, insurance, premiums, health policy, politics, law, regulation

The forces propelling countries to legislate universal health insurance for their citizens are complex. Comparative studies of universal health insurance programs around the globe so far have focused on patient outcomes, health care

spending, or systems reform (Cutler and Johnson 2004; Cutler et al. 2003; Davis 2008; Davis et al. 2007; Fuchs 1991; Reinhardt 2008; Reinhardt, Hussey, and Anderson 2004), but have not focused on how universal health insurance programs began. There is a body of literature on the history of social health insurance, with a significant number of works on Germany's long history of it (Bärnighausen and Sauerborn 2002; Saltman and Dubois 2004). However, few studies have comprehensively reviewed all universal health care systems. Although it is challenging to synthesize disparate historic sources to form an accurate account of such histories, understanding the forces shaping the establishment of universal health insurance programs is crucial to facilitate the continued spread of such programs. The purpose of this exploratory study is to examine two related questions: What are the specific pathways that individual countries have taken to establish their universal health insurance systems? What are the forces that drove governments to make universal health insurance a legislative priority at a particular moment in time?

METHODS

Country Selection

We examined industrialized countries whose health insurance systems were well established, widely critiqued, and in some measure comparable. These countries are Australia, Canada, Germany, Japan, the Netherlands, Singapore, Sweden, Taiwan, the United Kingdom, and the United States.

Search Strategy and Selection Criteria

We began by searching for "insurance, health" on MEDLINE. We then expanded this search to a wider variety of keywords (e.g., universal coverage,

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access, social, etc.) on both MEDLINE and Google Scholar. We continued via a snowball technique, looking for additional source material in the references and notes sections of articles and books that we thought were particularly relevant to the study. We ultimately selected literature for inclusion through a team-based, implicit review process.

Universal health insurance in this study was defined as “secure access to adequate health care for all at an affordable price” (Carrin and James 2004). We defined the year of universal health insurance as the year that each country passed legislation directly resulting in an increase in the proportion of people insured (in public or private plans) to at least 90 percent of the population. This definition was necessary because some countries passed early health insurance legislation, but then took decades to achieve universality via subsequent laws; others passed a law and achieved universal coverage within just a few years.

Although it could be argued that the definition’s “secure access... for all” should have a higher or lower cutoff (e.g., 85 or 95 percent), we considered the U.S.’s 83 percent coverage prior to 2010 as a low mark needing improvement and Taiwan’s 95 percent immediately after its National Health Insurance implementation as a high target. Therefore, we picked 90 percent as a reasonable goal. In addition, though countries could push the majority of people to participate, it was often the case that enrolling the last 10 percent of the population was a very lengthy, difficult process. Insurance was often deemed “universal” when the legislatures stated their intent to legislate coverage for everyone, but before all citizens were actually participating in the plan. Moreover, we defined “adequate health care” as the breadth of health care services available without considering the quality of care, which is a relatively new concept for which comparative data have only recently begun to emerge (Schoen et al. 2006; Davis et al. 2007).

Analysis of Quantitative Data

We began by considering a number of economic, geographic, demographic, and social factors that might facilitate the passage of universal health insurance legislation or, conversely, function as a barrier. Economic factors included the gross domestic product (GDP) per capita of each country from the year (or very nearly the year) of passage of universal health insurance and the change in GDP per capita during each of the 2 years before legislation. Geographic and demographic factors included geographic area, population size, and population density as they may affect health care financing and

delivery of care. Social factors included the Gini coefficient and ethnolinguistic fractionalization (ELF). The Gini coefficient is a measure of income inequity across a society and ranges from 0 to 1, with higher scores indicating more inequity (Atkinson 1970). ELF is “the probability that two randomly selected persons from one country will not speak the same language” (Taylor and Hudson 1972; Burkhart 1997); it is measured on a scale of 0–1, with 0 being the least heterogeneous and 1 the most.

Analysis of Qualitative Data

In the qualitative part of our analysis, we examined descriptive data from published narratives of each country’s path to universal health insurance. We identified and tracked three pairs of forces: (1) those that were grounded in the character and history of the people—the “historical context,” (2) “ongoing dynamic forces” that emerged 1–5 years prior to passage of the legislation, and (3) those that were specific to the moment at which the legislation became law—the “uniqueness of the moment.”

The forces of historic context included (1) each country’s level of social solidarity over time, where solidarity is defined as the “fact or quality, on the part of communities, etc., of being perfectly united or at one in some respect” (Oxford English Dictionary 2009) and (2) the history of specific events that shaped the country and long-term patterns regarding the granting of social benefits by the government. The ongoing dynamic forces included (3) the economic pressures and (4) the political pressures occurring around the time during which a universal plan was under debate. The forces of the uniqueness of the moment included (5) who, if anyone, provided leadership in the effort to attain universal health insurance, and (6) the legislative permissiveness of each country’s government at the time that universal health insurance legislation was being discussed.

The organization of the forces into pairs allowed us to be historically comprehensive when analyzing the different countries’ histories; that is, the historic context pair covers long-term history, the ongoing dynamic forces pair covers medium-term history, and the uniqueness of the moment pair covers short-term history. However, the forces were not necessarily mutually exclusive and at times even overlapped and built upon each other.

Representing Descriptive Data in Evidence Tables

To facilitate comparisons between countries, we gathered narrative evidence of each country's path toward universal health insurance and organized data into tables according to the six forces listed above. This allowed us to compare and evaluate the relative strength of forces that shaped each country's pathway. We also scored our findings on each of the six forces using a three-point Likert scale. A score of "low" (L) indicated that a force was noncontributory or a marginal promoting factor; "medium" (M) indicated that a force was a moderate promoting factor; and "high" (H) indicated that a force was a strong promoting factor.

We recognize that data are subject to different interpretations; therefore, when possible, we triangulated evidence from multiple sources. For example, economic forces were evaluated by a review of both quantitative data (e.g., GDP, etc.) and narrative descriptions. The data analysis team met weekly to discuss findings from the literature. Scores were assigned through a consensus process in which team members suggested ratings for a country and then defended those ratings during team meetings. As new evidence emerged from the continuing literature review, ratings were adjusted. This process was repeated several times throughout a one-and-a-half-year study period (2009–2010). To ensure that ratings for each force were assigned consistently across all 10 countries, we checked each country's rating against the ratings of the other nine countries studied. Thus, we ensured that the force was indeed stronger in countries rated "high" compared with countries rated "medium" or "low." Finally, we created a table sorted by year of legislation to see if any patterns emerged in terms of forces at work.

RESULTS

We found that there was substantial variation in economic, geographic, and socio-demographic factors across countries at the time that universal health insurance was legislated (Easterly and Levine 1997; La Porta et al. 1998; Maddison 2003; U.S. Department of Commerce Bureau of Economic Analysis 2008; UNU-WIDER 2008). There was also substantial variation among the six forces impacting the legislation of universal health insurance across countries (Table 1). However, several general patterns emerged as we reviewed these quantitative and qualitative data (see Table 1 for country force ratings compared, Table 2 for quantitative factors, and Appendices SA1, SA2,

Table 1: Six Forces Compared across Countries by Year

Country by Year Universal Insurance Achieved	Year	Historical Context		Ongoing Dynamic Forces		Uniqueness of the Moment Forces	
		Social Solidarity	Historical Patterns	Economic Pressures	Political Pressures	Leadership	Legislative Permissiveness
SET A: Universal Health Insurance achieved in or before 1958							
UK	1946	H	H	L	H	H	H
Sweden	1946	H	M	L	M	M	H
Germany	1953	H	H	L	H	L	L
Canada	1957	M	M	L	H	H	H
Japan	1958	M	H	L	M	M	H
SET B: Universal Health Insurance achieved in or after 1967							
The Netherlands	1967	M	L	H	L	L	M
Australia	1974	L	M	H	H	H	L
Singapore	1983	M	M	H	M	H	H
Taiwan	1994	L	L	M	H	H	M
U.S.	2010	L	M	H	H	H	M
Set A ≤ 1958 Median score		H	H	L	H	M	H
Set B ≥ 1967 Median score		L	M	H	H	H	M

Note. H (high) indicates that a force was a strong promoting factor; M (medium) indicates that a force was a moderate promoting factor; L (low) indicates that a force was a noncontributory or marginal promoting factor.

Table 2: Quantitative Factors for Legislation of Universal Health Insurance

Country (Listed by Year of Legislation) [†]	Economic Data [*]			Geographic and Demographic Data [*]			Social Data	
	GDP per Capita (Normalized to Thousands of 1990 Geary-Khamis Dollars)	Avg. Growth of GDP per Capita Prior 2 Years (%)	Geographic Size (Thousands of Square Miles)	Population (Millions)	Population Density (Persons Per Square Mile)	Ethnolinguistic Fractionalization (ELF) [‡]	Gini Coefficient [§]	
United Kingdom (1946)	6.7	-4.5	94.0 (2010)	49.2	524	0.11 (1960)	0.42 (1949)	
Sweden (1946)	6.1	1.9	173.7 (2010)	6.7	39	0.07 (1960)	0.48 (1945)	
Germany (1953) [¶]	4.9	8.3	137.9 (2010)	69.6	505	0.04 (1960)	0.40 (1950)	
Canada (1957)	8.6	6.0	3,855.1 (2010)	17.0	4	0.38 (1960)	0.32	
Japan (1958)	3.3	6.4	145.9 (2010)	92.4	633	0.01 (1960)	0.36 (1959)	
The Netherlands (1967)	10.3	2.6	16.0 (2010)	12.6	785	0.06 (1960)	0.36	
Australia (1974)	13.0	2.4	2,970.0 (2010)	13.6	5	0.11 (1960)	0.29	
Singapore (1983)	10.3	3.2	0.27 (2010)	2.7	10,055	0.32 (1960)	0.42	

continued

Table 2. Continued

Country (Listed by Year of Legislation) [†]	Economic Data [*]		Geographic and Demographic Data [*]			Social Data	
	GDP per Capita (Normalized to Thousands of 1990 International Geary-Khamis Dollars)	Avg. Growth of GDP per Capita Prior 2 Years (%)	Geographic Size (Thousands of Square Miles)	Population (Millions)	Population Density (Persons Per Square Mile)	Ethnolinguistic Fractionalization (ELF) [‡]	Gini Coefficient [§]
Taiwan (1994)	12.6	6.2	13.9 (2010)	21.1	1,518	0.26 (1960)	0.32
U.S. (2010)	30.1 (2009)	-2.0	3,794.1 (2010)	307.2 (2009)	81.0 (2009)	0.21 (1960)	0.47 (2009)
World average						0.33 (1960)	

^{*}Economic, Geographic, and Demographic data references: (Maddison 2003, 2010; Central Intelligence Agency 2010; International Monetary Fund 2010). Note: geographic size of countries (with the exception of Germany; see [†]) has not substantially changed from year of universal health insurance to 2010.

[†]Unless otherwise specified (next to a point of data), data are from year of universal health insurance legislation as listed in the first column. We defined the year of universal health insurance legislation as the year that each country passed legislation which directly resulted in an increase in the portion of people insured to at least 90 percent of the population. The insurance may not be comprehensive in scope. Some of the programs we studied only insured hospital-based care. For instance, 1957 is the year used for Canada, because in that year the country passed legislation creating universal health insurance for in-patient care. We recognize that universal coverage for doctors' visits did not become law until the following decade.

[‡]ELF scores range from zero to 1.0. High ELF may be more likely to lead to instability, poor quality institutions, badly designed economic policy, and disappointing economic performance (La Porta et al. 1998; Alesina et al. 2003). Countries with low ELF may be more likely to reach consensus and successfully implement a universal health program.

[§]Gini coefficient scores range from 0 to 1. The Netherlands and Germany data are based on disposable income; all others are gross income (UNU-WIDER 2008; DeNavas-Walt, Proctor, and Smith 2010).

^{*}Though all data for Germany (except for geographic size) is from the Cold War era, when Germany was split into East and West, all data (except for the ELF value) apply to the unified country; that is, although the ELF value is for West Germany only, all other data are for a combined East and West Germany. The data reflect Germany's modern borders. Though the universal health care legislation was passed by West Germany, Germany's long history with social health insurance and eventual reunification dictates consideration of economic, geographic, demographic, and social data for the entire country.

and SA3 for detailed country-specific narrative data). Overall, there appeared to be a division of the 10 countries into two groups based on the major forces driving the legislation (Table 1). The first group is composed of the five countries that legislated universal health insurance in 1958 or prior. The second group is composed of the five countries that legislated it in 1967 or later. In the first group, we found that the predominant forces driving legislation were the two forces of historic context (social solidarity and historic patterns), one ongoing dynamic force (political pressures), and one uniqueness of the moment force (legislative permissiveness). For the second group, the predominant forces driving legislation were the two ongoing dynamic forces (economic pressures and political pressures) and one uniqueness of the moment force (leadership).

Among economic factors, GDP per capita, normalized to 1990 Geary-Khamis international dollars (Maddison 2003, 2008; U.S. Census Bureau 2007; U.S. Department of Commerce Bureau of Economic Analysis 2008), ranged from a low of approximately \$3,300 in Japan in 1958 to a high of \$30,134 in the United States in 2009 (See Table 2). The average growth in GDP per capita during the 2 years prior to the legislation of universal health insurance ranged from a low of negative 4.5 percent in the United Kingdom (1946) to a high of positive 8.3 percent in Germany (1953). We found a wide distribution of economic circumstances showing that both economic upturns and downturns can create pressure for universal health insurance to be enacted (Table 2).

Such economic circumstances can impact and shape the forces of both economic and political pressures. These pressures can stem from general economic conditions (measured by GDP), increased health care costs, specific existing funding provisions, and other sources. For example, in the United States, the rapid increase in health care costs, coupled with the spreading financial crisis of 2007–2010, led to severe job losses and a growing number of American workers without health insurance through employment. This served as one of the factors that built support for the Patient Protection and Affordable Care Act of 2010. On the other hand, in Australia, Prime Minister Gough Whitlam exerted economic and political pressure when he threatened to withhold federal funding from public hospitals if states refused to sign the required hospital contracts for the Medibank program.

In terms of geographic and demographic factors, geographic area, population size, and population density varied widely between countries. Geographic area ranged from 270 square miles (Singapore) to 3.9 million square miles (Canada), with a median of 141,900 square miles. Germany (137,900

square miles) and Japan (145,900 square miles) were closest to the median geographic area. Population size ranged from 2.7 million (Singapore) to 307.2 million (U.S.), with a median of 19.1 million. Canada (17 million) and Taiwan (21.1 million) were closest to the median. Population density ranged from four persons per square mile (Canada) to 10,055 persons per square mile (Singapore), with a median of 514.5 persons per square mile. Germany (505 persons per square mile) and the United Kingdom (524 persons per square mile) were closest to the median (Table 2).

There was also a range of social factors among the countries. The Gini coefficient ranged between 0.29 (Australia) and 0.48 (Sweden), with a median of 0.38. Japan and the Netherlands (both 0.36) and Germany (0.40) were closest to the median (UNU-WIDER 2008). Ethnolinguistic fractionalization ranged between 0.01 (Japan) and 0.38 (Canada). Both Australia and the United Kingdom were at the median value of 0.11 (Easterly and Levine 1997; La Porta et al. 1998).

Although relatively low ELF scores were somewhat consistent with relatively high levels of social solidarity, there was little to no correlation between inequity (measured via the Gini coefficient) and social solidarity. Sweden, which had a relatively low ELF score of 0.07 and a relatively high Gini coefficient of 0.48 (in 1945 post WWII), exhibited very significant social solidarity. On the other hand, Australia, which had a moderate ELF score of 0.11 and a very low Gini coefficient of 0.29, exhibited very little social solidarity. In these two cases, as with the other countries, historic forces ultimately shaped social solidarity as much as, if not more than, quantitative social measures such as ELF and the Gini coefficient. Sweden's social solidarity was shaped by long-standing village democratic traditions (known as a "thing"), which in turn informed the push toward universal health insurance by the rising Social Democratic Party beginning in the 1920s. Australia's social solidarity, on the other hand, was dominated by its historic roots as a British penal colony and long-time status as a frontier.

When we examined the legislative permissiveness of each country's system of government, we found a predominance of countries with a parliamentary system (eight of 10 countries), in which one political party (or a coalition government) controlled both the legislative and executive functions of government. In Taiwan and the United States (non-parliamentary systems where the executive branch holds veto power), the same party controlled both the legislative and executive branches at the time of universal health insurance legislation.

We also found strong individual and party leadership at play. For example, Australia's Prime Minister Whitlam dissolved the parliament to outmaneuver the opposition (Gray 1996). President Lee Teng-Hui of Taiwan ordered his deputy premier to camp out in the legislature until the proposed legislation was approved. In the United States, after the Senate had passed a version of the bill, the Senate Democrats surprisingly lost their 60 vote super majority due to a special election. The leadership of President Barack Obama and Speaker of the House Nancy Pelosi was essential in the bill's passage by the House Democrats despite strong Republican opposition. This included placating and arm-twisting a handful of lawmakers on issues such as tighter control on insurance coverage for abortion, the availability of a public insurance option, and tax on "Cadillac" insurance plans (Goodridge and Arnquist 2009). The House version of the bill was passed in the Senate via the use of the parliamentary tool known as "reconciliation," which limits debate to 20 hours and requires only 51 votes (rather than the usual 60) to defeat a filibuster (Iglehart 2010). These exceptional political maneuvers by strong-willed leaders ultimately secured the passage of the legislation for universal coverage.

Countries also varied in terms of how long it took them to achieve universal health insurance. However, there appeared to be two notable types of pathways: steady progress and abrupt leaps. Germany is a near perfect example of a long steady pathway to universal coverage. Following the first comprehensive national health insurance law under Bismarck in 1883, coverage expanded gradually via a series of laws; it took 40 years to cover 60 percent of the population (Bärnighausen and Sauerborn 2002). It was only in 1953 that legislation effectively made the program universal in scope. On the other hand, Taiwan is a near perfect example of an abrupt leap into universal health insurance. With the legislation of 1994, Taiwan increased access to insurance by almost 50 percentage points to over 95 percent of the population within 1 year, prior to an impending presidential election (Chiang 1997; Cheng 2003).

However, these two pathways were not entirely mutually exclusive and there is no absolute standard; the remaining countries fell between Germany and Taiwan, generally leaning toward one side. For instance, the United Kingdom made an abrupt leap toward universal health insurance after World War II (Flora and Heidenheimer 2003), just a few years after the Beveridge Report. However, this leap built on the population's gradually increasing social solidarity during the first half of the 20th century, prompted mostly by the two World Wars. On the other hand, the recent

U.S. legislation, which will increase coverage from 83 to 95 percent of legal U.S. residents, is built on prior federal legislation (i.e., Medicare, Medicaid, and the State Children's Health Insurance Program) from throughout the 20th century. However, exceeding the 90 percent threshold only happened after an extraordinary push by political leaders who took advantage of legislative permissiveness.

DISCUSSION

Our descriptive synthesis has examined the specific pathways taken by 10 selected countries to establish universal health insurance, and our exploratory analysis has identified forces and conditions that helped countries initiate a universal health insurance program. We identified six different forces that interacted and built on each other in a wide variety of ways based on economic, geographic, demographic, and social factors, to push the 10 countries toward universal health insurance. This is important because the recognition of a variety of forces means that there is more than one way to achieve universal health insurance. For instance, although social solidarity has often been thought of as a prerequisite for achieving universal health insurance, our analyses showed that this was not always a necessary condition. We also found that universal health insurance can be successfully legislated in times of economic prosperity, as well as times of economic downturn. In fact, one of the most comprehensive health systems in the world, the National Health Service (NHS) of the United Kingdom, was created in a postwar environment when the GDP per capita growth rate averaged -4.5 percent in the preceding 2 years. Similarly, the United States passed its legislation in the middle of an economic crisis. Such economic downturns and resulting job losses may make disparities in the distribution of resources more visible and the desire to address them more pressing.

Countries of all geographic sizes with both large and small populations were able to enact universal health insurance. Large countries with much diversity may require regionally administered health insurance under a national umbrella. The ELF scores of the countries studied were relatively low compared with the world average (0.33), indicating that the population of each country was relatively homogeneous in terms of culture and language. However, it is interesting to note that Canada's ELF score was the highest (0.38) of any country we studied and above the world average, indicating that even with significant differences in language and culture across the population, universal

health insurance can be achieved. At 3.9 million square miles, Canada also had the largest geographic area and lowest population density of the countries we examined. Canada was influenced by the U.K.'s NHS and ended up with universal health insurance that is nationwide but organized and administered at the provincial level. Each province has a single-payer system, and although the federal government contributes to the cost of health care, provinces have the right to organize health care in ways that respond to their particular needs and traditions, provided the health plans fulfill five federal requirements (Mai-ori 1998).

We identified two distinct pathways to universal health insurance: steady progress and abrupt leaps. It is worth noting that compared with countries that passed universal health insurance laws earlier, the countries that passed the legislation most recently tended to do so through abrupt leaps, with few exceptions. Their shorter histories with universal health insurance make them ideal examples for other countries currently attempting to pass legislation that lack the long history needed for a steady pathway.

Our study is limited in several ways. First, because we only draw lessons from developed countries with universal health insurance, our findings may not be generalizable to low and middle resource countries. However, because of the numerous intertwined socio-political and cultural factors at play, it is nearly impossible to have valid control cases for the countries studied. Second, some of the evidence from the literature, particularly the descriptive evidence, may be open to other interpretations. We attempted to balance the use of both quantitative and qualitative data and triangulate sources when possible. Third, we were unable to locate comparative data across countries for certain groups that are believed by many to have influenced universal health insurance programs (Goodridge and Arnquist 2009). Chief among these are labor, professional, and industrial/business organizations (e.g., physician associations), whose contributions to legislation in this area deserve further study. Finally, we are investigating the legislation retrospectively across roughly one century. Our estimation of the relative strength of forces may be flawed.

Despite these limitations, the forces described in our model can serve as a starting point for discussions that may ultimately shape how and when a particular country establishes universal health insurance. There is no one specific combination of forces that is the golden ticket to universal health insurance, but more recent successes (e.g., Australia, Singapore, Taiwan, and the United States) strongly indicate a need for leadership to match generalized economic and political pressures to achieve universal health insurance. We invite other

researchers to evaluate, modify, and contribute to the framework of forces proposed here.

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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of this article:

Appendix SA1: Author Matrix.

Appendix SA1: Evidence Table for Historical Context by Country.

Appendix SA2: Evidence Table for Ongoing Dynamic Forces by Country.

Appendix SA3: Evidence Table for Uniqueness of the Moment Forces by Country.

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