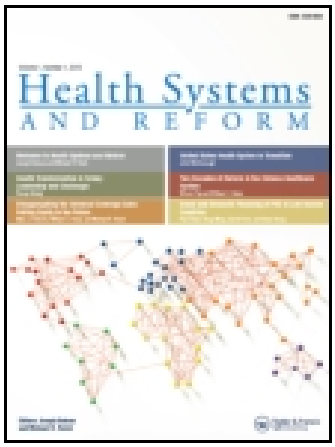

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The Long Road to Universal Health Coverage: Historical Analysis of Early Decisions in Germany, the United Kingdom, and the United States

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CONTENTS

Abstract—Over the last several years the once-obscure idea of Universal Health Coverage (UHC) has blossomed into a movement embraced by leading authorities in global health. Both the World Bank and the World Health Organization have designated UHC as a core objective, but many details of this concept have yet to be specified, including the political economy process by which countries can increase financial protection to move toward UHC. Using an analysis of historical literature, this paper examines the development of the two common mechanisms for providing financial risk protection: national social health insurance as developed in Germany, and general tax revenue as used by the United Kingdom to launch the National Health Service. Because of the prominence of organized labor groups in demanding increased financial protection in these two cases, the paper then considers a comparison case from the Progressive Era in the United States where labor groups were far less engaged. Based on the categories used in the historical literature, I develop a framework for comparing the cases in six areas: related legal and cultural heritage; macro-historical conditions; demand for increased social protection; politics of expanding government role in health; financing and delivery systems; and UHC-related outcomes. The paper concludes with some reflections from this analysis for low- and middle-income countries attempting to move toward UHC.

INTRODUCTION

Over the last several years the once-obscure idea of Universal Health Coverage (UHC) has blossomed into a movement embraced by leading authorities in global health. Both the World Bank[1] and the World Health Organization[2] have designated UHC as a core objective. Further, UHC is a leading candidate as one of the United Nation's post-2015 goals.[3] One possible explanation for the appeal of this concept is its consistency with humanitarian views widely held by practitioners of public health, namely that governments should

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assure as many services as equitably as possible for the greatest proportion of citizens. In keeping with this explanation, normative and ethical justifications have been invoked by leaders of opinions and institutions as motivation for the pursuit of UHC.[1,4,5]

However, the ascendance of UHC on the global health agenda and the general acceptance of a broad definition have not been accompanied by a clarification of many conceptual and practical issues that are important for actually making progress toward UHC. Thus far the discussion of how countries should pursue UHC has been conducted almost exclusively in technical terms, with particular emphasis on financing mechanisms.[6-13] This includes user fees, which have been discussed critically[14,15] and denounced by the World Bank's president as "unjust and unnecessary."[16] The centrality of financing suggests that many analysts see the difficulty of providing financial risk protection as the most important barrier to the advancement of UHC by low- and middle-income countries.

Even though the term "Universal Health Coverage" is only newly prominent in the health and medical literature,[a] there is historical precedent for moving toward its objectives if those are taken to be the expansion of social protection in health, for instance measures to limit the financial risks of ill health. This observation inspires the broad questions that guide this paper. First, when and under what political economy conditions have countries made—or considered making—progress toward the goals of UHC in the past? Second, what do past experiences suggest for low- and middle-income countries and for the donor agencies that assist them?

To operationalize these questions, this paper begins by discussing the selection of cases based on the two common mechanisms for providing financial risk protection: national social health insurance as developed in Germany, and general tax revenue as used by the United Kingdom to launch the National Health Service, and a comparison case from the United States to examine the role of labor groups more closely. Second, it uses a review of historical literature to examine these episodes from a political economy perspective to reveal some of the interest groups, political dynamics, and context of the process. Third, based on the categories used by historians in the literature I reviewed, I develop a framework for comparing the cases in six areas: related legal and cultural heritage; macro-historical conditions; demand for increased social protection; politics of expanding government role in health; financing and delivery systems; and UHC-related outcomes. Fourth, I conclude with some reflections for countries trying to move toward UHC now.

METHODS FOR HISTORICAL CASE ANALYSIS

This paper contends that historical cases can provide ideas useful for countries considering how to make progress toward UHC. There are three points of logic that underlie the argument. First, it equates the new term "UHC" with government social protection in health, meaning that it considers movement toward UHC as an expansion of social protection in health. This permits inferences about UHC from cases that pre-date the term.

Second, it contends that past decisions around social protections in health share enough similarities with current decisions to have some relevance. Choosing cases from long ago carries liabilities and benefits. An obvious liability is that the passage of time is bound to change many contextual factors for which it would be hard to account. However, historical perspective allows confidence in interpreting the significance of past events. The strength of inferences gathered from this analysis rests on the assumption that many general features of the cases are shared with current settings. These include the premises that the past and the present are reasonably similar in ways such as: governance is based on a social contract that includes government responsiveness to citizen demand, the sources of political power, the sources of economic power, the links between solidarity and willingness to redistribute, and a concept that responsibilities can lie on a spectrum of public and private.

Third, given that there are a great many possible historical cases from which to choose, explaining how they are chosen is important for establishing their relevance to other settings. Often, policy oriented research uses single case studies to explore an issue or event. Typically, this approach is invoked under names such as "best practices," "lessons learned," and "case study." These can have great value as illustrative studies, for instance the *Millions Saved* cases prepared by the Center for Global Development.[17] Although choosing cases because they show a successful outcome permits consideration of shared characteristics, it limits causal inference.[18] To help overcome some of the limitations common in comparative historical research and historical institutionalism scholarship, this paper employs explicit strategies for case selection and analysis.[19]

The cases considered in this study were selected on the following basis. Hsiao (2003) identifies social health insurance and general revenue as the two common mechanisms for providing financial risk protection in health systems.[20] The first examples of these as national policies were in Germany and the United Kingdom, respectively. To investigate the origins of these policies I consulted historical literature identified by searching in the Historical Abstracts, JSTOR,

and PubMed databases. I obtained books and articles that discussed aspects of the politics, economics, or history of the adoption of national social health insurance in Germany and the launch of the National Health Service in the UK.

To structure a comparison of the cases, I developed a framework based on the categories of analysis used implicitly or explicitly in the historical literature I reviewed. I included a description of the UHC-related outcome and a brief encapsulation of circumstances in five areas: the cultural and legal heritage of social protection, the macro-historical conditions, labor groups and the demand for increased social protection, the politics of expanding the government role in health care, and the financing and delivery systems that were used. (See **Table 1**.)

The historians whose accounts I analyzed gave prominence to the role of labor groups in demanding the social protections adopted nationally by Germany and the UK. To further investigate this factor, I added a third case to the comparison. I searched for a case that had as many similarities as possible to the German and UK cases, except for the role of labor groups. The United States was chosen because there were many similarities in cultural heritage, contemporary and current income, and in historic institutions, but the demand for increased social protection in the US came largely from reformers rather than labor groups.

The time periods of interest in Germany and the UK are identified by the decisions to expand social protection in health through national social health insurance and a national health service funded by general tax revenues, respectively. But it is not immediately obvious which time period in US history is most relevant and there is no easily identifiable turning point similar to those of the other countries I examine. In fact, there have been several waves of interest in increased social protection in US history, including in the Progressive Era of the 1880s to the 1920s, during the Great Depression, in the 1960s, in the early 1990s, and in the present. Of these, I argue that the Progressive Era was the period most similar to those of interest in Germany and the UK. This proposal rests on several points. First, the Progressive Era saw the expansion of public health authority in many dimensions, such as with the Food and Drug Act of 1906, one of the key developments leading to the Food and Drug Administration. Second, the Progressive Era's reforms resulted from the social disruption caused by industrialization in a dynamic very similar to that present in Germany leading up to Bismarck's 1883 legislation, and in the UK in the years before WWI, when the government legislated many important social protections for workers. Third, in this period, many US workers relied on industrial sickness funds—very similar to those of Germany—for insurance against health calamities. By the Great Depression, the importance of these sickness funds was diminishing rapidly because of competition by modern insurance companies employing actuarial methods. Fifth, Progressive Era reformers were in close contact with their European counterparts and were attempting to advance similar ideas in response to similar social changes using similar methods. In subsequent periods, some of these similarities were also present, but the US's institutions developed very differently from those in most of Europe, particularly with the political mobilization of the American Medical Association and rise of the modern insurance industry in the 1930s.[21-26]

Limitations

There are at least four important limitations in the approach I followed. First, key episodes may not have been identified in the literature I reviewed. Second, I was limited by my lack of access to primary sources. The materials I obtained offered interpretations by other scholars of how ideas developed and how political pressures acted within nations. Although this work can be assessed, it is still done at a level removed from the primary source documents. Third, conceptual uncertainty about what UHC means in the present leaves open for debate whether these past examples constitute something similar. Fourth, contextual differences between the historical events reviewed here and settings where UHC may be considered in the present restricts the relevance of these to a general level.

THREE DECISIONS ON SOCIAL PROTECTION

To discover how social protection has evolved, I examined important episodes in its history, selected as discussed above. I begin with the first national health insurance scheme—a groundbreaking step in social protection—established in Germany under Otto von Bismarck in 1883. Then, I show how and why the United Kingdom established its National Health Service after WWII. Turning last to the United States, I examine why the government did not expand social protections during the Progressive Era.

Bismarck and Germany's Social Health Insurance System, 1883

The 1883 launch of Germany's Social Health Insurance (SHI) system is a landmark in state-citizen relations that I examine in two parts. First, I explain the SHI system, and second, I investigate the historical political and economic context in which this innovation emerged. Why did Bismarck

Country	Related Legal, Cultural Heritage	Macro-Historical Conditions	Labor Groups and the Demand for Increased Social Protection	Politics of Expanding Government Role in Health	Financing and Delivery Systems	UHC-Related Outcome
Germany	Worker protections went back hundreds of years. State role in health similar to feudal tradition. Sickness funds offered insurance by employment type or location	National unification, industrialization, long-run economic growth	Industrialization increased worker mobility and occupational dangers, both of which reduced effectiveness of existing protections. Industrial workers expressed the demand politically through support for the Social Democratic Party	Bismarck expanded SHI to draw the support of industrial workers away from the Social Democratic Party, his chief political rivals. Workers embraced government solution.	Existing mechanisms retained, expanded	1871: National Social Health Insurance adopted for some employment categories
UK	Heritage of public charity dating to Roman times, 13th century poor laws. Complex system of tax-funded urban and national benefits, many linked to labor groups	World War II, industrialization, long-run economic growth	Industrialization and war exposed gaps in hodgepodge of existing systems; war increased population solidarity. Trade unions lobbied the Treasury during the war for increased protection	The tight labor market of WWII gave workers leverage to demand more benefits and simpler system. Treasury resisted, but agreed to write a report on the matter. Population solidarity very high, NHS concept broadly supported once announced	Existing mechanisms retained, expanded—national network of government facilities created during the war, private physicians brought into NHS	1947: National Health Service launched using general tax financing
USA	Strong tradition of individual rights, responsibilities, preference for market solutions. Workers had employment based sickness funds similar to Germany's and additional private insurance options	Progressive Era reforms, extension of government role in general, industrialization, long-run economic growth	Social reformers successfully advanced anti-capitalist agenda, expanded government regulation in many areas. Advocated for government role in health care. Borrowed many ideas from German counterparts. Labor groups not engaged	Social reformers: wanted government intervention, but had little political leverage. Labor unions: preferred flexibility of private options; believed government involvement would create inefficiency, limit choice. No national momentum; a few state referenda were defeated	Existing—no change	1880–1920: No expansion of government role in health care

TABLE 1. Comparison of UHC Outcomes and Contributing Factors, Germany, UK, USA

do it, and what were the antecedents upon which the system was based?

SHI is an important model for financing health care. Under SHI, all members of a group contribute to an insurance fund that offers defined benefits. The group's members pool risk and provide a steady stream of revenue, often via a portion of their wages. As insurance schemes, SHI systems do not share a standard mechanism for delivering services, although many have affiliated provider networks or standing arrangements with nearby facilities.

Bismarck's innovation in 1883 was to establish several so-called "sickness funds" that had mandatory enrollment and defined benefits. These funds covered members nationally, but only about 10% of the German population was eligible (required) to join one. Most of those included were industrial workers, including employees at salt works, metal works, railways, shipyards, and power plants, all of whom had their own fund. Benefits included sick pay, free pharmaceuticals, death benefits, and some in-patient and out-patient services.[27]

Under Bismarck's leadership, the German government took a fundamental step toward greater social protection in health. Its actions solidified the previously vague principle of government involvement in private health by specifying a mechanism to guarantee financing and define benefits, which would be delivered through existing public and private facilities. As shown by Bärnighausen and Sauerborn, over the course of roughly a century, this SHI system was extended piecemeal to include more and more employment categories until virtually all Germans were included. For instance, agricultural and forestry workers were enrolled in 1911, civil servants in 1914, the unemployed in 1918, non-working wives and daughters in 1919, all primary dependents in 1930, all retirees in 1941, the physically disabled in 1957, students in 1975, and artists in 1981. Over the same period, the mandatory minimum benefit package was expanded periodically.[27] Carrin and James have identified 1988—105 years after Bismarck's first sickness fund laws—as the date Germany achieved universal health coverage through this series of extensions to minimum benefit packages and expansions of the enrolled population.[28]

Why did Bismarck establish SHI, and under what conditions? Medical historian Henry Sigerist's 1943 study provides a model for understanding what political considerations motivated this transition and shows the social and institutional foundations on which it was based.[29,30] As shown by Sigerist, Bismarck's goal of establishing a system of social insurance was both a response to immediate political aims and a reflection of longstanding feudal traditions repackaged to fit within the new structure of a young nation. Historian E.P. Hennock has cast the development of the German welfare state as a response to the social needs created by industrial capitalism. It is important to consider Sigerist's political analysis within this larger economic framework.[24]

Following Sigerist's analysis, Bismarck proposed SHI as part of a strategy to weaken the fast-growing Social Democratic Party (SDP), which he viewed as a threat to his power and the monarchy under which he had united Germany. The SDP drew much of its support from Germany's industrial workers, and Bismarck knew that this constituency's primary concern was social protection. Rapid industrialization had drawn laborers from traditional agriculture into dangerous and uncertain employment, for instance in factories, mines, and railroads, where they were vulnerable to disease, accidents, and the business cycle. Bismarck's attacks on the SDP included proposing SHI to meet the primary demand of its supporters, which was for social protection.[29]

Further, Bismarck believed the state should provide social protection for the working classes. It reflected his heritage in the landed aristocracy of Prussia, where he as a feudal landlord was responsible for those who worked on his fields. Bismarck supported social protection for workers because he viewed labor unrest as a threat to the state: "The social insecurity of the worker is the real cause of their being a peril to the state," he had said publicly in 1849.[29] SHI would have also fit well with Bismarck's strong Christian faith and its emphasis on charity. A suspected hypochondriac, Bismarck may have identified personally with the workers' demands for health care as well.[31]

Bismarck's SHI system drew heavily on concepts that had long existed in the territories that formed unified Germany. Roman law held that employers were liable for the compensation of workers injured in accidents, although the burden of proof was on the workers. In 1838 Prussia passed a law placing responsibility on railroad companies unless they could prove negligence by employees or establish the cause as an "act of God." In 1871 an imperial statute expanded this standard to other industries and detailed a hodgepodge of responsibilities by occupation. Sailors were covered under all circumstances. Domestic servants were guaranteed medical services for illnesses, but their cost could be deducted from wages, for instance.[29]

In parallel, there was a centuries-old system of mutual benefit societies. These organizations—mainly guilds—were forerunners to modern unions and provided many of the same benefits, including disability payments, pensions, and support to widows. These were supported by the

contributions of a voluntary membership. But in 1854 a Prussian statute made membership compulsory and mandated employer contribution not less than half of that paid by workers. Previous to the mid-1800s, poor relief had been a matter of public charity rather than an individual right, but by the end of the feudal period there was broad middle class support for participatory government and guaranteed protections.[27,29]

Thus, many policies and mechanisms crucial to SHI predated Bismarck's 1883 Sickness Insurance Act. In fact, seven years earlier in 1876, over 850,000 citizens had insurance coverage through more than 5,000 sickness funds. Bismarck left the original structures essentially unchanged. For instance, benefit packages were not harmonized because sickness funds protested successfully to preserve their autonomy.[27,29]

The industrialization of Germany and its predecessor city-states is an essential element of this story. As noted, rapid industrial change disrupted traditional laborer support networks. And industrialization also provided the resources to facilitate and expansion of benefits and coverage. Angus Maddison's historical data show that Germany's GDP per capita grew by 50% between 1850 and the launch of SHI in 1883.[32]

THE BEVERIDGE REPORT AND THE BRITISH NATIONAL HEALTH SERVICE

The British National Health Service (NHS) was founded in 1948, designed from the beginning to offer all medically indicated services to any resident without payment at the point of service. As in Germany, the means by which health care was delivered—in this case largely by private physicians and public hospitals—pre-dated the establishment of a national health system.[33] In its moment of creation, the NHS contained innovations primarily related to its financing model. In this section I focus on these aspects of the NHS and describe the historical legacies and political forces that produced the UK's UHC system.

Government concern with poverty has an extremely long heritage in the UK. The Statute of Laborers in 1349 drew on Roman, Greek, and Palestinian concepts from antiquity and had lasting influence in its distinction of types of beggars. Most beggars were deemed a problem because they were believed able to work but were not doing so. A minority, however, were termed unemployable and thus permitted to beg on the basis of their inability to work. In this way the English government recognized a class of people who rightfully depended on public charity.[34]

For several hundred years English conceptions of poor relief continued to hinge on this distinction between those who could and could not work. By the 1700s a system had evolved where relief for the deserving poor was funded through taxes assessed primarily on households, but it was disrupted as industrialization progressed. Wealth was accumulating mostly through manufacturing, but the tax burden fell on households, many of which were doing less well in the transition. Further, the system was funded by region, meaning that poorer areas tended to have the fewest services and the greatest needs.[34,35]

Discontent among the poor and the upper classes led to a new Poor Law in 1834, which amounted to a transition from a church-centered social security system to one centered on the market economy. The comprehensive, if modest, church system was replaced by one whose protections derived from membership in smaller groups, such as trade-based associations that provided insurance. Inadequacies in coverage or the absence of coverage left many workers far worse off than they might have been a century earlier.[35] Poor nutrition, overcrowding, and unsanitary living conditions further undermined the effectiveness of the workforce. These pressures limited the already-tight labor supply and led to landmark reforms initiated by Edwin Chadwick, who had been the primary author of the new Poor Laws.[36]

Chadwick conceived of diseases and ill health as the result of specific factors, a view that became common only after the proof of the germ theory half a century later.[37] In his 1842 *Report on the Sanitary Condition of the Laboring Population in Great Britain,* Chadwick identified civil engineering, rather than medicine, as the discipline most helpful to health promotion. Proper water supply, drainage, and sewerage were paramount. Physicians could be retained as health officers who could identify problems and oversee the solutions. Chadwick advanced his views as more effective and less expensive than the alternatives. Urban waterworks and sewerage systems are his legacy.[38] This was his attempt to patch the holes in the security system created by industrialization and the new Poor Laws using technological solutions.[35]

The Public Health Act of 1848 followed from Chadwick's report. In it the national government recognized a formal role for the state in the prevention of disease for the population as a whole—meaning for all classes—even if the methods were applied only in urban areas. A period of prolonged and rapid economic growth from the 1850s almost until WWI provided resources for cities to build their sanitary infrastructure, kept unemployment low, and forestalled the need for a more comprehensive social and health security system. Freedom of the press increased over the same period, helping to foster solidarity among workers, which provided more informal and formal forms of insurance, as well.[35]

The Great War, the unstable 1920s, and the Great Depression, produced two decades of trial for these haphazard social

and health security benefit systems. First, where progress was made, as with the first statutory unemployment insurance plan in 1911, the growth in benefits did not bring many more people under coverage. Most working-class women were denied benefits, for instance. Second, the quality of medical care and medical facilities slipped well below that of other nations, creating primary problems in care and secondary problems in embarrassing international comparisons. Third, there were so many separate, narrow benefit mechanisms that it was very difficult to navigate them.[33,39]

The production demands of World War II placed labor groups in a very strong bargaining position. In 1941 trade unions petitioned the Treasury, complaining of the system's complexity and the overly numerous benefits, many of which were mutually exclusive. The trade unions wanted a simpler system that would be more comprehensive and easier to use. The Treasury obliged with increases in some benefits and a promise to investigate the matter. The resulting document became known as the Beveridge Report, after its primary author, economist William Beveridge, laid out broad principles of social protection and directly precipitated the establishment of the NHS.[33,39]

Although the Beveridge report is now known as a cornerstone of the post-war welfare state, it was created under circumstances that reflected both divided views on its author and its subject. In response to pressure from the trade unions, the Treasury had agreed to study social protection, but actually envisioned only a minor report, which it wanted to keep secret. The head of the Treasury opposed the report completely until he saw its chairmanship as a means to evict Beveridge from his ministry. Beveridge knew he was being sidelined, took the position with great reluctance, and was left to his own devices. The isolation left Beveridge free of the political and practical constraints that might have governed a consensus Treasury document. His report was an ambitious blueprint for a welfare state, although that term was not used. Benefits were standardized. Subsistence benefits were increased and extended for as long as needed. Contributions were to be made at flat rates by the state, employers, and individuals. Authority for the whole scheme would be nationalized, and to provide protection from health-related poverty, all medical care would be free at the point of service.[39]

The report was received with great public enthusiasm—Beveridge was photographed wherever he went—and the war was an important reason why. Where class had long divided the British, the war had a strong homogenizing effect. Families of all stripes shared air raid shelters together. Classes were mixed in the military and in relocation schemes. All shared the war's costs and all shared a terrifying external enemy. In this climate, there was very strong popular support for a socially equitable package of protections. Although politicians resisted initially, these principles were adopted largely unaltered and the NHS was established in 1948.[39]

The war also played a key role in the creation of the NHS's facilities and management authority. High casualty estimates prompted hospital construction throughout the country, widely dispersed for strategic reasons. These facilities then enabled the NHS to adopt a national presence from the beginning. The expectation of mass casualties also provided the impetus for coordinating all hospitals, some of which were run by local authorities and some of which were owned and run by independent private charities.[33]

As Dan Fox has argued, the NHS can be seen as a shift from the provision of cash benefits under earlier charity systems to the provision of health benefits. This possibility existed because medical knowledge had progressed sufficiently by the end of the 19th century. In the first proposals for a national health service in 1911, physicians were very supportive because they stood to benefit from this shift in orientation. In the NHS's launch of 1948 they were much more hesitant to support the scheme because of the implications of a single payer system. The cooperation of the British Medical Association was secured only after intense negotiation and promises to increase pay for physicians.[40]

Industrialization created the demand for increased social protection and also provided the economic resources to support Beveridge's plan. In constant units, GDP per capita rose by a factor of 3.5 between the Poor Law of 1834 and 1948 when the NHS was launched. That the UK was in a sharp recession in the late 1940s—1948's GDP/capita was only 87% of the wartime peak in 1943—suggests that the long-run growth may have been more important than the immediate economic climate. (All figures calculated from Maddison.[32])

SOCIAL PROTECTION AND INDUSTRIALIZATION IN THE US PROGRESSIVE ERA

Many of the same forces that shaped government social protection in Germany and the UK were important in the Progressive Era (1880–1920) in the United States, although contemporary health care arrangements in these countries have diverged widely since. As in Europe, industrialization in America exposed workers to new dangers while simultaneously disrupting traditional village and family support structures. And as in Europe, the growing economic importance of industrial workers brought increased political significance to their concerns, particularly through large unions

such as the American Federation of Labor, led by Samuel Gompers. Progressive Era reformers lobbied successfully for greater protection in many areas, which often came in the form of government regulations limiting big business or establishing health and safety standards. For instance, the Interstate Commerce Act (1887) and the Sherman Antitrust Act (1890) gave the government the power to regulate industries and curb monopolies. The National Child Labor Committee (1904) was an important step in eventually outlawing underage employment. The Pure Food and Drug Act (1906) was among the most important legislative steps toward establishing the Food and Drug Administration. At state and local levels, too, public health authority expanded rapidly through boards of health and medical licensing boards, for example. Workman's compensation laws were enacted in almost all states between 1911 and 1920. Progressives also argued for government-backed social protection in health, particularly during and after WWI, but ultimately they failed in this objective. In an era noted for expanding government authority and increased individual rights, it is striking that reformers were unable to realize their aims for some sort of government guaranteed health coverage system.

Economic historian John Murray has explored the political economy of health coverage in the Progressive era and has offered compelling explanations for the outcomes observed. As Murray reviews, US industrial workers in ill health relied on their savings, coworkers, charities, and sickness funds. The sickness funds were usually organized under a particular employer, or were operated by unions for their members—much like in Germany. These mechanisms provided "sickness insurance," a term that fell out of favor as overly Germanic and was replaced by the more English "health insurance" during WWI.[25]

The American Association for Labor Legislation (AALL) was the most important advocate for mandated health insurance, in Murray's analysis. In 1915, the AALL proposed a standard bill at the state level, which drew heavily on German examples and called for contributions from the employer (40%), the employee (40%), and the state (20%). Within two years, the legislatures of 15 states had considered the bill, and by 1921 11 states had produced detailed reports on health insurance. But no state ever passed the bill and only in New York did it pass even one legislative house.[25]

One obstacle was that the AALL had the support of only a tiny fraction of the nation's workers, even if "labor" was part of its name. Many workers were only interested in sick pay—a need already met by sickness funds—and were reluctant to pay for medical coverage, which they believed would be ineffective. The American Federation of Labor President Gompers himself rejected the AALL template because it had compulsory enrollment, which denied workers' right to choice, and income limits, which promoted class divisions. Workers preferred voluntary schemes to avoid paying for unwanted services; many viewed compulsory schemes with extreme suspicion. On average, American workers in voluntary funds contributed only about half as much as contemporary German workers enrolled in compulsory funds, primarily because Americans wanted fewer benefits. Because the AALL bill did not specify organizational and payment mechanisms, physicians withheld support for fear they would work more and earn less.[25]

Sickness funds grew in number and membership during the Progressive Era. Murray estimates that by 1920, about 30%–40% of the US's 30 million strong industrial workforce was covered by private, voluntary sickness insurance. These affiliations covered about 10% of the country's total population. Workers preferred these arrangements because the coverage and the assessments were more predictable than charity schemes and carried no social stigma for beneficiaries. Employers found that such funds aligned well with their interests because they helped limit costly absences and promoted stability in the workforce. Review boards, which often included physicians, assessed claims and paid benefits. Some funds included medical advice and care benefits to try to minimize time and financial expenses. Because employees did not seek employment based on the insurance, moral hazard was limited. Waiting periods, medical exams, peer pressure, and occasionally age caps, helped limit adverse selection.[25]

Progressive Era reformers campaigned for government health schemes in part by emphasizing the deficiencies of sickness funds. They claimed that benefits facilitated by the government would be more certain than those dependent on private businesses. They argued that without regulation many workers would not be able to join funds, and those who did could not be sure of fair premiums and benefits. But workers were not swayed in sufficient numbers. Many were content with their own insurance. The bulk of those eligible but not enrolled were younger workers who did not expect to need insurance, and older workers who had accumulated sufficient precautionary savings. Voters were not interested either. In a 1918 referendum on state health insurance, California voters rejected the measure by a margin of almost 3:1.[25]

The American economy grew rapidly during the Progressive Era, rising about 75% in constant per capita units between 1880 and 1920.[32] On a per capita basis, American income was around twice that in Germany, where the list of professions subject to mandatory enrollment was growing quickly in the same period. This suggests that economic constraints cannot explain why the US government chose not to become involved with health insurance in the Progressive Era.

DISCUSSION

To structure a comparison of the three cases, I developed a framework based on the categories of analysis used implicitly or explicitly in the historical literature I reviewed (**Table 1**). I included a description of the UHC-related outcome and a brief encapsulation of circumstances in five areas: the cultural and legal heritage of social protection, the macro-historical conditions, the demand for increased social protection, the politics of expanding the government role in health care, and the financing and delivery systems that were used.

Considered together these cases suggest some common features of the processes and conditions that underlie an expansion of government health systems. First, the three cases portray the process as very long, reflecting incremental development of financing and delivery systems, as well as in the demand for social protection provided by the government. In all three cases systems for financing and delivering care were developed in advance of the national decision to expand (Germany, UK) or not (US), and were retained largely unchanged. In the US, workers continued to rely on private mechanisms, as they had before and still do today. The financing systems in each case had begun as specific, narrow initiatives aimed at workers, and in the two cases that have produced UHC, the direct process of doing so took about a century.

These outcomes reflect an evolution in the expectations held by citizens about the services provided by their governments, which have also evolved over long periods. In both Germany and the UK, the specific heritage of workers rights dated many centuries into the past, and even those had deeper roots stretching back another thousand years or more. As these countries expanded systems of social protection, it reflected a change in what citizens demanded. This point is highlighted by the US case because a broader role was not demanded by labor groups and was therefore not taken up by the government in the progressive era. The comparative weakness of labor groups in US politics is one reason that they did not form the core constituency demanding social protection as in Germany and the UK. Although the US government did not act in the Progressive Era, the incremental expansion of benefits for the elderly and the poor with Medicare and Medicaid in the 1960s and the insurance mandate for most others through the Patient Protection and Affordable Care Act of 2010 suggest that weak demand by labor groups delayed rather than derailed the country's path toward increased social protection.

The dynamics of the three examples reveal that the UHC discussion is highly political and has unfolded according to normal political processes in each country. That UHC is political is intuitive because it concerns rights to benefits, responsibilities to pay, and fundamentally rests on redistributing resources from some groups to others. In Germany Bismarck used social protection as a bargaining strategy to win the political support of industrial workers. In the UK, industrial workers used their own importance in the war effort to leverage government action. In the US, reformers, workers, and other spoke in popular discourse, referenda, and a few formal votes to indicate their satisfaction with existing arrangements and their expectation that the government would not do better.

In each case, the social protection decision was taken within a time of broader social upheaval. Industrialization changed the structure of economies and societies. National unification, war, and more broad shifts in the relationship between governments and their citizens formed the background to the UHC discussion. This suggests that some larger social turmoil may be required to open a window of opportunity for UHC.

These three episodes all unfolded in times of long-run economic growth, but the US case shows that fiscal space alone does not lead to expanded government roles in health care. Similarly, none of these progressions stressed innovations in care quality, delivery mechanisms, or even financing mechanisms. In each case, the existing mechanisms were adapted with very few changes.

REFLECTIONS FOR LOW- AND MIDDLE-INCOME COUNTRIES

This investigation contends that historical inquiry can improve global health policymaking by providing insights into the political economy processes that characterize policy design, implementation, and adoption. Large questions about health systems, national progress, and other long term phenomena are both hard to specify and important to understand for those who would like to foster progress in these dimensions for developing countries. This examination of the three cases provokes five reflections for policy makers wishing to promote progress toward UHC and the agencies that assist them.

First, the cases exhibit autonomous evolution in three countries that are developed and wealthy. Formerly colonized countries were prevented from realizing their own independent development, which has been reflected in far worse outcomes in almost any measure. Colonization and other forms of external interference may have increased demand and solidarity among indigenous citizens, but they severely limited the development of economic and health systems needed to fund and provide care. These areas of financing and provision systems appear to hold opportunities

for technical advice and potentially financial support from development assistance agencies.

Second, UHC is intensely political and is characterized by domestic political debate. The role for international assistance in that process is unclear, because citizens themselves must decide what services they want, how those should be distributed, and which groups will provide the resources. Redistribution is required when expanding beyond formal employment groups, which in turn requires high population solidarity—another domestic political factor.

Third, in the long-term process of UHC, small steps in the three cases were very important. The arrangements that covered nearly all Germans or Britons were built over about a century in each case. If President Obama's Affordable Care Act succeeds then the US, too, will have taken about the same amount of time. This suggests that countries and development agencies should embrace opportunities of any size, and not necessarily look for chances to make sweeping changes rapidly.

Fourth, UHC financing drew on existing systems, but not necessarily health financing specifically. Although there are consequences to funding health services with general tax revenues versus insurance, there is no evidence that one system is better than another. These cases suggest that whatever heritage exists in a country should be the basis for further progress toward UHC.

Fifth, although the three cases cannot support a formal analysis of the effect of state capacity, it is intuitive that UHC rests on the strength of the state to facilitate the collection and redistribution of resources and regulate the subsequent provision of care. Weaknesses in the state—for instance, if it does not respond to the demands of all citizens, or if it does not have reliable or fair revenue generation mechanisms—are likely to limit its ability to move toward UHC. Thus another opportunity for development assistance agencies may lie in strengthening state capacity more generally.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

No potential conflicts of interest were disclosed.

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NOTE

[a] A PubMed search for the quoted phrase "Universal Health Coverage" identifies 207 papers in the last five complete years (2009–2013), compared with a combined total of 65 papers from all previous years. Search conducted 12 July 2014 using date range filters.

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